International Journal of Health Research and Innovation, vol. 3, no. 1, 2015, 1-15
ISSN: 2051-5057 (print version), 2051-5065 (online)
Scienpress Ltd, 2015

Cultural Differences in Dietary Patterns: A Simple Review

Ioanna Vgenopoulou[1], Vasiliki Adamopoulou[2] and Styliani G. Tziaferi[3]

Abstract

In recent years with the emergence of new social groups changes have been observed in many different areas. One of these is the health sector, forming a care in accordance with the cultural characteristics of patients. A simple review of literature findings helps to the understanding eating habits and standards arising from the cultural identity of each country. From 1995- 2015, articles in PubMed, Google Scholar and World Health Organization were researched, focused on the cultural diversity in dietary habits and nursing interventions, using as key- words "transcultural nursing and nutrition", "transcultural care". Totally, 80 articles were found and finally only 49 were used as they referred to dietary habits and patterns according to cultural differences. Dietary habits have a direct relationship with the culture of each individual. Every nation presents its own nutritional standards, which are affected by factors such as the individual religion, and geographical location (Europe, America and Asia). Also every culture has its own theories and beliefs about health and illness, which shape its eating options. Health professionals and nurses in particular must be culturally competent, respecting each culture, cultural beliefs and eating habits of patients. Thus, the provision of health care can be effective and culturally appropriate.

Keywords: Transcultural nursing and nutrition, transcultural care

1 Introduction

The comprehension of factors that affects the health and the illnesses is judged essential for the interpretation of changes that is marked in the past few years in the sector of health. The rapid attendance of immigrant population and the appearance of new social teams, in the services of health, re-defined the benefit of care by health professionals, emphasizing in the cultural characteristics of patients [1].

[1]Student, Department of Nursing, University of Peloponnese.
[2]Student, Department of Nursing, University of Peloponnese.
[3]Assistant Professor, Department of Nursing, University of Peloponnese.

Every form of society and every human behavior are unbreakably connected with the cultural background. The culture not only does it influence the religion and the philosophy but also influences questions of everyday routine such as diet, which is an important factor shaping the perception of health and illness [2].
The diet determines in an important degree the feeling of health and the well-being of each person. Adopting healthy eating habits, an average weight of body, the suitable rest and the exercise contribute in the maintenance of good health. In particular, the adoption of healthy eating habits includes food intake, which is sufficient in quality but also in quantity. However, poor nutrition contributes in the exhaustion of the organism, in the appearance of various diseases and in the deceleration or cancellation of recovery [3].
Regarding the health sector in Greece, in recent years, is given special attention to the diversity of cultural values and beliefs, due to increased immigrant population. In countries, such as England and the United States of America (USA), where the phenomenon of migration is intensive and appeared several decades ago, there is considerable controversial on how to approach culturally different people. Thus, health care professionals must cope with new social conditions that are created [4, 5].
In particular, nurses are in daily contact with patients of different nationalities and cultures, in the hospital or community settings. The relationship between nurse and patient is affected by various factors such as cultural identity, cultural values, religion, spiritual and philosophical beliefs [6, 7].
In short, the nursing focuses on the impact of the social and organizational structures in health, highlighting new skills for health professionals. Effective nursing care depends on the awareness of the diversity and values prevailing in each culture. Nurses may have different beliefs and values of the people who are treating, but must show understanding and respect for diversity [1, 8].

1.1 Definitions

Transcultural nursing: *a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways [9].*
Culture: *is the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them [10].*
Civilization: *is fundamentally a cultural infrastructure of information and knowledge that serves survival and continuity. What distinguishes a civilization from a culture is that this infrastructure, having reached a critical level of complexity, becomes autonomous from constituent cities, nations, and empires. In ordinary cultures, the passing of information and knowledge may depend upon imitation or oral communication; in civilizations, this cultural memory, etched into clay or drawn into papyrus, takes on a life of its own [11].*

2 Methods

In order to locate literature pertaining to the subject of transcultural nursing and dietary habits of different countries, online research was performed. We searched Pubmed,

Google Scholar and World Health Organization (WHO) databases for relevant articles and use as key-words "transcultural nursing and nutrition", "transcultural care". In addition, the reference lists of the retrieved articles helped us to find relevant articles that did not allocate through database searching procedure. We narrowed the search to studies published in English and Greek and articles were limited in time from 1995 to 2015. Moreover, we limited to those conducted in humans. We focused the search on articles referring to cultural diversity in dietary habits and nursing interventions. Totally, 80 articles were found, 15 of them were excluded on the basis of the title or abstract due to the non specific dietary habits and patterns. Moreover, 6 articles were excluded because of the reference to dietary patterns of countries, which are not part of the review. Other 6 articles were excluded because they were not available as full texts and 4 in different language than English and Greek. Finally, depending on the purpose of the study 49 articles were used.

3 Results

The way food is prepared and eaten is associated with the culture of every person. There are food groups that are essential for the diet of certain people based on culture, but remained as much basic when the members of that culture live in a different country as well. The teaching of the diet should be individualized according to the cultural values of each patient [12].

