ORIGINAL ARTICLE

Child malnutrition in the Wichí community and its social representations: an approach from Bourdieu's field theory

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ABSTRACT

Objective: To explore the social representations (SRs) of child malnutrition among fathers, mothers or guardians of the Wichí Indigenous community and healthcare professionals from the General José de San Martín department, Salta, using Pierre Bourdieu's field theory (FT). **Materials and methods:** A qualitative study was conducted within a social-critical and interpretive paradigm of SRs. Participant observation, in-depth interviews and focus groups were employed to collect data from healthcare professionals and Wichí mothers with malnourished children from the General José de San Martín department, Salta, until data theoretical saturation and intramethod triangulation were achieved. The analysis was based on Pierre Bourdieu's FT, using the categories proposed by the author. The study variables sought to understand the health field (HF) in a holistic, multidimensional and qualitative way. **Results:** In the HF, inequalities were observed in the dispositions of social agents according to the capitals at stake. For healthcare professionals, economic capital, understood as "institutional resources and assets," was considered the most important form of capital, while for the Wichí community, the focus was on "economic capital in relation to cultural capital" (self-sustainability and respect for their culture). Efforts to reduce these inequalities created ongoing tension and social pressure. Disagreements were also observed among SRs of child malnutrition, particularly concerning health indicators versus intercultural care, the Wichí language and worldview versus the Spanish language, the hegemonic biomedical approach versus ecological and intercultural perspectives, community support based on welfare versus community support based on respect for the Wichí culture, along with other actions decontextualized from the reality of the region. **Conclusions:** Given the existing disagreements and inequalities between healthcare professionals and the Wichí community, it is recommended to promote ways of being, doing and thinking in the intercultural and contextualized training approaches for healthcare professionals. This would enable more effective responses to child malnutrition in the Indigenous communities of Salta.

Keywords: Social Representation; Child Nutrition Disorders; Indigenous Peoples (Source: MeSH NLM).

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INTRODUCTION

Child malnutrition remains a critical public health issue that has long affected the Wichí Indigenous communities in northern Salta province, Argentina [1,2]. The Wichí—meaning "person" or "people" in their language—are an Indigenous group of approximately 40,000 individuals living across the provinces of Chaco, Formosa, Salta and Jujuy. Historically, their ancestors inhabited the western regions of the Gran Chaco, but over time they were displaced to the northern banks of the Bermejo River and the southeastern Chaco, where they formed interrelated villages or communities governed by an elder chief (*cacique*) and a council of male elders (*huef* or *huet*) [3]. Since the launch of the *Movimiento Nacional Campesino Indígena* (National Indigenous and Peasant Movement) in 2003 [4], women have increasingly assumed leadership roles as chiefs and heads of households, bearing the responsibility of providing care, support and protection for their communities. Traditionally, the Wichí subsisted on hunting animals (e.g., armadillos, yacares and rabbits), fishing and gathering wild foods such as coconuts, carobs, *cimarron* beans, prickly pears, *tasi* fruit and honey.

However, their ways of life and dietary patterns have been profoundly altered due to the loss of natural resources caused by deforestation, ongoing displacement, land expropriation and the redirection of rivers for agricultural purposes. One practice that endures is the collection of *chaguar*, a wild plant used in textile crafts that provide economic support [5]. The Wichí cosmology centers on a supreme being who governs the world, along with nature spirits and the souls of their ancestors who dwell in the mountains. They also firmly believe that plants and animals have souls and are considered sacred. Their traditional dwellings are huts built from natural materials such as branches, wooden poles and mud. While some communities located near urban centers have access to government-constructed houses made of brick or wood, most still lack basic utilities such as potable water, sewage and electricity [3,5].

Understanding child malnutrition among the Wichí requires a complex, multidimensional and non-reductionist analysis [2,6]: one that considers the interrelationship between the "positions" and "dispositions" of the various social agents involved (e.g., the community, health institutions, healthcare professionals, private organizations, among others) [6,7]. Social representations (SRs) are a form of socially constructed and shared knowledge [8], grounded in everyday practice and integral to the construction of a shared social reality [8,9]. These SRs—encompassing socially circulated opinions, beliefs and meanings—play a key role in shaping child feeding and caregiving practices within each community [10-12]. Exploring the SRs of malnutrition, as constructed and reconstructed by healthcare professionals, community members and caregivers of affected children, offers a deeper and more comprehensive understanding of the root causes of this issue from the perspectives of those directly involved [7,12,13]. This approach enables the formulation of public policies with meaningful and lasting impact [7,14].

