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# SOCIAL IMAGINARIES AND PRACTICES REGARDING DIABETES AND HYPERTENSION: A QUALITATIVE STUDY IN HIGH ANDEAN COMMUNITIES OF CUSCO, PERU

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## ABSTRACT

*The study addresses the spread and complexity of diabetes and hypertension in high-Andean communities in Cusco, where structural limitations of the healthcare system intertwine with cultural frameworks that shape*

*imaginaries and health practices. The research seeks to understand the imaginaries and practices of patients and healthcare providers regarding these diseases through a qualitative, interpretive phenomenological approach based on interviews with 33 key informants, direct observation of community interactions and healthcare routines, and thematic analysis using Atlas.ti. The findings show that the experience of chronicity is mediated by emotions such as uncertainty and mistrust, language barriers, tensions between biomedicine and traditional knowledge, and practices such as self-medication or the combined use of therapies. Furthermore, religious, cultural, and relational meanings emerge that influence treatment adherence and the legitimacy of the healthcare system. Therefore, the biomedical approach is insufficient if it does not incorporate the social imaginaries and practices of local actors; it is necessary to strengthen primary health care that is intercultural, territorially relevant, and centered on dialogue between biomedical scientific knowledge and local knowledge. Thus, it is recommended to design comprehensive interventions that integrate health, culture, and structural equity to improve social and health effectiveness.*

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**KEYWORDS:** Social Imaginaries and Practices, Diabetes, Hypertension, High Andean Communities, Primary Health Care, Biomedicine, Traditional Medicine, Peru.

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## 1. INTRODUCTION

Chronic noncommunicable diseases, particularly type 2 diabetes mellitus (T2DM) and hypertension, constitute a priority public health problem in Peru. According to the Demographic and Family Health Survey [1], 38.8% of the population over the age of 15 has at least one associated morbidity or risk factor, including diabetes, hypertension, and cardiovascular diseases. In rural high-Andean areas, such as the district of Challabamba in the Cusco region, this situation is exacerbated by structural limitations in the healthcare system and conditions of vulnerability that restrict access to specialized services [2].

Beyond its biomedical dimension, chronicity entails profound transformations in patients' life trajectories. In this regard, Bury [3] argues that diseases such as diabetes and hypertension generate a "biographical disruption" by altering routines, expectations, and social roles. This experience demands continuous processes of psychological and social adaptation, the effects of which can impact treatment adherence and mental health. In the Peruvian context, Loayza-Castro and Vera-Ponce [4] demonstrate that the time since diagnosis is significantly associated with the presence of depressive symptoms, especially between the first and fifth years, revealing the need to integrate the psychosocial dimension into the management of these conditions.

Addressing these socio-health phenomena requires an understanding of the social imaginaries that structure perceptions and practices surrounding the disease. From Castoriadis's [5] perspective, social imaginaries are composed of instituted meanings that guide collective life and shape relatively stable frameworks of meaning. In line with this, Coca and

Matas [6] note that such imaginaries are expressed in values, beliefs, habits, and behaviours that allow a society to recognize and distinguish itself historically. In the high-Andean communities of Cusco, these imaginaries manifest in the coexistence of conventional medicine—such as the use of metformin and enalapril—and traditional practices based on medicinal plants, whose relevance has been reinforced in recent contexts of health crises.

Treatment adherence is a critical factor in the management of T2DM. In this regard, Shahabi et al. [7], drawing on Pender's Health Promotion Model, demonstrate that adherence is a multidimensional phenomenon involving perceptions of benefits, economic and structural barriers, self-efficacy, emotions, and the quality of the relationship with healthcare providers. In settings where communication difficulties exist—such as the exclusion of Quechua from care—and negative perceptions of medications, these factors take on particular significance.

Furthermore, empirical evidence shows that structured educational interventions in primary care improve clinical and metabolic indicators. Elfakki et al. [8] report significant reductions in fasting blood glucose, waist circumference, and blood pressure following self-care education programs delivered by trained staff, highlighting the importance of effective communication and continuous support tailored to the sociocultural context.

In this context, this article seeks to interpret the social imaginaries and practices of patients with diabetes and hypertension in Challabamba, to understand their feelings, thoughts, meanings, and actions regarding conventional and traditional treatment. An approach that integrates epidemiological, psychosocial, and cultural

dimensions will allow us to overcome exclusively biomedical approaches and contribute to the design of more relevant policies and programs for populations in rural high Andean communities.

## 2. THEORETICAL FRAMEWORK

### 2.1. *Social Imaginaries and Rural-Andean Public Health*

The social imaginaries analysis in rural-Andean public health requires the articulation of two converging traditions: on the one hand, the theoretical foundation of imaginaries as a constitutive dimension of the social, and on the other, the structural and territorial study of rurality from a health perspective. From Castoriadis's *ontological perspective* [5,9], every social institution, including the health system, is grounded in imaginary meanings that guide collective practices, norms, and expectations. In the rural-Andean context, these meanings not only structure the understanding of the body and illness but also shape the legitimacy of biomedical knowledge, the relationship with the state, and community-based forms of care. Thus, public health cannot be understood as a merely technical mechanism but as an institution permeated by established imaginaries and instituting dynamics that emerge from communities.

In line with the above, Pintos [10] defines social imaginaries as frameworks of intelligibility that define what is visible and what can be said within a given social context. In high Andean regions, such frameworks determine which health issues gain public relevance and which remain marginalized. This analytical dimension is linked to the arguments of Baeza [11] and Cegarra [12], who maintain that social imaginaries directly influence the formulation and legitimization of public policies. In Andean rural areas, the prioritization of certain health programs responds not only to epidemiological indicators but also to social representations of poverty, vulnerability, and individual responsibility.

The discussion gains further relevance by incorporating the *territorial dimension* developed by Leider et al. [13] and Ziller and Milkowski [14]; these authors demonstrate that the unequal distribution of human resources and limited infrastructure in rural areas constitute structural determinants of health disparities. However, when linking these realities to the theory of imaginaries, it becomes clear that such inequalities are not solely the result of technical limitations but also of historical representations that position the rural as peripheral or secondary in state planning. In this sense, urban-centric imaginaries influence budget allocation and the hierarchization

of territories, reproducing inequities in high-Andean contexts.

Ma et al. [15] broadens the discussion by emphasizing the interaction between social determinants and health outcomes in rural populations. Their approach helps us understand how poverty, geographic isolation, and low educational capital interact with cultural conceptions of care. In the Andean region, where household economies are typically subsistence-based, material precariousness is intertwined with community imaginaries that value self-sufficiency and family care. This interdependence confirms Castoriadis's [5] thesis on the overlap between objective structures and social meanings.

From a *governance perspective*, Shu and Wang [16] argue that the effectiveness of rural systems depends on institutional coordination and the adaptation of national policies to local realities. This approach is consistent with Girola's [17] proposal, which highlights the temporal and narrative dimensions of imaginaries. High-Andean communities interpret health interventions in light of historical memories of exclusion or state neglect, which affects institutional trust. Thus, rural governance cannot be reduced to administrative efficiency; rather, it requires an understanding of the symbolic frameworks that shape the relationship between the state and the community.

The *communicational dimension*, addressed by García-Muñoz and Gómez-Gallego [18], takes on particular relevance in territories where information circulates through both institutional channels and community networks. Prevention or vaccination campaigns are reinterpreted through pre-existing imaginaries, which can reinforce or challenge the legitimacy of biomedical discourse. In crisis scenarios, as Jiménez et al. [19] note, scientific, religious, and conspiracy narratives coexist, competing to define the meaning of risk and collective responsibility. In rural Andean areas, these symbolic disputes are embedded in contexts of structural inequality described by Aliaga et al. [20], who demonstrate how imaginaries of marginality influence the social perception of certain diseases.

