Culture, Foodways & Counseling

SECOND EDITION

A Guide to Culturally Sensitive Nutrition Care in the United States

Diabetes Dietetic Practice Group

Kathaleen Briggs Early, PhD, RDN, CDCES
Kamaria Mason, MS, MPH, RDN, LDN
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CONTENTS

SECTION 5: Latin America

SECTION 6: Caribbean

SECTION 7: South Asia

SECTION 8: East Asia

SECTION 9: Southeast Asia

SECTION 10: Middle East and North Africa

SECTION 11: Religious Food Practices

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FOREWORD

The Need for Culturally Centered Nutrition Care in the United States

Being of bicultural heritage and a champion for nutrition equity, diversity, and inclusion throughout my professional career, I am thrilled and honored to write the foreword for the second edition of this book, *Culture, Foodways & Counseling: A Guide to Culturally Sensitive Nutrition Care in the United States*. In our increasingly globalized world and diverse nation, registered dietitian nutritionists (RDNs) and nutrition and dietetic technicians, registered (NDTRs) must be able to practice with cultural humility and competency. Diet-related health disparities are pervasive and are a call for a more culturally tailored and person-centered approach to address these disparities in clinical practice and in communities across the nation. It is clear that a one-size-fits-all approach to nutrition counseling and care is woefully inadequate. In fact, the *Scientific Report of the 2025 Dietary Guidelines Advisory Committee* examined the relationship between diet and health using a health equity lens and recommends flexible, healthy food patterns designed to meet people where they are with special attention to budgetary, cultural, and personal preferences.

Food, and more specifically, what we choose to eat, is not just sustenance; it reflects our heritage, belief systems, cultural identity, socioeconomic status, and more. Culture, which can be visible (conscious) or hidden (unconscious), shapes not only what and when we eat and how food is prepared and consumed, but also reflects more nuanced meanings of food behavior, such as social acceptability. When migrating to the United States, immigrants may change their traditional dietary practices and adopt those of the country where they migrate—a process known as dietary acculturation. This can be influenced by a variety of factors, such as home country, age at migration, socioeconomic factors, structural barriers, personal preferences, and political influences. The cities and towns where people migrate to, as well as the availability of foods of their cultures, also play a role in an individual's dietary patterns and foodways. It's also important to recognize that across regions of the world there is a vast level of heterogeneity and within-country diversity.

While there is still much work that lies ahead, the Academy of Nutrition and Dietetics has taken positive strides in its efforts to support inclusion, diversity, equity, and access (IDEA). The Academy of Nutrition and Dietetics developed its IDEA plan with the goal of creating a more inclusive future, tasking the IDEA Committee to monitor progress in achieving the goals outlined in the plan (refer to pages 18 and 19 for more about the IDEA Action Plan). In 2022, I had the privilege of cofacilitating training for Academy Member Interest Groups (MIGs), Dietetic Practice Groups (DPGs) and affiliate leaders—providing practical resources and speaking on issues such as implicit bias, cultural humility, and race- and ethnicity-based microaggressions. The development of the second edition of this book is yet another example of the forward movement in this much-needed space.

The knowledge and insights gained from this book are a starting point to a deeper understanding of the patients, clients, and communities you serve. This book is not meant to make you an expert or fully competent in another person's culture. It can, however, help you take a client- and patient-centered approach to nutrition care, by helping you eliminate your own assumptions and biases while recognizing the cultural needs and preferences of those that you work with and serve.

I would like to extend my gratitude to the authors and editors for their dedication to this important work and to you for your commitment to cultural humility and competency in your interactions with the diverse patients, clients, communities, and students you serve.

As you embark on the journey of reading this book, I encourage you to pause and reflect on your own culture and food practices and consider how you can make cultural sensitivity, respect, and humility central to your professional approach. Through self-awareness and enhanced knowledge, we can make a meaningful difference in our profession and the health of the nation.

Alison G.M. Brown, PhD, RDN
Past Chair, National Organization of Blacks in Dietetics and Nutrition (2020–2021)

PREFACE

Welcome to the second edition, retitled as *Culture, Foodways & Counseling: A Guide to Culturally Sensitive Nutrition Care in the United States.* This edition expands on the first edition, *Cultural Food Practices*, in both content and nuance. Every effort has been made to help readers recognize the important yet challenging complexities that contribute to everyone's foodways, regardless of their background. The goal of this book is to provide context and awareness of food and food-related beliefs and practices of cultures and faiths that are different from one's own and to foster nutrition counseling, education, and care that is provided with cultural sensitivity and humility.

Updating and expanding this book has been a collaborative effort, accomplished with a diverse group of authors and reviewers who have shared knowledge, insights, and counseling guidance from their own culture or religious practices. Their contributions allowed this edition to include a greater diversity of cultures and faiths that comprise the US populace today.

Rather than attempt to cover the many world cultures and cuisines, this book focuses on the cultures, food practices, and norms of specific cultures living in the US today, including: 1) indigenous and underrepresented populations with a long history in the US; 2) more recent immigrant generations, having roots in one or more other parts of the world; and 3) those who observe the beliefs and practices of one of the world's five major religions. The cultures and religions covered were selected based on their estimated and significant populations in the US and its territories at the time of this book's development.

Culture, Foodways & Counseling has been updated and enhanced to help readers apply principles of inclusion, diversity, equity, and access to nutrition and health counseling and care. This edition is organized and realigned as follows:

- The first chapter introduces many culture-focused concepts, including the explicit and implicit factors that comprise culture and that impact food and health behaviors. The roles of cultural humility, competence, and sensitivity among nutrition professionals are introduced as essential to providing inclusive, equitable, and accessible nutrition and health care for today's diverse populations. This chapter also addresses the challenges—and proposes practical actions—for providing culturally inclusive nutrition care.
- A new counseling and communication chapter focuses on application. It addresses ways to build personal cultural knowledge and humility; to overcome unconscious cultural barriers to effective counseling; to adopt culturally tailored communication practices; and to use culturally sensitive strategies and considerations in nutrition counseling and care.
- Section Openers present regional country/cultural overviews, including geography, natural environment and resources, ethnic and religious diversity, historical perspectives and influences, and present day and diaspora descriptions in the US today. A regional map offers

geographic context. A similar section opener introduces chapters on the five major world religions. A list of additional resources for each section is also included.

- Now expanded and updated, culture/country chapters from the first edition include: American Indians; Alaska Natives; African Americans; Mexican Americans; Central Americans; South Americans; Caribbean Hispanic Americans; Asian Indian Americans; Pakistani Americans; Chinese Americans; Hmong Americans; Filipino Americans; and Korean Americans.
- New culture/country chapters to this edition include: Caribbean Non-Hispanic Americans; East Africa: Kenyan Americans, East Africa: Ethiopian Americans, West Africa: Nigerian and Ghanian Americans; Arab Americans; Thai Americans; Vietnamese, Laotian, and Cambodian Americans; Japanese Americans; and Native Hawaiian and Pacific Islanders.
- Chapters on Islam and Jewish beliefs and food practices have been expanded. New chapters cover Buddhist, Christian, and Hindu beliefs and their food practices.

In addition, the content *within* each culture/country and religion chapter has been expanded:

- Commonly encountered health concerns are expanded beyond diabetes (the primary focus of the first edition). Now other chronic health conditions (cardiovascular disease, obesity, hypertension, and others) have been introduced as appropriate.
- Traditional/ethnomedical health practices are addressed in the culture/country chapters.
- Each chapter provides culture—or religion-specific counseling strategies and considerations, meant to help nutrition professionals better understand and respect the culture and faith practices of these cultures—and to support culturally sensitive nutrition care and counseling. These are meant to be used along with the general counseling guidance in Chapter 2.

For this edition of *Culture, Foodways & Counseling,* we made great efforts to find authors and peer reviewers from the cultures and faiths addressed. More than 90 authors and reviewers representing diverse cultural backgrounds within the nutrition and dietetics world shared their personal background, knowledge, and perspectives to create this book; a brief bio for each author is noted in the chapters; and peer reviewers are listed on pages iix through ix. All chapters went through a separate sensitivity review during the editing process to ensure cultural sensitivity, accuracy, and relevance.

We were committed to creating a valuable, culturally focused, food and nutrition resource to support inclusive, equitable, accessible nutrition care for diverse populations. Other resources on world and regional foods and cuisines can complement and provide further insights into the many foodways addressed in this book; some are noted in the Resources listed in the chapters. We acknowledge that not every cultural group or ethnic group with roots in a region of the world, nor every religious group served by nutrition and health professionals are covered in this book. However, we look forward to providing culturally specific content for more groups in this book's next edition.

Culture, Foodways & Counseling requires readers to be open to deeper and sometimes uncomfortable internal work, looking at their own experiences with privilege and bias. Concepts such as structural racism, dominant culture, food sovereignty, and narrative power have broadly influenced our health care system and medical models, and specifically practice guidelines, nutrition counseling models, and patient and client encounters. This book has been written with these challenges in mind. It is our hope that readers can find ways to overcome these barriers in their professional work in meaningful ways.

While this book has been overseen and published by the Academy of Nutrition and Dietetics, it can be a useful resource for anyone who works with underrepresented populations on issues concerning food, culture, eating behavior, and health.

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Kathaleen Briggs Early, PhD, RDN, CDCES, is a certified diabetes care and education specialist working in Yakima, WA. As a professor of nutrition at Pacific Northwest University of Health Sciences (PNWU), she teaches nutrition and chronic disease prevention and management. Prior to joining PNWU, Kathaleen worked for over a decade as a clinical dietitian and diabetes educator.