Pierre Bourdieu (1930–2002), a leading contemporary French sociologist, developed field theory (FT) as a framework for understanding a wide range of social and health realities [15,16]. Applying this theory to health sciences provides a means to conceptualize child malnutrition as a socially constructed issue and to reveal the structural inequalities that shape interactions among social agents [16]. Bourdieu's FT emphasizes the relationship between objective external structures (i.e., the positions individuals occupy within social fields and the types of capital they possess), internal subjective structures (habitus and dispositions of the agents) and social practices [15,16]. A field refers to a sphere of social life that has progressively acquired autonomy over time, organized around particular forms of social relations, interests and distinctive resources. Social agents operate within the field based on their accumulated capital [15]. This capital—whether material or symbolic—refers to the assets that grants agents unequal power and positions, and serves as the driving force behind their relationships with others. The forms of capital that carry the greatest weight in the social space are not fixed a priori but shift according to the sociohistorical context [16,17]. Analyzing these forms of capital may reveal dynamics that may not be immediately visible [17]. Finally, habitus is understood as a system of dispositions that shape how individuals perceive, think, prefer, feel and act, based on socially structured principles of perception and practice. It is what predisposes agents to behave in particular ways in specific contexts [18,19].

The aim of this study was to explore the SRs of child malnutrition among fathers, mothers or guardians of the Wichí Indigenous community as well as healthcare professionals from Tartagal, Salta, using Pierre Bourdieu's FT.

MATERIALS AND METHODS

Study design and population

This qualitative research was conducted within a social-critical and interpretive paradigm [20] to explore the SRs of child malnutrition among fathers, mothers or guardians of children from the Wichí Indigenous community in northern Salta province, Argentina, as well as among healthcare professionals working in the catchment area of the referral hospital. Repeated visits were made to the hospital—specifically to the *Servicio de Alimentación* (Food and Nutrition Service) and the *Centro de Recuperación Nutricional* (Nutritional Recovery Center)—and to local health centers and the homes of Wichí families, caregivers and mothers of malnourished children. Data collection methods included participant observation, in-depth interviews and focus group discussions, carried out until theoretical saturation was reached. Two focus groups consisted of Wichí mothers and community leaders, while the other two were composed exclusively of healthcare professionals working in the hospital's operational area [21,22]. Informed consent was obtained from all study participants. The tools used for data collection included field diaries, mobile voice recorders (cell phones), treatment protocols, and documents pertaining to the health, dietary and nutrition monitoring of the affected children.

Variables and measurements

The emerging variables were structured around the analyzed social field—namely, the health sector—and comprised forms of capital (power), understood as forces operating within the field and interacting among its social agents. These agents included healthcare professionals (physicians, nutritionists, nurses and health workers), mothers, fathers or guardians of malnourished children, chiefs and community leaders. The forms of capital at stake included cultural (in its embodied, objectified and institutionalized states), economic, social and symbolic capital. Embodied cultural capital referred to long-lasting dispositions acquired within the social field. Objectified cultural capital encompassed tangible cultural goods such as pictures, books, dictionaries, instruments and machines. Institutionalized cultural capital involved a form of objectification that confers entirely original properties on the cultural capital which it is presumed to guarantee. Economic capital included purchasing power, material possessions and the subsistence resources available to both the community and healthcare institutions. Social capital referred to the

relationships, social ties and reciprocal obligations among agents. Symbolic capital was understood as the prestige and recognition conferred by the social group within the field. Habitus was reflected in the SRs held by the community and healthcare professionals in relation to child malnutrition [18,19].

Analysis of the results

The research followed a dialogical and iterative process, alternating between theory and practice to construct and interpret the SRs within a qualitative framework. Data were subjected to intramethod triangulation [22] and interpreted using Bourdieu's FT. Emerging variables were categorized according to the positions and dispositions of the agents and the capitals they mobilized. The resulting categories were defined as dominant/dominant, dominant/dominated and dominated/dominated, depending on the prevailing types and accumulation of capital among the agents [18].

