Enfermería: Cuidados Humanizados, July-December 2025, 14(2): e4604 ISSN online: 2393-6606
doi: 10.22235/ech.v14i2.4604

Unveiling Conceptions of Development and Health Status in Diaguita Children within the Framework of Primary Health Care

Develando las concepciones del desarrollo y la situación sanitaria en niños diaguita en el marco de atención primaria en salud

Desvelando as concepções de desenvolvimento e a situação sanitária em crianças diaguita no âmbito da atenção primária em saúde

Olga Susana Faúndez Madrid[1]*, ORCID 0009-0007-0520-8360*
Camila Lucchini-Raies[2]*, ORCID 0000-0001-5704-9778*
Francisca Márquez-Doren[3]*, ORCID 0000-0001-8093-4687*

[1 2 3] *Pontificia Universidad Católica de Chile, Chile*

Abstract: Introduction: Monitoring child growth and development is a duty that responds to legal, ethical, and public health imperatives, and is fundamental to biopsychosocial well-being and human potential. Despite advances in health policies, indigenous children in Chile exhibit worse health indicators than the general population. Objective: To understand the meaning of development and health for Diaguita children cared for within the framework of PHC. Methodology: A qualitative phenomenological design was used, involving secondary analysis of 11 interviews with 8 Diaguita mothers and 3 health professionals who serve this population. Results: the analysis revealed 3 main categories: I. Perceptions about traditional aspects of child development and well-being; II. Diaguita cultural and community heritage; and III. Experiences with health systems. Conclusion: Diaguita families in Atacama understand child development from a holistic perspective, closely linked to their worldview and ancestral heritage, which is shared within their families and communities. Their experience with healthcare impacts their assessment and adherence to primary care, as they perceive a lack of interest in their culture and discriminatory treatment. Healthcare personnel also recognize a lack of tools to provide culturally relevant care.

Keywords: child development; indigenous people; cultural competency.

Resumen: Introducción: La supervisión del crecimiento y desarrollo infantil es un deber que responde a imperativos jurídicos, éticos y de salud pública, fundamentales para el bienestar biopsicosocial y el potencial humano. A pesar de los avances en políticas sanitarias, las infancias indígenas de Chile presentan peores indicadores sanitarios que la población general. Objetivo: Entender el significado de desarrollo y salud de las infancias diaguita atendidas en el marco de la atención primaria en salud. Metodología: Diseño cualitativo fenomenológico a través del análisis secundario de 11 entrevistas a 8 madres de familias

diaguita y 3 profesionales de salud que atienden a esta población. Resultados: El análisis reveló 3 categorías principales: I. Percepciones sobre los aspectos tradicionales del desarrollo y bienestar infantil; II. Legado cultural y comunitario diaguita; y III. Experiencias con los sistemas de salud. Conclusión: Las familias diaguita de Atacama entienden el desarrollo infantil desde una visión holística, vinculada a su cosmovisión y legado ancestral compartida en las familias y comunidad. Su experiencia con la atención sanitaria afecta su evaluación y adherencia a la atención primaria y salud, al percibir escaso interés hacia su cultura y tratos discriminatorios. El personal de salud también reconoce la falta de herramientas para ofrecer una atención culturalmente pertinente.

Palabras clave: desarrollo infantil; pueblos indígenas; competencia cultural.

Resumo: Introdução: A supervisão do crescimento e desenvolvimento infantil é um dever que responde a imperativos jurídicos, éticos e de saúde pública, fundamentais para o bem-estar biopsicossocial e o potencial humano. Apesar dos avanços nas políticas sanitárias, as crianças indígenas do Chile apresentam piores indicadores sanitários do que a população geral. Objetivo: Compreender o significado de desenvolvimento e saúde das crianças diaguita atendidas no âmbito da atenção primária em saúde (APS). Metodologia: Desenho qualitativo fenomenológico, por meio da análise secundária de 11 entrevistas com 8 mães de famílias diaguita e 3 profissionais de saúde que atendem essa população. Resultados: A análise revelou 3 categorias principais: I. Percepções sobre os aspectos tradicionais do desenvolvimento e bem-estar infantil; II. Legado cultural e comunitário diaguita; e III. Experiências com os sistemas de saúde. Conclusão: As famílias diaguita do Atacama compreendem o desenvolvimento infantil a partir de uma visão holística, vinculada à sua cosmovisão e ao legado ancestral compartilhado nas famílias e na comunidade. Sua experiência com a atenção sanitária afeta sua avaliação e adesão à atenção primária à saúde, ao perceberem escasso interesse por sua cultura e tratos discriminatórios. A equipe de saúde também reconhece a falta de ferramentas para oferecer uma atenção culturalmente pertinente.

Palavras-chave: desenvolvimento infantil; povos indígenas; competência cultural.

