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ADDRESSING CARDIOVASCULAR DISEASE RISK IN HUNGARIAN-AMERICAN POPULATIONS: A CULTURAL EXPLORATION OF TRANSDISCIPLINARY HEALTH PROMOTION

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Abstract Hungarian Americans share a unique culture of food traditions associated with their value system and way of life. Researchers, health care providers, and nutrition professionals counseling and treating a Hungarian-American population should develop a baseline of cultural understanding to achieve successful and long-lasting behavior change outcomes. The leading causes of death among Hungarians include ischemic heart disease (21.3%), stroke (13.4%), and cirrhosis (5.8%); all are directly or indirectly attributed to a traditional Hungarian diet coupled with a sedentary lifestyle. Health behaviors among Hungarian Americans can be partially explained by the Health Belief Model's value-expectancy construct. Understanding cultural expectations and their associated values serve as a foundation for health promotion programming to reduce risk of cardiovascular disease and comorbidities. This review explored numerous facets of Hungarian-American dietary habits in psychosocial, economic, historical, and cultural contexts. Health education and health promotion considerations were also examined.

Key words Cardiovascular disease, Hungarian-American, Health promotion, culture

Introduction

Hungarian Americans share a unique millennia-old culture of food traditions serving as a correlate to a value system and way of life that can be traced as far back as the earliest agricultural expansion in Northern and Eastern Europe (Teuteberg, 1992). The tumultuous Hungarian commonality of a colorful history, shared vicissitudes, and numerous global migrations spanning over ten centuries are culturally interwoven with traditional Hungarian food preparations, many of which may be linked directly to seminal events and phases in Hungarian history (Benda, Hanák, Nagy, Makkai, Niederhauser, 1988). Health care providers and nutrition professionals counseling a Hungarian American population should therefore endeavor to achieve a baseline understanding of the value systems of Hungarian culture, in order to accomplish successful epidemiological outcomes within the target population in respect to coronary heart disease (CHD) (Sisa, 1995). As such, it would behoove health educators to acquire a working knowledge of underlying Hungarian values that influence food and lifestyle choices.

The internal value systems of Hungarians involve complex social and religious constructs blended with a diverse panoply of external cultural components arising from numerous occupations by foreign powers throughout history, e.g. Austria, Turkey, and Romania (Benda et al., 1988). Perhaps the most salient academic concern in this regard is illustrated by the challenging proposition of counseling the quintessentially proud Hungarian who declares with indignation that they *would rather die* than abandon their traditional diet (Cartledge, 2011). Health education programs designed by well-intentioned nutrition or healthcare professionals unacquainted with the traditional Hungarian mindset presents as a dubious proposition at best. This consideration is especially pertinent to any nutritional scrutiny of home-cooked Hungarian fare from the perspective of health, especially when prepared by a Hungarian male's spouse, mother, or grandmother; thus likely to engender considerable resistance (Schuchat, 1981). Hungarians in general are prone to perceive any changes to their diet as equivalent to a form of *cultural mutiny*, a forsaking of one's core identity as a Hungarian (Cartledge, 2011). The confounding nature of these interventional challenges embedded in a practical discussion of the diet of Hungarian Americans may appear a seemingly insurmountable obstacle to overcome for the traditionally-trained American healthcare professional. Yet it may be reasonably posited that any cultural impediment to health promotion may be overcome when great care is exercised by healthcare professionals in the culturally-sensitive deployment of dietary modifications (Mark, Nagy, Kondacs, Deli, 1998). Individual health behaviors have been well-established as reliably consistent with the value-expectancy construct of the Health Belief Model (HBM) (Glanz, Rimer, Viswanath, 2015). An effective health promotion strategy directed at Hungarians should therefore incorporate potential value (risk reduction) and inherent expectations (cultural maintenance) within its methodology. Risk reduction emerges as a priority in this population when we examine epidemiological data revealing that, as of 2015, Hungary had the highest death rate from chronic diseases (including heart disease) of any nation in the European Union; thus it may be inferred that if this data is even marginally translatable to the Hungarian American population, specifically, then it should be a source of concern for American healthcare professionals, given that Hungarians are particularly prone to transplant traditional dietary and lifestyle proclivities from Hungary to the United States (European Commission..., 2015).