Patients often don't have many dietary choices. This means that people with particular preferences may not be able to choose the food they want, but there is a risk for inadequate intake of food. When the nurse realizes the reason for the reduced appetite of the patient, nurse must determine whether the problem based on culture. In this case the family or friends can bring food, so as to satisfy the nutritional needs of the patient, but at the same time to comply with dietary restrictions [12]. Some examples of different dietary habits that dominate in some countries are the following: In France, corn is considered feed for livestock, whereas in the USA is a common vegetable. In Italy, large quantities of pasta are consumed in everyday life. In Mexico, people prefer beans and Puerto Ricans usually eat a combination of spicy, cold and lukewarm food. Moreover, in Vietnam soup often is eaten at every meal, and the Middle East population often eats cheese and olives for breakfast [12].

3.1 Mediterranean Countries

The traditional Mediterranean diet is characterized from high consumption of olive oil, vegetables, legumes, fruits and unprocessed grains, moderate to high consumption of fish, low consumption of meat and meat products, and low to moderate consumption of dairy products. Moderate consumption of wine is characteristic, especially during meals, as long as this is acceptable to religious and social rules [13].

The beneficial effect of the Mediterranean diet is expressed as a whole rather than individual food and nutrients. It seems that the combination of food and biological interactions of the different components of the Mediterranean diet provide important health benefits. The beneficial consequences may also attribute to traditional food which constitutes the main body of the traditional Mediterranean diet [13].

The Mediterranean diet has been promoted as a prudent dietary pattern to maintain a good health status, mainly through favorable effects on cardiovascular risk factors and ultimately in reducing cardiovascular morbidity and mortality [14, 15]

3.2 England-USA

Food selection in people is a complex process and its numerous determinants have been well documented over the last 60 years. Food choice patterns are different in every country of Europe and socio-cultural determinants are known to influence these patterns. Another important influence on food selection is the increasing availability of places to eat out. People eat out either out of necessity or for pleasure [16-18].
In England, food may be viewed as an issue of necessity by a lot of people, and this has been well documented since the early 1800s. British population consumes more ready-prepared meals than any other European country and this may be an element in the country's increasing prevalence of obesity. In Britain the main meal is generally in the evening and younger adults tend to consume ready-prepared meals most often. In addition, British people have been portrayed as Europe's biggest shoppers of snacks. Crisps specifically are one of the UK's most popular snacks, particularly in young people [16, 19- 21].
The people from England and the USA typically eat three meals a day with bacon and eggs or cereal for breakfast, sandwiches and soup for lunch and meat, potatoes and vegetables for dinner [12].

3.3 Latin America-Spain

In Latin America, many people believe in the theory of "hot-cold" for the disease. This theory is used as a symbolic dynamic that is reflected in various substances such as food and herbs. It is believed that the hot and the cold must be located on a balance to maintain health. For example, menstruation that is considered "warm" condition is treated by ingestion "cold" food, medicines, or the application of certain procedures. Some women from Latin America avoid certain fruits and vegetables that can disrupt menstruation and this may cause a lack of important vitamins [22].
Traditional healers base their treatment of diseases in the pathology of "juices". According to this, the basic functions of the body are controlled by four body's fluids or "juices" .The blood (hot and humid), the yellow bile (hot and dry), black bile (hot and dry) and phlegm (cold and wet). The secret of good health is considered, the balance of hot (caliente) and cold (fresco, frio) in the body. From the perspective of nurses, dietary advice is sometimes necessary, as well as the special diets, when the patient believes in the theory of the "hot-cold" for the treatment of diseases. Sometimes, it is difficult to persuade patients that an asymptomatic patient is sick [12].

3.4 Asia-China

In Asia and China rice and vegetables are a staple food. Good health is achieved by a balance of "Yin" (female, negative, dark, cold) and "Yan" (male, positive, bright, warm). Non-balance is caused by wrong nutrition or intense emotions. Many Asian health care systems use herbs, diet, and the application of hot and cold therapy. Especially, they treat an "cold" disease with "hot" food. Also much Asian food contain high amount of salt

due to the use of soy sauce. This way, dietary advice, to reduce the salt in the diet is necessary [12].

3.5 Religion

The holy days and religious celebrations affect the choice of eating in almost all cultures. The religious beliefs prohibit certain Muslims and Jews to eat pork. For example, "Koran" (sacred text of Islam) forbids the consumption of pork. The fasting Ramadan lasts thirty days and provides the abstention from food and water during sunrise to the sunset. Food and water are necessary to correspond a person in his daily activities. Thus, this abstention has a significant impact on their health [23].

3.6 Middle East

Men and women eat separately in some cultures of the Middle East. This tradition is particularly important for meals of chronic patients in institutions, nursing homes and psychiatric institutions [12].