Received: 05/15/2025 Accepted: 11/04/2025

How to cite:
Faúndez Madrid OS, Lucchini-Raies C, & Márquez-Doren F. Unveiling Conceptions of Development and Health Status in Diaguita Children within the Framework of Primary Health Care. Enfermería: Cuidados Humanizados. 2025;14(2):e4604. doi: 10.22235/ech.v14i2.4604

Correspondence: Francisca Márquez-Doren. E-mail: fmarquez@uc.cl

Introduction

The monitoring of child growth and development constitutes an essential regulation within the health system, framed within public health strategies aimed at the comprehensive protection of childhoods. This practice arises not only as a response to technical guidelines

but also to ethical and legal frameworks at both international and national levels, [1] which safeguard the comprehensive well-being and the rights of children based on their human condition and identity. Its implementation contributes to the protection of human capital, the development of future generations, and the promotion of social equity. [2, 3] In this context, a comprehensive understanding of child health and development must take into account family diversity and life circumstances, adopting a holistic approach that encompasses not only physical growth but also its social, emotional, and cognitive dimension. [4]

Ethnicity is a structural social determinant that affects individuals' health, [5] linked to historical processes of discrimination. It constitutes a social construct often used to establish divisions and justify segregationist practices in various societies. [6] These social differences have historically been instrumentalized by dominant groups based on selective physical characteristics, generating structural inequalities. The social determinants of health approach allows for the reduction of these barriers and the addressing of complex problems linked to inequity, thereby promoting the transition toward universal health. [7]

Within this framework, understanding ethnicity as a structural factor allows for contextualizing the inequalities observed among Indigenous children, where this category interacts with other factors of social stratification, such as socioeconomic status. Poverty is arguably the most important individual determinant, and together they amplify the risk of health inequities. [8] Indigenous childhoods in the Americas have historically experienced higher levels of violence, lower levels of education, reduced access to basic services, and greater poverty. [9] This situation is reflected in the Chilean context, where, according to the 2017 Census, 596,582 children and adolescents belong to an Indigenous people, represented mainly by the Mapuche (79 %), Aymara (8 %), and Diaguita (4.3 %) groups; of the latter, one-third reside in the Atacama region. [10] According to the 2017 and 2022 CASEN surveys, Indigenous children and adolescents show high rates of income poverty and multidimensional poverty, with those under 3 years of age being the most vulnerable. Indigenous communities also show poorer health indicators compared to the general population, due to health problems associated with unmet basic needs, a condition referred to as epidemiological accumulation, in which high levels of common infections, degenerative and/or chronic diseases, and injuries coexist within the same epidemiological pattern. [11]

Indigenous peoples of Latin America conceive health as a form of integral well-being that links the human being, nature, and the sacred, and is grounded in the principles of balance, reciprocity, and respect for life. This approach has influenced legislative advances aimed at strengthening health systems aligned with the ethnicity and health policies promoted by PAHO/WHO. [12] Nevertheless, despite these normative advances, significant challenges remain in their implementation.

In particular, primary health care (PHC) faces difficulties in monitoring child health due to the limited evidence supporting such progress. This is partly related to shortcomings in the collection and management of standardized data on Indigenous health, which has restricted research to isolated experiences or case studies. Given that PHC plays a key role in monitoring child development, it is essential to deepen the understanding of Indigenous communities' realities. Within this framework, the present study seeks to contribute to a comprehensive understanding of the concept of development among Diaguita families and of the health situation of their children within the context of PHC in the Atacama region.

Methodology

This qualitative study, based on a phenomenological approach, relied on the analysis of secondary data obtained from eleven participants interviewed between October 2 and 5, 2023. The interviews were conducted within the framework of a primary mixed-methods study commissioned by the Chilean Ministry of Health (MINSAL), focused on the three Indigenous peoples with the largest populations in the country.

This study analyzed the interviews conducted with members of the Diaguita population, including eight mothers (DM) from families with children under nine years of age and three members of the healthcare team who provide primary-level services to this child population (HCPN, HCPNUT). Participant selection was carried out with the collaboration of Indigenous representatives from the region, also taking into account the families' connection to the public health network, information was verified with MINSAL. Through purposive sampling, the recruitment of at least eight families and two health professionals directly involved in their care was agreed upon.

The primary study, entitled "Mixed-methods study on conceptions of development, assessment, and health status of Indigenous boys and girls within the framework of comprehensive health monitoring carried out in primary health care", published the preliminary baseline results in the technical report "Invisible Childhoods: Challenges of Statistical Data and Biopsychosocial Indicators of Indigenous and Migrant Children" [13] in 2024. The publication of the full study results is still in progress.

Data for the primary study were collected through in-depth, semi-structured interviews. The guiding question was: 'What do you and your family understand by child growth and health?" Based on the participants' responses, they were asked to elaborate on emerging topics, complementing the conversation with questions related to collective childcare practices, personal and family care during this stage, and their experiences within the health sector.

