

# Multicultural Handbook of Food, Nutrition and Dietetics

Edited by  
**Aruna Thaker and Arlene Barton**



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**Aruna Thaker BSc PGDip RD**

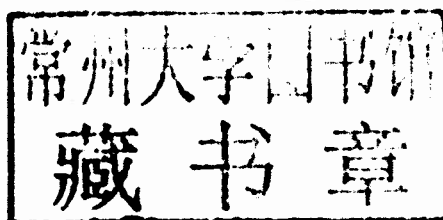
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 **WILEY-BLACKWELL**

A John Wiley & Sons, Ltd., Publication

This edition first published 2012  
© 2012 by Blackwell Publishing Ltd

Wiley-Blackwell is an imprint of John Wiley & Sons, formed by the merger of Wiley's global Scientific, Technical and Medical business with Blackwell Publishing.

*Registered office:* John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

*Editorial offices:* 9600 Garsington Road, Oxford, OX4 2DQ, UK  
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK  
2121 State Avenue, Ames, Iowa 50014-8300, USA

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*Library of Congress Cataloging-in-Publication Data*

Food, nutrition, and dietetics : a multicultural handbook / edited by  
Aruna Thaker, Arlene Barton  
p. ; cm.

Includes bibliographical references and index.

ISBN 978-1-4051-7358-2 (pbk. : alk. paper)

I. Thaker, Aruna II. Barton, Arlene

[DNLM: 1. Diet-ethnology. 2. Food. 3. Cultural Characteristics. 4. Dietetics. 5. Nutritional Physiological Phenomena-ethnology. QT 235]  
613.2-dc23

2011035251

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Set in 9.5/11.5 pt Palatino by Toppan Best-set Premedia Limited  
Printed and bound in Malaysia by Vivar Printing Sdn Bhd

[1 2012]

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# Acknowledgements

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The editors are grateful to following people for their assistance with coordinating the contents of the multipart chapters.

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# Foreword

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It is a pleasure to write the Foreword to this *Multicultural Handbook of Food, Nutrition and Dietetics*. As the editors say in their Introduction, they and their several contributors from many different backgrounds 'had a vision that culturally appropriate dietary information was needed..'. Some 30 years ago, there was virtually no systematic nor clear realisation in Britain or other European countries of what 'culturally appropriate' meant, and certainly little practical dietary information for specific peoples of any background. So this text brings together, probably for the first time, comprehensive portraits of regional and local ethnic and geographic food patterns and what is known of their relationship to the emergence of 'chronic disease' in respective populations. Having authors from many of those backgrounds write their relevant chapters adds key value, where outsiders would have been less able to grasp subtleties needed to understand food choice and dietary behaviour.

The editors should be congratulated on choosing appropriate authors, as should be the authors on delivering their effective texts. Each chapter begins with a brief historical outline, of how migration developed to Britain and more globally, who migrated, and where possible a sketch of how ties with original countries were maintained, helping reinforce trading to allow continued traditional diets to persist. Dietary variation *within* South

Asian origin communities has been the most neglected aspect of the considerable work now available, summarised elegantly in Chapter 1. In some settings, notably for African-origin people across the western hemisphere, the mortality on transport ships and conditions under slavery meant little direct connection with original western African roots could persist. Traditional foods faded for African-Americans, lost historically via forced transit only through the Caribbean, and with different climates for growing such crops. However, yams, sweet potato, edoes, occasionally cassava, and then green bananas and especially for Jamaicans, breadfruit still form a main focus of many Caribbean-origin households at home and abroad. While household soups remain strong features, dietary patterns are generally quite distinct from most directly west African peoples' diets. Hence the term 'African-Caribbean' is confusing – and should not include people of direct West African, and of Caribbean origin of African, descent under one heading. Chapter 6 outlining data from Ghana and Nigeria redresses that balance.

