



Mapuche health experiences in Primary Health Care from health workers and users in urban Chile

Experiencias de salud mapuche en Atención Primaria de Salud desde trabajadores sanitarios y usuarios/as en zona urbana de Chile.


Mónica Manríquez-Hizaut^a

 <https://orcid.org/0000-0002-5325-1749>
E-mail: mmanriquezh@uchile.cl


Jame Rebollo-Sanhueza^a

 <https://orcid.org/0000-0003-3245-1431>
E-mail: jame.rebollo@uchile.cl


Daniela Inglés-Yañez^a

 <https://orcid.org/0000-0003-0056-8432>
E-mail: daniela.ingles95@gmail.com


Rocío Klett-Fuentes^a

 <https://orcid.org/0000-0003-1458-0176>
E-mail: rocioklett@gmail.com

Cristián Lagos-Fernández^b

 <https://orcid.org/0000-0002-8937-4783>
E-mail: kinelagos@uchile.cl

Verónica Figueroa-Huencho^c

 <https://orcid.org/0000-0002-5422-6043>
E-mail: v.figueroa.h@iap.uchile.cl

^aUniversidad de Chile. Facultad de Medicina. Departamento de Kinesiología. Santiago, Chile.

^bUniversidad de Chile, Facultad de Filosofía y Humanidades, Departamento de Lingüística. Santiago, Chile.

^cUniversidad de Chile. Instituto de Asuntos Públicos. Santiago, Chile.

Abstract

This study describes experiences and perceptions on interculturality in Primary Health Care (PHC) from the perspective of health workers and Mapuche health users. For this purpose, a qualitative systematization of these experiences was carried out in a PHC Intercultural Health Program at an urban commune in Chile. Data were collected by means of individual and group interviews, respectively, with 19 users and 13 professionals. The semantic content analysis was performed. While service users perceive Mapuche health positively, assimilating it to the concept of interculturality, health workers reported that Mapuche health is respected but no integrated work is promoted. As barriers, participants cited administrative aspects, lack of integration, and scientific issues. In conclusion, recognition of indigenous health and greater occupational training on indigenous health and interculturality is necessary.

Keywords: Culturally Competent Care; Health of Indigenous Peoples; Mapuche Health; Ethnicity and Health; Cultural Diversity.

Correspondence

Mónica Manríquez Hizaut
Universidad de Chile. Avenida Independencia, 1027, Comuna Independencia, Santiago, Región Metropolitana, Chile.
Postal Code 8380453.

Resumen

Este estudio describe experiencias y percepciones sobre interculturalidad en Atención Primaria de Salud (APS) desde la perspectiva de trabajadores/as y usuarios/as de salud mapuche. Se realizó una sistematización cualitativa de experiencias de un Programa de Salud Intercultural en APS en una comuna urbana de Chile. Participaron 19 usuarios/as y 13 trabajadores/as en entrevistas individuales y tres entrevistas grupales, respectivamente. Se realizó un análisis de contenido semántico. Para los participantes, la salud mapuche es percibida positivamente, los/as usuarios/as la asimilan al concepto de interculturalidad, mientras que los/as trabajadores/as señalan que, si bien se respeta, no se promueve un trabajo integrado. Los/las participantes identifican como barreras aspectos administrativos, falta de integración y cuestionamientos científicos. Se requiere reconocimiento de la salud indígena y mayor formación de trabajadores/as sobre salud indígena e interculturalidad.

Palabras clave: Asistencia Sanitaria Culturalmente Competente; Salud de Poblaciones Indígenas; Salud mapuche; Origen Étnico y Salud; Diversidad Cultural.

Introduction

According to the last Population Census (INE, 2017), Chile is a multiethnic, multicultural and multilingual country; 12.8% of the population self-report to belong to some indigenous people, among whom 79.8% self-report to be Mapuche. Despite having a significant population representation, there is a cultural and political asymmetry that marks the relations between the national society and the indigenous world. For example, indigenous people have less access to health and poor results in critical health indicators (Heise et al., 2009; Oyarce et al., 2009; Moloney, 2010).

The Mapuche medicine perceives health from its cosmovision of life; as regards wellbeing, they consider both origins and spirituality, as well as the balance with nature. Therefore disease involves the rupture of this balance (Diaz et al., 2004). In response to the need for belonging in health care and improved access, intercultural health becomes relevant as a public health strategy to provide care to indigenous peoples.

