


Food prescriptions and limits of medicalization: polyphony and use of the media in an urban population of Mexico

Prescripciones alimentarias y límites de la medicalización: polifonía y utilización de medios de comunicación en una población urbana de México

José Alejandro Meza-Palmeros

 <https://orcid.org/0000-0003-2424-7879>

E-mail: alejandro.meza@ciesas.edu.mx

Centro de Investigaciones y Estudios Superiores en Antropología Social. Monterrey, NL, México.

Abstract

The argumentative approach of this work sustains that the “polyphony” speech integrated in the information associated with food, contributes to generate a community resignification regarding the proposed prescriptions by several discursive subjects, which are interpreted into “refractive feeding practices.” These could explain the limited impact that educational interventions have had to the “healthy lifestyles” promotion. The purpose was to study the refractive process related to a prescriptive information about nutrition and identifying the feeding practices generated precisely on a Monterrey, Nuevo León settlement, from their interaction with a discursive framework on key subjects, including the media. A polyphonic ethnography was conducted in ten months, and it included participant observation, ethnographical interviews and a survey. Three prescriptive discourses were identified: restrictive, selective and one associated with “medicamentation.” As a result of refraction of the mentioned discourses, the population generated substitution practices and a restriction on certain food products, expressing their concern for children’s health.

Keywords: Ethnography; Health Education; Social Media; Childhood; Health Policy.

Correspondence

Calle José María Morelos, 822. Monterrey, NL, México. CEP 64000.

Resumen

La línea argumental del presente trabajo sostiene que la polifonía discursiva contenida en la información relacionada con prescripciones alimentarias, que reproducen diversos sujetos discursivos, contribuye a generar resignificaciones en la población sobre las prescripciones propuestas que se traducen en prácticas alimentarias de refracción, las mismas que pudieran explicar el impacto limitado que han tenido las intervenciones educativas para la promoción de “estilos de vida saludables”. El objetivo fue estudiar el proceso de refracción de la información prescriptiva sobre alimentación e identificar las prácticas alimentarias generadas en la población de un barrio de Monterrey, México, a partir de su interacción con sujetos discursivos claves, incluidos los medios de comunicación. Se realizó una etnografía polifónica de diez meses de duración que incluyó observación participante, entrevistas etnográficas y una encuesta. Se identificaron tres tipos de discursos prescriptivos: restrictivo, selectivo y asociado a la medicamentación. Producto de la refracción de dichos discursos, la población ha generado prácticas de sustitución y de restricción de ciertos alimentos, manifestando con ello su preocupación por la salud infantil.

Palabras clave: Etnografía; Educación para la Salud; Medios de Comunicación Social; Infancia; Políticas de Salud.

Introduction

Health education is one of the main health policies to address the problem of childhood obesity. The intervention of the State to prescribe feeding practices in accordance with the biomedical discourse makes it possible to pose the problem as medicalization.

However, it is important to recognize that the population currently receives diverse, contradictory and continuous information through the media, in addition to information from health authorities (Carpenter et al., 2016), which highlights the polyphonic nature of medicalization, whose effects on the population should be studied, an aspect that constitutes a significant part of this study.

Health education has been shown to have a limited and inconsistent impact, particularly in the case of childhood obesity (Loveman et al., 2015). Different evaluations carried out in Mexico show similar results (Batis et al., 2016; Safdie et al., 2014), although, according to the latest health and nutrition survey, a decrease in the problem was reported in the north of the country (INSP; SSA, 2016). The discrepancies found express the existence of a differentiated adoption of feeding prescriptions and heterogeneous processes of medicalization.

One hypothesis that may explain this heterogeneity lies in the polyphonic character of the reproduction of biomedical discourse. This polyphony, as I will argue, implies diverse processes of signification and, consequently, the generation of “feeding practices of refraction.” Although these express the concern of the subjects and the implementation of measures to improve and care for their health, they are not necessarily those expected by the health authorities.

The polyphonic approach to the study of the process of health, illness, care, particularly in its semiotic dimension, contributes to the understanding of the processes of medicalization in general. The empirical findings will allow us to assess the effects that given health interventions have on the population, especially when integrating the analysis of the media, whose capacity to produce representations of health and disease is fundamental. (Gómez; Díaz, 2019).

Medicalization and polyphony

Medicalization refers to the influence that biomedicine exerts on (1) the definition of objects of intervention; (2) the construction of social representations of health and disease (Conrad, 1992); and (3) the creation of devices that make it possible prescriptions about illnesses, the body and daily life (Rose, 2007).

