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The Promotion Of Health Communication Through The Inclusion Of The Kichwa Language At The San Juan De Llullundongo Health Center (2023-2024)

Promoción De La Comunicación En Salud Mediante La Inclusión Del Idioma Kichwa En El Centro San Juan De Llullundongo (2023-2024)

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Summary

In rural and intercultural contexts in Ecuador, communication between health professionals and indigenous patients is hampered by language barriers, which compromises the equity and quality of care.

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This study aims to establish the relationship between effective health communication and the use of the Kichwa language at the San Juan de Llullundongo Health Center.

A quantitative, descriptive and correlational approach was applied, with a cross-sectional design. The sample is a census sample and includes 16 health professionals. A structured survey was used, validated by experts and analyzed using SPSS software.

The results show that 93.75 % of the personnel have no or little knowledge of Kichwa, and most of them are unable to provide medical information in that language. The 87.5% consider it useful to incorporate bilingual materials. The research concludes that the lack of linguistic competence limits the quality of care and violates the patient's right to understand their health process.

It is suggested that incorporating Kichwa is a communicative strategy and an act of cultural justice. It is recommended to strengthen intercultural training and implement public policies that guarantee linguistically relevant attention.

Keywords: Communication, Interculturality, Language, Language Barrier, Health.

Resumen

En contextos rurales e interculturales del Ecuador, la comunicación entre profesionales de salud y pacientes indígenas se ve obstaculizada por barreras idiomáticas, lo que compromete la equidad y calidad de la atención.

Este estudio tiene como objetivo establecer la relación entre la comunicación efectiva en salud y el uso del idioma kichwa en el Centro de Salud San Juan de Llullundongo.

Se aplica un enfoque cuantitativo, de tipo descriptivo y correlacional, con diseño transversal. La muestra es censal e incluye a 16

profesionales de salud. Se utiliza una encuesta estructurada, validada por expertos y analizada mediante el software SPSS.
Los resultados muestran que el 93,75 % del personal tiene un conocimiento nulo o bajo del kichwa, y la mayoría no logra brindar información médica en dicho idioma. El 87,5 % considera útil incorporar materiales bilingües. La investigación concluye que la falta de competencia lingüística limita la calidad de la atención y vulnera el derecho del paciente a comprender su proceso de salud.
Se plantea que incorporar el kichwa es una estrategia comunicativa y un acto de justicia cultural. Se recomienda fortalecer la formación intercultural y aplicar políticas públicas que garanticen una atención lingüísticamente pertinente.
Palabras clave: Comunicación, Interculturalidad, Idioma, Barrera Lingüística, Salud.

Introduction

In the context of primary health care, effective communication between health professionals and patients is an essential component to ensure the quality, safety and equity of services. However, in culturally and linguistically diverse contexts such as Ecuador, such communication is hampered by language barriers that limit mutual understanding, increase clinical risks and deepen inequalities in access to care (Estévez & Estévez, 2021; Maza, Motta & Motta, 2023). These barriers are particularly critical in indigenous communities such as San Juan de Llullundongo, where the majority of patients are Kichwa speakers, while health personnel communicate exclusively in Spanish.

Given this problem, the study entitled "Effective communication in health, associated with the incorporation of the Kichwa language in the San Juan de Llullundongo Health Center" was developed with

the objective of determining the association between effective communication in health and the use of the Kichwa language in this facility, during the period October 2023 to February 2024. To this end, three specific objectives were established: to diagnose the current situation of communication between health personnel and Kichwa-speaking patients; to identify the level of knowledge of the Kichwa language by the personnel; and to develop basic Kichwa-Spanish educational material to facilitate communicative interaction in the clinical context.

The need for this research is based on previous studies that have shown that language barriers generate negative consequences such as inadequate diagnoses, difficulties in understanding medical indications, low adherence to treatments and high patient dissatisfaction (Lazcano et al., 2020; De la Torre, 2022). In the specific case of the San Juan de Llullundongo Health Center, 93.75% of the personnel surveyed had no or low knowledge of the Kichwa language and more than 56% considered the implementation of support resources in that language to be very necessary (Toalombo & Chariguamán, 2024).