Dr. Early earned her undergraduate degree in food science and nutrition from Central Washington University (CWU). While at CWU, as a first-generation college student, she was selected for the McNair Scholar's Program, which led her to pursue her doctorate. Dr. Early earned her doctor of philosophy in nutrition from Washington State University, with her dissertation work focused on understanding goal setting and behavior change among underserved Mexican American adults with type 2 diabetes. Growing up in a lower-income household in an upper-income community contributed to her lifelong interest in sociodemographic inequities and health outcomes, and how to mitigate those inequities.

As part of her PNWU work, Dr. Early provides medical nutrition therapy and diabetes education at a local free clinic serving primarily Mexican American adults. Additionally, she has a busy research agenda emphasizing the impact of the social determinants of health on diabetes. Dr. Early also serves as a regular reviewer for several peer-reviewed journals, and a presenter for various medical conferences.

As a strong believer in meeting people where they are at, Dr. Early seeks to help others understand that changing lifelong habits related to eating, physical activity, and sleep is not easy, and it is even more difficult when there is not equal access to privilege and resources. To be effective agents of change for our patients, clients, and our profession, Dr. Early fosters the need to maintain positivity, open-mindedness, and cultural humility.

Kamaria Mason, MS, MPH, RDN, LDN, is an educator based in North Carolina who contributes to the nationwide discourse on public health nutrition. Her commitment to excellence in education extends beyond the classroom. Hailing from Michigan, she brings insights gained from her experiences in outpatient dietetics, local government, research, and community engagement, uniquely positioning her to shape the next generation of nutrition leaders.

As a cofounder of The Culture of Wellness, she works with organizations to empower individuals, communities, and food systems to make changes from the inside out to create a food culture where healthy choices are inclusive, balanced, and accessible. In her role at University of North Carolina at Chapel Hill Gillings School of Public Health, she focuses on bridging the gap between clinical and community nutrition, emphasizing person-centered care and cultural sensitivity. Through her involvement in local initiatives, Kamaria brings a nuanced understanding of the public health challenges faced by marginalized populations to the classroom, uplifting diverse perspectives while developing well-rounded, socially conscious nutrition professionals.

Kamaria completed her undergraduate degree in Women's Health and Gender Studies at the University of Michigan. She earned her Master of Science in Biomedical Science from Barry University and her Master of Public Health along with her Registered Dietitian credential from the Gillings School of Public Health. Kamaria believes that much of our identity centers around the dining table. Food culture extends beyond our food choices; it shapes how we engage with others in familial, communal, and professional relationships. Through food, we engage in shared experiences that influence how we connect with individuals and communities. Food is a powerful tool that brings us together.

Shamera Robinson, MPH, RDN, CDCES, is committed to promoting health equity and supporting healing within historically marginalized communities. Shamera has a background in public health and diabetes education. She earned her undergraduate degree in biology and public health from Spelman College. After becoming a dietitian, she furthered her expertise with a Master of Public Health (MPH) degree in nutrition from the UNC Gillings School of Global Public Health.

Shamera's passion for nutrition sparked after hearing the news of her grandmother's stroke. The lack of guidance her grandmother received upon discharge motivated Shamera to ensure that communities like hers have access to culturally responsive care. She believes that everyone, especially people from historically marginalized groups, deserves to receive nutrition care that is practical and relatable and honors cultural foodways.

As the cofounder of The Culture of Wellness, Shamera works with organizations to improve nutrition equity. She helps organizations develop inclusive resources to meet the unique needs of diverse groups. Through The Culture of Wellness, she also facilitates wellness workshops that empower women of color to use food as a tool for health and inner healing.

Shamera is a skilled public speaker, and her warm approach creates a safe space for individuals to nurture their relationships with health, food, and self. With years of experience in clinical, community, and public health settings, Shamera brings a well-rounded perspective to nutrition and dietetics. Shamera aims to create a world where every person has the opportunity to redefine health on their terms. At the center of this mission is celebrating and connecting with the nutritious foods that have nourished families for generations.

Roberta Duyff, MS, RDN, FADA, FAND, is a nationally recognized food and nutrition communicator, author, and educator, committed to translating sound science into practical, relevant food and nutrition guidance that promotes public health, while honoring cultural foodways and norms. She authored the award-winning *Academy of Nutrition and Dietetics Complete Food & Nutrition Guide*, secondary and college level textbooks, nine children's books, USDA Team/Nutrition resources, and other consumer and educational publications. In both the Academy of Nutrition and Dietetics *Communicating Nutrition* and *Nutrition & Diagnosis-Related Care,* she conveys the "whys and hows" of culturally sensitive communication and counseling to help eliminate disparities and build intercultural understanding and relationships.

Recognizing how cultural informants help ensure cultural sensitivity, Roberta collaborated with indigenous and other communities to codevelop a multicultural preschool nutrition curriculum for national Head Start, and resources for USDA's SNAP. Involving registered dietitians with cultural, first-language background, as well as translators, Roberta managed translations (Spanish, Chinese, Vietnamese) on issues such as infant feeding and diabetes management. Speaking in the US and abroad, she has addressed how cultural foodways impact education and counseling, including addressing commonalities and differences in dietary guidance at the Chinese Nutrition Association in Beijing.

Her interest in cultural foodways began with exploring her Czech heritage, then developed when experiencing diverse cultures and food practices in Asia and Africa during her academic Semester at Sea. She earned her bachelor's degree at the University of Illinois. Recognizing the role of sociocultural factors in food behavior, her master's degree research at Cornell University addressed food acculturation and decision-making within the Hispanic community in New York City and with Puerto Rican American youth in Chicago.

Roberta provides counseling and orientation support to inbound and outbound international exchange students and their families. As host parent, she embraces her global family from most regions of the world, experiencing life and foodways with some in their native communities. She volunteers with Welcome Neighbor STL, a community initiative supporting refugee women in food catering.

Roberta served as chair, Academy of Nutrition and Dietetics Food & Culinary Professionals (FCP) Dietary Practice Group; executive board, Society for Nutrition Education (now SNEB); President, SNE Foundation; and cochair, Global Culinary Initiative/Les Dames d'Escoffier International. Her terms on the James Beard Journalism Awards Committee helped define criteria for excellence in food-related journalism. Among her recognitions: Academy's Presidents' Lectureship and Medallion Award, Missouri's Dietitian of the Year and Lifetime Achievement Awards, and National Health Information's Gold Award.

Roberta travels extensively, handling culinary travel for her family-owned travel company. Her globally inspired recipes appear on the Academy of Nutrition and Dietetics eatright.org/recipes. Wherever she roams, visiting local food markets and sharing the kitchen and the table with local families are top priorities!

SECTION

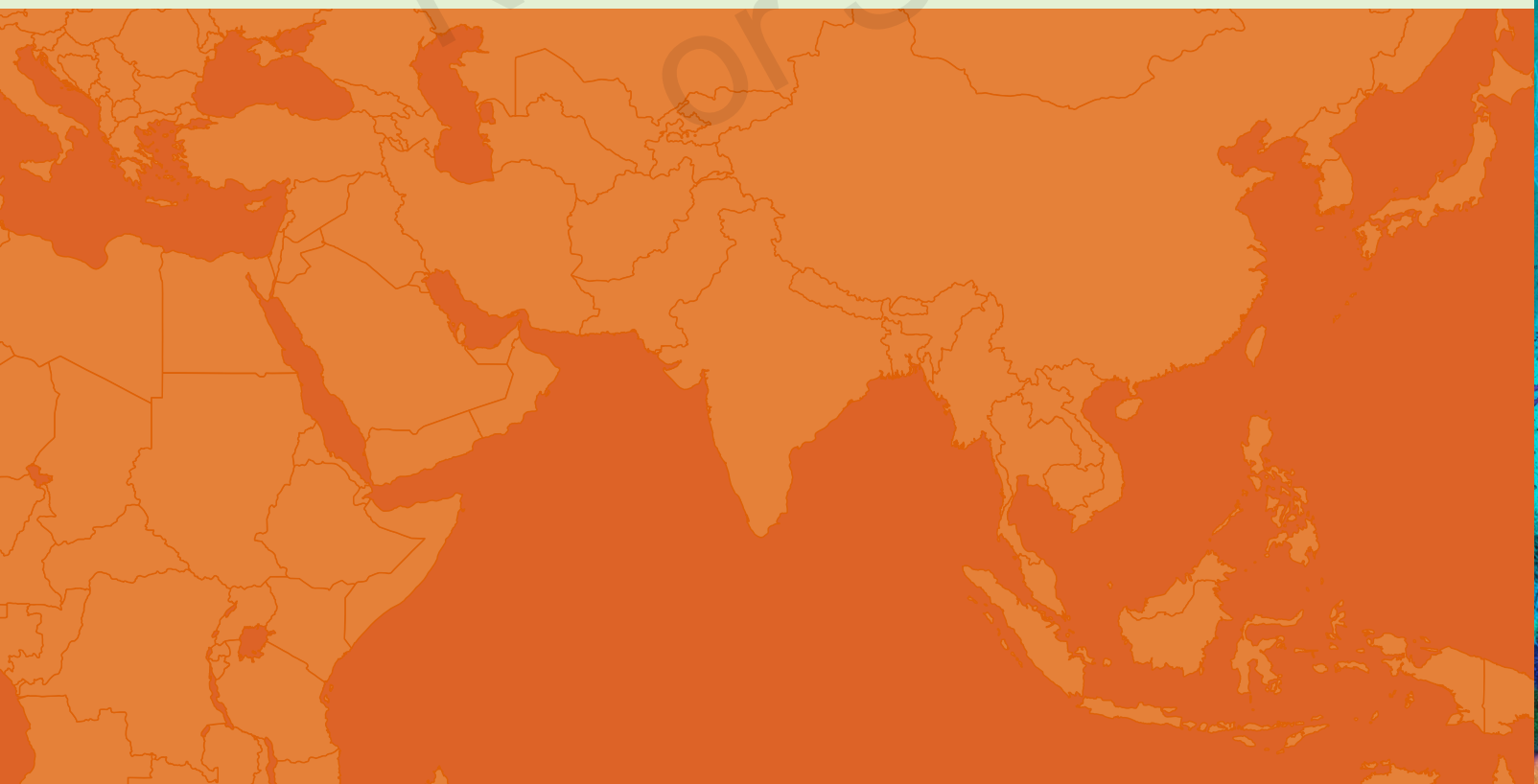
Culture, Foodways, and Counseling

Introduction to Culture, Foodways, and Counseling

"Tell me what you eat,
and I'll tell you who you are."