Health education, as Rosen (1985) points out, has been one of the main devices of state medicine for the construction of intervention objects since the 19th century.

Recent works have allowed us to appreciate the extension and diversity of medicalization devices, by identifying discursive subjects that maintain autonomy from the medical institution, such as the pharmaceutical industry (Conrad, 1992), non-governmental organizations, alternative medicines (Domínguez, 2019), and the media (Briggs, 2003).

This multiplicity of subjects that intervene in the process of medicalization from different positions, interests and interpretations, invites us to think in terms of polyphony, according to Bakhtin (1982).¹ For this paper, I consider as “discursive subjects” the agents that reproduce a certain discourse and, by “device,” I refer to the heterogeneous set of discursive and non-discursive practices (institutions, knowledge and media) whose objective is to obtain an intentional effect on behaviors (Agamben, 2011).

Refractive feeding practices

Some studies have shown the relevance of meaning processes in the adoption of food practices (Arcan et al., 2018). However, with exceptions such as the work of Théodore et al. (2011), the biomedical discourse is not analyzed, despite the fact that it is widespread in large sectors of the population. On the other hand, meanings have been studied independently of the material conditions of existence, although the fact that these are determinant (Drewnowski, 2012).

In this paper, I consider the concept of “refraction” (Voloshinov, 2009) as the articulation and resignification of polyphonic information in a given material context of life.

The aim of this work is to study the process of refraction of prescriptive information about feeding and to identify the feeding practices generated in the population in a district of Monterrey, Mexico, from its interaction with specific discursive subjects. The findings are the product of a research conducted through an ethnography carried out from January to October 2019.

Material and methods

The study area was chosen because of the opportunity to get in touch with an organization that operates there. One of the activities carried out by this organization is a periodic training called “minichef,” aimed at children between 5 and 12 years old. The objective is to encourage autonomy and independence by imparting cooking skills, as many of them remain at home alone while their parents work. Given that the trainings are conducted by women residents of the area, I considered it an ideal space for observation, since local values and meanings given to food would be reproduced there. I managed to get involved as an observer-participant for 20 sessions.

I applied a survey (n=60 households) as a starting point to learn about the population’s access to and use of media.

At the same time, I participated as a facilitator in 10 workshops to promote healthy lifestyles requested by the Directorate of Crime Prevention of the Monterrey Municipal Police, which develops a program called “Regios Trabajando,” whose main activity is the “recovery of public space.”

The workshops were attended by 12 women between the ages of 30 and 65 who share a common characteristic: they are caregivers of children, either as mothers (three) or grandmothers (nine), a characteristic that involves them in the feeding of children and the purchase of food. Part of their

¹ Coexistence of “a given set of ideas, thoughts, and words that is conducted through several separate voices, each sounding differently” (Bakhtin, 1982, p. 190).

daily diet consists of a considerable consumption of products containing high levels of sugar and refined flours. This reflects the limited availability of vegetables in the area.

During the workshops, a discussion was induced following three thematic axes: the effect of television and social networks on their feeding practices; evaluations about healthy food and practices carried out in accordance with these evaluations.

These activities helped me to enter the community and live with a family, getting involved in some of their daily activities of shopping, cooking and food consumption, including accompanying one of the grandmothers to a doctor's office to monitor her diabetes. I also attended, together with her, "food meetings" organized by a company that sells nutritional products in the area.

In addition to the actions described above, I participated as an observer in six workshops for the promotion of healthy lifestyles, three of which were organized by private companies, one by the State Women's Institute and two more by the Secretariat of Health. I visited 40 health centers as a simulated user (Meneses-Navarro; Meléndez-Navarro; Meza-Palmeros, 2018) to talk to health promoters and nutritionists.

I conducted 26 ethnographic informal and non-directive interviews (Guber, 2001). Five interviews were with women residents of the area, five with mediators (two members of NGO, two policemen and a physician) and 16 with key actors in the reproduction of the public biomedical discourse (nine health promoters, three nutritionists, two coordinators and two directors of State programs related to health education).

All the information obtained through my observations and conversations was recorded in a field diary. For its analysis, I used the dialogic perspective (Bajtín, 1982) locating and registering the participating discursive subjects in the food prescriptions addressed to the resident population in the study area. From each of the subjects, I identified the prescribed practices, the explanations and the arguments underlying them, determining the argumentative continuities and ruptures among themselves and with the written biomedical discourse.

