



Food consumption and obesity in Cochabamba, Bolivia: Healthcare professionals' perspectives and experiences

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ABSTRACT: The consumption of unhealthy foods and obesity are today prominent problems worldwide. In this article, based on qualitative, semi-structured, open-ended interviews with eight medical doctors and two nutritionists in Cochabamba, Bolivia, the relationship between food, obesity, and culture is discussed. The results show that the interviewees were concerned about people's unhealthy food habits and sedentary lifestyle, lack of time and money to prepare healthy food, oversized portions, stress, perceptions of the body that contribute to being overweight, unhealthy food habits in relation to social activities, and lack of knowledge about unhealthy eating. Although the healthcare professionals strived for a patient-centred approach, the patients' experiences were to some extent individualized, de-socialized, and medicalized in healthcare encounters. The interviews point to the importance of a holistic, multifaceted, interrelated, multi-dimensional, and culture-sensitive approach to food consumption, and indicate the necessity for medical practitioners and nutritionists to understand the cultural context in which people's ideas, values and norms are expressed, including the social and symbolic use of food, perceptions of the body, structural inequalities, poverty and lack of agency, as well as the risks of medicalizing both food consumption and the body. It is shown that healthcare professionals and their experiences can contribute to valuable insights concerning both healthcare encounters with overweight patients and when developing food-related public health policies.

Keywords: Food consumption, Obesity, Cochabamba, Bolivia

Introduction

Globally today, there is an alarming increase in obesity and related illnesses. To respond to this worldwide crisis, there is a need to know more about how people experience and understand the problem. Particularly important in this context are healthcare professionals who encounter obese patients daily. They have a unique insight into the suffering and experiences of obese and overweight patients and their families, as well as an understanding of how food-related interventions and policies can be beneficial, sustainable, and have long-lasting effects. This focus may also deepen our understanding of "how lived experiences of inequality become embodied to produce, uphold, and shape nutrition-related health disparities and alter nutrition interventions" (Owens 2024: 10).

To address the global 'fast food revolution' (Popkin and Reardon 2018) or 'fast food

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genocide' (Fuhrman 2018) and the 'globesity' phenomenon (Costa-Font and Mas 2016), several measures, interventions, and prevention strategies have been proposed. Among these can be mentioned: health fairs and campaigns; social support groups; nutrition and cooking workshops; dance and exercise; walking groups; the use of community health workers; nutrition education and food skills in schools; taxes on unhealthy foods; subsidies for healthy foods; nutrition labelling on foods; removing infrastructural constraints on healthy food production, and supporting agricultural diversification; a ban on marketing unhealthy foods for children; and the reduction of excessive portion sizes of foods and beverages at restaurants. However, it is not always clear how to implement these disparate interventions (Popkin and Reardon 2018; Hawkes et al. 2015).

In the Global South, which is particularly hard hit, this development is largely caused by a sedentary urban lifestyle, poverty, and a shift in diet from a low fat, low calorie, plant-based, whole food diet, to an unhealthy, nutrient poor, energy dense, ready-made, ultra-processed diet, high in refined carbohydrates, saturated fats, sugar and sodium. The poor living in urban centres in the Global South have been severely affected by the nutritional transition as they often do not have the economic means to avoid this kind of unhealthy food. Both adults and youth are affected, and obesity and overweight have also increased dramatically among children (Popkin and Gordon-Larsen 2004; Monteiro et al. 2013; Tzioumis and Adair 2014). This is further complicated by the fact that "[i]mported processed foods are often more readily available and easier to preserve than fresh, locally produced foods, which reorganizes both tastes and local material cultures of food production, fuelling the rising pandemic of malnutrition" (Waldstein 2018: 7).

