Redefining Health and Well-Being through a Cross-Cultural Lens

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Abstract

This paper redefines the concepts of health and well-being by examining them through a cross-cultural lens, emphasizing the significance of cultural context in shaping these constructs. While health and well-being are often perceived through medical or psychological frameworks in Western societies, this study explores how different cultures interpret and prioritize these ideas. By examining practices, beliefs, and values in diverse regions—including Indigenous, Eastern, and Western traditions—this research uncovers the varying dimensions of health, from physical and mental well-being to spiritual and community-centered approaches. The paper argues that a more inclusive definition of health and well-being requires an understanding of the socio-cultural factors that influence individuals' perceptions and experiences of these concepts. It also highlights the limitations of a one-size-fits-all approach to health promotion and the importance of integrating cultural competence into global health strategies. By analyzing cross-cultural variations in health and well-being, this paper offers a framework for more effective and culturally appropriate health interventions that address the diverse needs of global populations. Ultimately, it calls for a broader, more holistic view of health that incorporates the richness of cultural perspectives to promote well-being on a global scale.

Keywords: Health and Well-Being, Cross-Cultural, Cultural Competence

I.INTRODUCTION

In an increasingly interconnected world, understanding health and well-being extends far beyond biomedical definitions and clinical settings. Different cultures offer diverse perspectives on what it means to be healthy, how well-being is achieved, and which practices best support a fulfilling life. These variations are shaped by historical experiences, spiritual beliefs, social structures, and environmental factors unique to each society. Redefining health and well-being through a cross-cultural lens allows us to challenge Western-centric models, incorporate holistic and community-centered approaches, and promote more inclusive, equitable health policies. By exploring how various cultures perceive and pursue wellness, we can uncover valuable insights that enrich our global understanding of human health and foster systems that honour the full spectrum of human experience.

HEALTH AND WELLBEING

“Health” and “well-being” are often spoken of in tandem, as though inextricably linked—two concepts bound together, yet distinct in nature and not easily disentangled. Are these concepts overlapping but separate entities, one nested within the other, or are they co-constitutive dimensions of a larger whole? This

seemingly semantic question has real implications: how we define and relate these concepts influences health systems, care delivery, research priorities, and policy development. In this commentary, we explore the nuanced relationship between health and well-being, propose a reframed conceptual model, and advocate for an integrated framework that better reflects the lived experiences of individuals and communities across cultures.

The World Health Organization's seminal 1946 definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" marked a pivotal shift away from disease-centric models. It acknowledged that health cannot be reduced to clinical indicators alone. Crucially, this definition positioned well-being—largely subjective and self-defined—as central to the experience of health, alongside more objective biomedical evaluations. A person's health, therefore, involves not just physiological status confirmed by laboratory results or physical examinations, but also their self-perceived emotional, social, and spiritual state.

The rationale behind this expansive view of health was to correct a narrow focus on pathology and diagnostics that often neglected the person behind the patient. In the decades since, concepts such as the biopsychosocial model and patient-centered care have further expanded our understanding of the human experience in healthcare. More recently, the U.S. National Academies of Sciences, Engineering, and Medicine's 2023 report *Achieving Whole Health* articulated a vision of health that is "defined by individuals, families, and communities" across physical, behavioural, spiritual, and socioeconomic dimensions. Similarly, the U.S. Department of Veterans Affairs now centers its care model around what matters most to the patient, rather than a sole focus on disease states.

These paradigms reflect a growing appreciation for health as a multifaceted phenomenon rooted in subjective meaning and lived context. Yet, while centering the patient's perspective is essential, there is risk in underemphasizing the role of objective health indicators. Laboratory findings, physiological measurements, and diagnostic tools provide vital insights into health trajectories, particularly when disease processes are silent or pre-symptomatic. For instance, a person may feel subjectively well, while elevated blood pressure or abnormal glycemic markers suggest significant risk of future complications such as stroke or diabetic retinopathy. Ignoring such signals in favor of purely self-reported well-being may result in missed opportunities for prevention and early intervention.

A comprehensive understanding of health must therefore encompass both the subjective and objective realms. Function, whether physiological or psychological, is not merely a determinant of health—it is a fundamental expression of health itself. At a systems level, the integration of clinical practice with basic and translational research depends on this dual perspective. Mechanistic understanding—how the body adapts, heals, and functions in context—requires attention to objective data that are embedded in the ecology of the whole person.