Study area

The district is located on a hill in the southern part of the Monterrey metropolitan area. The gray concrete and tin roofs, mixed with underbrush, denote the precariousness of the predominantly self-built homes. According to official information (Inegi, 2010), the district has 2,600 inhabitants, of which 50% are women (1,289) and 23% are children between 0 and 11 years old (615). According to the same source, 90% of the population has basic services (water, electricity, gas and sewage); although I noticed that the supply is problematic. For example, drinking water is only provided at the top of the hill for twenty minutes a day. The predominant occupations are in construction, small businesses, and domestic work (in the case of women). Working conditions can be characterized as precarious: low wages (around USD 270 per month) and little job stability. There are five schools in the district, preschool to high school. There are a dozen small food outlets where junk food predominates and only three of them offer fruits and vegetables. Although some homes have fruit trees, there are no urban orchards.

Results

According to the information obtained through the survey, the most used media are television (95%), followed by social networks such as Facebook (72%), WhatsApp (68.3%) and YouTube (56.7%). 90% of the people surveyed reported having received information on health and 75% on nutrition through these media. Junk food (43%) and soft drinks (56%) are significantly consumed, despite the negative reputation of these products, in the opinion of 55% and 72% of people, respectively.

Subjects, devices and speeches

Physicians

From the interaction with these discursive subjects, the population is familiar with general dietary restrictions, especially for people diagnosed with a food-related disease, particularly diabetes. These restrictions were pointed out in the workshops.

Women frequently allude to “sinning” or having eaten “poison” when referring to foods that are “forbidden” by doctors, such as bread, flour tortillas, beef or coffee. The forbidden is strongly associated with pleasure and its restriction implies an act of self-control: “What causes harm is the tastiest,” said one participant.

During the consultation of a resident of the community whom I accompanied, the doctor said:

Another very common complication in diabetes, which frequently occurs in people who are overweight or obese, is that over time they have a vision loss, or in the worst cases, when the illness are very advanced and they have never taken care of themselves, their kidneys are damaged...in terms of what foods to eat or not to eat, everything that is carbohydrates and fats. (Field diary)

Unlike other studies (Théodore et al., 2011), which point out the generation of opposing categories between healthy and unhealthy practices, in the case I present, a food classification order was generated on what is forbidden or allowed. This is due to the association between the proposed prescriptions with pathological situations.

This has produced three situations: in the first place, these prohibitions, being contradictory to daily practices, are carried out episodically when they are related to illnesses or bodily disorders. Secondly, as they are associated with pathological or abnormal situations, the prescriptions have been identified with the adult or sick population, which tends to exclude children, who are considered a healthy population. Thirdly, this ranking order contradicts the proposals elaborated by other discursive subjects, as I will detail below.

Nutritionists and health promoters

These subjects propose a discourse centered on “healthy” food prescriptions of a permanent type, in opposition to the medical speech, which is episodic and structured in prohibition and pathologization. Through interaction with nutritionists and health promoters, the population became familiar with issues such as the “plate of good food” and with meanings such as the association between “energy”

and sugar, as evidenced by the talk on “healthy lifestyles” given by a nutritionist at a private nutrition center:

Carbohydrate is what gives us energy, only carbohydrate gives us energy. That is why we cannot live without it. And the brain only eats carbohydrates, the brain eats neither proteins nor fats, that is to say, if you are very hungry and you eat a piece of meat you will still feel uncomfortable because the meat filled your stomach, but the brain does not need protein, it does not do anything because the brain needs sugar... (Field diary)

Unlike nutritionists, who mainly provide individual consultations, health education is the main activity of health promoters. Most social workers, although they reproduce the discourse of lifestyles, do not receive biomedical training and even in the case of Nuevo León their curriculum does not include any subject related to health. The information they transmit is based on different manuals provided by the authorities that they “translate” and “adapt” to the population.

The circulation of such information follows an institutional hierarchical order; similar to what Briggs has reported (2003). The thematic content is decided at the central level, which corresponds to the Federation, then it is received by the State Health Promotion Directorate and, from there, it is replicated by health promoters of different hierarchies until it reaches the operatives, who reproduce the information to the population, assisted by “volunteer” promoters, residents of the populations to whom the information is addressed.

