Enseñanzas y Mareaciones¹:
Exploring Intercultural Health Through Experience and Interaction with Healers and Plant Teachers in San Martín, Peru

by

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B.A., University of Victoria, 2003

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MASTER OF ARTS

In the Department of Anthropology

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University of Victoria

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¹ Spanish translation for: Teachings and visions.
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Abstract

This research thesis explores how healers in the Peruvian Upper Amazon experience and negotiate their roles and knowledge systems at the interface of Amazonian, Western scientific and other medical knowledge systems at the confluence of community and environmental health. Experiences of identity, practice and place feature in this research among selected healers in the region of San Martín, Peru. Relationships with nature have sustained Indigenous populations in this region, and economic pursuits of natural resources have attracted many populations to the Upper Peruvian Amazon, making it an interesting site for the analysis of healers’ experiences at the interface of different knowledge systems. An emergent objective of this thesis has been to provide what healers in the region expressed to me as a need for an experiential approach to research on local medical knowledge systems. The resulting thesis is an ethnography of my experiences learning from healers and plant teachers about intercultural health initiatives on a regional level in Peru.
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CHAPTER 1
BACKGROUND

1.1 GENERAL INTRODUCTION

Experience of identity, practice and place form the basis of analysis for this study of contemporary medical knowledge systems among selected healers in the region of San Martín, Peru. Relationships with nature have sustained Indigenous populations and economic pursuits of natural resources have attracted many populations to the Upper Peruvian Amazon. These people and their knowledge systems are situated at the confluence of the past and present and expectations for the future. At this confluence in San Martín, a casual conversation with a farmer walking back from his chacra\(^2\) can reveal his opinions about American pop culture, terrorism and being caught between military and guerilla conflict. More in-depth discussions with farmers and healers reveals how medical knowledge systems are shaped by experience of identity, practice, place, and history.

Situated at the interface of historically-situated spheres of interaction, and at the confluence of Amazonian, Western scientific and other traditions of medical knowledge systems, the healing practices of local healers in the Peruvian Amazon provide a unique insight into the dynamic and interactive processes of knowledge acquisition, production, transmission, negotiation, use and translation. Perceptions of nature and spirituality also play a vital role in shaping local medical knowledge systems.

\(^2\) Cultivated land of the campesino or farmer.
1.2 Objectives

The objectives of this thesis are, primarily, to explore how healers in the Peruvian Upper Amazon experience and negotiate their roles and knowledge systems at the interface of Amazonian, Western scientific, and other knowledge systems, and at the confluence of historical processes and future expectations concerning contemporary community and environmental health. To explore the interface of medical knowledge systems and community and environmental health development, I attended local public health workshops, visited the centers of two non-government organizations working in community health projects in the region, and conducted a series of interviews with local healers.

A secondary, and emergent intention of this thesis, is to provide what healers in the region expressed to me as a need for an *experiential approach* to research on local medical knowledge systems. It was suggested by the healers that objective or external analysis of medical knowledge systems have fallen short of understanding the paramount importance of *experience* in health and healing. Taking the healers’ suggestion into consideration, following anthropological attention to the significance of embodied experience (see Csordas 1994), and answering to a large body of resource management and development literature that calls for closer attention to local knowledge systems (Ellen et al. 2000; Mackinson and Nøttestad 1998), chapter two of this thesis provides an in-depth discussion of experiential methods and how these methods have influenced me as both researcher and patient. Although I do not suffer from drug addiction, I attended regular healing rituals and ingested plant medicines, participating as a general, visiting patient at the Takiwasi Center for Research and Drug Rehabilitation. The ailments I was
treated for ranged from general nerviosidades or emotional anxieties, to specific physical illness such as giardiasis.

In this chapter, one, I have provided an overview of the objectives, terminology and research context for this thesis. In chapter two, I describe my methods, specifically the experiential approach that became a vital part of my research. In chapter three, I situate healers’ experiences within the theoretical framework of political ecology through a brief historical review of the region of San Martín, and national health initiatives in Peru. Chapter four outlines how my experiences of local NGO workshops contributed to my research and understanding of medical knowledge systems in the area of study. The interviews I conducted with healers are described in chapter five.

1.3 OVERVIEW OF TERMINOLOGY

In the context of this study, negotiation is a term used to describe the processes of discussion, contemplation, conflict, resolution, creative innovation, and selective practice whereby knowledge systems are adapted to accommodate and integrate different ideas and values. This research is focused on how local healers in a region of San Martín, Peru negotiate, practice and experience healing in the context of influence from and collaboration with other knowledge systems and practices. Of specific interest is how local healers interact with health practitioners of various different medical backgrounds, such as western-trained doctors and psychologists, as well as with researchers, developers, resource managers and policy-makers from other regional and international communities beyond the community of study. I focused on these interactions with the
intention of identifying obstacles to and opportunities for collaborative community and environmental health initiatives.

**Knowledge systems.** In the Amazon of Peru, people and their knowledge systems are not isolated from the influences of colonialist and neocolonialist resource exploitation, capitalist expansion, international economies of trade, politics and religion. Even the few indigenous groups who exist in relative isolation today (see Huertas Castillo 2004) have experienced and continue to experience the changing social and environmental landscape of capitalist expansion. Local systems of knowledge in Amazonian communities are not exclusively “local” or static. Contemporary local medical knowledge systems are a result of the synthesis of many knowledge systems intertwined through a long history of indigenous and introduced practices.

Pottier explains that knowledge production “is embedded in social and cultural processes imbued with aspects of power, authority and legitimation” and suggests that “the act of producing knowledge involves social struggle, conflict and negotiation” (Pottier 2003:2). Brodt outlines a model for knowledge systems to be “viewed as composed of hierarchical levels of abstraction, ranging from concrete practices to abstract concepts” (Brodt 2001:102). These explanations for what constitutes knowledge and knowledge systems address the dynamic processes that shape perception and practice. Rigid categories that define local and non-local knowledge systems, therefore, may or may not be adequate to explain the complex processes that contribute to the creation, change, disintegration and regeneration of knowledge systems. As departure points, I have chosen to use the terms “local Amazonian” and “Western scientific”, recognizing
that sometimes, by trying to distinguish these knowledge systems, practices, and identities from one another, I contribute to a bounded and static perception of entities rather than considering knowledge systems, practices and identities as dynamic and integrated processes. In some instances of community development, policy and practice, for example, local knowledge may be considered inferior to non-local, scientific or Western knowledge, while in other cases, local, traditional, or Indigenous knowledge may be romanticized and considered as superior to non-local knowledge systems and practices (Conklin 2002). In this research I have attempted to refrain from categorizing knowledge systems and, rather, to record the categories suggested by the healers while focusing on the interactive nature of knowledge systems.

Equity. Discourse on sustainable and culturally appropriate development has identified equity as an essential feature to be integrated into the development process, especially concerning issues of intellectual property rights (Arce and Fisher 1996:78; Mertens et al. 2005:115; Rosenthal 2006; Sampath 2005:54). Equity involves the recognition of subjugated peoples and knowledges, respecting their insight into issues of community and environmental health, and facilitating their access to resources and control over intellectual property. Mertens et al. (2005:115-116) suggest that the concept of equity has been developed out of concerns for the inclusion of women’s perceptions, problems and differing experiences in participatory research and community development. They

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3 Intellectual property rights (IPR) are defined as “a particular aspect of property covering ‘all things which emanate from the exercise of the human brain’ (Philps and Firth 1990 in Swanson 1995:181). Swanson explains that “the major intellectual property rights are patents, plant breeding rights, trade secrets, trade marks and copyright. The general principle behind IPR protection is that the ‘right holder’ is given some form of monopoly control over the economic exploitation of the material concerned” (Swanson 1995:182). (see also Brush 1993; Rosenthal 2006; Sampath 2005; Tsioumanis et al. 2003).
point out that feminist theories and practices have contributed to identifying obstacles and opportunities for the participation of women in community development issues.

Reductionist, dualistic categories and assumptions about knowledge systems and practices have been critiqued by feminist, political ecology, and development anthropologists as being problematic in both discourse and development initiatives. Assumptions and generalizations of knowledge systems and practices often deny the rights and insights of marginalized peoples and knowledge systems to be considered in defining access to their own resources and destinies, or attribute these systems and practices with a false perfection that may lead to unrealistic expectations (Bradiotti, et al. 1994; Plumwood 1993; Pottier et al. 2003; Shiva 1989). To avoid either delegitimizing or romanticizing local knowledge, it is suggested that we focus on how knowledge is situated within a wider social and historical context, continually changing in response to power relations and the influence of non-local knowledge systems and practices (Pottier 2003).

In the interest of evaluating sustainable\(^4\), appropriate, equitable, and effective collaboration strategies between different knowledge systems and practices to address community and environmental health issues, my research has focused on how healers describe their practices, if and how different medical knowledge systems are categorized or ranked, and how medical knowledge is negotiated at a community level— all within the context of healers’ social, economical, environmental and cultural relations.

\(^4\) Sustainable development is a term coined in the Brundtland Report *Our Common Future* in 1987 to describe: “Development that meets the needs of the present without compromising the ability of future generations to meet their own needs” (Lebel 2003:7).
Kincentric and relational views. Challenging development and research that reifies bounded assumptions of local and non-local, male and female, nature and culture, and other categories of knowledge and identity, some scholars are calling for a “kincentric” (Turner 2005:69) or “relational view of both organic and social life” (Escobar 1996:10; Ingold 2000:133; Pottier 2003:2). While the kincentric worldview specifically relates human, animal, and plant life through kinship ties, the relational view takes into consideration all elements contributing to community and environmental health, and promotes an understanding of the relations, local, non-local and otherwise, between these elements, rather than focusing exclusively on their distinctions. Similarly, the concept of socioecological systems, as proposed by Berkes and Folke (1998), has been drawn upon by researchers to “overcome distinctions between social systems and ecosystems” and to “provide a platform to address both the social and ecological contexts of human health” (Dolan et al. 2005: 196). Dolan et al. (2005:197) advocate for a socioecological approach suggesting that “it reflects the notion that human, community and biophysical health are interdependent, that the resilience (health) of a socioecolgical system is determined by both ecological and social factors, and that any understanding of health must integrate these biological and social explanations within a broader understanding of the political economy”. In my research I observed a kincentric worldview among select healers in San Martín. I propose that this kincentric worldview fits within a relational view of both social and ecological systems among these healers and is a fundamental element of their

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5 Turner (2005:93) describes a “Kincentric” approach to nature whereby environmental features and entities are imbued with humanness and are all related to us and to each other. Descola and Pålsson (1996:7) also explain that the Achuar Jivaro of the Upper Amazon: “consider most plants and animals as persons, living in societies of their own, entering into relations with humans according to strict rules of social behaviour: game animals are treated as affines by men, while cultivated plants are treated as kin by women”.
medical knowledge systems. Inquiring into community and environmental health with a *kincentric, relational, or socioecological* approach fits within the scope of the ecohealth approach.

*The Ecohealth Approach: Community and environmental health.* This research project follows concerns expressed in ecological, anthropological, and development literature that call for recognition of connections between human health, environmental health, and socio-economic factors (Berkes et al. 2000; Folke et al. 1996; Colding and Folke 2001; Dolan et al. 2005; Lebel 2003).

Recognizing these connections relies upon understanding local knowledge systems and practices concerning issues of community and environmental health (Lebel 2003:8). The Ecohealth approach, as outlined by Lebel for the International Development Research Center (IDRC) of Canada, asserts that human health and ecosystem health are inextricably linked, and therefore that researchers, community groups, and decision-makers should use the Ecohealth approach to guide human and environmental health development (Lebel 2003; Mertens et al. 2005:114). The three main tenets of the ecosystem approach are cited as *transdisciplinarity, participation,* and *equity* (Mertens et al. 2005:114).

In communities facing the dynamic processes associated with globalization⁶, such as market integration, economic development⁷, shifting subsistence strategies, and

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⁶ Heyck explains that globalization usually refers to the process of worldwide economic integration and may be viewed as an outcome, a carrier, and a feature of development. Globalization brings with it transnational integration of markets, products, and communications networks with social, political, and environmental systems to a degree previously unknown and unimagined (2002).

⁷ Economic development is a term used to describe the activities associated with development through economic growth. Basically, it refers to economic transformation whereby governments, international
urbanization, (ie: restructuring\(^8\)), resulting in negative and positive impacts on community and environmental health, the need to define appropriate strategies to integrate knowledge systems to address the associated impacts becomes paramount (Brodt 2001; Heyck 2002). Several studies and projects have demonstrated that community involvement and respect for local knowledge are fundamental to effective development strategies. There are several examples where large scale development projects involving agriculture, mining, and urban expansion have not taken local insights and concerns into consideration and have had degrading, toxic and even fatal outcomes for local communities\(^9\) (Lebel 2003, Pottier et al. 2003). These examples emphasize the need to focus on local voices. Jovel (1996: 31) proposes that the integration of Indigenous, Mestizo and Western science and technology is vital for improving natural resource use and contemporary conditions for people living in the Amazon Basin.

Landy (1977:468) suggests that due to the proximity of healers to processes of life and death, the role of healers may be more sensitive to the forces of change in any social system. Healers using plant medicines are also in an interesting position of being dependent on ecosystem health to provide the necessary remedies for human health. For example, Jungerius’s (1998) study of traditional herbalists in the Keiyo district of Kenya

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\(^8\) Restructuring is referred to by Dolan et al. (2005: 197) as “the human-induced acceleration (deceleration) in change in the statistical, spatial, or temporal distribution of a measurable physical, biological, economic, or social variable”.

\(^9\) Lebel (2003: 15), for example, outlines the case of an agricultural production boom and hydroelectric dam on the Sassandra River in Buyi, Côte d’Ivoire which resulted in economic, environmental, and social problems including pesticide pollution and inadequate waste management. Lebel (2003: 17) also describes the implementation of government policies in Chile and Argentina that have ignored the concerns and voices of the Indigenous Mapuche peoples leading to serious problems of poverty, poor health, and ecosystem degradation.
highlights herbalists’ connection to their environments by exploring their general landscape-ecological perceptions developed through plant harvesting, their knowledge of landscape-ecological factors determining plant growth, and the herbalists’ ability to deal with environmental change such as deforestation and soil degradation.

With healers’ involvement in both human and environmental health, a study of their perceptions of contemporary conditions for addressing community and environmental health proves insightful. To explore the connection between healers in San Martín and their environments, I have asked them to describe their healing practices and other livelihood activities, such as farming, that involve plants and to explain to me if and how they perceive a relationship between community and environmental health.

**Traditional, Indigenous, and Local Knowledge.** Among international resource managers and health practitioners, pharmaceutical companies, non-governmental agencies (NGOs), policy-makers and development planners, what is considered traditional, Indigenous, and local knowledge is being sought out for expertise in medicinal plant use, the potential role in maintaining community and environmental health, managing resources, and for its value to the political and economic identity of Indigenous peoples (Ellen and Harris 2000:22; Green 2004:213; Wayland 2003:483; Sillitoe 1998; Scott 1997). Scientific and multidisciplinary studies have begun to integrate local knowledge into areas such as resource management (Berkes 1999) and medicine (Brush 1993; Heggenhougen 1984; Greene 1998; Wayland 2003; see Callaway et al. 1996; 1998; 1999). In the context of medical knowledge systems in the Peruvian Upper Amazon, my research examines how different knowledge systems can be
appropriately integrated to address community and environmental health, whether or not dichotomous categories of knowledge systems present obstacles to integration, and if there are appropriate measures already in place to integrate knowledge systems.

**Healer, curandero.** In this thesis, I use the term healer or *curandero* to describe individuals who have undergone a process of apprenticeship in Amazonian medicine and who practice Amazonian medicinal techniques, though not necessarily exclusively using plant preparations, ritual and spiritual intervention. I do not use these terms healer and *curandero* as synonyms for “doctor”. I reserve “doctor”, or “*medico*”, as a term to specifically describe medical physicians who are trained in Western medicine. Two of the healers interviewed for this study are also Western-trained doctors. All healers in my study practiced Amazonian methods of healing.

**Practices**, in the context of my research, will be defined as experienced or embodied knowledge as it is employed in everyday or specialized actions and interactions. There are many terms in discourse and literature to describe healing *practitioners*. These include, but are not limited to, Healer, Doctor, *Curandero*, Sorcerer, Herbalist, *Vegetalista*, Witch, *Bruja*, Shaman, Nurse (Miles 1998:209; Glass-Coffin 2001; Landy 1977; Luna 1984a). For the purpose of this research, the term “healer” will be used to describe those people engaged in the practice of patient diagnosis, treatment, and the administration of medicine.

I have outlined shamanistic practices (below) because the literature suggests that shamanistic healing is a prevalent knowledge system in the region of study (Luna 1992;
Mabit 2001; Narby 1998). However, it was made clear in my fieldwork that although healers in San Martín are often referred to as shamans by others, they do not usually refer to themselves as shamans, but rather as curanderos, or vegetalistas.

**Identity** distinctions may be a factor contributing to the definition, validity, accessibility, production and negotiation of knowledge when dealing with issues of community and environmental health. Identity is influenced largely by history. For example, in Peru, distinctions between Indigenous, Mestizo, and White are rooted in colonial chronology, placing “Indian” and “Spanish” (or “White”) on either end of the linear continuum. Indian is often associated with the past and traditional ways, while Spanish or White is often associated with present and modern ways. *Mestizo* is a problematic category that lies somewhere in between these two extreme identity categories. In Amazonian contexts, the term Mestizo is very vague, meaning anything from acculturated, deculturated Indians, to various mixtures of white and Indian, to poor immigrants (Gow 1996:98; Luna 1984:31). The terms Indigenous and Indian are also difficult to differentiate. Gow (1996:98) describes Indians as “those people who are indigenous to the area, bearers of an authentic indigenous culture until the forces of acculturation sweep over them”. In anthropological literature, Indian and Indigenous are often used interchangeably. Ramos (1998:6) states that, unlike the negative connotations associated with the term Indian in Ecuador or the United States, which has been replaced with terms such as nativo or Native American, there are positive associations with the term Indian in Brazil. She explains that the indigenous movement of the 1970s and 1980s “reappropriated the term and infused it with a substantial dose of political agency”.
Indian (translated as *Indio*) in this context, comes to represent social actors whose ethnic and cultural identity is differentiated from the rest of the population (Ramos 1998:6). In the region of San Martín there are contexts where the terms *Nativo, Indígena,* and *Indio* are used to designate social actors who, either independently or working with non-government organizations, assert Indigenous rights and promote Indigenous knowledge transmission.

Gow (1996:98) suggests that we have overlooked the ongoing social practices that shape the words *White, Mestizo,* and *Indian,* and that, *in situ,* “these terms are not used to define people in abstract cultural terms but to locate them in specific social relationships. Castillo shares a similar opinion, stating that “no society, however remote and isolated, can live in the past, nor live excluded from regional socio-economic processes” (Castillo 2004:20). These statements emphasize the need to bring our attention to the interwoven social processes that contribute to the creation of identity, which in turn, may influence our perception and acknowledgement of knowledge systems and practices.

To situate healers within social relationships my research has considered how healers identify themselves, to what extent their identity influences their healing knowledge and practices, and how their identity affects their role in the negotiation of knowledge about community and environmental health.

*Amazonian Healing Practices.* Healing practices, like identity, are also influenced by history and contemporary social processes. Shamanism has frequently been used in literature to describe the healing practices of healers and herbalists in the Peruvian Amazon. There is no universally accepted definition for the term *shaman.* Often used
interchangeably with the terms healer, or *curandero*, the term shaman typically refers to individuals engaged in practices of ritualistic healing. More specifically, the term shaman may refer to an individual who believes in a layered cosmology, has the ability to release his or her soul to the cosmos, and has command and control of the spirits found within the supernatural realm which influence human destiny (Vitebsky 1995:184). The significance of these realm-transcending abilities is rooted in widespread belief among many Indigenous peoples, including those of Amazonian regions, that illness is caused in part by the supernatural realm, and that disease may be a loss of the soul, which has been led astray or taken by a spirit (Luna 1992:232; Eliade 1964:327). The power of the shaman resides in the ability to glean from the unknown some knowledge that will aid in alleviating the suffering of others (Glass-Coffin 1998:141).

Thomas and Humphrey (1996:1) feel that the political and social environments of shamanism have been largely overlooked in the process of defining generalized characteristics of the practice. Press (1971:743) refers to healers in his research as *curanderos* and complains that the creation of *curandero* categories has been done to the exclusion of understanding how their practices are defined by the particular milieu they serve. In his opinion scholars studying Latin America reify the stereotypes of what constitutes a “real” *curandero* (Press 1971:741.). The generalized characteristics of the *curandero* outlined in such studies highlight the shaman’s concern for the community, their lack of motivation by profit, and their religious identity among other themes (Press 1971:741). Press asserts that these generalizations deny the dynamic role of *curanderos*, as well as their dynamic participation in the global community as professionals and creative agents (Press 1971:741). Landy (1977) also emphasizes the creative agency of
healers. He describes the traditional healer “not merely as passive receptor of
modernization, science and technology, but as an incorporating technocultural agent and
as creator of new technocultural syntheses. The curing role is not only changed, but
resynthesized” (Landy 1977:471). A collection of studies on “Shamanism, History and
the State”, edited by Thomas and Humphrey (1992) provides more recent assertions
about the contemporary role of healers as political agents.

To ascertain the contemporary role of healers in San Martín, I have participated in
several medical treatments and healing rituals, observing the innovations, collaborations,
and integrations of medical knowledge systems, while also taking note of the significance
of the social, political, economical and environmental contexts in which these healers are
practicing.

Vegetalismo. My research project has involved working with healers trained as
Vegetalistas. In regions of Amazonia, Vegetalistas are plant specialists who have
acquired their knowledge from a variety of plants known as doctores or plant teachers,
and use this knowledge for diagnosis and sometimes healing (Luna 1986:32, 1984b:135).
In his study of vegetalismo, Luna inquired into the nature and identity of healing plants,
the dietary requirements of the healers, the transmission of shamanic power, the nature of
the “helping spirits”, and the function of the icaros given to healers by their plant
teachers (Luna 1984b:135). He found that under the title of vegetalista are many

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10 The word Icaros seems likely to “be a castilianism derived from the Quechua verb ikaray which means
‘to blow smoke’ in order to heal”. Icaros themselves are melodies taught to healers by the ingestion of
plants teachers. They are sung for the preparation of remedies, during healing sessions, and other activities
such as fishing (Luna 1992:233).
specialists including *purgueros*, who use *Ayahuasca*\textsuperscript{11} as a purgative; *tabaqueros*, who use tobacco; *camalongueros*, who use the seeds of camalonga (*Thevetia peruviana*); *tragueros*, who use caña— a strong alcoholic beverage distilled from sugar cane (*Saccharum officinale*); and *perfumeros*, those who use the essence of flowers (Luna 1984 b:136). Primarily, the various *vegetalistas* claim to acquire their knowledge from the plants through a program of isolation and strict diets. During these diets, the *vegetalistas* are taught by plants how to diagnose and cure illness, how to perform other shamanic tasks through magic melodies known as *icaros*, and how to use medicinal plants (Luna 1984b:135). Transmission of power from the plants involves an exchange of *yachay, yausa, mariri*, which refers to “knowledge” (Wamanwasi 2006:5) or “medicine”, in the form of a phlegm, usually imparted from the plant teachers or spirits themselves, a human teacher, or both (Luna 1984b:143). This phlegm will enable the healer to suck out illness from the bodies of patients. Learning powerful *icaros*, the melodies imparted by the plants, is also essential to the practice of the healer. Understanding that the transmission of medical knowledge relies upon relationships established with plants and spirits of the supernatural realm, is fundamental to understanding contemporary medical knowledge systems in the Peruvian Amazon.

*Transmission of Knowledge.* As Jovel (1996:24) points out, “knowledge of medicinal plants is embedded in oral tradition”, and “understanding of the physical environment, growth habits of medicinal plants and their association with other plants or animals

\textsuperscript{11} Discussed in more detail in Chapter 2.
provides the healer with very strong tools”. All of the healers of Luna’s (1984a:125; 1986:41) studies trace their medicinal expertise to the plants’ wisdom. Their access to the plants was determined by their work in the jungle environments and with other healers, mainly Indians, they met through the rubber trade and extraction of other jungle products. Luna describes *vegetalismo* as *Mestizo* shamanism that “is the product of the syncretism of the shamanism found among several Indian tribes and European religious traditions” (Luna 1986:41). His research suggests that socio-economic processes, such as the rubber trade, have greatly influenced the transformation and transmission of traditional healing practices in the Amazon. Migration through resource exploitation, the rural-urban interface, and contemporary processes of globalization provide interesting sites for the analysis of identity and healing.

**Globalization and the Rural-Urban Interface.** Urban healers in many cities of Latin America are often assumed to have derived their knowledge from ‘authentic’ Native sources. In Bogotá, urban healers observed by anthropologist Irwin Press (1971:744;746), claimed to have learned their trade “from ‘Indians’ and improved it through books”, or were born with special diagnostic powers in their hands, but also “learned to cure…from Indians in the jungles of Ecuador”. Although there is evidence to support the transmission of knowledge from rural to urban areas, there is no reason to limit the transmission in one direction. De Rios (1996:173-175) observes that “folk healing practices in urban jungle areas, including the Amazon city of Iquitos, represent a complex amalgam of traditional healing practices and twentieth-century medical science” and that this “kind of urban drug-adjuncted healing …must be viewed also as a complex
interweaving of tribal Indian beliefs with a minimal admixture of Mestizo Roman Catholic religious ideology”. DeRíos’s description of complex interweaving addresses the transcendence of, and interface between supposed dichotomies of knowledge systems that have been debated, including the dichotomy of traditional versus modern, or tribal Indian versus modern medicine.

Although the origins of knowledge are influential to the practice of healing, other anthropologists have critiqued research emphasis on where knowledge comes from. In his analysis of an “urban curandero complex”, Press (1971) challenges our tendency to narrow our focus on the origins and practice of healing. Press (1971:742) acknowledges that urban healers, in competition with hospitals, pharmacies, patent medicines, physicians, emergency centers, ambulance services, herbalists, curanderos, “spiritists”, homeopaths, naturopaths, osteopaths, etc., would necessarily have to be innovative. Although Press (1971:743) outlines previously studied categories for urban shamans, including: 1) brujas (witches), 2) spiritualistic mediums, 3) herbalists, and 4) sub-professionals, he maintains that typology studies as such are constrained and not conducive to understanding the complex relationship or influence of environmental and social phenomena. Press also calls attention to the expectations sewn into these categories which become problematic when individual behaviours transcend their stereotypes. To accommodate for healers’ individual innovation, and evasions of typecast, Press suggests opening up analysis to more stylistic descriptions. This approach would demonstrate the personality and creative human agency of urban healers.

Human agency and diversity resist confinement to the dominant directions of information flow. Vitebsky (1995:183) calls our attention to the dominantly perceived
pathways of information and challenges “any smooth model of ‘globalization’ as a one way current, an acculturation leading implicitly to a cultural homogenization”. Vitebsky critiques a one-way model whereby globalization is passed from ‘modern’ to ‘traditional’ societies, implying the subsumption of the latter by the former. In this model modern technology is adapted by the traditional people, and sometimes traditional knowledge is integrated into modern knowledge. An example of this model can be found in agricultural and medical development strategies whereby modern technologies, such as those implicit in the “green revolution”\textsuperscript{12}, are introduced to “traditional” or “developing” communities to “improve” agricultural practices. The use of quinine to treat malaria\textsuperscript{13} is an example of the integration of “traditional” knowledge into “modern” knowledge, or, more specifically, “traditional” medicine into “modern” medicine. Vitebsky (1995:183) contests a single direction flow of knowledge, however, and suggests that we regard “the global process as a continual realignment of a system of epistemological and political relationships”.

\textsuperscript{12} The “Green Revolution” refers to agricultural development that is based on industrial inputs such as chemical fertilizers and pesticides, mechanical cultivation techniques, and new crop varieties (such as genetically modified seed varieties. In Latin America, strategies of the “green revolution” created a sense of dependency on Western technology and markets due to the replacement of local crop varieties with genetically “improved” varieties, the “introduction of energy and capital intensive mechanized farming and the destruction of prehistoric agricultural infrastructure” (Erickson 1992:3).

\textsuperscript{13} Quinine, also known as Peruvian Bark, is harvested from several species of \textit{Chinchona} spp. During the Spanish conquest of Peru, the Spanish invaders were introduced to the bark of a rainforest tree that was used by the Indigenous population to treat fevers. There are several legends surrounding the transfer of this medical knowledge between the Indigenous peoples and the Spanish invaders. It became apparent to the Spanish that the bark of \textit{Chinchona} spp. could be used to treat malaria. In 1820, French chemists isolated the alkaloid quinine from the bark. Due to the high demand for this medicine, vast amounts of \textit{Chinchona} spp. were harvested and exported from South America to Europe. Colombia, Peru, Ecuador and Bolivia held a monopoly on the production of \textit{Chinchona} spp. through restrictions on the export of seeds and living plants. There is a whole history of seed smuggling that took place as Dutch botanists and the Dutch government colluded to cultivate \textit{Chinchona} spp. in Java and US botanists and the government smuggled and cultivated \textit{Chinchona} spp. for the War effort in 1942 when US troops in Africa and the South Pacific were suffering from malaria (Balick and Cox 1997:27-31).
Gow’s (1994) studies of shamanism also challenge the one-way flow of information. He suggests that urban shamanism is exported to rural areas. He challenges the idea of *Ayahuasca* shamanism as ‘authentic’ Indigenous knowledge, suggesting that it is actually urban knowledge that is transmitted to rural areas through socio-economic relations. He presents the argument “that *Ayahuasca* shamanism has been evolving in urban contexts over the past three hundred years, and that it has been exported from these towns to isolated tribal people to become the dominant form of shamanic curing practice” (Gow1996:91). Gow situates the *Ayahuasca* curing ritual within the context of the extractive industry, subsistence economy, and class relations in Amazonia. He attributes the expansion of *Ayahuasca* shamanism into “the world of forest Indians with the expansion of rubber production and debt relations (Gow 1996:109). Data from previous research done by Gow in the western Amazon suggests that shamanism has been transformed since the period of the rubber industry expansion. Prior to the industry, shamanism in Gow’s area of study was focused less exclusively on curing illness and more towards communication with forest animal spirits. Gow seeks to challenge the prevailing mentality that there exists an ‘authentic’, ‘pure,’ traditional knowledge among Indigenous Peoples that is static and unchanging. He asserts that *Ayahuasca* shamanism has developed through interactions dependent on socio-economic processes.

In my study of healers in San Martin, I have considered the socio-economic processes, such as the rubber trade and other economic resource booms and busts, as well as the environmental processes contributing to the negotiation of medical knowledge systems. I locate the healers experiences within the political ecology of San Martin.
**Political Ecology.** Political ecology is defined as combining “the concerns of ecology and a broadly defined political economy. Together this encompasses the constantly shifting dialectic between society and land-based resources, and also within classes and groups of society itself” (Blaikie and Brookfield 1987:17 in Paulson et al. 2003:205).

Political ecology is also defined as “the study of the manifold articulations of history and biology and the cultural mediations through which such articulations are necessarily established” (Escobar 1999:3), and as analysis that places local struggles within the context of development and intervention strategies, environmental variables, and “the mediation of government bureaucrats at local, regional, and national levels” (Little1999:255). By using political ecology as a theoretical framework for analysis my research examines the lived experiences of local healers. It takes into consideration the contested categories of knowledge and identity, while paying close attention to the socioeconomic, political and environmental contexts contributing to the continual processes shaping knowledge and identity.