According to researches about the eating habits of young people in Iran, it was found that they often receive less energy than is required. The intake of fibers was almost half of the recommended amounts. Trace elements, calcium, phosphorus, folic acid and iron are the most common ingredients that is inadequate. Also, adolescents and young adults in Iran consume food with low content of wholegrain and low amounts of fruits, vegetables, dairy products and unsaturated fatty acids. Skipping breakfast was frequent, whereas the consumption of fast food and snacks is another common food habit [24]. In Iran, people prefer mainly, various kinds of meat [25]. Over the last decade, the unhealthy lifestyle and poor dietary habits are increased in most Arab countries. This leads to the important increase in obesity for both children and adults [26]. Among adolescents aged 15–18 years, the rations that were overweight and obese in seven Arab countries ranged from 25% to 60% [27]. Moreover, data from the World Health Organization indicate that more than 60% of morbidity, disability, and mortality in these countries are caused by cardiovascular disease, diabetes, and cancer [28]. In Arab countries, adolescents consume low intake of fruit, vegetables and milk and a high intake of sugar-sweetened beverages, fast foods, and sweets [29].

3.7 Roma

The eating habits of Roma are closely linked with the occurrence of morbidity and mortality, such as cardiovascular diseases, metabolic diseases or tumors. The Roma population consumes increasing amounts of meat, flour, food, beverages, whereas does not consume fruits and vegetables [30].

3.8 Nursing Intervention

In daily contact with the patient, nurses are required to make important observations on the physical condition, level of nutrition and the response to treatment. In case of nutritional problems, they have to design and implement appropriate interventions [3]. The assessment of nutrition is crucial and essential especially in patients with a potential risk of problems

associated with their eating habits. A full assessment of food combines observation, interview, diagnostic tests and analysis of the factors that influence the dietary habits of people. To assess the level of food are useful diagnostic and biochemical tests that include measurement of blood components, proteins of blood, the level of hemoglobin, hematocrit and electrolyte concentration [3].

The model of Irena Papadopoulos, Mary Tilki and Gina Taylor could be applied to enhance the cultural competence of nurses about their eating habits and standards of various countries, focusing on human rights. According to this model, cultural competence is defined as the ability to provide effective care, taking into account the cultural beliefs, values, behaviors and needs of patients. The components of the model include cultural awareness, cultural knowledge, cultural sensitivity and cultural competence [2].

Cultural awareness involves reflection of personal values, beliefs and cultural identity of the nurse. Therefore, it is important nurse understand the different cultures and understand their preferences regarding the habits and practices of nutrition. The health professional must displace stereotypes and prejudices [2].

Cultural knowledge can be gained through a wide field of knowledge. This process requires intensive study and contact with different cultures, so the nurse can investigate the similarities and differences in nutrition between different cultural groups. Specifically, the nurse should know what type of food is associated with the culture of the patient. For example, it is important that nurse know that the Koran forbids Muslims to eat pork or that women from Latin America during menstruation do not consume hot foods. Typically, the diet influences the response to treatment [2, 31].

Cultural sensitivity on the status of the nurse to understand, respect and take account of the importance of cultural factors in care and to adequately address patients who differ culturally from him. The relationship should be collaborative and the nurse should show empathy, understanding and respect in eating habits and practices. The basis for a therapeutic relationship is the development of interpersonal and communication skills, so that health professionals could promote equitable cooperation, which requires trust, acceptance, facilitation and negotiation with people who need care. The health professional cannot provide culturally sensitive care if he abuses the power [2].

Cultural competence requires the formulation and implementation of the previous stages of awareness, knowledge and sensitivity. Further focus is done on practical skills, such as assessing the nutritional needs of the patient and other care skills [2].