This research is justified by the need to make visible and address the structural inequities faced by indigenous populations in health services. It also aims to contribute to the construction of more inclusive intercultural care by incorporating tools that recognize and respect linguistic diversity. As Petrone (2021) and Arrieta and Guzmán (2021) point out, effective communication in health cannot be limited to the transmission of information, but must consider the patient's cultural context and facilitate a comprehensive dialogue that promotes shared decisions. From this perspective, the incorporation of the Kichwa language is recognized not only as a technical measure, but as an act of communicative and cultural justice, consistent with the constitutional principles of the Ecuadorian State and with the linguistic rights recognized in national normative

instruments (National Assembly of Ecuador, 2021; Ministry of Public Health, 2017).

Effective communication in the field of health

Effective communication in healthcare is a fundamental component in achieving patient-centered care, which considers not only the clinical aspects, but also the social, cultural and emotional aspects that surround the experience of the disease process. This form of communication is conceived as a dynamic, intentional and bidirectional process, through which clear, precise, understandable and adapted to the patient's context information is transmitted, facilitating the understanding of diagnoses, procedures, treatments and subsequent care (Bravo, Jurado & Tejera, 2019). In contemporary health systems, communication has ceased to be a secondary competence to become a structuring axis of quality and safety of care.

According to Estévez and Estévez (2021), effective communication is not limited to the transfer of medical data, but involves the creation of a bond based on empathy, mutual respect and trust. This bond allows the patient to express his or her doubts, fears and expectations, as well as to actively participate in making decisions about his or her treatment. In turn, the healthcare professional can adapt his or her language, tone and communicative style according to the patient's individual characteristics, thus improving therapeutic adherence and satisfaction with the service received.

The communicative process involves several elements: the sender, the receiver, the channel, the code, the message and the feedback. Each of them must work in harmony to avoid distortions, ambiguities or silences that may affect understanding (Fernández, 2022). Added to this set are the nonverbal aspects of communication, such as body language, posture, eye contact, facial expressions and tone of voice, which are especially relevant when there are language differences or cultural barriers. In fact, several studies have shown that adequate

nonverbal communication can partially compensate for the patient's lack of language proficiency, generating feelings of security and respect (Zambrano et al., 2020; Sharkiya, 2023).

The scientific literature has highlighted that good communication is directly related to the prevention of medical errors, the reduction of complaints and litigation, and the improvement of clinical outcomes (Petrone, 2021). For example, the World Health Organization (WHO, 2022) has pointed out that more than 60% of adverse events in hospital services have their origin in communication failures. This reality acquires greater weight in scenarios of cultural and linguistic diversity, where effective communication must respond to multiple dimensions of the subject, including their worldview, values and their own ways of understanding health and disease.

In the intercultural context, communication not only has an instrumental but also a symbolic value. The use of one's own language, recognition of traditional practices and respect for the patient's cultural identity are elements that strengthen the therapeutic relationship and reduce the feeling of discrimination or exclusion. As Arrieta and Guzmán (2021) point out, effective communication in health should be conceived as an inclusive practice that allows the patient to feel heard, understood and respected, especially when he or she belongs to indigenous peoples or historically marginalized communities.

Finally, effective communication is a key tool for improving the quality of care, reducing inequities and promoting truly people-centered health. Its strengthening requires not only technical skills, but also cultural sensitivity, mastery of diverse linguistic codes and an ethical disposition to establish a horizontal dialogue with each patient.

Language barriers in intercultural contexts

In culturally and linguistically diverse settings, such as many rural and indigenous communities in Ecuador, language barriers constitute a structural limitation that directly affects quality and equity in access to health services. These barriers occur when health personnel do not understand and cannot express themselves in the patient's native language, which prevents fluid, clear and bidirectional communication. The immediate consequence is a decrease in the understanding of the diagnosis, adherence to treatment, and user confidence in the health system (Lazcano et al., 2020).

In primary care services, where interaction with the community is constant and profound, the absence of a shared language between health personnel and users generates a fragmentation of the therapeutic link. Cases have been documented in which the patient must resort to a family member as interpreter or limit himself to basic gestures and expressions, a situation that violates his right to receive dignified, understandable and culturally relevant care (De la Torre, 2022).

According to Cacace and Giménez (2022), language barriers constitute not only a communication problem, but also a form of structural discrimination. On many occasions, the lack of knowledge of the native language on the part of health personnel is accompanied by contemptuous attitudes or disinterest towards indigenous cultural practices. This generates in patients feelings of inferiority, shame and, in many cases, rejection of institutional health services.