### 1.4 Research Context

The ethnographic core of this research concerns the experiences of, and my interaction with, healers in the Upper Peruvian Amazon, in the region of San Martín. From May to November of 2006, I lived in Tarapoto, San Martin, Peru, attended healing rituals at the Takiwasi Center for Research and Drug Rehabilitation, received psychotherapeutic follow-up treatment, attended workshops for local intercultural health initiatives¹⁴, and

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¹⁴ Intercultural medicine refers to medical practices that are designed to address knowledge systems and patients of various cultural backgrounds, within a mutually respectful and educational framework.
interviewed various healers. Increased urbanization, the presence of ‘professional’ medical clinics and pharmacies, the promotion of local medical knowledge through non-government and government health development programs shape the economic and social context of healers, health, and healing practices in this area.

The main motivation behind my ethnographic work in the region of San Martin is to communicate to the local, academic and foreign community the creative agency of local healers in negotiating their knowledge systems within changing social, ecological and economic environments. Through this work, I emphasize the notion that all knowledge systems are dynamic, intercultural, and creative reconstructions of past knowledge to address contemporary experiences.

Tarapoto is an urban center of over 120,000 inhabitants, located in the department of San Martín in the Peruvian Upper Amazon. These inhabitants are of Indigenous, Mestizo and European descent. The healers who agreed to participate in my research are also of Indigenous, Mestizo, and European descent, including one healer of Japanese Peruvian descent. As an urban center, Tarapoto is conducive to studying intercultural medical systems due to the presence of diverse health practitioners, practices and medical resources. Stores, clinics, pharmacies, and market stalls sell medical products along the full spectrum from whole plants to synthesized pharmaceuticals. Some health practitioners are found in their chacras\textsuperscript{15} cultivating plantains, administering the medicine Ayahuasca through evening rituals (discussed below) to patients in their palm-thatch houses, while other practitioners work in tiled city clinics with nurses recording the blood pressure, weight and temperature of patients in the waiting room. There are

\textsuperscript{15} Chacra— a cultivated field of the campesino or farmer.
some health practitioners who do both. Using Takiwasi as a base for my research, I met with various healers working at the interface of knowledge systems (mostly the interface of Western and Amazonian knowledge systems) who work at Takiwasi or in the region. I was introduced to Takiwasi through my partner Gonzalo Brito Pons, who is a psychologist and therapist at Takiwasi.

Takiwasi Center for Research and Drug Rehabilitation (www.takiwasi.com), a five-acre park bordered by a river and located on the periphery of Tarapoto in the high Amazon of northern Peru, is dedicated to the study and practice of Amazonian medical knowledge systems combined with other medical practices, including western psychotherapy. In 1992 a French doctor, Jacques Mabit, his Peruvian wife Dr. Rosa Giove and several associates opened the doors of Takiwasi, beginning a pilot program for drug rehabilitation. Enlisting the help of several master curanderos, healers, who were willing to share their knowledge and work within the guidelines of western psychology, Takiwasi invited patients to voluntarily participate in the development of appropriate and effective treatment. Situated near the Huallaga valley, the site of contentious coca cultivation and production of pasta básica, or coca paste\textsuperscript{16}, Takiwasi has attempted to confront local addictions to the paste incurred through drug trafficking activities. Beyond coca paste, other drug and alcohol addictions are treated at Takiwasi, with patients coming from local communities or abroad (Mabit with Sieber 2006).

\textsuperscript{16} Pasta básica or basic paste refers to the product of the initial phase of processing coca leaves into cocaine. In this process the coca leaves are placed in large tubs or troughs where they are doused with chemical solvents to separate the alkaloid cocaine from the leaves. The resulting paste is further refined to obtain cocaine powder. Not to be confused with the chewing of coca leaves, the consumption of pasta básica is highly toxic and addictive due to the residue of chemicals found in the solvents used to extract cocaine from the leaves.
Participating in day-to-day activities, healing rituals and the ingestion of plant medicines at Takiwasi both as researcher and visiting patient, I conducted my fieldwork using participant observation, an experiential approach and filmed interviews with local healers. In the interest of evaluating collaborations between different knowledge systems to address community and environmental health, I have used the ‘interface approach’ as described by Pottier (see Pottier, Bicker and Sillitoe 2003). Within the context of global change and planned development, this approach “explores knowledge as embodied practice”, with a focus on the negotiation and production of knowledge at interfaces between local communities and non-local agents of change (Pottier 2003:2). Pottier also emphasizes the need to avoid assumptions and rigid distinctions between the local community and non-local agents. He suggests that “detailed attention to knowledge interfaces allows us to study what happens when ‘local knowledge’—which means different things in different places, and different things to people who share the same space— is translated for the purpose of national or international use” (Pottier 2003:3-4). With this approach as a guiding principle, I collected information about the experiences of healers in this region through Takiwasi and other NGOs in the area. My methodologies are described in the following chapter.
CH. 2 METHODS
ENSEÑANZAS Y MAREACIONES:
EXPERIENTIAL AND VISUAL METHODS IN ANTHROPOLOGICAL FIELDWORK

... mas bien conocer que contar pues. Tomando cuentas como es...
... it is better to know than to tell. By taking [the medicine] you realize how it is...
— Cristobal Salas, Peruvian vegetalista, ayahuasquero

Images are ‘everywhere’. They permeate our academic work, everyday lives, conversations and dreams. They are inextricably interwoven with our personal identities, narratives, lifestyles, cultures and societies, as well as with definitions of history, space and truth.
2.1 INTRODUCTION

This chapter explores ethnographic knowledge through experience and images. Drawing upon my personal experiences of living in Tarapoto Peru, participating as a patient in Amazonian healing practices, attending and filming local health development workshops, and filming interviews with local healers, I focus on the relevance of experiential and visual methods as tools for ethnographic research. Although my intention in this chapter is to highlight multiple ways of knowing, this is done through sharing my own experience as a white, middle-class, North American, female, anthropologist, studying the approaches and practices of contemporary healers in the Peruvian Amazon, to create and represent ethnographic knowledge. To do this, I adopt Pink’s (2001:18) definition of ethnography as:

An approach to experiencing, interpreting and representing culture and society that informs and is informed by sets of different disciplinary agendas and theoretical principles. Rather than being a method for the collection of ‘data’, ethnography is a process of creating and representing knowledge (about society, culture and individuals) that is based on ethnographers’ own experiences.

This dynamic, subjective definition of ethnography calls for attention to the experience, interpretation and representation of knowledge, reflexivity on the agendas and theoretical principles framing knowledge, and communication of (re-)created or represented knowledge. Attention, reflexivity and communication feature in this discussion of my process of fieldwork, research analysis and distribution of results. First, I present a discussion of my use of experiential methods of anthropology including inquiries into the realities of ritual space, visions and dreams. Second, through a brief review of visual
anthropology and ethnographic film styles, I address the use of film to reflect reality, to
construct reality, and as a social interaction to stimulate engagement with realities. Third,
I outline and provide examples from my experiences and use of images as tools for
knowing, negotiating, and representing knowledge in ethnographic research. This
chapter outlines the role of experiential and visual approaches to ethnography in
providing insights into the relationships between ethnographer, participants and their
environment, leading to a broader intercultural dialogue that respects multiple ways of
knowing.

2.2 Experiential Anthropology

During my fieldwork, health practitioners at Takiwasi expressed a need for more research
that includes an experiential perspective of Amazonian medical practices. Too often,
they suggested, researchers come to observe medical practices and document knowledge
systems without knowing, experiencing or explaining how these knowledge and practices
actively work upon and change the individual. Taking this expressed need for attention
to, reflection upon, and communication of experiential knowledge into consideration, my
research experience and analysis has been done taking into account not only the
narratives and interactions with healers, but also how their knowledge and practices have
affected me. This also addresses the movement within anthropology away from notions
of “objective” research towards more transparent and admittedly subjective research (see
Young and Goulet 1994). Another expressed concern, in literature and among studied
communities and individuals, is that too much research has taken information away from
a community, leaving the participants with nothing to show for their participation (Pink
2004:11). In an attempt to avoid this lack of reciprocity, my research project has the objective of communicating the study’s results through written and filmed media that will be distributed to the healers and their communities. It is hoped that this will contribute to continuous constructive dialogue surrounding the knowledge explored in this research. In the following paragraphs I briefly outline experiential research theory and methods, including attention to experiences of *ritual space, visions* and *dreams* in ethnographic fieldwork.

Experience as a way of knowing is not a new concept. The experience of fieldwork has long been cited as a rite of passage for anthropologists (Chierici 1999; Wengle 1983). Being changed by experiences during research, especially what are considered ‘extraordinary’ experiences such as rituals, visions and dreams, and considering these personal experiences as data, however, challenges the notions of objective research upon which a positivistic approach to knowledge acquisition depends. Often, experience of the field is used to contextualize research, to set the stage, to describe the setting. Less often is personal experience actually counted as material for analysis. In a volume dedicated to anthropologists’ experiences of being changed through fieldwork, editors Young and Goulet (1994) stress the importance of communicating experiences of personal change in ethnography. They advocate for an experiential approach to the study of accounts of dreams and visions, whereby “investigators involve themselves as much as possible in the lives and rituals of the people they live with in the field” (Young and Goulet 1994:305). In this process, anthropologists themselves become the experimental subjects and consider their personal experience as valid data for analysis. This approach runs contrary to normative and
positivistic research methods that emphasize the importance of maintaining distance between oneself as researcher and those who are being studied (Goulet 1994:19). Traditional anthropological training calls for a ‘detached’ gaze through which the informants (‘other’) and their beliefs can be observed by the researcher (‘self’) to collect ‘data’ that can then be analyzed according to academic agendas, theoretical trends, and then translated, and published as ethnographies for the academic world (Bacigalupo 1999:35). From this practice of maintaining distance and detachment, the personal experience of ethnographers has gone largely unwritten in academic literature, relegated, most likely (if at all), to their personal field notes. While an ‘objective’ approach may avoid ethnographic accounts that are considered self-indulgent, trivial or heretical, it also denies the acknowledgement and relevance of researcher- researched relationships, interactions and intersubjectivity. Anthropologists, as a result, “inevitably provide descriptions and analyses of what others do, think, dream, see and feel, without ever portraying themselves as doing, thinking, dreaming, seeing, and feeling in similar ways” (Goulet 1994:19).

There is, however, critical examination of such traditional anthropological methods, and a “growing awareness that the ethnographer can never produce an objective account” (Young 1994:167), and new, reflexive methodologies are constantly being created and revised to address subjective and intersubjective interactions between ethnographers and participants and “to understand the meaning of an individual’s experience in a specific cultural setting” (Swartz 1994:209). Goulet (1994:19) advocates for the recognition of ethnographers’ experiences of interaction in other life worlds as “viable tools of research”. The following ethnographic examples demonstrate how
ethnographers’ experiences of dreams and visions have been used as tools for their research in an experiential approach.

**Dreams**

Dreams and their interpretation play an important role in many societies as daily practice, as well as in systems of ritual healing. Ingold (2000), Canal (2004), Goulet (1994), Guédon (1994) and Bacigalupo (1999), provide ethnographic examples that indicate the significance and integral nature of dreaming for the waking lives of the Ojibwa (Anishinaabe) of central Canada, the Dene of mid-northwestern Canada, the Pumé of Venezuela, the Guajiro of Colombia, and the Mapuche of southern Chile, respectively. Ingold (2000:100) explains that for the Ojibwa (Anishinaabe), “the world of dreams, like that of myth, is continuous with that of one’s waking life”. Canal (2004:31) suggests that for the Pumé, images, particularly those of dreams, are central to the “constant and vital communication between the visible and the invisible world”. Guédon’s (1994:53) experience inquiring about and acquiring “dream power” led the older community members she was working with to explain repeatedly that “everybody who dreams is some kind of sleep-doctor, everybody has power”. With the pervasiveness and prominence of dreaming in everyday experience, Goulet (1994:34) asserts that “a growing proficiency in dreaming, remembering one’s dreams and interpreting one’s dreams according to local rules of interpretation allows the fieldworker to do better ethnography”. However, Ingold (2000:100) suggests that

> People in the West are encouraged to think of dreams as hallucinations, comprising a stream of free-floating images that exist only in the interiority of the unconscious mind, a mind that is freed during sleep from its bodily bearings
in the real world. Thus we consider the dream world to be the very opposite of the solid, physical world ‘out there’, just as illusion is opposed to reality, fantasy to fact.

With this separation of dreams from reality, the anthropologist who experiences dreams and considers them significant for research analysis is faced with the challenge of reconciling Western dualisms with commitment and respect for the people whose experiences they are studying and sharing.

In a review of her experiential research with a Mapuche Machi (healer, shaman) named Panchi, in southern Chile, anthropologist Ana Maria Bacigalupo confronts this dilemma and describes how her own dreams played a prominent role in her fieldwork. Bacigalupo had a dream that Panchi interpreted as summoning her to become Panchi’s yegulf or spiritual assistant. This interpretation moved Bacigalupo to reflect upon her role as ethnographer, considering her commitment to professional academic interests, and to personal relationships with Panchi and the Mapuche community. She notes that Panchi, “had asked me to abandon the role of passive ethnographer and actively reciprocate her years of generous teaching and friendship with what she needed most: life energy, faith and spiritual help” (Bacigalupo 1999:38). Through the negotiation of her role, and her participation as yegulf for Panchi, Bacigalupo gained insight into healing rituals that she may not have otherwise had access to as a detached observer or distant ethnographer. She writes:

These experiences and subsequent healing rituals with Panchi allowed me to understand her ritual synesthesia, the use of one sense to express elements belonging to another sense… Panchi never wanted to discuss ritual synesthesia.
She said it was as I felt it. It was the coming together of the senses, *Füta Newen*, the big power. It had to be played, felt, done, but never talked about”

(Bacigalupo 1999:39)

Once the anthropologist undergoes this experience, they face the challenge of how to effectively, appropriately, and most importantly how to respectfully communicate these significant experiences to an academic and wider audience, without violating the sacred trust of community members and research participants, while still meeting the requirements of academic inquiry. This raises questions of cultural appropriation, intellectual property rights and reciprocity. These delicate concerns need to be met within an ethical framework articulated and negotiated by both the participants and the researcher.

Among the healers of my study in San Martin, rituals, dreams and visions played a very significant role in the teachings they receive from the plant and spirit world. When asked how they learnt to become healers, all of the healers explained the very vivid dreams and visions that they had which inspired them to pursue the study of Amazonian medical practices. To gain an insight into the significance of *ritual, dreams* and *visions*, I took many opportunities during my fieldwork to participate in rituals, ingest dream-stimulating medicine, and to pay close attention to the visions that I had. As a part of my fieldwork observations I kept a detailed journal of these experiences, and whenever possible, attempted to draw pictures of what I saw. In ritual space, I felt it was inappropriate to take notes. However, as soon as possible after the closing of the ritual space, I took up my pen, paints and keyboard to record any gleaned insights.
In the following sections, I address the challenge of visually representing my experiences in ethnography. I highlight how visual methods such as audio-visual film, photography and drawing have been and can be used in ethnographic research. Specifically, I refer to the work of Grasseni (2004) in using film as an anthropology of attention, and reflexivity, Canal’s (2004) use of images to communicate experiences of ritual space, dreams and visions, and Pink’s (2004) definition of applied visual anthropology as social intervention, which resonate with the methods I have used in my visual and experiential fieldwork.

2.3 Visual Anthropology

Art, photography, drawing, film and multimedia technologies are all potential tools for shaping how anthropologists perceive and communicate ethnographic knowledge. This section provides an overview of visual methodologies, primarily film, in anthropology, ranging from films as objective methodology, to the practice of visual anthropology as intersubjective interaction. In the context of visual anthropology, objective filming has been referred to as a process that assumes the camera can film objects (people, places, things) to capture reality. Subjective filming, on the other hand, is referred to as a process whereby the filmmaker recognizes the influence that the camera and filmmaker have on the people, places, and things they are filming.

In a review of anthropological researching with a camera, Ruby (2000:41) suggests that “one motivation for the creation of a motion-picture technology was to provide scientists with a mechanism to record and study human behaviour”. With the emergence of film technology came the belief in ‘mechanical objectivity’ and the ability
for machines to produce authentic data. Ruby quotes Datson and Galison as asserting that “the camera apparently eliminated human agency” (1992:81-128 in Ruby 2000:42). Viewed as a tool for scientific investigation, motion-picture filming was adopted by anthropologists such as Margaret Mead and Gregory Bateson who used film as a means to capture culture (Pink 2004:4). Mead was specifically preoccupied with documenting the cultural behaviours that she believed were facing inevitable disappearance (Mead 1995:3). Other anthropologists such as Franz Boas also expressed an urgent need “to salvage and, if necessary, reconstruct as much of the traditional culture…as possible” (Ruby 2000:58). This sense of urgency to preserve disappearing types of behaviour, coupled with convictions of the scientific potential of film analysis, set the stage for the integration of film as an ethnographic tool. What this positivistic approach has been critiqued for, however, is its failure to recognize the dynamic and interactive nature of film as methodology. Moving away from the idea of archiving cultural ‘realities’ through film and notions of film as inherently objective material, other anthropologists began to explore subjective and interactive styles of ethnographic filming.

Observational, direct, vérité or participatory cinema movements that took place in the 1960s were developed as reaction to objective assumptions about filming and focused on reflecting the world, to “explore and depict life itself” rather than to provide propagandistic commentary (Barbash and Taylor 1997:24, 26). Within this movement, Jean Rouch, French anthropologist and ethnographic filmmaker, brought about the idea of anthropologie partagée (shared anthropology) (Rouch 1988:231; Barbash and Taylor 1997:24). His films engaged directly with filmed participants and demonstrated a style of filmmaking that acknowledged the shared relationship between participants and
researcher— their intersubjectivity. MacDougall also pursued this style, encouraging research participants to speak for themselves “to convey— or be prompted to convey— a broad spread of background information necessary as context for the film’s main narrative” (Banks 2001:150).

Contemporary movements in visual ethnography have explored visual techniques as tools to refine the ethnographer’s eye for local perception and to stimulate an interactive dimension of research. The following examples of visual ethnography resonate with the objectives of my visual and experiential research. They address the ‘education of attention’ and reflexivity (Grasseni 2004), how to represent and communicate elements of ritual space, visions and dreaming (Canal 2004), and applied visual anthropology in social intervention strategies (Pink 2004).

**Attention, Reflexivity, Communication and Advocacy in Visual Anthropology**

Grasseni (2004:15) outlines how her use of a video camera helped her “to gain insight into the skilled vision of a community of cattle breeders” in Italy. She discusses how filming provides ethnographers with an opportunity to reflect upon how ways of seeing are framed by practices. Comparing the skilled vision of the cattle breeders in identifying cattle with her own apprenticeship of the eye through filming the experiences of the cattle breeders and attempting to see their environments as they do, Grasseni (2004:16) highlights the importance of an “education of attention”. Her thesis is that “an apprenticeship of the eye can further our understanding of how practice and skills construct identity”. Furthermore, her research alerted her to the relationships between skill, identity and place. Grasseni’s observations about attention, the apprenticeship of
the eye and the relationships between skill, identity and place are significant to ethnographic research because they address the intersubjective relationship not only between research participants and the researcher, but also between experience and environment. Through actively engaging with the cattle breeders and attempting to experience their environment as they do, Grasseni was practicing both visual and experiential anthropology. From her work, I draw upon the idea of an education of attention and reflexivity, as well as an awareness of the experienced relationships between researcher, participant and the environment.

During her fieldwork, Canal (2004) photographed among the Pumé of Venezuela. She recognized the “constant and vital communication between the visible and invisible world”, and observed that:

Images, particularly images from dreams, are central to this communication. In this context, where the most relevant cultural images exist only in spoken narrative, photography and drawing enabled me to understand the experiential and sensory relationships of Pumé culture (Canal 2004:31).

Canal attempted to represent the Pumé relationship to vision, image and narrative by collaborating in image production with the Pumé. Canal’s photography was guided by Pumé accounts of what they considered to be significant aspects of their everyday life experiences. The Pumé themselves produced drawings to describe their culture, and Canal made drawings of the ritual space since it could not be filmed. Furthermore, this collaborative process inspired discussion and narratives that Canal used to represent the Pumé experiences (2004:31). Canal (2004:44) suggests that “in a context where dreaming is crucial for the construction of social life, photography and drawing have
produced ethnographic understandings that deepen knowledge of Pumé reality”.

Following Canal’s example, I have included photographs and drawings that illustrate and allude to my experience of ritual space, visions and dreams in my research.

Pink (2004:6) explains that “as social intervention, applied visual anthropology usually takes the form of problem solving that involves collaboration with informants and brings about social change”. She suggests that “private, public (government), and NGO (non-governmental organization) sectors value (audio) visual means of producing and disseminating knowledge that may be less accessible through written or verbal media” (Pink 2004:6). Especially in medical anthropology, Pink (2004:7) notices an increase in visual methods for “anthropologically-informed” documentary filmmaking in health research. My experience documenting local health workshops in San Martin, and the expressed desire of workshop facilitators to have copies of the film to show in subsequent forums, meetings, and conferences, both locally and at national levels, reflects this trend whereby health researchers are seeking visual representation to communicate intercultural health initiatives in the region. It is important, however, that these filmed documents are used in a context of discussion and debate, rather than as a substitute for experience. Pink’s suggestion of applied visual anthropology as problem solving, contributes to the idea that visual representation can facilitate dialogue on issues of public health. Keeping this responsibility in mind, I have attempted to make this research project a part of wider initiatives in the region to promote awareness of different knowledge systems as a form of creative problem solving for public health concerns.
These examples from other ethnographers have shaped how I have recorded, interpreted and represented my own experiences in the field. The following section outlines my observations and my experiential and visual approach.

### 2.4 My Observations as Patient and Ethnographer

The medical practices prevalent among those who practice Amazonian medicine in the region reflect specific relationships that are honored between humans, their environments and the spirit world. These kincentric relationships exist in frameworks of knowing, such as *yachay*\(^\text{17}\) among the Kechua\(^\text{18}\)-Lamas, an indigenous group in the region of San Martín. Understanding the medicine of this region requires a certain attention to the role of plants as living, relational beings rather than solely as medicinal products or commodities. Patients at Takiwasi are introduced to the Amazonian medical knowledge system through plant therapy treatment that highlights the respectful relationship that healers and patients must share with the plants.

For a resident or visiting patient at Takiwasi, an intense program of detoxification through purging and cleansing with plant medicines is administered by apprenticed *curanderos*. This is followed by psychotherapy sessions guided by a staff of western-trained psychologists, both local and foreign. Community life and community projects are also included in long-term patient care in order to encourage patients to immediately integrate aspects of self-discovery that may arise during treatment with the plants into daily interactions with other people. Weekly plant rituals, consistent plant therapy

\(^{17}\) Described further in chapter 3, *yachay* is knowledge that exists in everything and is also passed to healers through plant teachers or phlegm from other *maestro curanderos* (master healers).

\(^{18}\) In this thesis I spell “Kechua” with a “K” as I found it spelled in local documents of non-government organizations. In some literature it appears spelled as “Quechua”. In these instances I have maintained the “Qu” to remain true to the text cited.
(administered through tonics), and occasional *dietas* constitute the regime of plant medicine. Consistent throughout the treatment is the presence of the patient’s assigned psychologist, who also undergoes plant therapy to *experientially*, as opposed to theoretically, understand the patients’ process. My observations of these processes are discussed in more detail below. I also underwent these plant therapy processes at Takiwasi to *experientially* understand aspects of local medical knowledge systems.

Healers from other villages, who also participated in my research, helped me to gain insight into how healers outside of the Takiwasi context define and negotiate their knowledge systems in the context of changing social, ecological and economic environments. These healers practice the following methods of medicine as well, though they do so without the western psychotherapeutic accompaniment unique to Takiwasi.

**Purges**

Administered in the *maloca*, a large, round, palm-thatched shelter, purges involve the ingestion of plants that induce vomiting and sometimes diarrhea. Patients sit on low wooden stools, accompanied by buckets (for their vomit) and jugs for water. The healer ritually prepares the space by singing, blowing *aguardiente* with camphor, and/or *agua florida* into the air, and blowing tobacco smoke over individual cups of plant medicine. Each patient is called up to receive his/her medicine. The medicine is given some time to settle into the patients’ intestines after the patient has returned to his/her seat. Then, the patients’ drinking of water and vomiting begins. The patient is accompanied by the songs of the healer, and various rounds of *curacion* through which the healer sings over,
and blows tobacco smoke, and *aguardiente* (distilled alcohol) with camphor, or *agua florida* (perfumed water of floral essences) over the seated patient.

**Ayahuasca**

“There is a magic intoxicant in northwesternmost South America which the Indians believe can free the soul from corporeal confinement, allowing it to wander free and return to the body at will. The soul, thus untrammelled, liberates its owner from the realities of everyday life and introduces him to wondrous realms of what he considers reality and permits him to communicate with his ancestors. The Kechua term for this inebriating drink is—Ayahuasca (‘vine of the soul’)—refers to this freeing of the spirit”

— Schultes and Hofmann (1992:120)

*Ayahuasca* (*Banisteriopsis caapi*), broken down into its linguistic components, means:

*Huasca*—the Kechua word for vine, or liana, and *Aya*—which means souls, dead people or spirits. The *Ayahuasca* drink is prepared by boiling the bark of the vine with components of other plants. The common admixture in *Ayahuasca* preparation are the leaves of the shrub *chacruna*, which is said to “paint the visions” created by *Ayahuasca*. *Ayahuasqueros, Ayahuasca* specialists, in Peru have explained *Ayahuasca* as the child of the serpent spirit. This serpent spirit is the source of all healing knowledge and power. There are kinship relationships between plant and animal spirits that healers describe, like the serpent as the mother of *Ayahuasca* and *Ayahuasca* as the mother of tobacco (Narby 1998).

According to clinical research and scientific explanation, *Ayahuasca* is the mixture of the bark of the *Ayahuasca* vine, with admixtures such as the leaves from *chacruna* (*Psychotria viridis*). *Ayahuasca*, when taken alone, serves primarily as a purgative and is speculated to be good for removing intestinal parasites. It does stimulate some psychoactive activity, but not as much as when it is combined with other plants.
*Chacruna* contains powerful psychoactive dimethyltryptamine (DMT). DMT is not orally active, it is metabolized by the stomach enzyme monoamine oxidase (MAO). However, chemicals in the *Ayahuasca* vine, harmala alkaloids, inhibit these MAO enzymes from metabolizing the DMT. This allows the DMT to circulate through the bloodstream into the brain. Callaway (2006: 100-101) suggests that *Ayahuasca* is “without a doubt, one of the most sophisticated and complex drug delivery systems in existence”.

*Ayahuasca* is valued for its therapeutic and psychotropic effects. These effects include a general amplification of perceptions, an acceleration of mental functions, and the disarmament of rational ego defenses. These conditions promote the recovery and transformation of deep subconscious complexes. Experiences of *Ayahuasca*-induced states involve conscious dreaming in which the patient is both the protagonist and the guide for their own experience (Mabit with Sieber 2006:28).

*Ayahuasca* sessions in San Martín are carried out in the evenings. At Takiwasi, a ritual to prepare and protect the *maloca*, a large open-air shelter with palm thatch roof, is carried out with dimmed lights. Each patient and healer drink a small cup of the bitter brew of *Ayahuasca*. Everyone is seated on the floor in a circle. The lights are shut off completely, everyone waits for the medicine to take effect, the healers begin singing *icaros*, or sacred healing songs, while everyone begins to enter an altered state of consciousness for the next few hours. Sessions can last from four to eight hours. A more personalized account of the *Ayahuasca* session is described in the final section of this chapter.
**Tonics**

Administered to patients for various reasons, these plants are usually prepared in the form of a fusion and taken once or twice a day, in the morning and evening. Dietary restrictions are placed on the patient for the duration of this treatment, generally lasting a week, sometimes prescribed for longer, depending on the ailment and desired results. Tonics stimulate dream life, which contributes to material for further psychoanalysis. *Camalonga* or yellow oleander (*Thevetia peruviana*) is an example of a detoxifying tonic requiring exclusion of sugar from one’s diet and sexual abstinence.

**Dietas**

Isolated diets are highly recommended by Takiwasi for effective treatment. These *dietas*, usually taken every three to four months at Takiwasi, generally consist of the patient spending 8 days with dietary restrictions, isolated in a small *tambo*, or jungle cabin, visited only briefly 1-3 times daily by the healer and/or apprentice, and ingesting the essence of a *planta maestra*, or teacher plant. *Ajo Sacha* (*Mansoa alliacea*), for example, is a teacher plant that on a physical level addresses problems of discomfort, general pain and generates heat while reinforcing overall physical strength. On a psychological level, it fortifies will power, teaches empowerment, self-esteem, and the capacity for decision-making (Giove 2002:48). Staying in the cabin, with limited access to the river for bathing, allows the patient seemingly limitless time to reflect upon life and to experience the teachings of the plant that is prescribed to them for the duration of the diet. During the isolated diet, patients can fast, or adhere to dietary restrictions allowing only boiled rice, oats, and green plantains (see Fig.1). The exclusion of all salt and sugar is required.
Sexual abstention and avoiding any contact with people other than the healer, apprentice, or visiting psychologist is necessary. The post *dieta*, lasting at least 3 additional weeks, continues to exclude all sugar, pork meat, and sex. It is said that the exclusion of these elements from the body allows the human spirit, body and mind to be more open to the forest and the plants’ teachings. The *dieta* is an important element in Amazonian medical practices, and the healers’ apprenticeship involves extended *dietas* in which they receive the wisdom of the plants through dreams and *icaros*, the sacred songs that are communicated to them through the plant teachers.

![Image of food for dieta](image)

**Fig. 2.1:** *La dieta*. Food eaten during the *dieta* consists of boiled plantain, boiled rice, and boiled oats. No condiments are allowed and there is only one serving per day. Photo: Claire Sieber. October 2006.

My participation in these medical practices formed the foundation of my research in the region of San Martín. By going through each practice, I was able to create personal references that helped me to understand what the healers were talking about in the workshops I attended as well as in our interviews and interactions.
2.5 My Experiences as Patient and Ethnographer

This section outlines how I used the experiential and visual approach to give *attention* to, *reflect* upon, and *communicate* the experiences that I had interacting with healers, in their environment, in San Martín Perú. Examples from my experiential and visual treatment of ritual space, dreams and visions are provided.

*Attention*

Drawing upon Grasseni’s (2004:18) assertion that “video recording can serve as a tool for refining the ethnographer’s attention”, I describe here how the process of filming interviews and observations during my fieldwork brought my attention closer to selected details of healer’s narratives and their environments. I was looking for what Grasseni refers to as “the relationship between skill, identity and place”. In this particular context, I was looking for the relationship between medical practices, identity and environment.

Inquiring about his identity as a *vegetalista* and *ayahuasquero* (herbal doctor and plant specialist) I asked Winston Tangoa Chujandama, a local indigenous healer, how he learned his medical practices. Winston explained that his grandfather, who had raised him, was a well-known healer in the area. He spent his childhood helping his grandfather who would send him off into the jungle to collect plants. Winston described his knowledge of those plants as a sensory relationship. He knew those plants by sight, smell and taste—by collecting, preparing and using those plants with his grandfather. When he was older, his grandfather sent him on a *dieta* in the jungle. It was there that he received his first *icaros*, sacred songs through the teachings of the *plantas maestras*, the teacher plants. His was a process of experiential learning, an education of attention to the
relationships between people, their environments, and the world of spirits. Winston’s narrative brought my attention to the details of these relationships, which, in turn, helped me to cultivate my own relationship to the environment in which I was experiencing medical treatment. I began to recognize plants in the area, not only by sight, but also by smell, taste and medical experience. I focused my camera lens on many medicinal plants to aid my memory in identifying their shape, colour and visual essence.