Throughout, the text is 'flavoured' intriguingly with historical vignettes, as in Chapter 2 on the West Indies, that shows that the word 'barbeque' may have originated from the conquered Arawak or Taino Indians when the Caribbean islands were first colonised by Europeans. Chapter 3 on east Asia, and notably Chinese migration, both historically

and now short-term, is of great relevance with so many current Chinese government-funded projects globally, not least as dietary patterns change rapidly and for concerns over the traditionally high salt intakes both from popular Chinese cooking, and also in Japan. In both these dynamic nations and their migrants, high stroke rates from elevated blood pressure may be related to excess salt intakes, and rising smoking habits, which change dietary preferences but have often been minimised by religious restrictions elsewhere. There are also major opportunities in China itself to test whether formal trials, and/or local and regional government and tax initiatives, can cut that high salt content, and the over-consumption of both food and drink that goes with it. The authors bring out important results from Hong Kong, showing that short sleeping hours in a large survey was associated with higher BMI and presumably over-eating. Then a particularly welcome Chapter 5 contains important data on people of Eastern Mediterranean mainly of Arab origin, including Yemenis and Somalis, long-neglected but growing groups often but not just originally refugees, following the ravages of war and civil disruption. The fascinating account in Chapter 7

from among large UK groups of people from Polish, Greek and Turkish backgrounds and these original countries, plugs an important gap, at least in my reading. The final chapters set all this work into their maternal and child health & more clinical context.

The scientific basis generally remains wanting to link reliably particular food patterns, respective nutrient intakes, and their biochemical translation with most chronic 'disease' outcomes. In part, this is because the phenotypes of, for example, (high) blood pressure, almost as variable as food patterns in its measurement, and type 2 diabetes lack precision, except as related to excess body fat and less muscle mass. While basic and clinical science grapple with those issues, this book offers both general and more specialist readers insights into improving the measurement and understanding of diet among many of the world's major populations who migrated to Europe and beyond. It will be a very useful reference for any modern, properly informed health practitioner.

*Kennedy Cruickshank  
King's College & King's Health Partners, London  
December 2011*

# Introduction

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The UK is now a multicultural society and so dietitians and other health and food providers need to be aware not only of the medical aspects of a patient's condition but also their cultural requirements in terms of religion and traditional food choices.

In the 20th century, young men from different ethnic groups arrived in the United Kingdom from the former British colonies. These men arrived for work and had varying skill levels from unskilled to professional workers. Many of these men subsequently settled permanently with their families in this country. Research has shown that the traditional diets of their country of birth can, in most cases, be relatively healthy. However, following migration, lifestyle changes occur which can bring detrimental effects to their health. The incidence of chronic illness has been shown to dramatically increase in these minority groups, especially among the first generation of migrant workers.

In the western world there are increasing levels of obesity, cardiovascular disease and diabetes affecting all ethnic groups. It is important when developing strategies to address these issues and also when seeing individual clients to ensure that the messages are culturally acceptable.

Many registered and student dietitians have admitted that they have limited knowledge of the cultural requirements of the ethnic minorities they do not come into contact with regularly. When a patient or client is referred to them there are few

resources to consult to ensure that any dietetic treatment takes into account their religious or cultural needs and habitual food choices.

The editors and contributors had a vision that culturally appropriate dietary information was needed. And it was as a result of discussions with colleagues and students wishing to expand their knowledge that this vision was realized in this handbook.

The aim of this multi-contributor volume is to take this vision a step forward and provide in-depth dietary information on well-established as well as recently migrated ethnic groups.

The book is divided into nine main chapters:

- 1 South Asian Sub-continent
- 2 West Indies
- 3 East Asia
- 4 Israel
- 5 Eastern Mediterranean Region
- 6 West Africa
- 7 East and South East Europe
- 8 Maternal and Child Nutrition
- 9 Nutritional Management of Disease

In each of these chapters there are sections that relate to particular cultural groups from that region. It is envisaged that if you want information about a particular group you can go directly to the relevant section; however, you may find links to other chapters where more detail is available.

