THEMATIC ARTICLE

DOI: 10.12957/demetra.2017.28699

‘I ought to reeducate myself’: normative discourses and eating practices related to weight loss in women of the popular strata

‘Eu tenho que me reeducar’: discursos normativos e práticas alimentares relacionadas à perda de peso em mulheres de camadas populares

Tatiana Coura Oliveira[1]
Dina Czeresnia[2]
Eliane Portes Vargas[3]

[1] Universidade Federal de Viçosa, Instituto de Ciências Biológicas e da Saúde. Rio Paranaíba-MG, Brasil.

[2] Escola Nacional de Saúde Pública Sergio Arouca – Fiocruz. Rio de Janeiro-RJ, Brasil.

[3] Instituto Oswaldo Cruz – Fiocruz. Rio de Janeiro-RJ, Brasil.

Correspondence
Tatiana Coura Oliveira
Instituto de Ciências Biológicas e da Saúde, Universidade Federal de Viçosa, campus de Rio Paranaíba. Rodovia MG-230 – Km 7, CEP 38810-000. Rio Paranaíba, MG, Brasil.
E-mail: tatiana.coura@ufv.br

Abstract

The current article is a reflection about how normative discourses related to eating and health are held by overweight women, by considering that these discourses focus on dietary education and reeducation guidelines and actions. Educational feeding practices are historically based on the logic of risk driving the discourse on health, which include obesity-control approaches and interventions. Based on an ethnographic research carried out with women of the popular strata treated at a healthcare center in Rio de Janeiro, the reflections problematize the difficulty of connecting little-detailed information to a reflective and self-care process. The idea of rationality of autonomous subjects informed about the “nutritional value” of food or about the “risk of illness” is translated into guidelines that show limited results. The concepts of dietary education and reeducation found in the informants’ narratives show a model that ignores aspects related to the material conditions and sociocultural identity of the groups, since it suggests habit changes that do not comply with the daily life of these individuals.

Keywords: Healthy Eating Practices. Dietary And Nutritional Education. Overweight.

Resumo

Este artigo propõe uma reflexão sobre como os discursos normativos relacionados à alimentação e saúde são apropriados por mulheres que apresentam excesso de peso, considerando a centralidade destes discursos nas orientações e ações de

educação e reeducação alimentar. As práticas educativas em alimentação estão historicamente assentadas na lógica do risco, que, por sua vez, rege o discurso do campo da saúde, o que inclui as abordagens e intervenções de controle da obesidade. Com base em uma pesquisa etnográfica realizada com mulheres de camadas populares atendidas em um centro de saúde do Rio de Janeiro, as reflexões aqui desenvolvidas problematizam a dificuldade de conectar informações pouco criteriosas a um processo de reflexão e de cuidado de si. A ideia de racionalidade de sujeitos autônomos informados sobre o "valor nutricional" dos alimentos ou do "risco de adoecimento" se traduz em orientações que apresentam resultados limitados. As noções de educação e reeducação alimentar, presentes nas narrativas das informantes, evidenciam um modelo que desconsidera aspectos que se ligam às condições materiais e à identidade sociocultural dos grupos, propondo mudanças de hábitos que não se sustentam no cotidiano das pessoas.

Palavras-chave: Práticas Alimentares Saudáveis. Educação Alimentar e Nutricional. Excesso de peso.

Introduction

The aim of the article is to reflect on how normative discourses related to food and health are acquired by overweight women, considering the centrality of these discourses in educational guidelines and strategies in the field of nutrition. Food education is a conceptual framework in this field as well as in the practice of the nutritionist since the middle of the 20th century. Nutrition was established as a curricular discipline in the first professional training course promoted by the Serviço de Alimentação da Previdência Social (Social Welfare Food Service) (SAPS, 1944).[1-3] However, we believe that the concept of nutritional education promotes a limited understanding of the dimensions that are associated with eating as a social construct.[4] This reflection presupposes that the educational practices in nutrition are historically based on the logic of risk, which, in turn, governs the discourse on health, which includes approaches and interventions to control obesity.[5,6]

Over the past decades, most scientific publications in the field of health have strongly associated eating with the control of diseases, particularly the chronic-degenerative ones.[7] In this scenario, obesity has been pointed out in epidemiological studies as a risk factor for diseases such as hypertension, dyslipidemia, type 2 diabetes, coronary artery disease, stroke, osteoarthritis and

respiratory problems, among others.[8] In the field of nutrition, publications have reproduced biomedical research standards in studies focused on the centrality of the disease, placing greater emphasis on nutritional risk factors related to eating habits rather than on broader questions related to human nutrition.[9,10]