In 1992, the Mapuche Population Health Program (*Programa de Salud con Población Mapuche*, PROMAP) was created, and in 1996, the National Health and Indigenous Peoples Program (*Programa Nacional de Salud y Pueblos Indígenas*) was implemented. Some authors consider that these intercultural health programs were oriented to solve health problems by integrating resources from different medicines. However, they received little recognition from an administrative point of view, weakening their implementation.

In 2008, the Special Health Program for Indigenous Peoples (*Programa Especial de Salud para Pueblos Indígenas*, PESPI) was created, aimed to consolidate an intercultural health system, which previous programs failed to install, accepting the existence and validity of other healing systems complementary to the existing health systems (Manríquez-Hizaut et al., 2018). This program aims to:

Contribute to the reduction of inequity gaps in the health status of indigenous peoples,

through the participatory construction of health plans that recognize cultural diversity, promote complementarity between medical systems, and provide adequate health services responsive to specific needs, rights and epidemiological profiles. (Minsal, 2013, free translation).

Three main axes are established for the PESPI execution: *Equity, Intercultural Approach to Health, and Indigenous Social Participation* (Minsal, 2013). These principles are consistent with the guidelines of the Primary Health Care (PHC) Model existing in Chile (Minsal, 2012).

It is worth mentioning that the Chilean Health System is made up by subsystems, a public system (which covers more than 70% of the population) that has a health insurance called FONASA, and several health care centers throughout the country that make up the Assistance Networks administration. The second subsystem is the private system, made up of the Social Security Health Institutions (*Instituciones de Salud Previsional*, ISAPRES), which manage private health insurance (covering more than 20% of the Chilean population), and also counts on health care centers. The FONASA population may receive care in private health care centers through the free choice modality, but both systems operate independently under the regulations of the Chilean Health Authority.

It is particularly striking that the Chilean intercultural health programs mentioned above have only been designed and developed in the Public Health System, not being mandated to be implemented in the private system, although the indigenous population could opt for private health institutions (both insurance and care centers).

Studies in the Chilean health system expose a criticism towards the normativization or bureaucratization of the Mapuche health under the institutional logics of the Chilean State (Alarcón et al., 2004; Anigstein; López, 2006; Boccara, 2007), and the professionalization of indigenous cultures' knowledge (Bolado, 2012) as a lack of recognition and assimilation of these to the practices and ideologies of the Western medicine. Other studies identify communication issues between health professionals and Mapuche health agents, lack

of referral mechanisms, and lack of training in the Mapuche cosmovision (Alarcón et al., 2004; Vásquez, 2009).

This study was conducted in the context of primary health care, in an urban commune of Santiago de Chile, together with the Mapuche community Kallfulikan that has been implementing the PESPI program for 20 years. The aim of this study is to describe the experiences and perceptions about interculturality in PHC, from the perspective of health workers and the Mapuche health care providers.

Method

A case study was conducted, systematizing the experience as a participatory research process carried out with the Mapuche community that leads the experience studied. This specific scientific communication considered the interviews of workers and users related to the Mapuche health, in the context of PHC.

Design

The systematization of experiences corresponds to a participatory research process. Through qualitative methodology, the experience of workers and users in relation to the Mapuche health, in the context of PHC carried out in “La Ruka” (traditional Mapuche house that serves as a place for the preparation of medicinal herbs) of the Mapuche community Kallfulikan, was surveyed. In order to describe the whole experience, quantitative and qualitative data were systematized to rescue 20 years of implementation of a Mapuche medicine program in the context of PHC. In that program, social actors think over and review the processes, recovering local knowledge through a critical understanding of the factors that made them possible (Jara, 1994). This methodology has been recommended for these purposes (Hasen, 2012).

Participants and context

This study on the implementation of a Mapuche health program in the PHC context was conducted in

an urban commune of Santiago, Chile. The fieldwork was developed from August to November 2017. Nineteen users participated in individual semi-structured interviews. For PHC workers, three group interviews were conducted, with a total participation of 13 people from different professions and roles, with non-medical professionals presenting a numerical prevalence (Table 1). The final number of interviews allowed saturating information to respond to the objective of this study.

Table 1 – Participants’ characterization

	Users	Professionals
Number of participants:	19	13
Women	15	10
Men	4	3
Age range (years)	39-84	23-55
Ties to Mapuche culture	6	1
Time of link to Mapuche medicine	1 month to 5 years	from 6 months to 10 years

Analysis

Interviews were transcribed and reviewed before the next data production journey, in order to investigate emerging areas of interest to the project.