In this process, however, I realized the limits of filming which can only capture image and sound, and hope to evoke the other senses. Another indigenous healer in the region, Cristobal, alerted me to the drawbacks of depending upon film and field notes for learning. In an un-filmed conversation with Cristobal, I asked for the name of a plant we had been talking about in a previous interaction. I explained that I had it written down somewhere in a book, but that I could not remember the name. He scolded me, saying that I should remember the plant in my own memory, not in my book or on film. This statement alerted me to my own dependence on film and writing as memory tools. I realized at this point that my own experiential knowledge, my attention, and my memory were dependent on these tools. This, I believe, can be a danger with film. Although I consider it to be something that I can look at in more detail at a later date, this deference of learning can also be an obstacle to my experiential learning. With the camera, I focus on the visual sense, trying to capture the images that will best represent the information being transmitted. I focus on the auditory sense, trying to record the sentence that will best articulate the information being shared. The other senses, however, of smell, taste, touch and overall experience, are excluded from the gaze of the camera, which is why,
for many of my experiences, the camera stayed in the bag while I experienced the teachings with all my senses, and with my own memory.

**Reflexivity**

Reflecting upon one’s own subjectivity, bias, voice and influence in the ethnographic filming process is cited as integral to transparent and more representative ethnography (Henley 2004; Pink 2001, 2004:181-182). Although I was aware of these concerns in the actual filming process, it was in the analysis of the filmed interviews that my subjective influence became clear to me. Reviewing the filmed interviews I was able to pay close attention, not only to what the healers were saying, but also to my own voice. This revealed how my voice influenced the interactions. In my voice I heard bias for the answers I wanted to hear, guiding the conversation to subjects that I deemed relevant, and missing important points through my limited proficiency in Spanish.

The questions I asked, limited by my ability in Spanish and minimal experience conducting filmed, Spanish interviews, obviously framed the answers that I would receive. For example, concerning the *animas* or plant spirits, I asked Cristobal: *I know it is difficult, but could you explain the animas?* The framing of this question assumed that the *animas* are an unusual and complicated concept to explain, rather than the common, everyday experience of the healer, which they are. I assume it is difficult to explain, whereas really, it is difficult for *me* to understand, not necessarily for the healer to explain. I could have phrased the question as: *It is difficult for me to understand the animas. Could you please describe them for me?* This second framing of the question
admits my lack of knowledge and relies on the expertise of the healer to clarify the meaning of *animas*.

My focus on having certain questions answered clearly limited the healers to talking about what I deemed relevant for my research, rather than what they felt necessary to express about themselves and their practice. Although conversation is always relational, when reviewing the interviews, I felt I could detect instances where I may have been guiding the healers’ answers. For me, reviewing the filmed interviews was an effective reflexive tool, allowing me to evaluate my research methods. In the field, I reviewed the filmed interviews prior to subsequent interviews with the healers. This helped me to evaluate and improve my interviewing technique, as well as to identify topics that could be expanded upon. It would have been interesting to have included the healers in this evaluation of my efforts.

The visual frame of the filmed sequences depicts only the healers, not myself. The result is a filmed interview through my privileged eyes only, not including the healers’ gaze. Since these interviews were actually interactions between the healers and myself, it would have been appropriate for me to include myself in the frame.

I had also intended to edit my voice out of the filmed interviews. However, upon viewing the film sequences, I recognize the value of including my voice in the dialogue to contextualize the answers provided by the healers, and to provide a more genuine representation of the interaction.

Reviewing the interviews I also became acutely aware of their body language, to which I was partially oblivious during the interviews themselves, being more preoccupied with asking the right questions, adjusting the camera exposure and understanding the
answers provided by the healers. It seemed to me that there were several times I should have picked up on their wandering gaze and distractions as hints of being bored or anxious for the interview to be over.

With these critiques in mind, it is clear to me how essential the process of reflexivity is and how attention to the details of the filming process can lead to more effective analysis of the material created and can improve self-aware techniques for future filming.

**Communication**

My intention, through this filming process, was to create a film that would highlight the legitimacy and creative agency of healers and their knowledge systems. By doing this, however, I was able to see that the closest approximation to representing their knowledge that I could achieve would be to present the interviews as my own experience, understanding and representation of the healers’ experiences. I do not in any way pretend to speak on behalf of the healers. My idealistic vision for this project was to make it a collaborative effort whereby the healers would be able to contribute their input into how they would like to be represented. I envisioned the ‘perfect’ scenario whereby healers could draw for me the images that they see in their daily lives and in ritual space, visions and dreams. I imagined they could take the camera and film for me the activities that they deemed relevant in their daily lives, then sit with me to review, comment upon and edit the material to create a collective representation of their experiences. However, this vision assumed that the healers would have time and be willing to participate in my project. Once in the field, I experienced the generosity and trust that the healers
demonstrated in sharing their knowledge with me. They invited me to their homes, offered me *chicha* (fermented yellow corn beverage), answered my questions, signed my informed consent forms, and told me they trusted me to render an accurate representation of their knowledge through my editing skills. I realized that asking them to contribute more time, to a project of my design, was impractical and perhaps not appropriate under the circumstances of time commitment and time available.

The result has been a solo-editing project that I will distribute to the healers as a final product to ask their approval before more general distribution to their communities and mine. All of the healers were given the opportunity to remain anonymous, to review the material filmed about them, and to revoke that material at any time during the research process. All of them, however, chose to reveal their names on film, to entrust me with the film editing process, and to date, none have revoked the information provided.

My hope is that this project provides a screen through which healers can project some of their experiences for their community, the academic community, and my community audiences, contributing to dialogue about the interaction of various different knowledge systems. Ideally, this film should illustrate a challenge to the traditional-modern, scientific-indigenous, and mind-body dichotomies that continue to shape knowledge systems both in Peru and Canada. However, I recognize that this film cannot be a substitute for experience. It will be a limited representation of my interactions with healers and some of their experiences. If it is to be used as a tool for knowledge discussion and negotiation, it will necessarily need to be presented in contexts where the audiences are made aware that it is a representation of experiences, and not a static
archive of facts. This may be facilitated by a list, incorporated into the film, of guidelines and contextualization that encourage audiences to engage with the film and what it represents.

Provided that I receive the healers’ final approval, my intention is to distribute this film to the healers themselves, as well as to NGOs in their communities. Reasoning behind the distribution of this film follows, in large part, my felt responsibility to conduct research that has visible and accessible results which are returned, and hopefully are useful to the individual healers and their communities who were so generous in sharing their knowledge, experiences, time and space with me. The following section explores examples of the visual observations I was able to make during ritual space, visions and dreams, general observations, and filmed workshops while in the field.

**Representing Ritual Space: Ayahuasca**

As Canal (2004) points out in her reflections on research among the Pumé, ritual space is difficult, and often not appropriate or possible to film or photograph. I have seen visual representations of Ayahuasca sessions and I feel that they fail to represent the experience effectively. The visions occur within the individual, so that filming captures only the icaros, moaning, coughing and vomiting of the patients. I had opportunities to film the opening ceremony, that takes place in dim light, but a healer expressed discomfort with this because it has been filmed so many times. Therefore, to represent the ritual space I experienced at Takiwasi, I have chosen a description of the ritual healing proceedings involving Ayahuasca from my field notes, illustrated with some drawings and paintings of mareaciones, or visions that I experienced during the healing ritual. These notes and
drawings were made the day following my experiences because it was not possible to take notes in the complete darkness of the session. Immediately following the sessions, at about three or four in the morning, I was often exhausted and retired home to sleep instead of writing. I usually slept for three to five hours before writing down my experiences of Ayahuasca. The following passage is taken from fieldnotes that I wrote reflecting upon the ritual leading up to an Ayahuasca session.

Field Notes, el 12 setiembre, 2006. Tarapoto.

We are almost all seated on our cushions in a circle. Buckets, toilet paper, and blankets are at our feet for the session. The floor is covered in woven palm mats. The roof above our heads is palm thatched. We lean up against a half brick wall, and wait. The maloca, an open air ceremonial shelter, is round, but there is a front area for our attention. At the front, hanging on the wooden lattice against night sky, is a painting of Jesus on a cross with his heart blood red and beaming. Angels above him. Demons below. I am not Catholic, but this image still resonates somewhere in my consciousness. There are words around this painting that I cannot decipher.

Below the painting is where the healers sit. One healer is already seated. If you follow him from his bare feet up, he is draped in a dark Shipibo\textsuperscript{19} cloth, chocolate brown with black geometric lines that seem to map out some other worldly territory. His face, usually ironically content, is veiled in the tobacco smoke swirling out of a pipe he has carved from a wingo fruit. His forehead disappears underneath a bark-cloth band beaded in bright red seeds, and painted in geometrical designs. Rising up from the band are bright blue feathers, straight up. And underneath all of this is a black “anti-virote”\textsuperscript{20} tuque, as one of his fellow healers musingly suggested. He comes with his attire in a small red

\textsuperscript{19} Indigenous group in northeastern Peru.

\textsuperscript{20} A virote is an intrusive object or dart, sent by way of a spell or magic, to cause daño or harm to an individual by a brujo, or witch.
backpack, and admits he doesn’t carry other objects to the session because his grandfather insisted that a man is found inside himself, not in the things he brings.

The other healer, who will lead this session, has not yet arrived. His usual beige cushions are propped up against the wall, and a few dried leaves are bundled together for his icaros, sacred songs, and healings.

He comes in dressed in white with his black bag embroidered in golden and red threads: an elephant, designs from India, the embroidered words: Far Away. He sits down and unpacks from the bag:
- a white cloth (places it on the floor in front of him)
- a white cloth with embroidered edges and brown stains from the Ayahuasca liquid (he places this cloth on top of the other one)

He places, from the bag, on the cloth in front of him:
- a clear bottle of aguardiente with green leaves and camphor settled on the bottom half
- a clear bottle of lavender oil
- an opaque bottle of holy water
- various religious medallions of saints, including Saint Benedict
- an abalone-adorned cross

An assistant walks around with a bowl of burning palo santo, an incense, stopping in front of each one of us so we can wipe clean the air around us with its smoke. I have never asked why we do this, I just follow routine, and assumed meaning. Various other bottles appear beside the healers. A tall, plastic soda bottle filled with a dark brown liquid (this is the Ayahuasca brew). A small measuring cup with lid, filled with another dark brown liquid (this is strongly brewed tobacco juice).

Once the visiting patients are all settled into our spots, the main healer stands up and walks around the circle sprinkling holy water on our heads, and on the middle supporting beams of the maloca. He walks the same circle sprinkling salt
around each one of us. He sings into his bottle of *aguardiente*, takes some into his mouth and blows it in a specific way out behind him, to each side, in front, to the ceiling and to the ground. After, he puts some on his head, arms and hands.

He sings into the bottle of *Ayahuasca*. Then blows smoke into it and screws on the plastic lid. Going counter-clockwise around the circle, we each stand up and go to sit in front of him while he pours the dark, thick brown liquid into a small, blue (white inside so you can see the lumpy dark liquid) tin cup (like the kind some use for yerba mate in southern Argentina, the size of an espresso cup). Depending on the person, he will add a bit of tobacco or holy water to the brew. For me, he almost always adds holy water and holds a St. Benedict medallion under the cup while he prays. With his big *wingo* fruit pipe he blows tobacco smoke over the cup and hands it over. I usually say my own prayers holding my hand over the cup, asking *Madre Ayahuasca* for assistance and various answers, and then, following example, I say “*Salud con todos*”, and hear the response of “*Que Dios te bendiga*” while I drink down the extraordinarily bitter brew trying not to vomit instantly. I return to my spot, spit into my bucket for awhile as my saliva glands frantically attempt to clean out the acrid taste from my mouth, and wait for the plant to take effect.

The lights are turned off and we sit in darkness for about 20 minutes. The healers begin to sing. Figures 2 and 3 illustrate *Ayahuasca* visions I experienced. The following is a small excerpt from my field notes, written on the day following my first experience with *Ayahuasca*. Each session inspired many, many pages of notes.

Tiny flecks of light in the periphery of my darkened vision. The more faith I gave, the more elaborate the visions. The grid pattern I usually see when I get dizzy became vivid eyes looking sincerely at me, moving. I felt them like a shield, and when I asked them what they were, the multitude of eyes moved down-wards, revealing small crosses representing my deceased ancestors, all peering over me like guardians. Then I began to realize that they formed a continuum throughout the *maloca*, protecting all of us. The *curanderos*: Rosa,
Jacques, and Winston, all moving throughout this energetic field...My body began to feel light, and I slowly felt it drawn to one side, then another, almost slithering snake-like upwards into this other level. At first I could only see bits of vision at my periphery. The more I believed, the more I saw. I then felt I was a puma, looking out through the eyes of a puma, tentative, guarded, I felt like licking my paws, but resisted, feeling like I was still Claire, but a Puma was using my eyes. I tried to see if I could raise the hair on the back of my neck. Not really...I started to imagine, and to let the visions flow. Skeptical, I asked, “Is this just my imagination?” As a response, Ayahuasca showed me a big clay belly with a window into it. Then, while clearing another moon-shaped window into the clay belly, a voice inside me asked, “Just your imagination? Isn’t your imagination another way to see? An insight?”...

This vision I had helped me to let go, to some extent, of my skepticism and disbelief to really embrace the effects of the plant. Through this, I was able to engage with the experience and begin to understand that faith, belief and letting go of purely rational explanations are fundamental elements of the medical practices used in Takiwasi and in the region of San Martín. Figure 2 illustrates the ancestral eyes that I saw. I drew these eyes immediately following a purga with Rosa Sisa one afternoon a few days after my first experience with Ayahuasca. Figure 3 is a painting of an very vivid experience that I had with synaesthesia21 whereby I could see the icaro that Winston was singing to heal the patient beside me. Within this icaro I could see generations of healers—Winston’s community and ancestors—who had passed their medical knowledge through these sacred songs.

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21 Synaesthesia is described by Ingold (2000:268) as “the apparent capacity of certain perceivers to register an experience in one sensory modality on the basis of sensations delivered in another”. Ingold draws upon the work of Gebhart-Sayer (1985) among the Shipibo-Conibo of northeastern Peru to describe how shamanistic experiences involve seeing with the ears and hearing with the eyes. Specifically, shamans’ songs ‘can be heard in a visual way’ and the designs of those songs penetrate the body of the patient (Gebhart-Sayer 1985:162-164 in Ingold 2000:279).
Figure 2.2: Ancestral Eyes. These eyes appeared as the visual fabric of my first Ayahuasca session and became an integral part of all subsequent Ayahuasca experiences. Drawing: Claire Sieber. June 2006.
Figure 2.3: Seeing the Icaro. This image is drawn from a vision I had while under the influence of Ayahuasca. It depicts my experience of synaesthesia—seeing the sacred song, containing the knowledge and experiences of the healer’s ancestors, and going into the patient beside me (right) to heal him. Behind the healer (center) is his deceased grandfather who I perceived to be behind him as a guide and protector. Painting: Claire Sieber. August 2006.

**Reflexivity: Dreams through Drawing and Description**

The following example of my experience with Camalonga (*Thevetia peruviana*), a medicinal plant prepared in a tonic, illustrates how I came to include dreams in my
fieldwork and fieldnotes, and how the vividness of these dreams brought me closer to understanding the role of dreams for healers. The following is translated from a Takiwasi Camalonga fact sheet:

The preparation of *camalonga* requires 1 liter of water, 2 *camalonga* seeds, 1 pinch of egg yolk coloring (from package). Seeds are washed well, placed in a transparent bottle (preferably glass, avoid plastic) with one liter of water with a pinch of coloring. The bottle is exposed to direct sunlight in the morning (before midday) for at least 2 hours so that the liquid becomes orange with the solar energy. The dosage of *camalonga* is half a glass of the liquid, 1-2 times a day, depending upon the severity of the case. This can be taken in the evening before sleeping, or in the morning before eating. During the time of treatment, the patient should abstain from eating foods with sugar (including natural sugar, like fruits for example), pork and its derivatives, chili pepper and strong condiments (spices, pepper, mustard, etc.), alcohol and sexual relations. It is recommended to maintain a light diet that is healthy, with neutral flavors, preferably raw, boiled or roasted (avoid heavy foods such as sauces and anything fried). It is recommended to take the preparation for at least 8 days. Camalonga can be ingested during several weeks without problem. It does not have toxicity.

Frequently, while taking this remedy, strong and vivid dreams are experienced. It is recommended to pay attention to these dreams to clarify the cause of illness. For some patients, Camalonga produces drowsiness, and should therefore be taken in the evening before sleeping. For others, the contrary occurs and Camalonga acts as a stimulant, in this case it is better to drink in the morning when one wakes.

Camalonga has direct action on the nervous system and cleans bad energies (witchcraft, occultism, magic, negative infestations due to drugs, black magic rituals, inadequate sexual relations, etc.). It is also used in cases of paralysis.

These are my experiences ingesting *camalonga*:

*Field notes, El 13 de junio 2006. Tarapoto.*

I struggle to recall a time in my life when I have felt this weak and exhausted. Maybe it is this oppressive Amazonian heat that drains me of action to back up
my internal motivation. There are so many things I want to do, but by mid day I want to sleep. When I wake, my limbs can barely move. I felt this way a few times before taking Camalonga. But now I feel worse. I woke this morning feeling like I had to get out of bed to escape all of the anxiety dreams that are heavy in my restless mind. When I walk around my limbs feel very heavy and slow to respond. Walking around Tarapoto today made me feel like I had just climbed a mountain. Heat, lack of sugar, Camalonga, or general life fatigue, whichever of these factors (or all) that is sucking the life force out of me, I want to rise above it and feel energetic again. Perhaps this plant is showing me how much I depend on sugar, even if in small doses, to impart its energy into my daily life. Or maybe this plant has found a heavy morsel of evil that has been hiding in my gut, veiled by the soothing properties of sugar. Perhaps without sugar it writhes and sucks out all the remaining energy I have stored, wherever it can find it. The maestro healer did say something was lodged in my gut and that I have to kill it. How do I kill something like that? I feel I am just getting close to it, but my body craves even just a spoonful of honey in my tea, a piece of pineapple, will this soothe the beast we have uncovered? How do I get it out?

This personal account of *camalonga* medical treatment reveals my anxieties while taking a local medicine, embracing the healers’ diagnosis, and confronting my ‘illness’ through physical weakness and dreams. The next step towards understanding these anxieties was to discuss them with the healers and therapeutic staff at Takiwasi. Unfortunately I do not have an illustrated dream that coincides with an interpretive account of the dream material. So, in this chapter, I have sacrificed a verbal explanation for a visual representation. Figures 4 and 5 illustrate the anxiety dreams I was having.
Figure 2.4: Camalonga Dreams. This journal entry of mine from June 2006 documents and draws a vivid anxiety dream I had during my treatment with camalonga. It features the story of a black man with jewels for perspiration on his nose. He is telling me the tragic murder story of a woman he loved, and how the religious mafia responsible for her death, are after him because he knows what happened. I am compelled, in the dream and later in my half-awakened state, to replicate this story in film. I draw the very vivid story he told me, that appeared in the dream as both filmed media and sketches drawn on paper.
Fig. 2.5: Camalonga Dreams. This is the continuation of the journal entry, June 2006, where I have re-created the sketches that appeared to me in the dream.
Education of Attention: Photographing Plantas Maestras

The following photographs, figures 6-10 of plantas maestras, or plant teachers, were taken by me in an attempt to train my eyes to identify the plants, and to capture an aesthetic portrayal of the medical resources intimately known by the healers. Some of these plants were pointed out to me by one of the Takiwasi medicinal plant laboratory staff.

Figure 2.6: Ayahuasca (Banisteriopsis caapi). The bark is used in the preparation of Ayahuasca tea. Photo: Claire Sieber. October, 2006.
Figure 2.7: Chacruna (Psychotria viridis). Dimethyl-tryptamine is stored in the small pockets on the underside of the leaves. Photo: Claire Sieber. May, 2006.

Fig. 2.8: Chacruna. (Psychotria viridis). Photo: Claire Sieber. May, 2006.
Figure 2.9: *Yawar panga* (*Aristolochia didyma*). Photo: Claire Sieber. May, 2006.

Figure 2.10: *Chiric sanango* (*Brunfelsia grandiflora*). Photo: Claire Sieber. May, 2006.
Communication: Filmed Interactions

The documentary (in progress) from my research represents my experiences living in Tarapoto Peru, participating in Amazonian healing practices, attending and filming local health development workshops, and filming interviews with local healers. My intention is to return this ethnographic film to the participants of my research for their feedback and consent, prior to distributing it for educational purposes in their communities and mine.

I have chosen various examples to illustrate how experiential and visual approaches can provide insight into the relationships among ethnographer, research participants and the environments in which they interact. By confronting my own identity I recognize the influence that my presence has had in shaping the ethnographic knowledge that I present. While the healers themselves were able to direct my attention to other ways of knowing them, their work, their environment, as well as concepts of health and illness, I am aware that my research objectives also framed my inquiry and directed their narratives.

Rather than pretend to represent the experience of the healers, my research project is intended to communicate how their knowledge opened me up to experiencing and seeing communities, environment, and health differently. More of these experiences are provided in chapter 4. I stress the importance of my experiential approach that became an education of attention and reflexivity, and has challenged me to use different visual methods to communicate these experiences. With the paramount significance of ritual space, dreams, and visions to the everyday experience of the healers in this study, comes
the task of appropriately, respectfully and ethically representing these experiences. Careful consideration of issues of respect, commitment to research participants and communities, reciprocity, cultural appropriation, and intellectual property, have proven to be essential in my process of experiential and visual ethnographic study. Through first hand experience of the medical practices used among Amazonian healers, I was able to come closer to understanding aspects of the healers’ experiences. The following chapter provides a brief historic and contemporary context for healers in the region of San Martin.
Ch.3
HISTORY, HEALTH AND POLITICAL ECOLOGY

Figure 3.1: Political Party Propaganda painted on house in Tarapoto, San Martín, Peru. Photo: Claire Sieber. October 2006.

KNOWING:
“a practical, situated activity, constituted by a past, but changing, history of practices”
(Escobar 1995:9)

3.1 INTRODUCTION

To contextualize the contemporary experiences and knowledge systems of local healers, presented in chapter four and five, this chapter explores the relationship between history, economy, politics, environment —political ecology— and human health in the region of San Martín. The first section of this chapter summarizes historical and contemporary
accounts for the Amazon region of San Martín, focusing on patterns of colonization, neo-
colonization and modern economic development. “Boom” cycles of resource
exploitation are highlighted in this section because they represent heightened periods of
economic activity, immigration, conflict, and exchange between knowledge systems.
The second section reviews environmental policies of international and national
biodiversity conservation strategies and how these policies relate to traditional knowledge
systems. The third section of this chapter gives an overview of health initiatives,
undertaken internationally and within Peru over the last few decades, to address multiple
medical knowledge systems and public health. Attention to the class struggles within the
history of this region highlight how local economics and identity can simultaneously limit
access to scientific medicine, provide a catalyst for the maintenance of traditional
practices, and be the impetus for bringing these various ways of knowing together in
innovative new forms.

3.2 Setting of San Martín

Stepping off the airplane into the evening air of Tarapoto I feel the weight of
humid air, and I can smell damp earth, vegetation and wood smoke. Throughout
the night, roosters in neighbours’ courtyards alert me to their territory on the
local soundscape. By day, I begin to piece together human marks on the
landscape of San Martín: Moto-cars roam the streets in hoards— the drivers
looking to supplement or sustain their income. Political party slogans are painted
in pictographs on adobe and cement walls throughout the urban and rural areas.
“Modern” grocery stores have fluorescent lights, neatly shelved produce,
individually-packaged bags of grains and tile floors. The market, by contrast,
covers 4 sprawling blocks with a large collection of stalls, tables and storefronts,
wheelbarrels and tarps— all bountifully piled high with shoes, copied dvds,
polyester shirts, pineapples, papayas, bananas, plantains, potatoes, carrots, fish,
and chicken, and cluttered with sacks of grains, flour, beans and barrels of olives. The pharmacies have glass cases with bottled perfumes, shelves of diapers, and tins of formula. “Natural” medicine stores have glass cases with industrially packaged herbs. A small herb nook in the market has glass cases with Old Spice perfume, industrially packaged herbs, sea shells, and shelves with boxes of dried herbs—coca leaves, *malva, matico, pampa oregano*, mint, etc. and bottles filled with root infusions. Tarapoto city is a patchwork of paved and orange dirt roads, luxury cement homes with glossy tile, glass windows and finished roofs, cinder block houses constantly under construction with rebar sticking out of their roofs\footnote{It was explained to me that there is a certain tax break for those living in houses that are not complete. Many houses are “unfinished”.} and simple red adobe homes with or without cement finish. All these houses are built side by side. Vegetation sprouts out of any habitable niche—a roof tile, a ditch, an unused section of road. Greenspace is tucked into enclosed courtyards behind house fronts, displayed in plazas, or thriving on the edges where urban meets rural, where the *chacra* meets *el monte*. Tarapoto is surrounded by a landscape stitched together with dirt roads that connect villages, farmland and wilderness to urban markets. Large cleared lots with hundreds of squares of black tarps and drying coffee beans spread on top are interspersed between patterns of irrigated rice fields, trimmed with yucca [manioc] plots, fringed with maize, and bordered by plots of plantain. Signs on the side of the road read “Do not litter” and “Do not burn our forests”. There are plastic bottles in streams and rivers everywhere. There are small and large-scale fires sending blue smokey plumes into the heavy air.

With these field observations, I ask myself: How did San Martín become this contemporary scene that I describe? What has brought a researcher and tourist like me to this region to study the interface of medical knowledge systems? I suggest here that it is the human-nature relationship, and its manifold forms mitigated by social, economic and/or spiritual ends, that lie at the root of the identity, practice and place of contemporary healers in San Martín, and my interest in understanding their experiences.
As culturally diverse as it is ecologically, the department of San Martín has been transformed by a history of migration and changing relationships with the land base, its resources, and perceived territorial boundaries. The department of San Martín, designated a department in 1901, is located in the northeast of Peru (see figure 3.2). The official land base of the department of San Martín is an area of about 51,253 km², approximately 4% of the national territory. This land base is populated with an estimated 821,400 inhabitants (MINSA 2005). San Martín is bordered by the departments of Loretto to the northeast, Ucayali and Huánuco to the south, and Amazonas and La Libertad to the west. Within the department of San Martín, there are 10 provinces: Bellavista; El Dorado; Huallaga; Lamas; Mariscal Cáceres; Moyabamba; Picota; Rioja; San Martín and; Tocache. The province of San Martín, where I conducted most of my fieldwork, has a population of about 167,590, and the largest city of the region, Tarapoto, has about 69,350 inhabitants (MINSA 2005). I also conducted fieldwork in the neighbouring province of Lamas, which has a population of about 86,790 and the capital city of Lamas has a population of approximately 16,540 (MINSA 2005).

Found on the eastern side of the Andes, San Martín’s landscape is one of foothills and wide, but at times steep, valleys, covered by highland and lowland jungle, and small and large-scale plantations. It is traversed by the rivers of Huayabamba, Sisa, Mayo, and Huallaga which eventually feed into the Amazon River. The average annual temperature of 22.5°C (INEI) to 24°C and average annual precipitation of from 800 to 1,500 mm annually (Regional Government of San Martín 2004:27) provide a combination of heat and humidity that make this region ideal for the cultivation of many food and cash crops including rice, maize, sugar, coffee, cotton, tobacco and the contentious coca
(Erythroxylum coca). Lush vegetation, favourable growing conditions, and an abundance of natural resources are what have attracted many European and Peruvian immigrants to this Amazonian region.

![Map of Tarapoto and surrounding area. Source: Government of San Martín.](image)

Local and international interest in the natural resources of the Peruvian Upper Amazon shape the experiences of healers in this region who are finding new ways to define old practices in contemporary, globalized environments. A review of historical activity in this region brings attention to the processes of medical knowledge negotiation in present-day San Martín.

3.3 HISTORY

Histories in the Amazon

Recognizing that history is experienced and recorded in distinct ways, I present here a summary of historical accounts, first about anthropological research examples from the
Peruvian Amazon in general to situate San Martín within a larger Amazonian history. Second, I review the region of San Martín. These accounts are derived from literature reviews. Comments, observations and implications of these recorded histories are also discussed in more detail in chapters four and five of this research.

International macroeconomic agendas have been a driving force shaping cultural, economic, natural and spiritual relations in the Amazon over the past 500 years. Examples abound throughout history where Indigenous lands have been deemed valuable by foreign authorities for: their deposits of gold, silver and other minerals; their abundant and fertile forests or agricultural lands; their “heathen” souls to be saved; and in recent decades, their reserves of oil to be “explored” and medicinal plants to be “discovered”. In the Amazon, exportable resources such as rubber (Hevea spp.), barbasco (Lonchocarpus urucu—roots used for insecticide rotenone), oil, gold and coca have been the focus of much literature on historical influences. Colonialism, Christianity, rubber exploitation, gold mining, neocolonialism and modernism are all cited as influential processes that have created a movement of people and ideas into and out of the jungle (Taussig 2004, 1987; Gray 1997a, 1997b). Gray (1997a) outlines the influence of the more recent gold rush of the 1990s on the Arakmbut of Madres de Dios in southeastern Peru, referring as well to the migrations, killings and forced slavery of Indigenous peoples during the rubber boom one hundred years prior in this same region. Gow (1996, 2001) also discusses the influence of the rubber trade on the Piro of Bajo Urubamba River in the Peruvian Amazon. As Gow (2001:9) suggests, however, the Piro “had not simply submitted [to], or survived, or resisted” the historical circumstances they had endured with rubber trade. Rather, “they had turned around and invented a new way of
living which rendered their recent historical experiences coherent to themselves, and which they seemed to find both intellectually and emotionally satisfying” (Gow 2001:9). Gray also suggests that since the 1980s,

studies in lowland South America have broken away from viewing internal community relations as passive victims to external change, whether economic, political, or religious…Through interaction with the colonizing frontier, new aspects of ethnic identity and political ecology have emerged in the changing historical conditions of Amazonia (Gray 1997a:4-5).

I do not discount the suffering experienced by Indigenous and economically marginalized peoples of the Amazon, whose knowledge systems, lands and population have been subjected to projects of colonialism, neocolonialism and modernization. I refer here to the examples of the Piro and Arakmbut, and the analyses of Gow and Gray, to highlight the potential for creative agency among Amazonian inhabitants who assert their knowledge systems and identity in the historical present. Historical experiences of San Martín exhibit similar cases of cultural resilience, creative agency and the innovation of healers in bringing medical knowledge systems together to address health and illness in changing natural, social, economic, and spiritual environments.

**Histories of San Martín**

Prior to the arrival of the Spaniards, indigenous groups such as the Lamistas, Chazutas, Aguarunas, Achuar, and Shipibos are among some of the many culturally distinct groups who occupied the region of San Martín. In the areas surrounding Tarapoto, the Lamistas comprise the majority of the indigenous population. It is suggested that the Lamistas are
of Andean descent, specifically of Chanca origin, fleeing some 600 years ago, at the time of Inca expansion in the 1400s, in resistance to Incan sovereignty (Demange 2002; Marquardt 1999). This perspective is partially based on their language, Kechua, which is a variant of highland Quecha, differing from the languages of surrounding Indigenous Amazonian populations. Shortly after their arrival in Peru 1532, the Spanish conquistadores colonized San Martín as the first region under their control in the Amazon. Several expeditions into the region by conquistadores and Franciscan and Jesuit missionaries during the 1600s and 1700s had the specific intentions of expanding the Spanish empire into the jungle, keeping the Portuguese territorial expansion ambitions in check, and recruiting the local Indigenous populations for military and religious service (Tarapoto 2007).