These studies were not restricted to the scientific field as they were widely disseminated throughout the media to the general public.As the studies became available to the public, a concern for health-related issues became central to the daily lives of people.[11,12] One can find several television programs and weekly magazines specialized on issues related to the body, food, and health as well as the digital media, such as websites or blogs, that reproduce scientific discourse about healthy eating.[13-15]

Paradoxically, this increase in production and scientific dissemination of health-related themes is counteracted by the increase in overweight and obesity indicators, as weight excess affects almost 60% of the adult population in Brazil.[16] This scenario makes us question the normative approaches associated with the health discourse, whose limitations have been evidenced. Despite the complexity and importance of the macrostructural aspects in determining the global epidemic of overweight, the environmental nature of the problem is predominantly studied through more restricted concepts that approach the issue from an individual perspective such as risk factors and lifestyle.

As it is a public health problem, the global increase in the obesity indicators leads to the need to reflect on broader issues that are associated with eating practices in their micro and macrosocial context, whose transformations are not restricted to increasing access to nutritional information or prescriptive guidance.[17] The idea of rationality based on the idealization of autonomous individuals who are capable of making 'good choices' from information on 'risk of illness' or 'nutritional value' is translated into normative guidelines that have limited results.[18] This kind of reasoning leads to actions, in the context of health care, that limit the understanding of issues related to weight excess in contemporaneity.

Considering the above-mentioned aspects and based on an ethnographic research conducted in Rio de Janeiro[a] with women from popular strata cared for at a health center, our considerations problematize the difficulty of connecting disseminated information to a process of reflection and self-care, following these guiding questions: how is information provided for food choice? What elements compete in daily choices? How do we perceive the 'educative' character of the nutrition professional in this field?

a Thesis presented to the Epidemiology Graduate Program in Public Health of the National School of Public Health Sergio Arouca of the Fundação Oswaldo Cruz. Epidemiology Graduate Program in Public Health. 2016.

Method

The research field: FIELDWORK AND THE RESEARCH SUBJECTS

In ethnographic studies, theory combines empirical evidence based on a reflexive process of approximation between the researcher and the phenomenon that is to be understood.[19] Reflexivity present in this type of approach privileges research and its intersubjective relationship with social groups. Ethnographic researchcomplies with what and how reflexivity occurs, considering that empirical observation affects the field and social life and it is impossible to isolate the production of knowledge from the subject who produced it. The closeness of the researcher to the phenomenon under investigation is only possible if one understands that theory is inseparable from practice.[19,20]

The study was developed in a healthcare center that offers care to the residents of a set of communities in the territory of Manguinhos/RJ. This choice was made for two reasons: (1) this healthcare center is a reference for health care in the community; (2) security reasons related to the increase in violence in this area due to the aggravation of the economic and socio-political crisis in the country.

Considering the theoretical-methodological perspective of the study, the fieldwork was carried out between September and November 2015, according to the following steps: (1) observation of visits to the outpatient nutrition clinic, meetings of a multidisciplinary support group to overweight service users, and home visits carried out by a health agent in the territory; and (2) semi-structured interviews with twenty-one women from the healthcare service. Then, the organization, analysis and interpretation of the data were carried out based on the literature.

Observation and interviews were performed using previously prepared scripts. In the strategy adopted, the importance of including the point of view of the women interviewed was taken into account, that is, valuing the perspective of those who experience what is being discussed during the interaction with the researcher.[21] This resource was fundamental for a greater understanding of the subject, since the position of nutritionist of the main researcher of the study in the social structure tends to focus specifically on the issues addressed. In this sense, the need to better understand educational actions about food points to the importance of ethnographic studies in the field of food and culture.

The organization and interpretation of the data occurred in two stages. The first one consisted of the transcription of the interviews, reading, and re-reading of the material because the data needed to be sorted and classified. During this stage, the relevant structures and central ideas that stood out in the corpus were observed. The second stage consisted of horizontal and comprehensive

reading of the texts, allowing the construction of empirical categories. We sought to establish connections between the identified units of meaning and the literature. After the organizational analysis and classification, we grouped the classifications to understand and interpret the most relevant and representative aspects in the narratives of the group.[19] The principle of saturation of the addressed issues was adopted in the composition of the study to conclude the interviews.[22]

Characterization of the informants

The designation 'popular strata' or 'popular classes' assumed in this study is based on the anthropological tradition that characterizes certain social segments in urban contexts in Brazil as the "working classes".[23] Therefore, it does not correspond to a definition of the study group carried out exclusively by income classification criteria, but it rather considers broader characteristics that include the symbolic and cultural dimensions of certain social groups, especially those that are part of complex societies, such as the contemporary one, which result from large processes (such as globalization).