The tension between biomedical knowledge and local knowledge is analysed by Bermedo [21], who demonstrates that community practices incorporate spiritual and territorial dimensions of care. This approach aligns with that of Sosin and Carpenter-Song [22], who emphasize that access to healthcare is also symbolic and relational. In high Andean communities, trust in the system depends on its ability to recognize traditional practices and avoid

stigmatizing dynamics. Rosso [23] and Pérez [24], for their part, warn that certain imaginaries can reinforce processes of exclusion by associating illness with the moral or cultural attributes of individuals, a phenomenon that intensifies in rural contexts, where community visibility is greater.

On the other hand, Lister and Joudrey [25] contribute to the debate by examining specific challenges in rural settings, where the fragmentation of services and the stigma associated with certain conditions create additional barriers. This analysis aligns with the arguments of Padilla et al. [26] and Ponce et al. [27], who demonstrate that adherence to prevention programs depends on the alignment between public policies and community imaginaries. Riffo-Pavón [28] reinforces this line of thinking by highlighting the need for qualitative methodologies that capture the symbolic complexity of rural contexts, especially in culturally heterogeneous territories such as the Andes.

Furthermore, Arana [29] introduces the *socio-environmental dimension* by analysing how imaginaries regarding nature, development, and risk influence public health. In the Andean region, where community life is closely tied to the territory, representations of the environment shape care practices and perceptions of threat. This approach complements the structural perspective, integrating environmental and symbolic factors into an interpretive framework [13,14].

Therefore, understanding social imaginaries and rural-Andean public health requires an interdisciplinary perspective that acknowledges the co-constitution of territory, structural inequality, and symbolic production. Understanding health in rural high-Andean communities involves analyzing not only the distribution of resources and institutional governance, but also the historical meanings that shape the experience of the body, illness, and care. Only through this articulation between structure and social imaginaries is it possible to develop culturally relevant, territorially differentiated public health proposals oriented toward social inclusion and equity.

## **2.2. Primary Health Care and Chronic Diseases in High Andean Communities**

Primary health care (PHC) is regarded as the cornerstone of health care systems in the face of the steady rise in chronic noncommunicable diseases (CNCDs), particularly T2DM, hypertension, and chronic kidney disease. The epidemiological transition and population aging have shifted the focus from a model centered on acute events to one

oriented toward continuous, comprehensive, and longitudinal care [30–32]. This shift is not merely organizational but epistemological; that is, it involves recognizing that chronicity constitutes a complex, socially situated phenomenon shaped by structural determinants that extend beyond the strictly biomedical realm.

From the *perspective of the social determination of health*, various authors argue that CNCDs cannot be interpreted as the exclusive result of individual decisions, but rather as an expression of historical, economic, and political processes that shape risk environments. In this regard, Acero [33] argues that diabetes in Latin America is embedded in deregulated food markets and dynamics of labor precariousness, while Amorim et al. [34] emphasize that the burden of NCDs in Brazil disproportionately affects impoverished, racialized, and indigenous populations. This structural interpretation aligns with Cebrián [35], who identifies that glycemic control is conditioned by educational level, income, and geographic location. In high-Andean communities, these factors take on particular relevance due to rural conditions, geographic dispersion, and limited access to specialized services, positioning PHC as the main – and sometimes the only – available health care option.

The *territorial and community dimension* is analysed by Mora et al. [36], who show that in rural settings, the coexistence of diabetes and hypertension is linked to overcrowding, informal employment, and deficiencies in basic services. Kapil et al. [37], in a high-altitude rural setting, demonstrate that illiteracy and economic dependence among older adults' hinder treatment adherence. In this regard, Kamvura et al. [31] identify structural barriers to the provision of PHC services in low- and middle-income countries, such as staff shortages, system fragmentation, and weak coordination between levels. In this context, PHC is simultaneously strategic and structurally strained.

From an epidemiological and clinical perspective, the literature consistently highlights the high prevalence and the pattern of multimorbidity that characterizes CNCDs. Thus, several studies support the frequent coexistence of comorbidities in people with type 2 diabetes, complicating adherence and impairing quality of life [38]; prediabetes already indicates an accumulation of metabolic risk factors [39]; likewise, the interrelationship between diabetes, hypertension, and chronic kidney disease leads to comorbidity [32]. Furthermore, the late detection of kidney damage reflects failures in systematic monitoring at the primary care level [40]. This

epidemiological landscape underscores the need for responsive primary health care, with protocols for active screening and longitudinal follow-up.

Early detection is therefore a central theme of the debate. As such, the early identification of prediabetes allows for timely lifestyle interventions, thereby reducing disease progression and complications [39]; early diagnosis of chronic kidney disease reduces morbidity, mortality, and healthcare costs [32]; however, it is noted that in several contexts the quality of PHC services is insufficient, with a high percentage of uncontrolled patients [41]. This dynamic reveals that the mere existence of programs does not guarantee effectiveness unless accompanied by investment in diagnostic infrastructure, information systems and continuing professional development.

Health literacy and self-care emerge as central categories, though they are not without controversy. According to Carrasco et al. [42], low levels of health literacy are associated with older age and lower educational attainment, which affect the ability to understand medical information. Poblete et al. [43] argue that perceived social support improves self-perceived health in patients with hypertension and diabetes. However, the discourse on self-care becomes problematic when it shifts responsibility onto individuals and families without addressing structural inequalities [30]. Likewise, the narrative of healthy lifestyles can obscure material constraints [33]. In this way, PHC serves as a space for mediation between empowerment and social justice.

According to the previous theoretical approaches, there are three other dimensions of relevance. The *intercultural dimension* takes on special relevance in high-Andean and Indigenous communities, where care relies on community networks and traditional knowledge [44]. In this regard, Quan-Baffour [45], drawing on self-care deficit theory, argues that Indigenous medicine and the use of medicinal plants constitute legitimate forms of health agency. Thus, these perspectives converge in pointing out that PHC should not operate under homogenizing logics, but rather promote intercultural dialogue and recognition of local knowledge, particularly in Andean territories where health practices are intertwined with indigenous worldviews.

The *economic dimension* is another critical aspect, which, according to Dressler and Giménez [46], involves high out-of-pocket expenses for patients with CNCDs due to drug shortages, a situation that undermines financial protection and encourages treatment discontinuation. Conversely, patients with poorer self-perceived health use more services and

generate higher hospital costs, suggesting that a strengthened PHC system can act as a financial buffer for the system [47]. However, the workload overload in PHC hinders the strict implementation of clinical guidelines, highlighting the need for structural reforms in management and human resource allocation [48].

The *psychosocial dimension* broadens the analytical scope of chronicity. In this regard, Molina et al. [49] report a high prevalence of depressive symptoms among older adults with hypertension and diabetes, while Loayza-Castro and Vera-Ponce [4] identify an increased risk of depression in the first few years following diagnosis. Thus, the relationship between chronicity, adherence, and quality of life is upheld, underscoring that psychological impact influences the metabolic control of these diseases [7,50,51] his evidence converges on the conclusion that PHC must systematically integrate mental health into the management of CNCDs.

In this context, the role of community nursing is of utmost importance. Therefore, Zambrano et al. [52] view the nurse as a case manager, therapeutic educator, and facilitator of family networks. Mora et al. [36] highlights the nursing care process as a tool for identifying social determinants and designing context-specific interventions. Thus, in rural high-Andean contexts, where access to specialists is limited, this role takes on strategic centrality, although it requires institutional support and improved working conditions [48].