Conquistador and missionary expeditions also yielded a variety of medicinal plant knowledge that became available to European medical knowledge systems. In 1534, for example, information on *copaiba*\(^\text{23}\) was published in a report for Pope Leon X, by Herr de Estraburgo, as a remedy used by the Indians of the Amazon for the closing of wounds, and as an anti-tetanus balm applied to the umbilical cord of newborns (Salgado 2006). Several other medicinal plant “discoveries” were made by Europeans in the Amazon, no doubt owing to observations of local Indigenous peoples’ medical practices. Spanish expansion in the Peruvian jungle brought about the establishment of cities such as Moyabamba, founded in 1542, Lamas, founded in 1656, and Tarapoto, founded in 1782. These jungle cities became the sites of intercultural exchange, although primarily Eurocentric, violent and exploitative relations prevailed.

\(^{23}\) Copaiba (*Copaifera reticulata*): Plant medicine used for anti-infection and wound-closing (Giove 2002).
Economy: Boom and Bust Cycles

National and international demand for natural jungle resources has created a pattern of “boom” and “bust” cycles in San Martín (Kawell 2005; Maskrey et al. 1991). Economic booms exploiting rubber, wood, furs, barbasco, tobacco, cotton, coffee, coca and oil, to meet the needs of mainly North American and European industrial nations, have provided sporadic and unstable economic growth and collapse in San Martín, impacting the lives of Amazonian populations, namely the lives and livelihoods of Indígenas, campesinos, farmworkers and the economically poor. Economic booms of Peruvian coca, for example, demonstrate how fluctuating and polemic demands among national and international consumers can influence campesino cultivation patterns and local medical knowledge systems, and can contribute to local community and environmental health problems\footnote{Such as environmental pollution from pesticides for large-scale cultivation and herbicides used in contemporary eradication strategies, also the toxic chemicals such as solvents used to break down the leaves to render pasta básica, or basic paste before it is further refined into cocaine. Additionally, local addictions to pasta básica are a health problem resulting from intensified illicit coca crop cultivation and processing for export.}. The first coca boom\footnote{Ethnobotanists estimate that coca has been cultivated since 6000 B.C. (Starn, Degregori and Kirk 2005:407), in the Andes for 7000 years, and more recently in the Amazon (Balick and Cox 1996:169). Even under Spanish rule, coca continued to be cultivated (Gray 1997b:5) and formed an integral part of Peruvian, especially Andean, social and economic relations, medicine, and ritual. The product used in these instances, however, was the coca leaf itself, chewed with a pinch of lime (Ca₃CO₃) to induce the release of mild stimulant and nutrients into the bloodstream. Cocaine, in its refined form, came later, when, in 1860, a German chemist isolated the alkaloid cocaine from the coca leaf. Cocaine use for headaches, general anesthetic, and to cure opium addiction became popular in European and North American medical practices in the 1880s. The demand for coca at this time initiated the first international coca boom (Kawell 2005:430; Balick and Cox 1996:167-177).} in Peru was licit and catered to a European and North American market for medicine and tonics. The second, illicit, coca boom is discussed in further detail below. These booms brought with them large groups of entrepreneurs and migrant workers from national and international origins who, in turn, brought with them
variations of agricultural, religious, spiritual, ideological, and medical knowledge systems. In short, economic booms have facilitated the transfer of knowledge among locals and incoming migrant workers. There are several examples in local medical knowledge systems in San Martín that demonstrate this transfer of knowledge. Some local healers refer to the humoral system\textsuperscript{26} in their diagnosis, use manufactured products such as \textit{agua florida} and other perfumes, and invoke the protection of Catholic saints\textsuperscript{27}. Economic boom cycles throughout history have intensified knowledge exchange and defense throughout history—thereby allowing healers to integrate aspects of other knowledge systems, or deepening healers’ valorization of their own practices and beliefs.

\textit{Colonizing the Frontier}

The 1930s in Peru were marked by national interest in colonizing the national jungle frontier. In this government initiative, roadways were carved out of the jungle and Peruvians from other parts of the country were encouraged to resettle in the abundant lands of the Amazon (Kawell 2005:430; Gonzales 1992:105). The ‘living frontiers’ approach, from the 1940s onward, was promoted by the Peruvian government to encourage poor people from the Peruvian highlands to colonize the rainforest (Gray 1997b:76). Through initiatives promoting resource extraction, such as federal grants to colonists for the cultivation of export crops, and populating Amazonian areas with

\textsuperscript{26} The humoral system is based upon concepts of hot and cold diagnosis and remedies derived from the medical knowledge of Spanish colonial society. This was based on the classical Greek compendium of Dioscorides. The Spanish version in circulation during colonial times was edited by Andrés de Laguna (Jovel 1996:23).

\textsuperscript{27} Demange (2002: 32) and Jovel (1996:23) suggest that during the colonial period, healers were demonized and accused of being sorcerers. Therefore, the integration of Christian icons into their healing repertoire has been seen as a way to legitimize their practices (Demange 2002: 32).
immigrants, the Peruvian state was able to establish municipal government and extend its control into these regions (Gray 1997b:76).

Regions surrounding the Huallaga river valley saw increased settlement in the 1940s as single-lane road transportation opened up the area (previously accessible only by jungle paths and waterways), and coffee and tea plantations appealed to a few entrepreneurial settlers who employed Indigenous and Mestizo locals. During World War II, American interest peaked for the exploration and development of “strategic” jungle products such as rubber, medicines such as quinine, and insecticides such as barbasco. American funds went into improving the road infrastructure and research in the Amazon regions of Peru. When, after the war, American interest in these resources declined, so did the economy of these regions, San Martín included.

Beginning in the 1960s, and culminating in the 1970s and 80s, highway construction into the jungle interior and government agricultural incentives moved Peruvians, primarily from the Andes, but also from the coast, to seek opportunities for settlement in San Martín (Kay 1999:101; Tang T. and Pinasco 2005; WamanWasi 2006). The jungle colonization initiatives promoted by President Belaúnde Terry (1963-1968) created conflicts over land title, leading to the dispersion of indigenous peoples to other areas previously uncultivated and the overuse of agricultural surfaces (WamanWasi 2006:9), and general lack of environmental controls led to soil depletion, compromising the sustainability of development in this region (Tang T. and Pinasco 2005; Wilson and Wise 1986:108-109). Highway networks also connected resources from Andean and Amazonian regions to national markets and export opportunities on the coast (Wilson and Wise 1986). The Carretera Marginal, now known as the Belaúnde Terry Highway, is
the main highway connecting San Martín to the coast and Peru’s capital, Lima and was one of the major transport projects of the 1970s.

While the intentions for jungle colonization may have included the production of food crops for domestic consumption, provision of settlement opportunities for highland migration, and facilitation of efforts to control illicit coca production, it is suggested that the main impetus behind these projects “has been to facilitate exploration and extraction of petroleum and wood for export” (Wilson and Wise 1986:109). As Gray summarizes the situation, the Peruvian state has devoted its interests in the Amazonian regions over the past 50 years to securing frontiers, extracting wealth, and establishing political control (Gray 1997b:75). A review of major state policies that have influenced the political economy of San Martín is provided in the following sections.

**Peruvian Political Economy 1960s-1990s**

Economic and political instability in Peru over at least the past 50 years has contributed to marginalization of working class and campesinos, political insurgencies and civil warfare, contemporary attitudes of general mistrust, and lack of confidence in national government leadership for the region of San Martín. Nationally, Peruvian politics have been largely influenced by international incentives to modernize, such as from the Alliance for Progress 1961\(^\text{28}\), incentives to participate in international market economies, such as the “stabilization” strategies\(^\text{29}\) of the International Monetary Fund (IMF) and $25

\(^{28}\) It was in 1961 that the Alliance for Progress was established at the Hemispeheric meeting in Punta del Este in Uruguay. Under the direction of John F. Kennedy, this alliance sought to implement programs to develop and modernize Latin America primarily through foreign aid financing from the United States and lending agencies.

\(^{29}\) In the late 1970s, to the mid 1980s, Peru underwent several stabilization policies demanded by the IMF and other private transnational banks in return for debt rescheduling. The priorities of these programs were
million deposit from Occidental Petroleum in 1978 (Kuczynski 1981), and the allures and burdens of international loans, including guidelines and loans from the IMF and short-term loans from Mexico, Venezuela and Spain in 1978 (Kuczynski 1981). In this forum of international interest in Peru’s economy, political leaders of Peru have attempted to reform the nation’s market through various agendas of reform, multi-sector reorganization, resource exploitation and trade, and international lending.

Peru’s relationship with foreign investment and lending has been delicate. In the late 1960s and early 1970s, Peru was excluded from substantial development aid from Washington and the World Bank owing to national and international disputes over oil investment (Kuczynski 1981:6), military coup d’etats, and nationalization of the oil, fishing, and mining sectors in pursuit of economic development through domestic industrialization (Berrios and Blasier 1991:367). Military rule under General Juan Velasco Alvarado (1968-1975) took on a left-wing nationalist agenda including land reform, expropriation of several foreign companies, increased national control of natural resources and industrial partnership (The Economist Intelligence Unit 2006:5). Government tendency at this time was to invest in a modern industrial agricultural sector at the expense of regions where traditional agriculture was prevalent. Flawed distributional and agricultural reforms that favoured urban consumers over rural producers (Wilson and Wise 1986:101), combined with Velasco’s rejection of both

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30 In 1968, Belaúnde Terry was overthrown by a coup due to hostility towards his foreign investment policies in the oil sector and accusations of corruption in his administration (The Economist Intelligence Unit 2006:4).

31 Under agrarian reform, large haciendas were divided into agricultural cooperatives (Strong 1992:85), promising commitment to cooperative production and the protection of private small and medium-scale farmers (Wilson and Wise 1986:101). However, in action, these reform measures catered primarily to large-scale coastal irrigation projects (Wilson and Wise 1986:101).
capitalist and communist ideology (Berrios and Blasier 1991:367), may have contributed to the resentment felt by Peru’s Shining Path (a faction of the Peruvian Communist Party32), to Velasco’s policies.

By late 1977, under the government of Francisco Morales Bermúdez (1975-1980), the foreign debt of Peru was estimated to reach $5 billion. This contributed to pressures from the IMF to implement the ‘orthodox’ economic strategies of structural reform (Bamat 1983:147).

Belaúnde Terry was re-elected in 1980, ending twelve years of military rule. Also at this time, increasing foreign debt, climatic conditions hampering agricultural production, and political violence stressed the economy. In return for debt rescheduling allowances by private banks and the IMF, Belaúnde’s administration was directed to implement reform and trade liberalization (Pastor and Wise 1992:86; The Economist Intelligence Unit 2006:5; Kay 1999:102) through a neoliberal economic model in conjunction with an IMF stabilization program intended to reduce state enterprises, stimulate private investment and open up the Peruvian economy to domestic and international investment (Pastor and Wise 1992:85; 86-87). It is argued that this approach was “inappropriate to the Peruvian economic structure and failed to address class and distributional dynamics”33 (Pastor and Wise 1992:85). The resulting economic

32 Resistance to social hierarchies and monopolies of knowledge and resources have taken many forms in Peru. Indigenous revitalization movements in the Andes such as Taqi Onqoy, the rebellion of Juan Santos Atahualpa, Manco Inca II, Tupac Amaru II and Tupac Catari all exemplify historical class struggle and form a legacy of struggle that contributed to the formation of several communist parties in Peru. The Peruvian Socialist Party was founded in 1928 and changed its name to the Peruvian Communist Part in 1930 (Berrios and Blasier 1991).

33 Despite an initial increase in wages for farmers and informal sector income, wages fell over 35% from 1982-1985, and the agricultural-manufacturing terms of trade also fell more than 35%, resulting in drastic reductions in peasant income (Pastor and Wise 1992:94).
inequalities contributed substantially to political resistance movements and their increasing influence during this time.

Belaúnde Terry was replaced in 1985, through general election, by Alan García Pérez (1985-1990). García’s policy of limiting payments on external debt earned him resentment from the IMF and became an obstacle to Peru’s participation in international financial markets. It was during García’s reign in the late 1980s that the Peruvian economy was on the verge of economic collapse as Garcia’s developmental agenda and “policies fueled an agricultural crisis” (Kay 1999:102; The Economist Intelligence Unit 1997). This agro-economical crisis reduced licit opportunities for local farmers and increased the allure of the more lucrative illicit production of coca. At this time, the Shining Path also established footholds in the Huallaga Valley in San Martín.

**Coca, Communism, and Capitalism**

The *Sendero Luminoso* (SL), or ‘Shining Path’, came together under a Maoist Marxist ideology in the 1960s. During the height of its insurgency in the 1980s and 1990s, the *Sendero Luminoso* occupied villages and coca plantations in the Huallaga River Valley (stretching north from Huánuco Department to San Martin). It is documented that in the 1980s, the Shining Path initiated political work in the Upper Huallaga Valley, settling as coca growers and building up the organization with members from Tarapoto (Gonzales 1992:106). Whether or not *Sendero Luminoso’s* occupation of the Huallaga Valley was planned in a move to take control of the coca market, or a serendipitous union of circumstances, their protection of coca growers as a sort of “armed union” gave them
much power in the region\textsuperscript{34} (Kay 1999:102-103). \textit{Sendero}’s followers took refuge in protection from military interventions against coca cultivation, participated in an ideology that would wrest power and resources from government control, and enjoyed lucrative salaries through coca revenue.

According to the \textit{Sendero Luminoso}, “cocaine consumption was a ‘consequence of the putrefaction of the imperialist system’ while coca cultivation and consumption were an integral part of Andean economy and culture” (PCP 1997 in Kay 1999:104). This statement not only attempts to justify the cultivation and consumption of coca, but also makes very important distinctions between coca and cocaine, between the imperialist (or capitalist) and ‘Andean’ economy and culture, between supply and demand, and between producers and consumers. In San Martín, these distinctions extend to ideological and economic differences between coca as medicine and coca as commodity, between \textit{campesinos} and North American and European consumers, and they call attention to the different experience of nature as relational and nature as resource.

Economically, coca cultivation became a way out of poverty for many \textit{campesinos} in San Martín\textsuperscript{35} (Stong 1992:117; Kay 1999:101). During the 1980s, the

\textsuperscript{34} Besides protecting growers, \textit{Sendero} performed an intermediary role, acting as a kind of armed union for the growers, forcing traffickers to pay higher prices for coca than farmers could negotiate for themselves. The guerillas also enforced a restrictive social order—punishing drug users, closing down bars and brothels— which was popular with valley residents, who preferred \textit{Sendero}’s harsh justice to the corrupt formal system. Having created order while increasing local incomes, the guerillas garnered a base of support in the Upper Huallaga Valley and formed a local army of more than a thousand militants (Kay 1999:103).

\textsuperscript{35} Alan Garcia, Peruvian president (1985-1990), is quoted as having stated that the burden of national debt “had fallen on the shoulders of the peasants who, in growing coca, had encountered a solution to their poverty” (Strong 1992:117). Garcia was also known “to cooperate with U.S. drug control efforts to gain debt relief and development funds, but later encouraged the reinvestment of drug money as foreign exchange dried up, granting immunity to traffickers who repatriated hard currency” (Kay 1999:101). As Kay points out, coca production played a significant role in Peru’s economy in the 1980s earning between US$800 million and $1.2 billion annually which comprised “a third or more of the value of Peru’s legal exports and more than the combined value of copper and petroleum” (Kay 1999:101). The coca industry
Huallaga Valley became “the world’s single largest coca-growing zone” (Strong 1992:109). In response to the anti-government activities of the Shining Path, and the increase in drug trafficking cartels and activity, the Peruvian military “was given responsibility for counter-insurgency operations [and] widespread violations of human rights ensued” (The Economist Intelligence Unit 2006:5), particularly in designated “emergency zones” (Pastor and Wise 1992:112).

U.S. involvement in drug control through the Drug Enforcement Agency (DEA) played a major role in shaping the current political environment of the region. Kay suggests that “clumsy attempts by Peru and the United States to eradicate coca during the 1980s did much to galvanize the guerilla-coca coalition in the valley” (Kay 1999:104). These eradication projects36 adversely affected local coca farmers and led them to seek guerilla protection (Palmer 1992; Gonzalez 1992).

Today, while coca cultivation still exists in small pockets, especially in the Huallaga valley, and occasional reports suggest the persistence of guerillas in the area, the people of San Martín experience relative peace. Unless, however, they subsist in areas under the constant patrol of helicopters engaged in the exploration of potential oil reserves, the influx of tourists, or the curiosities of researchers looking for the next medical discovery. A discussion of how oil prospects, ecotourism, and bioprospecting as the next economic booms are shaping the region of San Martín follows below.

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36 Coca eradication was achieved through the testing and application of herbicides such as Tebuthion, manufactured by pharmaceutical company Eli Lilly, and the movement of ground crews wielding gas-powered weed cutters by helicopter to sites of coca cultivation (Palmer 1992:109; Gonzalez 1992).
Contemporary Economy and Population in San Martín

Contemporary development in San Martín is focused primarily on industrial agriculture of export crops, such as coffee cooperatives\textsuperscript{37}, rice, yucca [manioc], maize, tobacco, cotton, plantain, coconut and orange plantations; tourism, through the promotion of ecotourism and forest products that sustain biodiversity\textsuperscript{38}; and the exploration of hydrocarbons (Gobierno Regional San Martín 2006).

The contemporary population of San Martín is Indigenous, Mestizo and European. In the communities where I was interviewing healers, Indigenous and Mestizo individuals traced their descent to the Lamas and Chazuta, Indigenous communities of the area who speak jungle Kechua. The Kechua people are an ethnic group situated in the region of San Martín, dedicated principally to small-scale agriculture of burning and rotation (swidden), “cultivating biodiversity”, fishing and hunting (WamanWasi 2006:9). Their population consists of approximately 35, 000 people distributed in the five provinces of the region of San Martin: Lamas, Picota, Bellavista, San Martín, and El Dorado (Romero 2006). The Kechua-Lamistas, a particular group of Kechua-speakers, inhabit the village and surrounding jungles of Lamas. Even after several government

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\textsuperscript{37} Oro Verde is an example of a coffee cooperative located in Lamas, San Martín. Founded at the end of 1999, it initially came together as an initiative proposed by the United Nations to “wean producers in this region away from the illicit coca drug trade” (UMAS Amherst 2007).

\textsuperscript{38} Oil palm, Sacha Inchi (\textit{Plukenetia volubilis}) and cotton are examples of forest products that San Martinese are attempting to cultivate and promote within biodiversity conservation frameworks (Gobierno Regional San Martín 2004:7).
initiatives to eliminate poverty in the region (Participa Peru 2005), the Kechua-Lamistas remain, to a large extent, economically marginal in San Martín. Although perhaps viewed as an economic opportunity by the Peruvian government, foreign investors, multinational companies and select local populations, development of the oil industry in the Peruvian Amazon has been a contentious issue. In Lamas, Indigenous groups, along with NGOs, have recently organized to express their concerns through local radio and filmed media over oil exploration. Especially due to recent conflict in Ecuador (between Indigenous inhabitants and the Occidental company) over Occidental oil company’s environmental policy, members of the community of Lamas have been raising their concerns over the current oil exploration in their area. They complain that oil exploration and exploitation creates increased road access to their territories, accompanied by mass migration, resource exploitation and agricultural practices that degrade the land.

*Landscapes in Tension*

Due to their dependence on nature for healing practices, the healers of San Martín are linked to local conflict over land use. Healers experience what Escobar refers to as “landscapes in tension” which feature the “organic landscapes of the communities, the capitalist landscape of the plantation, and the technoscape of the biodiversity and

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39 Currently, the government of Alan Garcia (elected July 28, 2006) has been reported as pursuing a “broadly pro-market economic policy” and it is believed that “economic growth will be driven by the Camisea natural-gas project, as well as by growing exports of minerals, textiles and agricultural produce” (Economic Intelligence Monitor 2007:3). According to The Economist Intelligence Unit’s Country Report on Peru in January of 2007, “the third quarter of 2006 marked the ninth consecutive quarter of growth in Peru’s oil and gas sector” (Economist Intelligence Unit 2007:21). The report goes on to explain that “with large deposits continuing to be discovered, interest in the exploration of Peru’s oil and gas resources remains high, especially in the Amazon region of Loreto”, which borders the region of San Martin along the northeast (Economist Intelligence Unit 2007:21).
biotechnology researchers and entrepreneurs” (Escobar 1995:5). In San Martin, nature is 
the *chacra*, in which *campesinos* cultivate food crops, medicinal plants, and firewood. It is *el monte*, where *campesinos* collect medicinal plants, food, building materials, and 
where they fish and hunt. It is also the plantation, where *campesinos* cultivate cash crops 
and work for wage labour. Now, in and around Lamas and Tarapoto, nature is also 
attractive for sustainable development projects, subject to oil exploration and is a site of 
conflict between Indigenous and *campesino* territorial rights, and those of the 
government, local and foreign investors. Conflicting intentions for land use stem from 
different worldviews and economic conditions. Worldviews, whether they be categorized 
as capitalist, socialist, kincentric, Indigenous or otherwise, tend to hinge upon ideas of 
nature as resource or nature as relational.

In the worldview of nature as resource, our natural environments provide us with 
objects of value that are commodified and consumed, and have importance in the market 
economy and international trade. Although non-market driven frameworks may also 
perceive nature as a resource, these resources are not necessarily perceived as 
commodities or as having market value. To obtain objects of market value, nature is often 
refined into discrete substances. Oil is refined into petroleum products, metal ores into 
gold, silver, copper, etc., coca into cocaine, and species are extracted from ecosystems to 
be cultivated in mono-crop plantations.

The relational framework situates humans within a nature that is interactive and 
for which we share social relations and obligations, akin to what Nancy Turner describes 
approach through the presentation of various narratives of Indigenous oral tradition that
highlight the social relationships between humans, animals, plants and the Creator. She suggests that:

Philosophies from the Rarámuri [of *Gawi Wachi* in the eastern Sierra Madres of Chihuahua, Mexico] and Nuu-Chah-Nulth [west coast of Vancouver Island] confirm and reinforce the idea that humans do have kinship with all the other elements of their world. Ceremonies, customs and stories recognize and validate this connection, as do the ways in which people relate to their lands and resources. This kinship supports and nurtures humans, but brings with it obligations. The same responsibilities that most humans feel towards their own family members are, in the kincentric view of Indigenous peoples, extended to all life. It is the duty of all humans to acknowledge, and to look after, *all* of their relatives and to consider their health and well-being as inextricably bound to humans.

This relational, kincentric view does include the concept of nature as a resource, but not without responsibility to care for and maintain this resource.

When taken to its extreme, the view of nature solely as resource leads to the degradation not only of the environments surrounding humans, but also the fabric of human social relations. While relational, non-market driven perspectives of nature can also result in environmental degradation, acts that lead to degradation would likely be considered as transgressions of the reciprocal relationship inherent in human-environment-spirit relations. Colding and Folke (2001) suggest that social taboos are a good example of informal institutions\(^\text{40}\) that can guide human conduct towards nature,

\(^{40}\) Informal institutions in this context are described as “norms of behavior, conventions, self-imposed codes of conduct, and other enforcement characteristics...decentralized and self-enforced by a community, where no external authority is able to guarantee that social actors will abide to rules and procedures”(Colding and Folke 2001:585). These systems are contrasted with formal institutions “such as written rules, laws, and constitutions and are highly associated with the structural complexity of industrialized nations and their divisions of labor”(ibid.)
and could potentially contribute to biodiversity\textsuperscript{41} conservation and local resource management. As Escobar (1995:6) suggests, “from a Marxist perspective the separation of nature and society is seen as ideological, the unity of capital entails the fusion of use-value and exchange value in the production of nature”. This separation of nature and society is what makes commodification possible. A market-driven approach to nature, while requiring relations of economic exchange of capital, does not respect the reciprocal relationship between humans, nature and spirits. Industrial projects of agriculture, mining and manufacturing are geared to the extraction of resources, not necessarily the maintenance of kinship relations with nature. Although some efforts are being made for sustainability and environmental stewardship, resource-focused and market-driven notions of nature tend to conflict with the concept of Yachay, or knowledge in everything, as found among the Kechua Lamas in the region of San Martín.

\textit{Kechua Lamas and Yachay}

Resonating with Turner’s description of a kincentric worldview, the Kechua—Lamista worldview involves the relational concept of yachay or knowing (see also Luna 1984b:143), which they believe to be shared among all living things:

The word \textit{yachay} or \textit{yachá} in the quechua language of Lamas indicates, among other aspects, knowing. \textit{Yachay} is not only an attribute of humans, men and women of this region. \textit{Yachay} is also possessed by animals, plants, rivers, \textit{cochas, puquios}\textsuperscript{42}, and everything that exists. In the Indigenous world of the

\textsuperscript{41} Biodiversity, or biological diversity, (as discussed below) is defined by the United Nations Convention on Biological Diversity as “the variability among living organisms from all sources including, \textit{inter alia}, terrestrial, marine and other aquatic ecosystems and the ecological complexes of which they are a part; this includes diversity within species, between species and of ecosystems” (Sampath 2005:183).

\textsuperscript{42} \textit{Puquio} is Kechua for clean water spring.
quechua of this region of the Amazon everyone are people; the large majority of this Indigenous population has not participated in the separation, characteristic of modernity, that divides and opposes the human-nature relationship and that gives space to the notion of resources. In the absence of a subject—object relation, knowledge is not obtained through a mental apprehension of the object by a cognizant subject, rather, it is obtained through the empathy and understanding between the knowing and doing of people implicated in an activity. The resulting action, therefore, derives from a “minga” of knowledge, a relationship of cooperation and support of the yachay of humans, nature and deities. In this way, that which is done in the chacra is a result of a conversation among humans, the moon, dreams, plants, and the spirits of the monte (translated from Vásquez in WamanWasi 2006:5).

In this definition of knowing or yachay, relationships of cooperation and support are contrasted with modernity and the subject—object notion of resources. Healers in San Martín depend upon the concept of yachay for the transmission of knowledge from plants and maestro curanderos. If modernity and the resource view of nature separate humans from nature, then how do local healers situate themselves within modern medical knowledge systems? Especially in the discourse of science and rationality, where does the concept of yachay fit in? Vaquez (in WamanWasi 2006:5) suggests that yachay does not fit well into a modern model:

School, modern institutions and mediums of communication have brought to our lands the objective discourse of science and rationality, and with this have promoted the idea of nature as… an object that can be managed, exploited and

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43 Minga is a Kechua word used to describe a type of communal work, derived from a system of rotating farmer work during the Incan empire. All farmers would rotate to work together on all chacras.
commercialized. They have declared in sum, the death of nature. [From this perspective] the living and providing mother, *sachamama* or mother of *el monte*, has been relegated to the realm of myth and legend, to give way to concepts and factors of production, notions linked to development of capital markets.

Although the regional government of San Martín states that its mission is to establish sustainable, biodiversity-friendly development in the region, a general emphasis on regional competition in the agricultural sector could compromise this goal, placing more emphasis on modern technology than on understanding existing human nature relationships. Both foreign and local companies interested in participating in the global market economy have encouraged locals to narrow their conversation with nature to one-way communication: exploitation of the resources provided by nature for profit. Through the reduction of nature to objects of value, the knowledge of plants, rivers and animals is shut out. In a publication of “wisdom for the care of *el monte* and the water”, a collaboration of Kechua Lamistas and the NGO WamanWasi, it is stated that:

According to the Indigenous opinion, the loss of respect towards traditional wisdom of cultivating *chacras* and *monte* is due to the desire to create enormous fields of cultivation and the appetite for monetary gain in the short run. The situation experienced by current families who do consider the practice of their parents, who had significant areas of forest, is that now these areas no longer exist. This situation, plus the influence of an education system that gives little respect to local knowledge, the practice of de-sacralizing nature on behalf of certain fundamentalist religious sects, and the weakening of communal relations, has driven many agriculturalists to deforest areas of wilderness, letting the water disappear, which generates degraded areas of major intensity, such that the
diversity of cultivars, agricultural species and trees diminishes (translated from WamanWasi 2006:13).

This insatiable appetite for short term monetary gain, cited by the authors as a loss of respect for traditional practices, is the kind of economic development that is being criticized by some of the locals in San Martín who see the biodiversity replaced with mono-crop agriculture, and large-scale deforestation.

*Sangre de la Tierra, Blood of the Earth*

Kechua-Lamistas have been organizing to document and promote their traditional knowledge systems as defense and legitimization of their land use. The NGO WamanWasi has been accompanying a group of communities that have unified as the “Committee of Conservation for Biodiversity and Protection of the Environment” (Romero 2006). Composed of representatives from diverse Kechua communities, native farmers and the Ethnic Consultants of Kechua Peoples of the Amazon (CEPKA), this committee has taken on the role of overseeing the sociopolitical and cultural concerns of oil development in the region 44 (Romero 2006). Oil exploration and the awareness campaign surrounding it calls our attention to the interaction of resource and relational views of nature, and highlights how an economic boom, such as the potential for oil

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44 According to a report issued by WamanWasi in the fall of 2006 (Romero 2006), in 2005 the oil company Occidental Petroleum was granted authorization to explore an area of 870,896 hectares named Lot 103. At the time of the report, occupation of this area was in the phase of exploration. Since 2005, Occidental Petroleum and the Peruvian Ministry of Energy and Mines have held workshops providing information for a limited number of Indigenous communities who are recognized under the Indigenous organization FEPIKRESAM (Federation of Indigenous Kechua Peoples of the Region of San Martin). This federation is composed of 14 communities. WamanWasi complains that these workshops inform only the nationally recognized Indigenous communities, which represent only a small portion of the various different Indigenous and Mestizo communities who depend upon this land base.
development, can bring with it both opportunities to strengthen tradition in defense of nature, and obstacles to practice tradition if access to nature is compromised or denied.

3.4 ENVIRONMENT

Biodiversity Conservation

Biodiversity Conservation is a prevalent theme for economic, community and environmental development in San Martín (Government San Martín 2004). In the last twenty years, the term “biodiversity conservation”, originally the concern of a few biologists and environmentalists, has caught the attention of international policy-makers, developers, the general public in many areas of the world and, subsequently, politicians. On June 12, 1992, Peru joined 157 other countries signing on to the United Nations Convention on Biodiversity\(^\text{45}\), committing to objectives of conserving biodiversity, the sustainable use of its components and the fair and equitable sharing of the benefits arising out of the commercialization of biological resources (Sampath 2005:36). Perhaps the most significant point of departure that the Convention on Biological Diversity has had from earlier international environmental agreements, “is the recognition that conservation and sustainable use of biodiversity can only be tackled when viewed within the economic context in which biodiversity operates” (Sampath 2005:35). Recognition of economic factors of conservation has raised many questions regarding knowledge, land and resource management, access, ownership and commodification, which are especially debated in the context of traditional knowledge and Indigenous rights. For healers in San

\(^{45}\) The UNCBD was held at the time of the United Nations Conference on Environment and Development in Rio de Janeiro in June of 1992, and has come to represent an international landmark initiative towards sustainable development.
Martin who identify themselves or their knowledge systems as traditional or Indigenous, what are the implications of policies on biodiversity conservation?