Latin America has been particularly affected by the nutritional transition. Today, in some Latin American countries, two-thirds of the women, about half of the men, and about one tenth of the children under five years old, are overweight or obese. In Latin America, the dietary shift has brought about a poor diet of snacks and ultra-processed, deep-fried foods, with large amounts of saturated fats, sodium, sugar and refined carbohydrates. This consumption of unhealthy so-called junk food, together with a decline in physical activity, has resulted in high levels of type 2 diabetes, hypertension, and other related health problems in Latin America. Regrettably, this has also led to enormous economic and social costs (Popkin and Reardon 2018). These food products are sometimes tax-exempt contraband imports, and as such, they tend to be more economical, and are not subject to health inspections.

Bolivia is one example of this swiftly changing food pattern, and the country has experienced a rapid increase in obesity and related illnesses. Cases of diabetes, hypertension, obesity, kidney damage, and other pathologies resulting from metabolic damage caused by an unhealthy lifestyle and the consumption of cheap, unhealthy, junk food has increased (Quispe Condori, Wedel and Ledo 2025). This situation is worsened by the fact that the poorest and most vulnerable are not entirely included in the national healthcare system. The social security subsystem, which concentrates most of the resources, covers only about 20 per cent of the population, most of whom are from the middle-class. It is a pending task for the state to include the indigenous and native peasant population in the benefits of the social security system. Moreover, migration has led to urbanization and a decline in the importance of the agricultural sector. These changes have also created extensive pockets of contamination. Rural areas and urban peripheries experience the highest rates of morbidity and mortality due to air, soil, and drinking water contamination. Overall, rural and

marginalized urban regions face significant setbacks in healthcare services. (Ledo 2024a).

The city of Cochabamba is commonly known as the gastronomic capital of Bolivia (Kollnig 2018, 2020). Among *cochabambinos*, citizens of Cochabamba, traditional food frequently provokes sentiments related to culture and heritage. Many have nostalgic memories of tasty traditional dishes, and people link their identity to certain dishes and food habits (Quispe Condori, Wedel and Ledo 2025). However, in Cochabamba there is also a high prevalence of obesity and cardiovascular disease risk factors, including alcohol consumption, low consumption of fruits and vegetables, and low level of physical activity (Miranda, Bento and Aguilar 2020; Mamani Ortiz, Gustafsson et al. 2019; Mamani Ortiz, San Sebastián et al. 2019). A nutrition and development survey carried out in 2022 (CEPLAG-ASDI 2022; Quispe Condori, Ledo García and Arce Cardozo 2025) suggests that approximately 10% of the population of Cochabamba might be living with diabetes, and many of those affected are socioeconomically vulnerable. Multiple factors related to air, water, and soil pollution, exacerbated by the lack of access to basic water and sewage services, also play a role in the cycle of poverty, waterborne diseases, and gender inequalities (Ledo 2002, 2024b).

Generally speaking, “a thin and firm body has become evidence of the ability to control the self” (Waldstein 2018: 7). In a study with diabetic patients in clinical encounters in the United States, it was shown that patients had difficulties adhering to medical, nutritional, and lifestyle advice. In this context, treatment programs were based on a ‘Western’ ethics of self-care, self-discipline, individualism, and the cultivation of a disciplined productive self. This required a precise timing of food and drug intake, and generated “a habitus that mimics the rhythmicities of capitalist productivity related to the control of consumption” (Ferzacca 2000: 36).

In a study in the Netherlands, it was shown that so-called ‘ontonorms’ (Mol 2012), (in our understanding) certain established cultural norms about being and behaving in relation to the body and eating, are embedded in different kinds of dietary advice that are enacted in clinical encounters and imposed on patients. When, for example, a patient is told to count calories, a rational, controlled biophysical model, or ontonorm, is at play where food is energy (instead of pleasure), homeostatic stability is an ideal, and the mind is supposed to take control of the body to hinder hedonistic overeating. Similarly, when five different kinds of food items are depicted on a plate, such as grains (carbohydrates), vegetables/fruits (vitamins/minerals), meat/fish (proteins), oil (fats) and water (fluids), an ontonorm related to a biochemical and physiological world becomes visible. In this case, foods are seen as nutrients and the variety of food is important. Accordingly, the eaters, by using their cognitive control, should restrain from bad eating habits, such as eating only one category of food (Mol 2012).