Ethical considerations

The research protocol for observations and interviews was approved by the Central Ethics Committee of the Ministry of Public Health of Salta province (File No. 0100321-258640/2022-0) and by the Bioethics Committee of the School of Health Sciences at the Universidad Nacional de Salta (Governing Council Resolution No. 136/23).

RESULTS

Figure 1 illustrates the social field of child malnutrition, as analyzed in this study, along with its constituent elements.

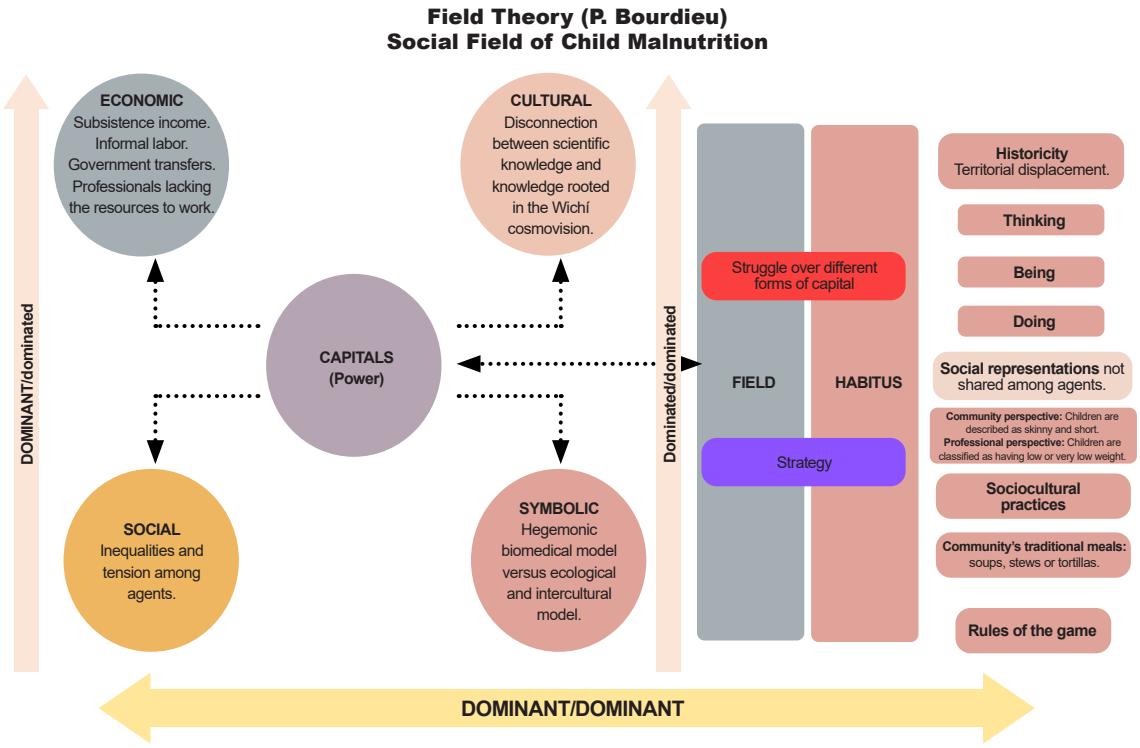

Figure 1. Field theory (P. Bourdieu): social field of child malnutrition

In Wichí families, economic capital was reflected in subsistence-level incomes that failed to meet the basic food basket, often due to indigence or informal labor. The community lacked the basic conditions required for dignified living, including adequate housing, sanitation, safe drinking water and proper waste disposal. Families residing closer to the city (kilometers 3 and 4) had access to government-built housing; however, these homes lacked electricity, running water and indoor sanitation facilities. In contrast, families living further away (kilometers 6 and 13) resided in wooden shacks with tin or cane roofs and dirt floors, with water pipes installed outside the homes. Livelihoods were primarily sustained through government-to-person cash-transfer programs, the sale of *chaguar, palo santo* and/or ceramic crafts, as well as informal food sales. Most families did not possess legal ownership of land, having been displaced from their ancestral lands. These lands were often repurposed for deforestation, burning or monoculture farming such as soybean cultivation. Some families had been relocated or evicted to more remote areas or to roadside settlements. Social organizations and individual donors sporadically contributed material assistance—such as clothing, food and medicine—but these actions were isolated and uncoordinated with the health system. Within healthcare centers, economic capital was evident in the limited availability of medical supplies for treating malnutrition. Healthcare professionals frequently reported feeling "overwhelmed" and "exhausted" due to the

lack of resources and supplies. Moreover, primary healthcare coverage reached only about half of the community's families.

