Culture, Foodways, & Counseling

SECOND EDITION

A Guide to Culturally Sensitive Nutrition Care in the United States

Diabetes Dietetic Practice Group

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CONTENTS

PREFACE

Welcome to the second edition, retitled as *Culture, Foodways, and 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 cultural background. The goal of this book is to provide context and awareness of food and food-related beliefs and practices of cultures other than 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 United States' 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, and 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 sensitive communication practices; and to use culturally inclusive 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 the section is also included.
- Now expanded and updated, culture/country chapters from the first edition include: American Indians; Alaskan 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, Laos, and Cambodian Americans; Japanese Americans; and Pacific Island Americans.
- 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, and Counseling,* we made great efforts to find authors and peer reviewers from the cultures and faiths addressed. More than xx 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 page xx. 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, and 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.

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

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 co-founder 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 UNC 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 University of North Carolina 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 co-founder 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.

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. Kathaleen 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 Kathy's lifelong interest in sociodemographic inequities and health outcomes, and how to mitigate those inequities.

As part of her PNWU work, Dr. Early continues to provide 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.

Roberta Duyff, MS, RDN, FAND, FADA, 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's *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 minority communities to co-develop a multicultural preschool nutrition curriculum for national Head Start, and resources for USDA's SNAP program. Involving registered dietitians with cultural, first-language background, as well as certified 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 the commonalities and differences in dietary guidance at the Chinese Nutrition Association in Beijing.

Her interest in cultural foodways began with exploring her mostly 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.

Believing in the power of cultural exchange, 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 food experiences 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's Food & Culinary Professionals (FCP) Dietary Practice Group (DPG); Executive Board, Society for Nutrition Education (now SNEB); President, SNE Foundation; and Co-Chair, Global Culinary Initiative/Les Dames d'Escoffier International and its culturally focused, philanthropic efforts. Her terms on the James Beard Journalism Awards Committee helped define awards' criteria for excellence in food-related journalism. She belongs to the Academy's Global and Religion Member Interest Groups, and to FCP and Nutrition Entrepreneurs DPGs. Among 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's eatright.org/recipes. Wherever she roams, local food markets, with their knowledgeable growers and vendors, and sharing the kitchen and the table with local families, are top priorities!

SECTION

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 minorities 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 wellbeing.

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 9 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
edhub.ama-assn.org/ama-center-health-equity

Online education center includes articles, reports, video series, and tool kits for equitable care in practice.

American Psychological Association, Equity, Diversity, and Inclusion: Inclusive Language Guide, Second 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

A validated assessment tool allows nutrition professionals to measure their own level of privilege based on upbringing, education and training, and professional practice.

Diversify Dietetics
www.diversifydietetics.org

A community for students, professionals, and educators dedicated to increasing ethnic and racial diversity in the nutrition and dietetics profession.

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

Diversity Style Guide
www.diversitystyleguide.com

EthnoMED, Integrating Cultural Information into Clinical Practice
ethnomed.org

Food and Agriculture Organization of the United Nations (FAO)
www.fao.org/nutrition/nutrition-education/food-dietary-guidelines/en

Food-based dietary guidelines (by country).

Food and Culture, 8th edition. 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
globalnutritionreport.org/reports/2020-global-nutrition-report/food-systems-and-nutrition-equity

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

A self-assessment tool to help recognize bias.

Health Information Translations
www.healthinfotranslations.org

Journal of Ethnic Foods
journalofethnicfoods.biomedcentral.com

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

Information by ethnic group, country, or culture on global languages and cultures.

Migration Policy Institute
www.migrationpolicy.org

National Center for Cultural Competence
nccc.georgetown.edu

National Institutes of Health, National Library of Medicine, Medline Plus: Health Information in Multiple Languages
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
oldwayspt.org/traditional-diets

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

Stanford Medicine, EthnoGeriatrics Culturemed
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)
transculturalcare.net/iapcc-r

A tool designed to measure the level of cultural competence among healthcare professionals and graduate students in the allied health fields.

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/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
- 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
www.cdc.gov/healthcommunication/HealthEquityGuidingPrinciples.pdf

- National Standards for Culturally and Linguistically Appropriate Services
  thinkculturalhealth.hhs.gov/clas/standards
- Office of Minority Health
  www.minorityhealth.hhs.gov

US Food & 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

The Resource Hub includes a variety of resources (articles, publications, awards, grants) to promote and advance inclusion, diversity, equity, and access.

International Affiliate of the Academy of Nutrition and Dietetics
eatrightinternational.org

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

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

Duyff RL. "Effective Nutrition Communication Is Tailored for the Target Culture," Chapter 13. 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,
Shamera Robinson, MPH, RDN, CDCES,
and 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 co-founder 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 UNC 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 co-founder 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 include 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.

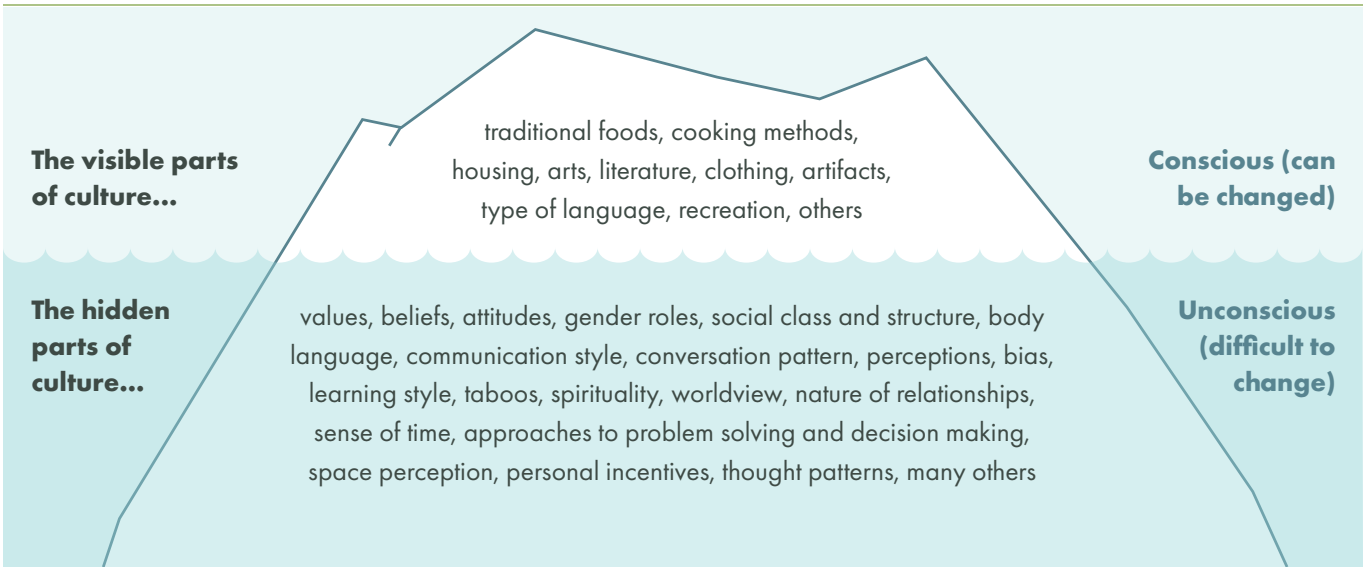
Introduction to Culture

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, displayed in Figure 1. 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 such as 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 patient's culture is a starting point for effective health and nutrition counseling, education, and care—but 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 patient'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]



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 water line 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 maleable, 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, including (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 not only from new immigrants but also 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 professonals, 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 culture different than one's own goes beyond merely 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). It recognizes that every person brings their own culture, family history, and worldview to the table, and 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."[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 (eg, 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 X for more on addressing bias in nutrition practice.

Diversity and Acculturation in the United States

The United States 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, equity, and inclusion (DEI) have become priorities in providing nutrition and

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 patients.
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 R. Effective nutrition communication is tailored for the target culture. In: Mayfield B, ed. *Communication Nutrition: The Authoritative Guide.* Academy of Nutrition and Dietetics; 2020.[3]

health counseling and care in the US today. Refer to Box 1 for definitions and to page XX for the Academy of Nutrition and Dietetics' DEI initiatives.[7]

The diversity of peoples and cultures in the United States 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 Hawaii 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), while 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 care 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. A 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 nondominant 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]

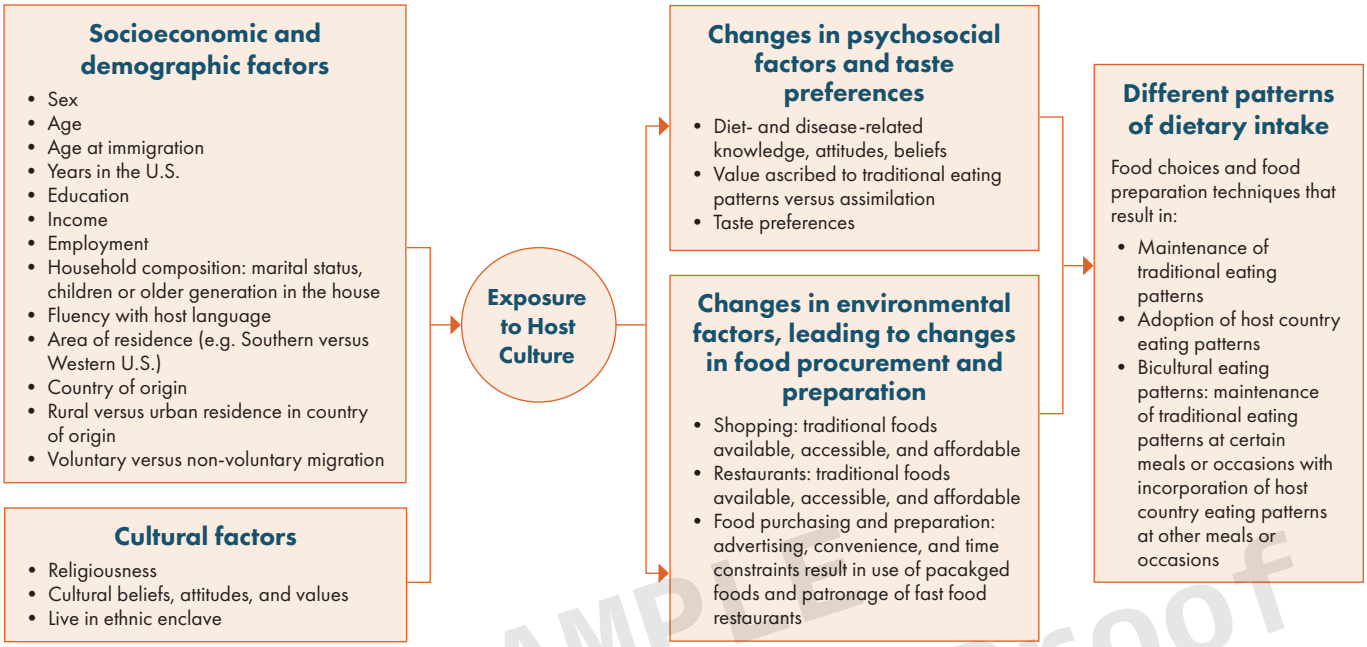
Recognizing the degree of acculturation is important for effective, culturally competent nutrition care.[18] Refer to Figure 3 and other comprehensive resources addressing dietary acculturation to learn more about the complex and multifaceted process of adopting the practices and values of another culture.[15,16,18] 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 and dietetics.[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: 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 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's 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/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 organizational, local-, state-, and federal-level policies.