The interconnectedness of human biology, behaviour, and environment further supports this integrated view. Our health is not an isolated state, but a product of dynamic interactions within multiscale ecosystems. Consider, for example, the human microbiome—shaped by our diet, living conditions, and even the microbiota of those we live with. Physiological processes such as tissue repair, immune regulation, and metabolic function are deeply entwined with both our internal biology and our external social and physical environments.

Contemporary research on salutogenesis—the process of health creation and restoration—requires systemic frameworks that capture this complexity. Health must be understood as a continuum, with well-being and dysfunction representing interrelated states across time and context. Measures like blood pressure or hemoglobin A1c are not merely tools for clinical decision-making; they are reflective of the underlying systems' health and resilience.

To advance this integrated understanding, we propose a framework (Figure 1) that situates individual experiences within broader social, economic, and ecological systems. This model incorporates:

Subjective well-being—a person's self-assessment of physical, emotional, and spiritual wellness, reflecting their internal perception and sense of balance;

Objective health function—physiological and psychological measures that track resilience, risk, and biological functioning;

Contextual determinants—including social, environmental, educational, and vocational dimensions that influence opportunity and access to well-being;

Health-related behaviours—which act as bridges between personal health and the social environments in which people live and act.

By placing individual health within a broader sociocultural and environmental matrix, this model supports a more inclusive, accurate, and actionable approach to health care. It honors the diverse ways health and well-being are defined and experienced across cultures, and it provides a more coherent path forward for interdisciplinary research, public health strategy, and clinical innovation.

II.HEALTH AND CULTURE: AN INTERWOVEN PERSPECTIVE

Before delving into the nuanced relationship between health and culture, it is essential to recognize that scholars across the globe—working in diverse medical, health, and healing environments—have employed a range of methodological approaches to develop varying theoretical frameworks related to health. This growing body of work has contributed to the emergence and rapid expansion of medical anthropology as a key subfield within anthropology. Practicing or applied anthropologists utilize these frameworks, methods, and ethnographic insights not only for academic inquiry but also for designing effective public health policies and programs aimed at addressing complex health-related issues in human societies.

As previously discussed, health-related practices are never culturally neutral. Rather, they are deeply embedded in, and shaped by, the socio-religious beliefs and customs of a community. These cultural norms and worldviews carry significant implications for how health and illness are perceived and managed. In this context, it becomes pertinent to revisit the foundational question: What is health?

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 1948). This comprehensive definition underscores the interconnectedness of psychological, physiological, and social factors in contributing to overall well-being. Consequently, health must be understood not simply as the absence of illness, but more broadly as a quality of life that reflects a dynamic equilibrium influenced by social and economic conditions.

Health is also often seen as an indicator of societal development. Studies focusing on the health status of specific communities highlight the intricate interdependence between social systems and health outcomes. Every culture, regardless of geographical or historical context, encompasses its own set of indigenous concepts and understandings related to health—ranging from beliefs about the causes of illness, diagnostic frameworks, and curative practices. These components collectively form what may be termed the health culture of a community.

In any discussion of health, it is common to encounter the terms *disease*, *illness*, and *sickness*—terms that are often used interchangeably but carry distinct meanings in medical anthropology. *Disease* refers to objectively defined pathological conditions of the body, regardless of whether these are recognized or experienced by individuals. In contrast, *illness* encompasses the subjective, culturally-informed experiences and perceptions of being unwell, including conditions that may not align with biomedical understandings of disease. *Sickness*, meanwhile, is a broader term that encapsulates all forms of ill health, including both disease and illness. According to Fabrega Jr. (1972), while *disease* is typically aligned with Western biomedical paradigms, *illness* is rooted in local, indigenous knowledge systems and shaped by sociocultural factors.

As emphasized earlier, culture—defined as the learned and shared behaviors and practices that govern human life—has a profound influence on health beliefs and practices. It not only determines how individuals perceive health and illness, but also shapes professional medical behaviours and health-seeking patterns. Culture is therefore a central determinant of health, guiding both personal behavior and institutional approaches to medicine. Understanding this cultural dimension is crucial for interpreting health patterns across populations and for designing interventions that align with local worldviews and practices.

