occurring on a global scale, debates about the correctness of certain diets, soon labelled “healthy”, assumed an undisputed importance2. A healthy lifestyle and diet became central to public health discussions and entered the consciousness of the general public through broadcast media and medical interventions.

Despite the absence of a clear and universally agreed-upon definition of what constitutes a healthy diet (the biggest disagreement being over the consumption of animal-source foods), opinions about and practices of healthy eating have become pervasive in many social contexts. Certainly, the recent rise of health conditions such as diabetes, obesity, hypertension, the metabolic syndrome, etc., and of the medical therapies associated with them, has contributed to turning dieting into a common practice.

In this age of the increased ‘healthicisation’ (Conrad 1992) of living -- the process by which ‘social or behavioural activities are deemed medical risks for well-established biomedical conditions’ (Conrad, 1992: 223) -- how healthy eating is understood by various actors deserves full examination. This article focuses on a healthy diet as a discursive social practice which is at once shared and contested. Drawing on one year of fieldwork in an Ikojts community of about 3,100 people in rural southern Mexico, I examine how concern over the changes in their diet is central for Ikojts living with diabetes and how, simultaneously, they largely disregard healthy eating as part of their medical nutritional therapy and, sometimes, even defiantly challenge it. The reasons

2 One of the first World Health Organization (WHO) initiatives to take into consideration chronic diseases and the importance of lifestyles in their development was the 2003 Framework Convention on Tobacco Control, followed one year later by the Global Strategy on Diet, Physical Activity and Health. Since then, the WHO has paid increasing attention to non-communicable chronic diseases and in 2008 launched the Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases. The WHO’s most recent NCD global action plan regards 2013-2020 and its focus is on ‘four shared behavioral risk factors — tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol’ (WHO, 2016).

Introduction1

At the turn of the new millennium, non-communicable chronic diseases acquired full visibility on the international scene as a matter of public concern, and the World Health Organization started to pay increasing attention to how “lifestyles” influence human health in both developed and developing countries. With the “nutrition transition" occurring on a global scale, debates about the correctness of certain diets, soon labelled “healthy”, assumed an undisputed importance2. A healthy lifestyle and diet became central to public health discussions and entered the consciousness of the general public through broadcast media and medical interventions.

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why a healthy diet provides the Ikojts with a language through which to articulate disquiet about food changes and, at the same time, provokes profound tensions are better understood if we consider how this discursive social practice encapsulates radically different stories, concerns and worlds.

In this article, it is argued that although emergent epidemics such as diabetes have spurred the Ikojts to reflect on the importance of food and eating traditions, their engagement with biomedical nutritional advice is characterised by ambivalence. If they agree with doctors that diabetes is linked to a deterioration of their food and eating habits, they also experience discordant feelings with regard to the “diabetic diet”, which often threatens their sense of identity and culture. In order to explore the seeming discrepancy between biomedical and lay understandings of food and health, I firstly focus on the (dis)encounters between patients and doctors over the “diabetic diet”, and, secondly, examine the Ikojts’ memories of past foodways, usually evoked with a sense of bitter-sweet nostalgia. A series of ethnographic anecdotes will help us to grasp the ‘awkward engagement’ (Tsing, 2005) between biomedical and lay approaches to healthy food and eating and will explain why diabetes, for the Ikojts, goes beyond individual responsibility for healthy eating. Their concern for how their foodways have changed is tied to wider, dramatic shifts which have occurred in their society.

Field site

The Huave -- or Ikojts (literally meaning “we, ourselves”), as they prefer to be called -- are a Mesoamerican indigenous population whose identity is traditionally rooted in their fishing activity. Today, the Huave number about 29,000 altogether, mainly distributed in four communities in southern Oaxaca, around the salty lagoons of the Isthmus of Tehuantepec on the Pacific Ocean. This article concentrates on the Ikojts of San Dionisio del Mar, who are primarily fishermen and peasant farmers, usually engaged in polyvalent activities (e.g., seasonal work, bartering, petty trade, and a range of casual jobs). In the 1990s, migration towards bigger Mexican cities and the U.S. became more common and nowadays remittances are part of many family economies. A small minority of Ikojts are asalariados, state workers with a biweekly salary, because of which they are considered privileged. This is clearly understandable in a place where most of the population lives in poverty and where only one point three per cent of it can be considered not vulnerable (CONEVAL, 2010).

To make money, families open tiendas, little shops, often just a few shelves filled with fruits and vegetables, pre-packaged foods, and soft drinks. And spread throughout the village are nearly forty cantinas, bars where alcohol and masculinity continuously reinforce each other.