The analysis used in this research followed a descriptive phenomenological approach inspired by Edmund Husserl [14] aimed at identifying meaning units and essential categories of the lived experiences within families. After transcribing the original audio recordings, an interpretative analysis was conducted using the Dedoose software. [15] The structure of the phenomenon was developed and validated jointly with the authors of the original study.

To ensure methodological rigor, the criteria proposed by Guba and Lincoln [16] credibility, auditability, and transferability) were applied under the supervision of the same experts, who also served as tutor and reviewer for this work. Throughout the entire process, the ethical principles established by Ezekiel Emanuel [17] for qualitative studies were respected, and the study was approved by the Ethics Committee of the Faculty of Medicine at the Pontificia Universidad Católica de Chile (ID: 231222001).

Results

The families were represented by Diaguita women, all of them mothers of Diaguita children, whose ages ranged from 31 to 46 years. Most had more than one child and at least seven years of experience attending child health check-ups within PHC. Four of them were employed in or had received training in the health field, while the others were mainly engaged in domestic work, occasionally complemented by informal or temporary

employment. All participants lived in or were actively involved with Diaguita communities, primarily in rural areas.

The children's ages ranged from 2 to 9 years. The professional group consisted of two nursing professionals and one Nutrition Specialist, all of whom had at least ten years of work experience in PHC.

An in-depth analysis of the interviews revealed three phenomenological categories: I. Traditional Perceptions of Child Development and Well-being; II. Diaguita Family and Cultural Legacy; and III. Experiences within the Health System.

Traditional Perceptions of Child Development and Well-being

In this category, the mothers' interviews revealed subcategories associated with: (1) physical health and cognitive development; (2) emotional and affective health; (3) social and spiritual health; (4) eating habits; (5) teachings related to self-care; and (6) the appreciation of significant others in child-rearing.

In the mothers' accounts, their children's physical health and cognitive development emerged as a persistent concern that permeates the entire child-rearing experience. This dimension is understood within the framework of child growth and development and is associated with the challenges children face in adapting to various personal and social demands. Alongside this, mothers assign a central value to emotional well-being and affective development, which they understand as processes linked to the emergence and consolidation of feelings. They also recognize that the way their children build their self-image will have a decisive impact on their emotional development and their ability to function socially in the future.

> I've noticed she's growing up; I've seen that she's starting to... you know, develop physically, like the body of a ten-year-old girl. So I have to be cautious, because now people might start looking at her differently (DM1).
>
> Because of the suspicion they have of him [speaking softly and slowly], there hasn't been much change. At this moment, he doesn't speak, he doesn't show signs of… for example… interacting with others. He doesn't point at things either. His daily behavior is… he goes into his tent and plays, and that's what he does every day (DM3).
>
> Here they are free to go out and play… [pause] J is always covered in dirt — he grabs the dirt and throws it up over his head, gets himself all dirty, and that's how he's happy […]. He's a happy child here (DM2).
>
> You know, he's still a child… but when a child grows up and has bad teeth, people look down on him, and that really lowers his self-esteem (DM4).

The eating habits of these families are closely connected to family traditions, which are also shared within the communities where they live or participate. These customs, passed down from generation to generation, represent a fundamental part of their cultural heritage—for instance, the use of herbs in food preparation learned from previous generations. From the perspective of health professionals, the practices observed are not easily distinguishable from those found in other communities, including families from other Indigenous peoples, migrant populations, or the general population.

> Also, as with herbs and that kind of things, we've always given that to our children with their milk—goat's milk, cow's milk—we always give it with that, with herbs from the hills (DM5).
>
> But yes, with solid foods, we often see that feeding starts earlier—but not with whish specific food (HCPN1).
>
> Regarding nutrition […] it's urban, so when they buy food, where do they go? To the supermarket or local stores. So, there isn't really anything special about… about their food, their diet (HCPNUT).

Mothers interviewed mention that they directly teach their children about the risks they are exposed to as they grow up, as well as the self-care practices they need to learn. These teachings mainly take place within the family setting, with the support of the community.

> So I go with her, I brush my teeth with her and teach her how to do it. Now I'm also teaching her how to bathe on her own (DM1).
>
> Now I'm teaching him to do things by himself—like putting the kettle on in case I'm not around (DM2).
>
> My daughter says, 'Mom, I want to go to my friend's house,' and I tell her, 'No—only where I can see you.' […] I don't know that girl's mother or father, so I can't let you go to a house when I don't know her parents (DM8).

The appreciation of significant figures in child-rearing—particularly the influence of grandmothers, as well as spiritual guides within their culture—emerges as another valued aspect in the upbringing process.

> She [the *machicúa*] told me the other day… she looked at him and said: 'Eli, you know that J has a problem with his eye?' I had noticed it […], she saw him looking toward the east and said: 'J's eye drifts a little.' Yes, I had noticed it; no one else had (DM2).

Diaguita Family and Cultural Legacy

In this category, several aspects emerge: (1) the contribution derived from belonging to one of these communities; (2) the transmission of values fostered by this belonging; (3) the practice of ancestral medicine; and (4) the perception of the cultural competence of the healthcare professionals who provide their care.