From perceptions of disease causation to diagnostic methods and treatment preferences, the cultural framing of health extends to the utilization and selection of available resources for preventive and curative purposes. All of these dimensions—prevention, diagnosis, and treatment—are culturally informed and reflect broader efforts by individuals and communities to adapt to their physical and social environments.

REFLECTION: CULTURE, COMMUNITY, AND THE ANCIENT ROOTS OF HEALTH

The word *culture* finds its roots in the notion of "cultivation"—not only of crops, but also of relationships, traditions, and communal bonds. Historically, culture and community have been inseparable concepts, reflecting the interdependent nature of human societies. Similarly, ancient understandings of health were deeply embedded in communal values and expectations. Health was not seen merely as an individual's internal state but rather as a measure of one's appropriateness and harmony within the collective. In such societies, when an individual's behavior deviated from communal norms, the result was believed to be an imbalance that could manifest as illness—not necessarily in the individual responsible, but potentially in others within the community.

In this worldview, health was a communal concern—a reflection of social balance and ethical conduct. Interpersonal relationships and social cohesion were seen as fundamental to both cultural life and physical well-being. Thus, historical notions of health, culture, and community were intricately connected, offering valuable insight into how shared values and behaviors have long influenced the way societies understand and respond to health challenges.

III. HEALTH AND CULTURAL DIFFERENCES: UNDERSTANDING THE INTERPLAY OF CULTURE AND HEALTH BEHAVIOUR

Every individual is born into a specific cultural context, which plays a fundamental role in shaping their values, beliefs, and behaviours—including those related to health. From birth through adulthood and into old age, individuals are constantly influenced by the cultural environments they inhabit. These cultural frameworks impact not only daily routines and social interactions but also perceptions of health, illness, healing, and well-being.

One of the most significant processes through which culture shapes health behaviour is acculturation—the dynamic process that occurs when individuals are exposed to and influenced by more than one cultural system. Acculturation involves the negotiation of cultural differences and the integration, rejection, or blending of cultural practices, including those related to health. Importantly, acculturative experiences are not uniform. Individuals from different cultural backgrounds may respond differently to similar health situations based on their cultural orientations, beliefs, and prior experiences.

For instance, when confronted with illness or a health concern, a person raised within one cultural setting may choose a response or treatment that appears entirely unfamiliar—or even inappropriate—to someone from another cultural background. Health behaviours that seem unusual or irrational in one society may be seen as normal and even essential in another. A striking example of this is found in religious dietary practices. In Hinduism, the consumption of beef is strictly prohibited, while in Islam, pork is forbidden. For adherents of these faiths, the mere thought of violating these dietary norms can lead to intense psychological distress or even manifest physical symptoms. However, it is important to note that adherence to culturally sanctioned dietary practices—when balanced and moderate—is not inherently harmful to health. Rather, it is the psychological impact of perceived violation or deviation from these norms that can contribute to negative health outcomes.

These examples underscore how the clarity and rigidity with which each culture defines acceptable health behaviors can affect individuals' well-being, creating uncertainty and stress when behaviors deviate from cultural expectations. Such tensions can have significant implications for physical, emotional, and social health. In this context, understanding the relationship between individual and collective identity becomes essential—particularly for applied anthropologists and health professionals working within multicultural settings.

A key area of investigation in medical anthropology is the concept of illness behaviour, which encompasses how individuals perceive, interpret, and respond to signs of illness. This includes the patient's personal experience of illness, the reactions of family members and caregivers, and the broader community's interpretation of symptoms and appropriate responses. Cultural beliefs strongly influence the selection of treatment strategies, the timing of medical intervention, and the type of health system—biomedical, traditional, or spiritual—that is sought during an illness episode.

Thus, any comprehensive study of health within diverse cultural communities must take into account the complex array of factors that influence both health and illness. Cultural context is not merely a backdrop to health behaviour—it is the very medium through which health is experienced, interpreted, and acted upon. In cross-cultural health research and practice, culture serves as both a lens and a language—a way of understanding and communicating about the body, illness, healing, and wellness.