A semantic content analysis was conducted on the experiences of PHC users and workers. The preliminary results of this study were analyzed with the Mapuche community in charge of the program, as part of the overall systematization process of the experience through a day of results presentation and discussion of the main findings. For this communication, this instance allowed validating the interpretations shown in results which, although not corresponding to their own stories as a community, seemed to be coherent in the global context of the experience. On the other hand, these results contributed to an internal analysis by the community, which is not part of this communication.

Ethical considerations

This study sought to know the experience of people linked to Mapuche medicine in PHC valuing and respecting their opinion. The research process was carried out jointly with the Mapuche community in charge of the program. All participants were volunteers, and a process of informed consent was carried out with each of them. Participants were identified with their age or profession and gender, respecting their anonymity. The results of this communication were discussed with the Mapuche community in charge of the program that authorized its publication, respecting their autonomy and following the agreements reached during dialogues between the community and the facilitating team. It should be noted that this study contributed with information for the internal analysis by the Community in charge of the program, pursuing greater engagement with the western health.

Results

Of the total number of participating users, 6 self-reported to be Mapuche and, of the workers, only one person identifies their Mapuche origin, but indicates to not keep any cultural practice (Table 1). Both groups present a positive vision of the Mapuche health and different opinions regarding interculturality and its application in PHC. They highlight the positive aspects of working with a Mapuche health team, identifying barriers to the recognition and valuation of Mapuche health in coexistence with biomedical practices. Following a description of Mapuche health experiences and intercultural health practices is disclosed, highlighting their characteristics, barriers and facilitators.

Mapuche health linkage experiences

Users access the Mapuche care optimistic about its effectiveness. Most have received recommendations from acquaintances and relatives, so they present high expectations, as reflected

in the following statement: *“I don’t mind waiting all afternoon, because it will work”* (man, 60 years old).

Those who have been receiving care for longer (6 months to 5 years) positively evaluate the care provided by the Machi (spiritual authority for the Mapuche people’s culture) because they recognize improvements in their lives, such as a decrease in pain, and better state of mind. A woman (60 years old), with emotion in her eyes and voice, relates her first care process; *“he (machi) sees your life”*. For her, the care with the machi was revealing. He discovered and inquired about aspects of her life that she thought were irrelevant to her current health situation. She was surprised that the machi *“sees the urine and knows so many things”*.

For users, the Mapuche health is understood as natural medicine. They value its accessibility, since it is easy to book a visit and there are no age or residence requirements. There is no costs for them, they do not ask for exams or purchase of medicines. So, there is no associated out-of-pocket expense, as it happens in the Chilean health system. In addition, they value “natural medicine” agreeing that the use of herbs is a non-industrialized therapy and, therefore, is better than the use of drugs. This is expressed in this statement *“water is water”* (woman, 70 years old).

There is a belief that herbs, being natural, are healthier because they do not harm the stomach and have no side effects; *“pills are good for one thing and bad for others”* (woman, 67 years old). They also add they do not have to take herbs for every illness. Herbal water, in its diverse and secret preparations, acts on different ailments.

A woman (39 years old) reports that since the first week she felt changes in her organism, for her *“coming to the Ruka is relaxing”*. The respondents reported to believe in the Mapuche medicine, trusting that it will heal them of all their ailments because of its natural character. They also have general knowledge about the Mapuche cosmovision related to the holistic understanding of health, the use of herbs as natural medicine and its effects on the body. However, none of them participated in other Mapuche traditions, more due to lack of time than for lack of interest.

Regarding the PHC workers, most of them are linked to Mapuche health because of their current work activity; when they arrived to work at the PHC center, the Ruka already existed. Some of them were introduced to this program, and others report to have participated in trainings on Mapuche cosmovision, although this is not an experience shared by all of them.

“[...] I spent about two months not knowing that the Ruka existed, and they talked to me about a Ruka and I said, where is it? Where is it? I’m going to go for a walk (laughs) and I went for a little walk and there I found it, but I didn’t have the experience of talking to the Machi” (Woman, Administrative position)

Some workers have had a Mapuche health care experience, either their own or of family members, which allowed them to learn about their worldview and their way of providing healthcare.