This form of discursive reproduction generates continuous resignifications during the circulation of the discourse and, therefore, the information received by the population is similar to the local common sense, with a tendency to underestimate childhood obesity.

The following is an excerpt of a conversation I had with a promoter at a health center I went to, pretending to be the parent of an obese child seeking educational talks.

If he is not physically active, if he is watching too much TV, those are the factors that make him overweight - she smiled, made a gesture of unconcern and continued talking-, but he is young, he is will be fine. Don't worry. When the parents work and leave them with the grandparents -the promoter made an expression, pretending she was talking to a child-: "what does my little boy want to eat?" Then the greasiest is the tastiest, isn't it? [Laughs]. (Field diary)

Government programs

Contact with the medical institution was intensified with the government's program Prospera², which consisted of conditional cash transfers. One of these conditions was attendance at prevention "talks," which included the promotion of "healthy lifestyles." With this program, the population interacted with nutritionists and health promoters, discursive subjects who, as I explained, structure a different discourse from that of physicians. The program disappeared at the beginning of 2019, so the population stopped attending the talks and, therefore, health education actions focused on individual consultation or in schools.

School facilities are an important device for introducing the lifestyle discourse to the community using the national program "Salud en tu Escuela" (Health in your School). As part of its lines of action, the promotion of "healthy habits and behavioral changes" is established (México, 2017) via talks aimed at schoolchildren about nutrition, given by promoters from the Ministry of Health who go once a month to schools.

According to a conversation held with the head of the Directorate of Crime Prevention, this agency has also incorporated into its actions the promotion of "healthy lifestyles" from a broad perspective of prevention and security. To this end, auditors such as nutritionists and other agents entered in the community, and, as in my case and with dissimilar interests, they reproduce a similar

discourse. The Directorate of Crime Prevention has used the intervention more for the purpose of questioning and approaching the population, considering the high incidence of crime in the area, as stated by a police officer from the "Regios Trabajando" program.

The discourse of "lifestyles" has focused on the implementation of individual actions (Menéndez; Di Pardo, 2009) which, without considering the material conditions of the population, reproduces a moralizing discourse that holds individuals responsible and tends to propose ideal practices that are unsustainable in the medium term, which encourages the episodic nature of the adoption of the prescribed practices.

Alternative medicines

In my visits to the district, I identified the existence of three spaces where private companies organize meetings in which they propose medicalization practices focused on the consumption of food supplements. According to their discourse, the products offered, elaborated on the basis of "scientific knowledge," provide better nutritional contributions than foods considered healthy.

During my attendance to one of these spaces, the "promoter," in whose house a nutrition talk was organized, mentioned that by consuming one of the milkshakes made by the company one could obtain many more nutrients than by eating any food, so that drinking one milkshake in the morning and another one at night was enough to "nourish" oneself. Another central element of this discourse lies in its conception of "natural" and the "loss" of nutrients involved in the process of distribution and storage of products. This general lack of nutrients is the main justification for people to buy their vitamins and products.

Unfortunately, we live in a world where everything is processed. The meat we eat is full of hormones. You people eat vegetables, don't you? You take care of yourselves. Do you eat

² Prospera was a government program aimed at addressing poverty, health and education of the Mexican population, in force from 1995 to 2018.

salads and fruits? That's fine -smiles-. If we lived in the countryside and picked our apples, our chard, it would be fine. But we don't. The apple you ate today -the person talks and points to an assistant- was frozen for months. It has no more nutrients... Why do you think there is so much obesity? We have no nutrients to help our metabolism... (Field diary)

Unlike the previous types of medicalization, which prescribe restrictive or selective practices, the discourse of alternative medicines proposes a consumption of medicines that generates a type of commercialized medicalization called "medicamentation" (Williams; Gabe; Martin, 2012). This process has encouraged substitution practices that, as I will discuss later, are relevant to understanding "refraction practices."

I thus identify three types of feeding discourse: the first I call "restrictive." It consists of reducing or eliminating certain foods and although it is associated with physicians, its logic is manifested in different types of "diets." The second, of a "selective" type, proposes to discriminate foods according to their identification with health. The third corresponds to the order of "medicamentation," through products that "promise" better health if consumed.

Media

The three above-mentioned discourses circulate in the media simultaneously. During a workshop, the discussion focused on "diets" that women follow daily. They named several that they learned about on Facebook or that were shared via WhatsApp, such as the "keto" diet, which consists of consuming only protein. They also pointed out some recommendations associated with selective discourse; for example, eat salad first before any food. Of course, advertisements for "weight-loss" drugs abound.