4 Labels of Figures and Tables

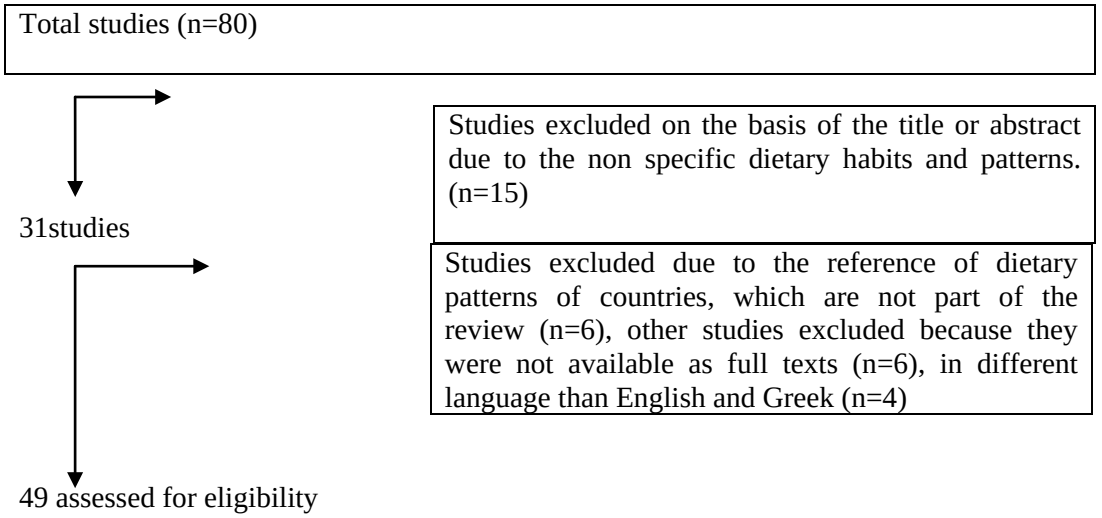

Figure 1: Diagram flow of literature review

Table 1: Table of simple literature review

COUNTRIES	AUTHOR/ YEAR PUBLICATION	TITLE	CONLUSION
Mediterranean Countries	Trichopoulou, 2010	Mediterranean Diet, Traditional Mediterranean Food and Health	The health benefits of the Mediterranean food have led to the acceptance that the Mediterranean diet is a healthy dietary pattern.
France, Greece, Spain	Martinez-Gonzalez et al, 2009	Mediterranean food pattern and the primary prevention of chronic disease: Recent developments	Mediterranean diet is recommended in the primary prevention of chronic disease, as well as in the secondary prevention of Cardiovascular diseases.
Belgium, Denmark, Finland, France, Germany Greece, Hungary, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, USA	Sofi et al, 2008	Adherence to Mediterranean diet and health status: Meta-Analysis	Greater adherence to a Mediterranean diet is associated with a significant improvement in health status, as seen by a significant reduction in overall mortality (9%).
Europe	Tountas et al, 2000	Health indicators in Europe	Cardiovascular diseases are responsible for 49% of all deaths, higher mortality is in eastern Europe. In addition, cancer mortality has decreased slightly in the European Region.
Europe	Scientific Technological Options Assessment (STOA), 1997	Nutrition in Europe, European parliament scientific and technological options assessment, Director General for research	Cardiovascular diseases are responsible for 180,000 premature deaths at the ages between 35- 64 years in the European Union, of which 60,000 can be attributed to dietary factors.
Brussels, Greece, Ireland, Luxembourg,	Trichopoulou et al, 1997	Methodology for the exploitation of HBS food	The diet is a risk factor for developing cardiovascular disease and various

Norway, Spain, United Kingdom		data and results on food availability in 5 European countries	cancers, which are the leading cause of premature death in Europe.
Spain	Aguilar et al, 2015	Effects of mediterranean diet on lung function in smokers: a randomised, parallel and controlled protocol	The Mediterranean-type dietary pattern has banaficial effects on lung function, in a population of smokers with no previous respiratory disease.
Asia, Australia, Europe, USA	Kailatzi et al, 2014	Effects of the Mediterranean Diet on Type 2 Diabetes' Incidence and Treatment: A Systematic Review	Current guidelines and recommendations from all the major scientific associations,encourage a Mediterranean dietary pattern for primary and secondary prevention of major chronic diseases.
USA	Shen et al, 2015	Mediterranean Diet and Cardiovascular Health	Mediterranean diet favorably affects numerous cardiovascular disease risk factors, such as dyslipidemia, hypertension, metabolic syndrome, diabetes and it has been proven to reduce cardiovascular disease incidence, reoccurrence, and mortality.
Europe	Sanchez-Tainta et al, 2008	Adherence to a Mediterranean - type diet and reduced prevalence of clustered cardiovascular risk factors in a cohort ofv 3204 high - risk patients	Following a Mediterranean diet was inversely associated with the clustering of hypertension, diabetes, obesity, and hypercholesterolemia among high-risk patients.
Europe	European Heart Network, 1998	Food, Nutrition and Cardiovascular Disease Prevention in Europe	Since the 50s, the "Seven Countries Study" showed that, comparing Northern Europe and USA, the Mediterranean countries are characterized by lower levels of heart diseases.
Italy	Balli et al, 1999	Nutritional Status and Dietary Habits of Children in the Province of Modena	The findings of fatty acids and haematic lipids reflect the findings of an unbalanced diet of children in the province of Modena.
Spain	García- Algar et al, 2009	Eating habits in children under 2 years old according to ethnic origin in a Barcelona urban area	Numerous inadequate feeding practices constitute nutritional risk factors and require preventive and educational interventions to improve the future health of children.
Central England, Southern France	Pettinger et al, 2006	Meal patterns and cooking practices in Southern France and Central England	Obesity is more common in England, because of ready-prepared meals and snack food, than France, where are predominant more healthy eating habits.
Europe	Frewer et al, 2001	Food, People and Society: A European Perspective on Consumers' Food Choices.	Socio-cultural determinants influence choice of food patterns. Important influence on food selection is the increasing availability of places to eat out. People eat out either out of necessity or for pleasure.
United Kingdom	Warde et al, 2000	Eating Out: Social Differentiation, Consumption and Pleasure.	There is explosion of interest in food, ranging from food scares to the national obsession with celebrity chefs. The practice of eating out has increased dramatically over recent years.
United Kingdom	Wright et al, 2001	Food taste preferences and cultural influences on consumption.	Crisps specifically are one of the UK's most popular snacks, particularly in young people. Thus, choice of food may be viewed as an issue of necessity by a

