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ASSOCIATION BETWEEN ADHERENCE TO THE MEDITERRANEAN DIETARY PATTERN AND HEALTH PARAMETERS AND RISK FACTORS: IMPLICATIONS FOR PUBLIC HEALTH

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Abstract. *The Mediterranean diet is currently recognized as one of the most important dietary patterns for the prevention of chronic non-communicable diseases, primarily due to its beneficial effects on cardiometabolic health. It is characterized by a high intake of fruits, vegetables, whole grains, legumes, fish, and olive oil, along with limited consumption of red meat and highly processed foods. The aim of this study was to assess adherence to the Mediterranean dietary pattern in the general population and to examine the association between the MedDietScore and selected sociodemographic, anthropometric, and health-related parameters. This cross-sectional observational study included 200 participants from the general population. Data were collected through an anonymous survey using the standardized Mediterranean Diet Score questionnaire, which was used to evaluate adherence to the principles of the Mediterranean diet. Information on daily physical activity, smoking status, body mass index (BMI), waist circumference, and the presence of hypertension, diabetes, prediabetes, and dyslipidemia was also analyzed. Statistical analysis was performed using descriptive and inferential statistical methods, with statistical significance set at $p<0.05$. The mean MedDietScore was 26.48, with the majority of participants demonstrating moderate adherence to the Mediterranean dietary pattern. Significantly higher MedDietScore values were observed among female participants compared with males ($p=0.0001$), as well as among physically active participants compared with physically inactive individuals ($p=0.0028$). A statistically significant negative correlation was identified between BMI and MedDietScore ($rho=-0.178$; $p=0.0116$), indicating that higher BMI was associated with lower adherence to the Mediterranean dietary pattern. A significant association was also found between waist circumference and MedDietScore ($p=0.0009$), with participants with larger waist circumferences showing lower scores. No statistically significant associations were observed between MedDietScore and smoking status, hypertension, or composite metabolic risk. The findings suggest that greater adherence to the Mediterranean*

dietary pattern is associated with more favorable anthropometric and lifestyle characteristics, highlighting the importance of promoting this dietary model within public health strategies. Furthermore, the results emphasize the need for continuous public education regarding healthy dietary habits and lifestyle practices.

Keywords: *Mediterranean dietary pattern, MedDietScore, risk factors, body mass index, public health*

Introduction

The Mediterranean diet is characterized by a high intake of vegetables, fruit, legumes, whole grains and nuts, with olive oil as the principal source of dietary fat, moderate fish consumption and limited red meat. Sustained adherence has been associated with a more favourable cardiometabolic profile in population-based research [1]. Clinical trials provide complementary evidence. In the CORDIOPREV study, patients with established coronary heart disease assigned to a Mediterranean diet experienced fewer major cardiovascular events over seven years than those assigned to a low-fat diet [2].

Anthropometric outcomes are also relevant. An analysis from the PREDIMED-Plus trial found that an energy-reduced Mediterranean diet, combined with physical activity and behavioral support, reduced total body fat percentage and visceral fat in older adults with overweight or obesity and metabolic syndrome [3]. These findings should be interpreted as effects of a combined lifestyle intervention.

Adherence to the Mediterranean dietary pattern varies across population groups. A Republic of Slovenian survey reported higher adherence among women, more educated participants and non-smokers [4], while a Greek national survey identified education and income as important correlates of lower adherence [5]. Associations with BMI and physical activity are less consistent. In a study of community-dwelling older adults in Spain, neither BMI nor physical activity showed a significant association with Mediterranean diet adherence [6].

This cross-sectional study aimed to assess adherence to the Mediterranean dietary pattern using the MedDietScore in a general-population sample and to examine its associations with sex, physical activity, smoking, BMI, waist circumference and selected cardiometabolic conditions.

Methods

This cross-sectional observational study included 200 participants from the general population and examined adherence to the Mediterranean dietary pattern in relation to selected sociodemographic, anthropometric and health-related characteristics. An anonymous questionnaire collected information on dietary habits, sex, daily physical activity, smoking status, body mass index (BMI), waist circumference, and the presence of hypertension, diabetes, prediabetes and dyslipidemia.