The authors of each section are experienced registered dietitians, mainly from the cultural group they are writing about. Each contributor not only has expert dietetic knowledge, but also long and varied experience of the traditional diets and diets on migration of the ethnic group. This makes the text highly practical. The editors have also contributed from their own experience and from the limited research data available for ethnic groups. The editors and contributors acknowledge that there are many lacunae in the literature as often different cultural groups are grouped together in research studies, which makes generalization difficult.

This book offers practical information about traditional diets, how they have changed on migration and the impact this will have on migrants' health. It gives much needed insight into the foods

commonly eaten in traditional diets and suitable alternatives available in the UK. It also provides best practice information and, where possible, what support is available from well-established voluntary organizations.

It is hoped that this resource will be valuable not only to dietitians and students who are presently working with different black and minority ethnic groups but also to other professionals who want deeper understanding of the needs of different ethnic groups.

Many people have played a part in the creation of this handbook and the editors would like to thank them all for their very valuable contribution.

*Aruna Thaker and Arlene Barton*  
*October 2011*

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# 1

## South Asian Sub-continent

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Sema Jethma, Ruple Patel, Aruna Thaker (Gujarat), Renuka McArthur, Jevanjot Sihra, Rupinder Sahota, Ravita Taheem, Sunita Wallia (Punjab), Zenab Ahmad, Bushra Jafri, Afsha Mughal, Rabia Nabi, Shamaela Perwiz, Tahira Sarmar, Ghazala Yousuf (Pakistan), Kalpana Hussain, Thomina Mirza (Bangladesh), Thushara Dassanayake, Deepa Kariyawasam, Vanitha Subhu (Sri Lanka)

The cultural groups from Gujarat, Punjab, Pakistan, Bangladesh and Sri Lanka have migrated from the South Asian subcontinent to the United Kingdom from different regions over last 60 years, mostly due to economic and political upheavals, and made the UK their home. As a result of the vast distances between the countries there were many differences in their cultural, traditional beliefs and diets but also many similarities as well. The reasons for these changes are many, but lifestyle changes, especially dietary changes, have had the greatest impact on health. The traditional diets which they were following were much healthier, more in line with what is currently recommended, but inclusions of some of the host country's unhealthy foods are having detrimental effects. This is now highlighted in scientific research; however, much of this is generic to those of South Asian origin rather than related to specific cultural groups. In this book, for the first time, an attempt has been made to provide detailed information on each of group. There is

information on migration, traditional diets and changes in migration, religious influences and on dietary considerations for specific diseases, such as obesity, diabetes and cardiovascular disease.

### 1.1 Gujarati Diet

*Sema Jethma, Ruple Patel, Aruna Thaker*

#### 1.1.1 Introduction

The South Asian sub-continent comprises India, Pakistan, Bangladesh and Sri Lanka. Four per cent of the total UK population is classified as 'Asian' or 'Asian British' and this group makes up 50.2% of the UK minority ethnic population (UK Census, 2001).

'South Asian' defines many ethnic groups, with distinctive regions of origin, languages, religions and customs, and includes people born in India, Bangladesh, Pakistan or Sri Lanka (Fox, 2004).