			lot of people.
England	Schlosser, 2001	Fast Food Nation: What the All-American Meal is Doing to the World	British population consumes more ready-prepared meals than any other European country and this may be an element in the country's increasing prevalence of obesity.
United Kingdom	Marshall, 2000	British meals and food choice: The Science, Culture, Business and Art of Eating	Food choice is defined by location. Thus, is illustrated the utility of this approach for dealing with complex data.
Europe	European Heart Network, 1998	Food, Nutrition and Cardiovascular Disease Prevention in Europe	The amounts of saturated fats that are consumed, are increased as the economic level is improved
England	Scarborough et al, 2008	The North–South gap in overweight and obesity in England,	Regional differences in overweight and obesity levels in England have mirrored those of Cardiovascular disease with higher levels in the North.
USA	Centre for Disease Control, 2006	State-specific prevalence of obesity among adults – United States	Enhanced collaborative efforts among national state and community groups are needed to establish effective programs and policies to reduce the prevalence of obesity in the United States.
England	National Centre for Social Research,2007	Health Survey for England 2005: The Health of Older People	Elderly people aged 65 and over were asked questions on core topics such as general health, smoking and consumption of fruit and vegetable.
Latin America- Spain	Taylor et al, 2010	Fundamentals of Nursing: The Art and Science of Nursing Care	The secret of good health is considered, the balance of hot (caliente) and cold (frio) in the body.
Latin America	Helman, 2000	Culture, Health and Illness	It is believed that the hot and the cold must be located on a balance to maintain health.
Latin America (Colombia, Brazil, Chile, Mexico)	Finck et al, 2013	Physical activity, nutrition and behavior change in Latin America: A systematic review	Physical activity and nutrition are key health behaviours. Nevertheless, researches report low prevalence of physical activity fruit and vegetable consumption in Latin America
Global (52 countries)	Hall et al, 2009	Global variability in fruit and vegetable consumption	Overall, 77.6% of men and 78.4% of women from the 52 mainly low- and middle-income countries consumed less than the minimum recommended five daily servings of fruits and vegetables
Africa, America, Asia, Europe	Pomerleau et al, 2004	The challenge of measuring global fruit and vegetable intake	Is showed mean intakes generally lower than current recommendations, with large variations among sub regions.
Asia- China	Taylor et al, 2010	Fundamentals of Nursing: The Art and Science of Nursing Care	Good health is achieved by a balance of "Yin" (female, negative, dark, cold) and "Yan" (male, positive, bright, warm). Non-balance is caused by wrong nutrition or intense emotions.
East Asia (China, Hong Kong, Japan Korea, Singapore)	Zhang et al, 2012	Trends in mortality from cancers of the breast, colon, prostate, esophagus, and stomach in East Asia: role of nutrition transition	There have been striking changes in mortality rates of many types of cancer in East Asia during the last several decades, which may be at least in part attributable to the concurrent nutrition transition.
Arab countries (Algeria, Jordan, Kuwait, Libya, Palestine, Syria, and the United Arab Emirates)	Musaiger et al, 2013	Perceived barriers to healthy eating and physical activity among adolescents in seven Arab countries: a cross-cultural study	Intervention programmes to combat obesity and other chronic no communicable diseases in the Arab world should be created.
Middle East	Taylor et al, 2010	Fundamentals of Nursing:	Men and women eat separately in some

		The Art and Science of Nursing Care	cultures of the Middle East. This tradition is particularly important for meals of chronic patients in institutions and nursing homes.
Middle East (Iran)	Akbari et al, 2014	Systematic Review on Diet Quality among Iranian Youth: Focusing on Reports from Tehran and Isfahan	Dietary intakes and habits of young Iranian people are not favourable. Implementing informative programs and developing practical policies should be noted.
Middle East (Iran)	Shaneshin et al, 2014	Validity of energy intake reports in relation to dietary patterns	Under- and over reporting of energy intake plays role in determining the dietary patterns is yet unclear, in the Middle Eastern countries, because of misinformation among Tehranian women aged 18-45 years about dietary intakes.
Eastern Mediterranean	Musaiger et al, 2012	Prevalence and risk factors associated with nutrition-related noncommunicable diseases in the Eastern Mediterranean region	The prevalence of overweight and obesity has reached an alarming level in most countries of Eastern Mediterranean. Many risk factors may be contributing to the high prevalence.
Arab countries (Algeria,Jordan, Kuwait,Libya, Palestine, Syria, and United,Arab Emirates)	Musaiger et al, 2012	Prevalence of overweight and obesity among adolescents in seven Arab countries: a cross-cultural study	Childhood obesity in Arab Countries is increased due to excessive food consumption and sedentary behaviors.
Middle East (Syria)	Bashour, 2004	Survey of dietary habits of in-school adolescents in Damascus, Syrian Arab Republic	More than 50% of the students in Damascus of Syria said that they had not consumed green vegetables and more than 35% had not consumed meat.

