

circumference of their waist. All these numerical measurements – characteristic of the ‘disease’ approach to ill-health (see Chapter 5) – ignore the *meanings* and social significance of food, meal-times, and the body itself for the people concerned, as illustrated in the case study of British Bangladeshis.

### Case study: beliefs about food and diabetes among British Bangladeshis, London, England

In two studies, in 1998 and 2000, Greenhalgh and colleagues,<sup>11,21</sup> studied beliefs about diet and diabetes mellitus among a group of 40 Bangladeshi immigrants in London. While some of these beliefs overlapped with the medical model, others were very different. The whole group recognized the importance of diet in diabetes control, and believed that one of the main causes of diabetes was too much sugar. They also blamed heredity, ‘germs’ and stress. In terms of foodstuffs, however, they divided them into two symbolic categories in terms of their perceived ‘strength’ (nourishing power), and ‘digestibility’. Strong foods were perceived as energy-giving, and included white sugar, lamb, beef, *ghee* (derived from butter), solid fat and spices. Such foods were considered crucial to maintain or restore health, and essential for certain festive occasions. They were considered dangerous, however, for the old or the debilitated (including diabetics), for whom weak foods (such as boiled rice or cereals) were more appropriate. Raw foods, and those baked or grilled, were considered indigestible, as were all vegetables that grow under the ground. They were considered unsuitable for the elderly, the very young or those who were very ill. Thus, the recommendation that diabetics should bake or grill their foods rather than fry them would not accord with their food beliefs. In contrast, molasses – a dark form of raw sugar, liquid at room temperature – was considered safe for diabetics to eat, and very different from lighter coloured white sugar, butter, *ghee* and solid

fat, which was forbidden. The whole sample believed that the onset and control of diabetes depended on the *balance* between food entering the body and emissions from the body, such as semen, sweat, urine and menstrual blood. An excess of any of these emissions was believed to cause illness and weakness, as in diabetes. In the Bangladeshi community, because communal feasts, festivals and social occasions are common (and usually involve the consumption of sweets and rich foods), a calculated compromise between social obligations and dietary compliance had to be made by both diabetics and their families. Finally, the value of physical exercise and weight-reduction had little cultural meaning for the sample. In general, larger body size (but not obesity) was viewed as an indicator of more health, while thinness was a sign of less health.

## INFANT FEEDING PRACTICES: CROSS-CULTURAL COMPARISONS

The care and feeding of infants is a central concern in every human group. There are widespread differences, however, in the techniques of infant feeding, whether breast, bottle or artificial feeds are used, and in the age and technique of weaning. Despite medical advice that, for a variety of physiological and emotional reasons, ‘breast is best’, breast-feeding has declined in most countries in the world this century. This is particularly the case in urban, industrialized societies or in non-Western societies undergoing modernization and urbanization. In most cases, moving from the countryside into the city results in a decline in breast-feeding. For example, the 1984 *World Fertility Survey*,<sup>53</sup> based on data from 42 developing countries, found that rural women in those countries breast-fed an average of 2–6 months longer than their urban counterparts. As Farb and Armelagos<sup>54</sup> put it, ‘mothers in many parts of the world often consider breast-feeding to be a vulgar peasant custom, to be abandoned as soon as the bottle can be afforded’.