Dominant versus Nondominant Cultures in Health Care

In most health care settings, both dominant and nondominant cultures exist among the 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 and dietetics. 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's 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. These 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/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 affect 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 and dietetics, 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!

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 have not) 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 or WIC 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.

Abbreviations: SNAP, Supplemental Nutrition Assistance Program; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children

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 joloff 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 offers 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*.

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, 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 my patients or clients 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 (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]

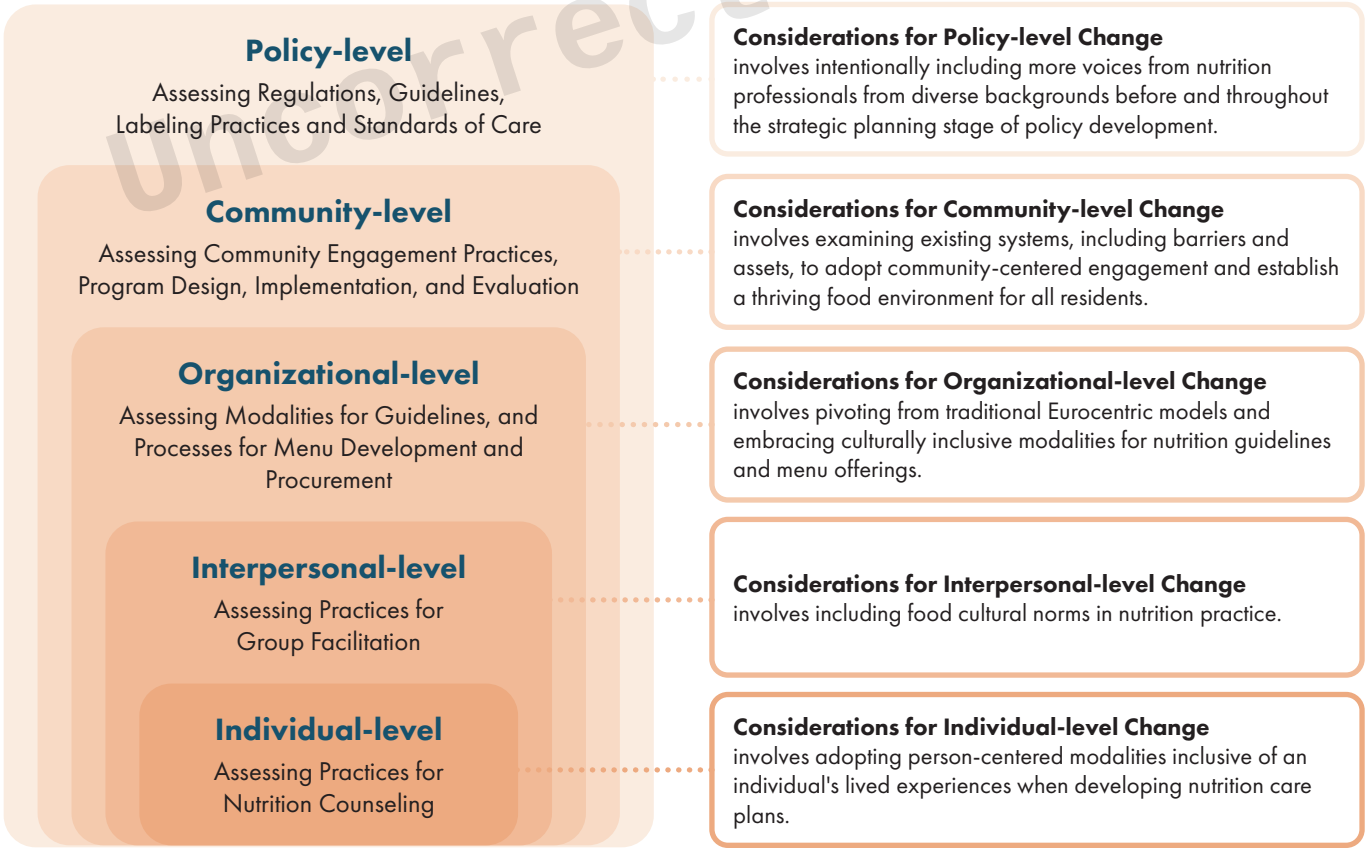
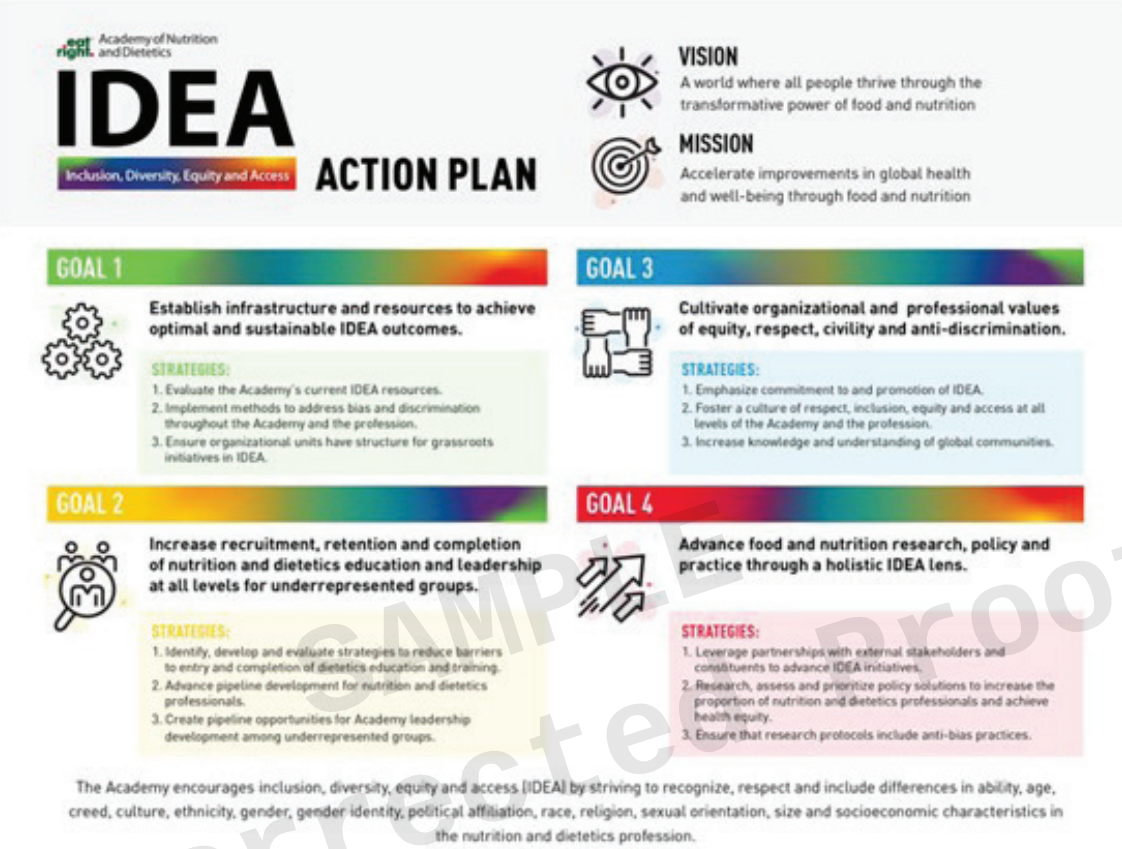


FIGURE 5 Action steps for inclusion, diversity, equity, and access[46]



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SECTION 2

American Indians and Alaska Natives

Get to Know the Cultures of American Indians and Alaska Natives

Roberta L. Duyff, MS, RDN, FAND, FADA

The chapters in this section address the common food practices, related health conditions, and nutrition counseling considerations for many American Indians and Alaska Natives—America's Indigenous people who link their ancestry back to those who settled in the Western Hemisphere at least 15,000 years ago and to their forebearers, likely much earlier.[1,2]

There are many terms for people with Indigenous ancestry who inhabit land that is the continental US today including "Native Americans," "Amerindians," and "First Nation people." Because the use and meaning of *Native American* has broadened in recent decades to include all Native (Indigenous) people in the US, its trust territories, and elsewhere in the Americas, *American Indian* is generally preferred for those who belong to Indigenous tribes of the continental US and *Alaska Native* for people of the Indigenous tribes and villages of Alaska.[3] Indigenous people of Hawaii are referred to as Native Hawaiian (refer to Chapter X).

There is no single American Indian culture. American Indians are culturally, ethnically, and linguistically diverse, and the US Department of the Interior, Bureau of Indian Affairs (BIA) reports that 574 tribal nations (variously called tribes, nations, bands, pueblos, communities, and native villages) are federally recognized.[3] As such, tribal nations are defined by the Indigenous people, places, cultures, and governance systems they encompass. Tribes, as nations within the US, have their own laws and are recognized as sovereign.