5 Discussion

The association of nutrition and diseases, and the protective effect of different dietary habits have been proven epidemiologically. The diet is a risk factor for developing cardiovascular disease and various cancers, which are the leading causes of premature death in Europe. Cardiovascular diseases are responsible for 180,000 premature deaths at the ages between 35- 64 years in the European Union, of which 60,000 can be attributed to dietary factors. Simultaneously, the Mediterranean diet has a protective influence against certain cancers, such as breast and cancer, which is evidenced by the lower incidence of cancers in southern Europe [32 - 35].

In addition, Mediterranean diet favorably affects numerous cardiovascular disease risk factors, such as dyslipidemia, hypertension, metabolic syndrome, diabetes and it has been proven to reduce cardiovascular disease incidence, reoccurrence, and mortality. Current guidelines from all the major scientific associations encourage a Mediterranean like dietary pattern for primary and secondary prevention of major chronic diseases. Moreover, it has been broadly reported to be a model of healthy eating for its contribution to an ideal health status, better biochemical profile and a better quality of life. [36-38]

Since the 50s, the "Seven Countries Study" showed that, comparing Northern Europe and USA, the Mediterranean countries are characterized by lower levels of heart diseases. Cardiovascular diseases are the leading cause of death in the world and in most countries of the America, cause 1,9 million deaths annually. However, a high percentage of these

diseases can be prevented with a healthy nutrition, physical activity, avoiding tobacco and other unhealthy habits. Surveys show that the amounts of saturated fats that are consumed, are increased as the economic level is improved [39, 42].

According to the World Health Organization (WHO), the incidence of diseases related to diet, is significantly different between Southern and Northern Europe. Mortality from ischemic cardiovascular disease in Southern countries (Greece, France, Italy) is smaller compared to the Nordic countries (Great Britain, Ireland, UK). At the same time, especially worrying is the fact that both the Northern and Southern Europeans from childhood and adolescence establish unhealthy eating habits [40 – 42].

Overweight and obesity are recognized as important risk factors for the development of various diseases. Globally, the pervasiveness of overweight and obesity is increasing. The prevalence of obesity increased in every state of the USA between 1995 and 2005, resulting in a nationwide rise from 15 to 24% over this period. For the last 15 years, it is generally known that the prevalence of obesity and overweight in England has been rising, for both men and women in all age groups and that United Kingdom rates are amongst the highest in Europe. Current estimates show that 67% of men and 69% of women in England are overweight or obese. In addition, geographic diversities in health in England are strong, as rates of chronic disease tend to be worse in the North of England than in the South [43-45].

Lifestyle and dietary habits in adolescence and young adults not only affect the general health, but cause long-term effects for the individual. Studies on the feeding habits of Iranian adolescents and young adults, showed that their eating habits are often unhealthy and harmful for their health. For this reason, the implementation of information programs and the development of practical policies should be noted for improving the quality of diet of adolescents and young adults not only to countries in the Middle East, but in general all over the world [24,42]. Epidemic of childhood obesity in Arab Countries is increased due to excessive food consumption and sedentary behaviors. Thus, promoting healthy eating and physical activity is essential improving the health status of children [46].

The Roma population consumes significantly smaller amounts of fruits, vegetables and dairy products, in comparison with the majority of the general population. Moreover, Roma women, compared with non-Roma women have an increased frequency of consumption of meat, flour, food and refreshments. The differences can be attributed to cultural differences between ethnic and socio-economic groups, the reduced availability of certain food because of poverty and the reduced level of knowledge and information regarding health and nutrition [30].

According to research during the last decades, in East Asia has been a substantial change in dietary habits, characterized by increased energy intake and increased consumption of saturated fat and red meat. Simultaneously, there has been a notable increase in the mortality from breast cancer, colon cancer and prostate cancer, while there is a sharp decrease in those of the esophagus and stomach [47].

Physical activity and nutrition are the key to promote health, protecting the body from various diseases. However, according to research in several Latin American countries were reported low levels of physical activity and consumption of fruits and vegetables. Physical inactivity and low fruit and vegetables are among the top 10 risk factors of mortality and morbidity in low and middle income countries. In Latin America and the Caribbean, the majority of deaths are caused due to cardiovascular diseases (31%) and cancer (14%). According to the WHO report in 2005, countries such as Colombia, Argentina, Brazil, Chile, Mexico, Venezuela, Panama reported low fruit and vegetable

intake (eating less than 600 grams of fruit per day), with higher prevalence appearing in women aged 15-44 and over 60 years [47- 49].

6 Conclusion

In a multicultural society, special challenge of health care is to provide qualified health professionals, who must be culturally competent to offer effective and culturally appropriate care. This is achieved through the cultural competence and appropriate knowledge, respecting the culture, beliefs, traditions and habits of each individual's diet. In this way, they contribute to the concept of "multidimensional health" but also maintain their own cultural and professional identity. So, health care professionals responding to the demands of today's society must adopt the appropriate attitude and behavior. The combination of cultural knowledge and sensibility on eating patterns of different people will contribute to a high quality health care.