The core principles of cultural understanding serve as a useful framework that is customizable to virtually any cultural group sharing the underlying commonality of intrinsic human values that transcend but do not conflict with distinctive cultural proclivities (Peto, 2007). The premise of this discussion specific to the Hungarian American population is thus predicated upon the principle that persons of every culture and ethnicity are imbued with a shared humanity that can serve as a platform for positive change, while also acknowledging with sensitivity that cultural

nuances should be considered by the healthcare provider or dietician as an indispensable component of program design and implementation (Glanz et al., 2015). The purpose of this review is focused on identifying effective CHD intervention strategies for the Hungarian American community via well-established principles of cultural acceptance, understanding, and competency tailored to the needs of Hungarian American populations.

Discussion

The Nutritional Content, Caloric Density and Cardiovascular Risk Factors

A typical Hungarian diet is generally described as *rich* by those new to traditional Hungarian foods, although not necessarily *rich* in respect to nutritional value or nutritional density, instead referring to caloric density and saturated fat content (Jenei, Pall, Katona, Kakuk, Polgar, 2002; Mark et al., 1998). To gain a better understanding of Hungary's cuisine, one must first examine Hungarian foods from a historical perspective. Hungarian dietary traditions, as practiced in Hungary and abroad, are essentially a delicate synthesis of ancient Asiatic influences amalgamated with Germanic, Italian, and Slavic elements (Teuteberg, 1992). The nomadic history of Hungarians, originally influenced by a hunter-gatherer diet and later by agrarianism, is apparent in the prominence of meat: pork, poultry, lamb, and beef, with fatty cuts more highly prized than leaner meat, cooked in lard or pork fat and served with generous portions of starches, followed by sugary pastries, sweet wines, and liqueurs (Martos, Kovacs, Bakacs, Kaposvari, Lugasi, 2012). To the quintessential Hungarian, these tastes are fondly reminiscent of his or her youth, imbued with considerable emotional context. Traditional foods also remind Hungarians of their proud indignant history of prevailing against occupation, oppression, and seemingly insurmountable odds (de Zepetnek, Vasvári, 2011; Sisa, 1995). The full impact of this sentimental consideration in Hungarian cuisine is difficult to quantify and rather difficult to grasp for persons not of Hungarian descent (Cartledge, 2011). To a typical Western cardiologist, Hungarian cuisine must surely epitomize the proverbial "heart attack waiting to happen", especially when consumed with any degree of regularity (Jenei et al., 2002; Mark et al., 1998). In any reasonable discussion of the Hungarian diet, fatty foods and sugary pastries appear at the forefront of CHD-related nutritional concerns among healthcare professionals equipped with even a rudimentary knowledge of the Hungarian diet (Muller-Nordhorn, Binting, Roll, Willich, 2008; Peto, 2007).

As documented by the 2010 Global Burden of Diseases Study (The Institute..., 2016), a collaborative project of over 500 researchers in 50 countries led by the Institute for Health Metrics and Evaluation at the University of Washington, the leading causes of death in Hungary include Coronary Heart Disease (21.3%), Stroke (13.4%) and Cirrhosis (5.8%), all of which may be directly attributed to a traditional Hungarian diet coupled with a mostly sedentary lifestyle (Jenei et al., 2002; Mark et al., 1998). It is indeed an axiom that correlation does not equal causation; however, an abundance of epidemiological and observational studies have established the etiology of CHD as closely linked to the overconsumption of sugary foods, starches, alcohol, and saturated fat (Labarthe, 2011; *The World Health Organization MONICA*, 1988). These dietary factors continue to endure as endemic influences on not only the development of atherosclerotic plaque but also hypertension, systemic inflammation, fatty liver disease, pancreatitis and cirrhosis (Jenei et al., 2002; Labarthe, 2011; Szigethy et al., 2012). Atherosclerotic plaque associated with diet-induced CHD is implicated in a host of cardiac-related chronic and acute conditions, including myocardial infarction, ischemic stroke, angina, and sudden cardiac death. A few studies have also identified the multivariate influences of diet versus a sedentary lifestyle as weighted measures of risk factors for ischemic heart disease (Jenei et al., 2002). By a significant margin, dietary influences and the comorbidity of central