Other studies on healthcare encounters with obese patients have shown the importance of context-sensitiveness within clinical care (Felder, Felt and Penkler 2016), how nutritionists mainly focus on the human metabolism and how they primarily view eating as a physiological need, thereby ignoring “the sensuous potential of food stuffs” (Christensen, Hillerstad and Holm 2017: 223). A study in Latin America pointed out the need to counteract medicalization and individualization by using a broader concept of healthy eating, involving the concept culinary care, which includes social interactions, pleasure and relationships, as well as “cooking skills, tradition, ancestors, and soils” (Yates-Doerr and Carney 2016: 313).

In this article, we seek to contribute with an insider's, on-the-ground, perspective to the current debate on food, obesity, and illness, by focusing on medical doctors and nutritionists working in Cochabamba. In their daily struggle to give the best possible care and advice to obese and overweight patients, we think that a study that focuses on healthcare professionals' experiences with patients and their families can contribute valuable insights into day-to-day obesity-related healthcare problems, as well as to help inform food-related public health policies. In an earlier publication focusing on the experience of obese patients suffering from type 2 diabetes, and their encounters with healthcare professionals in Cochabamba, we showed that many people had economic difficulties accessing healthy food, and/or adhering to a healthy diet because of limited agency, structural barriers, and cultural perceptions. This, in turn, was also related to eating an abundance of unhealthy food at social gatherings. In healthcare encounters, patients often received advice from medical personnel that were based on individual behaviour and the alteration of the body, and we pointed out the need to consider the patient's whole social environment (Quispe Condori, Wedel and Ledo 2025).

Material and Methods

Semi-structured, open-ended, qualitative interviews with two nutritionists and eight medical doctors were performed in various healthcare settings in Cochabamba, Bolivia, during January and February 2025. Both nutritionists were females. Six of the medical practitioners were men, while two were females. Medical staff worked primarily in public hospitals located in the central area of the municipality, while only a few were employed in healthcare facilities situated in peripheral zones. In general, the healthcare professionals reported attending approximately 14 patients per day, with an estimated consultation time of between 15 to 20 minutes per patient. All the interlocutors were working with obese and overweight patients who had, or were at risk of developing, type 2 diabetes. The conversations were about one and a half hours long and conducted in Spanish by the first author. Questions discussed involved ideas, perceptions and opinions about healthy/unhealthy food, clinical encounters, access to healthy food, patients' socioeconomic situation, social relations, lifestyle, food habits, perceptions of the body, and policy measures to increase health and promote the consumption of healthy food. All audio files were safely transferred and secured. The results were analysed through thematic analysis.

This study was approved by the Scientific Committee of the Directorate of Planning, Projects, and Systems at San Simón University, Cochabamba, (CP#: 0141-16-037-101-000-007) and was conducted in accordance with the ethical principles of the American Anthropological Association. All participants were informed about the objectives of the study, and verbally informed consent was obtained prior to each interview. Participation was voluntary, and all data was collected and analysed anonymously. No conflicts of interest occurred.

Results

Some of the medical practitioners expressed concerns about the fact that people today have become sedentary because more of them work in retailer and transport, while at the same time eating large amounts of carbohydrates. This, they said, meant that people were risking their health. They claimed that "Cochabamba is food" and that citizens of Cochabamba

ate large quantities of rice, potatoes, yucca and noodles, while almost avoiding all other vegetables and fruits. This preference was explained by the fact that these foods are low-cost, quick to prepare, and highly satiating. In this context, noodles were not described as a traditional food, but rather as a substitute for whole and less processed foods within broader economic and dietary transformations. This eating habit was often combined with various forms of junk food, including hamburgers, pizzas, biscuits and snacks, with large amounts of saturated fats, or instantaneous soups and precooked or ultra-processed food with preservatives, to “fill up the stomach.”