*Traditional Knowledge and Biodiversity Conservation*

Although the actual term “biodiversity conservation” is relatively new for developmental discourse, ethnobotanists are quick to point out that as a concept, biodiversity conservation has been practiced as a necessity among Indigenous people for centuries and is a fundamental aspect of their traditional knowledge systems (Turner 1997, 2005; Wood Sheldon and Balick 1995). As Wood Sheldon and Balick (1995:57) point out, “Indigenous approaches to ecosystem management, based on a detailed knowledge of a plant’s uses and biology, can provide invaluable long-term models for sustainable use”, specifically, traditional resource management in this context “reinforces a dynamic system that both conserves and exploits biological diversity. The role of traditional knowledge in biodiversity conservation has become a topic of much interest and contention in Peru where populations of Indigenous people have been cultivating knowledge systems through an intimate relationship with their land bases for centuries and are now faced with having to stake ownership of these knowledge systems in order to defend them in a market-based economy (see Greene 2004). The debate over traditional knowledge, biodiversity conservation and natural resources stems from two major global trends. The more general trend involves research and development of traditional knowledge as a means to conserve biodiversity through resilient techniques of resource management that have been practiced over centuries (see Berkes 1999; Turner and
Berkes 2006a and 2006b). The more specific (and contentious) trend focuses on the commercial value of traditional knowledge—specifically knowledge pertaining to plant medicines and other medical practices. This latter trend exploring the potential of plant products for commercial development, is known as bioprospecting. Bioprospecting, or, in the case of Indigenous people’s plants, biopiracy, as it is referred to by its critics, has become an international concern for indigenous communities, indigenous advocates, governments, and pharmaceutical and agrochemical companies. Greene describes bioprospecting as “the contemporary search for scientific-commercial utility in the world’s biological resources” (Greene 2004:213). Bioprospecting has gained momentum in Amazonian regions and the role of traditional knowledge has become difficult to define when entered into the equations of market value, commodification, patents and intellectual property rights46 (Johns 2000; Shiva 1997).

Debate over the role of traditional knowledge in sustainable development, and the role of intellectual property rights in safeguarding traditional knowledge, is based on two opposed viewpoints. Proponents of incorporating traditional knowledge into development strategies suggest that the ratified UN Convention on Biological Diversity “represents an important step in trying to overcome the colonial heritage that is inherent in the economic and technological power relations around the globe” (Merson 2001:291). Opponents suggest that the economic forces of globalization are resulting in neo-colonialism, and that IPRs are an extension of neo-colonial control over communally-

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46 Intellectual Property Rights (IPRs) are defined as “a particular aspect of property covering ‘all things which emanate from the exercise of the human brain’” (Philip and Firth 1990 in Swanson 1995:181). Swanson explains that “the major intellectual property rights are patents, plant breeding rights, trade secrets, trade marks and copyright. The general principle behind IPR protection is that the ‘right holder’ is given some form of monopoly control over the economic exploitation of the material concerned” (Swanson 1995:182). (See also Brush 1993; Sampath 2005; Rosenthal 2006).
owned resources (see Shiva 1997). Greene points out that “intellectual property is historically associated with an ideology of possessive individualism and romanticized individual authorship, a peculiar feature of and for capitalist societies” (Greene 2004:213). Critiques of IPRs and regimes of ownership highlight the challenges faced by Amazonian communities, developers, policy-makers and governments in trying to negotiate the exchange (value) of knowledge. Shiva also points out that regulations such as IPRs limit the creative and dynamic processes inherent in biologically and culturally diverse systems (Shiva 1997:7-17). In short, knowledge systems under private ownership are generally limited to static, narrowly defined entities, as opposed to fluid, dynamic, creative and reciprocal processes.

It is precisely these—the dynamic, creative and reciprocal processes of knowledge exchange at the interface of different knowledge systems—that my research in San Martín has focused on. Through my interviews and interactions with the healers, I recognized that their healing practices are constantly changing with the introduction of different methods and materials from different knowledge systems. One healer, for example, a perfumero working primarily with plant essences (perfumes) and river spirits, would icarar or sing into pharmaceutical products to activate them. Another healer, working in a western medical clinic, prescribed not only pharmaceutical products, but also herbal remedies. In my fieldwork, I found many examples where ideas were being exchanged between knowledge systems, contributing to an innovative body of knowledge that was neither traditional nor modern, but intercultural (defined below). This exchange of knowledge is not new. To the contrary, much of scientific medicine has depended upon the traditional medical practices of many cultures worldwide. It is believed that
some 25-50% of “scientific” medicines are derived from natural products (Davis 1995:40). Contributing, in large part, to the research, development and debate of traditional knowledge, in historical, modern and capitalist contexts, are the studies of ethnomedicine and ethnoecology.

*Ethnobotany and Ethnoecology*

Ethnobotany is a field of study with many definitions, subdisciplines, and applications. Originally, ethnobotany was explained as “the study of plants used by primitive and aboriginal people”, derived from its initial use by Harshberger in 1895 to describe his medical and botanical work in Mexico (Schultes and von Reis 1995; Zuluaga and Correal 2002:58; Balick and Cox 1996:3). Early studies in ethnobotany frequently documented “more than simple plant uses; they often recorded beliefs about the plants and human ecological relationships as well” (Minnis 2000:7). Since then, ethnobotany has been used to describe the “totality of human-plant relations in a culture and the direct interaction of people with plants” (Ford 1980 in Zuluaga and Correal 2002:58). Minnis (2000:4) suggests that ethnobotany is contemporaneously pertinent in two main aspects, the first being the “exploration for economically useful plants—the economic botany tradition—and the second concerns the quest for indigenous ecological knowledge”.

Discoveries of herbal remedies and the isolation of their chemical compounds or alkaloids used for scientific medicine have been the driving force behind much contemporary bioprospecting (Greene 2004:213). Quinine isolated from *Cinchona* spp., cocaine from coca, and the anti-cancer agents found in Pacific Yew (*Taxus brevifolia*) are examples of chemical plant compounds that have been used in medical research.
However, ethnobotanists Wood Sheldon and Balick warn against overemphasis on the search for chemical compounds alone, suggesting the “importance of matching our understanding of molecules with an ability to sustainably manage the larger natural systems in which they originate and flourish” (Wood Sheldon and Balick 1995:46). In addition to consideration of the larger natural systems in which medicinal plants exist, many emphasize the importance of recognizing the cultural, spiritual and economic systems in which the plants are entwined (Brent 2001; Shiva 1997, 1993:88-89; WamanWasi 2006). Scholars of the latter belief would fit within the scope of ethnoecology, a term used to describe “studies of the botany, science, or ecology of a particular ethnic group” (Fowler 2000:13). Increasingly, the term ethnoecology has been “used to encompass all studies which describe local people’s interaction with the natural environment” (Martin 1995:xx in Fowler 2000:13), moving beyond cataloguing plant information to include consideration of multiple aspects of human-environment interrelationships (Fowler 2000:13).

There are several international collaborative ethnobotanical and ethnoecological initiatives that consider the interaction of natural, cultural, spiritual and economic systems at a community level. These projects are aimed at preserving and strengthening traditional knowledge systems, simultaneously conserving the values and resources of small rural communities, including the SEAMP—TEKAM AKHA Plant Medicine Project in Thailand (Turner 1994-1995), and numerous community projects in collaboration with the Amazon Conservation Team (ACT) in Latin America, such as the
Shaman’s Apprentice Program, Ethnoeducation and the The Union of Yagé Healers of the Colombian Amazon UMIYAC\(^47\) (UMIYAC 2000; ACT 2004).

In San Martin, I participated in the workshops of local healers and NGOs who are collaborating to bring knowledge systems together for the improvement of public health. I was also a patient for a few healers who diagnosed and treated me with various traditional and modern resources. I discuss these in more detail in the following chapter, four. In the following section, I outline definitions of traditional medicine, the role of traditional medicine in international health initiatives, the negotiation of traditional medicine in global markets as a commodity and new economic boom, and how these have contributed to what are now defined as intercultural initiatives in San Martin.

3.5 HEALTH

*Traditional Medical Knowledge and International Development*

Traditional medicine, like traditional knowledge, has many different definitions in both policy and practice. Traditional medicinal knowledge, defined by the UN Convention on Biodiversity, is “knowledge of medicinal use of traditional and local communities or ethnobotanical knowledge, which can be registered or protected as a trade secret” (Sampath 2005:177). In 1966, Alland defined traditional medicine as an ecological-cultural-biological conceptual framework in which culture, biology, environment and sickness interrelate in an adaptive process between continuous circuits of adaptive

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\(^47\) Although admitting the difficulty in the “transition from oral tradition to a culture that sanctifies the written word” (Zuluaga in UMIYAC 2000:5), UMIYAC, together with support from the Amazon Conservation Team, has published a Code of Ethics for the Practice of Indigenous Medicine in the Amazon Piedmont of Colombia to address issues of environmental degradation and the loss of traditional knowledge. This volume is entitled “El Pensamiento de Los Mayores”, or, The Beliefs of the Elders (UMIYAC 2000). In collaboration with a Western-trained physician, a group of Colombian Elders document their concerns about the marginalization of Indigenous healers throughout colonial history, and outline their efforts to legitimate their medical practices on their own terms.
feedback (Zuluaga and Correal 2002:11). In Latin America, official study of traditional medical systems was initiated by the Institute of Social Anthropology at the Smithsonian Institute in 1951 (Zuluaga and Correal 2002:11). In the 1960s, worldwide attention to alternative healing knowledge came about, partially, due to the strategies of health development initiated by the Republic of China (Zuluaga and Correal 2002:12). Health development in China at this time was moving towards the combination of resources derived from ancestral Chinese medicine, with sanitary programs, illness prevention and western scientific medicine to address health problems of the large population (Zuluaga and Correal 2002:12). With ancestral herbal remedies more widely known and accessible to rural populations, the promotion of traditional Chinese medicine provided a more accessible and affordable solution to many health problems.

Quick (1982:254) explains that it was in the early 1970s that traditional medicine featured in discussions of health at the level of international health authorities. By 1975, the WHO developed the Program for the Promotion and Development of Traditional Medicine to encourage the participation of traditional health practitioners in primary healthcare programs for those countries whose traditional medicinal knowledge systems were well known and in use (Zuluaga and Correal 2002:12). These initiatives, however, have been critiqued because they sought primarily to train and incorporate local health practitioners into scientific medical systems, rather than to respect and value the prior knowledge, experiences and practices of local healers (Quick 1982; Last 1990). In his critique of WHO policy during the late 1970s and early 1980s, Quick (1982:255) sought to raise the concern that the motivations and content of current efforts to develop traditional medicine risk a reinforcement of the trend towards the imposition of
the biomedical model of health care into the lives of tribal people and co-optation of traditional medicine by government programs.

Quick’s (1982: 226) concerns extend to the 1974 UNICEF/WHO cooperative review whereby, in seeking to develop alternative approaches to satisfy basic health needs in developing countries, WHO and UNICEF proposed that “practitioners of traditional medicine should be trained for primary health care services”.

These approaches to public health were manifest in San Martín during the 1970s and 1980s, through public health outreach programs. Several parteras or local midwives, were taken to hospitals to be shown the birthing procedures in Peruvian medical institutions. I met one of these parteras, Nora, an Indigenous woman from the community of Chazuta, in a workshop on “Sharing Wisdom”, discussed in further detail in Chapter four. Nora spoke about her experience of being invited to the hospital with other parteras to learn about birthing,

*After a time people arrived looking for parteras to come to the regional hospital here [Tarapoto]. They brought me here because everyone was saying: “She should go, she knows”, they sent for me... but I did not want to go. I had various children and I did not want to leave them. They had to make me!*

*There were 18 women there... Some young women were afraid... they did not want to see... But I cooperated because I wanted to know. I went to look, eager to really know this hospital, to understand how they teach. And in truth, I saw that the birth is easy when it is a normal birth, straight, without any defect, it is quite easy. But if there is something out of place, a hand or rear end, it can be difficult. In this situation, you cannot help, because it is too complicated. You can send them to the hospital. There, in the hospital I learnt something more than what I had known.*

Nora explained that in rural areas like her community, when the birth is difficult and parteras refer mothers to the hospital, access and mobility become a problem.

Experiences like Nora’s demonstrate how some local healers have interpreted the
national and regional health development policies. However, it is important to recognize that these experiences occurred in a context of power relations. Even though, at the time of her visit, Nora was already an experienced partera, she was being taught how to assist birth according to western scientific procedures. Although I do not doubt that Nora was keen to learn, and did learn, about the hospital procedures, her experience demonstrates the one-way exchange of knowledge that was emphasized in the international, WHO, and national medical capacity-building programs. Nora’s comment about accessibility to these hospital services, and economic demands of scientific medicine in general, are primary concerns that came up in the evaluation of public health programs in the 1970s and 1980s (Zuluaga and Correal 2002:12).

The current role of the World Health Organization (2001) in projects promoting traditional medicine is to provide programme support in member states to facilitate the development of traditional medicine (TM) and complementary alternative medicine (CAM) so that it can be appropriately, safely and effectively integrated into national healthcare systems. The WHO also seeks to increase member state, scientific community and public access to accurate information about TM and CAM. WHO carries out these objectives working directly with Member States, national and international organizations, regional bodies, as well as with its network of “Collaborating Centres”\textsuperscript{48}. In addition to initiatives with such Collaborating Centers and databases, the WHO is working with

\textsuperscript{48} These “Collaborating Centers” include the WHO Collaborating Center for Traditional Medicine at the College of Pharmacy at the University of Illinois at Chicago, which “has a database on medicinal plants that contains coded information on natural products from 150 750 references” (WHO 2002).
various United Nations agencies involved in the development of traditional medicine\textsuperscript{49}.

As discussed in the section on Traditional Knowledge above, there is growing concern over how to develop traditional medicine considering intellectual property rights and the potential for misappropriation of traditional knowledge. Converting traditional knowledge into commodifiable products can remove it from the cultural systems and context within which it developed (though it may still remain in its original context as well). An example of the misappropriation of traditional medicine can be found in the case of an attempted patent on \textit{Ayahuasca} (Tsioumanis et al. 2003; Tupper 2006:4). In 1986, Loren S. Miller obtained a US Plant Patent (# 5, 751) on a supposedly “new” variety of \textit{Ayahuasca} (Tsioumanis et al. 2003:613). When, in 1994, the Coordinating Body of Indigenous Organizations of the Amazon Basin (\textit{Coordinadora de las Organizaciones Indígenas de la Cuenca Amazónica} —COICA) based in Quito, Ecuador, discovered this patent on this plant that Indigenous peoples had been using for generations in religious and healing ceremonies, they collaborated with a coalition of North American environmental law NGOs to file a petition requesting the cancellation of the patent (Greene 2004:220; Tsioumanis et al. 2003:613). The Indigenous peoples involved in the case were concerned with “having to recognize Miller’s proprietary rights over their sacred plant” (Tsioumanis et al. 2003:613). Upon review by the US Patent Office, Miller’s patent was rejected in 1999 upon the grounds that his specimen was not a

\textsuperscript{49} The UN Conference on Trade and Development (UNCTAD) is one agency that the WHO has collaborated with. This UNCTAD’s main goals have been “to maximize the trade, investment and development opportunities of developing countries, and to help them face challenges arising from globalization. Many of the world’s products are based on traditional knowledge and represent major sources of income, food and health care. Likewise, most plant genetic resources and other forms of biodiversity originate from or are found in developing countries. UNCTAD is accordingly heavily involved in the issue of protection of traditional knowledge. Currently, it is responding to concern that TM knowledge is at times misappropriated” (WHO 2002).
‘new’ variety of Ayahuasca, and that documentation of this variety existed prior to his patent claim (Tsioumanis et al. 2003:613).

COICA’s reaction to this case represents a firm rejection of individual ownership of a resource used by numerous healers throughout South America (and various religious groups worldwide). The president of COICA stated that “Ayahuasca is a sacred plant used to kill our illnesses, clean our spirits, and predict our future. Ayahuasca belongs to all of our communities that use it and therefore it is impossible that it could be the property of just one man” (COICA 2002:2 in Greene 2004:220). While traditional and complementary alternative medicine have become popular in development discourse and initiatives, it is increasingly recognized that these systems of medical knowledge must be understood on fundamental socio-cultural, economic and environmental levels. The following paragraphs outline the health organizations in Peru who are addressing concerns of access to and affordability of medicine, biodiversity and health, and intellectual property rights through intercultural initiatives.

**Intercultural Health**

What is interculturality in health? According to the Peruvian Ministry of Health (MINSA 2007), it is a process of articulating medical practices that benefit patients who belong to other cultures, within a mutually respectful and educational framework among different medical systems. In other words, intercultural initiatives bring together health practitioners from backgrounds of Amazonian, Andean, Western and other traditions of medical practice such as Chinese medicine, to negotiate patient treatment that respects diverse knowledge systems.
Movements towards intercultural medicine were marked in the 1990s when MINSA addressed traditional medicine through the creation of the National Institute of Traditional Medicine (INMETRA). This center was dedicated to the investigation and promotion of the therapeutic aspects of traditional medical systems.

At the forefront of state-sponsored intercultural initiatives in Peru is the National Center of Intercultural Health (CENSI). Formerly known as the National Institute of Traditional Medicine, CENSI was created in January of 2002 with the goal of articulating knowledge and practices of traditional, alternative and complementary medicine with academic medicine in the national system of coordinating and decentralizing health, to contribute to improving the level of health in the general population (MINSA 2007). The activities of CENSI include:

— proposing policies and strategies for intercultural health;
— promoting, developing and diffusing scientific research and technology in the field of interculturality and health;
— designing, implementing and strengthening botanical gardens, herbariums, and biogardens of medicinal and nutritional plants;
— proposing to execute plans, programs and projects for the transfer of technology, capacity building and educational extension in the field of traditional, alternative and complementary medicine;
— programming, standardizing, controlling and evaluating the development and articulation of alternative, traditional and academic medicine;
— developing and proposing standards that regulate and promote application of practices of intercultural health for healthcare, the production, use and commercialization of resources and natural products of medicine, nutrition and their derivatives;
— developing protocols of integration for the articulation and complementarity of intercultural health;
— participating as a technical, scientific, and standardized entity for the public and private sector of health;
— determining the validation of resources and natural products for their use in health;
— proposing, implementing agreements for national and international cooperation
(MINSA 2007).

At a regional level of health, the ForoSalud (Forum for a space of discussion and
proposals) takes on the role of civilian vigilance and social control over the health sector
and government (ForoSalud 2007). The ForoSalud is a group of civil society, primarily
western-trained health practitioners, who came together, originally in Lima, to evaluate
the situation of public health and to develop improvements. Through annual national
health conferences, members of ForoSalud meet to discuss public health projects,
problems and potentials. Arising out of these conferences are various thematic mesas or
committees devoted to subjects such as: Human Rights in Health; Medication;
Environmental Health; and Traditional and Complementary Medicine (ForoSalud 2007).

According to Mérida Aliaga, coordinator of the Mesa de Medicina Tradicional
(Committee of Traditional Medicine) of ForoSalud, ForoSalud is a social movement for
health rights respecting human rights, gender issues and interculturality, looking to
support national development with equity and social justice (Aliaga 2006). The Mesa de
Medicina Tradicional was formed at the second Conference of National Health in 2004,
based on the work of several committees already in place and focused on traditional
medicine as a valid resource to guarantee the health of the population. The Mesa de
Medicina Tradicional emphasizes values of dialogue, solidarity and justice as part of
citizen participation in the definition of policies of health and the transversal subject of
sustainable development in health and education. The objectives of the Mesa de
Medicina Tradicional are, in general, to systematize development proposals, and to
promote and research traditional and complementary medicine in Peru. More specifically, the *Mesa de Medicina Tradicional* seeks to develop situational diagnostics of traditional and complementary medicine and to initiate politically positioned polices for these medical systems. In May of 2006, I attended a workshop organized by the director of ForoSalud San Martín (at that time, now resigned). My experience at this workshop is summarized in the following chapter, along with a summary of some of my experiences observing and interacting with people involved with intercultural medicine initiatives in San Martín, Peru.
CHAPTER 4
INTERCULTURAL HEALTH INITIATIVES: SHARING KNOWLEDGE

Many aspects of Western medicine strike us as curious: the use of white robes, flashlights, and mechanical devices; the extraction of blood samples and x-rays to diagnose diseases; the wearing of stethoscopes; and the use of strange terminology. However, these observations do not lead us to dismiss Western medicine and its insights into the treatment of many diseases.
— Union of Yagé Healers of the Colombian Amazon, 2000

4.1 PERUVIAN INTERCULTURAL HEALTH INITIATIVES

As noted in the previous chapter, intercultural medicine refers to the medical practices that are designed to address knowledge systems and patients of various cultural backgrounds, within a mutually respectful and educational framework. Although there has been a tendency within some scientific inquiry to view certain traditional medical practices with skepticism, there is increasing awareness that science is also a tradition, whose practices may be viewed from outside with skepticism. Western medical science has a foundation in European herbal medicine, and much western scientific medicine is based on the isolation of, and/or synthesis, of chemicals from traditional herbal medicines (Ellen and Harris 2002). Keeping these points in mind helps to approach medical knowledge systems with less skepticism, and more respect. It also helps to deconstruct the power structures that prioritize a “modern” western medicine over a traditional Indigenous medicine.

Working towards my own understanding of what intercultural health initiatives involve, I began my field research by participating in daily activities and undergoing plant-based treatment as a patient at Takiwasi Research and Drug Rehabilitation Center
in Tarapoto. Through my contact with healers and staff at Takiwasi, I was then invited to participate in NGO-organized workshops on community and environmental health in the region of San Martín. I attended these workshops to gain an insight into the contemporary context of interaction between healers of Indigenous, Mestizo, European and other backgrounds, and to see if historical power structures of medical knowledge systems (i.e. modern – traditional dichotomy) influence these interactions. The workshops involved bringing together local Indigenous and Mestizo healers, including *parteras* or midwives, *sobadores* or massage therapists, *ayahuasqueros and vegetalistas* to share their knowledge with health promoters and western-trained health practitioners such as obstetricians, nurses and physicians, and to generate discussion about the opportunities and obstacles for intercultural health. This chapter is devoted to my experiences and observations of the work of three NGOs, ForoSalud, Takiwasi and WamanWasi, on projects related to intercultural health in the region of San Martín. Through these experiences, I gained important insight into the role of NGOs in providing a critical link between government policies and local practice.

4. 2 Foro Salud: Compartiendo Saberes: Sharing Wisdom

Through the *Mesa de Medicina Tradicional*, or Committee on Traditional Medicine, I had my first experience of intercultural dialogue about experiences of different medical knowledge systems. I was invited to participate in a workshop organized by Rosa Giove, a healer at Takiwasi and a western-trained doctor, and the ForoSalud. As discussed in the previous chapter, the ForoSalud is an organization of civil society working towards health projects that address health as a fundamental right of Peruvians (ForoSalud
Rosa Giove was the coordinator, at the time of the workshop, for the committee on Traditional Medicine and Interculturality. She had organized this workshop to bring together midwives, obstetricians, nurses, doctors and social scientists (all of whom were female) to define, discuss and demonstrate aspects of traditional knowledge systems in the Amazon. There were two men from Tarapoto who attended as part of their ongoing studies of Amazonian medicine for their environmental NGO. As a part of the workshop, two male ayahuasqueros (Takiwasi staff) were also present for discussion and demonstrations of healing. The workshop was organized into:

A. Opening Ceremony;
B. Introductory Presentation: including definitions of traditional medicine, power structures, obstacles to integration, legitimization of Amazonian healers, and reconciling systems of knowledge;
C. Sharing Experiences: opportunities for local parteras, and curandero to discuss their practice and for western-trained health practitioners to ask questions;
D. Ayahuasca session: evening ritual ingestion of Ayahuasca;
E. Follow Up: discussion and interpretation of Ayahuasca experiences with ayahuasqueros;
F. Closing Ceremony.

Through a review of the introductory presentation and intercultural dialogue, I discuss the various definitions of traditional medicine, examples of power structures in medical interactions and obstacles to the integration of medical knowledge systems.

**Opening Ceremony**

To initiate this workshop, we walked from Takiwasi, along a dirt road and forest path to the chacra and bio-reserve of Takiwasi, a distance of about five kilometers through the jungle. On our way, we were invited to collect one natural object, a seed, a leaf, a flower, an insect, to give as an offering in the opening ceremony. When we arrived at the maloca
or main ceremonial house of the Takiwasi *chacra*, we each went forward, explaining the significance of the offering from nature. One woman presented tiny little flowers to demonstrate the beauty in the tiniest of forms, one man presented a piece of vine because of its resemblance to the serpent which is the mother of the forest. These gestures brought our attention to the details of the jungle setting, and set us up to recognize the significance of respecting nature within Amazonian medical practices.

**Introduction: Traditional Medicine Defined**

Leading into the workshop discussions, Rosa invited all participants from various medical knowledge backgrounds to write their definitions for traditional medicine on a piece of paper. These definitions were read aloud. They included statements like:

*Tradicional medicine cures and prevents with that which nature offers us, because we are part of her.*

*Traditional medicine has been, is, and will be, a system of health that, since pre-Incan cultures, has achieved development and designs to solve problems of complicated disease in humans.*

*Traditional medicine is the cultural heritage of our country, since time immemorial, which possesses a richness of useful therapies for each one of the communities that practices it.*

*Traditional medicines are medical systems that vary in certain characteristics from one community to another, but they maintain structure.*

*Plants are a traditional form that can be used to prevent or control different diseases that currently occur.*
Traditional medicine is the knowledge and practices that come from the experiences of our ancestors to maintain the health of our whole beings—including our bodies, minds, souls, relations with people and with nature.

Traditional medicine is the collection of practices, ancestral knowledge, belonging to a community, that can evolve, change with time, and contribute to, explain and confront the health-sickness process, and prevent sickness, primarily valuing natural resources.

Traditional medicine is the best there is in life because it is fresh, using live plants and not antibiotics.

Traditional medicine is for healing yourself with nature, it is wisdom of nature.

Traditional medicine is the use of our natural resources, healing plants...it is a natural treatment.

Traditional medicine are the very ancient wisdom that have been obtained through observation and experimentation, that are transmitted orally, that are very connected with ritual practices that use plants or other elements from nature to achieve a balance in the body and therefore recuperate the health of the person.

Following these definitions, Rosa read aloud two definitions of traditional medicine.

First, she read the definition of Traditional Medicine by the World Health Organization (2005):

Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.
She then read the definition of **Traditional Peruvian Medicine** as outlined by ForoSalud 2006:

> [These systems] are open, non-exclusive systems of knowledge (meaning not closed, whatever knowledge or element that comes along can be incorporated into and form a part of the healer’s repertoire). They unite meanings and forms from different disciplines. Traditional Medical systems are current.

*In San Martin, for example, in places where money is scarce, MT is an accessible system. Agents of traditional medicine apply their techniques and knowledge, using resources of their environment to prevent, diagnose, and treat in a process of spiritual healing.*

Rosa’s comparison of these definitions demonstrates the initiative of ForoSalud to move beyond assumptions of traditional knowledge as a static system stuck in the past, while highlighting the creative agency of healers to use the resources available to them. Rosa also explained that spirituality plays an important role in traditional healing but is often considered an uncomfortable subject for many Western medical practitioners to address, owing primarily to their fears of dealing with religious issues.

**Sharing Experiences: Identifying Obstacles to Interculturality**

As discussed in the previous chapter, international and national health development initiatives of capacity-building, implemented since the 1970s, have sought to train local healers in western medical practices. I used the example of Nora, the *partera* or midwife, to illustrate an experience of these initiatives put into practice on a local level. Nora explained how she was eager to learn about western medical birthing procedures. Rosa
suggests that while these initiatives brought local healers and western-trained medical staff together, these interactions tended to be focused on one-way communication, and the western-trained medical staff missed out on opportunities to learn from the expertise of the local healers. Rosa explained:

When Señora Nora said that they took her to the hospital, so that she could attend births and so they could capacitate her— and probably teach her how to cut the umbilical cord to avoid tetanus, because there was much tetanus here at that time— surely, I am sure, that there were not many doctors who came wanting to learn from her— and she knows plenty. And all of the doctors who were there— believing that they knew more than her, and had wanted to teach her things— all lost her knowledge because they never asked her... This implies that the exchange of knowledge always has been given in a structure of power that is not equitable— one has more power than the other, and therefore makes the norms, saying “I know, and you will learn from me”, but they never have the humility to ask.

While Nora was able to learn from the western-trained practitioners, why was she being educated about western practices instead of the western-trained practitioners being educated about local midwifery practices? At this workshop, western-trained health practitioners were given the opportunity to listen to Nora’s experiences and ask questions about her practice. Nora explained how she began practicing as a partera:

I have learned since the age of 18. My mother called me, saying “Come and see, I am going to massage this woman who is going to have her baby” she told me. I did not know anything, but she called me and I went close to the baby, and started to massage there... she explained everything to me.... I felt the head quite normal, straight.... She had me try/practice everything, and truthfully I started to know... so many years I was there helping women [in my village].
Nora went on to explain how she attends to mothers in her community,

*I can say that I am in my community, always available to those mothers who are having children. I help them with their birth. But I do not help them with pills [or medication] because I do not have anything like that for them to take. I am in the chacra, in a community where there is not anything, not a general store, not a pharmacy—there is nothing. Only with plants, I give them plants to take. I am always taking care of them.*

Nora’s description highlights her availability to mothers in her community and the accessible plant resources that she can provide for their care. She alludes to limited geographical and economical access to pharmaceutical medicine and transportation to health centers.

Rosa Delmia, another *partera* from an adjacent region, spoke about her practices, and outlined some obstacles she has to being recognized by a doctor in her community as a legitimate midwife. Rosa Delmia began working as a *partera* through her experiences helping her daughters give birth. In her community, she has observed that most commonly, people with money can choose to give birth in the health center, while those who do not have money have their births at home or in her home. Obstacles of economic and access inequality and educational power structures feature in Rosa Delmia’s struggle to establish a collaborative relationship with her local health center.

Rosa Delmia has been through several capacity-building courses (national health promotion initiatives) since the year 2000, yet she has not received any material support from the local health center. She works with the poorer population of her community and has been buying all the materials she needs on her own. Rosa Delmia explains that in
other communities, the *parteras* have received equipment packages through their health centers and capacity-building courses, but she has not had this support. She did not clarify why she did not have this support, but, rather, alluded to the discrimination against her at her local health center.

After each birth that she assists, Rosa Delmia visits the patient over a four day period before taking the baby to the health center to be weighed and to receive vaccinations. She describes problems of access to resources through her local health center:

*The doctor receives me poorly. She yells at me and asks why I did not bring the mother to give birth at the health center. I reply “Doctor, in the first place, excuse me. It is fine that you have an education and studies that I do not have. I am from the countryside. But, the mother did not want to come to the health center. As well, sometimes the birth comes unexpectedly, it can happen in the middle of the night. And we, as parteras, we go out to attend to mothers in rain or shine. When the mothers want to go to the health center, I take them— but sometimes no one is there! The post is closed. So what do we do? We have to go to their house”.*

Rosa Delmia explains that she has had many problems interacting with this doctor. When she arrives with babies who have been born in places other than the health center, she is told that they cannot receive a health examination or vaccines because the health center only has provisions for babies born in the center. Rosa identified this as an obstacle to collaboration.

Rosa Delmia also drew our attention to the delicate subject of midwifery among some of the more reserved and shy women of her community, revealing their discomfort about having many people involved when they are giving labour:
These women cover themselves entirely when giving birth... They go into labour in a semi-seated position, but how do you retrieve the baby when they are in this position and completely covered? Well, I have uncovered them and they say “No! Do not uncover me, the air will get in”.

The concept of air getting in is a part of their local medical knowledge system. If cold air is let in and chills them, these women believe they are prone to various illnesses. Rosa Delmía explains that in this context, it is very important to cooperate with the patients, be conscious of their preferences and respect their concerns. This example also highlights how the need for privacy and concern of being uncovered, when compared with the procedures at the local health center, may be a deterrent for these woman to go to the health center to give birth.

