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Review Article

Bio-Cultural Dimension of Health as Reflected in Practices and Behavioural Pattern Associated with Food

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Introduction

Like most of material culture, food shapes the society's identity and cultural existence. But very often it puts the members of a community into a dilemma; the dilemma revolving round strict adherence to identity or making the food-based boundary more flexible and accommodative of other categories of food into one's own system. At present, scientific and clinical investigations target food to assess the proper nutritive value of the food items preferred or prescribed and strictly followed by the community members to whom traditional food items are the markers of social identity. This has a direct bearing on community's perception of health and poses a challenge to health care measures and ethics that are not conventionally focused in a community setting. The question arises as to whether scientifically based health models could automatically be transferred to or imposed on the community or whether the whole process represents a problem area, which means these could not be smoothly transferred to the community. When a community becomes conflict-prone, it tells upon the health of its members and food intake becomes irregular. One more question may also be involved with it, that is, the problem of bio-ethics. According to Ruth Chadwick & Mairie Levitt [1], the application of some broad principles is clearly related with changes in health care understanding, which may also apply to food in all its aspects. The four principles identified by them in this connection are autonomy, beneficence, non-maleficence and justice. The difficulty is in the present context principlism is almost totally individualist in the sense that the principles are very much concerned with the interests of individuals or, as in the case of justice, with resolving conflicts between the interests of different individuals in a community. Doubts have been expressed about the appropriateness of using them in the context of individuals rooted to a community because there is no single grounding of the principals involved. For instance, the question of autonomy may have significant implications both for the way in which it is applied and for dealing with conflicts and the working of other principles. It brings the dominating role of the 'Third Party', in this case State into play. As the promoter and provider of food, state takes up the leading role in including some items in the category of acceptable food which is in conformity with its known position with respect to national food. A divine component is sometimes invoked to protect a possible source of food, even raising it to the level of divine entity. Cow as a source of food may be an example. In such cases, state projects itself as the saviour and protector of normative values. State intervention in matters of food may take different forms. Very recently, a circular issued by the government-run Central School authorities on food items to be carried by the students as tiffin has created much controversy. The list of items include bread, vegetables, boiled gram seeds and fruits, but no non-vegetarian item, not even eggs, could find a place. Incidentally, in the Hindi belt of India vegetarian food is considered to be the ideal form of diet prescribed by the Hindu society. There is another side of it. Attaching principles to food intake has different manifestations. While in health care ethics autonomy of the patients is considered supreme, in the case of mental health more appropriate it is to intervene when necessary for the sake of patient's own protection. The basic question, however, remains, which is concerned with poverty, deprivation and depleted resources. Such conditions also speak of lack of food or lack of capacity to procure food. Again, failure to produce food is not a reflection of one's capacity to produce food. The production process is controlled by a host of other factors which are not entirely within the control of an individual. All in all, the contrast between the individualist and communitarian approaches to community health has been stressed time and again and here the focus could very well shift to food and food items.

Health professionals now show a greater inclination towards the guidelines provided by social scientists including sociologists and anthropologists in matters pertaining to health care and its differential manifestation. The guidelines lay stress on social factors like inequality, class, gender, ethnicity, which affect health in one way or the other. Social factors are considered highly relevant to the treatment of modern diseases and they operate at various levels – individual, community and society. It may not be just enough to take only a comprehensive etiological view in studying diseases. Chronic

diseases and illnesses also affect the personality of the individual, which is being influenced by a number of social and psychological factors. For example, in infancy or childhood such factors as lack of parental care and love, overindulgence, inconsistent rearing of children lay the foundation of a vulnerable personality. Their number is on the rise at an alarming rate. A type of dependence –independence conflict may emerge which is also reflected in food habits. This particularly applies to the habit of taking drugs, alcohol and other stimulants. The problem of social pathological condition is related with it. From an altogether different perspective, the sight of young Indian girls smoking cigarettes in a city's public places was unthinkable even some time back. More than pleasure seeking, girl's behaviour in this case symbolises an act of defiance, an assertion of rights for equality. In health studies individual understanding and experiences, even the negative ones, provide an important resource area. This resource area, when combined with the social and cultural environment in which people live, can provide the context in which information about health is received and illness is experienced. Much of this information about health, though self-reported, refer to the community or society the individuals belong to. Family is the immediate context to which the patient as an individual situates himself or herself. The emotional needs of an individual find fulfilment in the community of one's origin. Even when compromises are called for, as in the case of 'mixed' marriages involving individuals from different communities, the marriage-seekers try to retain their original cultural position unless, of course, they are debarred from retaining their community identity. In the event of any such excommunication, the psychic suffering of individuals increases manifold. Such incidents have health implications as well because food intake will be irregular. As they are under psychological stress, it will be reflected in their behavioural expressions. Social origin of psychological disorders may not be difficult to seek, which is increasingly given prominence. Attributes of the person in the form of physio-chemical, anatomical, physiological, bio-chemical features are combined with one's behavioural and functional representations. Academic engagement with food studies from the perspective of health has to tap this resource area, which has now become a routine exercise.