Studies conducted in indigenous communities in the Ecuadorian Sierra and Amazon have identified that Kichwa-speaking users face a triple barrier: linguistic, cultural and geographic. The lack of professionals who speak their mother tongue, the limited availability of informative materials in their language and the distance from health care centers create a scenario of exclusion that affects these

populations in a differentiated manner (Jiménez & Loor, 2022; Falcón, 2021).

Likewise, the absence of intercultural training in health professional training programs reinforces these barriers. In many cases, personnel have not received specific training to work in bilingual or multicultural contexts, nor do they have strategies to overcome communication difficulties with people who speak Kichwa or other ancestral languages (Petrone, 2021). As a result, the interaction between the patient and the professional is reduced to minimal and mechanical exchanges, which prevents a deep understanding of the symptoms, the perceived causes of the disease and the user's expectations about his or her recovery.

The persistence of these barriers has direct implications on health indicators. It has been shown that communities with a greater indigenous presence have higher rates of maternal mortality, chronic child malnutrition and communicable diseases, compared to urban mestizo populations (PAHO, 2020). Although these gaps have multiple causes, limited communication between health personnel and indigenous patients is a determining factor.

In this context, overcoming language barriers is not only a technical issue, but also an ethical, political and social challenge. It implies recognizing the language of the other as valid, necessary and enriching for the care process. Therefore, it is essential to advance towards the training of bilingual health personnel, the incorporation of community interpreters and the development of teaching materials in native languages, as part of a broader intercultural health strategy.

Intercultural approach and native language rights

The intercultural approach to health is based on the recognition of the cultural, linguistic and spiritual diversity of the peoples and nationalities that coexist within the same health system. This

approach is not limited to tolerance or inclusion of differences, but seeks to establish horizontal, respectful and symmetrical relations between different medical knowledge, such as biomedical and ancestral knowledge, as well as between languages and modes of communication (Cando & Quilligana, 2022).

In Ecuador, the regulatory framework supports this approach. The Constitution of the Republic recognizes Kichwa and Shuar as official languages of intercultural relations, along with Spanish (National Assembly of Ecuador, 2021). This provision implies that public institutions, including health institutions, must promote the use of ancestral languages in their services, guaranteeing the right of indigenous peoples to be attended in their mother tongue. This norm is complemented by the Regulation for the Application of the Intercultural Approach in Health Facilities, which establishes that every health center must have tools that facilitate attention to users in their native language, and that health personnel must receive intercultural and basic linguistic training (Ministry of Public Health, 2017).

From a human rights perspective, care in the mother tongue is related to the principle of non-discrimination and the right to cultural identity. The United Nations (UN, 2019) has pointed out that indigenous peoples have the right to culturally appropriate health systems that recognize their languages, customs and traditional ways of healing. This principle is essential to build trust between the user and the health system, and to prevent practices of exclusion or mistreatment by staff.

Care in the native language has positive effects both clinically and psychologically. On the one hand, it allows the patient to better understand his or her diagnosis, the medical indications and the possible risks of treatment. On the other hand, it promotes a greater emotional connection with the health professional, which helps to reduce the anxiety and stress generated by the disease (Sharkiya,

2023). In addition, the use of one's own language in institutional contexts revitalizes its social value, strengthens collective self-esteem and fosters pride in identity.

However, despite the current regulatory framework, the practical implementation of the intercultural approach has been limited. Many health units lack bilingual personnel, educational materials in Kichwa or institutional strategies to ensure respectful attention to the language and culture of their users (Falcón, 2021; Guapisaca, 2022). This demonstrates the urgent need to move from normative discourse to concrete operational policies, with an allocated budget, monitoring mechanisms and participatory evaluation by the communities.

In short, the intercultural approach to health requires not only changes in the curricular content of professional training, but also profound institutional transformations. It requires recognizing the native language not as a barrier, but as a key tool for equity, inclusion and quality of care. The incorporation of Kichwa into health services should be understood as a collective right, an act of linguistic justice and an indispensable component of a culturally relevant public health policy.

Contributions of previous studies on intercultural health communication.

Empirical research on intercultural health communication in indigenous contexts has gained relevance in recent years, in response to the persistence of structural inequalities in the access, quality and acceptability of health services ( ). Several studies in Latin America have shown that the use of the native language in health care contributes significantly to improving the patient experience, strengthening trust in the health system and promoting more positive clinical outcomes (Cuaila, 2022; Arrieta & Guzmán, 2021).