Therefore, considering the various theoretical approaches, PHC is a complex, community-based, and intercultural framework for addressing chronic conditions, but one that is constrained by structural inequalities, economic barriers, and organizational limitations. There is consensus on the need for early detection, longitudinal follow-up, health literacy, and strengthening the community's role [40,41,52]. However, it is also noted that without intersectoral policies that address social determinants and guarantee financial protection, PHC runs the risk of assuming responsibilities that exceed its operational capacity [33,34,46]. In high-Andean communities, this tension intensifies, requiring a comprehensive approach that integrates biomedicine, interculturality, mental health, territorial equity, and social justice as prerequisites for the sustainable and humanized management of chronic diseases.

### 3. MATERIALS AND METHODS

The research was conducted using a qualitative methodological approach, aimed at a deep understanding of the subjective and intersubjective

meanings constructed by social actors regarding social imaginaries and practices surrounding diabetes and hypertension in the high Andean communities of the Challabamba district in Cusco [53]. This approach prioritizes the interpretive analysis of lived experiences, social imaginaries, and everyday practices, situating the socio-health phenomenon within its natural and cultural context.

The research is basic-theoretical, as it seeks to construct conceptual categories through coding and categorization that allow for the analysis and understanding of the actors' experiences and social imaginaries, without any claim to statistical generalization [54]. The methodological design adopted is interpretive phenomenology, understood as a strategy that seeks to describe and understand phenomena from the perspective of those who experience them, capturing immediate experience and the world of everyday life [55,56]. From the perspective of interpretive phenomenology, experience is the starting point of knowledge and is shaped by the subject's perception and active interaction with their environment [57].

The study was descriptive and interpretive in nature. On the one hand, it characterized the feelings, thoughts, meanings, and actions of the social actors; on the other, it sought to make sense of and assign meaning to the testimonies and social processes described, thereby developing a situated understanding of the realities under study [58]. The study area comprises the high Andean communities of the Challabamba district, Paucartambo province, Cusco region, located at 2,816 meters above sea level and characterized by its climatic diversity, agricultural production, and conditions of extreme poverty [59]. In this context, the study focused on patients with chronic diseases—diabetes and hypertension—treated at the Challabamba Health Center (I-3) and the health posts in Parobamba (I-2) and Chimur during the 2022–2023 period [60].

The units of analysis were organized into four central categories: feelings, thoughts (cognitions), social meanings, and social actions or practices. These categories guided both data collection and analysis, allowing for the integration of the subjective dimension with the observed community and health dynamics.

### **3.1. Participants And Research Methods**

The study population consisted of 59 patients diagnosed with type 2 diabetes or hypertension who were receiving care at local health facilities. The sample was selected using non-probabilistic convenience sampling criteria, based on the

researcher's judgment and the voluntary participation of the participants [53,58,61]. The study included patients with existing conditions, health care personnel (doctors, nurses, and technicians), and family members or direct caregivers. In total, 33 interviews were conducted: 17 with patients with diabetes, 8 with patients with hypertension, 5 with healthcare personnel, and 3 with family members/caregivers.

The data collection techniques were diverse and complementary. Semi-structured and in-depth interviews were conducted, which allowed for the exploration of experiences, imaginaries, and strategies regarding chronic diseases [62,63]. The interviews were digitally recorded and conducted both in homes and at healthcare facilities, as appropriate. Direct observation was also employed, allowing for the recording of daily practices, community interactions, and healthcare routines [56,64,65].

Among the research tools used included interview guides structured by thematic areas [66] and observation forms for the systematic recording of behaviors and practices [67]. Additionally, life stories were developed to delve deeper into personal trajectories and situated experiences, in settings that fostered informant trust [68].

Complementarily, in order to strengthen the theoretical and argumentative basis of the study regarding "Social imaginaries and rural-Andean public health" and "Primary health care and chronic diseases in high Andean communities," the research team also made use of the GenAI tool: ChatGPT-5.3 de OpenAI.

### **3.2. Data Analysis Procedure**

The data and information analysis were conducted systematically and in several phases. First, the interviews were audio-recorded and manually transcribed into digital documents, ensuring the accuracy of the testimonies. The observation sheets and life stories were also digitized for comprehensive processing.

In a second phase, the data were organized and processed using Atlas.ti v.24 software, a tool specialized in the processing and analysis of qualitative data [69–73]. This procedure allowed for the coding, categorization, and establishment of relationships between units of meaning and behavioral patterns of the participants, linked to the four central categories of the study.

Subsequently, in the third phase, using the qualitative thematic content analysis technique and the coding process in Atlas.ti, 451 citations were

identified distributed across a series of emerging analysis subcategories for each of the four core analysis categories. These subcategories reflected social imaginaries, experiences, and social practices linked to chronic diseases and their treatment.

In the fourth phase, the most representative quotes were selected for each subcategory, and semantic networks were constructed to visualize the conceptual relationships between categories. The analysis and interpretation were based on qualitative content analysis and discourse analysis techniques, which allowed for an understanding of the construction of meanings and social narratives surrounding chronic diseases [74,75]. Furthermore, the interpretation was conducted by contextualizing the data within relational frameworks and broader sociocultural contexts, with the aim of explaining why certain social processes occur [63].

Finally, in the fifth phase, to ensure scientific rigor, principles of methodological and researcher triangulation were applied. Various data collection techniques (interviews, direct observation, and life stories) were combined to analyze the same phenomenon, and a process of triangular and collaborative analysis was developed among the members of the research team, strengthening the validity and consistency of the findings [76,77]. Likewise, a techno-methodological articulation between interpretive phenomenology and the use of Atlas.ti software was promoted as a strategy for integrating epistemological foundations and digital tools [57,78].

#### 4. RESULTS AND DISCUSSION

The adoption of a scientifically rigorous approach in the social sciences—presenting findings, analysis, and discussion in an integrated manner—reflects the necessary coherence with ontological, epistemological, and methodological nature of qualitative research. This structure is based on four fundamental pillars: first, the recognition that the coding and categorization of data constitute, by nature, an exercise in interpretation and theoretical discussion; second, the understanding of qualitative analysis as an inductive and iterative process that requires merging description and reflection into a single narrative flow; third, institutional validation by publishers specializing in the social and health sciences who consider this format the most effective way to communicate complex findings; and finally, moving beyond the traditional IMRaD model, with its positivist and quantitative roots, which rigidly separates results from discussion, ignoring that in the interpretive paradigm, data already carry a reflexive

weight from the moment of their analysis, so that their integration enhances analytical coherence and a deep understanding of social meanings [79–84].

##### 4.1. Patients' Feelings About the Disease

The analysis and understanding of social imaginaries regarding diabetes and hypertension in high Andean communities in Cusco involves the emotional dimension of patients. In this regard, the study has identified eight analysis subcategories that help elucidate the dynamics of chronic disease: a) Uncertainty regarding the disease, b) Quechua in medical care, c) Anxiety regarding unemployment, d) Trust in private healthcare facilities, e) Concern for family members with the disease, f) Distrust of public health care, g) Feeling of loneliness, and h) Concern regarding conventional treatment (see Table 1).

With regard to the uncertainty expressed in the intense bodily experience and the fear of death ( $E=24$ ), this can be interpreted as the production of imaginary meanings that establish the illness as an existential threat [5,9]; while Pintos [10] helps us understand how these schemas define what is visible and what can be said about the condition. This emotional dimension resonates with evidence regarding depressive symptoms associated with the diagnosis of ECNT [4,49] and with the recognition of chronicity as a socially contextualized phenomenon [30]. Weaknesses in monitoring and timely detection [40,41], coupled with structural territorial gaps [13,14], intensify the uncertainty, shaping the uncertainty as a result of the interaction between emotional fragility, structural precariousness, and symbolic frameworks regarding the sick body.