adiposity appear to statistically surpass lack of physical activity as independent variables in the epidemiology of CHD. It may be argued empirically that no amount of physical exercise can overcome the powerful influence of an extremely atherogenic diet such as traditional Hungarian fare. One recent study (Móczár, Borgulya, Kovács, Rurik, 2012) addressed the challenge of presenting a practical summation of primary care prevention strategies for CHD risk amongst a Hungarian population in the Hungarian countryside (2,489 adult patients of 29 primary care physicians between April 2004 and April 2006), which examined the interrelated influence of diet and lifestyle in the management of cardiovascular disease risk. Since this was a large-scale epidemiological investigation conducted by Hungarian researchers working with Hungarian primary care providers treating Hungarian patients, a lack of cultural understanding could not be reasonably postulated as a limitation in study design and implementation. Móczár, Borgulya, Kovács, Rurik (2012) conclusions highlighted distinct improvements in CHD risk reduction following a year of diet and lifestyle modifications of study participants. What remains unclear is, whether or not similar positive outcomes could have been achieved, from the perspective of patient compliance who had study protocol been implemented by foreign healthcare workers or dietitians lacking cultural competency in respect to the target population (Mitic, Abdelaziz, Madi, 2012). Extrapolated from known principles of cultural understanding in the healthcare profession correlated to the HBM, it does present as speculative that study participants responded well to change strategies as a direct result of not only a well-designed diet and exercise program, but also as a result of implementation guided by cultural sensitivity on the part of researchers and healthcare providers, therefore serving as a potentially useful template for CHD-targeted health intervention strategies for Hungarian populations residing external to Hungary, such as Hungarian Americans (Schuchat, 1981). The results of the aforementioned study may be viewed as empowering healthcare providers in the United States with the knowledge that positive health outcomes may indeed be achieved among Hungarian Americans, provided that a practical template of cultural understanding serves as the foundation for intervention strategies (Mitic et al., 2012).

Additionally, statistical data relevant to this discussion highlight the Hungarian diaspora of nearly 5,000,000 is roughly half the number of Hungarians residing in Hungary itself (9,844,686), hence about a third of Hungarians in the world live outside the borders of Hungary, including 1,501,736 in the United States (Hungarian Central Statistical Office, 2016; The World Bank, 2016). These numbers represent a statistically significant migration of culture and food traditions that cannot be reasonably disregarded by healthcare professionals practicing in the United States (Peto, 2007).

Cultural Characteristics Influencing Dietary Choices

In the interest of facilitating a coherent discussion of dietary choices implicit to individuals identifying as Hungarian, the following psychosocial constructs are worthy of consideration in the context of cultural understanding:

1. Most Hungarian males do not expect to live past age 60 and therefore tend to consciously choose “quality of life”, e.g. enjoyment of traditional foods and spirits shared with cherished family and friends, over health behaviors aimed at maximizing longevity (de Zepetnek, Vasvári, 2011).
2. The perception of traditional Hungarian foods as immutable iconic symbols honoring Hungarian culture and history, e.g. when celebrating traditional Hungarian holidays (frequent throughout the year), overindulgence in food and drink is generally considered a source of pride for the *true Hungarian* (Sisa, 1995).

3. Hungarian hosts tend to take personal offense if their guests do not willingly overindulge in food and drink to the point they feel physically uncomfortable. Hungarians are not generally known for their self-restraint in regard to self-indulgent behaviors (Sisa, 1995).

The aforementioned psychosocial constructs demonstrate that individuals hailing from a culture such as that of Hungary may indeed present as a considerable interventional difficulty for healthcare professionals employing conventional interventional strategies who are unused to what presents as an irrational resistance to positive change (Mark et al., 1998). The root cause of a quintessential Hungarian's unhealthy dietary behaviors is usually not a lack of education, it is instead attributable to a cultural perspective consistent with a somewhat unmindful attitude toward the future consequences of one's actions (Berend, Gyorgi, 1979).

These observations of typical Hungarian behaviors and social norms are not intended to stereotype or marginalize the Hungarian American population. The intent of examining cultural distinctions is to create a rational foundation for health promotion strategies aimed specifically at Hungarian Americans following their diet and lifestyle, not toward the outlier of individuals within this population group who have chosen to eschew their traditional foods in favor of a heart-healthy diet. The thoughtful health care professional should therefore temper cultural competency with a specific concern for treating each Hungarian American as *an individual* who may or may not be abiding by the traditions of their ethnographic origin (Miller, Rollnick, 2013).

