

SAMVARDHINI :- 01/06/2025

Volume – 7

Issue – 1

(ISSN ONLINE:- 2583-7176)

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The Lingering Effect of Colonial Trauma in Indian Food Habits: A Chronological Reflection

Sudipta Nandi

ABSTRACT

A highly (web) circulated speech excerpt from Lord Macaulay in 1835 stated that the high cultural and spiritual backbone of India should be broken by establishing the Anglo knowledge base and dismissing the existing Indian knowledge base¹. Although “Macaulay's Minute on Education” does not explicitly state the exact words, it reflects a negative attitude towards Sanskrit and other native languages in accessing existing knowledge bases². Modern India, with its “Atma Nirbhar Bharat” concepts and reformed knowledge bases, has recovered from the colonial effect to some extent. However, the neo-colonial components, including trade and foreign investment pressures, technological dependence, the carbon market, and consumer culture, are highly concerning, emerging threats. Contextually, colonial trauma still lingers in the negative attitude towards traditional foods like millet and preference for Western breakfast and dinner etiquette. Neo-colonial market's attention towards this opportunistic attitude reflects in intensified application of frozen and other harmful Western food models. Promoting the traditional, nutritional knowledge base, including Ayurveda, not only induces generational trauma-informed care but can reduce the concerning rate of food habits and lifestyle diseases.

KEY WORDS

Colonial trauma, Eastern food culture, food habit-based diseases, Neo-colonial food culture

Introduction

A 2023 study on the Indian population observed that approximately 100 million people have diabetes in India, which is 11.4% of the total population¹. A little deeper dig into British colonial policies, including cash crop-based agricultural policies, confirms that diabetes and other nutritional deficiencies in India have a direct connection to frequent famine-based metabolic changes during the colonial period. These habit and lifestyle-based diseases are further integrating with the western food habit, an integral part of colonial trauma. Contextually, colonial trauma refers to the deeply imprinted socioeconomic and psychological wounds inflicted by colonization. The cultural shame developed from lost identity, inferiority complex, destroyed knowledge system, and economic dependence alienated from traditional medicine, agriculture and governance. As a result, culinary colonialism establishes itself in Western-influenced food hierarchies and cast-based restrictions. Contextually, post green revolution (60s), millet was highly resisted (growing more wheat and rice) by urban Indians following the deeply rooted western notion of “poor man’s food”². Unfortunately, the colonial trauma still exists, and the neo-colonial market is using the same to impose Western diet and nutritional models. For instance, the continental and fast food market is consistently growing (7.3% annual growth rate) in India³. Considering the long-term, harmful effects of the trauma, this paper tries to explore its food habits formation points for potential solutions.

Objectives

The dominant knowledge system tends to influence the general food habits. Colonization discarded the traditional knowledge systems (Sanskrit, Arabic-based) and made the Western knowledge system dominant. As a result, the collective colonized mindset of India started to worship Western nutritional and habitual models. However, the UK (temperate oceanic) and India (tropical monsoon) always have two completely different weather patterns and geographical structures⁴. Naturally, the sudden, oppressive change (which continued for a long time) developed a conflict with the Indian digestive system and nutritional mindset. Post independence, the neo-colonial market players did not leave the Indian market. Rather, the western habitual patterns are made more integrated with

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1. <https://scienceindiamag.in/diabetes-indias-colonial-burden/#:~:text=Date:19/06/2025,Time:10:30 PM>
 2. <https://factly.in/review-in-the-international-year-of-millet-here-is-everything-you-need-to-know-about-millet/#:~:text=Date:19/06/2025,Time:10:35 PM>
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 4. <https://www.bbc.co.uk/bitesize/guides/zpykxsg/revision/3-Date:20/06/2025,Time:8:33 PM>

promotional events of fast and continental foods, particularly in urban areas⁵. Even the healthcare professionals tend to recommend Western-style diet charts and calorific models⁶.

Considering these multilayered (socioeconomic, consumer preference, lifestyle, health) risk patterns of the western diet in India, the objective is to determine the overall effect of the traumatized food habits and nutritional patterns on the Indian body and mind. The outcome can open the opportunity to develop culturally identity-based, country-specific, healthy food habits. Appropriate food habits can fight cardiovascular challenges, diabetes and other non-communicable diseases⁷.

Research Questions

Following the research objective, the paper has tried to answer the following questions.

1. How does culinary colonialism affect Indian food habits?
2. How do forced Western food habits affect Indian health?
3. How do neo-colonial market strategies maintain the Western diet patterns in India?