The informants were between the ages of 23 and 64 years. Concerning the nutritional diagnosis, eighteen presented different levels of obesity: level I (n = 8), level II (n = 5), level III (n = 5), and the others (n = 3) were overweight. In the family arrangements, consensual union at an early age was more frequent and families consisted of a woman and a spouse with children. In the group, there were also two single informants with children, a widow, and one woman whose husband was in jail.

As for occupations, thirteen interviewees worked in the formal sector in activities related to cleaning and general services (6), health services (4), cooking (1), office work (1), and nursing (1). Among those working in the informal sector, three worked as house cleaners, one as a manicure and one as a collector of recyclable material. There were also two pensioners from the National Social Security Institute (one for time of contribution, another for widowhood), and one unemployed woman. In most families, the income of these women was the only source of income (n = 9), while in the other ones their income significantly contributed to financial supplementation (n = 12). As for schooling, although their occupations required a lower level of education, most women had finished high school (n = 10), some had finished elementary school (n = 7), a few had finished or dropped out higher education (n = 3). Only one of the informants reported never attending school, although she was not illiterate.

Results and Discussion

How is information used for food choice? What elements interfere with everyday options?

The search for an adequate eating standard has become central in the daily lives of people, which is directly connected to life habits and body appearance.[11,12] The idealization of healthy eating, produced in the imagination of post-traditional societies, is closely related to the biomedical concept in the field of nutrition, which has become consolidated over the past decades.[18]

Science, media, and advertising especially contribute to the attribution of meanings to the concept of healthy eating. If, on the one hand, scientific production connected to the theme guides the development of guidelines and normative guidelines on what, how, when and when to eat, on the other hand, echoes of this same discourse are reproduced in specialized health and food magazines, television programs or social networks.[24] In this context, it is important to point out that the Internet has become an important platform for disseminating discourses related to "healthy eating", emerging as a privileged space for searching information, which, however, is biased.[25,26] For the sake of scope and resources, the use of internet is encouraged by some health professionals.

> *I was looking at something on the internet ... I saw a doctor lecturing on the internet ... He said that you have to watch yourself a lot, not to confuse anxiety with hunger. Right? That's what I don't know how to deal with. Am I feeling anxiety? So, I'll walk up and down stairs... No! I'm going to eat ... it's easier, right? (E 15, 29 years, BMI 57.7 kg/m2).*

Science and common sense are closely related. In this context, traditional beliefs have been constantly challenged in view of new ones and with the confusing discoveries of science, which, in a way, weaken the traditional criteria used in food selection and open space for new practices that shape the idea of 'fashion' food.[27,28] In this sense, the "scientific theories" are adequate for the daily life of people and they are resignified by common sense, as stated below:

> *Flaxseed meal, quinoa ... these things I have at home because they were on the news... the ... flaxseed meal to lower cholesterol - so I'm going to buy it and put it in my food, a little bit mixed with the beans... its taste is not great, it tastes like oil ... (...) Quinoa: I put a spoon of quinoa in green juice in the morning, it's good for I don't know what. I watch the news and I pay attention to everything (E3, 43 years, BMI 37.66 kg/m^2).*

The issues present in the narratives of the interviewees draw attention to the scope of access to information as well as to the variety of discourses related to food choice. The discourses are associated with health issues, sometimes with body esthetics, other times with the pleasure of eating, or the guilt of doing so. Fischler[29] calls the plurality of information surrounding the theme

'dietary polyphony', which ultimately generates a confusing set of know-hows, which he calls 'food cacophony'. This profusion and diffusion of information sometimes causes misorientation and doubts regarding food.

The multiplicity of information and appeals are spread through advertising, driving the selling of food and services by appropriation of the technical-scientific discourse and adding therapeutic advantages to advertising.[30] A segment of the food industry still uses the healthy brand to diversify products and advertising. These corporate identities and information are combined with other elements, such as taste, from a Bourdieusian perspective,[31] fomenting the construction of social meanings that guide behavior towards food.