Moreover, systematic investigations into health and disease in cross-cultural contexts must include detailed examinations of indigenous systems of disease classification, diagnostic methods, and treatment practices. However, such encounters carry the risk of ethnocentrism, where researchers or practitioners may unconsciously impose their own cultural assumptions and stereotypes onto the communities they study or serve. This can lead to misinterpretations, marginalization of local knowledge systems, and ineffective or culturally insensitive health interventions.

To avoid these pitfalls, it is crucial to approach cross-cultural health studies with humility, cultural sensitivity, and a commitment to recognizing the insider's perspective. Culture must be acknowledged as a central force in shaping not only the health behaviours of individuals and communities but also the ways in which illness is perceived, explained, and treated.

In conclusion, a deep appreciation for the cultural dimensions of health is essential for anyone working in health-related fields. Whether conducting research or delivering care, professionals must remain aware that health is both a biological and cultural phenomenon, and that meaningful engagement with cultural diversity is a prerequisite for truly holistic and effective health care.

IV. CULTURAL DIFFERENCES AND PHYSICAL HEALTH

In exploring the intersection of culture and health, it is essential to recognize that cultural influences extend beyond mental health to shape physical health outcomes as well. However, it is equally important to clarify that cultural variation is not the sole determinant of all physical illnesses. Certain diseases occur across cultural boundaries and are influenced by genetic and environmental factors alike. Thus, while some illnesses are biologically inherited or environmentally acquired, others are more directly influenced by socio-cultural practices and beliefs that shape individuals' experiences of, and responses to, disease.

GENETICALLY DETERMINED DISEASES

A prominent example of a genetically inherited condition is sickle-cell anaemia—a blood disorder characterized by the presence of abnormally shaped red blood cells. Under low oxygen conditions, these cells deform into a crescent or "sickle" shape, impeding blood flow and reducing oxygen delivery to vital organs, potentially resulting in organ failure or neurological damage. This condition is notably prevalent in parts of western Africa and southern India. Though it is more commonly observed among individuals of African descent, it is not a racial disease per se; rather, it reflects geographic and evolutionary adaptation—especially in malaria-endemic regions, where the sickle-cell trait provides a degree of resistance to malaria (Giger & Davidhizar, 1999; Williams et al., 1994).

Another genetically influenced condition is lactase deficiency, also known as lactose intolerance. This condition is marked by the body's inability to effectively digest lactose, the sugar found in milk. It results from a recessive gene with high penetrance and is commonly observed in older children and adults across certain populations, particularly those of East Asian descent. Symptoms include abdominal discomfort, bloating, and diarrhoea following the consumption of dairy products. While lactase deficiency has a genetic basis, it also reflects interactions with eco-cultural factors, such as dietary customs and traditional food availability (MacLachlan, 2006).

ACQUIRED DISEASES

In contrast to hereditary illnesses, acquired diseases emerge due to environmental, lifestyle, or socio-cultural factors. One illustrative example is nutritional rickets, which has been observed among Asian immigrant populations in Britain. Rickets, which impairs bone growth, has been linked to several cultural practices, such as limited sun exposure due to traditional clothing norms, vegetarian diets lacking in vitamin D, and the use of cow's milk in infant feeding. Public health campaigns like "Stop Rickets" and "Asian Mother and Baby" targeted these communities to raise awareness about vitamin D deficiency. While these initiatives acknowledged cultural dietary habits, they also drew criticism for focusing disproportionately on cultural practices rather than broader socio-economic determinants of health, such as poverty and inadequate healthcare access (Black, 1989; MacLachlan, 2006).

NUTRITION, CULTURE, AND HEALTH

Culture profoundly shapes dietary habits, which in turn influence health and disease. Food consumption patterns, food taboos, and meal preparation practices are often dictated by cultural beliefs and religious traditions. Studying these habits is critical for understanding health outcomes within any given community. Nutrition is central to physical development, energy production, and disease prevention. Terms such as "good," "adequate," and "optimum" nutrition are used to classify the quality of nutritional intake, which is vital for maintaining both physical and mental health (Shukla et al., 1990).