“[...] I have a lot of knowledge because I have accompanied my relatives’ treatment, so I know how they use the protocol, how they provide care” (Woman, Social Worker)

In general, they positively value the existence of the Ruka. They point out that its presence and recognition have given fame to the PHC center among the people who are attended at the Ruka and those who know about this experience;

“Person 2: [...] I think we hang on their fame (laughs).” (E3, P2: Nurse)

“Person 1: Yes because in reality patients come here from all sectors [...] patients get engaged and (they) want to change to this Center, because there is the Ruka” (E3, P1: Administrative)

Intercultural health in PHC

For one user, intercultural health is the encounter of cultures, with the recognition of ethnic culture

and its valuation in dialogue between health systems. Based on this belief the user identifies the lack of interculturality in the Chilean health system and in the country in general, as reflected in her statement:

“is that there is no intercultural health, there is a lack of merging both, they have to work together and for that there is a lack of more dissemination and for people to stop seeing Mapuche medicine as something esoteric, schools should teach Mapudungun (Mapuche language) so that since childhood children grow up with that” (woman, 38 years old).

For the other users, intercultural health is synonymous with Mapuche health, it is materialized in the Ruka, *“this is intercultural health”* (woman, 39 years old), as an alternative system, with different means and ends;

“The Mapuche do not have the same technology as public health, they can do complex procedures, each

one does their own thing and each health system fulfills different purposes” (Male, 87 years old)

Healthcare practices recognized by users do not account for interculturality as a dialogue between different cultural understandings of health. For example, there is no clear referral from the PHC center, nor do they receive information about this medicine, not even those who self-report to be a Mapuche. Although in the Ruka people are instructed to continue with medical treatment, some of them point out that they should stop the pharmacological treatment because they prefer herbs, but they do not report it in their medical check-ups at the PHC.

Regarding workers, most of them recognize intercultural health as the encounter of different cultures in dialogue, respect and complementarity. They identify positive experiences of linkage in the context of health promotion and prevention, and in family and/or individual referral, as well as recognize barriers for a better implementation of interculturality in the PHC (Table 2).

Table 2 – Characteristics of Intercultural Health in Primary Health Care

Categories	Main results	PHC workers' experiences and perceptions
Intercultural health conception	A dialogue between cultures is recognized, identifying the need to learn about other cultures, in health care practices, horizontality and complementarity with Mapuche medicine is emphasized.	<p><i>“interculturality is the relation between cultures that have a common work”</i> (Man, Psychologist)</p> <p><i>“I believe that interculturality has to do with the practical, focused on health care, (...) that deep down may we be tolerant and respectful towards all the arriving ethnicities and cultures (...) a framework of respect, tolerance, and finally not only of competence but complementation, that finally a hypertensive patient, for example, does not stop taking enalapril for meeting with the Machi or a Brazilian witch doctor, what do I know”</i> (Woman, Matron)</p> <p><i>“what I understand by intercultural health care is that it has to do a little with this field... it is more natural than Mapuche medicine and all, but also... in the way we are as actors and how we not only work with indigenous people, but also foreigners”</i> (Woman, Social Worker)</p>

continue...