For the mothers interviewed, the community provides significant support in essential aspects such as safety and child care.

> The good thing is that in the community, we're always there for each other (MD2).
>
> It's good for the children; they feel much more connected with the community. They also disconnect from electronic devices, relate much more to others, and learn more about the origins of the community, of the people […]. I take them there because they connect much more with who they truly are (MD3).
>
> I tell her that here the children, at least those M's age, are being raised well, far from much of the evil that exists down there (MD4).

> You don't see all the evil that's down there […]—imagine the robberies, assaults, carjackings. Here, on the other hand, you could say it's a bit more relaxed, calmer […]. That's also why I've stayed here—for peace of mind and for safety, so to speak (MD8).

Being part of a community strengthens cultural identity and provides families with a sense of belonging and pride. The transmission of values occurs mainly within the family context, where respect is the most frequently mentioned.

> I talked to her and took her so she could apologize […] as it should be done […] here we don't use those kinds of words (MD1).

> In my case, yes—and I'm still learning—that the children follow the same pattern I was raised with, in the sense of respect, always toward everyone, whoever the person may be, and among themselves as well; that's what's most important (MD6).

> When there are adults around, you stay quiet—adults talk, and children don't interrupt the conversation (MD7).

The use of natural medicine is a common practice and the first option mentioned by mothers for treating their children's ailments. These family- and community-based practices are not well known by the health professionals who provide their care. None of the interviews revealed knowledge of Diaguita *machicúas* participating in primary health care centers; only one mother mentioned the presence of healers from the Colla culture.

> Here, when someone gets sick, the first thing we use is… all the natural medicine (MD4).

> I prefer natural medicine over intoxicating her with medications and antibiotics […] it has to be something serious for me to take her to see a doctor (MD7).

> I think in the end those kinds of medicines could be incorporated more, so to speak, because many people prefer natural remedies over all the chemicals and things we take every day. So I think that's important too […] having the choice of whether one really wants natural medicine or… allopathic medicine (MD6).

> When the children get sick and things like that, they use herbs—yes, the types of herbs they mention, yes […] they have strange names, of course, I wouldn't know their names, but yes, they say that when the children have a stomachache, they give them herbs. They really believe in… natural medicine (HCPN1).

Regarding the assessment of the cultural competence of health professionals, limited knowledge of the Diaguita population they serve was observed. One professional noted family reluctance toward certain established health practices, such as childhood vaccination; however, it was not clear to which culture or group this applied to.

> The biggest differences I notice are with immigrants, those who have arrived recently, but with Indigenous people, no. I repeat, this is a center that serves a large portion of the population and all, but Diaguita people and so on—no, and if there are any, as I said, they're assimilated. They're part of the community (PHCNUT).

> Honestly, I've never attended families who say they belong to an Indigenous people. I think it may also be because the interview we conduct is never aimed at finding out whether they belong… to an Indigenous group (PHCN2).
>
> With vaccines, we often have to go out and look for them to administer the doses—it's not so standardized that they come in to get vaccinated. Maybe because of their beliefs… they might think that diseases won't really affect them (PHCN1).

Experiences within the Health System

In this category, three main themes were identified: (1) family experiences with the health system; (2) the experiences of young children in PHC centers; and (3) the professional assessments of care provided in PHC.

In relation to family experiences with the health care system, the mothers emphasized that childbirth care lacked an intercultural perspective, noting that their right to be attended by their own midwife was not respected, nor was their decision to have a natural birth.

> When I went into labor, I told them: I need you to call the meica, I said, because she's the one who's going to deliver my baby. And they said, 'Then you contact her.' But how could I, if I was in pain… (MD2).
>
> They don´t respect that right—we can't choose who attends our births. Midwives give anesthesia, but we don't want that—we want a natural birth with our traditional midwife. But they don't allow it (MD5).

They also shared negative experiences perceived as negligent and discriminatory behaviors, which were associated with feelings of frustration, uncertainty, and vulnerability—both in the care provided to their children and in their own treatment.

> In the health center, the first day the nurse didn't even look at her… The next day, she examined her completely. Why such a difference (MD1).
>
> She told me she was going to refer my son. She would take down all my information, but I don't know if she forgot, because in the end she never referred him. She would tell me, 'we're going to call you, we'll send you things so you can practice with him at home, I'll send it to you by WhatsApp,' she would write down my phone number and never did it. J learned to speak on his own (MD2).
>
> I think that although my son is still very young, during all this time that there's been a suspicion […] time has been lost that could have been useful for him […] it's frustrating to have to depend on the health system in order to see—or to have access to—a doctor (MD3).

In PHC, the mothers also identified discriminatory experiences in the care of their children, related to professionals' lack of information about the families' contexts, which hinders the development of empathy in the care provided.