Dietary adherence was assessed using the MedDietScore, an 11-component index with a theoretical range of 0 to 55 points; higher scores indicate greater adherence to the Mediterranean dietary pattern [7]. Adherence was described using low, moderate and high categories. Waist circumference categories were <94 cm, 94 to 102 cm and >102 cm for men, and <80 cm, 80 to 88 cm and >88 cm for women. Composite metabolic risk status was recorded as present or absent. Descriptive statistics comprised the mean MedDietScore, the observed minimum and maximum, and counts and percentages for adherence categories. The Kruskal–Wallis test assessed differences in MedDietScore by sex, smoking status and waist circumference category. The Mann–Whitney U test assessed differences by physical activity, hypertension and composite metabolic risk status. Spearman's rank correlation coefficient assessed the association between BMI and MedDietScore. Statistical significance was set at $p < 0.05$.

Results

The mean MedDietScore among the 200 participants was 26.48, with observed scores ranging from 6 to 43. Most participants had moderate adherence to the Mediterranean dietary pattern (n = 161; 80.5%). Low adherence accounted for 16 participants (8.0%), and 23 (11.5%) had high adherence (Table 1).

Table 1. Overall MedDietScore and adherence to the Mediterranean dietary pattern

Measure	Value
Participants, n	200
Mean MedDietScore	26.48
Observed MedDietScore range	6–43
Low adherence, n (%)	16 (8.0)
Moderate adherence, n (%)	161 (80.5)
High adherence, n (%)	23 (11.5)

Percentages use the full sample of 200 participants. Adherence categories retain the classification used in the analysis.

MedDietScore was higher among women than among men (mean 27.79 vs 23.52; Kruskal–Wallis p = 0.0001). Physically active participants also had higher scores than inactive participants (mean 27.29 vs 24.44; Mann–Whitney U p = 0.0028) (Table 2 and Figure 1).

Table 2. MedDietScore according to sex and physical activity

Characteristic	Category	Mean MedDietScore	p value
Sex	Men	23.52	0.0001

Characteristic	Category	Mean MedDietScore	p value
	Women	27.79	
Physical activity	Active	27.29	0.0028
	Inactive	24.44	

Values are group means. P values refer to comparisons of score ranks, using Kruskal–Wallis for sex and Mann–Whitney U for physical activity. Each p value applies to the full comparison.

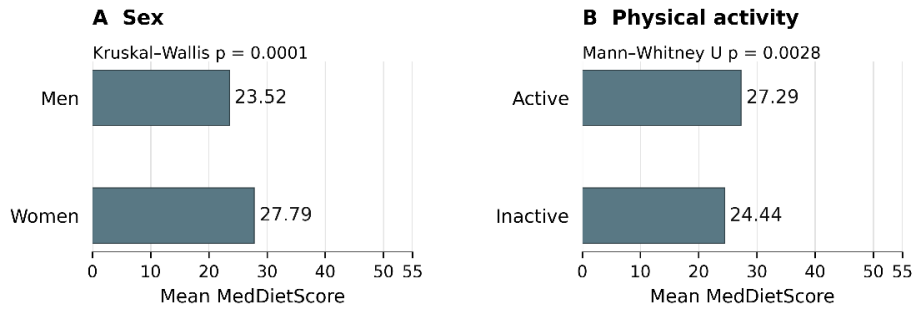

Figure 1. Mean MedDietScore by sex (A) and physical activity (B). Bars display group means on the theoretical 0 to 55 scale; p values refer to rank-based between-group comparisons. Error bars are not shown.

BMI showed a weak inverse association with MedDietScore (Spearman's ρ = -0.178; p = 0.0116). The overall comparison across waist circumference categories was statistically significant (Kruskal–Wallis p = 0.0009) (Table 3).

Table 3. MedDietScore in relation to BMI and waist circumference

Measure	Category	Mean score or ρ	p value
BMI	Continuous	ρ = −0.178	0.0116
Waist circumference	Men <94 cm	25.12	0.0009
	Men 94–102 cm	23.52	
	Men >102 cm	22.71	
	Women <80 cm	27.76	
	Women 80–88 cm	28.21	
	Women >88 cm	26.72	

BMI, body mass index; ρ, Spearman's rank correlation coefficient. Waist circumference values are mean MedDietScore values. The waist circumference p value is the overall Kruskal–Wallis result across categories, not a sex-specific or pairwise comparison.

Among men, mean scores decreased across the three categories, from 25.12 at <94 cm to 23.52 at 94 to 102 cm and 22.71 at >102 cm. The pattern was not monotonic

among women: mean scores were 27.76 at <80 cm, 28.21 at 80 to 88 cm and 26.72 at >88 cm (Figure 2). The overall test does not establish which individual categories differed.