The Ikojts identity, which differentiates them from the neighbouring Zapotecs (the largest and dominant ethnic minority in the Isthmus), is profoundly tied to the lagoons, the basis of their biocultural life. Being Ikojts, indeed, is largely a matter of geography (they are also called mareños, with reference to the marine landscape) and performance; on innumerable occasions, I heard definitions of ethnicity based on what and how food is eaten (nosotros puro pescado fresco, directamente del mar al paladar) or on what kind of job is carried out (vamos a buscar la vida en el mar).

Although fish and shrimp are prominent identity markers, their diet, in consonance with the Mesoamerican one, is also centred on corn. Despite the Ikojts’ high dedication to growing corn, the insufficient productivity of their lands has obliged them historically to depend on regional markets for the provision of corn and other foodstuffs. Given the Huaves’ marginal location in relation to these markets, their economic activities have been characterised by subordination. This unfavourable socio-economic position vis-à-vis the larger society became even worse with their inclusion into the market system (Cuturi, 1990: 62), which intensified between the 1950s and the 1970s, when the State took measures to shift local economic activities from subsistence to commerce. For the Huave, entering the market meant being subjected to a dual dependency: on the state banks providing credit for the primary activities and on the intermediaries, mainly Zapotecs and mestizos, who also controlled oil, roads, and public transport. At the same time, intensive fishing led to the overexploitation of the lagoons’ resources and contributed to habitat deterioration. Although still a more remunerative activity than farming alone, today fishing is in a state of crisis.

These transformations in the local economy have been accompanied by dramatic dietary change. An improvement in road conditions and increased interaction with the greater society facilitated the inclusion of refined foods, high in saturated fats and sugar, in the local diet.

Epidemiological data on the Ikojts are scarce and not easily accessible. It is hard to say how different their epidemiological profile is from that of the rest of the country. Fieldwork experience suggests that diabetes is, with hypertension, the number one health issue, similarly to the overall national situation. Recent data show that
Mexico’s prevalence rate of diabetes is higher than the average in the North American and Caribbean region (IDF, 2014) and that the country is second for obesity rates among the 34 countries in the Organisation for Economic Co-operation and Development (OECD, 2014). Also, diabetes is the second cause of death among the working-age population. In 2009, diabetes mellitus was the third cause of death in the indigenous municipalities, after heart disease and malignant tumours (SSa, 2012: 177-179) and 94.4 per cent of the deaths in indigenous municipalities in the country were due to non-communicable diseases (ibid.: 180). In the state of Oaxaca, diabetes mellitus was the second cause of mortality in indigenous municipalities, while nutritional deficiencies the seventh (ibid.: 193). Undoubtedly, rural and indigenous areas are significantly affected by the so-called double burden of disease (infectious and non-communicable). In San Dionisio del Mar, the Ikojts consider diabetes an epidemic since, as they say, ‘nowadays everyone has diabetes, from the time they are this little!’

In San Dionisio, 964 families are beneficiaries of the Prospera programme (a conditional cash transfer programme targeting health, nutrition, and education of poor families), which means that their family income relies heavily on these payments. As part of the health services, families receive check-up visits for the prevention and control of diabetes and hypertension. Primary attention is delivered at the local rural clinic, which runs under the auspices of the IMSS-Prospera and has been in operation since 1979. In 2014 there were two doctors in charge. They were médicos pasantes, i.e., newly graduated medical students carrying out their year of social service, a requirement for becoming professionally licensed or taking specialisation courses. In theory, the general population, insured or not, can access primary health care at the clinic for free. However, Sandionisians have mixed feelings about the quality and accessibility of this service. While the importance of the clinic as a first-entry point to health care is usually acknowledged, the clinic is also considered understaffed, under-equipped, inefficient and discriminatory. Lack of trust in what it offers is one of the factors that contribute to people’s medical out-of-pocket expenditures. In 2014, nevertheless, nearly 130 people with diabetes were assisted at the clinic; it was there that advice on how to eat was offered.

**Methods**

This article draws on ethnographic material collected as part of a larger research project, which analysed social representations and lived experiences of type 2 diabetes (henceforth diabetes) among the Ikojts. The aim was to understand how diabetes is made sense of in a rural poor-resourced population. The study, based on participant observation, lasted one year (2013/2014) and explored what life with diabetes is like. I mean the patients’ lives, of course, but there is also another dimension, that of the villagers who do not suffer from the disease but who, nonetheless, are deeply involved in the process of sense making. This research project was interested in learning what this relatively “new” illness meant at both a personal and a collective level.