Table 2 – Continuation

Categories	Main results	PHC workers' experiences and perceptions
Bonding experiences in promotion and prevention activities	Productive work experiences are found, which allow to understand the Mapuche world view and improve practices in health prevention activities.	<i>"(...) we organized the vaccination campaign... we had the opportunity to get together and obviously talk about the theme (...) on that moment they explained to us what their vision was and it obviously had many of the typically known myths; that is a business, what do I know, but they also gave us some tips to encompass that population, and one of the things they commented is that they cared a lot about who got vaccinated, (...), to them, those who got vaccinated were really important because there is an energy subject attached to it, so... it was suggested that we show them the different vaccinated people so that they would finally see that subject and open us the doors (...)" (Woman, Nurse)</i>
Bonding experiences in referral	As referral to Mapuche medicine, some professionals refer to users who consider complex cases or did not respond to biomedicine.	<i>"(...) when we do family work and the family has a Mapuche surname and there is a situation because they do not want to come or have a reason behind and the family cannot articulate, we refer them, to matters more related to bonding, if working there is possible (in La Ruka) beyond that, and it works sometimes" (Woman, Social Worker)</i> <i>"As a psychologist, I accompanied many patients when registering or making an appointment, but at the same time were referred with mental health doctors and according to the patient if they wanted to go or not, as it eventually happened" (Man, Psychologist)</i>
Bonding barriers	Lack of integration of the Mapuche healthcare workers as part of the PHC health team. To some, the professionals are not welcoming to other, the traditional Mapuche health workers are not available for integration.	<i>"they feel discriminated, so much so that they do not greet them, (...) they are shyer (...) and do not facilitate for them, and listen! but they are coworkers, and you facilitate things for your coworker (...) Therefore, not everyone feels that they belong [to the health team] and appreciates them, I believe there is a general respect for Mapuche culture but not any... appreciation" (Woman, Social Worker)</i> <i>"(...) they do not integrate much, as an example of when it happened, when we did the pie de cueca on September 18, they gave us sopaipillas and came as the Kallfulikan community to present themselves on a stand (...) they have been opening up (...) due to the circumstances, but they are closed off" (Woman, Social Worker)</i>
	Controversy about the scientific validity of Mapuche medicine and lack of a regulatory framework to protect intercultural practice.	<i>"We are measured by the accreditation of health centers, and we all work to accredit clinics, but this is non-existent on a regulatory or legal level for health... supplementary medicine, so you can find many shysters in this field" (Woman, Matron)</i> <i>"there is a weakness (...) that has to do with the legal framework, for example you, as a doctor, when referring to the Machi, who supports you legally? (...) the patient decompensated, it ended badly for them, if auditing or summarizing [make a summary or investigation] who referred them to the Machi, and why the Machi and not a cardiologist?" (Woman, Matron)</i> <i>"But this is inviting them to be Westerners (...) meaning we interfere by our means, where is the dialogue in that? "please dress like doctors, put on a white suit, and work on an office with no smoke" then it is not Mapuche medicine" (Man, Psychologist)</i>

continue...

Table 2 – Continuation

Categories	Main results	PHC workers' experiences and perceptions
Bonding barriers	The Chilean healthcare system has inflexible guidelines or protocols of health that would limit incorporating intercultural practices daily.	<p><i>"(...) it has to with listening, taking your time with someone and... things we cannot do, because there can be employees or even patients knocking on your door if you are over your 15 minutes (...), they (Mapuche health) take their time and people know it and respect it, we also have our own time, with the minutes being counted"</i> (Woman, Nurse)</p> <p><i>"... if it is a low-risk diabetic they will go once to the doctor and then to a nurse or nutritionist, (...) however in La Ruka I believe you have the option to go talk, sit down and talk to everyone, maybe not because you have the Machi's attention but they are a community, and I think that helps the patients a lot"</i> (Woman, Preschool Teacher)</p>

Source: Own elaboration based on the conducted interviews

Health professionals recognize that they do not perform anamnesis or provide differential care for people belonging to Mapuche communities. They even consider that it is not necessary since from their perception the Mapuche population does not request it, and they are adapted to the practices of the western system. On the other hand, they consider that interculturality takes greater importance to address the care of foreign population;

"[...] here we have perceived with our foreign users, Haitians; they do not perceive health as self-care, they perceive it differently [...] so perhaps knowing not only our ancestral cultures but also knowing these new brothers who are arriving, also allows us to know how to approach this person from the point of view of health" (Woman, midwife)

They recognize "cultural clashes" with migrant population, especially with the Haitian population, both due to language barriers and lack of knowledge of the health practices and beliefs of this population, which hinders the encounter with PHC activities in Chile;

"[...] in fact, the Haitian pregnant women are checked late because they are not used to having a preventive birth control" (Woman, midwife)

When professionals consider the possibility of incorporating changes in health care practices,

they identify that the existing barriers would not allow local changes without changes in the national PHC guidelines and policies. Even when these policies indicate that approaches such as integrality and interculturality should be incorporated, for professionals the care at the Ruka is more comprehensive and generates stronger link with users, in comparison with what is done at the PHC center. This is associated to the management based on health goals that do not incorporate interculturality and, in addition, to the inflexible timetable definition that hinders community work or coordination with the Mapuche health agents. Another aspect that hinders joint action is the unsuccessful instances of health workers training, whose experiences have not been continuous or universal and some of them have had problems with certification. This meant they were not recognized and therefore participation was discouraged.

On the other hand, in order to formalize a joint work some workers propose that the "Ruka services", such as the Machi's care and the delivery of medicinal herbs, should be incorporated to the PHC services basket and thus institutionalize the practices as a form of recognition. On the other hand, the Mapuche health agents should participate in team meetings held to coordinate management or address complex cases, thus contributing with their vision and being considered as a single team.