In the case of Peru, Cuaila (2022) conducted a quantitative study in health centers in the district of Huaylas, where it was found that patients attended by personnel with medium or high knowledge of Quechua reported greater satisfaction with the care received, better understanding of the medical indications and a more favorable disposition towards treatment follow-up. In contrast, users who were not attended to in their native language reported confusion, fear and distrust, factors that were associated with lower therapeutic adherence.

In Ecuador, Falcón (2021) designed a bilingual manual for oral health promotion in Kichwa-speaking communities in the Cañar canton. The results showed a significant improvement in the knowledge of oral hygiene practices after the use of the material. Similarly, Guapisaca (2022) developed an educational guide in Kichwa-Spanish for caregivers of bedridden people in rural communities of Chimborazo, and reported that the understanding of the content increased significantly when presented in the participants' mother tongue.

These studies agree that intercultural communication is not reduced to the literal translation of content, but requires a cultural and pedagogical adaptation that takes into account the prior knowledge, traditional practices and life contexts of the communities. Therefore, the production of bilingual materials should be accompanied by community validation processes, participatory workshops and continuous training for health personnel (Petrone, 2021; Jiménez & Loor, 2022).

In addition, the studies highlight the need to institutionalize these efforts through public policies that ensure their sustainability. The isolated production of materials or the occasional hiring of interpreters are not enough if they are not integrated into an intercultural health strategy that includes a budget, impact evaluation and active participation of indigenous peoples in decision-making (Cacace & Giménez, 2022).

The accumulated evidence confirms that the use of the Kichwa language in health services not only improves the quality of communication, but also constitutes a key tool for reducing inequities, respecting cultural rights and strengthening ties between the health system and indigenous communities. These studies provide a solid foundation to continue promoting applied research that generates contextualized and culturally relevant solutions.

Methodology

The present study was framed within a quantitative approach, with a descriptive and correlational scope, and a non-experimental cross-sectional design. This type of research allowed us to observe and analyze the variables as they appeared in their natural context, without direct manipulation by the researchers, and facilitated the collection of data at a single point in time, which was adequate to identify associations between effective communication and the use of the Kichwa language in the health care setting.

The study population consisted of the health personnel of the San Juan de Llullundongo Health Center, located in a rural area with a majority Kichwa-speaking population. Due to the small size of the total population, a census sample was chosen, that is, 100% of the available health personnel was included, consisting of 16 professionals including physicians, nurses, dentists and health technicians. This decision made it possible to carry out a comprehensive analysis of the perceptions and knowledge of all the actors directly involved in the care process.

The main technique used for data collection was the structured survey, applied directly and in person at the health facility, with prior authorization from the institutional management and the informed consent of the participants. The collection instrument was a

questionnaire prepared by the authors, composed of 20 items distributed in three sections. The first section included sociodemographic questions (age, sex, profession, years of experience). The second section addressed aspects related to the diagnosis of the communication situation between health personnel and Kichwa-speaking patients. Finally, the third section inquired about the level of knowledge of the Kichwa language and the perception of its importance in health care.

The content validity of the instrument was verified through the judgment of experts, who evaluated the relevance, clarity and coherence of the items with respect to the objectives of the study. Subsequently, a pilot test was carried out with a small group of professionals in another health center with similar characteristics, which allowed the instrument to be adjusted before its definitive application.

Once the information was collected, the data were organized and analyzed using IBM SPSS Statistics software, version 25.0. Descriptive statistical analyses (frequencies, percentages) were applied to characterize the main variables, and correlations were made between the level of knowledge of the Kichwa language and the perception of communicative efficacy in attention, using cross tables and graphs that facilitated the interpretation of the results.

The entire methodological process was carried out respecting the ethical principles of health research, guaranteeing anonymity, confidentiality and voluntary participation. Formal approval was obtained from the operating unit and any type of pressure or conflict of interest was avoided during the application of the instruments.

The methodology used made it possible to systematically and objectively identify the communication situation in the health center, as well as to establish relationships between the use of the Kichwa language and the perceived quality of the interaction with

indigenous patients, constituting a solid basis to support the proposals for improvement developed in the research.

Results

The results obtained through the application of the questionnaire to the health personnel of the San Juan de Llullundongo Health Center reveal a worrisome situation in relation to effective communication with the Kichwa-speaking population. Through statistical analysis it was possible to characterize both the level of knowledge of the Kichwa language and the staff's perception of their communicative capacity, identifying patterns that allow us to understand the barriers faced by the health care system in intercultural contexts.