A medical doctor explained that food in Cochabamba is “very influenced by North American culture of junk food, [with] excess of carbohydrates, excess of fat.” He continued: “This type of food is eaten at least three times a week, and on top of that people eat their *chicharrón* [meat, bacon and pork skin, prepared with the same fat of the animal and mixed with maize beer] during the weekend, with carbohydrates and fat, in plenty.” Another medical doctor also claimed that many ate late at night and that this was associated with obesity and being overweight: “This is energy that is not burned, because after dining one doesn’t do any exercise. Immediately, one sits down or lays down to watch TV.”

Food consumption among migrants, children and youth

In Cochabamba, there are many migrants from the countryside, and many are from high altitude places in the Bolivian *Altiplano*, or from poor localities in the western part of the department of Cochabamba.



The Bolivian *Altiplano*. Photo by Johan Wedel.

These migrants often have limited financial resources, and it was said that “they have to consume the most accessible and cheapest foods.” Another medical doctor added that the migrants traditionally have been eating large amounts of carbohydrates, and that every day they are used to eat “potatoes, *chuño* [dehydrated potato] and noodles.” In a similar vein, another interlocutor explained:

The diet in the countryside is richer in carbohydrates. ... When you work in the countryside, you do all kinds of activities, so you maintain the equilibrium between what you consume and what you spend. When these people come to the city, the energy spent is not the same and the activity level is not the same.

It was said that many of the migrant women in Cochabamba were dedicated to commerce, while the men were often public transport drivers or taxi drivers. This meant that they were sitting most of the day and, consequently, could develop obesity and related illnesses, such as type 2 diabetes.

The healthcare professionals were particularly worried about food consumption among children and youth, and the easy access of junk food and food with a large amount of carbohydrates, sugar, saturated fat and trans-fat. They claimed that children's portions were unnecessary large in restaurants, and the menus were often limited to sausages, French fries, and ice cream, or other hypercaloric food. A medical doctor said: "The portions are not for children. When I take my five-years-old niece to an ice cream shop they give her a tremendous ice cream of 300 grams. ... The portions are distorted." A nutritionist similarly said: "A lot of hypercaloric food has entered the country, it's too much for a child."

In many settings around the world, it is believed that mothers "can and should control their children's weight, and that childhood obesity is caused by poor parenting" (Gorlick et al. 2021: 68). This was also a commonly held idea among the interviewees. Several of them were worried about the food mothers gave to their children. One of the medical doctors argued that many mothers did not have time to prepare decent meals to their children and that families seldom ate in their homes: "Mothers cannot make sure that the children can have a good snack and buy chocolate biscuits and soft drinks." Similarly, a nutritionist said that nowadays there is less money, time, and possibilities to prepare food, as both parents often work outside the home. Before, she said, "the mother stayed home and was cooking." She continued:

Before, food was healthier. There were not so much canned food, French fries and processed things. Now, a lot of food is rich in sugar and fat, and that's why we all the time have more people with diabetes, even among children. Mothers play an important role here. Many mothers do not give good food to their children. They buy popcorn, French fries ... pure junk food ... [and] what they mainly sell in pensions and restaurants is food with an excess of fat, sodium and sugar.

Food consumption, socioeconomic factors, and stress

The interviewees agreed that lack of time and economic resources were part of the reasons for bad eating habits, and that those with less economic possibilities had to feed themselves with what they could get. Regrettably, choosing cheap 'Western' junk food often meant a less healthy diet. When referring to a "Western diet," the physicians described an industrialized and highly processed food pattern, rich in fats and low-cost ingredients, rather than traditional Western dietary models. A medical doctor explained:

A healthy diet is much more expensive than a Western [junk food] diet with fatty food. ... To have a balanced diet requires having a greater purchasing power. ... To eat a ceviche or fish will cost you 35 pesos [7 USD] while a chicken with processed potatoes will cost you ten pesos [1,50 USD]. So, what options are there for eating healthy?

Similarly, another medical doctor added that “it’s easier to buy a ten pesos chicken made with fat, or butter in the worst case, than buying a salad with a grilled chicken with another kind of oil and less salt.” Several of the interviewed physicians, most of them men, were overweight, a condition that was visible during the interviews and, in some cases, explicitly acknowledged by themselves. This fact situated their accounts within the same constraints of time, work-related pressure, and restricted food environments that they described for their patients. However, a medical doctor also said that it was mostly the poor and socioeconomically disadvantaged population that suffered from obesity and diabetes, because of their eating habits and lack of choices.