These experiences underscore the importance of establishing mutually respectful frameworks for education and practice, rather than the imposition of a one-way system of capacity building that perpetuates power structures and hierarchies among medical knowledge systems. This workshop gave me insight into the contemporary experiences of local healers at the interface of different knowledge systems, where power structures continue to shape roles and expectations. The workshop itself provided an example of efforts that are being made by some doctors to valorize, legitimate and learn from the experiences of Amazonian healers. The western-trained health practitioners and social scientists engaged with the *parteras* and *curanderos*, asking them many questions and comparing the experience of these healers to the experiences of healers they had worked with in other regions. Most people at the workshop participated in the evening *Ayahuasca* session as well, demonstrating an overall acceptance and willingness to learn about local medical practices.
4.3 TAKIWASI

As outlined in Chapters one and two, Takiwasi is located in Tarapoto, in the department of San Martín in the Upper Peruvian Amazon. This center is dedicated to the research of traditional medicinal plants and the rehabilitation of drug addicts. At Takiwasi, founder Jacques Mabit advocates a ‘blending of traditions’, combining local traditional knowledge with Western psychotherapeutic practices (Mabit 2001:11). The therapeutic methodology of the center is based on three parts including medicinal plant use, psychotherapy, and community life. The general objective of Takiwasi is “to reappraise the human and natural resources of the traditional medicines, and to devise a real therapeutic alternative to drug addiction” (Takiwasi 2005: www.takiwasi.com).

Interested in the intercultural aspects of Takiwasi’s program— valuing, researching and practicing local Amazonian medicine and complementing it with western therapeutic medicine—I visited the center on a regular basis during weekdays to make general observations and to participate in weekly purges and plant therapy. From my day-to-day observations at Takiwasi, I was able to identify five main venues of intercultural medical knowledge exchange through Takiwasi including:

1. Long-term patient, healer\(^{50}\), and therapist interactions;
2. Visiting researcher/patient, healer, and therapist interactions;
3. Seminars;
4. Workshops for long term patients (yoga, art, dance, karate); and
5. Community outreach and presentations at international conferences.

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\(^{50}\) Healers who directed plant rituals and healings were either local staff, or visiting healers from within the region of San Martín or other healing centers that Takiwasi has contact with in Pucallpa, Peru, Buenos Aires, Argentina, or Colombia.
Through each of these venues there were opportunities for patients, healers, and therapeutic staff, belonging to various cultural backgrounds, to experience, learn about and discuss the combination of Amazonian and western psychotherapeutic practices. I consider these interactions to be intercultural because of the combination of practices and the diverse background of patients and healers. Long-term patients have come from the local region of San Martín as well as from other areas within Peru, Brazil Argentina, Chile, Colombia, Venezuela, Mexico, the United States, Canada, France, Switzerland, and Spain. Healers have come from the local region of San Martín, other Peruvian Amazon regions and Lima, from Colombia, Argentina and France (though apprenticed in the Peruvian Amazon). Therapeutic staff have come from Tarapoto, Lima, Mexico, Brazil, Chile, the United States, Italy, and Germany. Healing practices at Takiwasi, though primarily Amazonian and western psychotherapeutic, also include patient participation in various therapeutic workshops and activities. Yoga, for example, was practiced with patients on average twice a week, over a two-year period and, through patient feedback evaluation, was reported to have provided positive therapeutic results (Brito Pons 2007).

Since I had limited experience with the interactions between long term patients, healers, and therapists, the seminars and the workshops or the community outreach and international conferences, I will focus instead on the experience that I know best: my own interaction as researcher and visiting patient with healers and therapists. To exemplify how I think Takiwasi is addressing the objectives of intercultural medicine, I have organized my experience of Takiwasi into:

A. Opportunities for research and contacts;
B. Amazonian medical treatment and interaction with healers; and
C. Psychotherapeutic follow-up sessions.

A. OPPORTUNITIES FOR RESEARCH AND CONTACTS

When preparing for my fieldwork, I had the intention of conducting research that was collaborative and could contribute to the research needs of an NGO or community in Tarapoto, San Martin. In December of 2005, I sent a letter of intention to Jacques Mabit at Takiwasi. I received a response from Jacques outlining opportunities for research through Takiwasi. He explained that the relationship between practitioners of traditional medicine (curanderos, sobadores, purgeros) and practitioners of western medicine (physicians, psychologists, nurses) is a theme of great interest to Takiwasi. Jacques pointed out that various traditional healers collaborate with Takiwasi and that it would be interesting to collect a history of their relationship with Takiwasi to see how they came to collaborate, and how they consider this collaboration. He also suggested that I interview western-trained therapeutic staff at Takiwasi to evaluate their level of acceptance, understanding and valorization of models and concepts of traditional medicine.

I developed my research proposal around this idea. However, when I arrived in the field, I realized that a large part of my fieldwork should be devoted to gaining an experiential understanding of the medicine that the healers were practicing in order to better appreciate their interactions with different knowledge systems. Through the staff at Takiwasi, I was introduced to other healers in the region who work independently of the center. During my fieldwork, several researchers came through Takiwasi to experience and study aspects of the treatments offered. As a research center, Takiwasi provides a supportive and friendly staff, ample opportunities to participate in healing rituals and interact with healers, and the accompaniment of a psychotherapist throughout
treatment. Takiwasi also maintains a laboratory in which plant medicines such as tinctures and tonics are prepared for use at the center and commercial sale. However, Takiwasi does struggle to maintain long-term funding\textsuperscript{51}, which limits the number of staff employed, and these staff are primarily focused on the patients of the drug rehabilitation program and accompanying administration. While this makes for a strong and dedicated team for the drug rehabilitation program, it is sometimes difficult for researchers to coordinate and impose research activities such as interviews over a short time period. Long-term internships or visits to Takiwasi are more conducive to establishing and maintaining ongoing contact and rapport with the staff.

B. Amazonian Medical Treatment

As outlined briefly in the methods section, chapter two, of this thesis, while at Takiwasi I underwent general Amazonian medical treatment combined with techniques of western psychotherapy and influenced by Roman Catholic practices. This involved a schedule of purges on Monday afternoons, Ayahuasca rituals and purges on Tuesday evenings, ongoing plant tonic ingestion, and a \textit{dieta}. Through this process, I became aware of illness in my body that was simultaneously physical, emotional, psychological and spiritual, and which I was not addressing with western medical systems. \textit{Memory recollection}, \textit{emotional anxiety reflection} and \textit{spirituality} were three significant themes that arose during my treatment at Takiwasi. These themes became important tools for my psychotherapeutic follow-up treatment, demonstrating the compatibility of Amazonian and western psychotherapeutic medical knowledge systems. The following paragraphs

\begin{footnotesize}
\textsuperscript{51} Funding from France was cut when the French government adopted the American stance on \textit{Ayahuasca} as an illicit drug.
\end{footnotesize}
outline my experiences and how these experiences contributed to my understanding of
Amazonian medical knowledge systems in this context.

Memory Recollection

Memory recollection was a significant theme of my experiences of the purgas, 
Ayahuasca, and dietas at Takiwasi. With the purgas, I felt the release of stressful
memories when I vomited, a general stimulation of memories throughout the purga
session, and attention to these memories in the calm and contemplative hours post-purga.
The following examples are excerpts from my fieldnotes, written shortly after the purgas, 
Ayahuasca, and during the dieta, that demonstrate this memory stimulation.

On May 26...Winston sang softly into the Yawar Panga, then, blew tobacco
smoke into the liquid...the apprentice brought me the cup of yawar panga, 
holding the smoke in the cup with his hand...I drank the bitter plant, waited, and
was then instructed to drink 3 jugs of water. After the first, I vomited, kept
drinking and kept vomiting...after a long time, I thought I was ready to walk
home, but I started walking out with Winston and then stopped to vomit in the
path. I spent the next hour or so, as the sun set, trying to lie down, but vomiting
from very deep...at one point, I vomited so hard that I lost myself in another time.
I felt the presence of two ex-boyfriends from high school, and I felt very insecure
and vomited up something vile that was lodged somewhere deep. After that
delirious moment I felt a warm, tingling exhilaration throughout my being.

This experience with Yawar Panga was probably the strongest sensation I had
with a purga. I seriously felt at this point that I had slipped out of consciousness,
and into a past memory of high school insecurity in the company of my ex-
boyfriends and peers. The simultaneous puking and gripping sensation of
insecurity helped me to feel that I was releasing or purging this emotion that had been lodged somewhere in my body for over ten years. As the healers at Takiwasi explain, the plants wake up the memory of the body. After this experience I felt relieved, and could let go of some past fear.


Figure. 4.1: Chinese bowl. This is a sketch in my journal from a post-purga contemplation of memories. Drawing: Claire Sieber. June, 2006.

The plants dig up memories from the soil of my mind. This bowl becomes a window into memories of my childhood: The store that family friends owned. They sold these bowls. Mom bought tiny ones for Carl…This bowl reminds me of the days Angie and I would play among the boxes in the storage room of the store…This bowl also reminds me of Carl’s interest in Chinese and Japanese traditions, the bowls, chopsticks, bamboo stick for Tai Chi, his zen moss garden with sukabai, his paintings and drawings…
Although seemingly insignificant, the memories linked to significant experiences in my life. I recognize that I am exposed to memory triggers constantly, but as the healers explain, the plants help us to remember these memories passing them through the heart, thus being able to actually feel and afterwards, to integrate the emotional meanings linked to them. In other words, the purge blurred the boundary between a cognitive awareness of my memories and the emotions related to them that were trapped in my body and now released with the vomit.

The small Chinese bowl that I brought with me to Tarapoto from Chinatown in Victoria was a simple object that I had chosen as a water bowl for my water-colour painting. This bowl took on enhanced significance after my paico purge, digging up memories about a close childhood friend who I had grown apart from, and helped me to get at the root of some of my anxieties about losing contact with friends, why I keep myself distant and non-committal with friends, while also reminding me of how important Angie had been as a childhood friend, which gave me deep gratitude.

Remembering my brother and his interest in Chinese and Japanese food, art, gardening and his same small Chinese bowls, also brought childhood memories to mind of how much I admired him and have been greatly influenced by his life. I remembered how difficult it was for me when I was 6 years old and he left for University. This memory had come up in a previous Ayahuasca session as well, where I confronted my childhood loss of my big brother’s constant presence. I could also trace this memory to my anxieties of attachment,
having had to deal with a long distant brother, and then long distant sister throughout my childhood. These emotional anxieties and the opportunity to reflect upon them in an environment conducive to self-expression and interpretation, such as Takiwasi, helped me to realize the value of actually taking the time to confront these memories, rather than to ignore them, or push them aside. It soon became clear to me that the suppression of painful memories could make me sick.

**Emotional anxiety reflection**

Guilt, insecurity, fear, envy and doubt. These were the main emotional anxieties that I felt emerge from my experiences with *Ayahuasca*. Talking to other visiting patients, I surmised that these were common feelings to arise in *Ayahuasca* sessions. There are also a few corresponding illnesses that are identified among local Amazonian healers, including *susto*— fear, *nerviosidades*— stress, nervousness, and *envidia, mal ojo*— envy or evil eye. The ability to see images and memories relating to these emotions helped me to confront them, to reflect upon how they influence my life, and to release some of the tension surrounding them from my physical system through vomiting and diarrhea. The visions inspired by *Ayahuasca* also played a fundamental role for me, providing me with visual tools to creatively overcome my anxieties of guilt, doubt, insecurity, envy and fear.

The following sequence (fig. 4.2) illustrates an *Ayahuasca* vision that I had about guilt. In the sequence, I felt that guilt and insecurity were embodied in an image of dirty, garbage-filled water. There was a hummingbird that had gotten too close to the water, fell in, and was almost drowning. However, in freeing itself from the water, the hummingbird survived and was liberated from the surges of guilt and insecurity. I felt
that the hummingbird represented me in some way, falling into bad times in my life, but always able to pull myself out. I remembered that when I was younger, my sister-in-law had spoken to me of a dream she had where I was a hummingbird and a salmon, because I was intense and determined. Throughout the Ayahuasca session, I would see the hummingbird go through this sequence any time that I had a memory that inspired guilt or insecurity. Even today, this image sequence comes to mind if I get bogged down in feelings of guilt and insecurity.

Figure 4.2: Hummingbird. This vision sequence appeared to me during my first Ayahuasca session in relation to my emotional anxieties of guilt, and insecurity. I came to recognize this sequence as a tool to bring myself out of self-loathing and shame. Drawing: Claire Sieber. August, 2006.

Although not educated in psychotherapy, I recognized immediately that the images produced by Ayahuasca surrounding my emotional anxieties, were very cathartic—through visualization of these anxieties I could accept them, take responsibility for them,
release them, or consciously work through them in my day-to-day life outside of Takiwasi. The psychotherapeutic follow-up definitely confirmed and elaborated upon this, and I began to see how these medical knowledge systems are complementary.

**Spirituality**

The drug rehabilitation program at Takiwasi emphasizes the importance of spirituality in the process of healing—“the Takiwasi program is based on the assumption that addicts have an innate need to explore transcendental, or spiritual, states of consciousness” (Mabit with Sieber 2006:30). This follows from the idea that the de-sacralization of Western culture and the absence of authentic rites of passage has left many people without a means to access and integrate experiences of states of consciousness. It is suggested that “in today’s secular society, drug users are basically cast adrift on the high seas of consciousness, with neither compass nor map of the territory, and they consequently tend to run aground or finish badly” (Mabit with Sieber 2006:27). Many patients who arrive at Takiwasi have connection to Peru’s Roman Catholic traditions. However, Takiwasi recognizes and respects that different patients have different spiritual backgrounds, and requires that patients develop their own way to explore and express their spirituality.

Although I was raised in a protestant Christian home and attended the United Church throughout my childhood and adolescence, and the Baptist church in my late adolescence, I had moved away from the church due to my skepticism of religion in general, and my concerns with the role of Christianity in acts of historical oppression and contemporary imposition of belief systems. Having been curious about Buddhism for a
long time—reading some Buddhist writings occasionally, being exposed to more Buddhist thought through my partner, Gonzalo, and encouraged by my therapist, and several visions (fig. 4.3) I had during plant sessions—I decided to further my exploration into Buddhism.

![Smiling Buddhist Monks](image)

Figure. 4.3 Smiling Buddhist Monks. This is a vision that I had during an Ayahuasca session. I had released my soul from my body and slipped between dimensions of space and time to glimpse the afterlife, or eternity. Noticing my presence, the Buddhist monks smiled and laughed at me in a friendly manner, shaking their heads as though to ask me “What are you doing here? It is not your time yet!” Painting: Claire Sieber. August, 2006.

It was probably during my *dieta* that I experienced the most significant connection to spirituality. It was suggested by my therapist that I take the plant *Ajo Sacha* (*Mansoa alliacea*), which is meant to address physical problems of general discomfort, pain and heat, and on a psychological level it reinforces strength and will power (Giove 2002:48). My therapist also explained to me that Ajo Sacha helps to develop one’s spiritual
connection. In my case, I connected with the writing of Thich Nhat Hanh, a renowned Zen master, poet and peace activist. During my eight days of isolation in the jungle, I had with me his book entitled “The Miracle of Mindfulness”. The writings of this book complemented what I was learning about Amazonian medical practices and psychotherapeutic attention to dreams and visions. Nhat Hanh advocates contemplative meditation and mindfulness in every act. Through this attention to my breathing, my thinking, my dreams, my every little action, I became painfully aware of the cacophony of my mind—always leaping to think of something else. In the setting of my jungle tambo, I was able to practice calming my mind, and appreciate the interdependence of everything around me. I read:

recall a simple and ancient truth: the subject of knowledge cannot exist independently from the object of knowledge…the practitioner meditates on mind and, by so doing, is able to see the interdependence of the subject of knowledge and the object of knowledge (Nhat Hanh 1975:70).

This passage resonates with what I have been studying in anthropology about subjective and objective perspectives, and with increasing global awareness of the interconnectedness of all systems. During the dieta I had the luxury of seemingly limitless time to sort through my memories, to reflect upon my relationships with people in my life, to dream about decisions that I needed to make about my life. I drew pictures, I wrote down thoughts I have never been able to articulate about my relationships with family and friends in my life. It was as though I could finally be myself, and not be distracted by all of the things I had to do. Daily meditation became my way of connecting to something deeper that had been pushed aside by all the day-to-day tasks I obsessed about. Yet, now I could practice mindfulness in those day-to-day tasks. I
realized, through this experience, how a connection with spirituality was strengthening my self confidence and contributing to my healing process. And I also realized how this practice could resonate through my days—in every action, every thought, I could practice mindfulness. This accessibility to healing felt very empowering.

C. PSYCHOTHERAPEUTIC FOLLOW-UP

Weekly therapeutic interviews with Jaime Torres, psychotherapist at Takiwasi, helped me to actually pay attention to, interpret, integrate and act upon the experiences I was having with the rituals and plant treatments. With his psychotherapeutic experience, and my personal experience, we were able to discuss and elaborate upon various aspects of my healing process. As a therapist described to me, this collaborative effort between the patient and psychologist is meant to co-construct the significance of the patients’ experience. This allows for the material that emerges from dreams and visions during plant treatment to be integrated into an explanation that has meaning for the patient. In other words, it is not the psychologist who imposes meaning, but through dialogue and negotiation meaning is created. In this sense, each weekly experience of taking plant medicine contributes to a coherent process of self-discovery, towards an overall therapeutic objective, which, in my case, was to overcome my emotional anxieties.

Through my experiences with plant teachers, the healers and the therapeutic staff at Takiwasi, I learned to value the people, plants, places and events that have
had profound influences in my life. The plants helped me to cultivate respect for my limits and gratitude for my abilities. Therapeutic plant treatment brought me closer to recognizing and valuing what I have, instead of always looking to fulfill more needs and more demands. My own process, as well as my interactions and discussions with therapists at Takiwasi, gave me insight into the drug rehabilitation process at Takiwasi. Through plant and psychotherapeutic treatment, patients must face their memories and emotional anxieties instead of escaping from them. Through the development of this intimate self-awareness, one becomes aware of what they already have, instead of always focusing on what they do not have. Especially during the *dieta*, many patients came to profound states of empathy and compassion for themselves and other people in their lives. During this time, a thorough evaluation of one’s life takes place on many levels, and contributes to the patients’ gratitude and resolve to really change self-destructive habits.

In addition, bringing the patients into a natural and ritual environment where plants are respected as teachers and medicine, as opposed to being exploited and consumed for recreation or for a fix, helps to cultivate a different relationship to the plant, one more akin to the kincentric or relational worldview. Furthermore, it should not go unnoticed that bringing North American and European patients into one of the largest coca-producing areas of the world can call attention to the economic disparities between major producing and major consuming countries, and potentially foster awareness of the local implications of international trade, both licit and illicit.
These first hand experiences with intercultural healing practices, including Amazonian plant medicines, ritual and discipline, western psychotherapeutic treatment, and spiritual development, brought my attention to how several different traditions can be brought together to nurture an understanding of my own health, and its relationship to community, environmental and spiritual health. These experiences also set me up for a more thorough understanding of the medical knowledge shared at the intercultural medicine workshop that I attended in Lamas.

4.4 **INTERCULTURAL MEDICINE WORKSHOP**

Cultivating an understanding of the interconnection between humans, nature and spirits became fundamental for my appreciation of the medical knowledge described by healers at the WamanWasi workshop on intercultural medicine. This workshop was organized by the Lamas-based NGO WamanWasi\(^{52}\) at the WamanWasi center in Lamas. WamanWasi is involved in projects for the preservation and promotion of traditional knowledge, Indigenous rights and biodiversity conservation, including seed-saving groups, community workshops and publications of traditional agricultural and medical practices (WamanWasi 2006; 2004). Luis Romero Rengifo, WamanWasi staff and one of the main organizers for the intercultural medicine workshop, pointed out to me in an

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\(^{52}\) NGO situated in Lamas, San Martín. Locally-run, politically autonomous center, funded by Swedish and Swiss institutes (Sociedad Sueca para la Conservación de la Naturaleza), and by Proyecto Andino de Tecnologías Campesinas (PRATEC). Responsible for organization of various educational, agricultural and medical projects that highlight and promote sustainable traditional practices for community and environmental health.
informal discussion that most community and environmental health problems\textsuperscript{53} in the region are a result of:

1. Lack of respect among/ between people;
2. Lack of respect for nature; and
3. Lack of respect for spirits.

To confront this lack of respect, WamanWasi, with financial support from Swedish and Swiss NGOs, organizes several projects in Lamas and the region of San Martín to focus on community and environmental health through education, agriculture, and medicine. Luis explained that the financial support from the foreign NGOs allowed for complete self-direction in the local projects. He expressed concerns with the “modernizing” priorities of the Peruvian government, especially in the education system whereby Peruvian youth are educated to prioritize other systems of knowledge, mainly Western, over local systems of knowledge. To facilitate respect for local knowledge systems and traditional medical practices, WamanWasi hosted a series of intercultural medicine workshops, including one featuring Chinese Medicine, through which local healers were able to engage in an intercultural dialogue about health and healing. I attended the Kechua Lamas medicine workshop of the series.

Lasting for two days, August 11-12, 2006, the workshop, entitled: Kechua Lamas Intercultural Medicine, brought together local Indigenous and Mestizo healers from several villages in the region to demonstrate their healing practices for the \textit{promotores de salud}\textsuperscript{54}, health promoters in the region, and to generate discussion about the experience

\textsuperscript{53} These health problems include community health problems such as respiratory problems, intestinal parasites, dengue, alcoholism, family violence, STDs, and environmental health problems of deforestation, and erosion.

\textsuperscript{54} \textit{Promotores de Salud}, Health Promoters are community volunteers who are trained (through government and non-government programs) to identify, prevent, and treat disease and to act as liaisons between the community and the public health system.
of healers, and how their knowledge can contribute to public health improvement. Some health promoters also had a chance to share their knowledge of local medical systems in discussion and through remedy preparation demonstrations. The healers at this workshop were apprenticed sobadores (massage therapists), parteras (midwives), vegetalistas (herbalists), and ayahuasqueros (Ayahuasca specialists). They provided demonstrations of how to prepare herbal remedies for birthing procedures, common ailments such as bronchitis, diarrhea, menstrual cramps, susto, mal aire de los niños (bad air in children), and how to detect brujería (witchcraft). Health promoters were encouraged to ask questions of these healers and their practices, and to share what remedies they themselves were familiar with. This exchange of experiences generated interesting discussion about local medical knowledge systems. The following comments are the main points that I gleaned from the discussions. Some of these comments reiterated the concerns that other healers had voiced at the previous workshop that I attended.

— (Pharmaceutical) medicine is expensive.

— Just like traditional Chinese medicine coexists with modern medicine, Kechua medicine can be maintained as a modern, living medicine.

— For our medicine to work, people must value it and believe in it.

— We have difficulty sometimes communicating with Western doctors.

— An obstacle to intercultural dialogue is that Western-trained doctors do not come to these meeting/workshops.

— Practice and experience are essential to learning.

Through this workshop at WamanWasi, I was able to establish contact with some of the healers and to then visit them to discuss their practices and experiences in further detail. The results of these interviews and interactions are in the following chapter.
Through these workshops, I was able to see how government policy is enacted at a community level. My experiences with ForoSalud, Takiwasi and WamanWasi, helped to clarify for me the role that NGOs can play in making sure that international and national policies concerning community and environmental health are actually negotiated and implemented equitably on a local, community level. Especially in the context of the Peruvian government’s recent move (2006) to increase state control over the activities of NGOs, it seems of paramount importance that NGOs are able to remain autonomous from government institutions to ensure critical evaluation of government initiatives. If economic, geographic and relational obstacles are impeding the collaboration between medical knowledge systems, then these obstacles need to be met with mutually respectful dialogue and negotiation of opportunities. The work of ForoSalud, Takiwasi and WamanWasi appear to me to be meeting these objectives by creating spaces where this dialogue, negotiation and innovation can occur. To further my comprehension of how healers perceive their role at the interface of different medical knowledge systems, the following chapter focuses on the experiences of four healers who I interviewed and interacted with on several occasions.
CHAPTER 5
Results from Interviews: The Experience of Healers

In this chapter, I discuss the results and my interpretations of the interviews and interactions that I had with healers in the region of San Martín. The four ayahuasquero healers presented in this analysis came from four different areas, although three of them apprenticed under some of the same master curanderos. Following Pottier’s definition of knowledge production as “embedded in social and cultural processes imbued with aspects of power, authority and legitimation” (Pottier 2003:2), I inquired into the negotiation of knowledge systems in San Martín, and how healers consider their role as healer in the context of community and environmental health concerns. I asked the healers a series of questions (see appendix 3) relating to how they identify themselves, how they decided to become healers, how they learned to become healers, how they relate to their environment, what they provide for their community and if they perceive any major changes in their way of life over the past ten years. Since all four healers expressed to me the importance of experiential learning, I have organized the results from their interviews around certain aspects of their experiences and how these experiences influence their knowledge and identity as healers. The first section outlines what I have categorized as their experience of identity, practice and place or environment. The second section addresses healers’ experiences of political ecology in the region. This includes changes in political and economic activity, and how these changes influence community and environmental health and medical knowledge systems in the region of San Martín. The final section focuses on healers’ experiences of interaction at the confluence of medical knowledge systems.
Even by using the same sets of questions with each healer, I could not fit their answers into neat categories of identity, practice, place, change and interaction. There were also instances of difference between the questions I was asking, how a healer would interpret those questions, and how the healer would choose to identify him or herself within or outside the context of our interviews and interactions. Taking these factors into consideration, I have used subheadings to organize the main themes that we discussed in our interviews and interactions. However, these headings include multiple, interconnected topics such as subsistence, economy, language, and knowledge that participants identified as important aspects of their experience as healers in San Martín.

5.1.1 Experience of Identity

I began each interview by asking the healers to provide their name. At this time, some healers gave additional information about their place of birth, and their practice, while others waited to be asked specific questions before elaborating on their background. I have chosen the following quotes and my own observations to introduce each healer.
A Peruvian *curandero, ayahuasquero*, from Chazuta, Winston apprenticed under the guidance of his grandfather Aguilino who was a healer of good standing and high reputation among the local population. Aguilino passed away in 1983, though his influence still guides the healing practices of Winston and Jacques Mabit. Winston works part time at Takiwasi in Tarapoto, administering *purgas*, including *Ayahuasca*, guiding and performing ritual healing sessions and practices, overseeing *dietas*, and preparing...
various plant medicines. He also has his own center in Chazuta where people come to him for various plant treatments. I met Winston through Takiwasi and he was generous with his time accommodating my lengthy interviews. When I asked how he identifies himself, Winston replied:

*I identify myself as Indigenous, from the jungle of the region. We also have Mestizo races here, but, how can I tell you, we have some Indigenous, or Mestizo, who have already, for some time, been identifying a little with modernization—but some of us do not yet have that vision. We still keep our identity, our culture.*

Winston made a clear connection between identity and culture, and suggests how modernization has been affecting this identity in his community. I asked Winston to explain what Indigenous means for him. He explained that:

*Well, we who belong as Indigenous, are those of us who are descendent from, how should I say, from tribes. I believe that...things are changing. My great, great grandparents were Indians, or Natives. My great grandparents already knew the people [other than Native], and conversed in their language a bit. But already my grandfather—by then things were already more or less, well there were already different types of origin. But they followed the same origin from nature, or from the tribes. Well...as the years go by, the children, the grandchildren— the generations are going and leaving their culture.*

Winston described his experience of identity in terms of history, place, origin, culture and language. He contrasts identity of Indigenous people in the region with modernization,
suggesting that Mestizos are Indigenous people who have moved more towards modernization. I discuss this in more detail in the section on *Modernization*. Winston also drew upon concepts of class to identify himself and his community. Several times in our interviews, Winston mentioned that he was of a ‘humble class’:

*I do not belong to a high class, no [I belong to] the middle class, the humble group. This is how we get by, each healer. As a healer I do not even feel boastful of that which I am, no. I have always liked to share with people, to teach them.*

Winston stresses the importance of being humble, going on to say how a healer cannot identify himself/herself as a good healer, but rather, that it is the community who decides a healer’s reputation. Winston admits that when he began working at Takiwasi he was attracted to ideas and the trappings of what he considers ‘modernity’. He decided, however, that he did not want to leave his culture. Sometimes he feels it is necessary to dress a certain way to interact with certain people, but he is not ashamed of his identity and Indigenous origins.

Winston’s experience of identity sets up important distinctions that are often made in this region between tradition and modernity, between Indigenous, Mestizo, Peruvian, European and other foreigners. His comments suggest that there is a dichotomous distinction between identities— a distinction that extends into economic and cultural status. Winston identifies himself with the people who are holding on to their culture, rather than leaving it. He associates with the humble class, not the high class. And he makes the distinction that he is not boastful about who he is, but rather, that he shares his knowledge.
Rosa Giove Nakazawa: Being a Female Doctor

Rosa is a Peruvian, western-trained doctor and *curandera, ayahuasquera.* I first met her at The Indigenous Knowledge Translation Summit\(^{55}\), at the First Nations University in Regina, Saskatchewan in March of 2006, organized by the Indigenous Peoples’ Health Research Center of Saskatchewan (Fig. 5.2). A member of NAHO had invited Rosa to speak at this knowledge translation summit after they had met her at Takiwasi through a seminar. In Regina, Rosa presented her work in intercultural medicine, and knowledge

\(^{55}\) Knowledge translation is defined by the CIHR (2002) as “the exchange, synthesis and ethically-sound application—within a complex system of interactions among researchers and users—to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products, and strengthened health systems.”
translation initiatives in San Martín. I remained in contact with Rosa, and upon my arrival in Tarapoto, despite her very busy schedule, we went out occasionally in the evenings for ice cream to discuss her work in the region of San Martín. I also ended up making regular visits to her clinic for my jungle ailments (yeast infections, giardia and intestinal parasites). Later, during a filmed interview, she described herself as a doctor, having been working in Tarapoto since 1979:

*I am originally from Lima, I was born in Lima, and I lived there until I was 25 years old, until I finished my degree. I studied there, I am a doctor, and at the end of my degree, for certification requirements, I had to come here, and I stayed here.*

Although she did not mention it in our interview, Rosa had explained to me previously that her Japanese name, Nakasawa, comes from her maternal side.

I inquired into how Rosa had decided to stay in Tarapoto instead of Lima. She explained some issues of gender inequality that she felt in Lima:

*...the problem is that in Lima, at this time, well, we are talking about some time ago [late 70s, early 80s], medicine was a masculine profession. Therefore, as a woman I had several disadvantages, and additionally, at this time I appeared much younger than I was, so that it was difficult for me to establish myself as a professional.*

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56 In San Martin, Rosa has been working with local patients, primarily women, to learn vocabularies of health and illness in Kechua medical knowledge systems. She is attempting to develop ways of effective communication between people educated in local Amazonian medical knowledge systems and Western scientific knowledge systems.
In 1979 she traveled with her husband (at the time) and their four children to complete her doctoral practicum in the region of San Martín, where she says that there was little state presence and many opportunities to develop health projects:

“When I came here [to San Martín] I came already married. My husband went to the area of Huallaga to implement a project we had there, they were communal first aid posts. We had a dream at that time to earn money and buy a trailer, a camping car, and as we went along we would generate enough income to be a rolling laboratory—because in reality, there were very serious problems at that time. In the rural areas, above all, people could not access doctors. I am talking about the years 1978-1979, there was not a highway built yet. There was a road open, but there were not buses that came here. In fact, to get here from Lima took me 10 days.”