In 2020, an estimated 3.7 million people identified as American Indian and Alaska Native alone, accounting for 1.1% of all people living in the US. An additional 5.9 million people identified as American Indian and Alaska Native and another race group. Together, the American Indian and Alaska Native population alone or in combination comprised 9.7 million people (2.9% of the total US population) in 2020.[4]

Geography and Historical Perspectives

The geographic origin of America's Indigenous peoples is unknown, but a longstanding and widely accepted theory dates their migration from northern Asia across the Bering Land Bridge to what is now Alaska and the Pacific Northwest in Canada and the US—dating back about 30,000 years ago. Other theories have been proposed, including evidence for a "highway" of nutrient-rich kelp that boats followed from Southeast Asia to South America and an Atlantic Crossing. Solid evidence dates widespread habitation of the Americas back at least 15,000 years ago.[2,5,6]

Over the millennia, Indigenous cultures developed, sharing ways of life and traditions through extensive trade and cultural networks. For example, The Mississippian people lived in flourishing settlements across the Midwest, East, and Southeast US from about the years 800 to 1540. Cahokia (in today's Illinois) was the religious center of the Mississippian culture and the second-largest urban center in North America. For 400 years, from about the years 950 to 1350, Cahokia prospered and at one point housed a peak population of 20,000.[7] Figure 1 shows the homelands of the major American Indian and Alaska Native tribes before colonization and forced removal: California tribes, Plateau tribes, Great Basin tribes, Pacific Northwest Coast tribes, Southwest tribes, Plains Indian tribes, Northeastern Woodlands tribes, Southeastern Woodlands tribes, and Alaska Natives.[8]

When the first Europeans arrived over 500 years ago, the Americas were widely inhabited. Yet in the years following, the Native population declined rapidly for assorted reasons: infectious diseases brought from abroad, enslavement, conflict, and forced removal. Over the years, the US government established laws to take over ancestral lands, establish reservations, and enforce discriminatory policies and practices. Historical trauma and societal disparities have resulted in inequities and challenges for many American Indian and Alaska Native people,[9] including from forced removal from their homelands beginning in the 1830s and the boarding school era starting in 1879. Over time, American Indian and Alaska Native people have been required to adapt and blend ancestral traditions and norms with mainstream US culture, resulting in a disruption of cultural traditions amidst loss of land.

Tribal nations were recognized as independent nations until 1871. That recognition ended with the Indian Appropriation Act, making American Indians subject to federal law, as nations within a nation. In 1924, US citizenship was granted to all Native Americans born in the US who were not already citizens; that included Alaska Natives. American Indian and Alaska Native people did not need to give up their tribal citizenship if they had it. Today, tribal members have citizenship in three sovereigns: their tribe, the US, and the state in which they live.[1]

Natural Environment and Resources

Over many millennia, America's Indigenous people hunted and gathered, gradually inhabiting lands with diverse geographic and ecological conditions. Over time they created and adapted their cultures, including their food practices and diets, using resources from the different natural environments that they inhabited: hot, moderate, or cold climates; ocean, lake, or river access; mountains, hills, plains, prairies, or deserts; abundant and scarce plant and animal life; and fertile soil or not fertile. Over time some Indigenous cultures developed subsistence farming techniques, allowing them to establish settled communities and societies; others were hunter-gatherer cultures, moving with the seasons.

Before contact with European explorers and settlers, the dietary practices and sustenance of Indigenous people depended on the availability, abundance, and safety of edible plants (leaves, stalks, flowers, fruit, roots, nuts, and seeds), as

FIGURE X Homelands of Major Tribes before Colonization and Forced Removal

Source: Park S, Hongu N, Daily JW. Native American foods: history, culture, and influence on modern diets. J Ethn Foods. 2016;3(3):171–177. [11]
www.sciencedirect.com/science/article/pii/S2352618116300750

well as game, fowl, fish, and other protein sources. Different environments produced different foodstuffs—and thus different food cultures. For example, the oceans, rivers, and streams of what is the Pacific Northwest Coast of the US and Alaska provided an abundance of salmon and other seafood; bison (buffalo) meat was a mainstay and protein source in the Midwest Plains; coastal areas of the Mid-Atlantic supplied oysters and clams; and in the desert Southwest and elsewhere, beans and corn (maize) were cultivated and consumed, as together they were a good protein source. The diversity of the ecoregions, along with the diversity of the people, resulted in distinct and varied food practices and cuisines, allowing them to survive and thrive in their ecological conditions where they lived. Historically, they were successful stewards and managers of the land.

Hundreds of foods that nourished native populations throughout history—and about 60% of the current world food supply—are indigenous to the Americas: among them avocado, chili peppers, chocolate, papaya, peanuts (groundnuts), potatoes, strawberries, and tomatoes. Three of those foods—beans, corn, and squash grown together in a mound system—are referred to as the "three sisters" because they complement one other agriculturally and nutritionally; see Figure 1 on page XXX. Today, many Indigenous foods continue to be a part of regional fare, and there is a growing awareness of food sovereignty within these Indigenous populations, noting "the right of peoples to healthy and culturally appropriate food, produced through ecologically sound and sustainable methods and to their right to define their own food and agriculture systems."[10]

Ethnic and Religious Diversity

Ancestry, ethnicity, geographic location, and spiritual beliefs shaped the many and diverse American Indian and Alaska Native cultural practices and traditions. Through their own

tribal arts, ceremonies, customs, languages, music, and social practices, each generation of Elders has passed down its values, traditions, and beliefs.

While many aspects of American Indian and Alaska Native cultures are apparent to outsiders (such as powwows, dance, ceremonies, drumming, and regalia), as with every culture, other aspects of American Indian and Alaska Native cultures (such as their core values, ways of interacting, and worldviews) are implicit. Common among American Indian and Alaska Native groups is a respect for Elders and the land.

The BIA reports that fewer than 200 tribal languages are spoken today, in contrast to an estimated 300 languages spoken at the end of the fifteenth century.[11] Although many Native languages have been lost over the centuries, some have been or are being preserved and translated into written form. Among American Indians and Alaska Natives today, English is the predominant language spoken at home, school, and work.

For thousands of years, American Indian and Alaska Native cultures shared and preserved cultural and generational knowledge and heritage through oral tradition, passing it down and preserving it for those who follow. This common indirect style of communicating, which may use storytelling, folktales, songs, chants, and poetry, can provide a rich cultural context before getting to the point(s) of a message.

Spirituality is woven into American Indian and Alaska Native cultures and, for many, into everyday life. Beliefs and practices, which vary widely among and within various American Indian and Alaska Native tribes, communities, and families, are typically rooted in traditions that predate contact with Europeans, in Christian religious practice that came later, or in a blend of both. Traditional American Indian and Alaska Native spiritual beliefs and practices view all aspects of life as well as health and all living things as interconnected. This holistic spiritual view, still held by many, respects the balance between the natural world and the human mind, body, and spirit.

Concepts of health and wellness vary among Indigenous tribes and communities but typically include a belief that the spirit cannot be separated from healing. Healing rituals, techniques, and beliefs held by traditional healers are often kept secret, except as they are passed from one healer to the next. Many healers have extensive knowledge of herbs and often use them in their healing practices.[12] Depending on the health condition and personal belief, individuals may use both traditional healing practices and mainstream allopathic (western) medical guidance and care. The Indian Health Service in the federal government serves the health needs of American Indians and Alaska Natives.

American Indian and Alaska Native Life Today

Geographically, American Indians and Alaska Natives reside and work today in cities and towns throughout the US. According to the BIA, about 56.2 million acres are held in trust by the US for various American Indian tribes and individuals, with approximately 324 land areas in the US administered as federal American Indian reservations (i.e., reservations, pueblos, rancherias, missions, villages, communities, and more).[13] A reservation is an area of land managed by an American Indian and Alaska Native tribe under the BIA. Not all recognized tribes have a reservation, and some tribes may have more than one, or may share a reservation with another tribe. American Indian and Alaska Native tribes, businesses, and individuals also own land as their private property, apart from designated Native American lands. Property rights, specifically over tribal lands, and economic opportunity related to the resources of the land are lingering issues.[9]

Today, American Indian and Alaska Native cultural groups are often classified or grouped by regional areas (refer to present day maps in Chapters 3 and 4). Indian reservations are associated with about half of the US federally recognized tribes, and they are home to many people. However, more than 80% of American Indian and Alaska Natives, who are scattered throughout the country, live outside of the reservations.[13]

The past two decades have brought significant gains in self-governance, or sovereignty, including food sovereignty.[10] New agreements in the USDA Indigenous Food Sovereignty Initiative were announced in 2022, which "promote traditional food ways, Indian Country food and agriculture markets, and Indigenous health through foods tailored to American Indian/Alaska Native (American Indian and Alaska Native) dietary needs." These initiatives support the restoration of traditional Indigenous foodways and agricultural economies, and seek to improve health through Indigenous nutrition.[1,14]

Many American Indian and Alaska Native communities have unique strengths that often go unrecognized by outsiders but that can contribute to positive outcomes.

These strengths may include extended family and kinship ties, long-term natural support systems, a shared sense of community responsibility, physical resources (e.g., food, plants, animals, water, land), Indigenous generational knowledge and wisdom, a historical perspective and strong connection to the past, survival skills and resiliency in the face of multiple challenges, retention and reclamation of traditional languages and cultural practices, the ability to walk in both the mainstream culture and the native culture, and community pride.[1]

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Indigenous American Cultural Food and Nutrition Resources

Alaska Department of Environmental Conservation, Food Safety and Sanitation Program. Traditional Foods
https://dec.alaska.gov/eh/fss/food/retail/traditional-foods

Alaska Department of Health, Division of Public Health. Chronic Disease Prevention & Health Promotion
https://health.alaska.gov/dph/Chronic/Pages/default.aspx

Indian Health Service, Health Promotion/Disease Prevention
www.ihs.gov/HPDP

Alaska Health Tribal Health Consortium: Traditional Foods and Nutrition
www.anthc.org/what-we-do/traditional-foods-and-nutrition

Alaska Native Tribal Health Consortium, Wellness
www.anthc.org/what-we-do/wellness

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Education Materials and Resources (Online Catalog)
www.ihs.gov/diabetes/education-materials-and-resources

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www.smithsonianmag.com/smart-news/interactive-map-shows-you-what-indigenous-land-you-live-on-180980920/. Of check https://native-land.ca

Indian Health Service
www.ihs.gov

Indian Health Service, Health Promotion/Disease Prevention
www.ihs.gov/HPDP

IHS Food Insecurity Assessment Tool and Resource List
www.ihs.gov/sites/diabetes/themes/responsive2017/display_objects/documents/clinicaldocs/ FoodInsecurityAssessTool.pdf

Native Diabetes Wellness Program. US Centers for Disease Control and Prevention. Traditional Foods
www.cdc.gov/diabetes/ndwp/traditional-foods/index.html

National Museum of the American Indian.
https://americanindian.si.edu

National Native Network Traditional Foods Resource Guide for Indian Health Service areas - Alaska, California, Portland, and The Great Plains
https://keepitsacred.itcmi.org/wp-content/uploads/sites/5/2015/06/Traditional-Foods-Resource-Guide.pdf

Native Wellness Program. Centers for Disease Control and Health Promotion, Department of Health and Human Services. Traditional Foods
www.cdc.gov/diabetes/ndwp/pdf

North American Traditional Indigenous Food Systems
https://natifs.org

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Secrest V. *Indigenous Home Cooking: Menus Inspired by the Ancestors*. Chatwin Books. Seattle, WA; 2021.