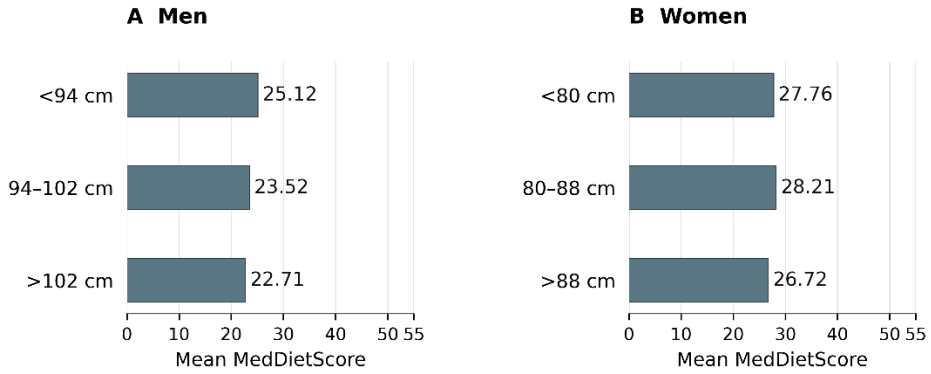

Figure 2. Mean MedDietScore across waist circumference categories in men (A) and women (B). Bars display group means. The overall Kruskal–Wallis p value is 0.0009; it does not provide separate within-sex or pairwise tests. Error bars are not shown.

Table 4. MedDietScore according to smoking status and health-related characteristics

Characteristic	Category	Mean MedDietScore	p value
Smoking status	Current smoker	25.30	0.152
	Former smoker	27.70	
	Never smoker	26.94	
Hypertension	Present	27.38	0.1334
	Absent	26.16	
Composite metabolic risk	Present	26.58	0.8708
	Absent	26.41	

Values are group means. P values refer to rank comparisons: Kruskal–Wallis for smoking status and Mann–Whitney U for hypertension and composite metabolic risk. Each p value applies to the full comparison.

MedDietScore did not differ significantly by smoking status (Kruskal–Wallis p = 0.152). Mean scores were 25.30 among current smokers, 27.70 among former smokers and 26.94 among never smokers. Participants with hypertension had a mean score of 27.38, compared with 26.16 among those without hypertension (Mann–Whitney U p = 0.1334). Mean scores were also similar in participants with and without composite metabolic risk (26.58 and 26.41, respectively; Mann–Whitney U p = 0.8708) (Table 4).

Discussion

Among the 200 participants, the mean MedDietScore was 26.48; 80.5% had moderate adherence and 11.5% had high adherence. Women and physically active participants had higher scores, while BMI showed a weak inverse association with adherence. These findings suggest that dietary habits accompany other lifestyle and anthropometric characteristics, although the cross-sectional design cannot establish the direction of these relationships.

The predominance of moderate adherence indicates scope for improving dietary habits. A Croatian survey also reported incomplete adherence to the Mediterranean dietary pattern [8]. Comparisons nevertheless depend on how adherence is measured. A review of scoring systems identified differences in their components and thresholds [9], while a seven-country MEDAS validation study found that agreement with food records varied between countries [10]. Adherence categories therefore need to be interpreted within the instrument and classification used in each study. Women had a 4.27-point higher mean score than men, consistent with Republic of Slovenian and Croatian findings [4,8]. MEDIET4ALL also reported better food-consumption scores among women, but no significant difference between women and men in its overall Mediterranean lifestyle score [11]. Dietary differences should not be assumed to extend to every health behaviour. Education and income, associated with adherence in the Greek EHIS-3 survey [5], could contribute to the difference observed here; our unadjusted analysis cannot separate their potential influence from that of sex. Physically active participants scored 2.85 points higher than inactive participants. Healthy behaviours may occur together: in ATTICA, participants who maintained high adherence were more active than those with persistently low adherence [1]. However, a Spanish study of older adults found no significant association between adherence and physical activity [6]. Age, social circumstances and the way activity is assessed may influence these differences, although their contribution was not examined in our study.