Rosa began her work in the Huallaga valley as a part of the Peruvian Ministry of Health (MINSA) obligations for university medical students in the late 1970s early 1980s. After nine years studying medicine, students were required to complete one year of practicum in another region, specifically in rural areas. She was involved in regional capacity-building programs for youth of the Huallaga Valley, teaching things such as birth control, detection of malnutrition in children, how to give presentations on prevention of sexually transmitted diseases, and how to create maps of populations at risk for bronchitis. Rosa explained that this was a good experience for her because of the mutual learning that occurred and how actively the local population was willing to collaborate in projects to
maintain their community health. At this same time, Rosa was also conducting research on malnutrition and local resources:

\[I\text{ did my research thesis on the conditional factors of malnutrition and the implications for health, looking into the use of local resources for the recuperation of nutritional health in the region.}\]

Rosa and her family returned to Lima for almost two years for additional schooling. During this time, Rosa was working in private clinics, conducting research on primary healthcare and alternative therapies. She returned to San Martín because she felt that there were more opportunities for innovative health projects in this region.

After a divorce, many years of active community participation, including the management of a private clinic and a cultural center, and health projects in San Martín, Rosa came into contact with local healers and began taking Ayahuasca. She also met Jacques Mabit, who she later married. Her collaborative work with Jacques Mabit in founding Takiwasi is featured in the section on experiential learning.

Rosa’s identity is very much linked to her work in intercultural medical initiatives. Although she does not describe herself as a traditional healer, she plays a very active role in Ayahuasca sessions at Takiwasi—singing icaros, and performing curaciones, or healing rituals, and has published a book about the use of Amazonian medicine in the treatment of drug addiction (Giove 2002).
Jacques Mabit: Being a French Doctor

Figure 5.3 Jacques Mabit during an interview in his office in Takiwasi, October 2006. Photo still from film: Claire Sieber. October, 2006.

Jacques Mabit is a French-Peruvian, western-trained doctor and curandero, ayahuasquero. I met Jacques through Takiwasi. Born and raised in New Caledonia, which is a territory of France, Jacques believes that:

Since a very young age I have always identified with being a French citizen outside of France.... Since the age of three, I was living in Africa... at the age of 12, I lived in France to begin secondary school. Because of this, the landscape of Tarapoto seems closer to what I knew in my childhood than France does. I lived my childhood in areas a bit tropical, with heat, people of colour. Therefore, it was not so strange [to move to Tarapoto], I did not go to an extreme, it was the
contrary. For me, [being here is] is akin to being in an environment of my childhood.

Jacques first came to Peru in 1980 as a medic with _Medecins Sans Frontiers_ working in the South of Peru on primary healthcare and first aid projects. This lasted until September of 1983 when he had an opportunity to work for a natural medical clinic in Lima. He was always interested in alternative medicine, but this project never got off the ground, so he returned to France to study natural medicine in Paris from 1984 to 1985. During this time of pursuing a diploma in natural medicine, Jacques was also working as a replacement doctor for doctors taking leave from their medical posts in Burkina Fasso, Bangladesh and India. Throughout his travels, Jacques always had a keen interest in alternative medicine, and a fundamental motivation to learn more about other dimensions of healing that are absent from what he calls modern scientific medicine:

_I knew that conventional or modern medicine and knowledge is not a lived knowledge. It is technical, technological knowledge, but not self-knowledge, not wisdom in fact._

...And so I had seen in all my travels in childhood, practices of traditional medicine, and surprising facts that could not be explained in Western terms—we do not have the capacity to explain these things—but they had effective results. So it was there that I saw an open door for me...There was a blind spot in the Western vision, there was something that escaped, and this, yes, this was what
appeared to me as interesting. How could one find access to things we do not see? How do we access this knowledge?

Having already come into contact with the wealth of traditional medical knowledge in Peru, Jacques decided to embark on a research project that would look into these other ways of knowing. He returned to Peru on successive visits, completing a medical anthropological research project on three zones of Peru, focusing on different medical knowledge systems, especially the plant remedies prominent in each zone: Coca in the Andes, San Pedro (*Echinopsis pachanoi*) on the coast, and *Ayahuasca* in the Amazon. It was in the Amazon, in Tarapoto, that Jacques later settled, focusing his energies into an apprenticeship with Winston’s grandfather, Aguilino Chujandama. Following a transformative experience he had in Calcutta, India (discussed in the following section on experience of practice), his travels and exposure to alternative therapies in many different countries, and the intense apprenticeship with local healers and plant teachers in Tarapoto, Jacques was inspired to engage with the idea of a research and drug rehabilitation center focusing on local Amazonian medical knowledge systems—Takiwasi.

Jacques clarification of his relationship to France as being distant since childhood, demonstrates his hesitation to be identified solely as European. As Jacques explains, his extensive experience living and traveling in tropical regions provided him with a sense of connection to Tarapoto, and a connection to the jungle. He also recognizes that he felt very limited by traditional Western scientific medicine and that there was always something that motivated him to explore what science could not explain. This search has
become a large part of the identity of Jacques, culminating in his work as healer and director of Takiwasi.

Cristobal Salas: Being an Ayahuasquero Campesino

![Image of Cristobal Salas, his son, and his wife](image_url)

Figure 5.4 Cristobal Salas (left) with son and wife Nemia at *chacra* in San Miguel del Rio Mayo, September 2006. Photo: Claire Sieber.

Cristobal is a Peruvian *curandero, ayahuasquero* from San Miguel del Rio Mayo. I met him in a workshop on Intercultural Medicine in Lamas, August 11-12 of 2006. He was providing demonstrations of his work as a *curandero*, preparing plant remedies, administering *sopladas* and various other medical practices, for an audience primarily composed of health promoters in the region. When I asked if I could interview him about his practice, he invited me to his home in San Miguel del Rio Mayo, about 45 minutes
northwest of Tarapoto by car, where he lives with his wife, Nemia, maintains a *chacra*\(^{57}\) and attends to patients when they seek him out for help.

Cristobal was born in Lamas, but has been living in San Miguel del Rio Mayo since 1952. He has been practicing as a *curandero* for 15 years, since the fateful illness he experienced under a *maldad*\(^{58}\) in the late 1970s, early 1980s. Since this experience led to his healing apprenticeship, I discuss it in the section on practice below. When, in our second interview, I asked Cristobal if he identifies himself as Indigenous, Mestizo, European or other, because sometimes these identities influence the practice of medicine, he replied that:

*No, for me everyone is equal. Whether you are Mestizo, Gringo, or Black—whatever colour. For me it is all the same. Because blood is only one colour. All of us are equal. But some, there are many people—there is racism. But now things have changed quite a bit. Now we all embrace, we appreciate one another, we dance together, drink together, spend time together, we enjoy each other’s company. In the past it was not like this.*

Cristobal explains that there used to be more racism in the region, but that there is more tolerance now for difference. Rather than choose a racial or ethnic category of identification, Cristobal defined himself in our interviews and interactions through the work that he does. He calls himself an *ayahuasquero*, a house constructor, and general labourer:

\(^{57}\) *Chacra* is the cultivated land of the *campesino* or local farmer.

\(^{58}\) *Maldad* is an illness that can be inflicted upon someone by a *brujo* or witch. It is usually commissioned for reasons of jealousy or envy. People pay *brujos* to inflict harm on someone they are jealous or envious of.
I work at many things. I go to the chacra, I haul firewood, I haul bananas, I help with things. Although I am well dressed I am working! (laughs). This is not to be ignored— it is the work of a campesino. It is the work of agriculturalists who labour the earth.

Identifying himself through his lifestyle, Cristobal makes an important connection between his identity and practice. His comments also highlight how independent healers do not depend solely on healing to sustain themselves. Cristobal’s identification with vegetalismo and the work of a campesino alerted me to some of the economic conditions under which independent healers in this region work. Compared to other medical professions, especially Western scientific professionals, Cristobal could not rely upon his healing practices alone to support himself and his family. His definitions of identity through practice also emphasize an economic identity that underlies much social interaction, especially between and among medical knowledge systems in San Martín.

Cristobal hints at an economic crisis he had with the maldad he experienced in his past, but suggests that he has come to count his health as a measure of life quality.

Before, I had my resources, I had my business. I had everything, everything. But then everything changed. I got sick and my resources diminished. But now, I pride myself on my health. I eat peacefully, I sleep peacefully, I travel peacefully, I enjoy time with my friends, we laugh, we make jokes, and all peacefully. That is the life.
The theme of tranquility, or peacefulness, surfaces many times in my conversations with Cristobal. I discuss this in the section on experience of place and environment. Cristobal’s experience of coming to be a healer through personal sickness is also discussed below. Cristobal’s comments about identity mark a movement away from racial prejudice in his community, and demonstrate Cristobal’s pride in what he does for a living both as curandero and campesino.

5.1.2 Experience of Practice: Plants, Animas, and Teachings

This section addresses the healers’ experiences learning and practicing medicine. These experiences are all intimately tied to the healers’ relationships to people, place and the environment, and spirits, which will be discussed in the following section. Among the healers’ teachers, there are two principal kinds of instruction: through master healers and through plants. Master healers share their knowledge through guided apprenticeships, and plant teachers impart wisdom through purges, dreams and visions. Here, I outline the role of master healers, and plant teachers in shaping the knowledge and practices of Winston, Rosa, Jacques and Cristobal through the practices of dietas, and purgas in the discipline of Amazonian medicine.

Winston: Grandfather and Plant Teachings

Winston’s path to healing was through his grandfather. From the age of two, Winston lived with his grandparents. They lived well, happy and healthy, despite the lack of material wealth that they experienced. Winston knew that his grandfather was a great healer, with extensive knowledge of plants, which motivated Winston. From the age of
nine, Winston began to walk with his grandfather in the jungle to collect plants. His
grandfather explained to Winston which plants were good remedies for specific illnesses:

\[ \text{When my grandfather had a patient to treat, he said to me “go bring this plant, go to the forest”. But I knew which plant it was, I knew the form. My grandfather did not have to be at the same place as me, I looked in other places and I knew the smell of the plant, what form the tree would have, the leaves...} \]

However, as an adolescent, Winston was not really interested in, and actually resisted
following the work of his grandfather, partially because of the demanding practice and
dedicated work required to heal. In spite of Winston’s resistance, his grandfather was always encouraging him to learn.

\[ \text{When I was fourteen years old, my grandfather explained clearly “you are going to learn with me”. I began to learn then, and with the first dieta, which lasted one month, I took various plants...There I had messages that the plants gave to me. It was not one plant, there were seven distinct plants. And there, I remember, when I was in my tambo, in silence—you would only eat one baked plantain, and you would eat, and you would relax there, and there would be a young boy who would accompany you (attend to you). Sometimes, not even my grandfather would come to see me—There I dreamt...I heard music under my bed, in the wilderness—this is in the wilderness! I heard a song. As my grandfather said, if the plant is for you, it will always bring you a message, the plant will teach you there, he said. And I really heard a guitar there [in my tambo], singing. I got up, to see with my...} \]
lantern, I looked, and nothing was there. But that voice, that song was already in my head. And I slept well.

This account demonstrates the importance of dietas and receiving messages from the plants in the formation of healers and their medical practices. At the age of 14, Winston was already drinking Ayahuasca with his grandfather, not continually, but occasionally. During this time, he received icaros.

Since they were a poor family, Winston was obligated to go through military service and training. When he returned from the service at age 19, Winston had been beaten and wounded through training. When he came home, his grandfather sent him on another dieta. During this dieta of 25 days, and other subsequent dietas, Winston received more messages from the plants, encouraging him to pursue the medical practices of his grandfather. At the age of 25, Winston already had icaros prepared, and what he calls an informative vision of the plants. He began work at Takiwasi as a guard, and it was here that he began taking Ayahuasca on a regular basis. Through Takiwasi, Winston met other healers. When his grandfather died, he needed to find other maestros. He apprenticed for a time under the guidance of Juan Flores, from Pucallpa. Winston stressed the importance of dietas to strengthen the healer physically, to resist illness.

Winston’s experience of learning his practice emphasizes the importance of exposure to both master healers and plant teachers. These maestro curanderos and plantas maestros guide the healer through discipline, dreams and messages that formulate the local Amazonian medical knowledge system.
Cristobal: Learning Through Sickness, Animas, and El Patrón

Cristobal came to heal through an experience of illness. Some people, who he did not choose to reveal to me, paid 100,000 soles to have a maldad placed on Cristobal. He was very sick as a result and admitted:

\[ I \text{ could not find my health. I walked to various villages, various cities, and I could not find it. On my return, I was already in serious condition, I went to the river, here to Pucallpa, and I went to Don Andrés Cachiki. Then he examined me and told me that I had to get my healing fast “if not, you are going to die”, he said. So immediately, I asked where I could go...he took me to his patrón. } \]

Cristobal outlines his experience with this patrón, a healer who agreed to become Cristobal’s patrón and to take on Cristobal’s treatment and healing. Cristobal’s treatment began with 15 days of plant baths in the early mornings. Then, through Ayahuasca sessions and dietas he received healing and knowledge. Cristobal’s patrón cured him with what Cristobal described as diablos or animas. When I asked him to clarify what these diablos or animas are, he replied:

\[ \text{When they are strong, superior, curanderos, they send their people. Just like when you tell your son “go over there, do this, do that”, they heal you...} \]

Many local people refer to medicinal plants as having these animas or diablos, which are considered as the spiritual essence or being of the plant. These “people” of the patrón—the diablos or animas—were sent to perform chupadas or sucking⁵⁹ on Cristobal’s neck.

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⁵⁹ Common practice among healers in this area. Involves sucking out illness, or the phlegm substance that is believed to be the cause of illness and suffering.
Cristobal explained that this was where the daño from his maldad was. During the time that Cristobal spent with his patrón, he experienced the presence of these animas. His patrón helped him to receive the healing knowledge through the transmission of a substance that sounds like what Luna (1984b:143) refers to as yachay. Cristobal related this experience to me:

    Well, they give you a little thing in your mouth, they give you ‘poc, poc’. From there, you do not heal until they give you order. They give you structure.

I asked if it is the animas that give structure, to which Cristobal replied:

    No, the patrón gives you structure. He says “come to heal”, and only then do you heal. You are called to heal. Like a student. Just like in the university, you are a student.

Still not understanding the role or function of the animas, I asked Cristobal to clarify. He told me that:

    They arrive like a human being, like a human being the animas arrive. Just like we are conversing right now...they do not tell you...[but] there are times when they will tell you in dreams.

I was informed that the animas of each medicinal plant (not just the ones in the Ayahuasca brew but the jungle medicine in general) are present when you drink the medicine Ayahuasca. They orient healers to help them learn and to “go beyond”.

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60 Yachay is also the Kechua-Lamas concept of knowledge, possessed by everything, including rivers, plants, humans, animals, rocks, etc. (see chapter 3 section landscapes in tension and Vásquez in WamanWasi 2006:5).
Healers call upon the *animas* with their *icaros*. Cristobal sings all of his *icaros* in Kechua.

*Well, I guide in Kechua. The animas of the plants all sing in Kechua. There is not one song that the plants have given me that is in Spanish, no. Everything is in Kechua. You have to be fluent in Kechua to sing these.*

This demonstrates the role of the Kechua language to Cristobal’s practice and identity as a healer. Both he and Winston identified the importance of Kechua in their identity and practice as local healers. I discuss this more in the section on change and modernization. Cristobal says he continues to drink *Ayahuasca* to advance his healing knowledge. His reflection on the role of plants, the *animas* of plants, and *icaros* demonstrates a dimension of medical knowledge that is not easily translated into scientific terms. The challenge of translating medical knowledge is addressed below in Rosa’s description of her experience coming to know aspects of Amazonian healing. I also discuss the obstacles for clear translation and access to knowledge and resources in the final section on interactions of medical systems below.

**Rosa: Inhibitions, Icaros and Self-Healing**

Not necessarily intending to pursue an apprenticeship in *vegetalista* or *ayahuasquero* medical practices, Rosa became involved in experiential learning of these practices through her participation in *Ayahuasca* sessions through her work with a cultural center she helped to run in the 1980s, in the homes of healers in and around Tarapoto, and through her travels with Jacques. The first three times that Rosa took *Ayahuasca*, she did
not really feel the effect. During her first session, she tried to monitor her vital signs, taking note of her heartbeat, and pulse. Rosa could not perceive any effect during this experience. In successive sessions, she thought that what she was experiencing were only dreams, that she had fallen asleep and that this was not the result or effect of the plant. She stopped participating in Ayahuasca sessions for two years because she felt that it did not work for her. However, as time went on, she started realizing things that Ayahuasca had indeed accomplished in her. She had lost certain fears that she felt before, such as her phobia of dogs. As she reflected on this personal accomplishment she remembered that she had visualized these fears in her sessions with Ayahuasca, and so she became intrigued with the therapeutic potential of Ayahuasca.

_How could these images that I saw forming in my mind, become active, or operative and activated to address substantial fears that I possessed, that I felt, that were part of my personal problems? So I returned to taking Ayahuasca to explore this, with very precise questions, trying to discover the link._

Perhaps some of the more formative Ayahuasca sessions that Rosa experienced were between 1988 and 1989, when the idea of Takiwasi was developing between her, Jacques, and a few other collaborators. Jacques had come to the region to study local medical practices and was seeking out local healers to practice with. Rosa felt that in one of the sessions where they drank Ayahuasca at the house of Jacques, she was overwhelmed with the intensity of the session, which generated many questions, doubts, and worries. This inspired her to participate in subsequent sessions to explore answers to those questions.
Rosa also explains the importance of dreams in her attraction to Amazonian plant medicines:

Well, I also returned to taking Ayahuasca because I was already having vivid dreams which indicated to me that I had to take plants. They were symbolic dreams in which the plants would approach me and tell me things. They spoke to me but I did not understand them. So they would say “Well, if you want to understand, you must take plants. Because if you do not, you are not going to hear. You are not going to open your ears”. I returned to taking plants because of this.

Rosa traveled with Jacques to various regions to meet other healers and participate in their medical practices. In an Ayahuasca session back in Tarapoto, following one of these visits, Rosa had an extremely vivid and strong vision that eventually led to her first icaro:

It was a tiny green woman. I saw her jump out of the bottle of Ayahuasca that was in the middle [of the room]. The lid jumped off, out came a sort of smoke, and the point of this smoke opened up, forming a flower with many petals. On the tip, that was very bright, like neon, there was a woman who danced. She danced lovingly, and sang. And when it was finished, she returned to the bottle, and the vision was over. This happened to me in two sessions, and in the second session I could identify the song as the same one from the session before. It was strange, because between sessions I had forgotten all about it. The second time it was stronger. The song was going around and around in my head during the whole
session. I could hear it, singing singing, many times. It was exhausting me. And, well, the session ended and during the whole following week I dreamt with this song, and it woke me up, it exhausted me, made me physically uncomfortable...

[during the day] I would be doing something, and the song would return to me.

For days following this experience, Rosa felt sick, tired and could not sleep well. She finally told Jacques, and drew for him a picture of what she had seen. He suggested that she sing it, and they recorded it. That night she slept well.

*It is as though I had something inside of me that wanted to get out no matter what.*

*It wanted to manifest itself, and it was not going to leave me alone until it did.*

At one point in the next *Ayahuasca* session, without realizing it, suddenly Rosa found herself singing. This was her experience of her first *icaro*. Since then, she has learnt several that she uses in collaboration with Jacques and other healers during *Ayahuasca* sessions for the purpose of therapeutic healing with patients at Takiwasi. Through various sessions, she came to understand that she would receive more *icaros*, one by one, but that at the same time she would need to be working on herself at a personal level, facing her own fears and doubts. The *icaros* then came to represent a personal therapy that could then be used in the healing of others.

Rosa also stresses the importance of the *dieta* in her experience of Amazonian medicine. She took her first *dieta* in 1988, and since then she has taken about one per year as time permits.
I believe that working with Ayahuasca is more spectacular, more visual, more seductive, more popular. More, surprising. But the dieta is important. It is a deeper kind of work, that actually allows the individual to change their register, to access other levels of knowledge. I think that the dieta is much more interesting than Ayahuasca.

It is true that the Ayahuasca sessions are more readily discussed in literature about Amazonian medical practices. The dieta is something that is difficult to explain, and more accessible through experience. I have attempted to provide an in depth account of the dieta in the chapter on methods.

Through her experiences with Ayahuasca and other plant teachers during dietas, Rosa came a long way from her original skepticism about the therapeutic effects of Amazonian medicine. She recognizes that these experiences have been integral to her understanding of local medical knowledge systems, and have provided her not only with personal therapeutic advantages, but have also been a large inspiration for her work bringing together different healers’ experiences for intercultural dialogue and knowledge translation in local community health initiatives.

Winston, Cristobal and Rosa demonstrate how patients and healers within the Amazonian medical knowledge system are encouraged to interact with and respect plants as living beings, rather than to treat plants purely as medicinal products or chemical resources. They all discuss how their personal lives have been influenced by their relationships to plants. In the following account, Jacques describes the significance of a personal search led him to explore different healing traditions.
Jacques: Personal Search and Healing

The key experience for Jacques that led him to seek out alternative ways of healing, ties in with experience of place and acceptance of a spiritual dimension that he believes is often excluded from scientific medicine. While working in Bangladesh as a relief doctor, Jacques decided to travel to Calcutta for two main reasons. One, because Calcutta was the city where one of his favourite poets, Rabindranath Tagore, had lived. And two, because he wanted to go to the worksite of Mother Theresa. Jacques soon found out that where Mother Theresa was receiving and assisting dying people was on the backside of the temple of Kali, who, according to Hindu mythology, is the god of death and resurrection. This connection did not go overlooked by Jacques. When he arrived at this temple where Mother Theresa’s work was being done, Jacques presented himself as a doctor to a nun who immediately asked him to assist a dying man. Going to his side, Jacques found the dying man in a coma, and could not communicate with him at all. Although Jacques had been working as a doctor in several clinics dealing with death and dying, he found himself unprepared in this situation. Thrown into an unfamiliar situation, without any of his medical supplies, the only thing that Jacques could think to do was to hold the man’s hand and offer him his presence, his energy:

He was dying, in a state of coma, in agony, and I could not communicate with him, nor did I even know his language. I could not do anything, I did not have any medical instrument and all I could think was: “What do I do? What do I do?”. The only thing that came to me was to hold his hand and inside I was saying “Look, I cannot do anything, I cannot do anything for you. Except maybe
be here. If I can offer my presence, my energy, what do I know? What is the point? But whatever, if there is something that can help you, well, here I am”.
And then the man died.

Returning to his hotel room after this experience, Jacques entered into an altered state of consciousness, without ingesting any substance. He had a vision that would mark him for life and lead him to his current work with Takiwasi.

I had the sense of taking distance from my whole life, as though I was able to see things from a distance. In my vision of the world, of life, everything was grey. I saw everything in uniform grey, without light, without colour...coming from my depression, from my despair, from death—everything without life, without anything. I had the sensation of wondering what was important for me. It was very despairing to see this. I told myself, I thought, “But, to be French or Chinese, what does it matter? What characterizes me? I am French, but to be French or something else is all the same. This was not important. To be a man? Well, no, I could be a woman, what does it matter? Being a man did not characterize me fundamentally. I could be a doctor, a butcher, a janitor, these things did not characterize me either...social elements did not define me essentially. So, in that moment, I had a very curious experience because I had the feeling that I was remembering myself...reminding myself that all my life, beyond these things on the surface— to be a man, to be a doctor, to be French— that beyond this there was something else, there was light. I saw this light. I saw it here in my abdomen, and within all of this grey that I saw, this light was the only
thing that was shining. It was the only light. With the sensation that I had always been aware of it. Of course, if you had asked me half an hour before “Do you have a light here?”, well, I don’t know how I could have answered. But in this moment, it is difficult to explain, I felt deeply that I had always been aware of this light.

It was this experience that led Jacques to abandon all of his concerns about what others would think of him and to focus on an internal exploration, to find out who he really was. Understanding this experience has been vital to Jacques and his work with patients at Takiwasi. One of the fundamental beliefs that he holds about drug addiction is that it results from an individual’s search for meaning and spirituality through the means of altered states of consciousness. Integral to the treatment of patients at Takiwasi is the support for this internal exploration without the use of drugs, but rather, through the guided use of medicine, ritual and spiritual practice. After this personal experience, Jacques dedicated his life to studying different approaches to internal exploration through various forms of medicine, spiritual practices such as meditation and prayer, and especially Amazonian medical practices of purgas and Ayahuasca rituals, and dietas using plantas maestros. It was through his own internal, personal exploration that Jacques was led to his current work with people addicted to drugs.

5.1.3 EXPERIENCE OF PLACE/ ENVIRONMENT

Throughout this research, I was attempting to get an idea of how contemporary healers in San Martín are negotiating their medical knowledge systems in changing social and
ecological environments. This section pulls out examples of healers’ mention of place or environment that came up in our conversations, and how they perceive the environment that they work in and/or depend upon for their practice.

**Winston: Plants as Living Beings**

As demonstrated in much of the discussion thus far, plants play a vital role in Amazonian medical knowledge systems. From our discussions, nature and plants also seem to be synonymous, corresponding with *el monte* (jungle wilderness), and *la selva* (Spanish word for jungle). When asked to explain the role of nature in his medicine, Winston said that:

> If you do not give any importance to nature, you are nothing. One must have communication with and love for nature...the plants are living beings, each one of them.

I asked Winston if there is a relationship between the health of nature and the health of the community, taking into consideration the neglect of tradition that we were discussing. To this he replied:

> Before, the old tribes never had problems with the environment. They lived happily. But if you go there, to a small native community, you will see that they do not take care of their environment. They throw out plastic bottles here and there. You see, they observe what others do—how shall I say, the monkey does what the monkey sees. That is how human beings are. Whatever the monkey sees, the monkey does. The human being is just the same. That which one can see, one
can apply, one can teach or one can do. You see, right now we are modernizing, the small villages are also doing this— they do not have their culture. But before it was not like this...before, I remember my grandparents never had problems with the environment...they had fresh, beautiful air. But now, the small communities throw garbage in the street, bottles in the street, they burn plastic, everything like that. Whatever they see...they want to learn.

Winston’s comments on maintaining the environment and the influence of ‘modernization’ resonate with concerns in the region about deforestation, and with Cristobal’s comments about clean air and health.

Traditionally, local inhabitants of the region have subsisted, and many continue to subsist, through small-scale swidden agriculture—a process of burning small areas of land to clear them for temporary cultivation, and then leaving them fallow for many years as the jungle takes over and regenerates that small area (see Marquardt 1999 and WamanWasi 2006). The replacement of small-scale agriculture with large-scale projects has contributed to problems of erosion, and large-scale deforestation is believed to have contributed to lack of moisture in the area and drought in the region. The landscape of Tarapoto is marked by small and large-scale agriculture, the air is constantly filled with the scent of wood smoke from kitchen stoves and land-clearing, and there are signs along the highways stating “Do not burn our forests”. There is not, however, an obvious distinction made between small-scale and large-scale swidden in the anti-burning campaign. This lack of distinction creates tension over whose farming techniques are causing the most environmental damage. Through conversations with locals, I
understood that some local inhabitants attribute deforestation to the *nativos*, others attribute the massive destruction to immigrants from the Andes who practice Andean farming techniques inappropriate to the jungle, while others consider modern industrial agriculturalists to be the source of ecological degradation. Through this local debate, I perceived a general link between community and environmental health.

*Cristobal: Pure Air, Health and Tranquility*

I asked Cristobal if there is a relationship between the health of the community and the health of the environment, nature and the *chacra*. Cristobal drew a direct connection:

*Clearly, health is the air and tranquility. If we did not have air, what would we do? We would asphyxiate. And we live from pure air, not contaminated air.*

I asked him how we access pure air, and where pure air comes from. He said:

*Pure air from the vegetation, from tall trees. And where there are machines, that is already contaminated air. Moto-cars*\(^ {61} \), *motors, cars, motors from some of those factories, that is where contaminated air comes from...Sometimes it causes sickness.*

I asked him to confirm then, the link between environmental health and our health, to which he replied that:

*Nature gives health and tranquility. It gives life to human beings.*

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\(^{61}\) Motor-bike-driven carts that crowd the streets of Tarapoto and provide informal employment for much of the male population.
This conception of the life that nature gives to human beings is fundamental to the reciprocal relationship expressed among some healers in the region of San Martín, and echoes through local literature and discourse on traditional agriculture (WamanWasi 2006; Compartiendo Saberes 2006). Cristobal’s assertion about pure air and tranquility as important to human health, though a seemingly simplistic analysis, is a succinct description of the relationship between community and environmental health. Within his comment about vegetation, pure air and tranquility, Cristobal summarizes the importance of harmonious economic, social, environmental and spiritual relations for health.

*Rosa: Nature and Reciprocity*

In the workshop on Sharing Knowledge, hosted by Rosa and her colleagues in ForoSalud, Rosa drew attention to the significance of reciprocity in human - nature relationships:

> If we are here and we see that the jungle is so beautiful, but soon it will be no longer, or that by deforesting our water will run out, we recognize that this also affects us, our life and our health. Then, [we see that] this concept is also important in the whole traditional system— which is not anthropocentric, the human being is not the only one for which nature is made, rather, we are a part of it, and we have obligations.... For all traditional cultures there is an exchange. I give something, I am given something... so that the notion of the purge also implies this exchange. It implies a return. That which is in excess, that which is contaminated, that which we have taken too much of, that is in our body, we return it to nature.
Rosa’s correlation between the medical practice of purging in local Amazonian medicine and the balance of exchange in human - nature relationships clearly demonstrates the importance of understanding local systems of knowledge and relationships to place, or environment, in order to understand local medical knowledge and conceptions of health. If they do not address local knowledge and experiences, how can medical interventions or community health projects be effective or accepted?

**Cristobal: Too Much Summer**

When I visited Cristobal and Nemia, they both explained to me how they had been experiencing too much summer. Nemia complained of the intense heat and its impact on the vegetation, especially her legumes, the beans. I asked if this heat was normal for the area and season, but both Nemia and Cristobal assured me that is was not. Cristobal demonstrated:

> Look, *(points to his land and banana trees), the banana trees are falling. It is beginning to diminish production. The production of the chacra. Whatever plant, when there is too much summer the plants do not produce very much…Too much summer señorita.*

I asked Cristobal to explain to me why he thought they were experiencing too much summer. He described to me the problems of heat, lack of humidity in the soil, lack of precipitation and the absence of winter. When I pressed him to speculate why they were experiencing this change in environmental conditions, he said:
Maybe there is no rain for reasons concerning God, or on the terrain, in the soil the plants—or better said— the trees are low.... When there are high forests they attract atmosphere, they attract clouds, they attract rain.

Cristobal went on to make an important connection here between the work people must do in their chacras to cultivate food to eat and sell, suggesting that this is a reason behind deforestation and low (second growth) trees. However, he makes it clear that some people, including himself, are reforesting their land. This dependence on land for sustenance, whether for familial food crops or cash crops, is an important economic aspect among the population in general in the region, healers included.

**Cristobal: Dependence on Nature**

Deforestation in the Amazon has been critiqued by many international and national organizations. During my fieldwork, people in Tarapoto were complaining of the unusually hot, dry summer we were having. When I casually asked local people why we were experiencing this climate change, they usually attributed it to deforestation. As Cristobal pointed out, there is much need in the region for plant resources, including food and firewood, so people are cutting down and burning trees to sustain themselves. They are also, however, re-planting their land.

_Some land we are reforesting. I already have forestation. I am reforesting, sowing more plants. Like wood species, to be able to find more kindling... because without kindling there is nothing. You would have to buy stoves that burn kerosene, or gas stoves. Firewood is economically essential. Because for_
gas and kerosene, you must have money. You must have money to buy it. If you
do not have money, you do not eat.