Ten Doable Ways You Can Enjoy Meals on Special Days
www.ihs.gov/sites/diabetes/themes/responsive2017/display_objects/documents/printmat/ TenWaysSpecialMeals_508c.pdf

Traditional Food Guide for the Alaska Native People. Alaska Native Tribal Health Consortium.
www.anthc.org/news/second-edition-of-traditional-food-guide-supports-modern-health

USDA Indigenous Food Sovereignty Initiative
www.usda.gov/tribalrelations/usda-programs-and-services/usda-indigenous-food-sovereignty-initiative

3

Alaska Native Food Practices

Desiree Jackson, RD, EMBA

This chapter gives an overview of the culture, health risks, and food practices of those who have Alaskan Native heritage. While offering generalized insights for nutrition counseling and care, the chapter acknowledges individual differences within this population.

Desiree Jackson is of Tlingit descent and belongs to the Tsaagweidi clan from Southeast Alaska. She specializes in Alaska Native traditional and customary diet. With over 20 years of tribal health experience, Desiree has authored books around the benefits of traditional diet and the nutrient content of Alaska Native foods. She has developed award winning campaigns around the preservation of Alaska Native diet and culture utilizing social media and videography platforms. She grew up eating local foods with her family, from bear meat in the farthest most regions of Alaska to pig roasts and frying fish on the beaches in Hawaii. Today, she passes on this tradition to her children whose first foods were herring eggs, moose meat, and wild berries.

Special thanks are due to the Alaska Native Tribal Health Consortium, specifically Claire Siekaniec, MSc, RD, CSSD (community educator), and Marcia Anderson, MS, RDN (health promotion program manager), for their review and input during the development of this chapter. Claire grew up in Alaska and developed an interest in and appreciation for Alaska Native traditional foods and their connections to culture and health. Her favorite food memory is snacking on wild berries found while hiking with family and friends. Marcia is of Alutiiq heritage and has a strong passion for Alaska Native traditional foods and plants as she grew up harvesting foods with her family. She fondly remembers enjoying a large family meal of fresh butter clams after long days of digging clams on the beach.

Cultural Overview

The Indigenous people of Alaska, also referred to as Alaska Native people, are the heart of Alaska. They have thrived in Alaska's vast, differing landscape for thousands of years. The scope of Alaska Native food and cultural practices reflect Alaska's vast regional differences and are unique from those of the Indigenous people living in the contiguous US.

Geographically, Alaska is the largest US state in and is home to more than 229 federally recognized tribes. The main groups and their approximate locations are represented in Figure 1. The name "Alaska" comes from the Unangax̂ (also referred to as Aleut) word for "Great Land." The state is also known as the Last Frontier and the Land of the Midnight Sun. Alaska covers 533,000 square miles and is surrounded on three sides by the ocean, with a total coastline of 33,000 miles. Alaska borders Canada, and for many tribes and communities along the border, Alaskans

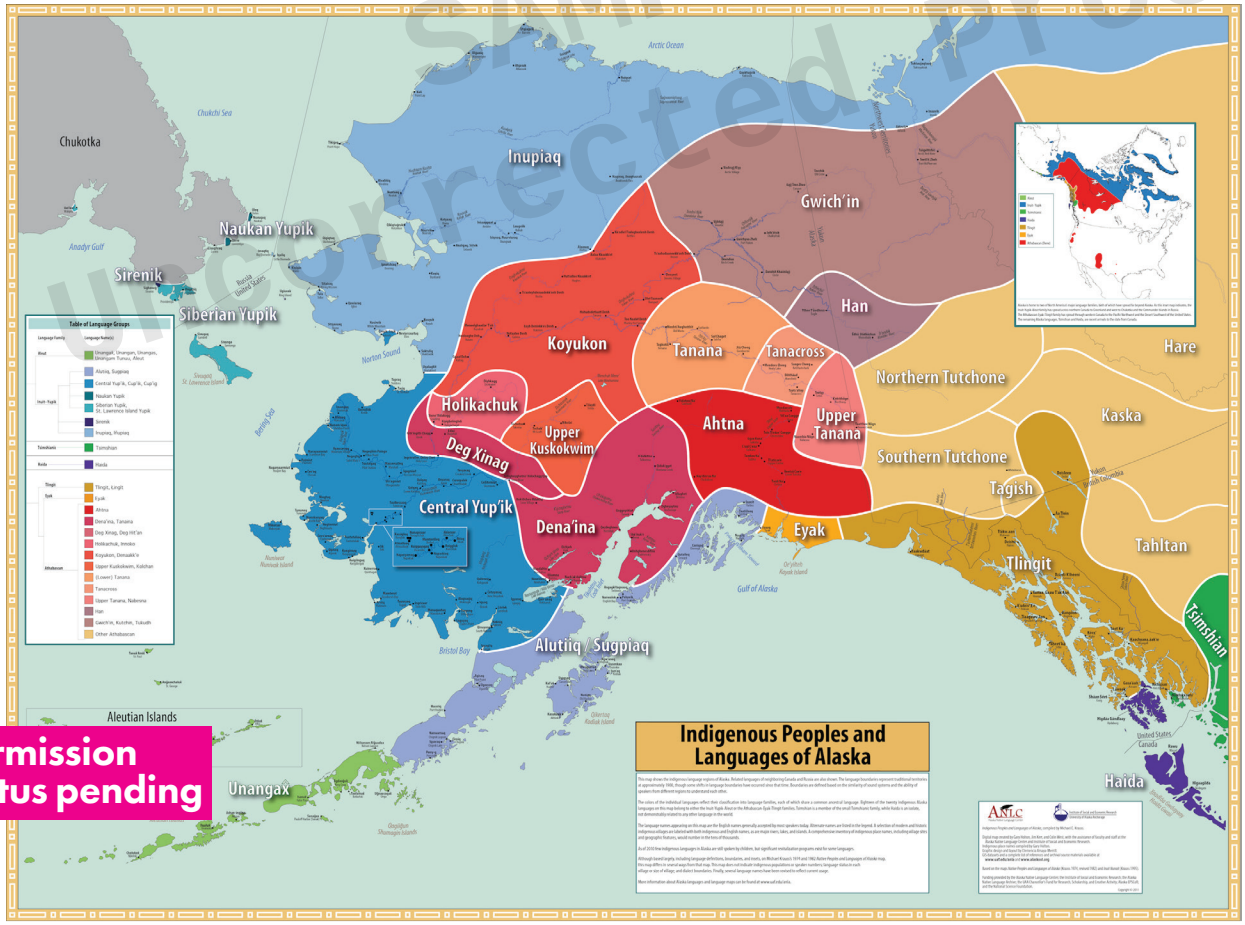
and Canadians share infrastructure, resources, and cultural histories. With Alaska's close proximity to Russia and being under Russian ownership until 1867 when it was purchased by the US, many Russian influences still exist today.[1]

Alaska's Indigenous languages are as varied and complex as the land itself. Within Alaska, there are five main regions separated by language boundaries. Among these regions, there are at least 11 distinct cultures[1]:

- Inupiat and St. Lawrence Island Yup'ik people mainly live in the northern and northwestern coastal regions.
- Yup'ik/Cup'ik people typically live in the western and Southwest area.
- Athabascan peoples live in the Southcentral interior region.
- Coastal Alaskan Native people (Eyak, Tlingit, Haida, and Tsimshian) reside in Southeast Alaska.
- Unangax̂ and Alutiiq (Sugpiaq) are the people of the Aleutian Islands, the Pribilof Islands, the western tip of the Alaska Peninsula, the Kodiak area, and the coastal regions of Southcentral Alaska.

The majority of Alaska's population resides in the urban areas, including Anchorage, Fairbanks, Juneau, the Kenai Peninsula, and the Matanuska-Susitna Valley. Connected by roads, railroads, and water systems, these communities are central to Alaska's supply chain. Alaska has a total population of just over 732,000, and Anchorage is home for close to half of the state's population, at over 289,000 people in 2022.[2]

FIGURE 1 Indigenous People and Languages of Alaska



permission status pending

Krauss M, Holton G, Kerr J, West CT. Indigenous peoples and languages of Alaska. Alaska Native Language Center and UAA Institute of Social and Economic Research. Fairbanks, AK; 2011.

Compared with 2020 US population data, the Alaska Native population is younger overall. A larger proportion (52.7%) of the Alaska Native population was aged 29 years or younger compared with 38.3% in the US. One in five (19.4%) Alaska Native people are aged 9 years and younger compared with 12.2% in the US, and older adults aged 65 years and older accounted for 8.6% of the total Alaska Native population compared with 16.5% of the US population. About three-quarters of the Alaska Native total population are between the ages of 0 to 44 years. Approximately one in five (19.4%) Alaskans is Alaska Native or American Indian. Of those, roughly one-third, or 52,082, currently reside in Anchorage.[3] There is a steady trend of Alaska Native people moving into urban areas to access services, job opportunities, and healthcare. As a result, the traditional Alaska Native value of sharing traditional foods is increasingly important. The sharing and exchange of traditional foods is essential to the nutrition, health, and sovereignty of Alaska Native people. Although the population is dense in the urban areas of Alaska, it is important to note that many of Alaska's Indigenous peoples choose to reside in small villages or remote, regional hub communities on or near their traditional lands.

In the Southeast region, Juneau is Alaska's state capital and the largest city in the region, with about 32,000 people.[2] Juneau is accessible only by water or air. Alaska's state ferry system, referred to as the "marine highway," connects communities such as Juneau to other coastal communities and the lower, contiguous 48 US states. More than 10% of Juneau's total population consists of Alaska Native people, the majority of which are of Tlingit, Haida, and Tsimshian descent.