A key factor in the close relationship between patients and healthcare staff is the use of Quechua in medical care ( $E=18$ ), where the experience of consultations without mutual understanding shows that the language barrier is also symbolic, as language mediates the recognition of the other as a subject of care. From Castoriadis's [5] perspective, the healthcare system operates under institutionalized imaginaries that privilege Spanish, rendering local meanings invisible; and Pintos [10] reinforces that what does not fit within the legitimate language remains outside the realm of intelligibility. This exclusion strains relational accessibility [22] and the intercultural dialogue consider central to recognizing indigenous knowledge [21,44,45]. Likewise, health literacy [42] and self-care [30] are limited when linguistic mediation is absent, thereby perpetuating structural inequities in high Andean regions.

Another emotional aspect is the distress caused by

unemployment (E=12). In other words, the inability to work following an illness reveals that chronic illness dismantles identities rooted in work and community reciprocity. For, according to Castoriadis [9], work constitutes an instituting significance that gives meaning to social life. The social determination of CNCDs [33–35] and evidence regarding rural conditions of overcrowding and informality [36] show that the loss of productive activity exacerbates pre-existing vulnerabilities [15]. This situation is intertwined with psychosocial and metabolic control impacts [7,50], demonstrating that work-related distress is not peripheral but a structuring component of the health-disease process in the high Andean rural areas. Moreover, work in the Andean world is the very essence of community life.

However, as a palliative measure, patients choose to entrust their treatment to private healthcare centers (E=11). The preference for private services, driven by the perception of greater efficacy, as described by Baeza [85] and Cegarra [12], can be understood as an imagined construction of differentiated legitimacy between the public and private sectors, influenced by historical memories of state exclusion [17]. However, this trust is strained by evidence regarding out-of-pocket expenses and financial risk in ECNT [46]; while Fuentes-Merlos *et al.* [47] argue that a strengthened primary healthcare system can mitigate costs and hospitalizations. Thus, the choice of private care reflects not only pragmatic calculation but also structural weaknesses in primary care [31] and persistent regional disparities [13,14].

One of the socio-emotional costs of living with chronic illness is concern for one's family (E=9). In other words, anxiety about the well-being of one's child and family demonstrate that the experience of illness is relational. As Castoriadis [5] argues, the family is the primary institution of meaning that structures the subject's identity. In high-Andean communities, where care is community-based [44], falling ill disrupts networks of reciprocity. Poblete *et al.* [43] show that social support improves self-perceived health, but when resources are limited – as indicated by the social determination described by Cebrián [35] – the emotional burden can intensify. In this scenario, PHC and community nursing [36,52] must integrate the family dimension as the cornerstone of comprehensive management of CNCDs.

Given the patients' socio-emotional landscape, mistrust in public health care (E=8) proves to be an added problem. Divergent diagnoses across facilities reflect fragmentation and weak coordination [31], as well as work overload that hinders the consistent application of clinical guidelines [48]. From the perspective of Pintos [10] and Girola [17], institutional narrative coherence is a condition of legitimacy; when this fails, perceptions of trust are eroded. The territorial gaps documented by Leider *et al.* [13] and Ziller and Milkowski [14], together with the structural overload noted by Acero [33], create a strained primary healthcare system that, by failing to respond uniformly, reinforces the perception of public inefficiency.

**Table 1: Patients' Feelings Regarding the Disease.**

| Analytical Category                      | Analytical Subcategory              |  | Rootedness (Quotations) | Representative Quotation (Participants' Testimonies)                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------|-------------------------------------|--|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patients' feelings regarding the disease | Uncertainty in the face of disease  |  | 24                      | "My head is burning, my vision is going dark, I see tiny round red dots; suddenly I close my eyes and when I open them again I see colorful leaves or straws – that scares me. Maybe I'm going to die; yes, if I were to die easily, that would be good. That scares me a lot" (Quote 6:5).                                                                                              |
|                                          | Quechua in medical care             |  | 18                      | "Sometimes they don't know Quechua, and I come in after we've looked at each other; we just look at each other because I don't understand them, and they don't understand me either. Sometimes there are some who know Quechua and tell the doctor that I've come for my pills, so only then do they give me the pills" (Quote 20:13).                                                   |
|                                          | Anxiety about unemployment          |  | 12                      | "I get bored, sometimes I even hate my kids. I haven't worked on the farm since my surgery; I'm taking better care of myself now. Only my husband goes to work, though I always cook. I close the shop and bring them food. I'm bored – maybe it's menopause too" (Quote 4:7).                                                                                                           |
|                                          | Trust in private healthcare centers |  | 11                      | "That's how things were going. I went to a private clinic; the doctors prescribed something for a urinary tract infection, but it didn't help at all. In Coya, one of my children got an appointment there, so I went in, and the specialists examined me... they checked everything. I wonder how they managed to do the exams – I was practically asleep when I arrived" (Quote 19:3). |

|  |                                          |  |   |                                                                                                                                                                                                                                                                                                                |
|--|------------------------------------------|--|---|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | Concern for the family, with the disease |  | 9 | "I was really worried, I cried, and I thought it was like cancer. I almost decided to take poison. I was completely overwhelmed; I couldn't sleep. I was in a total crisis, which is why I was crying. I was just worried about my little boy, who's still a child" (Quote 17:14).                             |
|  | Distrust in public health care           |  | 8 | "This illness is probably due to worry or anxiety, or maybe it's just my imagination – that's what people have told me – because I feel healthy. Sometimes doctors get it wrong, too: one tells you one thing, in Calca they told me something else, in Cusco something else – they don't agree" (Quote 23:3). |
|  | Feeling of loneliness                    |  | 7 | "I don't feel at ease, and since I'm alone, my house is far away from this whole area, so I can't even talk to people. When I go to Challabamba, I go to talk with my friends; sometimes that helps, and I even forget about my illness." (Quote 5:12).                                                        |
|  | Concerns about conventional treatment    |  | 6 | "I stopped taking the pill because I was feeling fine – I was worried it might suddenly affect a nerve. If I'm healthy, why should I take it? But when I went back, they gave me another pill; I only stopped taking it when I was feeling fine" (Quote 5:7).                                                  |

On the other hand, the feeling of loneliness (E=7) reflects the social imaginary of exclusion and abandonment in rural communities in the high Andes. Geographic isolation and the reported loneliness reflect the convergence between territorial dispersion [14] and emotional vulnerability, consistent with the high prevalence of depressive symptoms in older adults with ECNT [49]. In Castoriadis's [9] terms, illness can be experienced as a rupture of the social bond, although the community support described by Poblete et al. [43] demonstrates its protective potential. Community-based primary health care and the coordinating role of nursing [36,52] emerge as strategies to mitigate this loneliness, even though organizational and structural limitations restrict their scope [48].

Finally, concerns about conventional treatment (E=6), manifested in the intermittent discontinuation of medication due to fear of adverse effects, reflect the tension between biomedical rationality and local understandings of the body. In this regard, Quan-Baffour [45], Bermedo [21], and Rodrigues et al. [44] emphasize the legitimacy and recognition of traditional knowledge; while Angelini [30] warns that the discourse of self-care can shift state responsibilities without considering inequalities. Furthermore, low health literacy [42] and failures in continuous follow-up [41] weaken adherence, despite the importance of early detection and monitoring [32,39,40]. Within this framework, concerns regarding conventional treatment emerge as a phenomenon in which the healthcare structure, interculturality, and the imaginary construction of therapeutic risk interact in complex ways.