The inverse association with BMI was statistically significant but weak ($\rho = -0.178$; $p = 0.0116$). Food4Me likewise associated higher Mediterranean diet scores with lower BMI [12]. Intervention findings add an important distinction. The revised PREDIMED analysis found no significant between-group differences in bodyweight change with an unrestricted-calorie Mediterranean diet [13], whereas PREDIMED-Plus reduced total body fat percentage and visceral fat through a programme combining energy restriction, dietary advice, physical activity and behavioural support [3]. The latter findings cannot be attributed to dietary composition alone. Waist circumference provides information about adiposity-related risk beyond BMI, as discussed in the IAS and ICCR consensus statement [14]. In our study, however, the significant overall comparison ($p = 0.0009$) included six sex-specific categories. Scores decreased across categories in men but not consistently in women; the test therefore establishes neither a uniform gradient nor an association independent of sex. DIRECT-PLUS reported greater MRI-measured visceral fat loss with a specialised

green-Mediterranean diet than with a conventional Mediterranean diet, with physical activity promoted in both groups [15]. Our cross-sectional waist measurements cannot directly assess comparable changes in specific fat compartments.

The non-significant findings for smoking, hypertension and composite metabolic risk do not establish an absence of association. Smoking-related differences were reported in Republic of Slovenia and Spain [4,6]. A randomised trial of a Mediterranean diet combined with salt restriction reported lower blood pressure [16]; a secondary analysis of the same trial found reduced metabolic-syndrome prevalence [17]. These intervention outcomes differ from comparisons of current diet with existing diagnoses, and our composite indicator should not be equated with formally diagnosed metabolic syndrome. ADDITION-Cambridge documented dietary improvements after screen-detected diabetes [18], illustrating how changes following diagnosis could complicate cross-sectional associations. Whether this occurred in our participants is unknown.

Considering diet, activity, BMI and waist circumference together is a strength, but several limitations restrict interpretation. The cross-sectional design and unadjusted comparisons leave temporal ordering and confounding unresolved. Biomarker validation studies of dietary self-report instruments also show that reporting error can vary with BMI [19]. Multiple exploratory comparisons warrant caution, and unavailable subgroup sizes and confidence intervals limit assessment of precision. Incomplete item-level records prevent independent verification of score construction. The findings are therefore best treated as exploratory associations requiring confirmation with complete records and adjusted analyses.

Men and physically inactive participants may warrant particular attention in dietary support programmes. Practical assistance deserves consideration alongside education: a cluster randomised trial among US firefighters improved adherence over 12 months using nutrition education, food-access support and family involvement [20]. This offers an approach to evaluate in other settings. Repeated dietary assessments and follow-up of anthropometric measures would help determine whether improved adherence precedes changes in health.

Conclusion

In this study, moderate adherence to the Mediterranean dietary pattern predominated, while high adherence was observed in a smaller proportion of participants. Higher MedDietScore values were found among women and physically active participants, whereas BMI showed a weak inverse association with Mediterranean diet adherence. Significant differences were also observed across waist circumference categories, while no significant differences were found according to smoking status, hypertension, or composite metabolic risk.

These findings suggest that adherence to the Mediterranean dietary pattern is associated with selected lifestyle and anthropometric characteristics. Given the cross-

sectional design of the study, causal relationships cannot be established. Further longitudinal studies with adjusted analyses are needed to clarify the determinants of Mediterranean diet adherence and its relationship with metabolic health.

References

[1] Georgoulis M, Georgousopoulou EN, Chrysohoou C, Pitsavos C, Panagiotakos DB. Longitudinal trends, determinants, and cardiometabolic impact of adherence to the Mediterranean diet among Greek adults. *Foods*. 2022;11(16):2389. doi:10.3390/foods11162389.

[2] Delgado-Lista J, Alcala-Diaz JF, Torres-Peña JD, Quintana-Navarro GM, Fuentes F, Garcia-Rios A, et al. Long-term secondary prevention of cardiovascular disease with a Mediterranean diet and a low-fat diet (CORDIOPREV): a randomised controlled trial. *Lancet*. 2022;399(10338):1876–1885. doi:10.1016/S0140-6736(22)00122-2.

[3] Konieczna J, Ruiz-Canela M, Galmes-Panades AM, Abete I, Babio N, Fiol M, et al. An energy-reduced Mediterranean diet, physical activity, and body composition: an interim subgroup analysis of the PREDIMED-Plus randomized clinical trial. *JAMA Netw Open*. 2023;6(10). doi:10.1001/jamanetworkopen.2023.37994.

[4] Poklar Vatovec T, Jenko Pražnikar Z, Petelin A. Adherence and sociodemographic determinants of adherence to the Mediterranean diet among Republic of Slovenian adults and the elderly. *Nutrients*. 2023;15(14):3219. doi:10.3390/nu15143219.