> *"If I see that something is not working, I'll move to something else, I do not insist. For example, what helped me lower cholesterol was eggplant flour. (...) I used to buy quinoa but I don't buy it anymore because I think it is not relevant: eggplant flour is cheaper and the effect is the same" (E21, 57 years, BMI 28.50 kg/m²).*

If, on the one hand, products and "formulas" conveyed in the messages challenge the financial situation of the popular strata, on the other hand, they influence the imaginary of these women as possible alternatives for achieving success in relation to weight loss. Professional dietary prescriptions, often considered and denominated as 'educational practices', are confused with those in the media and associated with the selling of products marketed with the promise of achieving an ideal body shape, as argued by E3:

> *"I was on vacation and walking through Bonsucesso when a girl gave me a piece of paper. Then she invited me to go up to the building to try the product ... I said: I'm in a hurry and she said no, come on! It will take only 10 minutes! So I went. Arriving there, she gave me the shake. She asked me what flavor I wanted ... I wanted strawberries, I love strawberries! She made the strawberry shake. I drank it. I drank the tea. Then she said: Hey, come back tomorrow to take your measurements and so on so forth... then she showed me a bunch of things. (...) I lost 7 kg in two months. But it was very expensive!! (...) In February I went back to work and I couldn't go there every day. (...) I'll sell you the shake to take home and teach you how to make it. (...) I bought it and I started taking it ... this sucks, it's getting hard because I have to spend almost five hundred reais a month! "(E3, 43 years old, BMI 37.66 kg/m²).*

Insecurity and mistrust are often accompanied by a feeling of incompetence: there is a difficulty in well-intentioned, legitimate discourse appropriation regarding healthy eating, whose characteristics, however, do not promote a real approximation of those to whom it is intended. This is the key point of what has been called food education and/or 'educational eating practices': the disqualification of different ways of 'eating'. The idea of reducing eating to a strictly biological level is promoted by the discourse of health promotion granting space for the 'emptying of knowledge' of subjects.

> *(...) I'm going to have to learn a lot. I still have a lot to learn. As I said, the main thing is nutrition: learning how to eat well and healthy, isn't it? (E1, 45 years, BMI 37.8 kg/m²).*
>
> *But I've even discussed it with my husband, we are both chubby ... we will try to educate ourselves ... not only for esthetics, but for health too (E17, 28 years, BMI 30 kg/m²).*

In a similar direction to the logic of risk[32] that governs the health discourse and that is historically based on the premises of educational practices, food education holds the individual accountable since it assumes that people should use reason to make the best choices:

> *The psychologist told me this: the day you put it in your head that food is not a source of pleasure, but just a way to keep you alive, it will help you 90%. But it's hard to think like that! She told me: When you feel like eating ... read a book! I'm going to eat the book! (E15, 29 years, BMI 57.7 kg/m²).*

This situation increases guilt of those who cannot make the most adequate choice in the context of scientific knowledge.

> *I blame myself ... I blame myself for wanting to understand certain things that I don't understand. I didn't study ... my mind is not open to certain things that I did not study ... Because sometimes people say: don't eat bacon, it hurts you. Don'teat it ... Eatanapple. Then I'll say: but I'm in the mood to eat bacon, so I'm going to eat bacon. Because if I don't lose weight and if I feel like eating bacon, I'm going to eat bacon. I think a lot [...] (E13, 54 years, BMI 66.83 kg/m²).*
>
> *(...) I want eating to be something that ... doesn'tworry me. If I have lunch, I want it to be a trivial thing, just like brushing teeth, or combing my hair. Without feeling guilty (E15, 29 years, BMI 57.7 kg/m²).*

Blaming comes from the idealized existence of an autonomous subject capable of establishing cost/benefit relationships in their daily activities.[33] However, the limit of 'free choice' is challenged according to the possibilities and constraints that are arranged in a network of processes that differentiate the real alternatives of individuals and social groups. It turns out that effectively exercised rationality does not always correspond to the one recommended by risk studies, which do not give way to an understanding of the meanings that associate eating as a socially shared practice with sociability, pleasure and objective conditions of life.

There are dimensions related to the broader issues of access and financial resources regarding food consumption. A striking example of the re-signification of food-related discourse was presented by one of the informants who, justifying the lack of bread for breakfast, uses the presence of gluten, from the gluten free perspective, so in vogue recently, instead of acknowledging financial limitation: "(...) Sometimes when I have no bread, I just have black coffee. It is actually good because they say that bread has gluten and gluten is bad" (E12, 31 years, BMI 32.20 kg/m²).

