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Healthy eating, health care and gender: perceptions of men and women from the Northwest region of Santos-SP

Alimentação saudável, cuidado e gênero: percepções de homens e mulheres da Zona Noroeste de Santos-SP

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Abstract

This study examined the perception on health and healthy eating, as well as on food dynamics, of men and women from a economically vulnerable area. It is a qualitative study with semi-structured interviews with adults living in an area covered by a Family Health Unit. Reports of conceptions of health were heterogeneous, and respondents defined health as absence of disease and stress and as healthy habits and lifestyle. Most people associated the intake of fruits and vegetables with healthy eating while the intake of fat and sugar was considered inadequate. There are few differences between the discourses of men and women with regard to the perception of health and healthy eating. However, when it comes to food dynamics, men appear as protagonists only in celebrations with food, when they help their wives or when they wish to cook something different. In some cases, it is up to men to offer resources to food purchase, thus reinforcing the traditional role of males as providers and that of females as responsible for the family's feeding. The vulnerability of the territory did not appear in the discourse as a factor that influences their perception of health and healthy eating. Given the predominance of health initiatives based on risk reduction and standardization of bodies and lifestyles, the differences between men and women as regards their perception of health and healthy food turn gender into a relevant category in the field of health care nowadays.

Keywords: Health. Feeding. Gender. Culture. Food Habits.

Resumo

Este trabalho analisou a percepção de saúde e alimentação saudável, bem como as dinâmicas relacionadas à alimentação, em homens e mulheres de região de elevada vulnerabilidade. Trata-se de estudo qualitativo com entrevistas semiestruturadas com adultos residentes na área de abrangência de uma unidade de Saúde da Família. Os relatos sobre as concepções de saúde foram heterogêneos, e os entrevistados definiram saúde como ausência de doença, estresse e problemas na vida; hábitos e estilo de vida saudáveis. Em relação à alimentação saudável, a maioria das pessoas a associou ao consumo de frutas, legumes e verduras, enquanto a ingestão de gordura e açúcar foi considerada inadequada. Há poucas diferenças entre os relatos de homens e mulheres quanto à percepção sobre saúde e alimentação saudável; entretanto, quando se trata das dinâmicas alimentares, o homem aparece como protagonista apenas em celebrações, para ajudar a mulher ou quando sente vontade de cozinhar algo diferente. Em alguns casos, aos homens cabe ofertar recursos para aquisição dos alimentos, reforçando seu papel tradicional de provedor e a responsabilidade feminina de cuidar da alimentação da família. A vulnerabilidade do território não apareceu nos discursos como um fator que influencia a percepção de saúde e alimentação saudável. Diante da predominância de ações de saúde pautadas na redução de riscos e na normatização de corpos e estilos de vida, as diferenças entre homens e mulheres em relação à percepção sobre saúde e alimentação saudável colocam a categoria "gênero" como relevante no cuidado em saúde na contemporaneidade.

Palavras-chave: Saúde. Alimentação. Gênero. Cultura. Hábitos Alimentares.

Introduction

Scliar[1] identifies five distinct moments throughout the history of Health, namely: magical, empirical, modern, authoritarian, scientific, and social. In the first two, diseases related to natural/supernatural elements and a duality between body and mind were respectively observed. In the authoritarian period (eighteenth century), the absolutist state would demand solutions for the pestilences of the time based on the population's behavior change. The modern period (nineteenth century), with the development of sciences and research, is characterized by the search for a normal biological state. The scientific period, in the context of the Industrial Revolution, would be directed towards containing epidemics and maintaining the working class's health. The social

period, at present, is characterized by focusing prevention, an approximation with the population and the presence of subjective factors in the health-disease process.

From this perspective, the concept of health reflects economic, political, cultural, and social factors, as well as individual values, and scientific, religious and philosophical conceptions. The historical process therefore permeates the interpretation of issues related to the health-illness-care process.[1]

At present, risk has become the main element for the development of health care actions and recognizing and reducing risks have become the main objectives of interventions both from the Public Health perspective and from clinical perspectives, including what is related to food. However, current discourses on health care, the search for a perfect body, and a healthy way of life are part of most normative strategies of human life.[2]

In terms of nutrition, the focus on epidemiological risks leads primarily to professional practices based on the relationship between nutrient intake and the increase/decrease of the chance of becoming ill and/or dying, restricting actions to food prescriptions, understood as healthy, and reducing the complexity of food and current eating.[3,4]