> I felt uncomfortable […] the nurse came in and said, 'Take off his sock. All of it,' […] and I was so embarrassed taking it off, removing his sock, and the nurses just stood there looking like thinking that he came in with dirty feet […]. They didn't say anything, but I felt it […] it would've been easier if they had just asked me,

> 'Why did the little boy come like this?' […] and then it was like everyone started coming in to see, as they were saying 'Go see the child who's…' (MD2).
>
> The nutritionist didn't want to touch him. He peed himself, and she was supposed to examine him. 'Oh no,' she said, 'I'm not going to touch him.' But he's a child! […], and she even wanted me to clean the floor (MD2).
>
> It must take a lot to go to the health center. […] They were checking M's teeth, and he had one session left. They gave me an appointment, then called to reschedule, saying they'd call me again to set a new date — but they never did (MD4).

Regarding the care of their own children, the mothers described the well-child checkups as a mechanical, quick, and simple process. This evaluation is not perceived as sufficient to address all the relevant aspects of children's growth, development, and overall health.

> The checkup is something so quick, the child goes in and out […] they just weigh them, measure them, take a look and that's it, get them dressed (MD 2).
>
> It's something really simple—they just check height, weight, take the blood pressure, ask if you feel good or bad, look at the teeth… okay, that's it, next checkup in a year […], it's like they don't take much background information (MD 6).
>
> I'm not going to let the doctor keep seeing E—she'll see my *meica*. The thing is […] many health centers only have Colla healers. That's the issue, I'm not taking my daughter to be seen by a Colla healer. Obviously, I want my Diaguita *meica* to see her, because they have a different way of seeing things (MD 1).
>
> First, I would like that they would respect us for our culture, and in terms of health, we have our *machicúa*, which is very different in the remedies and in the way of treating health (FMD 5).
>
> I think that in the first interview, we should be asked if we belong to any ethnic group—and continue by asking if we use any alternative medicine, and if that works for us or not (FMD 6).
>
> There should be alternative medicine options for children as with adults—to give parents the right to choose (MD 7).

From the professionals' perspective, their accounts highlight limited preparation to provide care for Indigenous families, related to a lack of knowledge about their habits and the absence of culturally relevant tools. In particular, the lack or complete absence of training opportunities stands out, which results in the omission of this dimension as a relevant element in family assessment processes.

> The treatment is the same—there's no difference. As I say here, you have your schedule, and patients are generally given appointments, not in any special way or at a special time. In general, there isn't a specific program for attending Indigenous populations (PHCNUT).

> There should be more training and activities related to Indigenous peoples, because we don't really know much about their culture. So we end up trying to impose things that maybe they don't practice (PHCN1).
>
> I think maybe some parents could feel discriminated against if they're asked whether they are part of an Indigenous group. I probably wouldn't ask that question (PSE2).

Discussion and Conclusion

The conceptions of Diaguita families regarding child development, well-being, and health are grounded in a holistic vision which, although recognized within the current national health model, is not reflected with the same depth or coherence in its practical implementation. This perspective integrates physical, emotional, social, spiritual, and cognitive dimensions in an interrelated manner, together with a close connection to nature and the surrounding environment, expressing a worldview that is distinctive and deeply rooted in Indigenous peoples. [18-20] In this relationship with the environment, mothers strongly emphasize the value of children's free play in nature as an essential aspect of healthy development, underscoring the importance of this setting for learning and harmonious growth. [21]

Regarding aspects related to community belonging, the upbringing practices within Diaguita families center on the transmission of values, community participation, and the use of ancestral natural medicine, further reinforcing the holistic approach to health and its underlying worldview. Belonging to the community is key to strengthening family identity and pride, allowing for the preservation of traditions and the transmission of fundamental values such as respect for authority, others, and nature. [20] This finding highlights the importance of community ties in the child-rearing process and aligns with findings among Mapuche families with young children in rural agricultural areas, who emphasize the development of values such as responsibility, respect, and the formation of social and productive skills as part of their children's growth. [22] Indigenous peoples across Latin America maintain educational practices based on observation and community participation, which have evolved and endured over time.

On the other hand, natural, ancestral, or traditional medicine—currently referred to by the WHO as complementary medicine, defined as "a broad set of knowledge, skills, and practices based on indigenous theories, beliefs, and experiences, whether explicable or not" [23] used for therapeutic purposes—constitutes a cornerstone of Indigenous cultures in promoting family well-being. Despite its inclusion as a public health strategy, as proposed by the WHO, it has not yet been fully integrated into the national health system. In this regard, the lack of interest and acceptance among health professionals toward these practices remains a persistent issue within the broader debate and reflection on intercultural health. [24] Emerging evidence points to similar findings [25] which may be linked to an insufficient internalization of the concept of interculturality in health among healthcare teams—a situation partly rooted in social structures that perpetuate the subordination of minority groups and hinder respectful and transformative integration in the face of systemic inequalities. [26]