Because of the state's large size and different geographical regions, Alaska's climate varies greatly, as do Alaska Native people's traditions, beliefs, hunting, fishing, and gathering practices. The winter season in Southeast Alaska is mild, with average temperatures ranging from 19° to 40° F. The Southeast is classified as a temperate rainforest and receives substantial rainfall, resulting in vast timber growth and dense forests. This climate makes it ideal for salmon fishing, deer hunting, and plant and shellfish harvesting. The winter temperature in the northern regions of Alaska is quite different and can reach temperatures of –60° F. Seasonal cycles in this region mean a lot of food preservation takes place in the summer and fall months, and the winter season will often engage people in activities such as tool mending, crafting, and storytelling. Geographical and broad weather conditions make for differing traditional food availability and dietary patterns, along with varying lifestyles among Alaska Native families.

Throghout Alaska, seasonal daylight variations and temperatures exist and contribute significantly to the differences in local plants and traditional harvesting activities. In the far north, weather conditions are more extreme, ranging from 24 hours of daylight in summer to lengthy periods of darkness in winter. In northern communities such as Utqiagvik (pronounced "oot-kay-ahg-vik,"), formerly known as the city of Barrow, the amount of daylight correlates with hunting, eating, and celebration patterns. In the southwest, also known as the Yupik and Alutiiq/Unagan regions of the state, the weather is unpredictable, typically including high winds and seas, overcast skies, low visibility, and colder temperatures. These conditions make access into and out of rural communities difficult, which can lead to elevated food prices and often limited or poor-quality commercial food availability.

Refer to the section opener on page xxx for more about Indigenous people in the US and their cultures, including Alaska Native people.

Common Health Concerns

Alaska Native people were known for their low incidence of disease because of their active subsistence lifestyle consisting of traditional food consumption and harvesting practices. Due to the impact of colonization and persistent health inequities, Alaska Native disease rates have trended upward in recent years, often at higher rates than the national US average.[4] There are expanding movements to increase resiliency and strength through cultural activities, values, and practices that enhance intergenerational relationships and hands-on learning through storytelling, songs, dance, arts and educational workshops. Increased access to quality and culturally responsive healthcare services through the lifespan is a key component to reducing chronic disease in Alaska Native communities. Strategies to change the policies, systems, and environment in which people live can support healthy behavior changes to enhance healthy lifestyles and reduce chronic disease.[5,6]

Infant and Child Nutrition

According to the Alaska Native Epidemiology Center, in 2019, the unadjusted birth rate for Alaska Native people statewide was 18.4 births per 1,000 persons, which was 1.6 times that of Alaska Whites.[7] Alaska Native people also breastfeed their babies at higher rates than the overall US average. In 2019, over 90% of Alaska Native women initiated breastfeeding, and at 8 weeks post-delivery, nearly 74% were still breastfeeding.[8]

As children age, access to healthy foods can affect Alaska Native families' eating patterns. Because of the large geographic distribution and remoteness of communities across Alaska, fresh fruits, vegetables, and other healthy options can be hard to access in local grocery stores, leading to increased consumption of processed foods. The consumption of store-bought processed foods, including sugar-sweetened beverages, can have a negative impact on the health of Alaska Native people. From 2018 to 2019, 52.5% of Alaska Native mothers of 3-year-old children reported that their child did not drink any sweetened drinks (excluding soda) on the previous day and did not drink any soda, respectively, compared with 80.6% reported by Alaska White mothers, and 73% among Alaska overall. About 84% of Alaska Native mothers reported that their child did not drink any soda in the previous day, which reflects a significant increase in abstinence from 2014 to 2015.[9]

Diabetes

According to the US Centers for Disease Control and Prevention (CDC), from 2018 to 2019, American Indian and Alaska Native adults had the highest rates of diagnosed diabetes (14.5%) among all US racial and ethnic groups, compared with 7.4% in non-Hispanic White adults.[10] The prevalence of diagnosed diabetes among American Indian or Alaska Native people increased significantly from 2006 to 2013 but decreased significantly from 2013 to 2017.[11] Although undocumented, this decrease may be attributed to increasing access to health care and services to provide early intervention and health education. The Special Diabetes Program for Indians shows successful contributions with community-based, driven strategies and a best-practices focus to improve diabetes outcomes. Improvements in diabetes outcomes include a decrease in diabetes prevalence, mortality, kidney failure, hospitalizations for uncontrolled diabetes, and diabetic eye disease.[12] According to the American Diabetes Association, in 2018 about 8.8% of the adult population living in Alaska had diagnosed diabetes, while 33.8% had prediabetes.[13]

Overweight and Obesity

From 2015 to 2018, 36.3% of Alaska Native adults had obesity; the percentage of Alaska Native adults who had obesity varied by Tribal Health Region, ranging from 28.5% to 55.3%.[14] Access to healthy foods, socioeconomic disparities, and inclement weather conditions are among significant contributors to current obesity rates. During 2017, about 18.0% Alaska Native adults reported meeting the recommendations for physical activity.[15]

Cardiovascular Disease

From 2016 to 2019, the heart disease mortality rate for Alaska Native people was 183.3 deaths per 100,000 compared with 120.8 deaths per 100,000 among Alaska nonnative people.[16] Although traditional Alaska Native diets consist of lean protein foods, often high in omega-3 fats and low in saturated fats, Alaska's history with colonization and persistent health inequities have contributed to changes in diet and other lifestyle practices. These changes include using commercial tobacco products, adoption of western eating habits and foods, and decreased physical activity, all of which may contribute to health disparities in chronic disease in Alaska Native people. Shelf-stable processed foods high in calories, sugars, and fat are often less expensive and at times the most available foods in Alaska's grocery stores in remote communities. Current strategies to improve health through reduction of health disparities such as increasing access to health care, jobs, healthy cultural foods, educational opportunities and culturally tailored prevention activities are a strong focus to reducing disease rates.[17]

Cancer

Data from 2016 to 2019 shows that cancer is the leading cause of death among Alaska Native people.[18] Some cancers that are more common among Alaska Native people than US Whites include colorectal, lung and bronchus, nasopharynx, esophageal, kidney, and stomach. Alaska Native people have among the highest rates of colorectal cancer in the world.[19] Ongoing research is investigating whether increased fiber in the diet will result in healthier bacteria in the colon to reduce or prevent risk of developing colorectal cancer.

Social Determinants of Health

Historically, Alaska Native people were known for low occurrence of disease related to protective factors such as traditional foods and harvesting activities; cultural values; ways of life; and connections to land, family, and community. The influence of western culture via early Russian occupation and ownership, and eventually the purchase of Alaska by the US in 1867 leading to statehood in 1959, had a devastating impact on Alaska Native people who had lived on those lands for thousands of years. Alaska Native people were forced from their homelands, many of their children were sent to boarding schools, and their ways of life were discounted by western society. As a result, many generations of Alaska Native people are socially and emotionally affected by intergenerational or unresolved trauma, which has also contributed to health disparities in alcohol and drug use. From 2016 to 2019, alcohol use was the eighth leading cause of death among Alaska Native people and suicide was the fourth leading cause of death.[18] As past injustices are revealed for the first people of Alaska, healing and activities for building resiliency through culture are being implemented as protective factors.

Food Availability and Insecurity

Although Alaskan lands are rich in nutrient-dense plants and protein sources, commercial food consumed in Alaska is often very expensive. Almost one-quarter (23.2%) of Alaska Native people have a total family income that falls below the federal poverty level, significantly higher than the general Alaska and the US White population.[20]

Many families maintain multiple jobs outside of the home to sustain their family. This reduces time for traditional food harvesting, preparation, and preservation. The costs of hunting and preserving traditional foods such as fuel and transportation can also be a barrier to those with limited incomes or those who work full-time jobs. Warming climate changes affects the environment, land, water, and animals, in addition to disrupting the traditional food supply for families who have depended on hunting, fishing, and gathering these foods for generations.[21] Increasing reliance on store-bought foods, coupled with a decrease in traditional food harvesting can impact food security, which often leads to decreased consumption of nutrient-dense foods and higher intakes of less nutritious processed foods.

Government and Tribal Nutrition Services

Many federal, state, and tribal nutrition programs are available in Alaska, which provides services to the Alaska Native and nonnative populations. Federal programs include the Supplemental Nutrition Assistance Program (SNAP); the Commodity Supplemental Food Program (CSPF); and the Women, Infants and Children (WIC) Farmers Market Nutrition Program (FMNP). The WIC Program provides nutrition and breastfeeding education, counseling, support, nutritious foods, and referrals to needed services.

Another food resource, operated by the Alaska Native Tribal Health Consortium (ANTHC) is the Food Distribution Program on Indian Reservations (FDPIR), which provides access to healthy food for those in need. The program, funded by a US Department of Agriculture Food Nutrition Service grant, provides food packages to eligible Alaska Native households in tribal communities (on reservations and in approved areas that include at least one member of a federally recognized tribe).[22]

Tribes also can provide nutrition service support to tribal members in various ways, including via traditional food distributions, classes, harvesting education, and support; they may also provide food storage items, such as freezers and vacuum sealers. Many small communities have access to farmers' market boxes in the summer; many urban grocery stores now deliver foods for a small fee.

Access to Health Care

Anchorage is home to the Alaska Native Tribal Health System's central hub and hospital, the Alaska Native Medical Center (ANMC). ANMC offers advanced healthcare treatment to Alaska Native and American Indian people and is comanaged by Tribal Health Organizations (THO), Southcentral Foundation (SCF), and ANTHC. Current focus in the ANTHC is on comprehensive healthcare and prevention services built on the strengths of Alaska Native culture, patients working in close partnership with healthcare providers, and staying connected via telemedicine.[23] See Figure 2 Alaska Native Health System Map.

Most Alaska Native people rely on and receive their

FIGURE 2 Alaska Native Health System

[permission request sent]

health care through the ANTHC system, which is partially funded with federal dollars. Other monies to support programming can be obtained through insurance billing, other federal, state or foundation grants, charitable contributions, and other funding opportunities. Limited funding can impact a Tribal Health Organization's (THO's) ability to offer varying or expansive nutrition programs. Most villages in Alaska use a community health aide (CHA), a local trained healthcare professional working under the guidance of a physician and what is known as the Alaska Community Health Aide Manual. CHAs provide emergent, acute, or chronic care to the community. Other types of health aides in Alaska include behavioral and dental health aides.[24]

Traditional Health Beliefs and Practices

Many Alaska Native healing practices going back thousands of years are followed with an increasing interest and resurgence today. Traditional health beliefs and practices focus on prevention; living in a reciprocal relationship with the land, plants, spirits and animals; seasonal harvesting; family and community support systems; and life lessons taught through storytelling, observance, and hands-on learning.