References

[1] S. Zyga, Introduction to Nursing Science, Beta Medical Publishers, (2010).
[2] I. Papadopoulos, A. Kalokairinou, X. Kouta, Transcultural Nursing and Cultural Competence for Health Professionals, Pasxalidis Edition, (2011).
[3] X. Ragia, Basic Nursing, Theoretical and Ethical Principles, Medical Editions Parisianos, (2005).
[4] S. Bakaert, Minority integration in rural healthcare provision: An Example of good practice" Nursing Standard Journal, Vol.14, (2000), pp. 43–45.
[5] G. Manomenidis, Views Nurses for Patients with different cultural backgrounds, Nursing Journal, Vol. 48, (2009), pp. 439-436.
[6] P. Josipovic, Recommendations for culturally sensitive nursing care, International Journal of Nursing Practice, Vol. 6, (2000), pp.146–152.
[7] M. Kourakos and T. Kaukia, Nefhrology as a receiver of multicultural Influences, Nursing Journal, Vol. 46, (2007), pp. 355-361.
[8] S.C. Murphy, Mapping the literature of transcultural nursing, Journal of the Medical Library Association, Vol. 94, (2006), pp. 143-151.
[9] M. Leininger, Transcultural Nursing. Concepts, Theories, Research and Practices,NewYork,McGraw-Hill,(1995).
[10] J.P. Lederach, Preparing for peace: Conflict transformation across cultures, Syracuse, NY, Syracuse University Press, (1995).
[11] A. Bosworth, The Genetics of Civilization: An Empirical Classification of Civilizations Based on Writing Systems, Comparative Civilizations Review, Vol.49, (2003), pp. 9.
[12] C. Taylor, C. Lillis and P. Lemone, Fundamentals of Nursing: The Art and Science of Nursing Care, Wolters Kluwer Health, Lippincott Williams & Wilkis, (2010).
[13] A. Trixopoulou, Mediterranean Diet, Traditional Mediterranean Food and Health, Inspection Greek Dietitian - Nutrition, Vol. 1, (2010), pp. 13–14.
[14] A . Martinez-Gonzalez, M. Bes-Rastrollo, L. Serra-Majem , D. Lairon, R. Estruch and A. Trichopoulou, Mediterranean food pattern and the primary prevention of

chronic disease: Recent developments, Nutrition Reviews,Vol.67, (2009), pp. 111–116.
[15] F. Sofi, F. Cesari, R. Abbate, GF. Gensini and A.Casini, Adherence to Mediterranean diet and health status: Meta-Analysis, BMJ, Vol.337, (2008), pp. 1344.
[16] C. Pettinger, M. Holdsworth and M. Gerber, Meal patterns and cooking practices in Southern France and Central England, Public Health Nutrition, Vol. 9, (2006), pp.1020–1026
[17] L. Frewer, E. Risvik and H. Schifferstein, Food, People and Society: A European Perspective on Consumers, Food Choices, New York: Springer, (2001).
[18] A. Warde and L. Martens, Eating Out: Social Differentiation, Consumption and Pleasure, Cambridge: University Press, (2000).
[19] LT. Wright, C. Nancarrow and PMH. Kwok, Food taste preferences and cultural influences on consumption, British Food Journal, Vol.100, (2001), pp. 348–57.
[20] E. Schlosser, Fast Food Nation: What the All-American Meal is doing to the World, Penguin Press, (2001).
[21] DW. Marshall, British meals and food choice. In: Meiselman HL, Ed.Dimensions of the Meal: The Science, Culture, Business and Art of Eating. Gaithersburg, MD: Aspen Publishers, (2000), pp. 202– 220.
[22] CG. Helman, Culture, Health and Illness, UK, Butterworth Heinemann,(2000).
[23] D. Muftic, Maintaining cleanliness and protecting health as proclaimed by Koran texts and habits of Mohammed S.A.V.S., Medical Archives, Vol.51, (2000), pp. 41-43.
[24] F. Akbari and L. Azadbakht, Systematic Review on Diet Quality among Iranian Youth: Focusing on Reports from Tehran and Isfahan, Archives of Iranian Medicine, Vol.17, (2014), pp. 574-84.
[25] M. Shaneshin, M. Jessri and B. Rashidkhani, Validity of energy intake reports in relation to dietary patterns, Journal of Health, Population and Nutrition, Vol. 32, (2014), pp. 36-45.
[26] AO. Musaiger, HM. Al-Hazzaa, Prevalence and risk factors associated with nutrition-related non communicable diseases in the Eastern Mediterranean region, International Journal of General Medicine. Vol.5, (2012), pp. 199–217.
[27] AO. Musaiger, M. Al-Mannai, R. Tayyem, et al., Prevalence of overweight and obesity among adolescents in seven Arab countries: a cross-cultural study, Journal of Obesity, Vol. 5, (2012) pp. 981390.
[28] World Health Organization (WHO), Global Status Report on Non-Communicable Diseases, (2010), Geneva, Switzerland.
[29] HN. Bashour, Survey of dietary habits of in-school adolescents in Damascus, Syrian Arab Republic, Eastern Mediterranean Health Journal, Vol.10, (2004), pp. 853–862.
[30] E. Hijová, AM. Gecková, I. Babinská and Hepa Meta, Do eating habits of the population living in Roma settlements differ from those of the majority population in Slovakia, Central European Journal of Public Health, Vol.22, (2014), pp. 65-68.
[31] J. Campinha- Bacote, Becoming Culturally Competent in Ethnic Psychopharmacology, Journal of Psychosocial Nursing and Mental Health Services, Vol.45, (2007), pp. 27-33.
[32] G. Tountas, D. Triantafullou and S. Frishras, Health indicators in Europe, Greek Medicine Archives, Vol.17, (2000), pp. 89-100.