—Jean-Anthelme Brillat-Savarin,
***The Physiology of Taste*, 1825**

There is a profound connection between food and identity. What a person eats can reveal an array of information about their cultural background and lifestyle. Their food choices are not merely about sustenance but are deeply intertwined with personal values, beliefs, upbringing, and preferences. Food is at the center of how people connect with self, family, culture, spirituality, and tradition.



In the US, rapid changes over the last decade in the globalization of food and the recognition of cultural identity in health care have emphasized the need for health care professionals to access food- and nutrition-related guidance tailored to specific cultures. However, as with every group in the US, there is also great diversity among the various subgroups and religious and ethnic minority groups within the many cultures. This requires critical thought and sensitivity when providing care to patients and clients, using knowledge of food as a lens to view culture.

When nutrition professionals and other health care practitioners strive to understand and respect the food-related cultural, religious, and health practices of their patients and clients, they are better able to help them approach food choices and preparation methods that promote better nutrition without losing food's cultural flavors and appeal. Achieving this may sometimes involve working alongside cultural informants, interpreters, translators, cultural anthropologists, and even native healers. The result: culturally sensitive nutrition care with guidance for dishes and meals that are nourishing and more likely to prevent or manage heart disease, diabetes, obesity, and other food-related health conditions.

The chapters in this section, and throughout the book, stress the importance of assessing each individual based on degree of acculturation and change while avoiding the tendency to rely on assumptions. Looking for cultural clues and asking relevant questions in a sensitive manner will better equip nutrition and health professionals when addressing culture around each individual's food choices and behavior that can impact health and well-being.

Chapter 1 takes a look at culture, diversity, culturally sensitive health and nutrition care practices, and the challenges of fostering cultural inclusion and equity in nutrition and health care. Learning to serve patients and clients more effectively, with greater recognition of structural inequities and their ramifications, with more empathy and cultural humility, and with less rigidity and judgment is a win-win for everyone. **Chapter 2** offers strategies for increasing cultural self-awareness, competency, and humility; cross-cultural communication tactics; and practical approaches for enhancing effectiveness of nutrition care and counseling for those from many diverse cultures in the US. The culture- and religion-specific chapters that follow in Sections 2 through 11 give an overview of many cultural and religious food, nutrition- and health-related traditions and practices, enabling health care professionals to gain knowledge and understanding on their path to cultural competence and humility. These chapters offer ways to pivot and establish culturally inclusive practices and policies within organizations and health care practices.

Understanding the cultural importance of food and the practices related to preparing and enjoying cultural foods, therefore, is a requirement when providing optimal care. Lifelong cultural learning as well as educating and guiding colleagues and other health professionals to be culturally knowledgeable, sensitive, competent, and humble are important endeavors not to be taken lightly.

Resources on Cultural Foodways, Inclusion, and Nutrition Communication

American Hospital Association, Institute for Diversity and Health Equity
ifdhe.aha.org/hretdisparities/tools-resources

American Immigration Council
www.americanimmigrationcouncil.org

American Medical Association, American Association of Medical Colleges Center for Health Justice, *Advancing Health Equity: A Guide to Language, Narrative and Concepts* (2021)
www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf

American Medical Association Center for Health Equity
https://edhub.ama-assn.org/ama-center-health-equity

American Psychological Association, Equity, Diversity, and Inclusion: Inclusive Language Guide, 2nd Edition (2023)
www.apa.org/about/apa/equity-diversity-inclusion/language-guide.pdf

Deeply Rooted: A Special Report on Race and Diabetes
www.healthcentral.com/experience/diabetes-race?legacy=ew

Dietetics Privilege Assessment Tool
www.dieteticsprivilegequiz.com

Diversify Dietetics
www.diversifydietetics.org

Diversifying MyPlate Series: Q&A on Culturally Sensitive Approaches in Nutrition
https://foodinsight.org/diversifying-myplate-series-qanda

Diversity Style Guide
www.diversitystyleguide.com

EthnoMed, Integrating Cultural Information into Clinical Practice
https://ethnomed.org

Food and Agriculture Organization of the United Nations (FAO), Food-Based Dietary Guidelines (by country)
www.fao.org/nutrition/nutrition-education/food-dietary-guidelines/en

Food and Culture, 8th edition. By Furstenau NM, Safaii-Waite S, Sucher KP, Nelms MN. Cengage; 2024.

Food in Every Country
www.foodbycountry.com

Food Systems and Nutrition Equity Global Nutrition Report
https://globalnutritionreport.org/reports/2020-global-nutrition-report/food-systems-and-nutrition-equity

Harvard Implicit Association Test
https://implicit.harvard.edu/implicit/takeatest.html

Health Information Translations
www.healthinfotranslations.org

Journal of Ethnic Foods
https://journalofethnicfoods.biomedcentral.com

Multilingual Topics in Communication Sciences and Disorders
https://sites.google.com/pdx.edu/multicsd/home

Migration Policy Institute
www.migrationpolicy.org

National Center for Cultural Competence
https://nccc.georgetown.edu

National Institutes of Health, National Library of Medicine, Medline Plus: Health Information in Multiple Languages
https://medlineplus.gov/languages/languages.html

National Institutes of Health. Clear Communication, Cultural Respect.
www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect

Oldways Traditional Diets
https://oldwayspt.org/traditional-diets

SPIRAL: Selected Patient Information Resources in Asian Languages
http://spiral.tufts.edu/index.php

Stanford Medicine, EthnoGeriatrics Culture Med
https://geriatrics.stanford.edu/culturemed.html

The Cross Cultural Health Care Program
www.xculture.org

Transcultural C.A.R.E. Associates, Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals—Revised (IAPCC-R)
https://transculturalcare.net/iapcc-r

US Department of Agriculture

- Customizing the Dietary Guidelines Framework
  www.dietaryguidelines.gov/sites/default/files/2021-11/DGA_2020-2025_CustomizingTheDietaryGuidelinesFramework.pdf
- Food and Nutrition Security
  www.usda.gov/about-usda/general-information/priorities/food-and-nutrition-security
  www.usda.gov/sites/default/files/documents/usda-actions-nutrition-security-infographic.pdf
- MyPlate in Multiple Languages
  www.myplate.gov/resources/myplate-multiple-languages
- National Agricultural Library, Cultural and Traditional Foods
  www.nal.usda.gov/legacy/fnic/ethnic-and-cultural-resources-0
- National Agricultural Library, International Nutrition
  www.nal.usda.gov/human-nutrition-and-food-safety/international-nutrition
- Scientific Report of the 2025 Dietary Guidelines Advisory Committee
  doi:10.52570/DGAC2025
- Shopping, Cooking and Meal Planning: Culture and Food
  www.nutrition.gov/topics/shopping-cooking-and-meal-planning/culture-and-food

US Department of Health and Human Services

- CDC's Health Equity Guiding Principles for Inclusive Communication
  https://restoredcdc.org/www.cdc.gov/health-communication/php/toolkit/index.html
- National Standards for Culturally and Linguistically Appropriate Services
  https://thinkculturalhealth.hhs.gov/clas/standards
- Office of Minority Health
  www.minorityhealth.hhs.gov

US Food and Drug Administration, Office of Minority Health and Health Equity
www.fda.gov/about-fda/office-commissioner/office-minority-health-and-health-equity

Resources from the Academy of Nutrition and Dietetics

Cultural Cuisines and Traditions
www.eatright.org/food/cultural-cuisines-and-traditions

Diversity and Inclusion Resources
www.eatrightpro.org/practice/practice-resources/diversity-and-inclusion

Global Food and Nutrition Resource Hub
www.eatrightpro.org/practice/practice-resources/international-nutrition-pilot-project

IDEA Resource Hub
www.eatrightpro.org/practice/practice-resources/diversity-and-inclusion

International Affiliate of the Academy of Nutrition and Dietetics
https://eatrightinternational.org

Member Interest Groups (MIGs)
www.eatrightpro.org/membership/academy-groups/member-interest-groups

Nutrition Counseling and Education Skills: A Practical Guide, 8th ed. by Beto J, Holli B, Nutrition and Dietetics Educators and Preceptors. Jones & Bartlett Learning; 2023.

Chapter 13: Effective nutrition communication is tailored for the target culture. by Duyff RL. In Mayfield B, ed. *Communicating Nutrition: The Authoritative Guide*. Academy of Nutrition and Dietetics; 2020.