Findings

Q1.

The effect of colonial trauma/culinary colonialism is multi-dimensional. It still reflects in the tainted relationship with traditional foods (fermented foods, millet), honouring the west-imposed breakfast, tea and dinner models (table and cutlery usage), caste reinforced food codes, satisfaction with imported nutrients, high sugar and oil intake trends with fast and continental foods and some rigidities in agricultural policies. Notably, colonial cultures often introduce culinary oppression under the shadow of multiculturalism. However, indigenous or native populations see those (multicultural) policies as the persistent tools of colonial assimilation. The oppression of food sovereignty is not an isolated problem⁸. Rather, it combines with the concept of “romanticizing colonialism”. Portland’s Saffron Colonial restaurant and its colonial menu dedicated to Churchill were

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6. Green R, Milner J, Joy E.J, Agrawal S, Dangour A.D, **Dietary patterns in India: a systematic review**, British Journal of Nutrition, 116(1), 142-8, 2016.

7. <https://www.who.int/initiatives/behealthy/healthy-diet#:~:text=-Date:20/06/2025,Time:9:09 PM>

8. Grey, S, Newman, L, **Beyond culinary colonialism: Indigenous food sovereignty, liberal multiculturalism, and the control of gastronomic capital**, Agriculture and human values, 35, 717-730, 2018.

highly criticized for the reflection of the said concept⁹. Contextually, the 1943 famine of India, with a death count of 3 million people, was attributed by Churchill to the statement “breeding like rabbits”¹⁰.

The tainted relationship with traditional foods is developed with various strategic, colonized tools to diffuse the cultural identity in every colonized region on this planet. Peru’s regional detachment from potatoes and over-promotion of rice and pasta in local restaurants are prominent examples of those strategic implementations¹¹. In New Zealand, Maori foods were associated with “dirty foods” while Canada observed re-narration of indigenous foods by the colonials and marketing of the same only by indigenous populations in the colonial decades¹². The “dirty/poor people’s food” is not an uncommon theme for colonized India. Curry, Tiffin, and Cookbook culture intentionally suppressed the traditional staples and meal types, keeping the table and cutlery memories alive¹³. Moreover, the reshaping and alteration of the existing caste system shook the collective cultural identity and relevant food patterns¹⁴. In terms of agricultural policies, the 1769-1857 company rule period is worth mentioning.

Vandana Shiva, an important food sovereignty advocate, confirmed that British colonialism converted land into private property, creating the legacy of famine with rents, taxes, and cash crop restrictions¹⁵. Ancient India was in sync with the concept of “land as a common property”. Institutionalized landlordship or Zamindari integrated the monsoon dependence, investment and irrigation challenges with inadequate governance¹⁶. There were 12 famines during the 1769-1857 period. However, the East India Company never attempted to develop a general famine prevention system¹⁷. Additionally, the relief policies were a set of experiments with imports, grain storage and advanced loans. Although the Crown administration (1858-1947) developed a famine relief policy, there were 10 severe famines. Notably, the 1866 Orissa famine had not witnessed any precaution or voluntary

9. Grey, S, Newman, L, **Beyond culinary colonialism: Indigenous food sovereignty, liberal multiculturalism, and the control of gastronomic capital**, Agriculture and human values, 35, 717-730, 2018.

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17. <https://pwonlyias.com/upsc-notes/colonial-india-famine-policy/> -Date:22/06/2025, Time:10:47 PM

organization, although there were warnings¹⁸. Rather, the administration continued free trade principles.

Both the great famine (1876 and 1978) and the 1943 Bengal famine could not prioritize rice or wheat farming. Instead of those staples, the force was on cotton and Indigo farming. As a result, starving, paying high taxes and getting watery rice in the aid camps became a common famine theme. The “profit over humanity” theme promoted breads, cakes and tea for urban, rich natives while the rest of the population survived on wild roots or gruel¹⁹. A 2021 systematic review on severe malnutrition and (historical) famine exposure confirmed that they are consistently associated with a higher prevalence of cardiovascular diseases, hypertension, poor glucose metabolism and obesity²⁰.

Q2.