[33] Scientific Technological Options Accessment, Nutrition in Europe, European parliament scientific and technological options Assessment, General Director for research, Brussels, (1997).
[34] A. Trichopoulou and P. Lagiou, Methodology for the exploitation of HBS food data and results on food availability in 5 European countries, European Commision DAFNE 1 study, Research and Development, Brussels, (1997).
[35] S. Aguilar, M. Luján, S. Ayala, P. Moreso, F. Mateo, B. Gallisà, A. Val and S. Alberich, Effects of mediterranean diet on lung function in smokers: a randomised, parallel and controlled protocol, BMC Public Health, Vol. 15, (2015), pp. 74.
[36] P. Kailatzi, M. Matte and SG. Tziaferi, Effects of the Mediterranean Diet on Type 2 Diabetes' Incidence and Treatment: A Systematic Review, International Journal Of Occupational Health and Public Health Nursing, Vol.1, no.2, (2014), pp. 61-92.
[37] Sanchez-Tainta A., Estruch R., Bullo M., Corella D. et al., Adherence to a Mediterranean - type diet and reduced prevalence of clustered cardiovascular risk factors in a cohort ofv 3204 high - risk patients., Eur J Cardiovasc Prev Rehabil., Vol.15, (2008), pp. 589-593
[38] J. Shen, K.A. Wilmot, N. Ghasemzadeh, D.L. Molloy, G. Burkma, G. Mekonnen, CM. Gongora, AA. Quyyumi and LS. Sperling, Mediterranean Diet and Cardiovascular Health, Annual Review of Nutrition Vol. 35, (2015).
[39] European Heart Network, Food, Nutrition and Cardiovascular Disease Prevention in Europe, Brussels, (1998).
[40] F. Balli, L. Viola, A. Di Biase and G. Tarozzi, Nutritional Status and Dietary Habits of Children in the Province of Modena, Pediatric Medicine, Vol. 21, (1999), pp. 13-17.
[41] O. García- Algar, F. Gálvez , M. Gran, I. Delgado, A. Boada, C. Puig and O. Vall, Eating habits in children under 2 years old according to ethnic origin in a Barcelona urban area, An Pediatric Barcelona, Vol.70, (2009), pp. 265-70.
[42] J. Zhang, IB. Dhakal, Z. Zhao and L. Lang, Trends in mortality from cancers of the breast, colon, prostate, esophagus and stomach in East Asia: role of nutrition transition", European Journal of Cancer Prevention, Vol.21, (2012), pp. 480–489.
[43] P. Scarborough and S. Allender, The North–South gap in overweight and obesity in England, British Journal of Nutrition, Vol.100, (2008), pp 677–684.
[44] Centre for Disease Control (CDC), State-specific prevalence of obesity among adults, United States, Morbidity and Mortality Weekly Report, Vol. 55, (2005), pp. 985–988.
[45] National Centre for Social Research (2007) Health Survey for England 2005: The Health of Older People, London: Information Centre.
[46] A.O. Musaiger, M. Al-Mannai , R. Tayyem , O. Al-Lalla , E. Ali , F. Kalam , M.M. Benhamed, S. Saghir, I. Halahleh, Z. Djoudi and M. Chirane, Perceived barriers to healthy eating and physical activity among adolescents in seven Arab countries: a cross-cultural study, Scientific World Journal (2013), pp. 232164.
[47] C.Barboza, S. Monteiro, S. Barradas, O. Sarmiento, P. Rios, A.Ramirez, M. Mahecha and M.Pratt, Physical activity, nutrition and behavior change in Latin America: a systematic review, Global Health Promotion Vol.20, (2013), pp.65.
[48] J. Hall, S. Moore, S. Harper and J. Lynch, Global variability in fruit and vegetable consumption, American Journal of Preventive Medicine, Vol.36, (2009), pp. 402–409.

[49] JF. Pomerleau, KF. Lock, MF. McKee and DR. Altmann, The challenge of measuring global fruit and vegetable intake, Journal of Nutrition, Vol. 134, (2004), pp. 1175–1180.