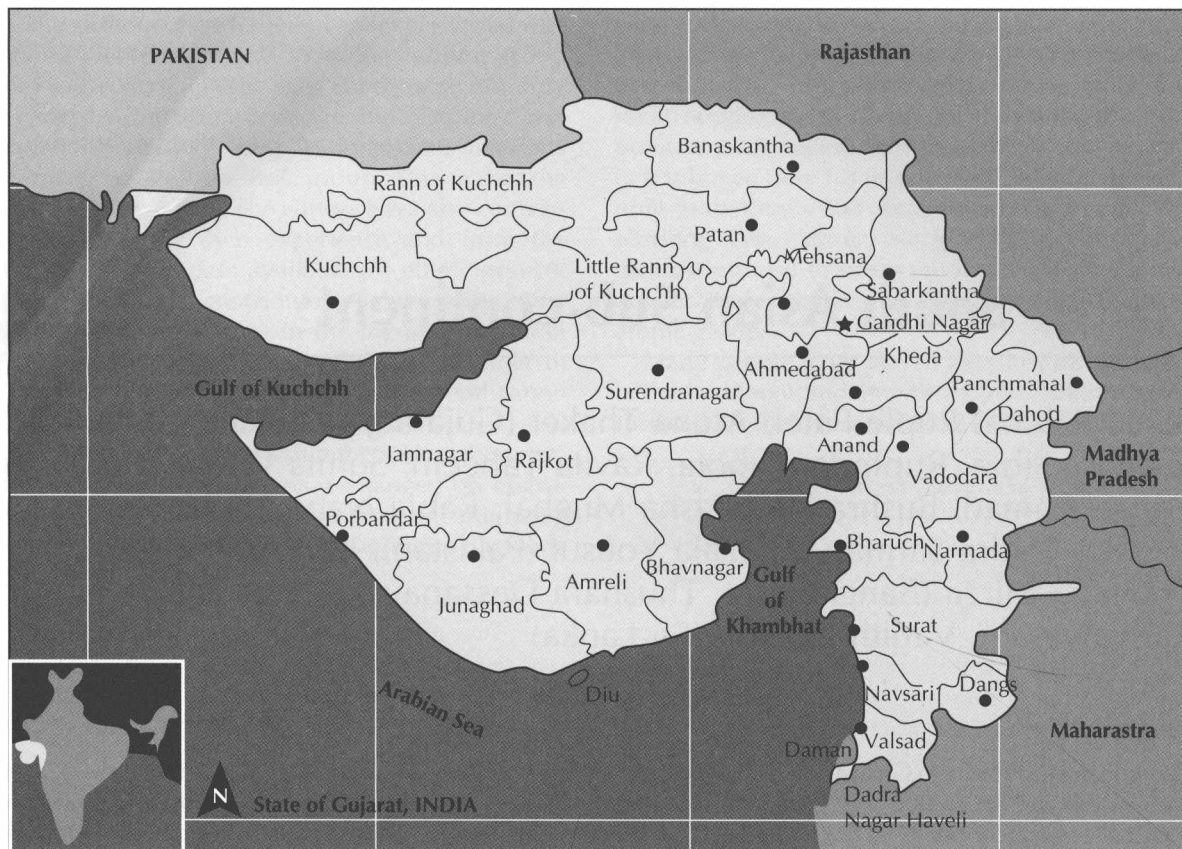


Figure 1.1.1 Map of Gujarat

Gujarat state is situated on the west coast of India and boasts a 1,600 km-long coastline. The Arabian Sea sweeps the western and south-western frontiers. The state extends from Kutch in the west to Daman in the south, with Pakistan to the north-west and the state of Rajasthan to the north and north-east. To the east is Madhya Pradesh and Maharashtra (Figure 1.1.1). This state celebrated the 50th anniversary of its formation on 1 May 2010.

Gujarat is one of the prime developing states of India and is known for its vibrancy and colourful profile. Traditionally, the population has engaged in agriculture as their principal occupation. It is the main producer of tobacco, cotton, peanuts (groundnuts) and other major food crops (rice, wheat, sorghum (*jowar*), millet (*bajra*), maize, red gram dal (*tuvar dal*) and whole pulses); crops account for more than half of the total land area. Animal

husbandry and dairy farming also play a vital role in the rural economy. Dairy farming – primarily milk production – is run on a cooperative basis and has more than a million members; it is one of the best examples of cooperative enterprise in the developing economy so that Gujarat is now the largest producer of milk in India. 'Amul' (Anand Milk Union Limited), formed in 1946, is based in Anand and is Asia's biggest dairy. Its products are well known throughout India.