Another factor the interviewees discussed was the relationship between food consumption, stress and obesity. They claimed that almost everybody experiences stress today, and that people in Cochabamba ate more because stress increased their appetite. Eating also became a way to calm anxiety. In addition, stress and lack of time caused people to exercise less, making them even more overweight. In the opposite way, people who were severely overweight could experience stress and depression when they did not manage to lose weight. A medical doctor said that there were many reasons for women to be overweight and to feel stress and depression: “They say that they eat [abundantly] because the husband beats them or because he has left, or because they have many children. So, they don’t have good eating habits.”

Tradition, culture, and perceptions of the body

Several of the interviewees also argued that people’s food choices were heavily influenced by tradition and culture, and that most people were not in the habit of eating healthy food, such as whole wheat bread, certain vegetables, or olive oil. In this context, foods that health professionals often describe as unhealthy were not without value for the population, but were associated with satiety, taste, sociability, and with ideas of prosperity and well-being in a context historically marked by food scarcity. One interlocutor claimed that especially elders were reluctant to change their way of eating and seldom ate vegetables and fruit, while another could also relate this disinterest in vegetables to his own family: “I was eating food from a healthy catering. My father saw what they had sent me and asked: ‘What is that? What is that green thing?’” Similarly, a nutritionist claimed that buying healthy food was not only about money and that people also needed to be better educated. She said that “there are people who won’t buy olive oil because it’s too expensive.” However, buying a product like olive oil can be very costly for someone with limited economic resources. The price of one litre of olive oil is approximately 24 USD, whereas the price of one litre of edible oil is approximately 2 USD.

Common cultural perceptions about the body were also related to being overweight and to obesity, both among adults and children. Women in Bolivia have been known to associate positive values with fatness (Brewis and Wutich 2015), and a medical doctor explained that “frequently health is evaluated based on the weight, [popularly meaning] that

one is healthy because one is fat.” Another medical doctor said that these days, in his clinic, he saw more macrosomic babies delivered by overweight mothers, and fat four-year-old children who looked like they were six years old:

Mothers think that the more her child eats the better, and that her child is healthy and strong. But this is not good health status. This is not equivalent to [good] health because the child will not be able to do exercise in a proper manner [and] ... will suffer from bullying.

A medical doctor had a somewhat idiosyncratic view of cultural beliefs in relation to obesity. He claimed that an obese person may be seen as living in opulence and believed to have a high income, and that obesity also has perceived positive cultural and socioeconomic connotations:

When a couple gets married, and one or both are gaining weight, it is seen in society as if they are doing well. ... A person who is chubby is fine, healthy, and apparently doing well. Sometimes it is difficult with preventive strategies to break with these popular cultural perceptions and imaginaries. They are deeply rooted in many places. ... Even some older healthcare personnel may think that a child should have a higher weight and that [eating in] excess is beneficial.

Obesity and gender relations

Some of the interlocutors related cultural perceptions of the body to the fact that many are overweight and obese in Cochabamba. This, in turn, was commonly related to gender relations and perceptions and ideas about wellbeing and family honour. This became apparent in the following case when a medical doctor met a married couple in his clinic. He related:

I was visited by a chubby patient. She was a *cholita* [a young indigenous woman] with her skirt and her husband. The *cholita* was chubby while her husband was skinny. I told her: “You are diabetic. You are already beginning with kidney problems. Your pressure is rising. You already have high cholesterol. ... Look at your legs, you already have problems with your arteries. They are already dilated. You have to lose weight.” Her husband said that she should not lose weight. He said: “I don’t like skinny women. The chubbier they are the better. ... It also means that I feed her well, that I support my family.”