The construction of intercultural rights in Chile began with the Indigenous Law, aimed at the contextual recognition of collective identities based on history, territory, and

intercultural relations. It also incorporated specific mechanisms for conflict resolution. This process became explicitly focused on the health sector during the Health Reform (2000–2005), with the enactment of the Health Authority Law in 2004. Subsequently, the General Administrative Regulation on Interculturality in Health Services (2006) was introduced. Finally, Law No. 20.584 (2012) guaranteed the right of Indigenous peoples to receive health care that is culturally appropriate. [26] In this context, it also became necessary to update health information systems, leading to the development of ministerial technical guidelines in this area. The inclusion of a question regarding Indigenous affiliation—established in Standard No. 820 on Health Information Standards—incorporated the intercultural approach into the health care model, in accordance with Article 7 of Law No. 20.584. [28] The omission of this question by health personnel may stem from a lack of awareness of these legal obligations. This situation generates feelings of injustice among the interviewed families, who perceive a violation of their right to culturally competent care. Such a right implies both quality and adequacy of care to their specific needs, consistent with the findings of a study on intercultural health from the Mapuche perspective. [29]

Concerning the assessment of the child growth and development program in PHC, negative perceptions focused on the manner in which care is delivered, emphasizing that the limited time allocated does not allow for a comprehensive evaluation of childhood development and contributes to a sense of limited benefit.

The conceptualization that emerges from the mothers' narratives—both from those with and without training or experience in the health field—reveals a similar understanding of child health and development. This suggests that lived experiences and shared cultural knowledge prevail over the influence of the biomedical approach, shaping a broader, relational, and contextual understanding of well-being and child development, consistent with Menéndez. [30] A relevant issue to consider is the quality of the available statistical records for assessing child populations. Paleczek Alcayaga and Bravo Uribe, through a critical analysis of the data sources and biopsychosocial health indicators of Indigenous and migrant children in Chile, identified significant gaps resulting from the lack of a consolidated mapping of sources, the absence of specific indicators for Indigenous populations, and the limited participation of communities in their design. [31]

The findings of this study reveal that the meaning attributed to child growth and development among Diaguita families attending primary care services, although aligned with the guidelines established in child health supervision programs, is perceived as insufficient for conducting a comprehensive assessment of their children. This perception arises from the consideration of sociocultural and community dimensions that are not always represented in current clinical and regulatory instruments.

Likewise, cultural relevance remains a scarcely developed aspect among the professional teams responsible for the care of these families. This limitation is understood as a threat to the quality of care provided, as it may reproduce standardized practices that fail to acknowledge the cultural diversity present in the territories. The lack of cultural appropriateness in health services affects both the care experience and the perception of health justice.

Accumulated experiences within the health system may negatively affect the healthcare process, as the lack of cultural recognition can erode the relationship between users and providers. This has implications for trust in the system, adherence to therapeutic recommendations, and continuity of care—dimensions that have been widely documented in intercultural contexts.

This study meets its objective by identifying the aspects valued by Diaguita families regarding the development and health of their children within the context of PHC. It also provides evidence of the need for a comprehensive approach to multiculturalism in health, promoting the translation of public policies and ministerial programs into sustainable local initiatives. The findings reinforce the importance of advancing toward culturally competent models of care that ensure equity, respect, and relevance in the health of Indigenous children. In this process, nursing professionals play a strategic role as facilitators of change, by raising awareness among health teams in alignment with the family health model in PHC. This involves incorporating interculturality through continuous training, mutual recognition and exchange of knowledge and practices, and the adoption of a critical perspective aimed at addressing inequities in everyday interactions. Participatory methodologies that promote dialogue, consensus-building, and ongoing evaluation are also needed.

The main limitations of this study relate to the use of secondary data, which restricts the depth and contextualization of the analysis regarding concepts of child development and health. Nevertheless, the credibility and interpretative coherence of the findings were ensured through the application of rigorous qualitative analysis criteria.

Future research would benefit from exploring these topics through diverse qualitative perspectives and complementing them with quantitative studies. This would enable the development of more precise indicators of Diaguita child health and contribute to a broader understanding of their well-being from a culturally situated perspective.

Bibliographical references

1. Truffello P. Tratados internacionales y legislación sobre infancia (1989–2020): recomendaciones internacionales del Comité de Derechos del Niño [Internet]. Santiago: BCN Chile; 2020 [cited 2025 Jan 15]. Available from: https://www.bcn.cl/asesoriasparlamentarias/detalle_documento.html?id=76604

2. World Health Organization, United Nations Children's Fund. Cuidado para el desarrollo infantil: adaptado para la región de América Latina y el Caribe [Internet]. Washington DC: OPS; 2019 [cited 2025 Jan 15]. Available from: https://iris.paho.org/handle/10665.2/51620