1

Foundations of Culture and Inclusion in Nutrition Practice

Kamaria Mason, MS, MPH, RDN, LDN
Shamera Robinson, MPH, RDN, CDCES
Kathaleen Briggs Early, PhD, RDN, CDCES

Kamaria Mason's experience in clinical, public health, and government sectors has focused on family-centered nutrition education. As cofounder of The Culture of Wellness, she consults with organizations to improve nutrition equity and support culturally inclusive programming. Kamaria's passion is to encourage families to adopt healthy eating behaviors through interactive cooking activities. As a professor at University of North Carolina at Chapel Hill's Gillings School of Public Health, she fosters dynamic learning with her students and emphasizes practical application, person-centered care, and cultural sensitivity. Her favorite food memory is her dad giving her tidbits of the browned steak while cooking pot roast for Sunday dinner, and the scrumptious and delectable smells permeating the house!

Shamera Robinson has a background in public health and diabetes education. As cofounder of The Culture of Wellness, she consults with organizations to improve nutrition equity and curates wellness experiences tailored for women of color. As a skilled speaker and facilitator, Shamera uses food as a tool to promote health and inner healing. Her favorite food memories involve spending summers in Mississippi with her granny and eating the most delicious rice for breakfast. The rice was made with at least a stick of butter, a sprinkle of sugar, and the most love in the world. It was always perfect.

Kathaleen Briggs Early is a professor of nutrition at Pacific Northwest University of Health Sciences where she teaches nutrition and chronic disease prevention and management to medical students and also acts as the sole dietitian and diabetes educator for a local free clinic serving primarily Spanish-speaking adults from Mexico. As a first-generation college graduate, Dr. Early has always had a strong interest in improving health equity across socioeconomic and racial-ethnic boundaries. One of her favorite cultural food memories includes her friend, colleague, and coauthor Lily Gonzalez, sharing a meal of paella and getting Lily's help with understanding more about *capirotada* (Mexican bread pudding)!

Food and culture are deeply intertwined, with food choices and the food-related behavior of daily life woven into the fabric of every culture. The study of food culture focuses on the customs, traditions, and social norms related to food consumption, preparation, and production. It encompasses culinary traditions and rituals, specific foods and ingredients, cooking methods, eating patterns, and the attitudes and beliefs related to acquiring, handling, preparing, and serving food. Food culture is shaped by a combination of historical, geographical, environmental, social, economic, and cultural factors, and it plays a significant role in shaping individual and collective identities.

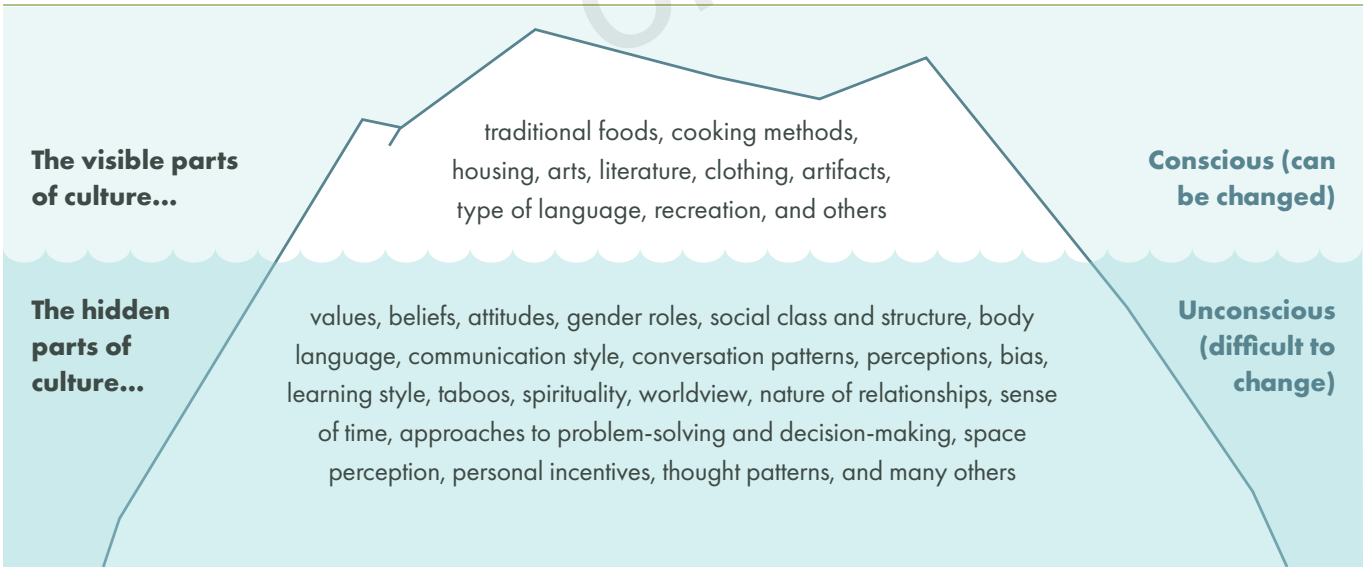
Introduction to Culture

Culture refers to the languages, practices, beliefs, behaviors, rules, and collective identities that members of a group or society develop.[1] Culture is acquired, passed between generations, and affected by a variety of factors including language, socialization, food, religion, geography, and the environment. Patterns that a particular group adopts as part of their culture can be reinforced through geographic isolation or through segregation resulting from socioeconomic status or other sociocultural factors. Culture is always changing. It can be influenced by those living both within and outside of the culture and by external factors such as the media. Culture can also be thought of as a group's shared behaviors and experiences of everyday life.

As a concept, culture is abstract. For that reason, its definition and complexities often are explained with visual models. One such model is the iceberg model of culture, displayed in Figure 1. Some aspects of culture, such as foods and cooking practices, language, and housing, are shown above the iceberg's waterline. These aspects are easy to see, even by those with limited exposure to the culture; they may be easier to change for some but not everyone. However, most aspects of any culture including beliefs, communication style, body language, gender roles, and approaches to decision-making are hidden below the water line and not easily seen, especially by those outside of the culture. These hidden aspects underlie cultural norms and influence what is above the waterline. They are harder to perceive, understand, and change, even by those who are part of the culture.[2] Norms are learned behavior patterns that are common within cultures and shaped by the values, attitudes, and beliefs of their members; in other words, norms are what individuals within a cultural typically do in given situations.[3]

Learning about the visible aspects of a person's culture is a starting point for effective health and nutrition counseling, education, and care—but it isn't enough to fully understand food- and health-related behavior. It also requires cultural humility (discussed later in this chapter). Probing to understand aspects of a person's culture that might be hidden, or below the waterline, and then providing food and nutrition services with cultural understanding and respect is essential to a successful encounter.[3]

FIGURE 1 Iceberg model of culture[2]



The section openers in this book along with Chapters 3 through 29 provide insights into some visible parts of many cultures and religions. Chapter 2 as well as the culture- and religion-specific counseling guidance sections in each chapter address issues of culture that lie below the waterline and address how to effectively provide food and nutrition counseling and education with cultural sensitivity, competence, and humility. While there is much more nutrition and health professionals should know and understand beyond the content in this book, together these chapters can help in providing culturally sensitive and inclusive nutrition care.

Demographics of Culture

Cultures often contain subcultures (a distinct culture within a culture). Subcultures typically maintain some of a parent culture's attributes, but a subculture may form when a group of people have a common set of experiences or values that differ from those of the dominant culture, with varying obligations and values. One example is American Indians, who share some cultural practices with other Indigenous peoples in North America and Alaska but also have distinctly unique cultural practices and characteristics within their own tribes or the clans within those tribes. Cultures and subcultures can be identified broadly by similarities they share—both implicit and explicit. These characteristics relate to and often result from demographic differences. Some of these characteristics are malleable, while others are not. Thus, being of the same ethnic background does not necessarily equate to being of the same culture.[3]

Multidimensional Identity

Cultural identity is multidimensional, arising from and influenced by many factors. These factors include (1) age, skin color, and ancestry, which cannot be changed; (2) educational experiences, geographic location or neighborhood, income level, and others (perhaps invisible), which can be influenced or changed; and (3) situational and historical context of the social, cultural, and political events in someone's life, which includes structural barriers that cannot be changed.

Subcultures often arise out of exposure to various socioeconomic or educational situations, religions, ethnicities, generations, and geographic regions. For example, people who are devout may be more diligent with adhering to the dietary practices or laws mandated by their religious faith compared to those with a secular identity within that faith.

The multidimensionality of culture affects how people see and perceive the world and, importantly, how the world sees and perceives individuals. These dimensions are part of the large group of influences on food and health practices and behaviors. Health care professionals must be knowledgeable about the factors influencing the cultural groups they serve and understand cultural norms and behaviors in order to communicate effectively within that culture or subculture.

Individual Identity

One's cultural identity is not finite, nor is one person within a culture the same as another person from that culture. Effective nutrition communication and counseling must be rooted in the uniqueness of the individuals on the receiving end.

Educators and counselors of all backgrounds within and outside the nutrition profession must appreciate and recognize the shared values, attitudes, beliefs, and subcultural norms of those being educated or counseled. Cultural shifts may significantly affect attitudes, knowledge, and behavior related to food and health. For example, with acculturation, second-generation immigrants differ from new immigrants and from those of subsequent generations. Nevertheless, all people, regardless of cultural identity, are individuals. People in groups may outwardly appear homogenous, yet they have unique individual qualities. For health care professionals, resisting the temptation to stereotype in cross-cultural communication is essential.