This crucial point that Cristobal has made highlights the need to consider the economic
conditions that are at the root of deforestation in San Martín. Many people cannot afford
kitchen appliances that require fuel or electricity, they rely, instead, on firewood to cook
with. Cristobal’s explanation of his chacra reforestation also seemed to me to be stated
in defense of himself and other local inhabitants who depend upon nature for subsistence
and yet are subject to criticism about how their agricultural practices are degrading the
land. These examples of dependence on and conflict over natural resources leads into the
following statements about historical, political and economic activity experienced by
healers in this region.

5.2 Experience of Political Ecology

The healers’ descriptions of their experiences of political insurgency or terrorism,
activities of illicit drug trafficking, and national and international development projects in
this area provide an insight into the contemporary political economy of San Martín,
namely medical practices and agriculture. In the milieu of economic poverty and
political instability, many of the regions’ inhabitants had experienced first hand the
conflict between the state, insurgents, military, drug traffickers, farmers and other
residents. When asked about this time of political instability, through the 1980s -1990s,
many people in the region of San Martín explained how they were asked to choose sides,
and how difficult it was to be caught between the paramilitaries and the guerillas. The
following examples demonstrate the pervasiveness of the conflict in the everyday lives of the healers at this time.

**Winston: Guerilla Occupation**

A resident of Chazuta, an area occupied by the Shining Path during the 1980s-1990s, Winston, like many others, experienced the difficulties of mitigating community relations, attending to his *chacra*, and avoiding conflict during civil war.

*People I knew became terrorists. They came with the idea that “we’re going to have the strength and power of the government”.... I saw much terrorist activity in my community.... They occupied chacras... they asked for collaboration. If you did not help, they would kill you. But their downfall was that they were not politically prepared.... The big error they made was that they depended on fear.*

Winston explained that during this time there was much trafficking of drugs, women and men, which continues to some extent today. The United States has made numerous studies and reports on the contemporary coca cultivation and the insurgency situation (see Berry, Curtis, Hudson and Kollars 2002: 68) in the Huallaga Valley. There are reports of continued traffic in coca, but also, more recently, there are reports of opium poppy (*Papaver somniferum* L.) cultivation and continued Shining Path activity with links to other insurgency groups in Colombia (ibid.).
Rosa: Access and Civil War

Rosa’s experience illustrates the difficulty of working in the area during the 1980s and 1990s without being accused of collaboration. Many locals complained that the paramilitaries and guerillas alike would demand assistance and if you were caught by either side assisting the other, the consequences were severe. In Rosa’s case, her medical work at this time was put on hold:

*To begin with, I worked with my husband. We had a medical center, but afterwards, there were many political problems here in this zone, much tension. There was terrorism and drug trafficking. They took me to their camp. Our medical center was closed down because there were patients who would sometimes come without money to pay, so there were cases where we covered their treatment, and there was a case where we covered the treatment and it was a terrorist who had dengue. He had dengue, but he came with a fever, I did not suspect he was a terrorist. I was taken to a camp to be interrogated—ah, it is all a long story, but there was much instability and we had to stop going out into countryside. We had been going out into the countryside with personnel to work on an awareness campaign about de-parasitation in small communities. We were deparasiting with medicinal plants…but we had to suspend this because there was no longer security…we could no longer circulate easily.*

At this time, several communities were inaccessible, limiting the circulation of resources and personnel. In reaction to the political conflict of the 1980s and 1990s, national and international interest in economic alternatives to drug trafficking, and increased state
presence in Amazonian areas to prevent political insurgence has resulted in projects of development and modernization which have had varying influence on the lives of contemporary inhabitants. The following are examples of how the healers believe development has influenced their communities.

**Cristobal: Economy and Way of Life**

I asked healers who had lived in the region for a long time, if they noticed any change in the area over the past ten years. I received varied opinions, also determined by where they were living. Healers from more rural areas seemed to indicate that their villages had not changed very much, but did suggest that the cities were changing, or ‘modernizing’. I asked Cristobal if in the last 10 years he had experienced a change in the environment or community in which he lived. Cristobal replied by saying:

> The way of life here? Clearly we live among our work, breeding our animals, the pigs, the livestock, the goats. According to the preference of each person, of each human being. There are some times when the human being, sometimes when he/she does not have a place to work or to be. Of course having a place is something— you have your chacra, you cultivate, you harvest, you plant, everything you can do, you do...from there comes everything, how shall I say, the payment of the people, the wage of the labourer. You get paid, you harvest, you sell. Meanwhile you live.

Cristobal went on to explain how the change in climate disrupts the economic earnings of the farmer by reducing production on the chacra, demonstrating, again, that vital link
between daily experiences of living and the environment. Another source of sporadic income for Cristobal is the visits of foreigners from Italy and Sweden. He says they like to drink Ayahuasca. Increasingly, tourism in the form of ecotourism and shamanic tourism are playing a role in the lives of healers who are sought out for their expertise in Ayahuasca sessions and dietas. I asked Cristobal how much he charges for a session, to which he replied that he offers the low price of 50 soles (about $15.00 CAD). Other healers in this region also depend up their chacras and increasingly upon tourists to supplement their subsistence income.

Winston: Healing Centers and Chacra

The work of Winston is divided up into his commitment to Takiwasi, his own healing center in Chazuta where he receives locals and tourists, and the food crops he keeps on the side. Managing to live between both as collaborative healer at Takiwasi, and independent healer in Chazuta, he distinguishes the work of collaborative and independent healers:

It is distinct to work for an NGO—where you must pay the employees, hold seminars to generate income and resources to help people—which is a bit different than being an independent. As an independent, you need to work in something else as well.... Some other healers in the region, who are not as well known as us, are agriculturalists, managing livestock, being resourceful. But myself as well, I have my center, and when I do not have patients, I have my corn crop, my rice crop on the side... to provide for my children, to sustain them. But if you are known [as a healer], you are known. You could be three weeks without
work, afterwards 1, 2, 3, 4 people come to participate in a dieta, or to drink Ayahuasca. But this is not enough. You must pay for water, light, food, children, transportation, clothes— it is a lot.

Again, tied into the economy of the healer there is a dependence on agriculture for sustenance. Although neither Jacques nor Rosa have agricultural work on the side, they both work different aspects of health and healing to earn a living. Rosa operates her own private medical clinic in addition to her work in alternative therapy with patients at Takiwasi. Jacques provides seminars through Takiwasi to visitors from all over the world. These seminars are the main source of income for Takiwasi center. Healing as a profession in this area seems to require economic supplementation from other income-generating activities.

Winston: Development, Change and Modernization

When I asked Winston if he has seen a change in his community in the last ten years, in agriculture, medicine— economic resources, he explained that he believes things are more or less the same. People eat, drink, and live. Although I should have been wary of comparing Winston’s answers to those of Rosa, I wanted to understand why Rosa felt there was much change in Tarapoto while Winston was saying that there was not much change in his community over the past ten years. I explained to Winston that in Tarapoto, Rosa has noticed a change in the last ten years of more development. Making it clear that I did not consider development to be good or bad, I asked Winston if the
people in his community were experiencing this so-called development, or if they maintained their own rhythms of life. His response was:

"Yes, I believe that there has been a bit of development, but the people continue to follow their same culture.... Yes, there has been quite a bit of development, but the same culture persists, they follow the teachings... because, as Dr. Rosa told you, there is quite a bit of development in the country, but I do not feel any of this. Those who feel this are the people in the city. The people of the city feel the development, but the people in the small communities, more humble, do not experience any of this development... they feel the same. There is no change for them.

Winston’s answer illustrated a difference between his perspective and Rosa’s. While the urban areas appear to be changing, the rural areas are not as affected by this change according to Winston. The major change that Winston does express is the process of what he calls ‘modernization’ in which people are leaving their culture, their tradition behind. Winston’s experience and explanation of modernization is as follows:

*To modernize means you leave your origin. To modernize means you leave your tradition, you go to another level... In other words, you want to get to the upper class.... Those of us who want to modernize, want to have everything: cars— they want to have everything material or artificial. That is how you modernize yourself. Then you no longer see your origins, how you have been raised, how you have lived. That is modernization.*
Some people are losing their tradition, their origins. And there are many times when we do not value our origins, who we are. But there are people from other places, from other worlds, who come to visit us, they value our identity, our origin, who we are. Still, there are others like us, or others like them who do not value this. For this reason, the languages, like jungle Kechua are being lost, little by little— but they are becoming more appreciated...this is what is currently happening.

Winston is making the distinction between a high class and tradition. He suggests an idea of modernization through material wealth that obscures Indigenous connection to tradition. What is interesting is that he challenges the one-way loss of tradition with increasing external valorization of local culture through the visits of foreigners. In this sense, Winston seems to criticize the implications of modernity, while simultaneously recognizing how tourism has benefited the valorization of tradition. He points out that there are both locals and foreigners who do appreciate local Amazonian knowledge systems, and locals and foreigners who do not.

Along with the cultural loss that Winston attributes to modernization is the loss of language. Language is mentioned by both Winston and Cristobal as something that is integral to the identity and practice of healers.

**Winston: Language**

Tying in with his comments on the loss of culture, tradition, and identity, Winston refers to language as an example of something that is simultaneously a source of pride and embarrassment for his community.
There are some people who do not even want to speak Kechua...I speak Spanish, I speak Kechua. I would never say I am Winston and I do not speak Kechua—yes I speak Kechua...some people ignore their own language.

Winston insists that he speaks Kechua wherever he goes without shame. As a healer, Winston has come to value his profession on a local, national and international level. He recognizes that tourists are seeking out Amazonian knowledge systems and has developed many connections through his work at Takiwasi. Winston uses his ability to speak Kechua as a symbolic connection to his tradition.

Cristobal: The Return of Kechua

As discussed in the section on experience of practice, Cristobal considers fluency in Kechua to be crucial for his practice of healing. He mentions the loss, yet also the recent recuperation of the Kechua language in his community.

Kechua had been forgotten, but recently it has returned to be placed, of course again, in the customs—that which was before is returning again to be current...Of course the elders, my mother, my father spoke Kechua, but that changed, and Kechua was already being forgotten...now the teachers are learning Kechua [in the schools]...it is also being taught to the students.

According to Cristobal, Kechua is now a subject, something old that local teachers and students are beginning to value and learn again in schools. He points out that understanding Kechua is a large part of understanding local medical knowledge. He too
asserts his fluency in Kechua as a symbol of his connection to Amazonian medical tradition.

5.3 Interaction Among Medical Systems
This section addresses how healers perceive medical systems. I found this subject very difficult to treat in the interviews. I tried to ask healers if they could identify different ways of treating health or illness, without actually asking them if they recognize the categories of local Amazonian medicine and western scientific medicine. Through my awkward questioning, however, I realized that Cristobal and Winston did indeed make a distinction between what they called scientific and traditional medicine, but that this distinction was primarily economic. Rosa and Jacques, on the other hand, made clear distinctions between scientific and traditional medicine, suggesting that scientific medicine excludes, to a large extent, any spiritual component that is integral to the traditional practices of San Martín. These four healers all recognize and point out that scientific medicine is economically more difficult to access than local Amazonian medicine. Jacques and Rosa point out that Amazonian medical systems are difficult to access by scientific medical systems because of the dimension of plant *animas* or spirits that science does not explain well.

Winston: Pharmaceuticals and Plants
Referring again to people seeking to ‘modernize’, to associate with material wealth, Winston makes the distinction between medical systems and those who use them based on primarily economic criteria.
They are not the people who have been raised like us. For them, everything is from the pharmacy. Pharmacy is not something we are a part of—if you have a headache, you have a plant, if you have a fever, you have a different plant, or you have another problem, you have to ingest plants, have a plant bath, so that it calms the things you have in your body. And the people who are modernized, no not want the plants, everything for them is scientific medicine...This is modernization now for the people. For the rest of us, it is our culture.

Look, I will make it very clear for you...Traditional medicine is in high demand by people of the poor class...As a poor farmer, from the origin that we are, natives, we cannot compete with the — we do not have the resources that could bring us to a hospital, so we turn to the style of the elders, who have taught us to be able to deal with different types of illness with traditional medicine.

Winston suggests that those who have money turn to scientific medicine and pharmaceuticals, while those who are poor, depend upon traditional medicine. He identifies two types of medicine in life: pharmaceutical medicine and cultural, or traditional medicine.

**Cristobal: Access and Resources**

Cristobal explains that if there is an illness he cannot deal with, he sends his patients to the medical post where there are nurses who can attend to them. When I inquired about
the service at the medical post, Cristobal complained that there are many things lacking at this facility.

*What we need here, in this health region, is a doctor. This is a populated center, San Miguel. It is about time we had a doctor who was present...There are many things lacking. The nurses are there from time to time...They return [home] at mid-day, and then who attends [to the patients]?...I advocate a lot for San Miguel, but I cannot do it alone...[we need] a doctor, a doctor who is stable. Who would be, to serve the community."

Cristobal explained that the government helps very little with health. He shares the concern with his wife Nemia that San Miguel is a forgotten community, and suggests that it is the urban inhabitants who receive more medical attention, not the rural communities.

*To be like the city, that is more advanced in science, [the government] could help us, but here, that is very difficult. Because here, if you do not have money, you die. If you have money, you live."

Confused as to why Cristobal would discount his own medical practices as being able to attend to the health of San Martín, I asked him about plants and if local people were then responsible for their own health. He replied that indeed, some plants pull you out of sickness, and within the community, people support one another. Cristobal pointed out that he and his wife contribute to this community support through the medical service at their house.
The comments made by Winston and Cristobal highlight the connection between ideas of economic wealth, development, modernization and scientific medicine. Access to scientific medical services seems to be determined by economic and geographic conditions, whereas valorization of traditional medicine seems to be limited by prejudice and misunderstanding. The experiences that Rosa and Jacques discuss, concerning their pursuit and practice of local medical knowledge, demonstrate some obstacles to respectful integration of medical systems.

**Rosa: Medical Intolerance and Innovation**

When she first arrived in the region of San Martín, Rosa was engaged in much research aimed at innovative strategies to improve community health. She explains that communication between western-trained doctors and local inhabitants of the region was poor:

> At this time, the state system [of health care] was terrible. It was very elitist, very far from the scope— not only on an economic level, a geographic level, but most of all, on a cultural level. Well, even today this persists a bit. But the official system of health unauthorized, disregarded, absolutely did not respect the beliefs, the thoughts— the perceptions and understandings of the population [here] about health.

> People would go first to a healer, or they would ask a doctor if their child could be suffering from susto— mancharino, the Kechua word—, or if they could be cultipado, or any of those terms, those nosologies of illness from a cultural origin. The doctors would not only make fun of the patient, but would also
sometimes renounce their suggestion as though they were—sometimes the doctor would be 26 or 27 years old, just beginning, and the patient would be a woman of 50 years, and the doctor felt authorized to yell at her, to scold her as though she was a child of 5 or 6 years old who had done something wrong. And this still persists in many places.

Rosa’s account gives an idea of why there are sentiments of shame, embarrassment and devalorization surrounding Amazonian knowledge systems. Since her time in Tarapoto, Rosa has been working on projects of knowledge translation to avoid the types of scenarios described above.

**Rosa: Knowledge Translation**

Even when she was working in Lima, Rosa experienced medical cases that did not fit into scientific medical categories. For example, there were people who complained of cold air entering their bodies. Rosa wanted to know how, from her western medical perspective, she could explain that illness and what effect it has on a physical level.

*I wanted to know why a massage, for example, could cure a sprain, or how a child with a fever or diarrhea could be cured without pharmaceuticals and only a massage. These were things that, according to the criteria of medicine that I learned, correspond almost always with a cycle of cause and effect—primarily bacterial agents. Why would maneuvers made over the body be able to resolve these problems? Where, in my western medicine, was the notion of energy? If we depart from the idea that there are many biochemical processes in our bodies it is*
obvious that we must generate in some way certain static, energetic, magnetic, or electric charges. We must have an energetic field. And this energetic field is completely excluded from the instruction of [western] medicine...So this seemed to me a very interesting field of study, to research, and also to work in. I have tried to begin to make my language more adequate and appropriate, including terminology from the local population because this is a necessity for communication.

Rosa continues with this project of developing an appropriate means of communication between the medicine that she learned in university, and the medicine that she has been learning in San Martín. Her efforts demonstrate how a western-trained healer, originally coming to the region to teach local inhabitants about medicine, has, in turn, learned medicine from the locals.

**Jacques: Legitimizing Pursuits**

After years of studying scientific medicine, Jacques was unsatisfied with the limits of scientific knowledge for healing, always believing that there was something beyond the scope of science that the western rational gaze could not explain. As he moved further into his personal exploration of other medical systems, he met with much skepticism from those around him, yet not without the support of a few key people.

*I was lucky enough to meet people...who allowed me to persist, to say that I was not completely crazy. Because there was so much opposition, [people asking]*
“No way, so many studies devoted to medicine only to go and meddle in those things? And furthermore, you do not have your life—you are so unstable”.

Jacques confrontation with skepticism exemplifies how education in scientific medicine is often prioritized over studies of other medical systems. There is a connection as well with scientific medicine as a profession and source of stability in life. To fully commit to other disciplines or cultures of knowledge is seen as sacrificing one’s respectable professional status. However, as demonstrated in chapter 4, there are several local initiatives in San Martín that are working to create a space where respectful intercultural dialogue on medical practices can be realized.

5.4 Concluding Remarks

This chapter has focused on healers’ experiences of identity, practice, place, political ecology and interacting medical knowledge systems in San Martín. By listening to healers talk about their experiences, I understood a bit more clearly how historical structures of power have shaped identity, practice and place in this region. Primarily, it is the economic resource booms, civil wars, immigration and development initiatives that have contributed to economic instability and inequality in San Martín, which, in turn, creates differential access to medical systems based on income. However, it is these same processes that have created the dynamic conditions for information exchange and constant reproduction of medical knowledge systems.

The healers make clear distinctions between traditional Amazonian and modern scientific systems of knowledge in this region based on economic differences. Modernity
is often linked to an economically superior class, and pharmaceutical and scientific medicine is quoted as being associated with modernization because it is expensive and comes mostly from urban areas and institutions. Traditional medicine is associated with cultural and spiritual wealth, as opposed to the modern material wealth.

These dichotomies, between tradition and modernity, between Indigenous and ‘modernized’ or Mestizo or European, between traditional medicine and scientific or western medicine, appear to act as both obstacles to the integration of medical practices, as well as incentives to promote traditional medicine. The obstacles are that poor people cannot afford scientific medicine, and some scientific doctors remain skeptical and prejudiced about traditional practices. However, the incentives to promote traditional medicine are that it addresses local health problems in the language and practices that local people are often familiar with, poor people can afford it, it is suitable for the treatment of many ailments that scientific medicine cannot address, such as susto or maldades, and internationally it is being sought out as an alternative to western medical practices. The healers in this study seem optimistic about their role as healers. Although economic and spiritual disparities are a major theme in their comments about interacting medical systems, they each have created a niche for themselves, practicing their medical knowledge at the interface of different medical systems, taking advantage of the conditions at this interface to negotiate their role as healers.

Winston takes on the role of healer for local and international drug addicts, tourists, and his community, cultivating food crops on the side and providing for his family. Rosa takes on the role of western-trained doctor, Amazonian healer at Takiwasi, translator of medical knowledge systems, national and international advocate for
traditional and intercultural medicine and provider for her family. Cristobal takes on the role of ayhuasquero and healer for his community, campesino, advocate for the community of San Miguel and provider for his family. Jacques takes on the role primarily of Amazonian healer and founder of Takiwasi, Western-trained doctor, international advocate for traditional medicine, and provider for his family. The roles of these healers are inseparable from the historical and contemporary context in which they practice, giving them an interesting perspective on the impacts of political, economic and environmental change on community and environmental health in San Martín.
CHAPTER 6
CONCLUSION:
INTERCULTURAL HEALTH IN SAN MARTIN?

Summary of Research Objectives

Since the 1970s many health development programs have focused on the role of traditional knowledge for community health (see Zuluaga and Correal 2002; WHO 2002; Quick 1982). Since the United Nations Convention on Biological Diversity in 1992, there has been increasing interest in the value of traditional knowledge for environmental health (Sampath 2005). International policy-makers have developed ways of addressing community and environmental health as integrated conditions—one cannot exist without the other—that involve the alleviation of economic disparities through market integration (Sampath 2005). However, developmental objectives to relieve economic inequalities through the commodification of food and medicinal products may run contrary to some local Indigenous, relational and kincentric worldviews, and may actually perpetuate rather than alleviate economic inequality.

Throughout this thesis, I have been inquiring into the role of healers at the interface of historically-situated spheres of interaction, and at the confluence of Amazonian, western scientific and other traditions of medical knowledge systems in San Martín. Specifically, I wanted to know how healers negotiate their role and distinct medical knowledge systems in relation to community and environmental health. This inquiry necessarily moved me beyond how healers address the human body and ailments such as bronchitis and diarrhea to involve questions of spiritual and energetic dimensions.

An emergent objective of this research project has been the negotiation of my own experiential approach to anthropological fieldwork. To gain a better understanding
of local healing practices I have used this approach to embody some of the knowledge healers have shared with me through experience. By participating in purgas, Ayahuasca sessions, dietas, other remedies and medication, I trusted the healers’ medicine and came to know it through myself, through what Zuluaga and Correal refer to as “anthropology though pain” (Zuluaga and Correal 2002), and to really appreciate the complementarity of Amazonian medical knowledge systems with western psychotherapy. I saw, felt and heard some of what the healers explained to me through my own experiences, and through paying more attention to dreams and visions. I used these as data rather than as background to my study. In future research endeavors, I will likely pursue an experiential approach, yet within a more thorough analysis of the historical and contemporary political ecology of the region of study to better situate the experiences of study participants, our interactions and my experiences as a North-American, white, middle-class, female anthropologist.

In my research I attended workshops on community and environmental health projects. At these workshops I observed the NGOs in San Martín which organized them, and the healers and health promoters of various backgrounds who participated in them. Through my observations, I learned about how participants negotiate the meanings of traditional, Kechua Lamas, scientific, western, and other medical knowledge systems. I watched healers demonstrate the preparation of various remedies, and I listened to the questions that health promoters asked, thereby experiencing how an intercultural space is created to negotiate these knowledge systems.

By listening to healers’ experiences of their identity, practice, place or environment, political ecology and interaction with different medical knowledge systems,
I became aware of the historical and contemporary processes of political, economic, environmental, and spiritual change that shape medical knowledge systems. These experiences highlighted some of the obstacles and opportunities for interactions and collaborations among health practitioners in different positions and of different backgrounds. Most of the obstacles identified were geographic, economic, or social. Most of the opportunities were based on individual healer innovation and a few individuals coming together to create an intercultural space where healers of various backgrounds felt comfortable sharing their experiences. Prior to my fieldwork, my understanding from literature on development was that local voices are often not considered in development initiatives. However, in the field I found several examples of intercultural initiatives in San Martín where local voices are valued in the development of innovative, accessible and affordable health programs.

**Fieldwork Questions, Fieldwork Answers**

Questions that I proposed to answer in this research project are outlined in the following paragraphs. During my fieldwork and reflection upon my fieldwork, these questions also generated more questions which I attempt to answer in this section.

**Political Ecology**

*What historical processes have given meaning to local knowledge systems and practices?*

According to historical accounts, the region of San Martín has been the site of extensive resource extraction and the project of jungle colonization in Incan, colonial, neocolonial and now modern and global expansion. The constant flux of migration following
resource extraction, political movements, government development initiatives and other economic opportunities has contributed to the exchange of knowledge systems. Increased urbanization and ties to urban areas have also contributed to dichotomous categories of class, identity, and knowledge systems. Indigenous, Mestizo and European ideas, identity and practices have been combined, and yet are still defined and opposed categorically. Government health initiatives since the 1970s have contributed to a ranked system of medicine through the imposition of western medical practice on local healers in capacity-building programs. The association of science and western medicine with modernity has also given scientific and western medicine a privileged or superior position in local communities. More recently, increased tourism and valorization of traditional medicine from external communities has highlighted the cultural wealth of traditional medicine and is currently challenging the hierarchical organization of medicine in the region of San Martín.

**Healing Practices**

*How do healers in San Martín describe healing practices?* Healrs who participated in this study expressed a distinction between traditional medical practices and western medical practices.

**Traditional medical practices** were described as involving training through apprenticeships under the guidance of *maestro curanderos* and *plantas maestras*, through *purgas, Ayahuasca* and *dietas*. The dreams and visions resulting from these experiences were referred to as important messages and/ or the teachings of the plants. Each plant has a spirit or *anima* that the healers call upon for healing, and the *maestro curanderos*
provide the discipline with which to structure the experiences with plant *animas.* Experience for the apprentice is often accumulated through assisting the *maestro curandero* in ritual and general healing practices. Traditional healing practices address disease as imbalances in the body that must be addressed with *purgas*—purging the body of illness, *sopladas*—blowing smoke to calm and protect the patient, *chupadas*—sucking the *flemocidad,* phlegm or illness out of the patient’s body, and *sobadas*—massaging the illness out of the body. Plant *animas* are called on by the healers for the specific characteristics, such as the ability to strengthen resolve, and to protect against *brujería* (witchcraft), that they provide for the patient. Traditional medicine is seen as accessible to the local population because it is affordable and herbal remedies can be cultivated, harvested and prepared in the *chacra.*

**Western medical practices** were described as involving training through university and experience working in various clinics or governmental and non-governmental health projects. Western medical practices were associated with modernity, pharmaceuticals and so-called “objective” scientific research that excludes, to some extent, notions of energy and spirituality. However, healers who primarily practice local Amazonian medicine explained that if the health problem is serious and beyond their capabilities to resolve, they will refer their patients to the hospital or available western-trained health practitioner.

Concerning the question of “*What categories of knowledge systems are recognized and contested in this community?*”, healers also identified traditional and modern as the two categories that are recognized and contested. When I inquired into “*How are these knowledge systems negotiated at a community level? (Are they*
ranked?"), I found that yes, these two categories of medical knowledge systems are ranked, yet this ranking occurs simultaneously in different ways in different contexts. When comparing traditional medicine to western medicine, healers native to the area ranked western medical knowledge as economically superior, and yet ranked traditional medicine as culturally superior. They made references to their Kechua language and the value of traditional medical knowledge for health and tranquility. Healers who came to the region in the late 1970s or 1980s (Rosa and Jacques) also rank traditional medical knowledge systems as culturally superior, citing the wealth of wisdom that these systems have, especially when compared to scientific knowledge systems that exclude spiritual dimensions. For these latter healers, who are also western-trained doctors, scientific medicine is valuable, but lacking in a critical dimension.

**Intercultural Health**

The Peruvian government has created several initiatives for intercultural medicine through the Peruvian Ministry of Health (MINSA). At the community level, these knowledge systems are being negotiated through the creation of intercultural spaces that NGOs are organizing to bring together health practitioners from diverse backgrounds to exchange experiences. Through this negotiation of medical knowledge systems, obstacles and opportunities for collaboration between knowledge systems are being identified. As obstacles, local access to western medicine was described as being limited due to geographic concerns, such as the sporadic presence of western-trained health practitioners at rural medical centers/posts; economic concerns, such as the high price of pharmaceuticals and economic poverty in the region; and social concerns, such as the
educational or economical power structures that persist and perpetuate prejudice against practitioners of traditional medical practices. This leads into the question of “What are the relations among different medical knowledge systems?” and “Are dichotomous categories an obstacle to understanding and integrating knowledge systems?” In San Martín, I would suggest that yes, dichotomous categories do exist, but that there are many initiatives at a local level whereby government and NGOs are striving to bring different medical knowledge systems together and to highlight their similarities, complementarity and potential opportunities for collaboration between health practitioners of diverse backgrounds to address concerns of community and environmental health.

**Equity**

*Is there equity in the negotiation of local healing practices, public health policy and environmental resource management?* In the negotiation of local healing practices, I listened to the experiences of healers who confronted problems of not being recognized as legitimate healers by doctors at their local health centers. Although these cases could be a result of individual conflict, they may also represent lingering attitudes of racism and academic arrogance in the region that is outlined in the literature and that was commented upon in the interviews and interactions that I had with healers. For environmental resource management I had limited experience in local negotiations and policy-making. However, it was pointed out to me by members of WamanWasi that some economic development projects in the region, under the claim of having completed national requirements of prior informed consent, have excluded several Indigenous communities in their negotiations of land to be used for the exploration and extraction of oil. This has
the potential to create conflict among local inhabitants whose territories are being used without their having been consulted or agreeing to the conditions. As well, if some communities are being consulted in region, while others are not, this has the potential to divide communities along lines of political economic conflict.

**Knowledge Integration**

*Are there appropriate measures in place to integrate knowledge systems?* Policy is in place on international and national levels to integrate knowledge systems. One question is whether or not these policies make sense or are enacted in practice. I observed intercultural initiatives designed by NGOs to critically analyze government policies regarding community and environmental health, as well as to address and implement these policies on a local level. However, there are still obstacles of economic restraints, geographical access and relations among healers, involving prejudice and questions of legitimacy.

**Role of Healers**

*What are the roles of healers in a contemporary context?* In the contemporary context of San Martín, the role of healers appears to be one of creative integration of the practices they are familiar with and that they have received through training either through *maestro curanderos, plantas maestras*, apprenticeships, university institutions, capacity building training or otherwise, and the practices that they have been exposed to through personal experiences of illness, through government health policy or those practices that are requested by their patients and/or international and government policy. The result is a
collection of healers who combine traditional and western, local and non-local practices, beliefs and resources to confront concerns of community health. Healers in San Martín are also faced with questions at the interface of community and environmental health. Healers, who are dependent on their environment for plant medicines, *plantas maestras*, subsistence and income, are necessarily having to evaluate their relationship to nature in a region that is faced with extensive deforestation, climate change and numerous infectious diseases caused by social, environmental and spiritual conditions.

Another condition that healers are facing in their contemporary contexts is the emerging tourism industry promoted by national and regional governments. In Tarapoto, specifically, there are several centers that cater to tourists looking for *Ayahuasca*, and other traditional medicine experiences.

**Representing Indigenous knowledge**

There are concerns expressed in anthropological literature that environmentalists romanticize Indigenous knowledge. It is suggested that Indigenous people are promoted by environmentalists as being closer to the environment and therefore holding the wisdom to save the contemporary world from community and environmental health crises worldwide (Brosius 1997). In my research I did not intend to essentialize local Indigenous knowledge in San Martín as the wisdom that will save the world. What I did intend to highlight is a relational difference to nature that exists in the medical knowledge systems of San Martín, and to suggest that a deeper understanding of this relational difference is key to intercultural health. I posit that a market-driven and economic approach to community and environmental health development, as advocated by the
United Nations Convention on Biological Diversity, is incomplete. I advocate for a more in-depth understanding of local, relational views of nature or “biodiversity conservation” in medical and environmental knowledge systems before the imposition of market-driven development and values. Yet I ask how it is possible to promote Amazonian knowledge systems without romanticizing or essentializing them? For future research, I would ask:

1. Are intercultural approaches appropriate for the promotion of local knowledge systems without romanticizing or essentializing local ways of knowing?
2. Does practicing intercultural health hold the promise of addressing community and environmental health?
3. How can obstacles of economic inequality be confronted, and removed, without compromising a kincentric or relational worldview in favour of an exclusively market-driven resource worldview? Are these worldviews compatable?

**Experience, Insight, and Responsibility**

Through my experience with healers at this interface, I have come to understand that there are several ways to approach health and illness. Looking to the interface of medical knowledge systems provides insight into the various ways that humans have come to negotiate their relationship with nature. With growing international interest in and awareness of the use of Amazonian medical knowledge comes the responsibility to respect the community and environments within which these knowledge systems have emerged, changed, and been maintained through the creative and political agency of many healers, their plant teachers, and their communities.
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