#### 4.2. Patients' And Healthcare Providers' Perspectives On The Disease

According to Table 2, another analysis category of social imaginaries regarding chronic diseases relates

to the rational dimension, based on which ten analytical subcategories emerged in the study: a) Causes of diabetes and hypertension, b) Inadequate care at health centers, c) Chronic disease changes lifestyle, d) Symptoms prior to diagnosis, e) Consequences of conventional treatment, f) Complementarity between traditional and conventional medicine, g) Treatment and laboratory tests as disease management, h) Diabetes as a silent pandemic, i) Overweight: a precursor to high blood pressure, and j) Acceptance of complementary medicine. The first six were identified by the patients, while the remaining four were identified by healthcare personnel. These subcategories serve as points of reference for analysing the socio-health phenomenon of diabetes and hypertension in high Andean communities.

The imaginary of the origin of diabetes and hypertension, attributed to a traumatic emotional event – "emotional diabetes mellitus" (E=47) – reveals a constitutive imaginary in which chronic disease is explained through a biographical and affective logic rather than a metabolic one. For example, the experience of grief is transformed into an imaginary meaning that lends intelligibility to the condition [5,9]. This symbolic framework does not deny the biomedical dimension, but reinterprets it through local cultural frameworks, confirming Pintos's [10] argument that social imaginaries define what can be said and thought about the body. From the perspective of primary health care, diabetes is the result of structural factors: food markets, precarious employment, and poverty [33–35]. Tension arises when structural discourse coexists with emotional narratives. In this situation, PHC, as an intercultural mediator, must integrate both rationalities to avoid reducing the experience to an isolated glycemic imbalance [30].

Diabetes and hypertension become more chronic

as the imaginary of inadequate care in health centers takes hold (E=31). “You could be dying and they’d still leave you sitting there”, this account of neglect reflects a historically entrenched imaginary of state exclusion. In this regard, Girola [17] emphasizes that memories of marginalization shape institutional trust; in high-Andean contexts, the precariousness of waiting times and care reinforces the perception of the state as distant. This is consistent with the structural findings of Leider et al. [13] and Ziller and Milkowski [14] regarding the unequal distribution of

human resources in rural areas. From the PHC perspective, the formal existence of programs does not guarantee effective quality [31,41]. In other words, the urban-centric mindset translates into concrete experiences of neglect in rural high-Andean communities. Thus, the gap is not only technical but also symbolic: prolonged waiting erodes the system’s legitimacy, affecting adherence and reinforcing private care strategies, even in contexts of economic precariousness [46].

**Table 2: Thoughts Of Patients and Healthcare Personnel Regarding the Disease.**

| Analytical Category                                                 | Analytical Subcategory                                               | Rootedness (Quotations) | Representative Quotation (Participants’ Testimonies)                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Thoughts of patients and healthcare personnel regarding the disease | <b>Patients</b>                                                      |                         |                                                                                                                                                                                                                                                                                                                                                        |
|                                                                     | Origin of diabetes and hypertension                                  | 47                      | “My case is because my son died, already a civil engineer. My wife and I cried, we despaired daily, we became ill, and when we went to EsSalud they diagnosed us with emotional diabetes mellitus” (Quote 40:1).                                                                                                                                       |
|                                                                     | Poor care in health centers                                          | 31                      | “I got treatment privately with my own money, what’s the point of SIS, because in Challabamba they don’t provide care, you could be dying and you’d still be sitting there. For example, I had my blood tested, I was there from 7 a.m. and they attended to me at 2 p.m.” (Quote 4:1).                                                                |
|                                                                     | Chronic disease changes lifestyle                                    | 29                      | “His diet has changed, he can’t eat much meat, salt too, he has to drink more water, although we always tell him to drink it without sugar, herbal tea without sugar. That has been quite difficult for him” (Quote 33:3).                                                                                                                             |
|                                                                     | Symptoms before diagnosis                                            | 27                      | “Symptoms like headaches, frequent urination, and extreme thirst” (Quote 1:10).<br>“Sometimes I saw little colored spots in my vision – maybe it’s because I’m lacking vitamins, I thought. Those rainbow-like spots would appear and then disappear” (Quote 5:1).                                                                                     |
|                                                                     | Consequences of Conventional treatment                               | 16                      | “There is a pill that makes my tooth hurt, so I only want to take herbs, some brothers tell me that pills are harmful to the kidneys” (Quote 24:7).                                                                                                                                                                                                    |
|                                                                     | Complementary approach between traditional and conventional medicine | 8                       | “I always take the herbs and the pills; I always take them while resting, herbs and pills together” (Quote 19:17).<br>I take both; the herbs help with the pain... but also, when my pills run out, I have to keep going to the clinic to get more (Quote 21:8).                                                                                       |
|                                                                     | <b>Health personnel</b>                                              |                         |                                                                                                                                                                                                                                                                                                                                                        |
|                                                                     | Treatment and laboratory testing as a means of disease control       | 6                       | “Once the diagnosis has been made, we proceed to start the treatment, always starting the treatment with the most basic one, to go according to the patient’s tolerance” (Quote 29:6).                                                                                                                                                                 |
|                                                                     | Diabetes as a silent pandemic                                        | 6                       | “Making them understand takes more time, for example, I tell them: maybe you may not have symptoms, in themselves these diseases are like pandemics, but silent, because supposedly you are fine, but inside the problems are progressing” (Quote 5:7).                                                                                                |
|                                                                     | Overweight: A Risk Factor for High Blood Pressure                    | 5                       | “Frankly, 50% are obese or overweight; we need to change the mentality, the education, promote exercise, good nutrition; from there we can change things” (Quote 28:7).                                                                                                                                                                                |
|                                                                     | Acceptance of Complementary medicine                                 | 5                       | “We have a patient who has been receiving treatment for 7 years, having a value of more than 500. And in the month of March, it was very low, and I asked her what else she was taking, indicating to me that there is a yellow flower plant that grows in swampy areas, she is a honey producer and consumes it because I am a witness” (Quote 26:4). |

Lifestyle changes in high-Andean communities are more complex due to structural difficulties;

however, in the face of chronic illness, patients are forced to make changes to their daily lives (E=29), including changes to their diet and restrictions: “You can’t eat much meat, salt, sugar, ...”. These practices demonstrate a partial internalization of the biomedical discourse on lifestyles. However, Angelini [30] and Acero [33] caution that an emphasis on self-care can obscure material constraints. Moreover, in high Andean communities, where diet is linked to subsistence economies [15], changing habits entails reconfiguring cultural and productive practices. In this sense, the transition toward a “sugar-free” diet entails a reframing of pleasure, tradition, and hospitality; which, according to Pintos [10], implies that health is redefined in tension with what is culturally legitimate. In this regard, PHC must avoid moralizing about lifestyle and, instead, integrate health education with social justice [34].

Given that there are gaps in access to health services in high-Andean communities, the identification of chronic diseases has traditionally been based on specific symptoms prior to diagnosis (E=27). References to headaches, polyuria, polydipsia, and visual disturbances show that the body signals symptoms before medical intervention. In this regard, Mirabal and Vega [39] highlight the importance of early detection, but the narrative shows that the symptoms were initially interpreted as a “vitamin deficiency,” which confirms the thesis of García-Muñoz and Gómez-Gallego [18] that biomedical information is filtered through pre-existing cultural frameworks. Furthermore, the diagnostic gap also reflects weaknesses in primary health care [40]. Thus, the delay is not solely due to the patient’s cognitive limitations; it is systemic. The interaction between limited health literacy [42] and insufficient monitoring creates a space of vulnerability that reinforces the silent progression of the disease.