[5] Kontele I, Panagiotakos D, Yannakoulia M, Vassilakou T. Socio-demographic determinants of Mediterranean diet adherence: results of the EU-National Health Interview Survey (EHIS-3). *J Hum Nutr Diet*. 2025;38(1). doi:10.1111/jhn.70023.

[6] Navarro-Martínez R, Mafla-España MA, Cauli O. Mediterranean diet adherence in community-dwelling older adults in Spain: social determinants related to the family. *Nutrients*. 2022;14(23):5141. doi:10.3390/nu14235141.

[7] Panagiotakos DB, Pitsavos C, Stefanadis C. Dietary patterns: a Mediterranean diet score and its relation to clinical and biological markers of cardiovascular disease risk. Nutr Metab Cardiovasc Dis. 2006;16(8):559–568. doi:10.1016/j.numecd.2005.08.006.

[8] Gerić M, Matković K, Gajski G, Rumbak I, Štancl P, Karlić R, et al. Adherence to Mediterranean diet in Croatia: lessons learned today for a brighter tomorrow. Nutrients. 2022;14(18):3725. doi:10.3390/nu14183725.

[9] Hutchins-Wiese HL, Bales CW, Porter Starr KN. Mediterranean diet scoring systems: understanding the evolution and applications for Mediterranean and non-Mediterranean countries. Br J Nutr. 2022;128(7):1371–1392. doi:10.1017/S0007114521002476.

[10] García-Conesa MT, Philippou E, Pafilas C, Massaro M, Quarta S, Andrade V, et al. Exploring the validity of the 14-item Mediterranean Diet Adherence Screener (MEDAS): a cross-national study in seven European countries around the Mediterranean region. Nutrients. 2020;12(10):2960. doi:10.3390/nu12102960.

[11] Boujelbane MA, Ammar A, Salem A, Kerkeni M, Trabelsi K, Bouaziz B, et al. Gender-specific insights into adherence to Mediterranean diet and lifestyle: analysis of 4,000 responses from the MEDIET4ALL project. Front Nutr. 2025;12:1570904. doi:10.3389/fnut.2025.1570904.

[12] Celis-Morales C, Livingstone KM, Affleck A, Navas-Carretero S, San-Cristobal R, Martinez JA, et al. Correlates of overall and central obesity in adults from seven European countries: findings from the Food4Me Study. Eur J Clin Nutr. 2018;72(2):207–219. doi:10.1038/s41430-017-0004-y.

[13] Estruch R, Martínez-González MA, Corella D, Salas-Salvadó J, Fitó M, Chiva-Blanch G, et al. Effect of a high-fat Mediterranean diet on bodyweight and waist circumference:

a prespecified secondary outcomes analysis of the PREDIMED randomised controlled trial. Lancet Diabetes Endocrinol. 2019;7(5):e6–e17. doi:10.1016/S2213-8587(19)30074-9.

[14] Ross R, Neeland IJ, Yamashita S, Shai I, Seidell J, Magni P, et al. Waist circumference as a vital sign in clinical practice: a Consensus Statement from the IAS and ICCR Working Group on Visceral Obesity. Nat Rev Endocrinol. 2020;16(3):177–189. doi:10.1038/s41574-019-0310-7.

[15] Zelicha H, Kloting N, Kaplan A, Yaskolka Meir A, Rinott E, Tsaban G, et al. The effect of high-polyphenol Mediterranean diet on visceral adiposity: the DIRECT PLUS randomized controlled trial. BMC Med. 2022;20(1):327. doi:10.1186/s12916-022-02525-8.

[16] Filippou C, Thomopoulos C, Konstantinidis D, Siafi E, Tatakis F, Manta E, et al. DASH vs. Mediterranean diet on a salt restriction background in adults with high normal blood pressure or grade 1 hypertension: a randomized controlled trial. Clin Nutr. 2023;42(10):1807–1816. doi:10.1016/j.clnu.2023.08.011.

[17] Filippou C, Thomopoulos C, Konstantinidis DG, Dimitriadis KS, Chrysochoou CA, Tatakis FA, et al. Effect of DASH vs. Mediterranean diet accompanied by a salt restriction on metabolic syndrome and cardiometabolic risk factors in adults with high normal blood pressure or grade 1 hypertension: secondary analyses of a randomized controlled trial. Hellenic J Cardiol. 2025;85:24–37. doi:10.1016/j.hjc.2024.05.006.