Interventional Components of Ecological Approaches to Dietary Change

A comprehensive understanding of the psychosocial foundation for dietary choices of a specific demographic serves as the contextual basis health promotion strategies likely to elicit authentic behavioral changes leading to reduced cardiovascular disease risk in a target population (Glanz et al., 2015; *The World Health Organization MONICA...*, 1988). A discussion of cultural context in dietary choices should ideally evolve into discussions of effective interventional strategies. The value-expectancy principle of the HBM proposes that successful behavioral change templates should factor in the inherent duality of a specific motivation serving as both a determinant of sustaining an unhealthy behavior and, conversely, as a potentiator for positive change. An individual must weigh the value they place on a specific pattern of behavior against their perceived susceptibility to a chronic disease state such as CHD or an acute episode such as myocardial infarction arising as a result of that behavior (Glanz et al., 2015; Skrabski, Kopp, Rózsa, Réthelyi, Rahe, 2005). The established premise of this investigation is that Hungarian Americans' consumption of their traditional foods deemed hazardous to their health by cardiologists and nutrition professionals are also foods that are strongly associated with their culture. Nevertheless, this emotional drive replete with potentially negative health consequences can also serve as a platform for change. The core psychological principle of this argument is that an individual who is a sociocultural product of a specific population may be motivated to safeguard her health in the service of *interpersonal* rather than *intrapersonal* motivations (Miller, Rollnick, 2013). The same Hungarian American who emphatically proclaims that they would never forsake greasy blood sausage, pancakes and sweet wine, may also readily admit that the only priority which ranks higher for them than enjoying traditional foods is the empowerment of surviving to participate in social activities with family and friends in the years ahead, e.g. holidays and family milestones, and to be able to pass on their accumulated wisdom to a new generation (Skrabski et al., 2005). This dichotomy highlights the HBM construct of cultural fatalism contrasted against a traditional Hungarian belief system of self-efficacy and the willpower to overcome adverse circumstances, both within the external context of family and society, as well as the internal context of personal

health. This duality of purpose may indeed present as a challenge for the healthcare professional seeking to reconcile the health implications of Hungarian cultural norms related to diet counterbalanced against a deep abiding love of family (Skrabski et al., 2005). Furthermore, it may also be useful to consider that the culturally-sensitive application of change strategies based on the HBM aimed at reducing dietary risk factors in CHD may be best accomplished within this demographic via carefully designed elicitation of incremental changes in diet and lifestyle, as opposed to unrealistic expectations of complete dietary overhaul that proposes the elimination of staples in the traditional diet. This approach necessitates a prudent elicitation of the third HBM principle – an expectation or belief that certain actions will prevent or resolve a specific chronic or acute disease state at an “acceptable cost”; in this example, “cost” defined as a perceived compromise of the individual's visceral enjoyment of life (Glanz et al., 2015). This impediment to progress may be ameliorated, or at least diminished, via the healthcare professional or dietician suggesting, for example, that fatty cuts of meat may be substituted with leaner cuts, traditional pastries replaced with lower glycemic versions using alternative sweeteners, and strong liqueurs such as palinka substituted with red wine, all accomplished without drastic alterations of traditional recipes thereby encouraging higher patient compliance (Martos et al., 2012; Sarkadi-Nagy et al., 2012). When counseling Hungarian Americans on diet, one must remain mindful that any proposed dietary alternatives are being directed at a community of individuals that take great pride in indignation toward their mortality and personal vulnerability, as previously delineated (Cartledge, 2011). It may nonetheless be posited that the basic human instinct for survival and the desire to endure are drives that may supplant cultural paradigms, if appropriately presented to the individual, consistent with the core principles of the HBM (Glanz et al., 2015).

An additional consideration in the emotional cost analysis of traditional Hungarian fare is the actual financial costs of those foods versus a healthier diet, often falsely perceived by Hungarian Americans as much more expensive than their traditional diet, a factor that was examined in a recent study (Iski, Biro, Ungvari, Rurika, 2016) in respect to Hungarians living within Hungary, one which may not implicitly apply to Hungarian Americans per se, yet is still worthy of consideration. In this comparative study, researchers analyzed the cost in Hungarian currency of three specific dietary protocols: traditional Hungarian, low energy, and diabetic, while accounting for the ingredients of each meal and corresponding retail costs. Energy content, relevant medications, and expenses related to lifestyle were also factored into study design. Researchers concluded that the low energy diet and a physically active lifestyle were not only the most cost-effective combination but also the one most likely to achieve favorable health outcomes. The authors referenced similar findings by studies in the United States and the United Kingdom examining the costs of a junk food diet contrasted against that of a healthy foods diet, all arriving at similar conclusions in their cost analyses. One notable concern uncovered by the Hungarian study was the occasional inclusion of pizza and fast food by study participants, illustrating the point that even Hungarians consuming a mostly traditional diet sometimes stray from their customary eating habits at American fast food chains that have become ubiquitous cross-cultural contaminants of traditional diets both in the United States and in Hungary (Schröder, Fito, Covas, 2007). It is pertinent to note that Hungarians who infrequently stray from their traditional diet do so by eating foods at Western fast-food chains that are even more unhealthful than their own traditional diet, highlighting the health impact of the corporatization and globalization of the food supply in modern industrialized nations (Popkin, 2006), a separate topic outside the scope of this investigation.