Cultural Competence and Humility

Many health care professionals have learned the general principles of *cultural competence*: to know the key features of various cultures and to understand body language cues, customs, and traditions, including their food- and health-related practices. However, achieving competence in a different culture goes beyond learning facts about a culture or knowing the language. It is about the ability to view values, norms, and behaviors as unique aspects of a culture while also not assuming that all people within a particular culture have these attributes.

Working toward cultural competence is an ongoing process, with the goal of learning about other cultures and becoming confident, comfortable, and competent when interacting with people of cultures other than one's own. *Cultural humility* goes beyond cultural competence and has three important tenets:[4]

- lifelong learning and ongoing self-reflection,

- mitigating power imbalances, and
- institutional accountability.

Like cultural competence, cultural humility begins with self-awareness and progresses along a continuum (refer to Figure 2). Cultural humility recognizes that every person brings their own culture, family history, and worldview to the table, and it requires deep, open-minded engagement with other cultures.

As it applies to multicultural medical education, the term cultural humility was coined by Melanie Tervalon, MD, MPH, and Jann Murray-Garcia, MD, MPH, and used in their landmark article, Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education.[5] Cultural humility requires striving to understand one's own cultural background and biases, which may influence interactions with others. It also means committing to ongoing lifelong learning and active engagement with the people being served (e.g., patients or clients, including those from similar or different backgrounds) as well as colleagues, students, and organizations.[5]

Learning to regularly appraise personal beliefs, attitudes, and actions is pivotal in overcoming biases and capably providing culturally effective and sensitive care.[6] Seeking to understand how one's own background and biases influence interactions with those who are culturally similar and different is an ongoing and lifelong process. Refer to page 16 for more on addressing bias in nutrition practice.

Diversity and Acculturation in the United States

The US is recognized for its cultural, ethnic, and religious diversity—beginning with a rich legacy of Indigenous cultures, then further diversified by others who came to this nation for countless reasons over more recent centuries, including as immigrants, refugees, and enslaved people. Recognizing this diversity, providing equitable and culturally

FIGURE 2 From cultural knowledge to cultural humility

Progress toward cultural humility can be described as a continuum. Where do you fall along the continuum?

Cultural Knowledge	Knowing characteristics, values, beliefs, lifestyles, problem-solving strategies, and norms of the target culture; for example, knowing its foods and food beliefs, behavior, and restrictions; knowing about access to food and health services and about predominant health issues and customary practices.
Cultural Awareness	Openness to changing attitudes, biases, and perceptions when interacting with diverse cultures; for example, becoming aware of healthy foods and food preparations that are unfamiliar. Sensitivity to or awareness of the similarities and differences in situations among various cultures, and the awareness of the sensitivity in active communication and other cultural communications.
Cultural Sensitivity	Awareness of cultural differences and similarities without judgment and without conveying that one way or one type of advice is right or superior; for example, holding back advice on food practices until learning more.
Cultural Competence	Readiness to communicate and function effectively with a target culture that may have values, attitudes, and norms different from one's own; for example, having the ability to respect cultural food norms and provide appropriate guidance. Characterized as a skill that can be taught, trained, and achieved and is often described as a necessary and sufficient condition for collaborating effectively with diverse people.
Cultural Humility	Involves entering a relationship with another person with the intention of honoring their beliefs, customs, and values. Entails an ongoing process of self-exploration and self-critique combined with a willingness to learn from others.

Adapted from Duyff RL. Effective nutrition communication is tailored for the target culture. In: Mayfield BJ, ed. *Communicating Nutrition: The Authoritative Guide.* Academy of Nutrition and Dietetics; 2020.[3]

inclusive nutrition care and counseling is a priority in the US today. Refer to Box 1 for definitions and to page 14 for more on nutrition equity and food security.[7]

The diversity of peoples and cultures in the US translates into the diversity of cuisines. This comes not only from Indigenous groups, settlers, formerly enslaved people, immigrants, and refugees but also from ongoing cultural and societal changes that have occurred throughout history.

Many diverse groups have contributed important influences on cuisines in the US, both with ingredients and with their methods of producing, preparing, and serving food. Examples come from several cultural interactions. Alaska Natives and Northwest American Indians helped bring salmon and berries to the forefront. With colonization, Europeans brought chickens and wheat to the Americas. People from Hawai'i and the Pacific Island US territories such as Guam, as well as US territories in the Caribbean such as Puerto Rico, helped to popularize various dishes made with seafood, coconut, and certain tubers. Indigenous people in North, Central, and South America shared beans, corn, tomatoes, and potatoes. Descendants of enslaved people demonstrated how to use greens, hot peppers, okra, and peanuts in creative ways; okra originated in Africa, while peanuts and peppers first came from the Americas.[8]

Everywhere in America's diverse culinary tapestry, there are examples of the many contributions of diverse peoples and cultures, including from some who still observe the cultural norms and food practices similar to those of their ancestors.

BOX 1

Defining Diversity, Equity, and Inclusion[7]

Diversity The presence of differences within a given setting. People have differences with respect to race, religion, skin color, gender, biological sex, national origin, disability, sexual orientation, age, body size or shape, education, geographic origin, and skill characteristics, among others. Diversity refers to the composition of a group of people from any number of demographic backgrounds, identities (innate and selected), and the collective strength of their experiences, beliefs, values, skills, and perspectives.

Equity The recognition that each person has different circumstances and needs, and they are allocated the resources and opportunities required to reach an equal outcome. "Health equity" or "equity in health" implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. Equity is not the same as equality, which means that everyone has access to the same opportunities or resources.

Inclusion The intentional, ongoing effort to ensure that diverse people with different identities can fully participate in all aspects of the work of an organization, including leadership positions and decision-making processes. Inclusion is engaging each individual and making everyone feel valued. It is the act of establishing philosophies, policies, practices, and procedures so that organizations and individuals contributing to the organization's success have a more level playing field to compete and equal access to opportunities and information.

Recent Immigration History

Throughout US history, immigration has had a significant and evolving impact on the nation's culture—and this also includes nonimmigrants on short-term visas who are a temporary part of American communities. Immigrants are typically defined as first-generation (i.e., not born in the US), second-generation (i.e., born in the US, but their parents were not), or third-generation (i.e., they and their parent[s] were born in the US but their grandparents were not).

The American Immigration Council provides a summary of the unique impact of immigration, noting that the US currently has more immigrants (total number, not per capita) than any other country in the world. In 2019, the council reported that 44.9 million, or one in seven US residents (14%), was an immigrant (defined as foreign born). One in eight residents was a native-born US citizen with at least one immigrant parent. Of those immigrants, about 52% (23.2 million) were naturalized, and 8.1 million immigrants were eligible to become naturalized US citizens.[9] According to the Migration Policy Institute, 45.3 million immigrants (13.6% of the US population) were living in the US in 2021, which equates to nearly a threefold increase since 1970, when just 4.7% of the total US population were immigrants.[10]

Health professionals need to understand the impact of immigration on health care and, in turn, the impact of their interactions with people who are immigrants (or refugees). Many Americans born in the US have one or more immigrant parents, who can have important influences on a family's sociocultural lived experiences, behaviors, and beliefs. As of 2019, 38.3 million people in the US (12% of the

total population) identified as US-born Americans with at least one immigrant parent.[9] Asking about family structure and needs and including family roles in discussions about nutrition and health are useful approaches that dietitians and other health professionals can employ to be more effective when working with those who are not part of the dominant US culture; this is addressed in Chapter 2 and culture-specific chapters that follow.

People immigrate to the US for different reasons and can have various immigration statuses. A Green Card, officially known as a Permanent Resident Card, allows someone to live and work permanently and legally in the US. A variety of circumstances and requirements are involved in obtaining a Green Card that go beyond the scope of this book.[11] The terms *refugee* and *immigrant* sometimes are used interchangeably to describe individuals relocating to a different country, yet the terms are not synonymous. The term *refugee* describes someone who is unable or unwilling to return to their country of origin due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.[12] In contrast, immigrants include those who relocate as a means to improve their lives by seeking employment, joining family members in another region, or pursuing education.[11] All refugees are immigrants, but not all immigrants are refugees.

Acculturation Is a Process

Acculturation, defined in nuanced ways across many fields—sociology, psychology, and medicine, among others—refers to the extent that a particular cultural group (often an Indigenous, immigrant, or minority group), family, or individual adopts the majority culture's traditions and practices. Acculturation can be a fluid process, where people or individuals move into and out of more dominant cultural groups, resulting in varied behaviors of traditional practices and adopted customs. The closer someone is to immigration status as a first-generation immigrant, the more likely they are to retain customs, behaviors, and traditions from their culture of origin. The further out from first-generation status a person becomes, the more likely they are to become *bicultural*, where aspects of both the culture of origin and the new cultural group are adopted.[13] Over time, immigrants typically acculturate to varying degrees. Immigration may also foster *enculturation.* This is the process of maintaining or reclaiming one's heritage culture through learning and internalizing cultural values, norms, beliefs, and practices.