Research combined participant observation of real-life situations of people with diabetes, both inside and outside the clinic, and interviews with patients, doctors, nurses, and traditional healers. As an unmarried, young female, I worked more closely with women and this also explains why I spent most of my time in kitchens. Culinary chats (Abarca, 2007) became primary sources of information on local culture, family and economic relations, and health. The research comprised semi-structured interviews with 38 people with diabetes that addressed their beliefs about diabetes causation, health-seeking behaviours, and interactions with biomedical and traditional therapists. Nearly eighty informal interviews with people with and without diabetes were carried out on a range of different topics, including change in foodways and eating habits. Interviews were usually conducted in Spanish and a few times in the Huave language, with the support of a bilingual (Huave-Spanish) research assistant. The content of the interviews was analysed and coded using a deductive process that allowed exploration of three main topics: aetiology (diabetes causality beliefs at personal and collective levels); health-seeking behaviour (which therapeutic figures patients sought help from and what their experiences were); phenomenological experiences (from bodily sensations to fears and day-to-day strategies for attaining well-being). Alongside this deductive work, an inductive research path was also followed, eliciting unexpected themes from interviewees’ testimonies that informed follow-up interviews. Data analysis revealed that concern about dietary change was mentioned by all the 38 interviewees and that eating healthily was considered important for well-being. In what follows, I illustrate the general background against which the awkward engagement between biomedical and lay understandings of healthy food and eating unfolds. This will allow us to subsequently explore the Ikojts’ approaches to food.
Well-being, a lost condition?

All of the Ikojts, when asked about the causes of their diabetes epidemic, talked of a change in diet that weakened their bodies and made them vulnerable to new diseases such as diabetes and cancer. They recognised that eating healthily was key to well-being and indicated delocalised, processed, and industrially produced foods as particularly harmful. The noxious quality of these foods was synthesised in two words: *la química*, namely the chemical additives that make food not only unhealthy but also metonymic of more profound changes occurring in their society, such as loss of community wellness and food sovereignty. Meche, a woman in her fifties, told me one sunny afternoon:

> My mother was old when she died. And she died with all her teeth and without any hair. Her hair was so dark, beautiful! Before, people didn't eat beef and chicken, just fish. Or they ate what they could find in the mountains: iguana, armadillo, deer, wild rabbit. Now, people eat chicken so often and -- can you believe it? -- fattened chicken (pollo de engorda) is cheaper than home-raised chicken (pollo de rancho)!

Considerations of this type, highlighting how people used to be strong and beautiful and live to be centenarians because of a diet centred on the products available in their own lands, are extremely common. Historically accurate or not, these accounts reveal a meaningful and deep disquiet about changes in their diet and health.

Most of the narratives I collected about food and health were structured within a bipartite temporal framework, where foods as they were produced and consumed *before* were signified positively as healthy, tasty, and safe, while foods as they are consumed *now* were indicated as harmful and flavourless. Ascertaining what “before” referred to timewise was difficult. Indeed, in people’s narratives, before could refer to the long-ago time of their ancestors, to their grandparents’ time, or to their own childhood. In all cases, food memories were usually filled with nostalgia, sweet and bitter at once.

Notwithstanding the general agreement on this bipartite temporal framework, people included slightly different things in their lists of healthy and unhealthy foods. Older people, for instance, more readily indicated the shift from a fish-centred to a meat-centred diet as causative of all sorts of perils: ‘People start to eat beef as children and their blood changes, and then they get ill’. Younger people, instead, mentioned soft-drinks as culprits, even though they were also the first consumers of carbonated drinks.

Despite the widespread concern about this change in foodways and the recognition of a need to eat “healthily,” biomedical recommendations on reducing energy and fat intake were largely disregarded and sometimes even openly challenged. The following ethnographic vignettes will exemplify the awkward engagement that characterises biomedical and lay (dis)encounters on healthy food and eating.