Genetic Commonalities of Hungarians as a Haplogroup

A *haplotype* is a group of genes in an organism that are inherited together from a single parent, while a *haplogroup* is a group of similar haplotypes sharing a common ancestor with a single-nucleotide polymorphism (SNP) mutation. Numerous SNP mutations associated with Hungarians specifically and Eastern Europeans in general have been identified, with minor genomic variations from median values specific to individuals within the population (Cambien, Tiret, 2007). A statistically relevant genetic blueprint emerges as significant to this discussion, which include the following SNP's that have been identified as genomic influences in the etiology of CHD:

1. Atherosclerosis: USF-1 and FGB (Kalina, Czeizel, 2004).
2. Cardiovascular disease (general): FMN2, FSRC1, CRP, HSPD1, HSPE1, MTHFD1L, NOS3, MMP3, MYBPC3, SMAD3, CDH13, ACE AND SEZ61 (Szalai et al., 2004; Tregouet et al., 2009).
3. Cardiovascular disease (cholesterol level): CELSR3, ARHGAP30, EDN1, LPL, LIPC, CETP, MC4R and PLTP (Bereczky et al., 2007).
4. Familial hypercholesterolemia (common amongst Eastern European haplogroups): PCSK9, APOB AND LDLR (Kalina, Szab ki, Czeizel, 2003).
5. Myocardial infarction: MIA3 and WDR12 (Andrikovics et al., 2006).

The topic of predisposing genetic etiologies presents anachronistically as an expression of genetic determinism. A subset of society believes that our DNA dictates the destiny of our health outcomes, including CHD. This fatalistic notion unfortunately conforms to the Hungarian zeitgeist of destiny as an insurmountable force in one's life. The HBM emerges again as a potential vehicle for change, sharply contrasted against the flawed notion of hereditary determinism embedded in the mindset of many Hungarians (Cartledge, 2011). Hungarian Americans *want* to believe that they can change; they need only be *lead to the light*. Successfully addressing the topic of genetic predispositions lies in educating the Hungarian American, in layman's terms, about the critical role of nutrigenomics and epigenetics in gene expression, to convince the individual that their genes are in fact *not* their immutable destiny. Genetics may be a loaded gun, but it is environment that pulls the trigger (Egger, Liang, Aparicio, Jones, 2004; Mutch, Wahli, Williamson, 2005).

Non-Dietary Comorbidities of CHD Presenting as Additional Risk Factors

Comorbidities in the etiology of CHD in the Hungarian American population includes the prevalence of Metabolic Syndrome, both in Hungary and in the United States (Ford, Giles, Dietz, 2002). Metabolic Syndrome is comprised of five chronic conditions: Central obesity, elevated serum glucose, hypertension, hypertriglyceridemia, and hyperlipidemia/decreased HDL (Grundey et al., 2005). A recent cross-sectional study (Szigethy et al., 2012) examining Metabolic Syndrome in Hungarian populations profoundly spotlights the endemic nature of this problem. The study's methodology involved physical and laboratory screening of 2,006 Hungarian individuals, aged 20–69 years, for indicators of Metabolic Syndrome. Population prevalence was estimated via sample frequencies. The age-adjusted prevalence was found to be 38% in males and 30% in females, pointing in the direction of both genetic and epigenetic influences (Egger et al., 2004; Poyrazoglu, Bas, Darendeliler, 2014).

Additional covariate etiologies of CHD include the prevalence of smoking and excess alcohol consumption in the Hungarian culture (Chow et al., 2010; Popova, Rehm, Patra, Zatonski, 2007; Tombor et al., 2010). The influence of alcohol and nicotine as prominent causative factors common to numerous chronic disease states, e.g. CHD, cancer, diabetes, cirrhosis, pancreatitis and lung disease, are well-documented. Studies published in the last