Frame switching, also known as *code switching*, may occur for some bicultural people and those from non-dominant groups who adapt their thinking, language, and behavior to match the cues in their current cultural context. For example, some bicultural individuals may express their personalities differently depending on the environment and people present.[14]

Dietary acculturation, a form of nutrition transition, is a complex process that occurs when individuals or families migrate from one country to another (or migrate within a country) and gradually adopt the eating patterns and food choices of a new environment. It is influenced by many factors and is not a simple one-direction process.[15,16] The degree of dietary acculturation can be measured formally in many ways and is often culture specific, as identified in the food similarity index (FSI). The FSI assesses how similar immigrants' diets are to same-aged US-born people of all racial or ethnic groups.[17]

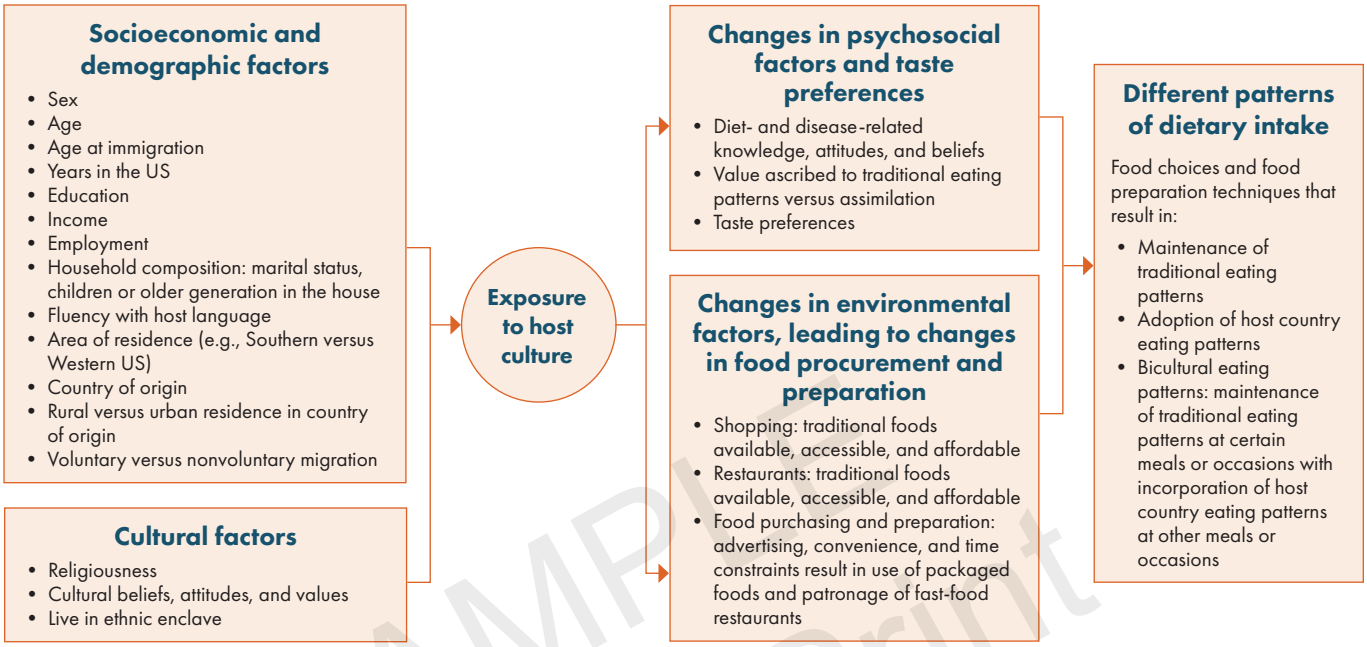
Recognizing the degree of acculturation is important for effective, culturally competent nutrition care.[18] Refer to Figure 3 and other comprehensive resources addressing dietary acculturation to learn more about the complex and multifaceted process of adopting the practices and values of another culture.[15,16,18] For additional discussion of dietary acculturation and suggested counseling strategies, refer to Chapter 2.

Cultural Sensitivity in Health Care

By 2060, more than half of the US population will be people of color. Yet the percentage of people of color in the US working in health professions today is far less, including in nutrition.[19] With the exception of health professionals of Asian descent, people of color are underrepresented in occupations involved in diagnosing and treating health issues. That includes medicine, dentistry, dietetics, occupational therapy, pharmacy, physical therapy, physician assisting, speech-language pathology, and registered nursing.[20,21]

The US health care system has long-standing institutional biases and discrimination that compound the challenges discussed in this book.[5] Efforts are underway by practitioners and researchers to correct this imbalance.[5,22,23] Practitioners can help to mitigate this situation by being more self-reflective in cross-cultural interactions and communications and striving to meet its challenges by becoming more culturally aware as they move along the continuum to cultural humility. Box 2 offers tips for ongoing self-reflection and lifelong cultural learning and inquiry.

FIGURE 3 Proposed model of dietary acculturation[16]



Adapted with permission from Satia-Abouta J, Patterson RE, Neuhouser ML, Elder J. Dietary acculturation: applications to nutrition research and dietetics. *J Am Diet Assoc.* 2002;102:1105–1118.[16]

BOX 2

Committing to Lifelong Cultural Learning

Recognize your own cultural background and how it influences your perspectives: these include your personal values, beliefs, assumptions, norms, and biases, as well as your beliefs and practices about food and health. Consider how these perspectives might affect your interactions, teaching, counseling, and care with someone of a culture other than your own.

Accept and acknowledge what you do not know about other cultures and learn from others. Building a trusting relationship begins with empowering those whose culture differs from your own. Seek out new and unfamiliar places and situations, even when they feel culturally uncomfortable or awkward. Participate appropriately in the culture, rather than just being a spectator.

Read, listen, observe, and question. Being highly informed is not required for thoughtful, curious, and respectful discussion. Asking about cultural differences shows interest, eases conversation, and indicates care.

Earn trust over time. Some people/clients/patients may need to overcome their own misperceptions and cultural biases about you. When health professionals can talk comfortably about their own culture, others may feel more comfortable sharing theirs. Recognizing that others may have a bias toward you may help you to better understand the effect of bias toward others. Once established, trust enables open dialogue about one another's cultures and misperceptions.

Be authentic in searching for common ground and differences. Accept and learn from cultural mistakes and miscommunication. They are inevitable. Apologize for any insensitivity or offense rather than allowing mistakes to become barriers.

Stand with and support cultures other than your own. Such support and caring builds trust and motivates others in the target culture to listen and comply with nutrition and health counseling.

While learning the language of a non–English-speaking culture is certainly useful and encouraged, it is not required to have a productive and culturally humble interaction. Oftentimes body language and other cues are just as important. For example, offering a handshake and a greeting of ¡*Mucho gusto*! to a Mexican person can be a welcoming and friendly way to begin a session even when working through an interpreter.

Cultural Inclusion: Why It Is So Important

Providing inclusive and equitable care requires recognizing and examining the root causes that contribute to health disparities and inequities, including barriers to wealth, health, education, and food security. Inadequate access to fresh produce, dairy foods, meats, poultry, and seafood occurs in concert with these root causes and contributes to nutrition inequities. That, in turn, results in increased incidence of poor nutrition outcomes in socially and economically marginalized communities. Refer to Box 3, which defines health disparity and health inequity.[7]

Based on the Centers for Disease Control and Prevention definition, *social determinants of health* are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. These conditions include economic stability, education, social and community context, health and health care, and built environment. Specific to nutrition and dietetics, poverty limits access to healthy foods and safe neighborhoods.[7]

Establishing culturally inclusive approaches that promote health and nutrition equity begins with examining existing systems and power structures on all levels of a social ecological framework and by recognizing the social determinants of health.

BOX 3

Defining Health Disparities and Health Inequities[2]

Health disparities Preventable differences in health status linked to inequitable distribution of social, political, economic, educational, medical, and environmental resources, which negatively affect health outcomes and which socially disadvantaged populations experience.

Health inequities Differences in health outcomes or in the distribution of health resources between population groups that arise from the social conditions that people face. Not all health disparities are health inequities, in that health inequities are unfair and could be reduced by the right mix of policies at the organizational, local, state, and federal levels.

Dominant Versus Nondominant Cultures in Health Care

In most health care settings, both dominant and nondominant cultures exist among health care professionals, supporting staff, and their patients. The differences can be based on gender, age, race, ethnicity, sexuality, religion, income, abilities, and more. For example, the dominant culture within the US health care system is White, upper-income, heterosexual, able-bodied, male, Christian, and US-born.[24] Nondominant cultures in health care include people of other races, socioeconomic status, gender identities, abilities, ethnicities, religion, and citizenship status.

Members of a dominant group tend to possess more power, resources, and influence. As a result, people who hold dominant identities are in a position to develop systems, structures, and processes that benefit and reflect the values of those within their group. This pattern reinforces a culture that caters to the experiences and expectations of the dominant group. Members of the nondominant culture, who historically have less power and influence and fewer resources, are often ignored or marginalized. While there are individual exceptions to this principle, it is important to remember that advantages and disadvantages are embedded at the structural level.

Most nutrition professionals identify as White, female, and middle-aged, which is an ongoing trend based on periodic surveys of nutrition professionals.[25] This suggests that

nutrition professionals who hold these dominant identities have historically set the standards for what is considered healthy, how to provide food and nutrition guidance, and who participates in the field of nutrition. Voices of nutrition and dietetics professionals who do not hold a dominant identity have not always been included, making it difficult for them to feel seen, heard, or considered within standard US nutrition recommendations. Deeply ingrained Eurocentric dietary recommendations and nutrition practices can also make it difficult for historically excluded or minimized groups to be accepted and supported in the field of nutrition, as reflected in the struggle to improve diversity in health care settings and practices.[26]

Dominant groups affect more than culture; they dictate policies, systems, power structures, and narratives. Narrative power gives individuals within the dominant group leverage to set rules and dictate norms that shape society and human behavior.[27] With diverse perspectives and valued input from all groups, the distribution of power and resources can be more inclusive and equally distributed.