First, the level of knowledge of the Kichwa language turned out to be remarkably low. As shown in Table 1, 62.5% of the personnel reported having no knowledge at all, while 31.25% reported a low level. Only 6.25% reported an intermediate level and no professional reported a high level of proficiency. This finding is significant considering that the majority of the population served communicates in Kichwa as their first language. The lack of basic proficiency in the local language severely limits professional-patient interaction and reflects a lack of intercultural language training in the training processes of health personnel.

Table 1: Level of knowledge of the Kichwa language among health personnel

Knowledge level	Frequency	Percentage
Null	10	62,50%
Under	5	31,25%
Intermediate	1	6,25%
High	0	0%
Total	16	100%

Source: Own elaboration based on survey data, 2024.

Regarding the ability to explain medical procedures or provide relevant information in Kichwa, 62.5 % of the staff indicated that they are unable to do so, which implies a direct limitation in conducting clinical interviews, offering treatment indications or informing about preventive measures. This lack of effective communication is also evident when receiving information from the patient: 56.25 % reported difficulties in understanding when the user expresses him/herself only in Kichwa. These figures reflect a fragmented communicative environment, where the absence of a common linguistic channel generates discomfort, insecurity and potential errors in care.

Table 2 shows the level of staff's ability to communicate in Kichwa according to different clinical situations, such as the explanation of diagnoses, the indication of treatments, the understanding of information and the promotion of preventive practices.

Table 2: Ability of staff to communicate in Kichwa in specific clinical situations

Clinical situation	You can communicate	Cannot communicate	Partially communicates
Explain medical diagnosis	2 (12,5 %)	11 (68,75 %)	3 (18,75 %)
Indicate treatment or medication	1 (6,25 %)	12 (75 %)	3 (18,75 %)
Receive patient information in Kichwa	4 (25 %)	9 (56,25 %)	3 (18,75 %)
To provide prevention indications in Kichwa.	1 (6,25 %)	13 (81,25 %)	2 (12,5 %)

Source: Own elaboration based on survey data, 2024.

The analysis of this table shows that the greatest limitations occur when providing preventive indications and explaining medical treatments or diagnoses, since more than 75% of the personnel are unable to express themselves in Kichwa in these contexts. This limitation directly compromises the patient's right to be informed and to understand the procedures applied to him/her.

Likewise, more than half of the staff (56.25%) cannot adequately understand the information that Kichwa-speaking patients express in their language, which represents an obstacle both for the construction of the clinical history and for the identification of key symptoms. Only a small percentage manage to communicate effectively or partially, which reinforces the need for institutional intervention.

Another relevant finding is that 87.5% of the staff stated that it would be useful or very useful to have educational materials or bilingual communication tools (Kichwa-Spanish) in the facility. This opinion represents a concrete opportunity to design practical and accessible resources that facilitate communicative interaction, improve the quality of care and increase user confidence in the health system.

In summary, the results evidence a situation of high linguistic vulnerability in the clinical context of the health center studied. The absence of functional knowledge of Kichwa and the lack of institutional strategies to address this deficiency reinforce inequalities in health care. Nevertheless, a positive willingness on the part of the staff to incorporate support tools is recognized, which represents a favorable basis for the implementation of training actions and intercultural materials that promote more equitable and culturally relevant care.

The results obtained in this research highlight a structural problem in the intercultural rural health system: the absence of an effective communication channel between health personnel and Kichwa-speaking patients. This finding is in line with De la Torre (2022), who argues that language barriers are one of the main limitations in providing quality care to indigenous populations in Ecuador.

This coincides with previous studies that identify a low level of intercultural linguistic training in health professionals (Falcón, 2021; Jiménez & Loor, 2022). This deficiency directly compromises the effectiveness of the medical act, especially in the stages of diagnosis,

treatment and health promotion. Difficulty in expressing and understanding medical information in the patient's native language prevents the construction of a solid therapeutic bond and undermines the principle of equity in care.

Likewise, the data reveal that most staff cannot explain procedures, indicate treatments or provide preventive guidance in Kichwa, which has a negative impact on the patient's understanding of their health condition and the actions necessary for their recovery. This communication gap, as indicated by Lazcano et al. (2020), can lead to medical errors, non-compliance with treatments, increased clinical complications and mistrust of the health system.