Discussion

The Mapuche health experience in an urban commune is positively valued by users and by primary health care workers who are bound to it. These experiences, however, reflect a gap in the incorporation of interculturality in PHC, since users do not recognize dialogue between cultures or health knowledge. Workers identify a lack of recognition and joint work attributable, on the one hand, to administrative aspects of the Chilean health model that do not allow for flexibility in their practices and adaptation to a different health worldview. On the other hand, it is attributable to the will and attitudes of some professionals regarding the lack of scientific validity of the Mapuche medicine, and the risks that this would imply for the population's health. Similar results are reported in contexts of maternal and child health in Colombia, where health professionals consider that indigenous women are not aware of the health risk involved in pregnancy and particularly childbirth (Castillo-Santana et al., 2017). It clearly evidences a hegemony of biomedical health as a standard of quality in health, based on its scientific effectiveness, and a difference in the understanding of physiological processes that in the indigenous worldview may be considered part of the life cycle of women (Castillo-Santana et al., 2017).

This study shows a parallel coexistence of two health systems, which enable access to Mapuche health in the city, both for the Mapuche and non-Mapuche population. As another study points out, the experience of urban context allows the maintenance of cultural projects strategically aligned with the guidelines of the Chilean system for access to resources. This, however, implies greater control, subordination and standardization of the Mapuche health system (Anigstein; López, 2006). Other studies have identified the asymmetry of the Chilean biomedical system with the Mapuche health system, and the lack of theoretical and practical clarity about the concept of intercultural health as main barriers

for the implementation of interculturality (Pérez; Nazar; Cove, 2016). Asymmetry is common in other contexts, and demonstrates the unwillingness of health personnel to make room for indigenous health, relying on structural and ideological biomedical hegemony (Castillo-Santana, 2017; Mendes et al., 2018).

In the Latin American experience, an analysis of planning for equity in health points out that, although the countries consider the “marginalized” population, less than half address indigenous peoples and only in four cases the attention to migrant population is explicit (Kavanagh et al., 2021). On the other hand, comparative case studies in the region (Mignone et al., 2017) point out that, despite the attempts to articulate cultural approaches within the broader health system, it is not as effective, evidencing institutionalized racism in hospitals and other sectors of the health care system.

In general, interculturality policies in health has been considered of low impact, either due to weak social participation, lack of continuity and satisfaction with care and the need for intercultural dialogues for the articulation of knowledge, as reported in the case of Brazil (Pedrana et al., 2018; Mendes et al., 2018), or due to lack of resources and the sequence of arbitrary and exclusionary policies, as found by a study in Mexico (Campos; Peña; Maya, 2017). In particular, as in our study, the lack of trust between traditional health agents and Western health professionals is identified as an obstacle to intercultural work, pointing out in some cases not only a resistance from medical systems, but also religious ones, even if they seemed to be not so influential (Mignone et al., 2017).

The challenges for primary care in Chile to effectively incorporate interculturality are: first, to allow spaces for integration in which indigenous health agents participate in the health team on equal terms and without the need to adjust or validate their practices; second, to strengthen the initial and continued training of health professionals and workers on interculturality and Mapuche or indigenous health in general;

and, third, to know the cultures present in their territories, especially, due to the coexistence with other cultures due to migration. Workers participating in this study recognize this last, which has been the subject of interventions that include cultural competencies to perform the health anamnesis (Chepo; Astorga-Pinto; Cabieses, 2019). Fortunately, new doctors in Chile show interest in practicing in indigenous settings precisely because of the interculturality experience (Mignone et al., 2017).

This study corresponds to a particular experience; therefore, its results are not transferable to the national reality of implementation of the indigenous health program in Chile. Other studies have clearly stated the need to increase research in indigenous population, pursuing a reversal in inequalities of access, and resolving inequities in indigenous morbidity and mortality indexes (Kolahdooz et al., 2015; Cortés-García, 2020). In Chile, new studies should investigate experiences of intercultural health implementation in rural areas and other regions of the national territory.

Finally, we should consider that neoliberal policies, deepened after the dictatorship, fostered the bureaucratization of indigenous health practices (Bolado, 2012), and reflect the barriers imposed by the Chilean State on the implementation of programs that seek to recognize and maintain the coexistence of indigenous health. Therefore, even if progress is made in intercultural health policies, without a comprehensive and structural response that overcomes fragmented policies on indigenous rights, which attempt to separate environmental issues and territorial claims from health issues, a situation common to all of Latin America (Martínez, 2015), it will be impossible to comply with international treaties that protect and recognize the rights of indigenous peoples, signed by Chile.