The Bolivian population is largely patriarchal and unequal in terms of gender (Camargo 2019) and this interaction illustrates the gender dynamics present in clinical encounters. While the physician makes recommendations to the woman from his position of biomedical authority, the husband intervenes to reaffirm his masculine role as provider, suggesting that his wife’s body size is evidence of care, economic capacity, and family honour. Consequently, the recommendation to lose weight comes into conflict with culturally embedded expectations surrounding gender values, masculinity, femininity, marriage, and wellbeing.

Giving advice and recommendations in healthcare encounters

During healthcare encounters, the medical doctors and nutritionists also discussed eating unhealthy food and overeating in relation to their patients’ social and family relations. One medical doctor applied what may be called a ‘restrictive’ discourse (in comparison to a

selective one), as it consisted of “reducing or eliminating certain foods” (Meza-Palmeros 2021: 7) and said that he often told his patients to restrict their eating and drinking behaviour at parties and social events. He explained the importance of “saying no to a doughnut.” He gave an example of how he could talk to an obese and diabetic patient:

[I say]: If you're going to eat that, it's going to continue to affect you. You have to learn to say no. That means depriving yourself of eating delicious [food]. Or drinking when everyone else is having a good party, and saying, “Well, I can't anymore because I have to take care of myself.”

Several interviewees noted that this type of advice, which placed responsibility on individual self-control, and that emphasized individualism and an ethics of self-care (Ferzacca 2000), frequently proved difficult to follow and was sometimes contradictory in everyday life, especially in social settings where eating and sharing food were closely associated with sociability, care, and a sense of belonging (Quispe Condori, Wedel and Ledo 2025). Nevertheless, during clinical encounters with obese patients, the healthcare professionals emphasized the importance of educating their patients to reduce the intake of carbohydrates, eat healthier food, and do some kind of exercise. Several of the interviewees also expressed concerns about heavy metals and preservatives in food, and that vegetables sold in markets, such as broccoli and salad, were not sufficiently washed and needed to be disinfected. One medical doctor was particularly worried about the excessive consumption of processed food as this, he said, could also provoke gallstones.

Overall, healthcare professionals would recommend eating only one kind of tuber or cereal during a meal, choose grilled, non-fatty chicken instead of pig, choose banana or egg instead of bread, and eat more protein rich, healthy vegetable food, such as chia seeds, quinoa seeds and amaranth seeds. In their accounts, chicken occupied an ambivalent position: it was described as unhealthy when fried or cooked with added fats, but as a healthier alternative to pork when grilled or prepared with less oil. These recommendations were often presented as educational strategies during clinical consultations. Frequently, biophysical, biochemical, and physiological cultural models, or ontornorms, were enacted by both the physicians and the nutritionists (Mol 2012; Christensen, Hillerstad and Holm 2017). A medical doctor said that he explained to the patient how to count carbohydrates, to eat less and to eat more protein, vegetables and fruits. Another recommended using a drawing of a plate divided into proteins, carbohydrates and salad. Similarly, a nutritionist said:

I try to personalize the diet according to the socioeconomic capacities of the patients. Of course, I also consider their tastes and preferences. I think the most basic advice in our environment is the consumption of water, fruits and vegetables. Concerning carbohydrates, they should be consumed in moderation. It is not possible to eliminate them totally as the dishes in Cochabamba are very high in carbohydrates.

Both the medical doctors and the nutritionists experienced that many patients had difficulties adhering to advice, and they struggled to get their message through. In some cases, it was of little use to suggest a certain change of lifestyle or physical activity, as this was believed

to require too much from the patient. A medical doctor said: "One cannot recommend gymnastics to a patient who is 60, and who is diabetic, hypertense, and obese, to reduce the belly and burn calories. It's impossible to say this." Another medical doctor also felt a necessity to employ a more provoking and even bizarre language related to uncontrolled behaviours, even though physical impairments may be something quite natural for a person of advanced age, to explain the risks of unhealthy foods, obesity and of being overweight:

I say to the patient: "How long do you want to live? You could live five more years, but if you want to live longer and in good condition, you have to change your lifestyle." ... I could say: "If you want to reach your 80s in good condition, then begin to change here, because if you don't change here, you will be wearing diapers in your 80s".