In this context, health, body and food are understood as a historical and cultural object, thus capable of social control. Perceptions and concepts about what health is, as well as what healthy eating is, are mutant and rebuilt in the daily lives of subjects and collectivities.[5] In the context of contemporary food, adequately eating is one of the habits of a healthy way of life that is defined as the search for eating moderation, following a healthy eating proposal based, in most cases, on the dichotomy between what is allowed and what is forbidden.[6]

Culturally and historically, women and men understand and relate in different ways to health and nutrition, insofar as the way of conceiving the masculine and the feminine implies certain models of bodies, values and behaviors to be followed by people.[5] In health, one important difference concerns the way men and women seek health care. It is known that women seek more basic care services when compared to men and they tend to seek specialized health services, distancing themselves from actions of health promotion and disease prevention.[7]

From food perspective, Contreras & Gracia[6] have shown differences found in the simple act of cooking, illustrating that in many cultures women are linked to food at home, while in societies where cooking is gaining a distinct status the role of chef cook is delegated to men.

Considering the professional challenges facing the current panorama of health and illness, the social construction of gender and the health/healthy concepts and the sovereignty of scientific discourses in detriment of lay knowledge, this article has analyzed the perception of health and healthy eating, as well as the dynamics related to food, from the perspective of men and women resident in a region of high vulnerability in the Brazilian city of Santos, São Paulo.

Methodology

A qualitative approach study was carried out. According to Minayo[8] (p. 623):

> Understanding is to exercise the capacity to put oneself in someone else's shoes, since, as human beings, we are able to exercise this understanding. To understand, one must take into account the individuals' singularity because their subjectivity is a manifestation of total living. But it is also necessary to know that people's experiences take place in the context of collective history and are contextualized and involved by the culture of the group in which they are inserted.

The research was carried out with residents of an area covered by a Brazilian government Family Health Unit (USF, in the Portuguese abbreviation) located in the Northwest area of the city of Santos, São Paulo. Seven men and nine women, aged between 20 and 40 years, were interviewed after signing an Informed Consent Form (ICF). The study was approved by the Research Ethics Committee (REC) of the institution (Instrument no. 733141 of July 30, 2014).

The data collection was performed through semi-structured interviews and the transcripts were analyzed by the technique of content analysis.[9] The information obtained was grouped into four categories: 1) On the site and population studied; 2) On constructing the concept of health and the search for care; 3) On constructing the concept of healthy eating; 4) On the dynamics of food. The speeches were identified with W (woman) and M (man), considering the gender category as an analytical boundary of the speeches.

Results and Discussion

On the site and population studied

The area has received a very intense migratory flow in the last decades and has about 100 thousand inhabitants. Despite the existence of medium-standard housing, a large part of the community lives on stilt houses, without an adequate access to sanitation and basic infrastructure, which has repercussions on living conditions and health of those who live there.[10]

The territory studied has several establishments that market food, such as bars, grocery stores, vegetable retail shops, free markets, and some supermarkets, specifically on the main avenue of the region that connects the Brazilian municipalities of Santos and São Vicente, and various wholesaler networks stand out.

The USF participating in the study covers four very heterogeneous regions. Region 1, geographically close to the USF, is characterized by masonry houses and well structured houses.

Region 2 consists of a government subsidized housing. Region 3, called "paths," presents extreme social vulnerability, represented by simpler residences and stilt houses. And finally Region 4, farther from the USF, has masonry houses in an area of intense commerce and many health, education, leisure, and cultural facilities.

Sixteen interviews were carried out, four of them from each region, totaling nine women and seven men, aged between 20 and 40 years. Respondents did not present marked differences according to the areas of residence, with fourteen individuals contributing to the family income, alone or sharing this with a family member.

Of the nine women interviewed, seven share the income with other family members, one is responsible for the family's total income, and one does not participate in the family income. Regarding men, of the seven respondents, three share the income, three are responsible for the total income, and one does not participate in the family income.

With regard to food preparation, 15 of the respondents report that a woman is responsible for the food preparation. In relation to food purchases, 11 people reported being an activity exclusive to women, while three reported it being an activity shared with other family members. Only one man reported being solely responsible for procuring and preparing food.