Foreign influence and westernization discouraged traditional healing beliefs and practices of many Alaska Native people, and in many circumstances, traditional health practices were not allowed. Currently, many Alaska Natives are interested in recovering cultural activities that were once denied or lost and revive them through storytelling, written accounts, recordings, and various forms of education. Traditional Alaska Native values and beliefs for promoting health, preventing disease, reducing pain, and enhancing emotional wellness are being incorporated into practices by western-trained physicians. At the Anchorage Native Primary Care Center, operated by Southcentral Foundation, customer-owners can receive traditional healing services from tribal doctors in combination with care from their conventional healthcare providers.

Many Alaska Native communities use a traditional healer, an entrusted member of the community with abilities, knowledge, and skill in various cultural forms of healing.

There are many different names for traditional healers throughout Alaska. Traditional healers may come from a long line of traditional healers, receive training from another traditional healer, or may have an inborn knowledge and skill transcending generations. Traditional healers may work with various forms of healing to include plant medicine, prayer, body manipulation, arts and crafts, song and dance, talking circles, or one-on-one counseling.[25]

Traditional Plants as Food and Medicine

A vibrant part of the traditional history of the Alaska Native people is the use of plants for food and medicine for nutritional purposes, prevention of disease, and treatment of ailments such as colds, coughs, flu, bug bites, cuts, and stomach aches. Some parts of this tradition are still practiced today; indeed, traditional plant knowledge has been passed down from one generation to the next. Treatments may include use of whole plants or plant parts. Leaves, roots, bark, fruits, flowers, bulb, resin, and seeds are used for healing through infusions, salves, decoctions, tinctures, as poultice, chewed in raw form, and in steam inhalation. What specific plants are used, how they are used, and what they are called are as diverse as the cultural and language groups of the Native people in Alaska.[26] The varying climate zones and ecological environments, from tundra and coastline to Arctic and forest, lend to differing plant types and usages among the various regions. Devil's club, Labrador tea, and fireweed are among several commonly known and used plants in traditional healing.

Devil's club (*Oplopanax horridus*) is considered one of the most powerful medicinal and spiritual that Alaska Native people use. It is considered a sacred medicine by many from Southeast and Southcentral Alaska. A member of the Araliaceae or ginseng plant, devil's club is purported to treat arthritis, fever, wounds, and respiratory and gastrointestinal conditions. The inner bark of devil's club root is boiled to make an infusion ("tea") or made into a topical salve.[26–31]

Fireweed is a widely enjoyed traditional plant, as all parts of the plant can be used for food and medicine. Infused leaves are consumed as a soothing drink to relieve an upset stomach or constipation. Cut raw stem can be applied to skin ailments like cuts and boils to aid in healing.[26–31]

Labrador tea (*Ledum palustre*) is the common name for the three related plant species from the Rhododendron family. The leaves and flowering shoots may be steeped in water to create a drink that may help treat inflammatory conditions such as rheumatism and skin troubles, as well as relieve colds and stomach issues.[21] Labrador tea is used by Athabascan, Haida, Inuit, Tlingit, and Tsimshian people; it is also called Tundra Tea, *Ayuq*, or Hudson Bay tea. Experts recommend caution with Labrador tea and suggest only drinking it in small amounts due to a substance ledol, which can cause sickness such as cramps and heart palpitations. Pregnant women should avoid drinking Labrador tea.[26–31]

Blueberry bushes (*Vaccinium alaskanum*) are one of the dominant shrubs in Alaskan coastal forests and in forest openings. The berries are used as a food, and a tea-like beverage made from the leaves and branches is believed to help lower blood sugar. Berry juice can be used as a wash for a sore mouth or a gargle for a sore throat.[26–31]

Trees are used throughout Alaska for their healing, decongestant, and pain-relieving properties. The cottonwood tree (*Populus balsamifera*) is a member of the willow family and is known for its aspirin-like qualities. The resin in the cottonwood buds is used as a healing salve to sooth and relieve pain. Branches from the birch tree family, such as alder and white birch were often used as switches in a steam bath to relieve aches and pains. Spruce needles can be used as a decongestant by boiling the branches in hot water or by drinking the fresh tips in tea infusion.[26–31]

Wormwood, also known as stinkweed, is a highly prized and powerful traditional medicine. It is known by many different names depending on the region. It can be consumed in small amounts as a healthful tonic, to relieve sore throats, or applied to cuts and sore muscles.[26–31]

Ethical plant harvesting practices are seen as vital to the sustainability of the plants and necessary to ensure that plants will grow plentifully each year. Interest in traditional plant knowledge is reemerging. It is important to respect the traditional knowledge of Indigenous peoples and follow intellectual property laws that protect cultural practices, knowledge, and resources. Alaska Native people show respect to the land by taking only what is needed and offering something in return for harvesting the plant, such as water, tobacco, a prayer, and more. A key reminder is to always learn from a traditional healer or other plant expert and to ensure that a plant is 100% identified, as many plants have poisonous look-alikes.

Traditional Food Practices

For Alaska Native people, the harvesting, processing, eating, and sharing of foods is essential to individual, group, and cultural identity. Understand the diversity of Alaska Native people and their customary food practices is challenging, so it is important that practitioners consider tribal, regional, and sometimes clan affiliations. Alaska's many tribes are driven by their values and cultural norms, which can be similar from one tribe to another. For example, Alaska Native people hold the highest regard or respect for their ancestors, animals, nature, and humanity. Their cultural and customary hunting, fishing, growing, and gathering practices all center around respect and giving thanks to what provides them nourishment.[32]

For Alaska Native people, traditional foods are an integral part of the culture as well as parts of their physical and spiritual health. Historically, traditional foods were managed with care and reciprocity by Alaska Native people so that a sustainable harvest was a continuously available resource. Every plant or animal part (flesh, bone, and skin) was used for food and also to make baskets, utensils, clothing, and other tools. Today, many of these practices remain so that nothing is wasted and the land is taken care of to ensure that the earth, harvested plants, and animals are always respected.

Common traditional foods consumed by Alaska Native people are listed by region in Box 1.[32,33]

Harvesting Traditional Foods

Alaska Native people have lived off the land for thousands of years, nourished by wild greens, seaweeds, roots, berries, shellfish, marine mammals, finfish, birds, bird eggs, and large and small game. Today, Alaska Native people still harvest and eat traditional foods with the same respect and gratitude for what the land provides.

Historically, many Alaska Native tribes relied heavily on traditional methods of hunting, fishing, and gathering, which included migrating to seasonal harvest locations. Today, fewer Alaska Native people migrate for seasonal harvesting because of modern living conveniences, but some still travel to their family fish camps or favorite harvesting areas to find available food sources. Fish camps are a favorite place to work together, share traditional foods, celebrate, and engage in harvesting traditions. These shared practices are an integral part of their cultural, family, and community well-being.

Some tribal communities incorporate various forms of crop cultivation as a traditional part of their food ways. A well-known example involves the Tlingit and Haida people of Southeast Alaska who were known to cultivate potatoes and other wild plants in the spring and return to harvest their bounty in the late summer. The origin of potatoes in this region is unclear, but they are thought to trace back to trade routes to Mexico and South America and contact with Europeans. Athabascan people were known to grow potatoes, vegetables, and even some cereal grain for food and trade, which they possibly learned from the Hudson Bay Company. Historians know less about gardening traditions practiced by other groups of Alaska Native people. Today, community and school gardens, along with increasing interest in agriculture and mariculture, are on the rise in Alaska. Climate change and a strong movement for food sovereignty by Alaska Native people are motivating an interest to manage their own resources and define their own cultural-based food systems with a local voice, while considering new information and technologies that may work in their regions to expand and maintain the food systems. Food sovereignty also helps to ensure food security; a food-secure community is a protective factor and contriubtes to a strong, vibrant, and resilient community.

Food Preservation and Preparation Methods

Reliable food storage and preservation methods for traditional food have been essential for Alaska Native people for survival and to ensure nourishment throughout all seasons.

Historically, communities in the North Slope of Alaska often relied on underground food cellars as a way to preserve harvested food. Cellars dug into permafrost, soil that remains frozen year-round, provide a natural source of refrigeration for traditional foods such as meat from land animals, marine mammals, fish, birds, and plants. Some cellars do not maintain temperatures below freezing all year but may still be used to age and ferment foods. Communities in other regions of Alaska used temporary cellars, in non-permafrost soil, to ferment and age fish and marine mammals. Aboveground, elevated structures, referred to as caches, are also used throughout Alaska for food storage and preservation. Climate change may pose risks to cache and cellar use due to hazards from storms, flooding, and changes to stability of the structures. While some communities in Alaska continue to use cellars and caches for food preservation, electric refrigerators and freezers are now common.