Healthcare professionals' thoughts about policy measures

The healthcare professionals also had various ideas, suggestions, and policy measures about how to reduce obesity and create a more health-promoting environment in Cochabamba, and in Bolivia in general. A medical doctor claimed that on the local political level, it was important to promote physical activity. Other suggested recommendations and policies were a tax on ultra-processed food, the promotion of seasonal vegetables and fruits, and healthy food kiosks. Several healthcare professionals also requested clear and unambiguous labelling for all food products, indicating, with symbols, signs, colours and big letters, information about nutrition, carbohydrates, fats and sugar, with the aim of warning people about unhealthy food. In a similar vein, to better protect children, they also asked for special children's menus in restaurants with healthy dishes, and that menus should include information about the number of calories for each meal.

Discussion

The most important issues discussed by the healthcare professionals, based on their experiences with patients and their families, can be summarized as: unhealthy eating habits; a sedentary lifestyle and lack of exercise; lack of purchasing power to buy healthy food; lack of time to prepare healthy food; oversized portions and unhealthy food for children in restaurants; experiences of stress in relation to bad food habits; cultural perceptions of the body that contribute to fatness; the need to refrain from social activities that involve unhealthy drinking and eating; and the need to educate people about unhealthy and healthy food. In addition, more overarching structural interventions, such as governmental and fiscal policies, were also suggested. Overall, these were all relevant and important questions when promoting healthier food consumption and a healthier lifestyle.

The medical doctors' and nutritionists' experiences, thoughts, and advice covered a broad area of interrelated problems. Taken together, they illustrate the importance of holistically considering cultural, social, economic, and political issues in relation to the nutrition transition and obesity epidemic in Cochabamba, Bolivia and the Global South in general. Hence, their valuable experiences with obese and overweight patients, often over many years, point to the importance of a multi-dimensional and interrelated approach, but also that there is no 'quick fix' to the problems surrounding food consumption, obesity, and

illness. On the contrary, these conversations indicate the necessity to understand food consumption in all its complexities, considering both people's limited agency in relation to structural factors and the environment, people's ideas, values and perceptions, and the social and symbolic use of foods. Hence, there is a need to emphasize the whole context in which people's values and norms are expressed (Page-Reeves et al. 2013), and in particular to focus on socioeconomically vulnerable groups, such as migrants and poor women.

Although the healthcare professionals commonly strived for a patient-centred approach and for acknowledging the uniqueness of each patient in healthcare encounters, the patients' experiences and their lifeworld were also to some extent individualized, de-socialized, and medicalized. When this took place, the medical doctors and nutritionists risked reducing their patients to their individual, objectified, biological bodies (Felder, Felt and Penkler 2016).

When asking patients to refrain from eating sweets and unhealthy foods during social events, when helping them to count calories or draw a healthy food plate, or when generally discussing nutrients and 'food behaviour' (Fischler 2011), there was also a risk of downplaying the fact that eating is an important contextual and meaningful social act (Fischler 2011; West 2021; Quispe Condori, Wedel and Ledo 2025). Food brings people together, it is not "just another form of consumption; it cannot easily and completely be 'privatized' and regarded as an ordinary merchandise or commodity" (Fischler 2011: 532). Moreover, in this process, the healthcare professionals were promoting a certain, and potentially counter-productive, way of dieting techniques, approaches and advice, in particular norms based on the idea that the overweight body and certain food consumption is 'problematic' and depends on cognitive control and self-discipline (Mol 2012; Ferzacca 2000).

During the interviews, children's food consumption was also discussed at length. In general, parents are often considered to be the most important figures when controlling and regulating their children's weight, and mothers are frequently blamed if their children are obese (Ulijaszek et al. 2017). This "stigma by association" (Gorlick et al. 2021: 69) became apparent as several of the healthcare professionals claimed that mothers often did not prepare nourishing meals for their children, and that children were left alone to eat junk food that made them fat. Being obese as a child increases the risk of chronic illness as an adult (Tzioumis and Adair 2014), and child obesity after infancy must obviously be taken seriously, but blaming mothers without adequately recognizing their limited agency due to lack of time and resources does not contribute to a complete understanding of the problem. This pattern should instead be seen in its broader societal, socio-economic, and socio-political context as "it does not make sense to blame parents for childhood obesity when society has changed in a way that favours obesity" (Ulijaszek et al. 2017: 199).