How important are community actions and individual experiences as community members with regard to selection of food items and consumption pattern associated with the prescribed items? A lot of discussion has been made on the arguments put forward by Mary Douglas [2] in this connection. Her observations that the structure of meals and the use of specific food items, such as biscuits, not only served to signal and reinforce social integration but also strengthen the boundaries and hierarchies still make sense. The list of such items could be longer, which have further consolidated such formations. Not only the content of meals, the purpose for which these are served and the occasions when these are served are important considerations. They, however, carry different meanings to different sections of population. It cannot be said that the younger people are averse to traditional food, but it carries a different meaning to them, and they use it for their own purpose. They are against traditional restrictions to certain food items and are prepared to accept certain food, unless there is a political reason for not doing so. Political forces now operate with social cause exercising greater effective control over the people. When the meanings of traditional food practices, relying more on consumer items, become deep-seated, the working class people or common people at large find it difficult to accept the advice of scientific authorities who do not appreciate their social rituals on the ground that these are against progressive ideas. Still, there is much of flexibility with the rapid change in the social situation. Even the tribal people, to whom inequality was never the determining social principle, have started rating a food product on the basis of its use, application and popularity. Ethnic food has found a place in the modern food stalls. Similarly, the popularity of food now depends more on its commercial value rather than on its ritual value. How quickly meaning and emphasis change with growing demands may be explained with the help of a simple example. There is obviously a difference between mahua or mahul (Madhuka indica. Sapotaceae) fruit and the drink made out of it which is not only a favourite drink of the Santal tribe but has considerable ritual value attached with it. The two have now been combined in the form of raw materials and final product. From yet another consideration, the market value or commercial value of mahua drink far surpasses its ritual value. In one study with Isherwood, Douglas [3] enjoined readers to take seriously the social and ritual bases of various forms of rhetoric and decision making. Such a process would also include consumer choice, environmental and other risk analyses [4] and the decision taken by bureaucracies [5]. Food preferences and food value, scientific as well as ritual, may be periodically reassessed from all these considerations. The ritual basis of symbolic pollution associated with some food used to count a lot. It still counts but is no longer mandatory. Bureaucracies, on the other hand, take decisions which expose tribal people and people with a strong sense of community attachment to the world of consumers forcing them to adopt a consumer-oriented frame of mind. As a result, their traditional food items have changed or are in the process of being changed in line with modern choice and preferences. What is more, they themselves have started accepting modern food without any hitch. In the name of eco-tourism unchecked entry of modern food and drinks has become a common phenomenon. Side by side, the harmful effects of commercialisation are clearly in view. While passing through a Santal village in an area on the western part of the Indian State of West Bengal, which is frequently visited by the tourists, I could notice roadside stalls packed with soft drinks and fast food items – a stark reminder of the traditional concept of purity being in danger. I admit that this was not quite the spirit of Douglas's position as reflected in her book Purity & Danger [6]. The context was also different. But there may not be much scope for any dispute about the impending danger of fast food encroachment on the traditional food habit. Hierarchic tendencies are gradually entering into tribal areas, producing a new group of beggars and brokers. At another level, traditional food items are presented in the form of cuisines as markers of community identity. Food in this case is used to raise their voice as an assertion of group identity. On the other side, inequality is no less reflected in the mode of

consumption of food in the form of different items. During my visit to Bangladesh a few years back, the present occupant of my parental house in a village in Bangladesh, who happened to be an enlightened Muslim, made all necessary arrangement for my visit there. But he arranged our lunch with a Hindu family staying some distance away. He did not think it proper to invite us to lunch with him and his family members in the house which was now occupied by him. Paradoxically, he openly acknowledged that I was the real owner of the house and property and he was simply performing the role of a care taker. As far as I am concerned, I did not have a clear picture of the house since I was born in India and the impression I had about it and its surroundings was more in the form of a hazy reproduction of a long-lost image. Emotionally, we could unite ourselves, but differential use and preparation of food continue to remain as an obstacle to our union in the real sense of the term. The way food is combined with ethics and religious identity depends on the historical forces in operation in specific areas. Majority of Bali's population are Hindus, but the manifestation of their identity is in sharp contrast with the strict adherence to ritual and food pollution or the concept of purity and pollution ideally associated with Hindus. The Balinese Hindus are less rigid about maintaining purity and pollution with regard to food. Because of their strong sense of attachment to Bali as the land of their ancestors and its history being an integral part of their existence, food and food restrictions followed in a typically Hindu society are of lesser importance to them. To put it in another way, food functions as the unifying factor between Balinese Hindus and the rest of Indonesian population. This, again, may appear to be a one-sided assessment. Religion has been held responsible for many differences and norms affecting the fundamental values and behavioural pattern including health behaviour. The fundamental values of religion are rarely intelligible to the people to whom customary practices and religious symbols used as a group identity are more important by which they can promote themselves as a distinct entity. Any encroachment into their basic identity will cause untold suffering to them, they believe. A number of medical anthropological studies, in their revelations, have shown the use of food as a reflection of inequality and differentiability in no uncertain terms.