For instance, the Garo community's traditional diet—centered on rice, vegetables, pulses, and moderate meat consumption—exemplifies a culturally embedded system of nutrition that supports digestive health. Their avoidance of spicy or fried foods and the inclusion of plant-based alkali in cooking may explain the low prevalence of gastric disorders such as ulcers. Moreover, the Garos understand that certain foods can aid in recovery from illness, while others should be avoided during specific conditions. For example, during illnesses like chickenpox, non-vegetarian foods are avoided, and in cases of diarrhoea, fluids such as lemon and coconut water are commonly administered (Hasan, 2008).

These cultural dietary practices are not merely nutritional—they are also social and symbolic, often tied to religious observances and communal rituals. UNESCO has observed that when food-related practices are culturally structured, introducing dietary changes without cultural sensitivity can lead to social and health imbalances (Shukla et al., 1990).

TRADITIONAL HEALING AND CULTURAL CONCEPTIONS OF THE HUMAN BODY

Beyond nutrition, cultural beliefs also play a central role in how communities conceptualize the human body and disease. Traditional healing systems, while often effective and culturally meaningful, may sometimes result in unintended side effects. In some cases, these effects have been misunderstood by outsiders unfamiliar with the cultural context. For example, the Vietnamese practice of coin rubbing—intended to relieve illness—can cause visible skin lesions that have been misinterpreted as signs of child abuse. Similarly, in some Chinese communities, pinching the trachea to alleviate coughing can result in bruising that may be misread by health professionals unfamiliar with the practice (MacLachlan, 2006).

While modern biomedicine often critiques the side effects of traditional practices, it is crucial for anthropologists and health practitioners to understand and evaluate these practices within their cultural framework. Awareness of both the physiological consequences and the symbolic meanings of such practices is vital for delivering culturally competent healthcare. Rather than dismissing traditional health beliefs as

irrational, efforts should be made to educate communities about safer alternatives or adaptations that respect cultural norms while safeguarding health.

Different cultures also maintain distinct understandings of the human body, interpreting illness as the result of imbalances caused by physical, psychological, nutritional, or spiritual disturbances. These holistic views emphasize the interconnectedness of body, mind, and spirit, and often involve preventive and curative practices tailored to the community's worldview.

V. SUMMARY AND CONCLUSION

A comprehensive understanding of applied or practicing anthropology necessitates a thorough exploration of the intricate relationship between health and culture. This interconnection is multifaceted, involving a wide range of factors that shape how illnesses are perceived, experienced, expressed, and treated across different societies. Culture—defined as the learned and shared patterns of human behaviour—plays a central role in shaping both personal health behaviours and professional medical practices. As such, cultural perspectives are foundational for interpreting the health status of populations and developing appropriate preventive and therapeutic responses to the diverse challenges presented by different physical and social environments.

Health-related practices are invariably embedded within cultural frameworks. Socio-religious beliefs, rituals, and taboos influence both mental and physical health outcomes. For instance, *culture-bound syndromes*—mental or behavioural health conditions recognized only within specific cultural groups—highlight the cultural specificity of illness experiences. These syndromes often reflect the collective worldview of the community and affect not just psychological well-being but also community perceptions of health.

While mental health is deeply influenced by cultural interpretations, physical health too is shaped significantly by cultural beliefs and practices. However, cultural variation should not be misunderstood as the sole determinant of all diseases. Certain conditions, such as genetically inherited diseases or environmentally acquired disorders, occur across all cultural groups. Nevertheless, the way a community understands and responds to illness—be it physical, psychological, nutritional, or spiritual—is closely aligned with its cultural context. This highlights the deeply intertwined nature of health and culture in shaping human well-being and healing practices.

Furthermore, medical anthropologists play a pivotal role in enhancing health service delivery and communication by contextualizing health care within the lived experiences of local communities. By integrating cultural insights into health research, resource allocation, service accessibility, and community engagement, anthropologists contribute to a more nuanced understanding of health care utilization and outcomes. As noted by Nichter (1992), the involvement of anthropologists in health research can be proactive, analytical, and dedicated to solving community-based health problems.

In an increasingly interconnected world, global health challenges underscore the inseparability of health and culture. Practicing anthropologists, with their cross-cultural expertise, are uniquely positioned to facilitate culturally informed interventions and promote health equity across diverse populations. The integration of anthropological perspectives into public health practice not only enriches health research but also fosters meaningful and sustainable change in community health outcomes worldwide.

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