On constructing the concept of health and the search for care

Regarding health conceptions, respondents' answers were heterogeneous and point to three directions: absence of disease, adequate habits, and absence of problems such as stress.

The first aspect concerns the conception of health related to absence of disease, reported by four women and one man:

> [...] Having no serious health problem, controlling hypertension, not being diabetic, controlling... performing physical activities and avoiding addictions. Thank God I have none. Every once in a while I have a beer. That's it: preparing for old age that shall come. (M8)

> Living better, having no pain. Quality of life, moving forward in life without being bedridden, this is already health. (W2)

The concept of health understood as the absence of diseases is evidenced in several studies with different audiences, such as by Dias,[11] who has studied mothers of children up to two years old living in a municipality in the Brazilian state of Minas Gerais, and Silva & Bessa,[12] in a research with elderly people from the outskirts of the Brazilian city of Fortaleza, CE.

Statements also point to a concept crossed by habits such as physical activity practice and absence of addictions, and the term "control" appears as necessary for maintenance of health.

> [...] lifestyle. The way a person is living, what they are eating, education. I think all this has to do with health. (M7)
>
> Health? Eating properly. Sports. (W11)

Separavich & Canesqui[7] show that, for men, health and body care means the practice of physical exercise in the first place, followed by seeing a doctor in extreme circumstances.

Two respondents defined "health" as the absence of problems related to subjective aspects such as stress.

> [...] a person feeling well. With no problem at all. With no stress and nothing like that. (W10)
>
> [...] having no 'headaches,' you know? Like me... I have high blood pressure, cholesterol, everything... (W16)

In this context, headache must be understood not as a physical pain but as stress, annoyance. For the respondent, the problem does not appear to be her hypertension condition but its causes or even the difficulties that the treatment may bring to everyday life.

The meaning present in these discourses shows health as dependent on the individual's social context. According to Minayo,[13] "life's anxieties" were the main cause of health problems among adult men and women living in favelas (slums in Brazil within urban areas) in the city of Rio de Janeiro, being responsible for the emergence of other ills and associated with a series of symptoms and many complaints. The author relates this problem to a "feeling of oppression and an insane difficulty in carrying out family projects, all built on surviving in everyday life" (p. 368).[13]

One of the respondents believes that climatic conditions directly interfere with her health: "Health for me is linked to the weather. If it is too hot, I feel terrible. A cooler weather makes everything perfect for me" (W10). Climatic factors influencing health were also pointed out by Minayo,[13] insofar as factors of nature were related to anxiety, body pain, chronic diseases recrudescing, flu and colds.

When questioned about what they believe to be good health, respondents reported daily habits: "Three things, in my opinion: sleeping well, eating well and performing physical exercises." (M8). A relevant part of the respondents (11 individuals) said that what is good for their health is healthy eating or good nutrition associated with physical exercise: "Healthy eating, physical exercises and also much liquid. To keep it up." (M3). And one of the women associates health with hygiene

and basic sanitation practices: "Physical exercises, healthy eating habits, correctly washing hands, sanitation and such things" (W1).

The respondents' statements seem to agree with a discourse of polarity, as discussed by Costa & Bernardes,[14] which point out that in classifying health as an absence, a complex situation of bipolarity is created, in which disease and health are in an opposition relation and the opposition implies affirming health by negating disease.

When asked about measures taken when facing a health problem, most respondents replied that they visit doctors or health facilities. Self-medication as a care strategy was recurrent, especially in cases of symptoms already known and previously experienced.

> [...] I see a doctor. I take medicines. If I know what it is, I already have the medicine at home, I have already gone through this situation some other time and have the medicine at home, then I self-medicate. (W1)

Minayo[13] argues that the biomedical standard is the dominant model of "care" and that it has mechanisms of approach, advertisement and imposition that legitimize it. According to Mandú & Silva,[15] individuals choose drugs as resources for solving health problems influenced by advertisement and stimuli resulting from health services biomedical practices which are difficult to leave without a prescription.

The difficulty of accessing services and taking care of health problems was pointed out by two respondents, including the difficulty of not being able to have a follow-up on both public and private health services:

> [...] I have medical insurance but I hardly ever go to the doctor! You go to a polyclinic e get nothing. Then the health insurance cost has risen... I had to do it. It is outrageous. I haven't used this health insurance yet. When it is not possible, I buy some medicine at the drugstore and try not to think about it. (W15)

On the other hand, one of the respondents explicitly states that gender patterns are related to how health is handled, that is, that men seek less health services.