On the television channels most watched by the surveyed population (Multimedios and Televisa) a product called "Sabifrut" appears frequently, advertised as "a drink made with real aloe vera."

The first shot of the advertisement frames a woman, presumably the mother of two smiling

girls. Her voice explains the production process of the merchandise based on images typical of a rural context. The woman enunciates the phrase "it is good for my family," accompanied by the image of a physician, who lists the components of the drink and its benefits.

The use of symbols associated with health, such as the natural, and the authority figure of the physician is frequently used by the harm reduction industry, as Nichter (2006) has called it. This discursive strategy has been quite effective. According to the survey conducted, "Sabifrut" is one of the sugar-sweetened beverages most consumed by children in the studied community.

Authorized knowledge

A fundamental element in understanding the reasons why the population accepts the information received is the configuration of this information as "authorized knowledge" (Browner; Press, 1996), which, according to the authors cited, is a body of standardized knowledge, with a high degree of formalization, but above all with greater legitimacy than other knowledge due to the effectiveness attributed to it and the position of power of origin. As I explained above, biomedical discourse constitutes an authoritative body of knowledge among the studied population.

The media also constitute a field of authorized knowledge. Contrary to what Browner and Press (1996) point out, I consider that the norm is not dispensable to configure authorized knowledge, as is its capacity to guide behaviors.

During the workshops, I noticed that women had developed certain practices, such as avoiding some products, based on information shared on Facebook or WhatsApp. One of them avoids buying and consuming milk products, after news spread on social networks that they were associated with cancer. For a similar reason, the "minichef" group avoids eating sausages.

Notwithstanding the authority of the various discursive subjects, the population frequently questions their prescriptions. For example, on one occasion a woman from the community told me that the diagnosis of her son's childhood obesity,

made by a physician during a consultation, was because the professional “was not very good.”

The diversity of subjects and devices that prescribe feeding practices gives rise to a contradictory discursive reproduction. According to my observations, the population has developed a strategy to deal with these contradictions: choosing those fragments of information that are congruent with explanatory models practiced in their daily lives. In this sense, the information is “refracted” on the basis of discursive discrimination.

Refraction

One of the women who had previously mentioned that she liked salads commented that she considered healthy to eat green vegetables, alluding to the fact that “green” was “natural.” Subsequently, she added that during her consultations it had been explained to her that she had to eat natural products. This participation was accompanied by another participant who said that as these products were from a farm and, in her opinion, healthy was the most natural, it was not contaminated. In rural life everything was healthier, since it came directly from nature. (Field diary)

The participant mentioned above valued clearly and positively the medical prescription, since it coincides totally with the previously established association between what is natural and what is healthy. This semantic association is frequently reproduced in social networks, particularly by the concern expressed by different users about processed foods, especially users who, at the same time, are subjects associated with medical institutions.

This opposition between the natural and the processed food recalls the work of Mary Douglas (2003), in the sense that the artificial, which is added, contaminates, configuring an ordering structure of meanings that makes it possible to distinguish those foods that are permitted or desirable from those that should be restricted. This ordinance has been well exploited by the “harm reduction industry” to advertise food products.

Like Douglas (2003), I believe that the constant informational contradictions inherent in polyphony generate ambiguous messages. Insofar as they cannot be easily incorporated into the established order in the structure of meanings, they constitute open spaces for resignifications and therefore for refractions.

From this perspective, it is possible to propose that part of the persistent consumption of soft drinks, particularly Coca-Cola, can be explained as a product of a refraction of the semantic association between sugar and energy reproduced especially by subjects belonging to medical institutions. These people refer to the biomedical meaning of energy as a metabolic capacity indispensable for life. In contrast, for the population “energy” has connotations associated with bodily and mood sensations. During fieldwork, I observed in different occasions that people drink Coca-Cola when they “need energy” or their blood pressure is “low.” In this logic, children drink this beverage when adults notice them “weak” or “sad.”

Of course, as I noted earlier, material possibilities are important elements of refraction. During a conversation, one of the workshop attendees told me that she followed the nutritionist’s recommendations as far as economically possible. After this, I simply “buy what I can afford,” she said. As we said goodbye, she showed me a container with oat, pointing out that it was what had left and that it might not be enough to complete the instructions of a prescription book acquired via WhatsApp, which included the consumption of oat five times a week.