BOX 1

Common Alaska Native Traditional Foods by Region[32,33]

Inupiaq (North Slope Borough, Northwest Arctic Borough [Including both Bering Strait and Norton Sound Health Corporation Regions])

Moose
Caribou
Herring
Salmon
- King (Chinook)
- Sockeye (Red)
- Silver (Coho)
- Pink (Humpies)
- Chum (Keta)

Seal, seal oil
Tomcod
Whitefish
Bowhead and Beluga whale
Muktuk (whale skin and blubber/fat)
Sheefish
Walrus
Geese
Ptarmigan
Seagull eggs
Crowberries
Blueberries
Cranberries
Cloudberry
Beach greens
Dandelion greens
Fireweed leaves
Wild Rhubarb
Seaweed
Sourdock
Tundra Tea
Wild chive

Athabascan (Interior: Tanana Chiefs Conference region and YK Delta)

Moose
Beaver
Muskrat
Caribou
Duck
Grouse
Salmon
- King (Chinook)
- Silver (Coho)

Sheefish
Whitefish
Goose
Cranberries
Raspberries
Blueberries
Fireweed
Wild onion
Wild rhubarb
Wild potato
Fiddlehead
Labrador tea
Sourdock

Unangax̂/Alutiiq (Eastern Aleutian Tribes)

Moose
Caribou
Beaver
Porcupine
Salmon
- King (Chinook)
- Sockeye (Red)
- Silver (Coho)
- Pink (Humpies)
- Chum (Keta)

Pike
Whitefish
Halibut
Smelt
Octopus
Seal, seal oil
Sea lion
Sea otter
Trout
Goose
Ptarmigan
Duck
Chitons, clams, sea urchins
Chocolate lily
Beach lovage
Cow parsnip
Labrador tea
Fiddlehead
Fireweed
Seaweed, kelp
Wild chive
Crowberries
Salmonberries
Cranberries
Blueberries
Nagoonberry

Yup'ik–Cup'ik (Yukon-Kuskokwim Delta Health Corporation region)

Moose
Caribou
Salmon
- King (Chinook)
- Sockeye (Red)
- Silver (Coho)
- Pink (Humpies)
- Chum (Keta)

Whitefish
Herring
Blackfish

Box continues

BOX 1 *(continued)*

Lush fish
Seal and seal oil
Beluga muktuk
Muktuk (whale skin and blubber/fat)
Pike
Geese
Ptarmigan
Tundra tea
Crowberries
Cranberries
Blueberries
Cloudberries
Beach greens
Fiddlehead ferns
Fireweed
Kelp
Lamb's quarter
Nagoonberry
Oysterleaf
Wild rhubarb
Sourdock
Spruce tips
Stinging nettle
Watermelon berry
Wild chive
Goosetongue

Tlingit, Haida, Tsimshian (Southeast Alaska Regional Health Consortium region)

Deer
Moose – select areas
Shellfish
- Shrimp
- Dungeness crab
- King crab
- Clams

Salmon
- King (Chinook)
- Sockeye (Red)
- Silver (Coho)
- Pink (Humpies)
- Chum (Keta)

Halibut
Seal and seal oil
Black cod, cod, and lingcod
Yellow-eye snapper
Herring and herring eggs
Seaweed, kelp
Sea asparagus
Salmonberries
Huckleberries
Blueberries
Crowberries
Thimbleberry
Watermelon berry
Strawberries
Labrador Tea
Chocolate lily
Beach Greens
Fireweed
Goosetongue
Sourdock
Fiddlehead
Stinging nettle

Other common methods of food preservation include drying, freezing, canning, salting, and fermenting. Foods that are often canned or jarred include salmon, wild game, sea asparagus, and berry preserves. Land animal and marine mammal meat, fish, and plants may be dried or salted. Traditional Alaska Native fermented foods include fish heads, fish eggs, beaver tail, seal and walrus flipper, and whale. Some food preservation methods are also a means of preparation, such as canning, smoking, drying, or storing in fish or seal oil. Other common methods of food preparation include baking, frying, steaming, and boiling. Examples of foods with preparation methods unique to Alaska include the following:[33]

- Seal oil is a popular food across Alaska. It is rendered from seal blubber and is often used as a dipping oil for dried meat or fish and a variety of other foods, a preservation for harvested plants, or a flavoring in dishes such as soups, stews, and akutaq (agutak).
- Muktuk (maktak) is whale blubber and skin. It is eaten raw or frozen but may also be cooked or pickled. Whale is primarily harvested in northern, coastal communities, but it is often shared among tribes and enjoyed by many.
- *Akutaq/agutak* is a popular dessert consisting of a blend of berries and whipped fat (caribou, reindeer, moose, seal, or Crisco). There are many variations of *agutak*, and the ingredients often reflect the recipe's region. Meat or fish, harvested greens, or sugar may be added.
- Fish head soup is a highly valued dish, consumed throughout Alaska Native communities. It is typically made by boiling cut fish heads in water or broth and may include additional ingredients such as onion, celery, carrots, potato or rice, and seaweed or beach greens.
- Fish pie is a baked dish prepared with simple ingredients such as rice, fish, and a crust. Various other ingredients

such as onion, cabbage, and other vegetables may be mixed in. Recipes for fish pie commonly use salmon but depend on what type of fish is available.

- Herring eggs are an Alaska Native delicacy. They are normally harvested on ribbon kelp or hemlock branches. They may be eaten raw, poached, or dried.

Traditional Meal Patterns

Traditional Alaska Native diets are high in animal and fish proteins, healthy fats, with plant foods (berries, greens, roots, seaweed) in lesser amounts but still a significant part of diet, especially during the summer months.[26] The most prevalent nutrients in a traditional Alaska Native diet are vitamins A and B12, omega-3 fats, iron, and protein. Traditional plants, although consumed in small amounts, also contribute important nutrients to the overall diet. Reasons for eating more traditional foods include the belief that they are more nutritious, healthier, tastier, and less expensive than store-bought foods, along with being culturally important.[32]

Salmon is a foundational, cultural, and traditional food among Alaska Native people throughout the state. Salmon has important connections to the culture, economy, spirituality, and Alaskan way of life that goes back thousands of years. This food source helps to sustain tribes throughout the year today, as it did millennia ago. In recent decades, factors like climate change and policy issues related to fishing are contributing to decreased salmon runs and access, which is having a detrimental impact on access to this traditional food source.[34] Recognizing the vital role that salmon plays in the culture and economy of the Alaska Native population, many efforts are focused on salmon stewardship.

Many Alska natives are increasing consumption of added sugars, saturated fats, salt, refined grains, and other processed foods.[32] For many Alaska Native families, especially along coastal regions, Russian colonization influenced diet and meal preparation with the introduction of flour, salt, and domesticated animals. Dishes like fish pies, breads, and fried pastry became a common part of household meals. American influences also brought increased access to flour, sugar, salt, and domesticated animals, which changed dietary consumption patterns, blending traditional foods with commercially purchased foods.[1]

Reasons for decreased intakes of traditional foods can include cost of gear and equipment, fewer hunters in the

community, more full-time jobs, less time to hunt and gather, moving away from the village, lack of or expensive transportation, decreases in understanding of traditional knowledge, and reduction in availability or quality of traditional foods.[32]

However, many programs today are focusing on a resurgence of traditional foods in home meals and in a variety of other settings: health care and long-term-care facilities, schools, correctional facilities, food assistance programs, community organizations, and tribal entities. This includes traditional harvest and preparation practices. "Knowledge bearers" assist in these practices, typically Elders who have a memory of traditional foodways and knowledge of food harvest and preparation. In the Alaska Native culture, an Elder is a respected individual who has a wealth of cultural information and knowledge to share and has lived an extended and healthy life. *Store Outside Your Door* is a tribal health web-based video series that highlights different communities' cultural activities and traditional food practices to be shared with future generations and medical providers (see Resources on page XXX). These videos feature Elder interviews in their traditional language, Alaska Native wisdom, and the nutrient content of traditional foods.

From region to region, Alaska's climate, soil, and geography may produce similar plant-based foods but with different—perhaps higher—nutritional profiles. A study performed by the Department of Natural Resources and Environmental Sciences examined wild berries growing across Alaska and found that more extreme climates can significantly affect the nutrient content. Berries that grew in harsher climates protected themselves by producing higher levels of antioxidants.[35] These antioxidants act as protective factors, positively impacting health when consumed. Another study showed that wild berries collected and tested in the first experiment ranged from three to five times higher in ORAC (oxygen radical absorbance capacity) value than cultivated berries from the lower 48 states.[36] Alaska Native people often speak about how store-bought blueberries do not compare to the flavor of those picked wild in Alaska.

Whether harvested from the land or sea, traditional foods are sources of macronutrients and micronutrients and are high in antioxidants and phytonutrients. The nutrient density of traditional foods, the physical energy and effort required to harvest them, and the connection within tribal communities and culture lead to healthy and thriving Alaska Native populations.

In Alaska Native communities, multigenerational households are common, often with grandparents and grandchildren living in the home. Meals commonly include extended family members, as sharing foods is an Alaska Native value and traditional foods are eaten and enjoyed together. In rural Alaska, meals are prepared and consumed at home. Alaska Native people living in urban areas may eat away from the home more often, as restaurants and grocery stores are more accessible. Although there is atrend to purchase more foods from stores, meals served in rural areas are more likely to consist of a blend of traditional and store-bought foods than of urban meal patterns.

Special Occasion Foods: Traditional Rituals, Celebrations, and Holidays

Food is an integral part of Alaska Native cultures and of many tribal rituals, celebrations, and community or family special occasions. Today, Alaska Native people may celebrate both traditional spiritual holidays and Christian holidays, such as Christmas. Alaska Native calendars include most US federally recognized holidays. Indigenous Peoples Day (the second Monday in October) and Elizabeth Peratrovitch Day (February 16) are celebrated statewide. Born in 1911, Peratrovich was an American civil rights activist, Grand President of the Alaska Native Sisterhood, and member of the Tlingit nation who worked for equality on behalf of Alaska Native people.

Tribes gather for a biennial Haida, Tlingit, and Tsimshian cultural event in Juneau called Celebration during the first week of June to pass on cultural knowledge to Alaska Native children. This 4-day event, which began in 1982, includes traditional canoe racing; dance performances; Northwest Coastal arts; film screenings; poetry gatherings; Native fashion shows; language, cultural, and history workshops; food; and more. Food contests offer a way to introduce traditional Native foods and their health benefits.[37]

Large gatherings with food are not limited to holidays, funerals, and other special events. Significant traditional food-based harvesting events are also celebrated. For example, in Utqiagvik (formerly Barrow), when a bowhead whale is harvested, the community comes together and eats the whale's blood, meat, and fat to celebrate and honor the harvesters. In Sitka, tribal members come together annually to celebrate the harvest of herring eggs and honor sustainable herring harvesting for future generations.

Many events celebrated in Alaska Native cultures include food at the gathering referred to as a potluck or potlatch. For many Alaska Native families, participating in these activities is an honor, and they pay tribute to Elders by sharing the harvest with them and ensuring that they are served first. These events often begin with a blessing or prayer.

Current Food Practices

Alaska Native tribes and communities have experienced many changes since the first contact with the West during the historical Russian occupation of the region in the 1700s, followed by the gold rush and Alaska becoming a US territory in the 1800s, statehood in the mid-1900s, and more recent influences that have come with the oil industry, commercial fishing, tourism, and more.