The cultural capital of healthcare professionals was legitimized by the universities and educational institutions that awarded their degrees, as well as by the knowledge disseminated within the healthcare system and experience accrued throughout their careers. However, in general, few professionals had received adequate training in issues related to interculturality or Wichí culture. As a result, child malnutrition was primarily addressed through the treatment of symptoms from a biomedical perspective, without integrating the community's customs, values, beliefs or attitudes toward health. The medical practice was grounded in a formal and scientific framework, relying on pharmacological treatments and diagnoses based on physical examinations and complementary or auxiliary tests. This treatment, which was standardized and uniformly applied to all children, failed to consider the health-illness determinants according to Wichí cosmology, thus limiting a comprehensive approach to the problem. On the one hand, social organizations provided material aid; on the other, they transmitted knowledge that differed from that of the Wichí and was dogmatic in nature. In contrast, Wichí knowledge systems were ancestral, rooted in their understanding of the health-illness process and interpreted through their own belief systems. Chiefs and community leaders validated and upheld this knowledge and traditional practices for managing malnutrition and related conditions such as diarrhea and respiratory infections. Treatments often included culturally appropriate foods and medicinal herbs (*yuyos*), guided by low levels of alarm. Typical meals consisted of wheat tortillas, stews and soups, enriched with cereals (rice), noodles and vegetables. In the past, traditional techniques—such as using earthenware vessels to clarify and filter water—were employed but have since been lost. Most mothers and chiefs had limited formal education, typically having completed only primary school. Cultural transmission remained predominantly oral, characterized by parenting styles that emphasized emotional closeness and strong bonds with children. In terms of cultural capital, handicrafts played a central role in expressing the community's artistic identity and relationship with nature.

The community's symbolic capital was reflected in the status and high esteem afforded to chiefs and the legitimacy granted to traditional healing practices. Tensions emerged between these culturally rooted practices and the formal health system, as healthcare professionals predominantly adhered to a hegemonic biomedical model rather than the ecological and intercultural approach to health care.

Social capital was reflected in the interactions among social agents, which were marked by tensions and disagreements over how to address child malnutrition. Clear inequalities were evident in the timing, modes and frameworks of care. Professional approaches differed significantly from those of the Wichí community. Additionally, disparities in access to health services among community members further exacerbated existing inequities.

Finally, habitus was shaped by the SRs of child malnutrition. Among healthcare professionals, malnutrition was understood as a "physical, biological condition treatable through curative interventions," with children's weight classified as "low" or "very low." The Wichí community was described by these professionals as "a problematic population who did not return for follow-up appointments" and as "having a language and sociocultural practices not shared by them." From the professionals' perspective, the causes of malnutrition were attributed to "their own cultural practices." Additionally, they expressed frustration over the "lack of resources and supplies," the "abandonment by political authorities" and the "lack of recognition for their work." In contrast, the Wichí community described malnourished children as "skinny and short" and noted "difficulties in learning at school." Health was understood as "a state of harmony between nature, body, spirit and mind." A healthy body was conceived as an "empty vessel," whereas illness was understood as a vessel in which "lies enter," "pain is present" and "beings" cause disease. Within this worldview, mothers were perceived as the only caregivers capable of ensuring their children's well-being. SRs were translated into social practices, such as mothers seeking guidance from chiefs or community leaders on matters related to childcare rather than consulting healthcare professionals. Alternatively, mothers sought care from professionals who adopted an intercultural approach, maintained a history of respectful engagement with the community, and had the endorsement of the chief. In terms of diet, families typically prepared familiar meals such as stews, soups and tortillas. When caring for their children, mothers tended to speak softly, using gentle eye contact and calm tones. By contrast, the raised voices of healthcare professionals were perceived as "shouting" or "scolding," which instilled fear and led community members to remain silent during consultations.