[18] Savory LA, Griffin SJ, Williams KM, Prevost AT, Kinmonth AL, Wareham NJ, et al. Changes in diet, cardiovascular risk factors and modelled cardiovascular risk following diagnosis of diabetes: 1-year results from the ADDITION-Cambridge trial cohort. Diabet Med. 2014;31(2):148–155. doi:10.1111/dme.12316.

[19] Freedman LS, Commins JM, Moler JE, Arab L, Baer DJ, Kipnis V, et al. Pooled results from 5 validation studies of dietary self-report instruments using recovery biomarkers for energy and protein intake. Am J Epidemiol. 2014;180(2):172–188. doi:10.1093/aje/kwu116.

[20] Hershey MS, Chang CR, Sotos-Prieto M, Fernandez-Montero A, Cash SB, Christophi CA, et al. Effect of a nutrition intervention on Mediterranean diet adherence among firefighters: a cluster randomized clinical trial. JAMA Netw Open. 2023;6(8). doi:10.1001/jamanetworkopen.2023.29147.

POVEZANOST PRIDRŽAVANJA MEDITERANSKOG OBRASCA ISHRANE SA ZDRAVSTVENIM PARAMETRIMA I FAKTORIMA RIZIKA: ZNAČAJ ZA JAVNO ZDRAVLJE

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Sažetak. *Mediteranska ishrana danas se smatra jednim od najznačajnijih nutritivnih modela u prevenciji hroničnih nezaraznih bolesti, prvenstveno zahvaljujući povoljnom uticaju na kardiometaboličko zdravlje. Zasniva se na visokom unosu voća, povrća, integralnih žitarica, mahunarki, ribe i maslinovog ulja, uz ograničenu konzumaciju crvenog mesa i industrijski prerađenih namirnica. Cilj istraživanja bio je procena stepena pridržavanja mediteranskog obrasca ishrane u opštoj populaciji i ispitivanje povezanosti MedDietScore sa odabranim sociodemografskim, antropometrijskim i zdravstvenim parametrima. Istraživanje je sprovedeno kao opservaciona studija preseka u opštoj populaciji na uzorku od 200 ispitanika. Podaci su prikupljeni anonimnim anketiranjem primenom standardizovanog Mediterranean Diet Score upitnika, kojim je procenjivan stepen usklađenosti ispitanika sa principima mediteranske ishrane. Analizirani su podaci o svakodnevnoj fizičkoj aktivnosti, pušačkom statusu, indeksu telesne mase, obimu struka i prisustvu hipertenzije, dijabetesa, predijabetesa i dislipidemije. Statistička obrada podataka sprovedena je primenom deskriptivnih i analitičkih statističkih metoda, uz procenu statističke značajnosti na nivou $p<0,05$. Prosečna vrednost MedDietScore iznosila je 26,48, pri čemu je najveći broj ispitanika pokazao umeren stepen pridržavanja mediteranskom obrascu ishrane. Statistički značajno više vrednosti MedDietScore zabeležene su kod ispitanica ženskog pola u poređenju sa muškarcima ($p=0,0001$), kao i kod fizički aktivnih ispitanika u odnosu na fizički neaktivne ($p=0,0028$). Utvrđena je statistički značajna negativna korelacija između BMI i MedDietScore ($rho=-0,178$; $p=0,0116$), što ukazuje da viši BMI prati niži stepen pridržavanja mediteranskog obrasca ishrane. Takođe, potvrđena je statistički značajna povezanost obima struka sa MedDietScore ($p=0,0009$), pri čemu su ispitanici sa većim obimom struka imali niže vrednosti skora. Povezanost MedDietScore sa pušačkim statusom, hipertenzijom i kompozitnim metaboličkim rizikom nije dostigla statističku značajnost. Dobijeni rezultati ukazuju da je veći stepen pridržavanja mediteranskom obrascu ishrane povezan sa povoljnijim antropometrijskim i životnim karakteristikama ispitanika, što potvrđuje značaj promocije ovog modela ishrane u okviru javnozdravstvenih strategija. Rezultati istraživanja dodatno ukazuju na potrebu kontinuirane edukacije stanovništva o značaju pravilnih prehrambenih navika i zdravih stilova života.*

Ključne reči: *mediteranska ishrana, MedDietScore, faktori rizika, indeks telesne mase, javno zdravlje*