3. Organización Panamericana de la Salud, Fondo de las Naciones Unidas para la Infancia. Desigualdades en salud en América Latina y el Caribe: una línea de base para los Objetivos de Desarrollo Sostenible para mujeres, niños y adolescentes [Internet]. Washington DC: OPS; 2023 [cited 2025 Feb 12]. Available from: https://iris.paho.org/bitstream/handle/10665.2/57794/9789275326282_spa.pdf?sequence=1&isAllowed=y

4. Ministerio de Salud de Chile. Norma técnica para la supervisión de la salud integral de niños y niñas de 0 a 9 años en la atención primaria de salud: actualización 2021. Capítulo 3 [Internet]. Santiago: MINSAL; 2021 [cited 2025 Feb 12]. Available from: https://www.minsal.cl/wp-content/uploads/2021/12/Capi%CC%81tulo-3-Web.pdf

5. Organización Panamericana de la Salud. Determinantes sociales de la salud [Internet]. Washington DC: OPS; 2025 [cited 2024 Nov 23]. Available from: https://www.paho.org/es/temas/determinantes-sociales-salud

6. Otero Puime A, Zunzunegui Pastor MV. Determinantes sociales de la salud y su influencia en la atención sanitaria. In Zurro AM, Jodar i Solá G, editors. Atención familiar y salud comunitaria: conceptos y materiales para docentes y estudiantes. Barcelona: Elsevier; 2011, p. 88-99.

7. Monteiro L, Pellegrini A, Solar O, Rígoli F, Malagón L, Pastor Castell-Florit A, et al. Determinantes sociales de salud, cobertura universal de salud y desarrollo sostenible: estudios de casos en países latinoamericanos. MEDICC Rev. [Internet]. 2015[cited 2025 May 12];17(Supl):S53–61. Available from: https://mediccreview.org/determinantes-sociales-de-salud-cobertura-universal-de-salud-y-desarrollo-sostenible-estudios-de-caso-en-paises-latinoamericanos/

8. Organización Panamericana de la Salud. Determinantes sociales de la salud [Internet]. Washington DC: OPS; 2025 [cited 2024 Nov 23]. Available from: https://www.paho.org/es/temas/determinantes-sociales-salud

9. Naciones Unidas, Comisión Económica para América Latina y el Caribe. Pobreza infantil en los pueblos indígenas y afrodescendientes de América Latina [Internet]. Santiago: Naciones Unidas; 2012 [cited 2024 Nov 23]. Available from: https://repositorio.cepal.org/server/api/core/bitstreams/8d456b8b-7803-4174-af70-3f81903d0890/content

10. Instituto Nacional de Estadísticas. Resultados CENSO 2017 [Internet]. Santiago: INE; 2025 [cited 2025 mar 20]. Available from: http://resultados.censo2017.cl

11. Servicio de Salud Coquimbo. Anexo 7. Diagnóstico de salud de los pueblos indígenas de Chile [Internet]. Coquimbo: SSC; 2021 [cited 2024 Nov 20]. Available from: https://www.sscoquimbo.cl/gob-cl/documentos/files/aps/19-11-2021/ANEXO-07-2022.pdf

12. Organización Panamericana de la Salud. Política sobre etnicidad y salud [Internet]. Washington DC: OPS; 2017 [cited 2024 Nov 23]. Available from: https://www.paho.org/sites/default/files/ethnicityhealth-policy-2017-es.pdf

13. Martínez D, Alcayaga C, Farías A, Márquez F, Lucchini C, González M, et al. Las infancias invisibilizadas: desafíos de los datos estadísticos e indicadores biopsicosociales de niños y niñas indígenas y migrantes. Temas de la Agenda Pública [Internet]. 2024[cited 2025 Mar 20];19(180):1-22. Available from: https://politicaspublicas.uc.cl/publicacion/las-infancias-invisibilizadas-desafios-de-los-datos-estadisticos-e-indicadores-biopsicosociales-de-ninos-y-ninas-indigenas-y-migrantes/

14. Husserl E. Ideas relativas a una fenomenología pura y una filosofía fenomenológica. Trad. Gaos J. Mexico: Fondo de Cultura Económica; 1992.

15. Socio Cultural Research Consultants, LLC. Dedoose [Internet]. Los Angeles CA; 2023. Available from: https://www.dedoose.com

16. Castillo E, Vázquez M L. El rigor metodológico de la investigación cualitativa. Colombia Médica. 2003[cited 2025 Oct 10];34(3):164-167. Available from: https://www.redalyc.org/comocitar.oa?id=28334309

17. Emanuel EJ, Wendler D, Grady C. What makes clinical research ethical? JAMA. 2000 May 24-31;283(20):2701-11. doi: 10.1001/jama.283.20.2701.

18. Sánchez M. Espiritualidad indígena y participación femenina. Lectora [Internet]. 2016[cited 2015 Mar 1];22:59–65. doi: 10.1344/Lectora2016.22.5

19. Luna G. Ser Diaguita en la región de Coquimbo. In Reyes C, editor. Del museo a la identidad viva. Yo soy Diaguita. 2nd ed. Coquimbo: Letrearte; 2021, p. 95–105.