Food (dis)encounters in the “diabetic diet”

Iselda, 68 years old, sells *atole*, a corn-based drink. Mother of six and wife of a husband struggling with alcoholism, Iselda relies on her activity for economic independence, which gives her some power over her husband who often spends much of his money on alcohol. *Atole*, and corn in general, is for her something more than just food: it lies at the core of her identity as an independent, strong woman. Iselda has been diagnosed with diabetes for three years and takes her oral medication regularly. However, she expresses concern about excluding corn-based foods from her diet and adamantly refuses to follow the doctors’ advice:

> You cannot eat this, you cannot eat that, but doctors can’t just simply prohibit atole! If I don’t drink atole I’ll die, atole is my strength. I drink two cups of atole early in the morning with a roll and I feel warm inside. How can they possibly prohibit atole? I’ll stumble when walking, I don’t agree, that’s why when I go to the clinic and they check my sugar, it’s high, because I’m angry, every time I check my sugar it is high. In any case I won’t give up my corn. If I die then I die, but corn is my strength, I say.

In San Dionisio, as elsewhere, people with diabetes find it very difficult to comply with doctors’ dietary guidelines. Reducing their intake of corn, a carbohydrate-rich food, sounds counterintuitive, illogical, and even harmful. Corn is considered not only beneficial but constitutive of life itself, grounded in the very body of the Ikojts, and reflected in their sensorium. Indeed, a specific, sensuous term is reserved for judging corn-based foods: *nawet*, which can only express goodness, a polysemic goodness that seems to make reference to eating in a tasty, healthy, and correct way. Corn-based foods cannot be said to be sweet, *nangan*, or salty, *najtix*. They are right just as they are, simply good. Cuturi has already noted how corn-based foods, among the Huave, seem to be exempt from subjective judgements, as personal taste cannot call into question the goodness of such life-constituting foods (2002: 267). This is one of the reasons why the “diabetic diet” is often rejected or adhered to with so much difficulty: the way the Ikojts nourish a healthy, strong, and prosperous body -- by
eating corn -- is being jeopardised by their disease and the medical nutritional therapy associated to it.

Iselda’s anger against the doctors’ advice (which makes her sugar rise) resonates with the anger that Yates-Doerr (2011) documented among Guatemalan women with diabetes. According to her, anger results because biomedical advice on healthy eating challenges women’s sedimented practices of eating, cooking, and feeding. The friction arises when abstract nutritional standards seek to erase taste and intimacy, which are at the basis of women’s sense of culinary expertise and sense of self (2011: 302). We find here a (dis)encounter between biomedical and lay approaches to healthy eating. It could be said that medical nutritional therapy generates a zone of awkward engagement, where words such as healthy food and eating ‘mean something different across a divide’ (Tsing, 2005: xi). For Iselda, health and strength imply eating corn in abundance. Her stumbling while walking, perhaps while selling atole door to door, will affect her well-being, including not only her personal health but her status as a provider for her family.

Another woman, Sandra, says that the weight loss she has experienced over the years because of diabetes has led to low self-esteem and a loss of femininity. Indeed, plumpness responds to local images of health and beauty. The association of thinness with sadness and plumpness is associated to it. As he writes, ‘biomedicine tries to reduce food but have totally failed to alter eating behaviours. This is because, as he writes, ‘biomedicine tries to reduce the act of eating to a simple physiological function and totally disregards the complexity of the act’ (2006: 173-174).

Doctors prohibit everything: We can't eat tamales, tortillas, pork, can't drink atole, or pozole! Nothing. But I do eat and drink ever-thing. Maybe only a little but I do drink. Sometimes we cook fish tamal, it’s so tasty! I need to eat it, even if just one! But the doctor says no, I can't eat it because tamal is pure corn dough. The doctor says that all my [heart] cubicles, all the holes of my veins are going to be blocked. Shrimp, I can't eat. Fish: Only roasted but not fried, and with little salt! But I love salt. Coffee? Without sugar, of course. But sometimes I just feel like drinking it with sugar and so I do. And I feel perfectly fine. But the doctor says that it's going to be bad in the long run. So, at my check-up visit, my sugar is high. I don't measure what I eat. [...] That's why my sight is fading, according to him. And I shouldn't eat watermelon, or mango. I can eat apples but only green apples. The red ones are too sweet. But those are the ones I like. When I go to the city, I buy a big, red apple. And peaches as well. The doctor says fruit is ok but only bitter fruit. This is what he told me.

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Feelings of anger and shame stemming from the illness experience impose an additional burden on already fragile health conditions. In San Dionisio, people believe that there is a toxic correlation between overwrought, negative emotions (such as anger) and the intake of certain foods. An angry person should especially refrain from eating foods that can absorb evil, like eggs, or foods indexed as “cold” according to the local hot/cold classification. Living with diabetes was described by many people as triste, a sad condition. It was said to be a state that entails emotional upheavals and renders adherence to “healthy eating” even more challenging. Medical recommendations suggesting patients eat chicken broth and vegetables for instance might be deleterious for diabetics in a bad mood: chicken is locally classified as cold and this humoural characteristic can be toxic to a person who is emotionally out of control. Biomedical and lay understandings of healthy eating, sometimes, do not coincide.