References

ALARCÓN, A. et al. Política de salud intercultural: perspectiva de usuarios mapuches y equipos de salud en la IX región, Chile. *Revista Médica de*

Chile, Santiago, v. 32, n. 9, p. 1109-1114, 2004. DOI: 10.4067/S0034-98872004000900013

ANIGSTEIN, M.; LÓPEZ, V. Medicina mapuche en la ciudad. Resignificaciones de la práctica médica mapuche en el siglo XXI. *Gazeta de Antropología*, Granada, n. 22, p. 1-9, 2006. DOI: 10.30827/Digibug.7106

BOCCARA, G. Etnogubernamentalidad. La formación del campo de la salud intercultural en Chile. *Chungará*, Arica, v. 39, n. 2, p. 185-207, 2007. Disponível em: <<https://scielo.conicyt.cl/pdf/chungara/v39n2/arto3.pdf>>. Acesso em: 27 maio 2022.

BOLADO, P. Neoliberalismo multicultural en el Chile postdictadura: la política indígena en salud y sus efectos en comunidades mapuches y atacameñas. *Chungará*, Arica, v. 44, n. 1, p. 135-144, 2012. DOI: 10.4067/s0717-73562012000100010

CAMPOS, R., PEÑA E., MAYA, A. Aproximación crítica a las políticas públicas en salud indígena, medicina tradicional e interculturalidad en México (1990-2016). *Salud Colectiva*, Lanús, v. 13, n. 3, p. 443-455, 2017. DOI: 10.18294/sc.2017.1115

CASTILLO-SANTANA, P. et al., Salud materna indígena en mujeres Nasa y Misak del Cauca, Colombia: tensiones, subordinación y diálogo intercultural entre dos sistemas médicos. *Saúde e Sociedade*, v. 26, n. 1, p. 61-74, 2017. DOI: 10.1590/S0104-12902017168743

CHEPO, M.; ASTORGA-PINTO, S.; CABIESES, B. Atención inicial de migrantes en Chile: iniciativa en atención primaria de salud a un año de su implementación. *Pan American Journal of Public Health*, Brasília, v. 43, e71, 2019. DOI: 10.26633/RPSP.2019.71

CORTÉS-GARCÍA, M. Etnicidad y salud. Una reconceptualización necesaria. *Revista Ciencias de la Salud*, Bogotá, v. 18, n. 1, p. 6-9, 2020. Disponível em: <<https://revistas.urosario.edu.co/revistas/revista-ciencias-de-la-salud>>

edu.co/xml/562/56262799001/index.html>.
Acesso em: 27 maio de 2022.

DÍAZ, A. et al., Conceptos de enfermedad y sanación en la cosmovisión mapuche e impacto de la cultura occidental. *Ciencia y enfermería*, Concepción, v. 10, n. 1, p. 9-16, 2004.

DOI: 10.4067/s0717-95532004000100002

HASEN, F. Interculturalidad en salud: competencias en prácticas de salud con población indígena. *Ciencia y enfermería*, Concepción, v. 18, n. 3, p. 17-24, 2012.

DOI: 10.4067/s0717-95532012000300003

HEISE, K. et al., Incidence and survival of stomach cancer in a high-risk population of Chile. *World Journal of Gastroenterology*, Pleasanton, v. 15, n. 15, p. 1854-1862, 2009. DOI: 10.3748/wjg.15.1854

INE - INSTITUTO NACIONAL DE ESTADÍSTICAS. (Chile). *Censo de Población 2017*. Santiago: INE, 2017.

JARA, O. *Para Sistematizar Experiencias*. San José de Costa Rica: Centro de Estudios Publicaciones Alforja, 1994.