> [...] I don't try to know anything, no prevention, nothing, you know? Men's stuff, right? (M11)

Braz[16] and Gomes et al.[17] have concluded that the construction of masculine subjectivity and the understanding of what it is to be human make it difficult to adopt self-care practices because as men are seen as virile, invulnerable and strong, seeking health services, under the perspective

of preventing diseases, could be associated with weakness, fear and insecurity. It could, therefore, bring them closer to the representations of the feminine universe, which would imply possibly mistrust about this socially instituted masculinity. This puts them in a position of physical and mental vulnerability, since they can not admit fragility or illness, which makes them susceptible to risks of aggravating a disease that could be avoided.

On constructing the concept of healthy eating

Of all respondents, 13 defined "healthy eating" with eating fruit and vegetables. Associations were also made between healthy food and the absence of fats and oil, and the presence of meat and fish.

> [...] fruit, vegetables, not much oil, not much fat... This is healthy eating indeed. (M3)
>
> [...] vegetables! I think vegetables are healthy... salads... And I think meat is healthy and fish is healthy. (W4)

In many responses it was noted that consumption of fat and sugar is considered aversive, which is definitely not compatible with a healthy diet: "[...] No way you can say lots of fat is healthy... lots of candies." (W4).

One of the respondents mentioned that healthy eating means "having all kinds of nutrients that the body needs." (W1). In this sense, Sant'Anna[18] deals with the current new trend of producing "functional food," that is, foods that are consumed aiming the bioavailability of nutrients that bring some benefit to organisms. According to Freitas & Santos,[19] the meaning of health and healthy eating, in a context of subjectivities, is permeated by biomedical discourses, which lead individuals to reproduce normative discourses (fruits and vegetables, for example) detached from the history of people, family and communities.

Although it was not possible to notice differences in the content of the interviews between women and men, when the topic was healthy eating, one of the respondents stood out, in that she classified eating well as eating what she wants, associating the habit of eating vegetables with people being choosy:

> Well, girl... eating well. Whatever you want! With beer. No such things as fats, these picky eaters' stuff. Eating well and that is it. I love junk food! I really do! This vegetable stuff routine, this is for picky eaters. Having a Brazilian Feijoada is eating well. And having beer. (W9)

In this context, the duality between food and nutrition presented by Villagelim[4] is inserted when it relates nutrition to biological components and eating to social and cultural components and the senses. For the respondent, in a singular context, her food experience and life history allow us to construct another meaning for eating well, distant and resistant to hegemonic discourses. The meaning of food is the result of the experience in a social world and feijoada, mentioned by the participant, is a symbolic capital, an identity for Brazilians and the region studied. There are meanings and symbols that announce definitions based on how individuals enter the world and as resistance to a hegemonic discourse about patterns of food and bodies that associate the idea of healthy with a certain aesthetic pattern, especially for women.

Another issue pointed out is the relationship between healthy eating and "food allowed," resulting from prohibitions/restrictions, as treatment for some pathology: "Eating only what is allowed. I'm only eating a spoonful of rice, beans, I'm not eating fat, I'm not eating bread because of prediabetes" (W13), which indicates that food has gained a new meaning from the need for restriction due to some disease, such as diabetes.

When questioned if they consider themselves as healthy eaters, most of the participants affirmed positively, except for two respondents, who reported having eating problems related to lack of time to eat on schedule and the consumption of certain types of foods, high in calories:

> I don't think so. Actually I never follow a schedule for eating. Usually it is always good to have an eating schedule. My life is hectic, I've got no time for this. (M11)
>
> Not a bit. Because I'm going to have some egg, some fried foods, plenty of pasta, and lots of soda. (W10)

Azevedo[3] argues that food has undergone a process of rationalization that gives it a dietary character, with an enormous influence on the population's understanding about healthy eating, conceived as having foods with low fat, salt and sugar, rich in fruits and vegetables. The restrictive aspect of this perspective follows the idea of healthy eating in an "energy-quantitative" aspect.

One of the respondents reported that he considers the diet partially healthy, since he can not lose weight by following the diet routine he has: "Sort of... As much as I decrease (food consumption), I am unable to lose weight, I always keep the same weight" (M2). In this context, Witt & Schneider[20] point out that concerns about beauty are in the spotlight for all humanity and aesthetic care has been spreading every day. This process has a major impact on self-image, especially among women, who feel compelled to have a lean body.