Even when “healthy eating” guidelines are fully understood, their application in everyday life is full of pitfalls. Indications may appear simple in theory but in reality are anything but easy to follow. This is how Dorotea, 50, diabetic for three years, describes being on a special diet:

Doctors prohibit everything: We can't eat tamales, tortillas, pork, can't drink atole, or pozole! Nothing. But I do eat and drink every-thing. Maybe only a little but I do drink. Sometimes we cook fish tamal, it’s so tasty! I need to eat it, even if just one! But the doctor says no, I can't eat it because tamal is pure corn dough. The doctor says that all my [heart] cubicles, all the holes of my veins are going to be blocked. Shrimp, I can't eat. Fish: Only roasted but not fried, and with little salt! But I love salt. Coffee? Without sugar, of course. But sometimes I just feel like drinking it with sugar and so I do. And I feel perfectly fine. But the doctor says that it’s going to be bad in the long run. So, at my check-up visit, my sugar is high. I don't measure what I eat. [...] That's why my sight is fading, according to him. And I shouldn't eat watermelon, or mango. I can eat apples but only green apples. The red ones are too sweet. But those are the ones I like. When I go to the city, I buy a big, red apple. And peaches as well. The doctor says fruit is ok but only bitter fruit. This is what he told me.

Dorotea seems to remember the dietary recommendations of her doctor by heart, including the nuances (red vs. green apples) between what is allowed and what is restricted. Regardless of this knowledge, she challenges her dietary plan openly. Dorotea’s case defies a central tenet in public health strategies: that well informed patients will make “correct” decisions and adhere to prescribed therapies. Through his work with Innu people in Canada, Roy (2006) illustrates how prevention campaigns aimed at tackling diabetes and promoting healthy eating habits have been successful in disseminating biomedical approaches to food but have totally failed to alter eating behaviours. This is because, as he writes, ‘biomedicine tries to reduce the act of eating to a simple physiological function and totally disregards the complexity of the act’ (2006: 173-174).
with diabetes in the United States, analyses how food becomes a source of conflict between patient and doctor. Ferzacca treats medical nutritional therapy as a particular ‘historical reality of food and eating that comes into play with other historical realities in the lives’ of people with diabetes (2004: 43). In fact, the “diabetic diet” promotes a ‘loss of memory’ by imposing a universal, mathematically based, diet (ibid.: 60) which de-historicises lived food experiences in order to introduce a new pattern of eating (ibid.: 51). Resistance to this de-historicisation is expressed in Dorotea’s words: ‘I don’t measure what I eat’, which seem an admission of culpability as well as an open challenge to the incapacity of medical nutritional therapy to recognise the embodied historical dimension of eating.

As we have seen, judgements of taste, both in their subjective and cultural dimensions, also play a key role in people’s eating habits. Judgements of taste are built on lived experiences and constitute a form of embodied knowledge. They are inscribed in deep temporality, exercised intuitively, and nourished by narrative. For this reason, food and eating have an extraordinary capacity to make the self and participate in the construction of individual and social identities. The act of eating is not only self-asserting but also hetero-directed: ‘What people decide to eat says something about who they are, both to themselves and to their world’ (ibid.: 57).

It is exactly this identity-building capacity of food and eating that also allows us to understand why the medical recommendations on healthy eating were instead scrupulously followed by Catarina, a non-indigenous woman married to an Ikojts. Catarina was one of the rare cases of diabetics on peritoneal dialysis who was able to discontinue it after one year of treatment. She liked to talk about herself as a success story: ‘My doctor says that only four out of 1,000 people discontinue dialysis’. When Catarina talked about herself and her diabetes, she usually emphasised her eating and hygienic habits, which were different from (read better than) those of her fellow Sandionisians. Catarina liked to speak of her non-indigenous origins and her past spent in Mexico City, where she studied to become a teacher. Her memories about life in San Dionisio when she first arrived are unpleasant and filled with episodes demonstrating, in her opinion, that Sandionisians were primitive and dirty. She often mentioned her culinary skills and judgements of taste, so different from those of the other women, to underline her unrelatedness to the village. In her telling, food was a sign of distinction (Bourdieu, 2010) and her adherence to the “diabetic diet” a sign of moral superiority. Her familiarity with recipes based on vegetables and white meat marked a substantial difference from Ikojts women:

When I go to the market and buy veggies, for example parsley, then people ask me “What do you use it for?” and then they smell it and say that it stinks! They are not used to eating it, they don’t know how to use it, they don’t consume any kind of veggies.