One of the factors contributing to poor adherence to treatment for chronic diseases in high Andean communities is related to the consequences of conventional treatment (E=16). That is, the fear that “pills damage the kidneys” reflects an ambivalent view of biomedicine. In Andean contexts, care integrates spiritual and physical dimensions that are not limited to pharmacology [21]. Suspicion toward medication can be understood as a reaction to actual or perceived adverse experiences. From a clinical perspective, Mayne [32] and Arellano et al. [38] highlight the complexity of multimorbidity and side effects. However, when information is not adequately communicated, mistrust emerges.

Therefore, Sosin and Carpenter-Song [22] emphasize that accessibility is also relational, where mistrust erodes adherence, leading to treatment discontinuation [46].

In the face of mistrust toward biomedicine, complementarity between traditional and conventional medicine is necessary (E=8). Here, the simultaneous use of “medicinal plants with pills” exemplifies a model of pragmatic complementarity. For this reason, Rodrigues et al. [44] and Quan-Baffour [45] recognize the legitimacy of indigenous medicine as a health agency. This practice can be interpreted as an instituting dynamic that reconfigures the biomedical institution without rejecting it [5]. In this context, intercultural PHC must acknowledge this hybridization, avoiding homogenizing logics [44]. That is, rejecting traditional medicine would reinforce imaginaries of imposition; critically integrating it strengthens adherence and therapeutic dialogue.

However, from the perspective of healthcare personnel grounded in the biomedical approach, four subcategories of analysis emerged within the rational dimension as manifestations of social imaginaries. On the one hand, treatment and laboratory testing as a means of disease control (E=6), where healthcare personnel emphasize stepwise protocols and laboratory monitoring. This approach responds to the need for longitudinal follow-up [40,41]. According to Mayne [32], early monitoring prevents renal complications. However, Perry et al. [48] caution that staff workload limits rigorous implementation. Thus, the technical rationality of the laboratory may come into conflict with the patient’s experiential rationality. In this situation, PHC requires strengthening the role of community nursing as a mediator between biochemical indicators and subjective experience [52].

For healthcare personnel, diabetes as a silent pandemic (E=6) has become the established social framework for alerting and managing the disease. This is because the metaphor of the “silent pandemic” highlights the difficulty of making an asymptomatic disease visible; consequently, Mirabal and Vega [39] had already warned about subclinical progression, and Deribe et al. [41] report high rates of uncontrolled disease. Furthermore, the absence of symptoms reduces risk perception [10], and multiple narratives compete to define risk [19]. In this scenario, PHC faces the communicational challenge of translating epidemiological evidence into culturally intelligible meanings.

Consistent with the asymptomatic nature of chronic diseases, the social imaginary among

healthcare professionals has established being overweight as an indicator and risk factor for high blood pressure (E=5); consequently, professional discourse links obesity and hypertension, emphasizing education and exercise. This perspective is consistent with Arellano *et al.* [38] and Mayne [32] regarding the accumulation of metabolic factors. However, Acero [33] warns that focusing the problem on “mindset” can obscure structural determinants. In high-Andean communities with limited economies and poor recreational infrastructure [15], behavioral change depends not only on individual will but also on structural justice.

Finally, the acceptance of complementary medicine (E=5) by healthcare personnel represents a significant step toward the integration of local knowledge. In other words, the professional recognition of a “yellow-flowered” plant that improves blood glucose levels reflects intercultural openness. In this regard, Rodrigues *et al.* [44] argue that the dialogue of knowledge strengthens legitimacy. In the words of Castoriadis [5], such recognition implies an instituting transformation within the biomedical institution. However, the challenge lies in integrating scientific evidence without delegitimizing local knowledge. Here, intercultural primary healthcare requires flexible protocols and rigorous evaluation, avoiding both uncritical romanticism and epistemological denial [45]. Therefore, the sustainable management of diabetes and hypertension in high Andean communities requires strengthening infrastructure and governance, but also recognizing the instituting dimension of social imaginaries, integrating interculturality, mental health, and territorial equity as structural pillars of the PHC model.

### 4.3. Social Meanings Of Disease

The dynamics of daily life, as seen through the eyes of patients with diabetes and high blood pressure, take on a different meaning and significance than usual. In this regard, as a result of empirical field research, as shown in Table 3, three subcategories or conceptual frameworks have emerged that help us understand the health-illness relationship in the rural highland communities of Cusco: a) God as a source of strength and solace, b) Dietary changes as a stressor, and c) Beliefs regarding blood tests.

With regard to the subcategory “God as a source of strength and solace” (E=13), the results show that turning to God as a source of strength and solace in

the face of illness constitutes a social imaginary that shapes the experience of suffering in high Andean communities. From the perspective of social imaginary meanings, faith operates as a symbolic framework that guides the interpretation of suffering and the healing process, confirming that health practices are not limited to the biomedical dimension but are embedded in shared cultural and spiritual universes [5,9,10]. In this sense, patients’ references to prayer and trust in God as a resource for coping with illness reflect a system of intelligibility where care is articulated with religious beliefs, reinforcing the idea that collective representations define what is considered legitimate in terms of well-being and healing [12], [85]. Likewise, the coexistence of religious faith and medical care confirms the thesis that health systems must be embedded within pre-existing symbolic frameworks that shape the relationship between the community and health institutions [17,18]. From an intercultural perspective, these spiritual practices also engage with local knowledge of care, demonstrating that, in rural contexts, coping with illness integrates spiritual, community, and biomedical dimensions [21,44,45].

On the other hand, dietary change as a stress factor (E=7) is established in the social imaginary promoted by healthcare institutions. However, in the participants’ accounts, dietary modification emerges as an emotionally difficult experience that introduces tensions into the daily lives of patients with chronic illnesses. This finding confirms that adherence to nutritional recommendations does not depend solely on individual decisions but is conditioned by social structures, cultural habits, and economic conditions that shape lifestyles in rural contexts [33–35]. In high-Andean communities, where daily eating is deeply linked to cultural practices and material availability, dietary restrictions can be perceived as a symbolic and emotional loss, generating stress and resistance to change, as suggested by the accounts of patients who experience difficulties in giving up traditional foods. This socio-health phenomenon coincides with the debate on self-care, where some authors warn that the promotion of healthy lifestyles may obscure the structural limitations faced by rural populations [30]. In turn, limited health literacy and conditions of poverty influence the understanding and sustainability of therapeutic recommendations [37,42]. Here, social and family support can mitigate tensions, facilitating adaptation to the changes required by treatment [43].

*Table 3: Meanings That Patients Attribute to the Disease.*

| Analytical Category                             | Analytical Subcategory                              | Rootedness (Quotations) | Representative Quotation (Participants' Testimonies)                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------|-----------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Meanings that patients attribute to the disease | God as a source of strength and a source of comfort | 13                      | "I felt a little sad, but I say it depends on the Lord. We are believers, brothers of the Peruvian church. I trust in God and I go to church once a week. There they help us with prayers for those who are sick. Also, the Lord heals us; we must have faith" (Quote 22:1).                                                                                                                                          |
|                                                 | Dietary change as a stress factor                   | 7                       | "The hardest thing for her was not eating what she likes: coffee and cheese. Before, for example, she would eat coffee with 3 or 4 pieces of bread, that has also been reduced, and I would tell her: Mommy, you shouldn't eat, and she would get upset and say to me, 'What am I going to eat then?' That's why, I no longer tell her that 'she shouldn't eat,' I just tell her, 'Eat, but at least!'" (Quote 33:9). |
|                                                 | Beliefs about blood tests                           | 5                       | "In Coya they were taking blood from me, I would ask them, 'Why are you taking so much blood from me?' I looked sad. 'Where are you taking it?' 'Will you give it back to me? Maybe you're going to sell it,' I said" (Quote 19:25).                                                                                                                                                                                  |