Santos et al.,[21] in a reflection paper based on a bibliographical review, affirm that dissatisfaction with the body is systematically produced, causing women, especially those of low socioeconomic levels, to feel that they are always far from what is the valued – and unreachable – standard as an ideal.

Scagliusi et al.,[22] in a quantitative study on body dissatisfaction of mothers residing in the city of Santos, including the region of the present study, have shown that the majority of women were dissatisfied with their body sizes, and the practice of restrictive diets and risk behaviors for eating disorders was frequent. These findings reinforce that contemporary society views leanness as an ideal situation for social acceptance among women and rejects obesity, associating fat with disease and lack of control over the body. Exaggerated demands about weight and measures, especially for women, generate personal dissatisfaction and distortions of body image.

Teo,[23] studying the discourse and the construction of common sense about food in women's magazines, has noticed an exaltation of good shape, in an ambiguous relationship between beauty and health, coupled with sometimes misguided eating practices and attested by a statement classified as allegedly scientific and by a socio-aesthetic discourse based on contemporary beauty patterns resulting from a socio-historical moment of valorization of technologies of aesthetics and the defense of individualism and competitiveness.

Historically, concern for body and beauty was restricted to women. Men, from the 21st century, began to worry about their bodies in terms of being strong, powerful and manly, from a well-defined musculature, which shifts the search for the construction of a perfect body from a restricted feminine concern.[24]

The guarantee of food and nutritional security, understood as the right of all to regular access to quality food and in sufficient quantities, without this compromising access to other essential needs, depends on articulated actions that include, besides the price practiced by the market, availability, production, distribution, and physical access to food.[25] The respondents, residing in an area of high vulnerability, did not attribute financial difficulties to a healthy diet, nor did they find it difficult to physically access the purchase of foodstuffs, which could be hampered by the narrow streets and alleys characteristic of Region 3 stilt houses settlement. What would restrict healthy eating was related to the short time for eating, the presence of diseases that demanded food restrictions, and food choices recognized as unhealthy by the respondents, whose reasons could not be explored in this study.

Bertran,[26] in a study with Mexican women from three socioeconomic strata, found that healthy eating is permeated by complex and contradictory issues, which include the wide diversity of food available, the adverse consequences of overeating, and the pursuit of pleasure and perfect bodies, regardless of the social stratum. In the present study, these issues predominated in discourses to the detriment of the issue of social and health vulnerability present in the territory.

On eating dynamics

In almost all the interviews it was possible to identify that, in the family context, female figures represented in the roles of wives, mothers, sisters, and daughters, are responsible for feeding all the residents of the house. This responsibility is as much for the preparation as for the purchase of foods consumed by the family. And in some cases there is the partial division of the other activities not carried out in the kitchen, reported by three men and one woman:

> [...] I live with my parents, three children and my husband... We [my mother and I] buy everything. We go to the grocery store, have a list and bring everything. The only thing they [father and husband] do is to give us a ride from the store. (W4)

Analyzing the relationship between food and gender, it is known that, historically and culturally, it is up to women to prepare food and clean utensils as their "natural" responsibility and as part of caring for the household members.[6] In some cases, men have the role of offering resources for the purchase of foodstuffs, whether financial or related to transportation: "My mother. She cooks. I pay for it, but she is the one who cooks." (H8).

Men appear only in the context of the kitchen, occasionally as the family cook to help their wives or when they feel like cooking. It is not a matter of co-responsibility, but rather of a sporadic participation.

> [...] Because I'm hardly at home. When I'm at home, I do my best to help her. (M11)

When asked about why women are responsible for feeding the whole family, the discourses point to justifications such as "women like to cook" or "they know how to cook and do not work outside the home," which allows us to identify a certain essentialness of the attributions as constituting women's life and universe.

Although important political achievements can be observed in terms of gender equality, in the domestic environment the division of tasks does not seem to have undergone much change. In this study, women are generally responsible for managing the family's food demands, such as purchasing and organizing menus. Other authors show that women are usually recognized as responsible for the family health by means of feeding them.[27,28] For Contreras & Gracia,[6] men participate in tasks that precede cooking, such as the purchase of foodstuffs and also the preparation of some dishes, such as roast meats. Thus, the convenience of ready-to-eat food/meals, the technology of

household equipment, the provision of food outside the home, and the entry of women into the labor market have not removed their role as protagonists in food preparation.