Within the health field, capital was unequally distributed, resulting in dominants and dominated agents. The dominant/dominant group was represented by the health institution and the State, which established and enforced the rules of the system. Conversely, the dominated/dominated group consisted of Indigenous communities—Wichí mothers and families—who were compelled to accept those externally imposed rules.

DISCUSSION

The analysis of the SRs of child malnutrition, using Bourdieu's FT, revealed differences in the forms of capital as perceived by the Wichí community compared to those recognized by healthcare professionals. For healthcare professionals and social organizations, economic capital, understood as "institutional resources and assets," was considered the most important form of capital, while for the Wichí community, the focus was on "economic capital in relation to cultural capital," including self-sustainability and intercultural facilitators.

Efforts to bridge these inequalities generated social tensions and pressure, manifesting in the rejection of community demands, linguistic barriers, communication breakdowns, and the implementation of decontextualized plans and interventions. As a result, divergent SRs emerged—both in the understanding of malnutrition and in the practices aimed at addressing it—across the various social agents involved. These disagreements were evident in four key areas: 1) the focus on health indicators versus intercultural care, 2) the Wichí language and worldview versus the Spanish language, 3) the hegemonic biomedical approach versus ecological and intercultural perspectives, and 4) community support based on welfare versus community support based on respect for the Wichí culture.

Symbolic capital was shaped by a hegemonic, Western, positivist and patriarchal health system, in which healthcare professionals were positioned as the primary holders of knowledge related to health promotion, disease prevention and the treatment of malnutrition. Social organizations, on their part, introduced new practices that served to reinforce power dynamics. The intermediaries in this field were classified as dominant/dominated agents—i.e., healthcare professionals who adopted an intercultural approach, respected Wichí culture and its forms of expression, and were still required to comply with the health policies of the hegemonic model.

Several scholars have examined the sociocultural determinants influencing the health–illness process in the Wichí community. Some of them emphasized the importance of intervention strategies that not only address the nutritional needs of Wichí children but also incorporate family care practices and recognize the community's sociohistorical context [4,20,21]. Additionally, the cost-effectiveness of such interventions has been linked to local-level situational analysis and community acceptance [23-25]. Leavy [26] argued that the self-production of food and access to adequate housing—both critical to improving children's nutritional status—are significantly constrained by the lack of access to rural land and the absence of legal land titles. The author underscored that "the violation of the territorial rights of Indigenous populations is a determining factor in understanding the emergence of nutritional deficits in the child population." Other contributing factors identified in the literature include low literacy levels, the absence of supportive community networks [24-27], culturally specific dietary practices (such as the consumption of stews) and beliefs related to breastfeeding [27-30]. Furthermore, residing in rural areas, belonging to an Indigenous ethnic group and having parents without stable income-generating occupations were found to be associated with higher rates of child malnutrition [20,31,32]. While the aforementioned studies have sought to understand SRs from the perspective of the Wichí community, the present research goes further by directly comparing such SRs with those held by healthcare professionals. This comparative analysis enables the identification of both convergences and divergences that influence how child malnutrition is understood and treated. The application of Bourdieu's FT further highlights the inequalities structuring the field under study, offering insight into the positions and dispositions of the various social agents involved in this complex issue.

In conclusion, the analysis of SRs of child malnutrition by the various social agents involved enabled a holistic and multidimensional interpretation of the health field. The application of Bourdieu's FT in this context proved valuable in understanding the approaches and mechanisms that shape the health–illness process of child malnutrition, particularly when viewed through the lens of socially constructed dispositions.

Given the existing disagreements and inequalities between healthcare professionals and the Wichí community in addressing child malnutrition, it is recommended to promote intercultural ways of being, doing and thinking in healthcare professionals. This would facilitate closer engagement with the Wichí community, grounded in a comprehensive perspective and accompanied by effective public policies aimed at addressing child malnutrition among their children.

Authors contributions: MPC was responsible for the methodology, fieldwork and data analysis. CAC contributed to manuscript writing and revision, methodology and results. MPM participated in fieldwork and manuscript revision. ERT conducted fieldwork and interviews and contributed to manuscript revision. APCB was responsible for the methodology and manuscript writing and revision.

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