Discourses such as nutrition education, usually undertaken in the context of health care and promotion, have the power and authority to denote social practices as legitimate and therefore healthy. By not paying attention to the wider sociocultural and economic contexts of production, for example, weight excess, this type of strategy sometimes takes on a moralistic tone, producing guilt and suffering in groups of individuals that cannot adapt to the model prescribed. Identifying the dietary practices of 'marginalized' groups as unhealthy has sometimes justified and maintained certain inequalities in healthcare itself: "He [the doctor] gives several instructions. First on diet, leave this one aside" (E2, 47 years, BMI 55.55 kg/m^2).

By not recognizing 'the other', an apparently objective knowledge is created, which, however, limits the understanding of the historical and social conditions that distinguish social groups from each other, sustaining unequal power dynamics and obscuring the fact that what is considered legitimate and healthy may even be temporarily relative.

The logic of the concept of food education based on the perspective of nutritional value and rationality of choices has influenced considerable coping strategies for Brazilian food problems, if not all of them, both in the collective and individual spheres.[2,3,34] A reflexive analysis by Lima et al. [34] on the historical perspective related to nutritional education between the years 1980 and 1998 argues that there is a conceptual shift that marks the transition from the idea of a population in situation of 'food ignorance' to the social representation of nutritionists as educators in the scope of their professional training and practice. However, food education strategies have shown limited advances even though the practice has been adopted in health care and public national policies.[16] This situation gave way to the notion of 'reeducation' as part of the strategies to cope with excess weight that proposes the resumption of pleasure in food through individual self-control. This idealization is present both in professional practice and in the social imaginary.[35]

The complexity of the issue, which will be discussed in more detail below, lies within the limits of autonomy regarding the different possibilities of food choice. In a context of transforming social rules connected to "eating" and the multiplicity of information and advice given to subjects, added to financial limitations experienced by certain social groups, choices are much more complex: "(...) I haveheardthatjuice [powder] iscarcinogenic. What am I supposed to do? It has to be fruit ... fruit is better, but fruit is expensive. So juice has to be made from powder" (E12, 31 years, BMI 32.20 kg/m^2).

Food reeducation: an alternative proposal to diets?

Although poorly contextualized in the scientific literature produced in the field of food and nutrition, the concept of reeducation arises in the 1990s because of middle and upper classes discourses related to an experience associated with healthy eating.[36,37] It is implied that 're-

educated' individuals will no longer have problems with weight as they are aware of what can and cannot be done.

Intimately associated with the idea of lifestyle, the concept of nutritional reeducation is central in the current discourse for the promotion of healthy eating. It also emerges in the popular strata, as it can be seen in the informants' narratives, as something that can meet individual's desires and promote definitive weight loss. In essence, the proposal is against the strictness of diets by resuming the pleasure of eating:

> *(...) I convinced myself that I wouldn't go on a diet, diets are scary!... or regimes, oh my God! I'm re-educating myself! It is less traumatic. Imagine you spending your whole life hearing: diet! diet! diet! My whole life hearing the same thing. It's tiring! (E15, 29 years, BMI 57.7 kg/m²).*

Due to the idea of flexibility and innovation, reeducation presents itself as a strategy for developing taste by redefining eating, as if the resumption of pleasure in doing so could be aligned with the discourse legitimized by the science of nutrition. The idea of flexibility replaces instructions that indicate prohibition, such as "cut" or "cannot eat", as argued by E5:

> *Not me ... let's say ... eat ... it's ... (...)I'm telling you, I re-educated myself every day. I don't drink soda any more. But if I must eat lasagna, I will eat a piece: moderately. Neither gluttony nor despair. Just moderation (E5, 28 years old, BMI 25.1 kg/m²).*

Individuals called to participate in daily learning about what and how much to eat, how and when to eat, exercise control of desires and pleasures connected to food. Moderation is a term associated with the health discourse present in the reeducation proposal. In this sense, a 'healthy condition' would imply a positive expression of their identity, as obesity is supposed to be the result of bad choices. However, this is not an easy task. There are particularities in the possibilities of access and form of consumption among the different social groups to which the market adapts. Economically disadvantaged social groups are more restricted to consuming cheap, practical and palatable foods, which, ultimately, conform to the working-class taste.[31]

> *From what I see on television, you must eat healthy food, salad, and other things ... Now I putcheese in food... [sigh]. And I know it's bad. I eat it with bread, pasta, instant noodles... Are you going to say that this is good? Of course not, I'm not dumb. Can I say that food that is ready in 3 minutes is healthy? It's not! It's not... No way. (...) And we know that we eat poorly, we do, but... (E1, 45 years, BMI 37.8 kg/m²).*

The positive expectations associated with dietary reeducation express the negative meanings attributed to the diet within the group. Issues related to the cost of maintaining the diet, time

needed for food preparation and consumption, and food restriction, are present in the narratives.