The state is currently experiencing rapid urbanization, with 37.67 per cent of the population living in 242 urban areas according to the 2001 census. Over the last four decades it has become an industrial powerhouse, thereby reducing its dependence on agriculture. Oil, fertilizers, chemicals and textiles production attract many outsiders from across India.



The population of Gujarat state was 50,671,017 according to the 2001 census. Some 89.1% of the population are Hindus, Muslims account for 9.1%, Jains 1.0% and Sikhs 0.1%. The density of population is 258 persons per km<sup>2</sup>, which is less than that of other Indian states.

Gujarati is one of the 14 main languages of India and is spoken by an estimated 47 million people worldwide making it the 26th most commonly spoken language in the world. In Gujarat 71% speak Gujarati; the rest (29%) speak Hindi. Almost 88% of the Muslims speak Gujarati while the other 12% speak Urdu. In addition to Gujarati, Kutchi is widely spoken in Kutch District. Almost all Jains speak Gujarati and a few speak Marwardi as well. Gujaratis form the second largest of the British South Asian-speaking communities, with important communities in Leicester and Coventry, in the northern textile towns and in Greater London.

### *Migration to the United Kingdom*

Britain has had commercial links with Gujarat since the early seventeenth century when the British East India Company first set up a trading post in Surat in 1612.

Migration was common from Gujarat during the 18th century. When the winds were favourable, people travelled in dhows (traditional Arab sailing vessels) to East Africa, especially Zanzibar, for cloves and other spices.

In 1896, when Kenya, Uganda and Tanzania were part of British East Africa, migration from Gujarat and Punjab started for the construction of the railway from the Kenyan port of Mombasa to Kampala in Uganda to provide a modern transportation link to carry raw materials out of Uganda and to import manufactured British goods to East Africa. After the construction was completed many of these workers remained in East Africa and established substantial Indian minority communities. Their numbers may have been as high as 500,000 in the 1960s. Apart from being employed to manage the railways, they ran businesses which were, and in some cases remain, the backbone of the economies of these countries. These ranged from small rural grocery stores to sugar mills. In addition, Indian professionals – doctors, teachers, engineers and civil servants – in privileged positions played an important role in the development

of these countries. After independence from Britain in the 1960s, the majority of East African Asians migrated or were expelled from these countries (in the 1970s from Uganda). Most moved to Britain, India or other popular destinations like the United States (USA) and Canada as they had acquired British citizenship.

The first Gujaratis to come to UK were students in the late nineteenth century for further studies, especially in law. Notable among them was Mohandas Karamchand Gandhi, born in Porbandar on the western coast of Saurashtra. He was the pre-eminent political and spiritual leader of India during the independence movement, pioneering *satyagraha* (resistance to tyranny through mass civil disobedience), a philosophy firmly founded on *ahimsa* (non-violence), which inspired civil rights movements and demands for freedom across the world.

Prior to Indian independence in 1947 small numbers of students, sailors and emissaries migrated to the imperial capital by exercising the right of all colonial subjects to study, travel and settle in UK. This was followed by different types of migration during the postwar period of decolonization, as the British government began recruiting labour from its former colonies to fill vacancies in its industrial sectors.

Later the main growth of Gujarati communities in UK came when their experience in the textile and steel industries was welcomed at a time of labour shortages. These South Asian workers typically followed an arrangement known as 'chain migration', which involved men from villages and districts (generally in Gujarat, Bengal and the Punjab) migrating temporarily to industrialized inner cities and sharing dormitory-style accommodation while searching for employment as semi-skilled labourers. When the government began to restrict entry into Britain in the 1960s, many of these men decided to stay permanently, sponsoring their immediate families and establishing their lives in different parts of UK.

### *Current UK population*

There are 300,000 Gujarati language speakers in the UK, including East African Gujaratis, many of them in Leicester, Coventry, Bradford and the London boroughs of Wembley, Harrow and Newham.