However, a noteworthy aspect of the findings is the positive disposition of health personnel to receive institutional support, as evidenced by the 87.5% who valued as useful or very useful the incorporation of bilingual materials in Kichwa and Spanish. This data is key for the formulation of sustainable public policies that include continuous linguistic training, creation of visual and didactic tools, and strengthening of the intercultural approach in health facilities. As Cacace and Giménez (2022) point out, the intercultural approach cannot be limited to a regulatory framework, but must be a living and daily practice in professional practice.

From a normative point of view, the absence of bilingual staff and materials in Kichwa represents a contradiction with the provisions of the Constitution of Ecuador (National Assembly of Ecuador, 2021) and the Regulations for the Application of the Intercultural Approach in Health Facilities (Ministry of Public Health, 2017), which guarantee the right of indigenous peoples to receive care in their mother tongue. The lack of effective implementation of these legal mandates reflects a gap between institutional discourse and daily practice, which deserves to be urgently addressed through coordinated actions between the Ministry of Health, universities and local governments.

From the results and reflections of this research, several lines of study emerge that could strengthen the approach to this problem. In the first place, it would be pertinent to conduct qualitative research with Kichwa-speaking patients, in order to understand from their experience how they perceive the quality of care, what emotions the language barrier generates and what strategies they use to communicate in health services. This approach would contribute to broaden the view from a user-centered intercultural perspective.

Second, longitudinal studies are suggested to evaluate the impact of Kichwa language training programs for health personnel, observing changes in the quality of care, patient understanding and therapeutic adherence. This type of research would allow establishing evidence on the effectiveness of the interventions and justify their scalability in other areas of the country.

A third relevant line of research consists of designing and validating visual and auditory educational materials in Kichwa, applied in clinical contexts, and evaluating their acceptance, usefulness and results. These materials could include infographics, explanatory audios, posters, medical consultation guides, among others, always validated with community participation.

It would be necessary to deepen comparative studies between different health centers with indigenous populations, in order to identify good practices, replicable models and specific challenges according to the region or nationality. This would make it possible to build a broader framework on the communicative situation in intercultural health in the country.

Finally, the results of this research coincide with the existing literature in demonstrating that the lack of proficiency in the Kichwa language significantly limits the quality of care in rural indigenous contexts. At the same time, a favorable scenario is identified to implement improvement strategies, which should not only focus on language as

an instrument, but also on the integral respect for the patient's cultural identity, from an ethical, technical and legal point of view.

Conclusions

The findings obtained throughout this study allow us to affirm that effective communication in primary health care contexts with indigenous populations is deeply conditioned by linguistic factors. Empirical evidence shows that the absence of functional knowledge of the Kichwa language among health personnel constitutes a critical barrier that directly affects the quality, safety and equity of the service provided. This reality reinforces the thesis that health communication cannot be understood only as a technical process of information transfer, but as a culturally and socially situated practice, where language is a central element to ensure mutual understanding and respect for the patient's identity.

From the conceptual framework of intercultural health and the constitutional principles that protect the right to receive care in the mother tongue, the situation detected in the San Juan de Llullundongo Health Center is evidence of non-compliance with the regulations in force in Ecuador. Despite the fact that Kichwa has been recognized as an official language of intercultural relations, its use in clinical spaces continues to be marginal, which configures a form of structural exclusion that reproduces historical inequalities.

The research showed that most health personnel do not have the minimum linguistic competencies necessary to establish adequate interaction with Kichwa-speaking patients. This limitation is more evident in key moments of the care process, such as the explanation of diagnoses, the indication of treatments and the promotion of preventive practices. However, a favorable attitude towards the implementation of linguistic support resources and bilingual

materials was also identified, which represents a concrete opportunity for institutional intervention.

The critical interpretation of the results leads to the conclusion that the training of health personnel should incorporate the intercultural approach in a cross-cutting manner, not as a complementary content, but as an essential professional competence. The promotion of the Kichwa language in the clinical setting should not be understood only as a functional communication tool, but as an act of cultural justice and as an effective strategy to improve therapeutic adherence, patient satisfaction and clinical outcomes.

The development of this research opens new possibilities for the design and implementation of training strategies and didactic materials that facilitate intercultural dialogue in health services. It also provides evidence to support public policies aimed at linguistic equity in health care. Finally, this study experience invites us to rethink the model of care from a plural logic, where the patient's language ceases to be a barrier and becomes a bridge for mutual recognition, dignity and quality in health care.

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