Other determinants of refraction correspond to pragmatic elements such as time. On another occasion, a conversation with another workshop participant was interrupted by the crying of her grandson. The woman got up and took a plastic container out of the refrigerator, opened it and gave it to the baby, who immediately took it as if it were a baby bottle. The woman indicated that it was apple baby food, showing me with satisfaction that it was low in sugar. Later, she explained that, for her, who had to get up very early in the morning, make breakfast for her children and husband, go to work as a maid, come back to prepare food and

then take care of her grandson, it was very useful to find practical products that would save her time.

Behind this pragmatism are precarious material conditions, accentuated by a feminization of care, which in this case falls on grandmothers, who help their daughters take care of the children while they fulfill their working hours.

The discursive refraction generates diverse practices whose purpose manifests a concern for protecting children's health. In one of them, which I call "substitution practice," a product considered harmful is replaced by another, as in the case of adults consuming light products. In the case of children, soft drinks have begun to be replaced by juices or sugary drinks that are advertised as natural products. An example of this, as already mentioned, is the consumption of "Sabifrut."

Another common practice in the community is to manage food according to a schedule. For example, children are restricted from consuming junk food, but it is allowed on weekends or at parties. These practices, which I call "restriction," try to reduce the harm of a product by controlling its consumption.

During a meal at a family's home, when distributing the soft drink, the grandmother served herself only half of the glass, filling the remaining half with water. When I asked the reasons for this behavior, the grandmother replied that drinking "too much" soft drink was harmful. When I asked why the same criteria had not been applied to the children, she commented that they were not sick. A neighbor invited to the meal commented that she did not give soft drinks to her children, preferring to give them drinks that she had seen on Facebook that "purify the blood." According to some videos, he showed me, these were products with aloe vera whose purifying effect was explicitly pointed out. (Field diary)

Children are excluded from some restriction measures, but at the same time, they are subject to practices whose justification is to provide them with better health. In other words, the avoidance of harm is not the only element involved.

During a talk for diabetics at a health center, the nutritionist indicated that to treat hypoglycemia it was advisable to eat some apples, although the effect was greater if they were boiled. One of the assistants, seated behind me, commented that from that moment on she would give boiled apples to her son.

The desire for the health of children is a more important incentive for feeding practices than those aimed at avoiding harm, although many of these, as I have been explained, are refracted by the population.

Discussion and conclusions

From the discursive subjects and devices identified in the prescription of feeding practices in the study area, I recognized the presence of three types of discourse: restrictive, selective and that associated with medicamentation. These findings demonstrate the polyphonic and contradictory nature of the nutritional prescriptions that the population receives daily. The discursive discrepancies are articulated and inserted into a material and meaningful structure through a process that I call "refraction," generating food practices that are incomprehensible or even undesirable for the health authorities. It could explain the poor results obtained for the adoption of healthy practices, particularly for children, from the perspective of these authorities.

Despite their contradictions, these discourses have four elements in common: (1) they are prescriptive, (2) they individualize the problem, (3) they explain the situation through a biological conception, emphasizing the "natural," and (4) they appeal to an authority figure, particularly a physician. These elements constitute the structure of a biomedical discursive genre, which punctuates its dominant character and highlights the polyphony of medicalization processes in social groups. On the other hand, it confirms the link that exists between the biomedical nutritional discourse and the food industry, as Marion Nestle states (2018).

Another contribution consists of showing the authority that the media and social networks

have in the production of feeding practices, a circumstance that should be incorporated in the studies of medicalization processes, considering that the little incursion of public instances in these technologies has left a communication niche for health to the market. In this sense, there is sufficient evidence in the literature to demonstrate the effectiveness of the use of electronic media for the modification of feeding practices (Gamboa-Delgado; Izeta; Amaya-Castellanos, 2018). However, these strategies tend to consider the subjects as passive recipients of information, particularly children (Equipo Editorial, 2013), an aspect questioned in this paper and which should be considered in the design of health policies.

Regarding the limits of medicalization, several studies have suggested that the contradictions between the health information known by the population and its practices can be explained by an inadequate perception of risk (Hossain et al., 2019).

Nevertheless, in the light of the ethnographic findings of this work, it is possible to question this affirmation. I believe that, indeed, the information provided has important limits to induce food practices, but not because of its content or its ineffectiveness in communicating a risk, but because of the polyphonic and contradictory characteristics of its reproduction.

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