In Catarina’s case, diabetes and the adherence to biomedical healthy eating rules have provided her with an additional discursive practice that allows her to reaffirm who she is (not) in a place that she finds she belongs to only partially.

The cases that I have so far illustrated cast light on how healthy food and eating are diversely understood and mobilised by people with dissimilar life situations and specific concerns at stake. Biomedical guidelines can be seen as counterintuitive, incorrect, burdensome or appropriate, depending on a number of biographical and contextual factors that influence people’s choices. In this zone of awkward engagement, healthy food and eating not only mean different things but are also employed strategically according to particular identity-building purposes. The encounter between biomedical and lay understandings of healthy food and eating is characterised not only by incongruence but also by ambivalence. The appearance of diabetes on the cultural scene and the biomedical discourses on healthy eating have certainly made Ikojts reflect on their foodways and eating habits. Their considerations of food have developed in tandem with biomedical ones, yet they only partially overlap. Moreover, public health discourses on eating healthily have been creatively adopted by Ikojts to make sense of emergent diseases and unsafe foods.

Thus far we have analysed how the “diabetic diet” both puts a strain on and offers an opportunity for self-expression at a personal level. In the rest of the article, I instead dig deeper into the Ikojts’ collective memories of food and culture. In doing so, I hope to disentangle the ‘ironic contradiction’ (Lang, 2006: 225) by which most of the people with diabetes I worked with rejected medical advice on healthy eating while agreeing that change in foodways was at the core of the diabetes epidemic.

**Bitter-sweet memories of food and culture**

As we saw earlier in this article, the Ikojts idealise their past through images of food sovereignty, autarchy, and abundance epitomised by prosperous lagoons. Being part of people’s childhood experiences, this idealised past is sometimes not distant in time. They often say emphatically, in a satisfied tone: ‘When I was little, our food was sabroso (tasty)’. The goodness of their food
(good for health, good in taste) is linked to two aspects: its copiousness and the simplicity of its preparation. Prudencia, a 55-year-old woman living with diabetes for 18 years, relates:

*When I was a child, fishermen threw their nets into the sea and caught such big fish. While they were fishing, the oven in the kitchen was warming up. We would cook fish in it, with a bit of chilli and that’s all. Each fish was so big that my mother divided it into three pieces and gave them to us [her sisters and her]. We ate fish with beans and rice or we salted it [to conserve it]. Nowadays where would you find such big fish? Only a few small ones!*

Accounts of this kind are recounted by both men and women. Often these memories, part of everyday discourse, are triggered by considerations of present-day food scarcity, typified in the lagoons’ loss of productivity. One morning, for example, I woke up and went to the kitchen where two members of my host family, Carmen and Julia, were discussing the high price of fish. Carmen remembered how rich and happy the previous generation of Ikojts was, when the lagoons provided plenty of fish, the mountains wild game. Today, Carmen reflected, fishermen have to risk their lives far out in the open sea to catch enough fish. And, she added, the scarcity in local foods has made people selfish and stingy, something God punishes with less food on the table.

In people’s recollections, not too long ago, food was place-based and sufficient. This felicitous state of things was made possible by a sense of a harmonious relationship with all the elements of the cosmos; respect for the lagoons and generosity between people assured food abundance and the making of moral and healthy Ikojts. Indeed, well-being is often associated to communal living. This is how Rosario talks about food security and human solidarity in the past:

> Before, rains were regular and we could eat our own corn. The lagoons gave us fish. People went to the shore to wait for the fishermen. They asked them for some fish, “How much does it cost?” and fishermen replied, “Nothing!” They gave it to them for free. Nowadays, people don’t want to share anymore.

An unwillingness to share betrays a shift in the work ethic (i.e., working principally to make a subsistence living and sharing excess food) that goes along with a steady abandonment of subsistence activities, which are increasingly unviable.

Flavia Cuturi, who studied Huave narratives of food nostalgia, highlighted how the Huave of San Mateo del Mar describe the ‘right’ economic behaviour, one that maintains a cosmological equilibrium between humans, nonhumans, and God, as ‘*ataaq respetar*, respect’ (Cuturi, 1990: 61; emphasis in original). The work of fishermen and peasant farmers was, and partially still is, considered of high ethical value; it is through *najiet*, work, that men create themselves as full persons while also strengthening and feeding their communities. As noted by Olivia Harris, who carried out fieldwork among rural Andeans, work is a performance of value (2007: 159) that contributes to the making of personhood and the celebration of community power.