> *Because it is not easy to keep a diet today. It's not easy ... It's very easy to say ... ah ... I'm going to eat an orange, a banana, an apple. First of all, in my case, I don't have time (E1, 45 years, BMI 37.8 kg/m²).*

> *I even thought: on Monday, I'm going to start a diet. I'm going on a diet! But I can't (E9, 51 years, BMI 35.58 kg/m²).*

In this sense, reeducation presents itself differently from 'dieting' by proposing permanent changes in eating habits, with self-control being one of the central aspects of the process:

> *I managed to reduce carbohydrates. But I failed... being... more active. There were two goals. So I continued with both because I failed one of them. Being more active is very difficult, very difficult. I'm very sedentary. This one is the most difficult for me. (...) I have to reeducate myself, I am becoming literate in the area of food (E15, 29 years, BMI 57.7 kg/m²).*

As seen in the narratives, reeducation adopts the same strategy as nutritional education: self-care recommendations associated with a normative prescription, which is almost always far from the cultural and financial reality of the informants. People cannot sustain this situation in their daily lives a long time.

> *[...] with a diet you must buy steak every day, which is expensive ... vegetables, which you have to buy every day, are very expensive; and other things. Brown rice... whole wheat bread. And so it ends up becoming very difficult because today you start something, but then you don't have any more money. Then you start skipping things... and you gradually give up (E2, 47 years, BMI 55.55 kg/m²).*

The imaginary possibility of eating everything without feeling hunger, although being attractive, implies making daily choices. However, the exercise of self-control increases responsibility and, consequently, guilt, as pointed out by an informant: "(...) But it is because I couldn't accomplish correct reeducation ... a bad example. But one day I will be able to correctly reeducate myself!" (E17, 28 years, BMI 30 kg/m²).

Individualization of choice is distant from the collective scope, allowing a greater disruption of the socio-cultural construction that is connected to the eating habits, opening space for new rules that can cause some degree of 'gastro-anomia'.[38]This experience requires a continual exercise of discipline and, while seemingly increasing the decision-making power of the individual, actually reinforces their responsibility as well as their anxiety. This increases the search for "nutritional miracles", fostering consumer demands.

As discussed, weight loss programs that reproduce a technical-scientific discourse are re-elaborated within an advertising logic that offers a range of foods and/or remarket existing products.[35] This situation fuels the market that, in addition to offering ultra-processed products as an allegedly healthy alternative, also offers the 'cure' by selling not only products, but also services of higher or lower quality, depending on the target audience. The narrative of E15 expresses the greater exposure of certain groups to the consumption of healthcare services and doubtful services:

> *I went to a doctor in Caxias, who has even been arrested (...). He gave me a formula, a super expensive one! Almost R$200.00. I even have visions with it. (...) I wasn't hungry, I didn't eat ... I would put a bit of the power under my tongue, it made me feel light ... But I had to do order it from a dispensing pharmacy: everything was great! (...) when I stopped taking it, I gained twice as much weight (E15, 29 years, BMI 57.7 kg/m²).*

Market expansion in the context of reeducation is also connected to the use of technology. In the field of nutrition, there is a diversity of applications for cell phones that allow calorie counting, keeping food diaries, monitoring energy expenditure to control water intake, the latter being one of the resources used among the informants. In the context of relearning, the new technologies are incorporated into our daily lives as "important tools" for the self-control process, which are used to foster the promotion of "good health".[39,40]

> *Oh... there is an application that helps keeping track of water intake, (...) it asks for your height, your weight and age to calculate how much water you need to drink and such... I put in all my info: 3.10 liters of water, it didn't round it up to three... But why 10 milliliters? [laughs] It was per weight, right? OK. Then I set the alarm of the application for every 2 hours... (...) If I didn't stop it, a message would soon come: you forgot to drink water. Then I started... a glass... I had a glass of 300 mL, I had to drink three liters per day.... ten glasses. Man, if it's hard to drink one, imagine ten. Every two hours, I started... First day, annoying, drinking water and going to the bathroom to pee... Later, I increased the amount of water on the application to 500 mL because I knew that 500 mL would mean 6 cups a day [...] Now I drink water... I removed the application. Now I drink water correctly (E3, 43 years, BMI 37.66 kg/m²).*