Racism in Health Care

When addressing a person's cultural background, regardless of the setting, it is important to understand that race and ethnicity have different meanings. These terms should not be used or viewed interchangeably. *Race* typically describes physical traits, while *ethnicity* focuses on cultural identification. Refer to Box 4, which delineates important differences between the terms.[7,28]

BOX 4

Defining Ethnicity and Race[7,28]

Ethnicity A social construct that divides people into smaller social groups on the basis of characteristics such as shared sense of group membership, values, behavioral patterns, language, political and economic interests, history, and ancestral geographical base.

Race A social construct that artificially divides people into distinct groups on the basis of characteristics such as physical appearance (particularly skin color); ancestral heritage; cultural affiliation; cultural history; ethnic classification; and the social, economic, and political needs of a society at a given time period. Racial categories include ethnic groups.

The American Medical Association identifies systemic, cultural, and interpersonal racism as the foundation of a public health crisis that perpetuates health inequities among minority populations and within marginalized communities.[29] Racism is often trivialized as individual acts of prejudices, either implicit or explicit, that benefit White people and hurt people of color. This is referred to as interpersonal or individualized racism. However, "the most damaging racism is built into systems and institutions that shape our lives."[27]

Racism at many levels and its subsequent barriers to achieving health equity need to be considered within the health care system. The following three types of racism, which are pervasive and often "invisible," all challenge equitable health care.

Structural racism, often referred to as institutional racism, includes systemic factors such as different access to goods and services, dissimilar societal norms, and policies that shape systems-level hierarchies and that establish inequities and disparities—for example, gaps in health care.

Cultural racism includes harmful racial or cultural stereotypes that lead to power imbalances, institutionalized discrimination, and culturally unsafe practices that diminish or disempower a person's cultural identity and well-being.[24,29] In simple terms, it is the belief that another's culture is inferior to one's own.

Individualized racism, sometimes referred to as interpersonal racism, includes implicit and explicit individual beliefs, attitudes, or acts of prejudice or bias that occur between individuals that are hurtful.

Not to be confused with racism, *colorism* is a form of discrimination based on skin color that privileges people with lighter skin tones within a racial group and places people with darker skin tones at the bottom of the racial hierarchy. Such discrimination can occur between different races (interracially) and also within the same race (intraracially).

Structural Racism and Nutrition Disparities

Nondominant groups have been economically and socially marginalized throughout US history. These structural disadvantages—including limited access to employment, education, health care, and nutritious foods—result in disparate health outcomes. When it comes to nutrition, communities of color are often affected disproportionately

by diet-related chronic diseases.[30,31] Before nutrition professionals can provide inclusive nutrition and health care for those in these communities, the root causes contributing to health inequities—in other words, structural racism—must be recognized, examined, and addressed.

For example, African Americans disproportionately experience food insecurity and higher rates of obesity compared to White Americans.[32,33] Institutional barriers to healthy eating contribute to this racial disparity, which include an increased density of fast-food restaurants in predominantly Black and Brown communities.[34,35] These structural inequities are a result of discriminatory practices like redlining, a practice from the 1930s where communities considered to be high-risk were denoted on a map with a red line and were denied financial services, including credit and insurance, based on their race or ethnicity. This resulted in a lack of basic resources in these communities, such as grocery stores and hospitals, fewer job opportunities and transportation options, and lower-quality education compared with predominantly White areas.[30,36,37] These barriers to wealth, health, education, and food security still occur in many under-resourced areas, demonstrating why structural racism continues to affect the current food environment.

Addressing Nutrition Disparities

Poor nutrition is a leading cause of illness in the US and contributes to more than 600,000 deaths per year.[38] Multiple factors influence this statistic. Often poor nutrition is associated directly with varying levels of both food and nutrition insecurity present in historically disinvested communities throughout the country. Food insecurity and nutrition insecurity, as defined in Box 5, often coexist.[38] Both types of insecurity affect a person's ability to prioritize traditional nutrition recommendations. In addition to disinvestment, economically marginalized communities are often flooded with energy-dense food choices from an overabundance of fast-food restaurants and convenience stores. These food outlets typically have limited offerings, often lack fresh fruits and vegetables, and have limited selections of culturally familiar and preferred foods.

The root causes of health inequities include built environments where people live and work, as these factors can greatly influence food choices, food experiences, and health behaviors. For example, have you asked someone to eat more fresh produce and also considered what that change requires?

BOX 5

Defining Food Insecurity and Nutrition Insecurity[38]

Food insecurity Inadequate access to readily available, nutritionally adequate, and safe foods acquired in socially acceptable ways for all individuals of a household that can lead an active and healthy life.

Nutrition insecurity Inconsistent access, availability, and affordability of foods and beverages that promote well-being, prevent disease, and, if needed, treat disease, particularly among racial and ethnic minority populations, lower-income populations, and rural and remote populations including Tribal communities and Insular areas.

What if the nearest grocery store is over 20 miles away and the nearest farmers market is more than 30 miles away, but a convenience store that sells mostly chips, ice cream bars, and other inexpensive, energy-dense snack items is within walking distance? In this case, fresh produce is neither the easiest nor the most accessible option. Cost and food quality are other factors to consider. Some convenience stores may offer produce and other nutrient-dense items; however, if the items are of low quality and high price, many individuals residing in under-resourced communities may not have access to them.

Inadequate access to grocery stores, farmers markets, fresh produce, dairy foods, meats, poultry, and seafood, as well as to proper and safe food storage greatly affects urban and rural communities that have been socially and economically marginalized. Practitioners should be prepared to recognize and address these challenges. Using Box 6, consider how structural racism may weigh on the communities where you live and work.

Cultural Sensitivity in Nutrition Practice

Structural racism and cultural racism impact food choices, food experiences, and health behaviors—and ultimately health outcomes. Within the scope of nutrition, cultural racism may present itself in practices and recommendations made when counseling and providing nutrition education. Most often the intent is good, but when it lacks cultural understanding, there can be unintended consequences.

BOX 6

Pause to Assess Food Access in Your Community

Examine the communities where you live and where you practice to better understand the availability of and access to food. These questions may help you pinpoint areas where structural racism may have (or may not have) affected the food environment in these communities. Ask yourself the following:

- What is the nearest food store and what foods does it offer/sell?
- Is public transportation available within walking distance to and from a food store or market? If so, what does this look like?
- Where is the nearest food store or farmers market with access to affordable and quality produce?
- Does the food store or farmers market accept SNAP (Supplemental Nutrition Assistance Program) or WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) benefits, or both?
- How prevalent are fast-food restaurants and convenience stores, and what types of foods do they sell?
- How easy is it to find businesses that sell or serve inexpensive energy-dense foods and beverages in the community? What about nutrient-rich foods?
- Are there food stores, markets, urban gardens, or produce stands in the community that offer a variety of foods, herbs and spices, or other ingredients that fit the cultural preferences of the community? If so, where are they?
- Are there food pantries or food banks in the community that offer a variety of foods including produce? If so, where are they?

It's important for readers to remember that these areas are not being critiqued. The goal of this exercise is to help you better understand the communities where we all live and work and to examine access within them as we consider the lived experiences of the individuals we serve.

To embrace cultural sensitivity in nutrition practice, avoid fixating on or demonizing individual ingredients, especially culturally specific ingredients. Otherwise, this may lead to distrust between nutrition professionals and their patients or clients. For example:

- providing a blanket recommendation to replace white rice with brown rice or quinoa to boost fiber in a dish such as jollof rice from West Africa;
- using cauliflower in place of plantain to reduce carbohydrates in a traditional dish such as Puerto Rican mofongo; or
- suggesting eliminating or replacing a salty condiment, such as fish sauce in a dish for pad Thai, to reduce sodium.

When considering altering recipes or substituting ingredients—especially culturally specific ingredients—nutrition professionals can build trust by demonstrating their understanding that specific ingredients are woven into the cultural authenticity of certain dishes and that removing them would threaten the identity of the dish. Open

discussions about ingredients in traditional dishes and food preparation techniques offer an opportunity to have a better understanding of foods' cultural significance while also providing nutrition education.

Before suggesting a substitution or modification of a cultural dish, research the history of the dish and its ingredients and preparation from authentic sources, such as cultural cookbooks or from cultural informants. In many cases, it may be possible to identify dishes in which substitutions or modifications can be made in ways that preserve culturally meaningful food practices. Be aware that modifying or reinventing recipes in an inauthentic way may be perceived as *cultural appropriation*, the act of taking or using elements from a culture without showing an understanding of or respect for that culture.

Promoting Positive Cultural Encounters

Cross-cultural encounters play a significant role in patient experiences. Cultural sensitivity in nutrition counseling and education applies not only to food and nutrition recommendations but also to how that guidance is delivered. Positive cultural encounters are person-centered and encourage cross-cultural exchanges. They avoid harmful stereotypes, empower individuals, and promote practices that celebrate the cultural identity and well-being of an individual. Cultural encounters that are welcoming and inclusive help to establish trust and rapport. In contrast, when a person's cultural identity is not acknowledged, respected, and supported, this could lead to a negative patient-provider experience and poor outcome.

For nutrition professionals, positive cultural encounters offer opportunities to explore cultural food behaviors. These encounters can show patients how all foods, including those relevant to their culture, can fit into a healthy diet. This also requires understanding that socioeconomic factors impact food behavior and health, and that different cultures and different people will have varying ideas of what being healthy means.[39] Practical strategies for facilitating culturally sensitive, positive encounters, such as encouraging patients to bring food labels and packages of ingredients they prepare at home, also are detailed in Chapter 2.