According to Casotti,[29] unlike other spaces in the house, which have ambiguous identities and may be dominated by other family members, kitchens have a feminine identity. They are most often defined as females' spaces in which even women who work full time and do not like cooking report some kind of activity with the preparation of food.

In the family environment, few men cook and their participation in food preparation and other household activities, such as cleaning the house, washing dishes and washing clothes, is small. When they do some of these activities, their work is considered as "helping" women. This happens when women can not perform these tasks, for example, when they become ill.[27]

According to Romanelli,[30] there is a tendency for desexualizing[a] the act of cooking. And as a result of this process, it is possible to identify a reification of the place of male privilege, inasmuch as men's role in the kitchen has visibility in the media and is neatly associated with leisure, a prominent profession, pleasant and restful activities of preparing sophisticated and refined dishes in a social segment represented by entertainers, sportsmen and executives, rather than ordinary men, and in counterpoint to the formal and stressful work environment. Among those interviewed, this occurs even when one considers the difference in context, since men's adherence to food preparation occurs only on special occasions, with the daily food preparation being a feminine task.

Final thoughts

Regarding the concept of health, the population studied stated that having health means the absence of disease, having healthy habits and lifestyle, and not having problems or being stressed. When considering healthy eating, respondents define it as consuming fruits and vegetables as well as controlling the intake of fats. The responsibility of taking care of the family's food, whether buying, choosing or preparing food, in most cases, is the women's. Concerning the perception about health and healthy eating, there are few differences between men and women. The results reveal greater complexities for gender apprehending when it comes to healthy eating and food management, pointing to the richness of the universe to be further explored.

a It should be noted here that sex is a diverse category of gender. The idea of gender denaturalizes the masculine and the feminine, which define and are restricted to the biological dimension. This note is necessary so that we can indicate that, in our understanding, the most adequate word would be "degenderizing" the act of cooking and not "desexualizing."

Therefore, it is necessary to invest in a dialogue between food and gender as an analytical category, because it is strategic for one to be able to understand the meaning of food in people's lives. It is also necessary to invest in the study on individuals' contexts and socioeconomic conditions and to understand how cultural pedagogies of gender affect food inside and outside homes. Increasingly, one must understand issues of femininity and masculinity related to food and eating.

References

1. Scliar M. História do conceito de saúde. PHYSIS: Rev. Saúde Coletiva 2007; 17(1):29-41.
2. Czeresnia D. Ciência, técnica e cultura: o conceito de risco epidemiológico. In: Czeresnia D. Categoria vida: reflexões para uma nova biologia. Rio de Janeiro: Fiocruz; 2012. p. 9-26.
3. Azevedo E. Reflexões sobre riscos e o papel da ciência na construção do conceito de alimentação saudável. Rev. Nutrição 2008; 21(6):717-723.
4. Villagelim ASB, Prado SD, Freitas RF, Carvalho MCVS, Cruz CO, Klotz J, et al. A vida não pode ser feita só de sonhos: reflexões sobre publicidade e alimentação saudável. Ciênc. Saúde Coletiva 2012; 17(3):681-686.
5. Melo CM, Oliveira DR. O uso de inibidores de apetite por mulheres: um olhar a partir da perspectiva de gênero. Ciênc. Saúde Coletiva 2011; 16(5):2523-2532.
6. Contreras J, Gracia M. Alimentação, sociedade e distinção social. In: Contreras J, Gracia M. Alimentação, sociedade e cultura. Rio de Janeiro: Editora Fiocruz; 2011. p. 211-87.
7. Separavich MA, Canesqui AM. Saúde do homem e masculinidades na Política Nacional de Atenção Integral à Saúde do Homem: uma revisão bibliográfica. Saúde e Sociedade 2013; 22(2):415-428.
8. Minayo MCS. Análise qualitativa: teoria, passos e fidedignidade. Ciênc. Saúde Coletiva 2012; 17(3):621-626.
9. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª ed. São Paulo: Hucitec; 2014. 407 p.
10. Mendes R, Capozzolo AA, Lima Junior RT, Andrade V, Souza BM, Silva MGPS, et al. Tessituras e participação: extensão na região noroeste de Santos. Rev. Ciênc. Ext. 2014; 10(1):7-16.
11. Dias G, Franceschini SCC, Reis JR, Reis RS, Siqueira-Batista R, Cotta RMM. A vida nos olhos, o coração nas mãos: concepções e representações femininas do processo saúde-doença. Hist. Ciênc. Saúde-Manguinhos 2007; 14(3):779-800.
12. Silva MJ, Bessa MEP. Conceitos de saúde e doença segundo a óptica dos idosos de baixa renda. Ciênc. Enfermagem 2008; 14(1):23-31.
13. Minayo MCS. Saúde-doença: uma concepção popular da etiologia. Cad. Saúde Pública 1988; 4(4):363-81.