A 2020 report by the National Institute of Nutrition highlighted that both urban and rural regions of India consume more energy from carbohydrates and less energy from protein, compared to the recommended energy requirements. More specifically, the recommended minimum intake levels from carbohydrate and protein should be 45% and 17% of energy, respectively. However, the urban and rural populations intake 51% and 65.2% energy from carbohydrate, while 11% from protein daily²¹. In terms of dairy products, only 8.7% of rural and 14.3% of urban populations intake the recommended level. Lower consumption of fruits, vegetables and dairy products increases the risk of abnormal obesity, overweight and other nutritional disorders. Contextually, urban India has a prevalence of 53.6% for abnormal obesity and 9.3% of chronic energy deficiency (CED), while rural India demonstrates 18.8% for abnormal obesity and 35.4% of CED²². Additionally, the western diet, particularly the standard American diet (SAD) elements like white bread, sweetened cereals, cookies, candies, cakes, ice-creams, pizzas, and sausages are highly dominating the daily intakes²³. These foods are enriched with a high content of sodium, sugar, trans and saturated fats. A 2023-24 household survey observed that 10-11%

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of the food expenditure belongs to processed foods and beverages for both rural and urban populations²⁴. With these statistics, the sedentary lifestyle is increasing the risk of non-communicable diseases, including diabetes, from the early age of 20. Also, SAD is associated with 28-30% higher risks of heart failure, type 2 diabetes and cancer. Poor diet awareness and access to the five recommended food groups offer a 16.6% malnourished population and 38% of unhealthy food consumers²⁵. The emerging (forced) Western diet pattern has a hidden, strategic, socially engineered, neo-colonial theme.

Q3.

The socially engineered strategies are quite direct nowadays. Contextually, the popularity of fast-food advertisements reflects some of those strategies. For instance, those advertisements trigger the convenience theme of modern busy lifestyles. The promotion of “quick” and “hassle-free” elements makes people forget the appropriate nutrient requirements²⁶. Moreover, the visual appeal with graphics and an integrated supply network creates a never-ending demand environment. Social media influencers and branding strategies also make them a popular option. A recent ready-to-eat food market assessment confirms that the market will expand to \$2933.31 million by 2031²⁷. A higher rate of travelling and working populations are making these foods irresistible. Of course, there are health-conscious people, who are aware of the risks of obesity and diabetes. But they are a minority. However, these neo-colonial strategies did not enter the domestic market smoothly. Rather, those were well-crafted ecopolitical plans. Post independence and the Second World War, many third-world countries, including India, became a key part of American foreign policy. The contemporaneous American deputy assistant Komer mentioned that a communist or pro-Soviet neutral transformed India can be a big threat, like losing to China²⁸. The thought process introduced Public Law 480 under the shadow of a permanent food aid program. This strategic foreign policy tool made India highly dependent on the American food supply, and the 1956-60 urbanization and industrialization could not stop the hunger challenge²⁹. Naturally, this background for the green revolution was

24. <https://www.indiatoday.in/health/story/is-indias-rising-spending-on-processed-foods-linked-to-diabetes-heart-disease-2659293-2025-01-03> -Date:23/06/2025, Time:11:47 AM

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drowned in the overuse of chemical fertilizers and pesticides supported by American agricultural institutes. The 1966 famine witnessed restrictions on wheat aid to intensify urgent demand cycles. As the traditional farming techniques were rejected by government subsidies, America became successful in implementing the structural violence in the top-down agricultural model³⁰. The violence still reflects in modern agricultural policies because the agricultural reconstructions are fragmented.

Limitations

Considering the diversity of India, the study should have considered regional specifications and different weather patterns. However, the study findings offer a generalized set of findings for the Indian dietary patterns. Moreover, the chronological study has not strictly followed all the years of the colonized period. Rather, specific times, famines, and relevant diseases are highlighted. Also, all the diseases and disorders related to (forced) food habits are not discussed.

Conclusion

Considering the thrifty gene hypothesis, frequent famines, droughts and other disasters expose the populations to major nutritional stressors. As a consequence, the gene develops a selective resistance to insulin³¹. Sedentary lifestyle and energy-heavy diet with saturated fats, ultra-processed foods further intensify the challenge. As modern India is struggling with obesity and diabetes (grateful to the colonial past), the target population desperately needs fast and processed food meters. Moreover, awareness of standard nutrients, calorific values and physical activities can change the scenario. Government and policymakers should promote the staple and green needs of the population. Additionally, traditional, decentralized agricultural strategies should combine with modern strategies to create a middle path for feasible reconstruction. The traumatized, negative attitude towards alternative medicine (Ayurveda) and Yoga requires attention from the newer generation. Dosha balancing is an affordable diabetes management process in Ayurveda. Government incentives for such traditional tools may change the westernized attitude of “nature as a conquest”.

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