KAVANAGH, M. et al. Planificación para la equidad en la salud en la Región de las Américas: Análisis de los planes nacionales de salud. *Pan American Journal of Public Health*, Washington, DC, v. 45, e106.2021. DOI:10.26633/RPSP.2021.106

KOLAHDOOZ, F. et al., Understanding the social determinants of health among Indigenous Canadians: priorities for health promotion policies and actions. *Global Health Action*, Londres, v. 8, n. 1, 27968, 2015. DOI: 10.3402/gha.v8.27968

MANRÍQUEZ-HIZAUT, M., LAGOS-FERNÁNDEZ, C., REBOLLEDO, J., FIGUEROA-HUENCHO, V. Salud Intercultural en Chile: Desarrollo histórico y desafíos actuales. *Revista de Salud Pública*, Bogotá, v. 20, n. 6, p. 759-763, 2018. DOI: 10.15446/rsap.v20n6.65625

MARTÍNEZ, M. Reconocimiento sin implementación: Un balance sobre los derechos de los pueblos indígenas en América Latina. *Revista Mexicana de Ciencias Políticas y Sociales*, v. 60, n. 224, p. 251-278, 2015. DOI: 10.1016/s0185-1918(15)30010-6

MENDES, A. et al. O desafio da atenção primária na saúde indígena no Brasil. *Pan American Journal of Public Health*, Brasília v. 42, e184, 2018. DOI: 10.26633/RPSP.2018.184

MIGNONE, J. et al. Best practices in intercultural health: five case studies in Latin America. *Journal of Ethnobiology and Ethnomedicine*. *Springer Science and Business Media*, Nova York, v. 3, n. 31, 2007. DOI: 10.1186/1746-4269-3-31

MINSAL - MINISTERIO DE SALUD. (Chile). *Orientaciones para la implementación del Modelo de Atención Integral de Salud Familiar y Comunitaria*. Dirigido a equipos de salud. Santiago: MINSAL-OPS, 2012. Disponible em: <<https://www.minsal.cl/portal/url/item/e7b24eef3e5cb5d1e0400101650128e9.pdf>>. Acesso em: 27 maio 2022.

MINSAL - MINISTERIO DE SALUD. (Chile). *Orientaciones Técnicas Programa Especial de Salud Indígena (PESPI)*. Santiago: MINSAL, 2013. Disponible em: <http://www.bibliotecaminsal.cl/wp/wp-content/uploads/2018/01/030_OT-y-Guia-Pueblos-indigenas.pdf>. Acesso em: 27 maio de 2022.

MOLONEY, A. Protests Highlight Plight of Chile's Mapuche. *The Lancet*, Amsterdã, v. 375, n. 9713, p. 449-450, 2010. DOI: 10.1016/s0140-6736(10)60181-x

OYARCE, A.; PEDRERO, M. Una metodología innovadora para la caracterización de la situación de salud de las poblaciones indígenas de Chile: limitaciones y potencialidades. *Notas de población*, Vitacura, n. 89, p. 119-148, 2009.

PEDRANA, L. et al. Análise crítica da interculturalidade na Política Nacional de Atenção às Populações Indígenas no Brasil. *Pan American Journal of Public Health*, Brasília, v. 42, e178, 2018. DOI: 10.26633/RPSP.2018.178

PÉREZ, C., NAZAR, G., y COVE, F. Facilitadores y obstaculizadores de la implementación de la política de salud intercultural en Chile. *Pan American Journal*

of Public Health, Brasília, v. 39, n. 2, p. 122-127, 2016. Disponível em: <<https://www.scielosp.org/article/rpssp/2016.v39n2/122-127/>>. Acesso em: 27 maio 2022.

VÁSQUEZ, M. *Salud Intercultural y políticas públicas: La experiencia de la organización Taiñ Adkimmn en la comuna de la Pintana*. 2009. 133 f. Tesis (Magíster en Antropología y Desarrollo) - Universidad de Chile, Santiago, 2009.

Authors' Contribution

Manríquez-Hizaut, Rebolledo Sanhueza, Klett-Fuentes, Inglés-Yañez, Lagos-Fernández and Figueroa-Huencho contributed to the design, data production, data interpretation and analysis, writing of the first draft of this manuscript and further versions.

Acknowledgements

To the Mapuche community Kallfulikan, and to the participants of this study for supporting us in the challenge of moving toward cultural relevance in health. And to the Ministry of Social Development of Chile that contributed by Funding the project of Systematization of Experiences "Exploración de la percepción de usuarios, agentes tradicionales de salud y equipo de salud acerca del acceso, atención intercultural y participación de población indígena en el Centro de salud mapuche Kallfulikan, Ruka Cesfam Los Castaños, La Florida" through the Fondo Chile de Todas y Todos 2016.

Received: 04/01/2022

Resubmitted: 03/20/2022; 04/01/2022

Approved: 04/05/2022