14. Costa ML, Bernardes AG. Produção de saúde como afirmação de vida. Saúde e Sociedade 2012; 21(4):822-35.

15. Mandú ENT, Silva GB. Recursos e estratégias em saúde: saberes e práticas de mulheres dos segmentos populares. Rev. Latino-Americana de Enfermagem 2000; 8(4):15-21.

16. Braz M. A construção da subjetividade masculina e seu impacto sobre a saúde do homem: reflexão bioética sobre justiça distributiva. Ciênc. Saúde Coletiva 2005; 10(1):97-104.

17. Gomes R, Nascimento EF, Araújo FC. Porque os homens buscam menos os serviços de saúde do que as mulheres? As explicações de homens com baixa escolaridade e homens com ensino superior. Cad. Saúde Pública 2007; 23(3):565-574.

18. Sant'Anna DB. Dietética e conhecimento de si. In: Rago M; Veiga-Neto A, organizadores. Para uma vida não-fascista. Belo Horizonte: Autêntica; 2009. p. 83-94.

19. Freitas MCS, Santos LAS. Sobre a fenomenologia do comer saudável no mundo da vida: breve ensaio. In: Freitas MCS, Silva DO, organizadores. Narrativas sobre o comer no mundo da vida. Salvador: EDUFBA; 2014. p. 33-39.

20. Witt JSGZ, Schneider AP. Nutrição estética: valorização do corpo e da beleza através do cuidado nutricional. Ciênc. Saúde Coletiva 2011; 16(9):3909-3916.

21. Santos MA, Garcia RWD, Santos ML. A sujeição aos padrões corporais culturalmente construídos em mulheres de baixa renda. Demetra 2015; 10(4):761-774.

22. Scagliusi FB, Pereira PR, Stelmo IC, Unsain RF, Martins PA, Sato PM. Insatisfação corporal, prática de dietas e comportamentos de risco para transtornos alimentares em mães residentes em Santos. J. Bras. Psiquiatria 2012; 61(3):159-67.

23. Teo CRPA. Discursos e a construção do senso comum sobre alimentação a partir de uma revista feminina. Saúde e Sociedade 2010; 19(2):333-346.

24. Santos ARM, Silva EAPC, Moura PV, Dabbicco P, Silva PPC, Freitas CMSM. A busca pela beleza corporal na feminilidade e masculinidade. Rev. Bras. Ciênc. Movimento 2013; 21(2):135-142.

25. Rocha C, Burlandy I, Magalhães R. Segurança alimentar e nutricional: perspectivas e desafios para as políticas públicas. Rio de Janeiro: Editora Fiocruz; 2013. 225 p.

26. Bertran M. Alimentación e incertidumbre en la vida cotidiana en la ciudad de México: narrativas sobre la alimentación saludable. In: Freitas MCS, Silva DO, organizadores. Narrativas sobre o comer no mundo da vida. Salvador: EDUFBA; 2014. p. 33-39.

27. Assunção VK. Comida de mãe: Comida de mãe: notas sobre alimentação, família e gênero. Cad. Espaço Feminino 2008; 19(01):233-253.

28. Fonseca AB, Souza TSN, Frozi DS, Pereira RA. Modernidade alimentar e consumo de alimentos: contribuições sócio antropológicas para a pesquisa em nutrição. Ciênc. Saúde Coletiva 2011; 16(9):3853-3862.

29. Casotti L. À mesa com a família: um estudo do comportamento do consumidor de alimentos. Rio de Janeiro: Mauad; 2002. 157 p.

30. Romanelli G. O significado da alimentação na família: uma visão antropológica. Medicina 2006; 39(3):333-9.

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