Addressing Bias in Nutrition Practice

Each person has unique lived experiences that affect their perceptions, and everyone has both explicit (conscious) and implicit (unconscious) biases. Health care professionals have been found to have the same amount of implicit bias as other people.[40]

Whether conscious or unconscious, these learned perceptions affect how each person views the world and interacts with others. Even with the best intentions and expertise, health care professionals are subject to potential biases, often prompted by skewed messages (family beliefs, media, curricula) that affect clinical decision-making. These perceptions can result in stereotyping and individualized racism, including implicit bias, microaggressions, and explicit bias as defined in Box 7.[7,41]

BOX 7

Defining Bias, Implicit Bias, Explicit Bias, and Microaggressions[7,41]

Bias A disproportionate judgment in favor of or against an idea or thing, usually in a way that is closed-minded, prejudicial, or unfair. Biases can be innate or learned. People may develop biases for or against individuals, groups, or beliefs. Bias may be conscious or unconscious.

Implicit bias Also referred to as unconscious bias, this is when individuals are unaware of how their understanding, actions, and decisions affect certain groups. These biases, which can be favorable or unfavorable, are activated involuntarily and without awareness or intentional control. Unconscious beliefs about others do not necessarily align with one's conscious, declared beliefs. People tend to hold unconscious biases that favor those most like them (in-group).

Explicit bias Also referred to as conscious bias, when individuals are aware of their prejudices, attitudes, and resulting actions toward certain groups. Their positive or negative beliefs about or preferences for a particular group are conscious. Explicit bias can result in numerous "isms," such as racism, sexism, ageism, classism, ableism, and heterosexism.

Microaggressions Brief verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative prejudicial slights and insults toward stigmatized groups, particularly culturally marginalized groups that often result from an individual's implicit bias. Refer to the Academy of Nutrition and Dietetics IDEA terms (see Resources on page 4) for additional related content on microassaults, microinsults, and microvalidations.

Confronting Implicit and Explicit Bias

Implicit bias may be learned and expressed unconsciously when providing nutrition counseling or nutrition education. Explicit bias occurs when stereotypes, prejudices, and attitudes consciously influence behaviors, care, and clinical decisions.[8] The scenarios that follow illustrate examples of implicit and explicit bias in the context of nutrition counseling and education.

SCENARIO: *A patient living in a historically marginalized community meets with a registered dietitian nutritionist (RDN) to discuss dietary changes for eating more fruits and vegetables to better manage their blood pressure. The RDN recommends the patient choose frozen or canned fruits and vegetables that do not contain salt or added sugars as the best way to increase fruit and vegetable intake.*

- **Underlying implicit (unconscious) belief**: The RDN unconsciously assumes their patient from a historically marginalized community has limited access or means to obtain fresh fruits and vegetables.
- **Corrective actions**: Establish an accurate understanding of the food sources available to the patient and their purchasing habits by asking if and where they purchase, grow, or source produce. Then develop individualized recommendations based on the person's dietary needs that are inclusive of their lived experience, built environment, and cultural preferences.

SCENARIO: *While reviewing the patient's chart, another health care professional noticed that the patient was not progressing in reducing their blood pressure through changes in diet and added a note to the chart stating: "The patient is noncompliant with treatment regimen and is reluctant to change at this time."*

- **Underlying explicit (conscious) belief**: This professional assumes that people from historically marginalized groups are less likely to adhere to treatment recommendations and chooses a negative and judgmental descriptor like "noncompliant" while neglecting to try to understand possible structural and personal barriers.[42,43]
- **Corrective actions**: Talk with the patient to understand why they are not progressing with the current treatment plan. Ask questions to learn about barriers to and readiness for change. Avoid labeling a patient with negative terms, such as noncompliant. Once an accurate understanding is established, collaborate with the patient to adjust the care plan to better meet their needs and health goals.

Remember that conscious (and unconscious) assumptions followed by deliberate actions can lessen the overall quality of nutrition and health care for an individual or a specific group. When confronting implicit and explicit bias, remain open-minded and nonjudgmental in approaching and understanding perspectives and lived experiences that may be different from your own. Using Box 8, do some self-reflection to uncover possible areas of personal bias. Creating an open and trusting environment to explore is the foundation of establishing culturally inclusive, person-centered care.

BOX 8

Pause to Assess Yourself

Examine whether and how your perceptions and actions (body language, facial expressions, and nutrition recommendations) change based on your encounters with different types of people. These questions may help pinpoint areas where you hold conscious or unconscious beliefs or biases, which can affect your nutrition counseling or practice decisions.[44]

Ask yourself

Do factors such as age, physical or mental ability, race, ethnicity, sex assigned at birth, gender identity, English language proficiency or accent, socioeconomic status, education, or body size:

- affect my personal comfort and perceived personal safety?
- affect the way I communicate with colleagues, patients, clients, or their families?
- influence the amount of time or quality of time I spend with patients or clients?
- inhibit my ability to relate to the emotions, concerns, or barriers that people experience?
- change the types of counseling, goals, and/or treatments I recommend?

Adopting Culturally Inclusive Approaches in Nutrition Practice

Nutrition equity and food security is the foundation of a healthy community where optimal health for all—irrespective of ability, age, economic situation, education, ethnicity, religion, gender, or race—is the goal. To establish culturally inclusive and equitable approaches for nutrition practice, the existing systems and power structures that deliver food- and nutrition-related products and services must be examined. Efforts to make those systems more equitable must be supported on all levels.

Social Ecological Models

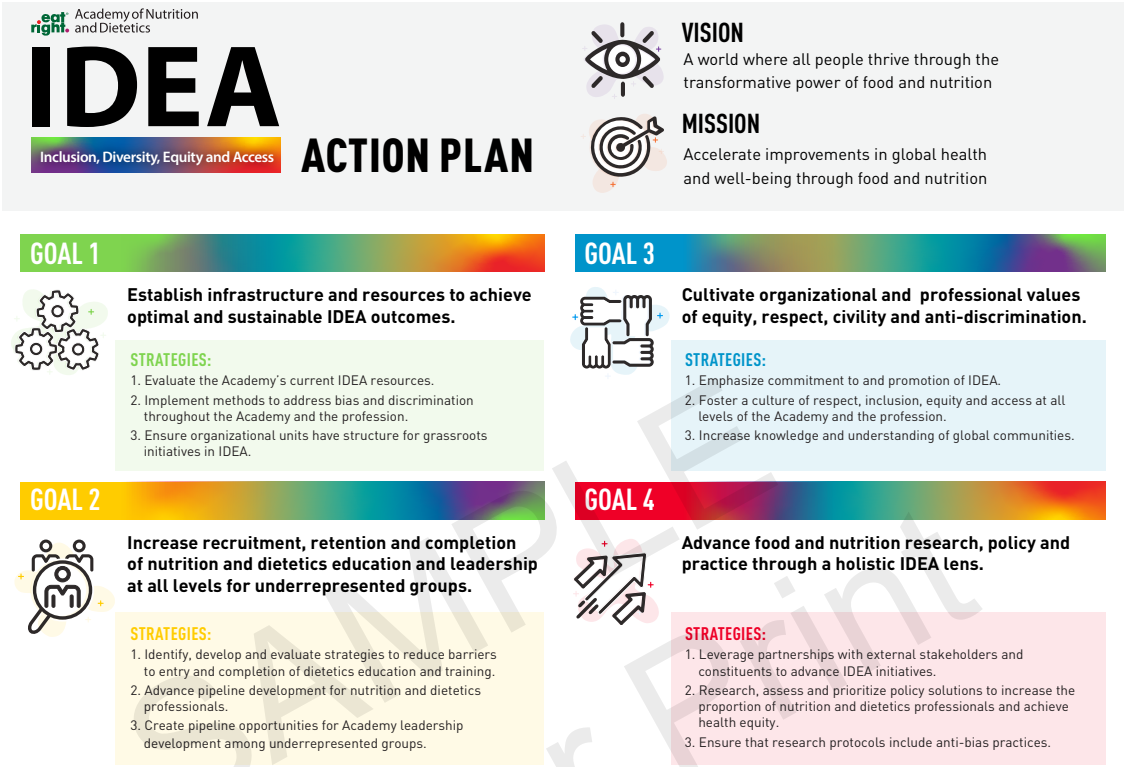
Social ecological models indicate the complex interactions among societal, community, and individual factors that lead to nutrition equity and food security. Various factors such as the food environment in neighborhoods and communities, access to educational resources, and public policy influence nutrition equity. A framework for examining existing models of care shown in Figure 4 presents essential considerations for change at all levels, from the overriding level of policy-making down to the individual.[45]

IDEA Action Plan

The Academy of Nutrition and Dietetics encourages inclusion, diversity, equity, and access (IDEA) by striving to recognize, respect, and include "differences in ability, age, creed, culture, ethnicity, gender, gender identity, political affiliation, race, religion, sexual orientation, size, and socioeconomic characteristics in the nutrition and dietetics profession." To integrate IDEA into the profession, the Academy of Nutrition and Dietetics adopted an IDEA action plan (refer to Figure 5).[46] The plan's overarching goals were approved by the Academy of Nutrition and Dietetics board of directors in April 2021 and incorporated into its strategic plan as four major areas of focus.[47]

FIGURE 4 Framework for examining existing models of culturally inclusive nutrition care[24]

FIGURE 5 Action plan for inclusion, diversity, equity, and access[46]



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Resources

Refer to Resources on Cultural Foodways, Inclusion, and Nutrition Communication on pages 2 through 4.

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