The recent intensification and monetisation of production and consumption respond to a different economic logic and ethic that are at odds with communal living. The overexploitation of the lagoon has resulted in the contamination and pauperisation of the ecosystem, evident in an increased difficulty in fishing. It is alongside the ensuing decline in the fishing economy that the Ikojts have experienced a dietary transition towards meat and processed foods. This shift from fish to meat (beef, pork, chicken) -- with the parallel loss of diversity in meat consumption itself (given the decreasing availability of game) -- can be considered the most dramatic change in Huave food habits, both in cultural and health terms. It revolutionised, at one and the same time, the values surrounding eating, the ways in which food helps to build a sense of place, and the practices through which the Ikojts constitute themselves as an ethnic group. Moreover, as Cuturi suggests, meat consumption is also an ‘anti-economic behaviour’ (1990: 64) given that chicken and pigs were traditionally raised as monetary back-up for emergencies; women are, therefore, ‘eating their money’ (ibid.: 64).

Fish is still highly valued and some people believe that meat consumption weakens bodies. At the same time, however, meat is also considered a sign of distinction (Bourdieu, 2010) and a way for people to feel modern and wealthy, more similar to white and mestizo people. The above demonstrates that people speak about food ‘in ways that suggest affective ambivalence and internal contradiction’ (Holtzman, 2009: 8).

This change in diet is thought to have caused the progressive weakening of bodies. Vulnerability appears as an incorporated condition, literally ingested, and passed through generations. Pedro, a peasant farmer whom I asked about the diabetes epidemic, used an agricultural metaphor to convey the idea of the progressive bodily decay of the Ikojts: ‘At the first harvest, watermelons are..."
big; at the next harvest they are smaller; then even smaller. It seems to be so with younger generations: they are getting weaker and weaker'. When I asked him to explain his metaphor he contended that people are vulnerable because they eat industrial food, la química, while before they only ate locally produced food. Moreover, they used to eat only fresh food: 'We cut the fish and it was so fresh there was still blood. If we wanted to conserve it, then we salted it. Now people refrigerate it'.

Refrigeration, thought to deteriorate the quality and taste of food, is perceived as a deviance from genuineness. Refrigeration alters the hot and cold humoural balance in foods which, when ingested, have an adverse effect on health. In addition, refrigeration symbolises the loss of communal living since what can be preserved is usually individually enjoyed. As Alberto remarks: 'We used to eat fresh fish and if there was anything left we offered it to the neighbour, but today people put food in the fridge'. Refrigerators are however especially useful to women who often supplement the family income with informal economic activities, such as selling meals or food/beverage products (e.g., soft drinks, ice, ice lollies, yoghurts, sweet snacks).

For the Ikojts, it is not only processed and refrigerated foods that weaken the body. The abandonment of ethically superior work such as farming is also responsible. Farming connotes the peasant’s connection with the land and with God, rain mediating between the three of them. Every year after Easter, religious officials make a pilgrimage to a sacred island where they climb the rocks and reach the cave at the top. They bring offerings, light candles, play cane flutes and deer drums, and pray the entire night. They ask for rain and wellness (monapakiyi): ‘Here the elderly come to ask for water, the elderly ask for health, ask for life for everybody, ask for a good harvest so that we can have food for the children of God’. The rainy season, which is expected to start in May or June, is fundamental for both a good harvest and the regeneration of the lagoons. Farming is work that relies heavily on hope, es el trabajo de la esperanza, as it depends on uncontrollable factors such as climate and God’s will. This hope, which might be seen as a particular form of trust, is what nourishes the tie between peasant farmers, land and God, and what keeps the entire community healthy.

The value of their work is appreciated as contributing to the community’s general well-being. Yet farmers are also the poorest in the village and their work is physically demanding. These days the young generations are less interested in farming: the rewards are few and not of a monetary nature. The decline in agricultural workers is associated with inactivity and sloth: ‘Young people only want to rest, they lie down with friends, have cold drinks, and that’s when diabetes comes’.

Peasants also recognise that the loss of farming does not merely reflect a change in values and attitudes; it is also an economic issue because farming has become unfeasible. Migration, with the consequent abandonment of the fields, is often the only option available for making a living.