Finally, given that the diagnosis of chronic diseases involves laboratory analysis, beliefs regarding blood tests (E=5) emerge among patients. These social imaginaries reveal the existence of uncertainty and mistrust toward biomedical procedures. Suspicion regarding the fate of the extracted blood—including the possibility that it might be sold—highlights how the healthcare experience is interpreted these phenomena through symbolic frameworks historically constructed within contexts of inequality and institutional distance. From the perspective of social imaginaries, this landscape reveals how communities develop explanations that seek to make sense of poorly understood medical practices, shaping interpretations that may challenge the legitimacy of the healthcare system [5,9,10]. This phenomenon is linked to the communicational dimension of public health, where the circulation of institutional information competes with community narratives that reinterpret medical procedures [18,19]. Likewise, mistrust may be linked to collective memories of exclusion or state neglect that influence the relationship between rural communities and health services [16,17]. Consequently, healthcare accessibility is not only material but also symbolic and relational, requiring intercultural strategies that incorporate local imaginaries to strengthen institutional trust [22,26,27].

#### 4.4. Actions of Patients and Health Personnel in the Face of Disease

The fourth analysis category of social imaginaries pertains to the practical dimension, referring to the actions of the actors; according to Table 4, seven subcategories of analysis have emerged in the study: a) Use of traditional medicine in the treatment of the disease, b) Self-medication in the treatment of the disease, c) Non-compliance with medical instructions, d) Difficulties in the referral process, e)

Limited primary health care in the district, f) Importance of patient follow-up, and g) Brief and basic information for patients.

Regarding the use of traditional medicine in treatment of illness (E=66), the use of medicinal plants as an everyday therapeutic resource demonstrates that the treatment of illness in high Andean communities is embedded in cultural systems of care that coexist with biomedicine. From the perspective of social imaginaries, these practices are understood as established meanings that guide the relationship between body, nature, and illness [5,9], and these imaginaries define what a community recognizes as legitimate in matters of health [10]. In this regard, Bermedo [21] notes that care in Andean contexts integrates spiritual, territorial, and community dimensions. This approach aligns with Rodrigues et al. [44] and Quan-Baffour [45], who argue that traditional medicine constitutes a valid form of health agency. However, when the biomedical system fails to recognize this knowledge, symbolic access to the health system is weakened [22], highlighting the need for intercultural PHC.

Another action taken by patients relates to the subcategory of self-medication in the treatment of disease (E=21). In other words, the independent purchase of medications – even at high cost – reveals individual strategies for managing the condition in contexts where institutional access is limited. From the perspective of the social determinants of health, Acero [33] argues that chronic diseases are embedded in socioeconomic structures that shape therapeutic decisions, while Amorim et al. [34] demonstrate that impoverished populations bear a greater burden of disease and healthcare costs. In this context, self-medication is linked to the organizational weaknesses of health systems described by Kamvura et al. [31], particularly staff shortages and system fragmentation. Likewise, Dressler and Giménez [46] show that out-of-pocket

spending among patients with chronic non-communicable diseases can undermine households' financial protection. From the perspective of social imaginaries, these practices can be interpreted as socially legitimized responses when the formal system loses its capacity to respond and resolve issues [10].

Consistent with the above, patients' disregard for medical instructions (E=7)—such as salt intake or denial of the link between sugar and disease—reveals tensions between biomedical discourse and the cultural frameworks that guide daily life. In this regard, Angelini [30] warns that the self-care approach can be limited when it places responsibility on the individual without considering structural determinants. In this sense, Carrasco *et al.* [42] show that low levels of health literacy hinder the understanding of medical instructions. However, from Castoriadis's [5] perspective, social practices are grounded in deeply rooted imaginary meanings that are not transformed solely through clinical prescriptions. Likewise, the coexistence of traditional therapeutic knowledge described by Bermedo [21] and Quan-Baffour [45] introduces alternative interpretations of the causes and management of illness, creating a scenario where medical instructions compete with other cultural frameworks of meaning.

Furthermore, given that the complexity of chronic diseases requires specialized treatment, difficulties arise in the referral process (E=3). In other words, difficulties in accessing referrals or specialized tests highlight structural flaws in the coordination of the healthcare system in high-Andean communities.

Kamvura *et al.* [31] note that in many health systems, coordination between levels of care is limited, which hinders continuity of care. This problem is exacerbated in rural areas, where gaps in infrastructure and human resources restrict access to specialized services [13,14]. Furthermore, the existence of health programs does not guarantee their effectiveness when sufficient diagnostic capacity is lacking [41]. Therefore, difficulties in the referral process reflect a structural tension between the problem-solving role expected of PHC and the institutional limitations that characterize the organization of health systems in rural contexts.

However, from the perspective of healthcare workers, the management of chronic diseases involves three key challenges: first, limited primary healthcare in the district (E=31). The shortage of medical staff prevents community visits and clinical follow-up, revealing the structural limitations of primary healthcare in rural communities. According to Kamvura *et al.* [31], the lack of human resources is one of the main barriers to the provision of health services in low- and middle-income settings; meanwhile, work overload at the primary care level hinders the implementation of clinical guidelines and preventive measures [48]. From a territorial perspective, the unequal distribution of infrastructure and professionals perpetuates historical disparities between urban and rural areas [13], [14]. These inequalities are also linked to institutional perceptions that have positioned rural areas as peripheral spaces in health planning [10,12,85], limiting the operational capacity of primary health care in high-Andean communities.

**Table 4: Actions Of Patients and Health Personnel in the Face of Disease.**

| Analytical Category                                             | Analytical Subcategory                                   | Rootedness (Quotations) | Representative Quotation (Participants' Testimonies)                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------|----------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Actions of patients and health personnel in the face of disease | <b>Patients</b>                                          |                         |                                                                                                                                                                                                                                                                                                                       |
|                                                                 | Traditional Medicine Use in the Treatment of the Disease | 66                      | "My sister-in-law gave me a yellow plant, polo polo, it has a red stem, those are small and grow in humid places, I take it myself for 15 days, I also leave it, it is the only plant I take." (Quote 18:8)                                                                                                           |
|                                                                 | Self-medication in the treatment of the disease          | 21                      | "I buy (medicines) in boxes, even though it costs, I also use injectable medicine for my foot pain, it costs me almost 60." (Quote 13:9)                                                                                                                                                                              |
|                                                                 | Failure to follow medical instructions                   | 7                       | "The staff tells me not to do this, not to do that, but I always eat with salt. Food should have salt; I don't listen to them." (Quote 19:25)<br>"The doctor told her to eat less sugar, but she doesn't understand. She says it's a lie that she's craving sugar." (Quote 32:5)                                      |
|                                                                 | Difficulties in the reference process                    | 3                       | "In Paucartambo they won't give me a referral, even though we paid for it" (Quote 9:8).<br>"I didn't get an ultrasound. They give me orders and years, months go by, they don't call you, they don't know if there's an opening, that's how they wear you down and waiting isn't even worth it anymore" (Quote 10:7). |
| <b>Personal de salud</b>                                        |                                                          |                         |                                                                                                                                                                                                                                                                                                                       |

|  |                                             |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--|---------------------------------------------|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | Limited primary health care in the district | 31 | "Community visits couldn't be carried out because there are no medical staff, so we're thinking of organizing ourselves better so that we can reach out to patients; the staff can go out to provide them with treatment or come in to examine them. Because it's not just about giving them treatment and that's it – it's about bringing them in to check their blood sugar and making sure they're taking their medications." (Quote 29:6). |
|  | Importance of patient follow-up             | 7  | "There is no follow-up, for example, we in Majopata did campaigns, where patients learned about these diseases, but in itself there is no follow-up for patients with diabetes and hypertension. There are even goals, for example, if the patient does not come, follow-up must be done, the establishment is large with categorization 1-3: it lacks medical personnel, laboratory, to be a large institution" (Quote 27:8).                 |
|  | Brief and basic information for patients    | 5  | "I feel identified with them, I feel in their place, and I have to transmit it to them in the Quechua language. I make them aware of the consequences of not receiving treatment for high blood pressure. On one occasion, I even gave a talk with slides about diabetes and hypertension; some came. There are patients in Saway, and it is better to do it in remote places" (Quote 26:2).                                                   |