decade (Britton, McKee, 2000; Popova et al., 2007) compared alcohol consumption in Eastern Europe, including Hungary, to other European countries. Researchers concluded that heavy alcohol consumption by Hungarian males is the second-highest in Europe, accentuated by a high proportion of binge drinking, and the highest in Europe in Hungarian females. The alcohol-attributable burden of disease in the Hungarian population can hardly be overstated as a CHD risk factor. The degree to which these findings are applicable to Hungarian Americans is difficult to quantify, as is the relative contribution of diet, alcohol consumption, and nicotine use to CHD risk, but it is logical to deduce from known data that CHD risk is indeed multifactorial in nature. Positive adoptions in health behavior tend toward concomitance and are rarely mutually exclusive, as proposed by Protection Motivation Theory (Milne, Sheeran, Orbell, 2000). Many Hungarian Americans who have transplanted their traditional atherogenic diet from Hungary may also have transplanted other unhealthful habits, such as smoking and excessive alcohol consumption (see Table 1). Therefore, successful dietary interventions to reduce CHD risk may also need to address the correlative issues of alcohol and nicotine use, as well as numerous other lifestyle factors outside the scope of this discussion, e.g. excess stress, inadequate sleep, and a sedentary lifestyle, as part of a complete and holistic approach to CHD prevention.

Table 1. Selected Social Determinants of Health for Hungarian-Americans

Social Determinants of Health	Health Effects
Language Barriers; Dietary Shift towards a Westernized diet; Tobacco Use; Cultural Barriers; Excess Alcohol Intake; Sedentary Lifestyle/Physical Inactivity; Resistance to Dietary or Lifestyle Changes	CVD; Diabetes (Type 2); Obesity (BMI \geq 30); Hypercholesterolemia; Ischemic Stroke; Metabolic Syndrome

Culturally Influenced Cognitive Dissonance

Hungarians for the most part will tend to eat whatever they *want* to eat, not what they are *told* to eat (Szeitz-Szabó, Biró, Biró, 2012). The health promotion challenge is therefore implicit to convincing Hungarian Americans to want to eat healthier foods, while at the same time taking great care to respect their culture and traditions, constructed on a solid foundation of self-efficacy (Glanz et al., 2015; Mitic et al., 2012). It presents as unrealistic in a cultural context to seek a quick and easy solution to health promotion via the oversimplification and dichotomizing of self-indulgent behavioral patterns contrasted against the relatively trite counterpoint of safeguarding one's health, which is often not a priority for many individuals, Hungarian or otherwise. When counseling a Hungarian American, he or she, especially if older, may expect a specific form of formality in verbal communications between strangers that bears some resemblance as a cultural nuance to that of traditional Japanese societies. An example of this cultural nuance in conversation translatable to English would be a statement such as "It is better for *a person* to eat this, not that", instead of "It is better for *you* to eat this, not that". A conservative Hungarian American might very well take offense from the latter. In exploring the various permutations of health promotion aimed at Hungarian Americans, we find ourselves returning consistently to the recurring themes of cultural sensitivity and cultural competency as common threads in effective health promotion strategies (Mitic et al., 2012).

Summary

This review explored numerous facets of the psychosocial, economic, and cultural context of dietary habits of Hungarian Americans as an extension of their cultural roots in Hungary. We have highlighted key points in Hungarian history that have profoundly affected traditional Hungarian foods and the associated cultural mores. We also reviewed an array of relevant empirical evidence for cultural norms influencing diet that are consistent within the target population. The role of predisposing genetic and epidemiological factors in the progression of CHD and associated comorbidities common to haplogroups of Hungarian origin were also examined. Analyses of health-related statistical data pertinent to Hungarian populations in the US and Hungary were presented and quantified, with an emphasis on migrational components of epidemiology. Dietary recommendations relevant to reduction of CHD risk with the highest potential for realistic integration into a traditional Hungarian diet were identified and delineated, contrasted against recommendations deemed contextually unrealistic. The aim of this investigation is not to offer quick solutions for health promotion strategies; it is intended solely as a rational framework for dietary CHD intervention that respectfully acknowledges the distinct cultural identity of the Hungarian American, recognizing that a significant portion of that population is heavily influenced by the culture and food traditions of their native country and, as a result, continues to suffer negative health consequences. The authors' aspiration is that this investigation may serve as a useful template for healthcare professionals seeking to approach the Hungarian American population with a higher benchmark of cultural competency. The foundation for cultural competency in a healthcare setting, in respect to any culture, should ideally be predicated on the responsibility of healthcare professionals to first demonstrate empathy via knowledge and understanding of a given culture before they can proceed effectively with eliciting authentic behavior change within a population of likeminded individuals sharing a common thread of history and culture.

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