The Ikojts’ preoccupation not only with food consumption but also with food production when talking about diabetes and food insecurity marks a significant difference from biomedical approaches to metabolic disorders, one that deserves the full attention of policy makers. Indeed, as Guthman (2011) has remarked, medical discourse tackles health issues by focusing on food consumption, ignoring the politics of food production, which actually lie at the heart of the nutrition transition. Moreover, biomedical messages about (un) healthy foods and the quantification of nutrients in everyday diets transgress people's foodways, which are deeply rooted in histories at once idiosyncratic, biographical, and collective. This violence erases people’s enactments of (self)care through eating, cooking, and feeding, generating discomfort and anger against doctors (see Yates-Doerr, 2015). This helps to explain why even though diabetics do take care of themselves by taking and adjusting their medication and learning about the biomedical recommendations on healthy eating, little positive impact has been achieved. The question of how health conditions can be improved remains therefore open and urgent. Exploring people’s ambivalent food experiences in times of unprecedented metabolic health challenges has important implications for conceptualising public health policies.

Conclusions

In one of the founding works of medical anthropology, Hahn and Kleinman proposed analysing biomedicine as a sociocultural system which constructs itself as disentangled from society, strictly focused on physiology (1983). Because of this culturally specific construction, biomedical approaches to health and illness tend to locate disease or non-normal conditions inside the body, a body which, ultimately, is thought of as universal. This ‘physical reductionism’ (1983: 313), a central tenet in biomedicine, has also informed conceptions of healthy food and eating, largely based on mathematical equations that balance nutrients.

This construction has spread and consolidated itself during the last fifty years, as concerns for the nutrition
transition increased and metabolic disorders began to dominate the globe, a result, according to public health experts, of modernisation. Even though the global character of such processes is undeniable, a closer look at local foodways demonstrates the existence of a variety of transitions that follow different speeds, patterns, and whys (Yates-Doerr, 2015). Biomedical advice on healthy eating fails to capture these nuances and the profound complexity of eating habits, sedimented in time, reinforced and validated by the daily visceral experience of sharing food together. This abstracted version of the act of eating is at odds with people’s everyday experiences, which are made of objective constraints to accessing “healthy” food as well as of subjective and collective food life histories that resist the ‘loss of memory’ promoted by medical nutritional therapies.

This article, albeit focused on a tiny group of people, offers insights into the plurality of meanings that the nutrition transition can have in rural and disadvantaged places. It sheds light on the motives for both the embrace and rejection of the healthy eating concept by people who are severely struck by diabetes and other health issues. In particular, it contends that contemporary foodways and the meanings attached to them must be understood in their complexity and, above all, in their ambivalences and internal contradictions.

As we have seen, the appearance of diabetes on the Ikojts cultural scene has determined an ‘unexpected disruption’ (Becker, 1997: 4) in their lives and induced them to reflect on their eating habits. The healthy eating concept that informs diabetes treatments constitutes a discursive social practice that the Ikojts are simultaneously adopting and contesting. Unlike previous approaches to health and illness that stress the differences between biomedical and lay perspectives, here we find (dis)encounters that operate in a ‘zone of awkward engagement,’ where words are the same (or similar in kind) while their meanings differ. The emphasis that biomedical treatments place on healthy food and eating has made inroads into San Dionisio, but the way the Ikojts articulate these words indicates that, for them, healthy eating both includes and transcends the realm of individual responsibility. Diabetes has opened a space for reflection about larger issues affecting their community that include their suffering as a people whose biocultural identity is endangered. The way they link diabetes, dietary change, and suffering is not exclusive to them, resonating as it does with other indigenous experiences. ‘When Melbourne Aborigines talk about trying to manage their diabetes, it is not only their sugar that is out of balance, it is their whole life’ (2000: 1458), report Thompson and Gifford. Similarly, Linda Garro illustrates how, among the Ojibway/Anishinaabe of Canada, diabetes is viewed ‘as yet another consequence of the disruption and destruction of the Anishinaabe way of life’ (1995: 45).

Despite the bitter taste of these food and cultural losses, perhaps memories of food and culture can offer a path towards a re-appropriation of health and well-being (Illich, 1976) and an integral approach to food and health issues. After all, the Ikojts recognise that a change in their diet and physical activity is at the basis of their diabetes epidemic. It is however a change they contextualise within a larger and more meaningful cosmological and socio-economic disorder. Bitter-sweet memories of food and culture should be appreciated as a bridge, no matter how unstable, between biomedical and lay understandings of food and health, one that provides an opportunity for creative solutions.

References