Another institutional issue relates to the importance of patient follow-up (E=7). This is because the lack of systematic follow-up for patients with diabetes and hypertension reflects a critical weakness in the management of chronic diseases. These conditions require continuous monitoring, early diagnosis, and long-term management [32,40]. Furthermore, Deribe et al. [41] note that many health programs often lack effective mechanisms to ensure such follow-up. From the community-based PHC perspective, Zambrano et al. [52] highlight the role of nursing as a case manager and coordinator of family networks, a function that Mora et al. [36] consider key to identify social determinants and adapt interventions to the local context. However, these strategies require institutional support and the availability of human and financial resources, which, according to Perry et al. [48], remain insufficient in many rural health systems.

Finally, given the context of rural high-Andean communities, health personnel rely on providing brief and basic information to patients (E=5). In this regard, educational activities conducted by health personnel in the Quechua language demonstrate efforts to improve health communication within intercultural contexts. In this regard, Carrasco et al. [42] emphasize that health literacy is fundamental to understanding the treatment of chronic diseases, although its effectiveness depends on sustained educational processes. From a communicational perspective, García-Muñoz and Gómez-Gallego [18] argue that health information is interpreted within social and cultural networks that mediate its meaning. In high Andean communities, these dynamics are embedded in collective imaginaries regarding illness and care [5,10]. Therefore, health education must incorporate linguistic and intercultural mediation, because the transmission of brief biomedical information is insufficient if it does

not engage with local knowledge and care practices [44].

#### **4.5. Theoretical-Methodological and Practical Contributions**

Fieldwork grounded in interpretative phenomenology enabled the analysis and interpretation of findings concerning social imaginaries and practices related to diabetes and hypertension in High-Andean communities of Cusco. As a result of this process, four main analytical categories were constructed: feelings, thoughts, meanings, and social practices. From these dimensions, additional subcategories emerged. First, within the emotional dimension, eight analytical subcategories were identified. Second, within the rational-cognitive dimension, ten conceptual subcategories emerged, accounting for the origins of disease, the symbiosis between traditional and conventional medicine, and the acceptance of complementary medicine. Third, within the symbolic dimension, three subcategories emerged – spiritual, dietary, and cultural – regarding approaches to disease management. Fourth, within the practical dimension, seven subcategories were identified, reflecting actors' behaviors in response to diabetes and hypertension. Thus, the study's principal contribution lies in the emergence and configuration of more than thirty categories and subcategories, enabling a comprehensive analysis, understanding, and interpretation of coping with chronic non-communicable diseases in rural High-Andean communities.

Furthermore, the study provides empirical evidence that the chronicity of diabetes and hypertension in High-Andean communities is a socio-structural and intercultural construction, in which emotions, hybrid rationalities, and local practices mediate adherence and care, conditioned

by territorial precarity and systemic weaknesses in primary health care. Therefore, the practical implications are oriented toward reconfiguring care through a relational, territorial, and intercultural approach. In this regard, the following actions are proposed: institutionalizing linguistic-cultural mediators; integrating traditional and conventional medicine into local protocols; strengthening continuity of care through community-based follow-up; implementing context-sensitive health education; and developing family- and community-level interventions aimed at reducing distrust and improving sustainable therapeutic adherence.

#### **4.6. Study Limitations and Future Research**

The study presents limitations inherent to the qualitative approach and the interpretive phenomenological design, as the findings are based on in-depth subjective and intersubjective experiences of a focused yet socioculturally representative group of actors directly involved in addressing diabetes and hypertension in high Andean communities of Cusco. The aim is not statistical generalization, but rather to provide a reference for similar contexts. The non-probabilistic convenience sampling, grounded in the researcher's judgment and participants' voluntary willingness, and limited to 33 key informants from communities in the district of Challabamba, may restrict the diversity of perspectives.

Therefore, for future research, it is recommended to approach the phenomenon investigated from a mixed methodological approach, to ensure the comprehensiveness, pragmatism and transferability of the study's findings.

### **5. CONCLUSIONS**

The emotional dimension of social imaginaries regarding diabetes and hypertension in the high Andean communities of Cusco shapes an experience of chronicity shaped by both structural determinants and shortcomings in the healthcare system, where empirical findings confirm theoretical perspectives on uncertainty, linguistic barriers, institutional mistrust, socio-emotional distress, and intercultural tensions in treatment, reinforced by territorial inequalities, job insecurity, geographic isolation, and fragmentation of services. The findings also reveal limitations, such as the fragility of primary health care, low health literacy, discontinuity of care, weak coordination between levels of care, and a lack of cultural relevance in service delivery. Now, the most notable aspect of the findings is that they highlight the socio-emotional and intercultural dimensions of

chronic noncommunicable diseases in high-Andean contexts, integrating structural conditions and subjective experiences. Therefore, it is recommended to strengthen intercultural PHC, incorporate effective language mediation, promote a family-community approach, improve continuity of care, and design contextualized, sustainable, and territorially relevant treatment adherence strategies.

The rational dimension of social imaginaries regarding diabetes and hypertension reveals a convergence between biomedical and sociocultural rationalities, where patients articulate biographical, emotional, and pragmatic explanations, while health personnel prioritize technical and epidemiological approaches. This coexistence confirms that the understanding of the disease is simultaneously structural, symbolic, and experiential. However, limitations persist due to gaps in the quality of care, intercultural communication, and socioeconomic determinants that influence treatment adherence. Here, the main contribution lies in highlighting the hybridization between traditional and conventional medicine as an institutional strategy. Therefore, it is recommended to strengthen an intercultural PHC that integrates local knowledge, improves relational accessibility, and articulates structural interventions with contextualized health education.

The social meanings of disease are shaped at the intersection of spiritual symbolic frameworks, cultural practices, and relationships of trust/distrust with the biomedical system, where faith, diet, and diagnostic procedures acquire contextualized meanings. From the perspective of social imaginaries, the findings confirm the centrality of culture in the experience of illness. However, the contextual nature of the results should be noted; they are limited to rural high-Andean communities in Cusco with specific sociocultural, economic, and symbolic conditions, and their transferability is feasible to similar contexts. Therefore, non-biomedical dimensions stand out in the understanding of chronic noncommunicable diseases; hence, it is recommended to strengthen intercultural approaches and communication strategies to improve adherence and institutional trust.

With regard to the practical dimension, it is evident that the actions of patients and healthcare personnel are shaped at the intersection of sociocultural knowledge, structural limitations, and institutional capacities. The findings support the argument regarding social imaginaries and the social determination of health by explaining practices such as traditional medicine, self-medication, and non-

compliance with medical instructions as rational responses in contexts of low healthcare responsiveness. Likewise, gaps in referrals, the limited scope of PHC, and weak follow-up reflect persistent systemic gaps. The study provides

empirical evidence for an intercultural and territorialized PHC system; therefore, it is recommended to expand resources, promote continuity of care, and advance culturally relevant educational strategies.

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