The proposal to "educate again" or "reeducate" as the beginning of a new food order is, to a large extent, doomed to failure because it does not break with the normative and taxing discourse, as observed above. It is important to understand that in addition to the biological necessity inherent to the maintenance of life, we 'eat' according to a social organization and a certain way of producing and distributing food, 'we eat' according to our groups and classes we belong to.[4]When a true debate around the issues that stimulate the current obesity pandemic are not addressed, which are not restricted to nutritional information, reeducation,as currently practiced, will repeat the same model that limits the development of eating habits that are consistent with the daily life of social groups. Just as in the case of dietary prescriptions that deny practices and

dietary experiences associated with the culture of the groups, there is little chance of sustaining proposals for reeducation that try to silence not only the social and affective dimensions, but also fail to consider certain economic and market impositions on "eating".

Final considerations

The aim of this article was to reflect on the normative discourses and dietary practices related to weight loss in women of the popular strata from the idea of food reeducation that emerged from their narratives. Based on the arguments, it was found that the biomedical discourse regulates prescriptive behaviors related to food and the body, disregarding, in most cases, the social situation of the different groups, mainly those in financial vulnerability. These recommendations are far from concrete possibilities of achievement, which increase anxiety and suffering of those who cannot adapt to the prescriptive model. Although the concept of reeducation emerges as an alternative for change among the interviewees, it ends up being as limiting as the conventional dietary prescription because it is also based on a normative perspective of healthy eating. In this sense, what would be the 'educational' role of the professional nutrition? There is no simple answer to this question, what was found, however, is the urgent need to increase understanding and coping strategies for excess weight using approaches that respect not only the material conditions, but also issues that include the culture and identity of social groups. Without further analysis and understanding of the different dimensions that are associated with the pandemic, it is unlikely that the problem of obesity will be reversed.

Contributors

TC Oliveira, D Czeresnia, and EP Vargas participated in all the stages of the article development from the study conception to the final revision.

Conflict of interest: The authors state no conflict of interest.

References

1. Boog MCF. Educação nutricional: passado, presente, futuro. Rev Nutr. 1997; 10:5-19.
2. Lima ES. Gênese e constituição da educação alimentar: a instauração da norma. História, Ciências, Saúde - Manguinhos 1998; 1:57-83.
3. Santos LAS. Educação alimentar e nutricional no contexto da promoção de práticas alimentares saudáveis. Rev Nutr. 2005; 18(5):681-692.

4. Canesqui AM, Garcia RWD. organizadores. Antropologia e nutrição: um diálogo possível. Rio de Janeiro: Editora FIOCRUZ; 2005. 306 p. Antropologia e Saúde.

5. Ayres JRCM. Epidemiologia, promoção da saúde e o paradoxo do risco. Rev Bras Epidemiol. 2002; 5(Supl.1):S28-S42.

6. Azevedo E. Reflexões sobre riscos e o papel da ciência na construção do conceito de alimentação saudável. Rev Nutr. 2008; 21(6):717-723.

7. Duncan BB, Chor D, Aquino EML, Bensenor IM, Mill JG, Schmidt MI, et al. Doenças crônicas não transmissíveis no Brasil: prioridade para enfrentamento e investigação. Rev Saúde Pública 2012; 46(Supl.1):126-134.

8. World Health Organization. Obesity: preventing and managing the global epidemic: report of a WHO consultation. Geneva: WHO; 2000. WHO technical report series; 894.

9. Bosi MLM. Profissionalização e conhecimento: a nutrição em questão. São Paulo: Hucitec; 1996. 205 p.

10. Camargo Jr KR. As armadilhas da concepção positiva de saúde. Physis 2007; 17(1):63-76.

11. Beck U, Giddens A, Lash S. Modernização reflexiva. São Paulo: Editora Unesp; 1997.

12. Giddens A. Identidade e modernidade. Rio de Janeiro: Jorge Zahar; 2003.

13. Castiel LD, Ferreira MS, Moraes DR. Os riscos e a promoção do autocontrole na saúde alimentar: moralismo, biopolítica e crítica parresiasta. Ciênc Saúde Coletiva 2014; 19(5):1523-1532.

14. Santos LAS. Os programas de emagrecimento na Internet: um estudo exploratório. Physis 2007; 17(2):353-372.

15. Farias SJSS, Fortes RC, Fazzio DMG. Análise da composição nutricional de dietas da moda divulgadas por revistas não científicas. Nutrire 2014; 39(2):196-202.