These many influences have impacted the diets of the Alaska Native people. During this time, loss of access to lands and traditional hunting and harvesting rights often limited traditional food intake coupled with an increase in consumption of western foods. This coincided with an increase in chronic health conditions like diabetes, heart disease, and cancer.[38]

Today, approximately 95% of commercial foods are imported.[39] Consequently, with these dietary changes there is often an increased intake of processed foods, sugary drinks, and store-bought, packaged foods, as noted in Box 2. Many efforts in Alaska Native communities are underway to reduce the reliance on the modern food consumption practices and to return to more traditional foodways, sustainable harvests, and self-reliance around food.

Common nutritional concerns are related to intakes of calorie-dense, nonnutritive foods, especially sugar-sweetened beverages. Healthy Alaskans 2030, a statewide health improvement plan managed jointly by the ANTHC and the State of Alaska's Department of Health and Social Services prioritizes a number of objectives related to healthy weight for children, reducing intake of sugary drinks, and increasing physical activity among adolescents.[40]

Concerns have been expressed about toxins and contaminant levels in traditional foods, especially for those foods consumed in high amounts today, such as moose, caribou, fish, seal, plants, and berries. Some contaminants are concentrated more in certain parts of the animal, such as the liver, kidneys, or fatty tissue. Traditional foods are still recommended until further studies are done, as the benefits of consuming and harvesting traditional foods appear to outweigh the risks.[32]

BOX 2

Examples of Energy Dense, Nontraditional Foods Consumed by Alaska Native People

Sugar-sweetened beverages:

- Soft drinks
- Fruit juice–flavored drinks
- Energy drinks
- Powered fruit beverage mix

Pre-packaged foods

White rice

White bread

Pilot bread (hardtack, or hearty flat bread with a long shelf life)

Counseling Strategies and Considerations

Understanding and respecting the culture and tribal histories of the land is essential for effective nutrition counseling. Traditional lifestyles should be encouraged, but challenges that Alaska Native families and nutrition practitioners face in today's environment must be recognized. For example, a common feeding practice globally and in some areas of Alaska includes family members prechewing food for their babies. Current guidelines are that this practice poses risks for transmitting pathogens that cause illness; however, many families in Alaska continue this practice, similarly to others around the globe.[41] Breastfeeding is encouraged, and many mothers may breastfeed their children into toddlerhood and even beyond.

Alaska Native people often engage in a blend of Western and traditional practices, use current technology, receive education, and hold professional jobs, but they also continue to speak their language, harvest traditional foods and plants, and participate in cultural activities such as crafts, song or dance, and practicing the traditional values of their people. Elders are more likely to follow a traditional and subsistence food preference diet; however, some live in urban areas where access to traditional foods can be a barrier leading to poor health. The younger generations have more exposure and intake of prepackaged and convenience foods typical of a western diet.

As previously noted, Alaska is a costly place to live, food expenses are high, and food availability is limited in remote locations. There is often limited access to healthy, store-bought foods, potable water, and financial resources, all of which should be taken into consideration when providing nutrition counseling.

Nutrition counseling of patients with Alaska Native heritage depends heavily on individualized assessment and not on assumptions about their cultural heritage and involvement. Refer to Tips and Strategies for Nutrition Counseling and Care of Alaska Natives. Chapter 2 addresses general guiding principles for culturally sensitive nutrition assessment, communication, and counseling.

Tips and Strategies for Nutrition Counseling and Care of Alaska Native People

Use the cultural encounter questions on page X to help assess individual food and health practices.

Communication

Be aware that direct eye contact may be uncomfortable for some Alaska Native patients, as it could be a sign of disrespect. Watch the patient and mirror how they give eye contact. Some may look at you directly, others may just glance, and some may look downward.

Avoid speaking too loud or too fast and allow for pauses in conversation. Many Alaska Native people are quiet and respectful and tend to observe and reflect before responding. Be patient and allow time for patients to respond. For some, English is a second language.

Do more listening. Be mindful not to interrupt, not do the majority of the talking, not change the subject, and not ask too many questions. Allow adequate time for the patient's questions.

Be sensitive to properly interpreting the client's body language, such as nodding the head, which can mean "I understand," raising eyebrows, which can mean, "yes, I agree," and a furrowed brow, which can mean "I am confused, and I don't understand."

Acknowledge and respect the experience and wisdom of Elders; use the term *Elders* appropriately, referring to individuals who not only have lived a long life but also maintain a healthy lifestyle and have a wealth of culture information and knowledge. Avoid equating the terms Elders and older adults.

Refer to Alaska Native people as Indigenous or First Nations, or by their correct cultural affiliations. For example, use the tribal term Yupik or Inupiat, or the more general term Inuit, but never Eskimo. Ask an Elder or other cultural informant if you are unsure. Avoid generalizing based on where Alaska Native people live or their cultural or tribal affiliation.

Avoid sensitive topics: for example, avoid referencing Indigenous protocols or hierarchies in a joking way; do not refer to groups by western names such as Eskimo or Indian; and do not reference the amount of "Indigenous blood" (or blood quantum) a person possesses, which can be a controversial issue.

It is common for Alaska Native people to offer food or gifts as gratitude. Not accepting gifts or foods can be seen as disrespectful. Know in advance your policy regarding the appropriateness of accepting gifts.

Understanding of Health Conditions

In addition to the cultural encounter questions on page X, ask what a patient already knows about a health condition and if they have received treatment (medical or traditional). Talk about how other family or community members may also be managing a similar health condition.

Be aware that many Alaska Native patients from small villages may be shy and may not want to "burden" their health care providers with questions. If you have a trusting relationship, they will likely be very appreciative of information and education on health issues.

Do not assume that younger patients are not knowledgeable about a traditional diet or that an Elder is a traditional food expert. Instead, provide a safe environment for patients to express their personal levels of understanding and practice about food, traditions, and health beliefs.

If written materials are provided, provide those that are culturally sensitive to capture interest and connection. Engage the services of a translator for materials in a Native language; see Chapter 2. As a supporting resource, refer to Alaska Native Languages Apps, Fonts & Keyboards (www.alaskanativelanguages.org/fonts-keyboards) to find Alaska Native language smartphone applications.

Use of Complementary and Alternative Medicine

Ask whether patients consume traditional plants—and in what forms, what types, and how they harvest them. Seek support from naturopathic doctors in Alaska who are experienced in the use of traditional plant-based remedies and who can be a support to assist in navigating their use by Alaska Native populations. If there are no health risks, find ways to incorporate these remedies into a counseling plan.

As appropriate and when possible, involve other health providers in treatment teams. Many Alaska tribal health organizations now incorporate the services of tribal doctors, who may be certified by a credentialing body. They may have practice restrictions, which include the use of medicinal plants without agreement from a referring allopathic physician.[42]

Family Demands and Dynamics

Be mindful that many Alaska Native patients bring extended family or children to their appointments. Involve extended family in discussion and care plans when appropriate. Take time to understand

the patient's history and ask where they are from and where they live. Parents, grandparents, and extended family are of great significance and importance to most Alaska Native people.

Plan with the patient and family how to manage the diet-related health condition and support individual and family nutritional needs, recognizing the demands of work, cultural practices, and everyday life, and recognizing food access and resources for food storage and preparation. Know and understand the patient's community and the dynamics of their food availability.

Seek insights from Elders, as they can serve as invaluable informants for the lifestyles, food and health practices, beliefs, and other aspects of their Indigenous culture. Asking for their help also helps build trust with the client and their family and community.

Be patient, as schedules in rural communities often revolve around seasons, not necessarily by set schedules, which may lead to patients showing up late for their appointments.

Nutrition Counseling

Many traditional food resources show the nutrient benefits of traditional food, including the *Traditional Food Guide for the Alaska Native People*.[33] This guide contains nutrition information and preparation tips for wild Alaskan meats, fish, seafood, and plants that are part of Alaska Native food cultures, with the goal of preventing and treating chronic diseases.

Recommend reducing consumption of store-bought foods that are high in added sugars and saturated fats, and low in nutrient density (refer to Box 2).

If fresh vegetables or fruit are costly or unavailable, encourage canned, dried, or frozen produce (reduced in sodium and/or sugars as necessary). Encourage consumption of whole grain foods as appropriate. Gradually switching to whole wheat flour and whole grain products are potential strategies to increase fiber intake.

Encourage the consumption of traditional foods such as fish, game meat and birds, sea mammals and fish, and whale and seal oils. Educate patients about the health benefits of eating omega-3 fats (e.g., salmon, herring, trout, and whitefish, mammals, seal oil) at least twice a week.

If the client is interested in food preparation methods to decrease dietary fats, recommend using small amounts of fish oil, seal oil, or vegetable oil spread instead of butter or margarine.

Lactose intolerance is common among Alaska Native people. Suggest calcium-rich alternatives, including jarred/canned salmon (with bones), which is also a source of vitamin D. For those who are not intolerant of dairy foods, recommend shelf-stable, aseptic (ultra-high-temperature pasteurized) milk, evaporated skim milk, or powdered milk, which can be stored at room temperature for those with limited access to food stores.

Encourage clients to gather wild greens, pick berries, and grow vegetable gardens when and if the season, climate, and geography allow. Honor hunting, fishing, and foraging traditions.

Create a "pantry list" of shelf-stable foods, chosen for food variety and cultural preference—and that matches nutrition guidance for health and management of chronic disease, such as hypertension, cardiovascular disease, or diabetes.

Ask about food security and refer patients to supplemental food programs such as WIC, SNAP, FDPIR, tribal nutrition programs, and more as necessary.

Address food safety. Refer to guidance from the CDC (www.cdc.gov/botulism/botulism-alaska-foods.html), noting concerns about the high incidence of botulism, especially from fermented Alaska Native foods, seal oil, and dried, unsalted fish. Advise healthy options for shelf-stable foods (e.g., canned foods) for those in remote areas, with limited food access. Encourage following traditional ways of fermenting foods.

Find ways to include traditional foods on menus for food service programs and institutions that serve Alaska Native people, such as schools, Elder lunch programs, childcare centers, and healthcare facilities. The Alaska Food code allows the donation of traditional wild game meat, seafood, plants, and other food to a food service of an institution or a nonprofit program (note that certain foods are prohibited because of significant health hazards).[43]

Recognize challenges that are unique to living in remote areas of Alaska. For example, never assume that it is easy or even possible for someone to access safe water. Bottled water is often flown into the rural areas of Alaska that lack potable water. In some areas, water is more expensive than sugar-sweetened beverages.

Resources

Refer to Indigenous American Cultural Food and Nutrition Resources on page XX.

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