In the study of 'modern' disease forms, social science perspective seems to have attained a level of acceptability and is no less relevant than bio-medical science. What Turner BS [7] has realized earlier may still provide some food for thought. As he observes, "... the general practitioner will come to depend more and more on sociological skills as their education in the physiological, chemical and biological aspects of disease and illness becomes increasingly less relevant in the treatment and management of patients. The age of heroic medicine has been replaced by the mundane medical management of chronic as opposed to acute illness."

Management and subsequent treatment of modern diseases will continue to depend on the essential social functions operating at the level of individual, community and society as a whole. Along with advertising of harmful substances such as alcohol, tobacco, opium, narcotics, emphasis has now shifted to providing health services in a situation where social conditions and behavioural addictions have far-reaching consequences. By shifting their emphasis from social to bio-cultural, anthropologists demonstrate their preference for an integrated approach, much in conformity with the discipline's basic stand on following a holistic model. The whole approach needs to be looked into from a situation of change in disease pattern and the combined effects of biology and culture in the process of change. Changes in biological factors are not easily observed or observable over a short period of time. Changes in culture, however, lead to advances in forms of various therapies devised and made available to restore health and create suitable conditions for the maintenance of health. When the goal is to promote health, it calls for an integrated approach covering all aspects of human life. It entails addressing the biological as well as cultural factors that contribute to sickness. As is generally understood, in sickness physical and mental ailments undergo a process of socialization. Even if we claim that we are not sick, the society we live in may be sick upsetting all our expectations. Food may not be directly responsible for producing sickness episodes suggestive of disruptive social effects, but its choice and preferences may be subjected to a process of social validation. Furthermore, there is no uniform pattern which can be developed on the basis of food consumption. In some cases food and the way it is taken may prove to be an impediment to good health, while in some other cases it actually promotes good health. The differentiation has much to do with 'non-medical factors than on the quantity of medical care' [8,9]. The connotation 'non-medical' refers primarily to cultural factors or factors which are culture-specific and environment-conditioned. The major non-medical factors are derived mainly from the social and physical environment affecting a specific group of people in matters pertaining to public health. Community perspective could be an important consideration in such cases. When safety promotion is undertaken by the members of the community to ensure public security, it works much better. In Bhutan school children and young people are required to contribute labour in the name of voluntary service to keep surroundings clean, to make people safety conscious while crossing roads and the results are encouraging. One reason why Bhutan is up in the scale of happiness could be its success in removing social inequalities to a considerable extent, where freedom enjoyed by the females in some fields is comparable to that of the males. Development has significant impact on health and health behaviours. If diseases connected with development refer to certain pathological conditions caused by the implementation of development schemes, these are certainly on the increase. The recent incident at Bowbazar in central Kolkata of India, where scores of old residential buildings crumbled down as a result of underground tunnelling of Metro Railway Project is a glaring example. Not only have the residents become homeless within quick time, they had to vacate their houses in short notice forcing them to leave almost everything behind. They only add to the ever-increasing morbid population of the city. The cumulative effects of the disaster can never be compensated. Loss of community feeling, disruption in functions of family as a cohesive unit and in neighbourhood relations will have long-term repercussions in mental and physical health. Much of future health care will ultimately depend on modifying the practices

used to restore health. The difficulty is relationships between the biological, behavioural and social-cultural processes cannot easily be expressed in the form of a life-cycle model. When environmental and community effects are added to such a system, it becomes more complex which may not give much scope for prescription or deduction of predictable rules to be followed. Even then, such a 'synthesis', which was anticipated or the importance of which was realized long time back, is a necessity for better living.

Note

This article is based on the keynote given by the author in a Seminar on "Bio-Cultural Approach to Health Studies" organized by the Department of Anthropology, Vidyasagar University, Midnapore, West Bengal, India in 2017.

References

1. Chadwick Ruth, Mairie Levitt (1998) Ethical Issues in Community Health Care. Arnold, London.
2. Douglas Mary, Nicod M (1974) Taking the Biscuit: The Structure of British Meals. New Society 19. London.
3. Douglas Mary, Isherwood Baron (1978) The World of Goods: Towards an Anthropology of Consumption. Basic Books, New York, USA.
4. Douglas M, Wildavsky A (1982) Risk and Culture. University of California Press, Berkeley, USA.
5. Douglas M (1986) How Institutions Think. Syracuse University Press, New York, USA.
6. Douglas Mary (2002) Purity and Danger: An Analysis of Concepts of Pollution and Taboo. Routledge, London.
7. Turner BS (1987) Medical Power and Social Knowledge. Sage, London.
8. Fuchs VR (1978) The Great Infant Mortality, or What Caused the Slump?
9. Moore LG (1987) The Biocultural Basis of Health. Waveland Press, Illinois, USA.

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