20. González R, Carvacho H, Jiménez-Moya G. Psicología y Pueblos Indígenas. Annu Rev Psychol. 2022[cited 2025 Jan 15];73:S1-S32. doi: 10.1146/annurev-psych-092421-034141

21. Whitebread D, Neale D, Jensen H, Liu C, Solis SL, Hopkins E, et al. El papel del juego en el desarrollo del niño: un resumen de la evidencia [Internet]. The LEGO Foundation; 2017 [cited 2025 May 1]. Available from: https://educrea.cl/wp-content/uploads/2020/03/papel-del-juego.pdf

22. Herrera F, Mora G. Interculturalidad e infancia rural: trabajo y cuidado en La Araucanía, Chile. Rev Latinoam Cienc Soc Niñez Juventud [Internet]. 2023[cited 2025 Mar 7];21(3):1–20. doi: 10.11600/rlcsnj.21.3.5058

23. Lobos C. Medicina complementaria [Internet]. Instituto de Salud Pública de Chile; 2019 [cited 2025 Mar 7]. Available from: https://www.ispch.cl/newsfarmacovigilancia/14/images/parte05.pdf

24. García L, Wahren J. Atención primaria de la salud e interculturalidad en comunidades diaguitas en Salta y Catamarca, Argentina. Cienc Intercult [Internet]. 2022[cited 2025 Mar 2];32(1):86–105. doi: 10.5377/rci.v32i01.16237

25. Veliz L, Bianchetti AF, Silva M. Competencias interculturales en la atención primaria de salud: un desafío para la educación superior. Cad Saude Publica [Internet]. 2019[cited 2025 Mar 1];35(1):e00120818. doi: 10.1590/0102-311x00120818

26. Galdámez L, Millaleo S. La interculturalidad vacía: derecho a la salud intercultural de los pueblos indígenas y personas migrantes en Chile. Acta Bioeth [Internet]. 2022[cited 2025 Mar 1];28(1):25–34. Available from: https://www.revistadeantropologia.uchile.cl/index.php/AB/article/view/67278

27. Poblete M, Goldstein E. Políticas de salud intercultural en Chile. Desde el PROMAP (1992) hasta la normativa vigente en la actualidad [Internet]. BCN Chile; 2019 [cited 2025 May 12]. Available from:

https://obtienearchivo.bcn.cl/obtienearchivo?id=repositorio/10221/27514/1/BCN_Poblete___Politicas_de_Salud_Intercultural_en_Chile_final.pdf

28. Ministerio de Salud de Chile. Orientaciones técnicas pertinencia cultural en los sistemas de información en salud. Variable de Pertenencia a Pueblos Indígenas en los Registros y Formularios Estadísticos del Sector Salud [Internet]. Chile; 2018 [cited 2025 Mar 1]. Available from: https://repositoriodeis.minsal.cl/Publicaciones/2018/Noticias/2018.08.28_OT%20PERTINENCIA%20CULTURAL_web.pdf

29. Pérez C, Sepúlveda D, Cova F, Nazar G. Salud intercultural desde la visión de las comunidades mapuche de Cañete y Tirúa. Rev Cienc Salud [Internet]. 2020[cited 2025 Mar 1];18(1):152–168. doi: 10.12804/revistas.urosario.edu.co/revsalud/a.8778

30. Menéndez LE. Modelos de atención de los padecimientos: de exclusiones teóricas y articulaciones prácticas. Ciência & Saúde Coletiva [Internet]. 2003[cited 2025 Oct 22];8(1):185-207. doi: 10.1590/S1413-81232003000100014

31. Paleczek Alcayaga H, Bravo Uribe D. "Les diaguitas estamos vivos en El Olivar". Praxis Arqueológica [Internet]. 2021 [cited 2025 Nov 4];2(1):5-20. doi: 10.53689/pa.v2i1.15

Funding: Secondary analysis article, whose original project, "Mixed study on conceptions of development, assessment, and health status of indigenous children within the framework of comprehensive health supervision carried out in primary care," was funded by the Chilean Ministry of Health, tender ID 757-20-LE23..

Data availability: The data set supporting the results of this study is not available.

Authors' contribution (CRediT Taxonomy): 1. Conceptualization; 2. Data curation; 3. Formal Analysis; 4. Funding acquisition; 5. Investigation; 6. Methodology; 7. Project administration; 8. Resources; 9. Software; 10. Supervision; 11. Validation; 12. Visualization; 13. Writing: original draft; 14. Writing: review & editing.

O. S. F. M. has contributed in 1, 2, 3, 5, 6, 9, 13, 14; C. L. R. in 1, 2, 3, 5, 6, 9, 10, 11, 14; F. M. D. in 1, 2, 3, 5, 6, 9, 10, 11, 14.

Scientific editor in charge: Dr. Natalie Figueredo.