16. Instituto Brasileiro de Geografia e Estatística. Pesquisa nacional de saúde: 2013: ciclos de vida: Brasil e grandes regiões. Rio de Janeiro: IBGE; 2015. 92 p. Disponível em: http://biblioteca.ibge.gov.br/visualizacao/livros/liv94522.pdf

17. Castro IRR. Desafios e perspectivas para a promoção da alimentação adequada e saudável no Brasil. Cad Saúde Pública 2015; 31(1):07-09.

18. Viana MR, Neves AS, Camargo Junior KR, Prado SD, Mendonça ALO. A racionalidade nutricional e sua influência na medicalização da comida no Brasil. Ciênc Saúde Coletiva 2017; 22(2):447-56.

19. Peirano M. Etnografia não é método. Horiz Antrop. 2014; 20(42):377-391.

20. Minayo MCDS, Guerriero ICZ. Reflexividade como éthos da pesquisa qualitativa. Ciênc Saúde Coletiva 2014; 19(4):1103-1112.

21. Fraser MTD, Gondim SMG. Da fala do outro ao texto negociado: discussões sobre a entrevista na pesquisa qualitativa. Paidéia 2004; 14(28):139-152.

22. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saúde Pública 2011; 27(2):389-394.

23. Duarte LFD. Da vida nervosa nas classes trabalhadoras urbanas. Rio de Janeiro: Zahar; 1988.

24. Andrade A, Bosi MLM. Mídia e subjetividade: impacto no comportamento alimentar feminino. Rev Nutr. 2003; 16(1):117-125.

25. Moretti FA, Oliveira VE, Silva EMK. Acesso a informações de saúde na internet: uma questão de saúde pública? Rev Assoc Med Bras. 2012; 58(6):650-658.

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

27. Paty M. A ciência e as idas e voltas do senso comum. Scientiae Studia 2003; 1(1):9-26.

28. Oliveira TC, Czeresnia D, Vargas EP, Barros DC. Concepções sobre práticas alimentares em mulheres de camadas populares no Rio de Janeiro: transformações e ressignificações. Interface 2018; 22(66): (no prelo).

29. Fischler C. Obeso benigno e obeso maligno. In: Sat'Anna D, organizadores. Políticas do corpo. São Paulo: Estação Liberdade; 1995. p. 69-80.

30. Gracia-Arnaiz M. Comer bien, comer mal: la medicalización del comportamento alimentario. Salud Pública de México 2007; 49:236-242.

31. Bourdieu P. Gosto de classe e estilo de vida. In: Ortiz R. Pierre Bourdieu. São Paulo: Ática; 1983. p. 82-121.

32. Czeresnia D. Ciência, técnica e cultura: relações entre risco e práticas de saúde. Cad Saúde Pública 2004; 20(2):447-455.

33. Bagrichevsky M, Castiel LD, Vasconcellos-Silva PR, Estevão A. Discursos sobre comportamento de risco à saúde e a moralização da vida cotidiana. Ciênc Saúde Coletiva 2010; 15(Supl.1):1699-1708.

34. Lima ES, Oliveira CS, Gomes MCR. Educação nutricional: da ignorância alimentar à representação social na pós-graduação do Rio de Janeiro (1980-98). História, Ciências, Saúde – Manguinhos 2003; 10(2):603-35.

35. Santos LAS. Da dieta à reeducação alimentar: algumas notas sobre o comer contemporâneo a partir dos programas de emagrecimento na Internet. Physis 2010; 20(2):459-474.

36. Boog MCF. Educação nutricional em serviços públicos de saúde. Cad Saúde Pública 1999; 15(Supl.2):S139-S147.

37. Brienza AM, Mishima SM, Frederico P, Clápis MJ. Grupo de reeducação alimentar: uma experiência holística em saúde na perspectiva familiar. Rev Bras Enferm. 2002; 55(6):697-700.

38. Fischler C. Gastro-nomie et gastro-anomie. Communications 1979; 31(1):189-210.

39. Tonkin E, Brimblecombe J, Wycherley TP. Characteristics of smartphone applications for nutrition improvement in community settings: a scoping review. Adv Nutr. 2017; 8(2):308-322.

40. Bert F, Giacometti M, Gualano MR, Siliquini R. Smartphones and health promotion: a review of the evidence. J Med Syst. 2014; 38(1):9995.

Received: May 09, 2017
Reviewed: June 22, 2017
Accepted: August 15, 2017