A more holistic approach to child obesity requires raising one's gaze and focusing on reducing inequalities and contributing to a more nuanced and comprehensive food policy. Interventions that seek to reduce childhood obesity require collective and political responsibility, focusing on capacity building and empowerment for poor, low-income families and disadvantaged groups (Ulijaszek et al. 2017), such as, for example, using taxes and subsidies to redirect prices to more healthy products (Popkin and Reardon 2018), as was discussed by some of the interviewed healthcare professionals.

In relation to the health professionals' experiences about people's positive cultural connotations to overweight bodies, there is obviously a need for information and education

about the health risks with obesity and overweight, in particular “heart, liver, and kidney disease, high blood pressure, and diabetes” (Waldstein 2018: 7), but it is also important to consider how body fatness is valued in different societies (Ulijaszek 2024). From a Western perspective, the ideal body for both sexes is “lean, strong, androgenous and physically ‘fit’ ... through which the core cultural values of autonomy, toughness, competitiveness, youth, and self-control are readily manifest” (Scheper-Hughes and Lock 1987: 25). Hence, in the context of the current obesity crisis, there is a risk that healthcare professionals, influenced and affected by Western and biomedical ideals, contribute to a stigmatizing view where “body size is both increasingly medicalized and equated with moral categories such as sloth and indiscipline” (Felder, Felt and Penkler 2016: 405). In biomedical healthcare encounters, there is always a risk of emphasizing standardized procedures and dehumanizing patients by reducing them to their biological bodies, and, in so doing, neglecting the uniqueness of each patient and lessening the importance of sociocultural and subjective factors (Felder, Felt and Penkler 2016).

The medical doctors’ and nutritionists’ discussion on what people should eat, and what to avoid, also point to the importance of not individualizing and medicalizing consumption habits. Consumption of food, and ways of being and acting in relation to food, should be understood as multifaceted, and influenced by political-economic factors that decide what is available and at what prices. Large industrial fast-food chains aggressively promote ultra-processed products, such as burgers, pasta, pizza, nuggets, biscuits, and sugared drinks, contributing to poor nutritional health (Monteiro et al. 2013; Ulijaszek 2024). Moreover, this is further complicated by the fact that “industrially produced foods are [commonly] believed to be superior to foods that can be grown at home. The convenience foods produced by agribusiness corporations provide extra leisure time for women and may signify higher social status” (Waldstein 2018: 4). As was also touched upon by the healthcare professionals, there is an urgent need to promote healthier consumption choices, and it is important to find ways to make it more profitable for the food industry to produce healthy foods. The challenge for interventions and policies to be effective, also for socio-economically vulnerable and lower-income groups, is to find ways to make healthy eating cheaper, less time-consuming, and tasty (Popkin and Reardon 2018).

Conclusion

The consumption of unhealthy foods, obesity, and being overweight, are prominent problems today, all over the world, and particularly in the Global South. The interviews with the medical doctors and nutritionists in Cochabamba point to the importance of a holistic, multifaceted, interrelated, multi-dimensional, and culture-sensitive approach to unhealthy food consumption and the problems surrounding obesity. Their experiences as professionals, and particularly their meetings with patients, covered a broad area of cultural, social, economic, and political topics. This indicates the necessity to understand the whole cultural context in which people’s ideas, values, and norms are expressed, including the social and symbolic use of food, perceptions of the body, structural inequalities, poverty and lack of agency, experiences of stress and lack of time, as well as the risks of medicalizing food consumption and the body in healthcare encounters. Healthcare professionals’ perspectives and experiences are important as they can contribute insights about healthcare encounters and advice to patients suffering from obesity, as well as when developing food policies, and they are vital if interventions are to succeed.

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