



DESIGNING CULTURALLY RESPONSIVE HEALTH & NUTRITION PROGRAMS

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APIAHF
ASIAN & PACIFIC ISLANDER
AMERICAN HEALTH FORUM

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About Us



The Asian & Pacific Islander American Health Forum (APIAHF)

is a health justice non-profit organization dedicated to improving the health and well-being of more than 20 million Asian Americans, Native Hawaiians, and Pacific Islanders (AA & NH/PIs) living in the United States and its jurisdictions. For 35 years, the Asian & Pacific Islander American Health Forum has powered through the highest levels of government to represent the voices of unheard communities in the United States of America and its affiliated jurisdictions. The APIAHF was led to its establishment in 1986 by a number of visionary Chinese American physicians that paved the way for Asian American, Native Hawaiian, and Pacific Islander communities to receive health care and other social services for the years to come. At the time, there was no presence in the nation's capital on the health of AA & NH/PIs. Combined with the release of the seminal Heckler Report on Minority Health which reinforced the false and harmful model minority myth, there was no recognition of the needs of low-income and immigrant AA & NH/PI communities in federal policy, including in federal funding. The APIAHF was created to fill that gap and to be the voice of AA & NH/PI communities in federal policy.

The APIAHF has been a key agent behind several national health advocacy and policy campaigns, including the creation of the White House Initiative on Asian American and Pacific Islanders, the passage of the Affordable Care Act, and more recently the restoration of Medicaid eligibility to COFA Migrants across the US. To this day, the APIAHF has remained a clear, strong voice in the nation's capital ensuring that Asian American, Native Hawaiian, and Pacific Islander communities are well represented in federal policy. Our **mission** is simple and that is to *achieve health equity for AA & NH/PI communities through law, policy, and practice*, with a promising **vision** of *creating a healthier future for AA & NH/PIs that is inspired and driven by community*. We use the voices of our communities to help inform and continue to motivate policymakers to support our vision.

35
Years

Serving over 35 years of leadership, advocacy, and movement building

25
Million

APIAHF is a leading voice for over 25 million AA & NH/PIs in the U.S

170
Partners

Working with over 170 CBO's in all states & U.S Territories

1M
Enrolled

Helped enroll nearly 1,000,000 AA & NH/PIs in the Affordable Care Act

Janice Hey Yin Chow 鄒希妍



Janice Hey Yin Chow, MS, RD, is a San Francisco Bay Area-based Registered Dietitian, recognized nutrition expert, author and speaker. Through her private practice The Mindful Chow, she empowers Asians, Native Hawaiians and Pacific Islanders to break their cultural obsession with thinness using the Health At Every Size® approach and seek mind-body health. She obtained a Bachelor of Science in Nutritional Science from University of California, Berkeley before completing her Dietetic Internship and Masters of Science in Dietetics & Nutrition at Tufts University.

Janice has 10 years of experience in clinical nutrition, community wellness and nutrition education promoting cultural competencies. She has worked with conditions such as diabetes, cardiovascular diseases, kidney diseases, and eating disorders. Her writing and expertise have been featured in numerous publications, media outlets and podcasts including *Real Simple*, *Good Housekeeping*, *MSN*, *WellSeek Collective*, *Mx. Asian American*, and many more. Moreover, she is a regular reviewer for multiple journals that publish nutrition research and serves as a mentor for Diversify Dietetics. Lastly, she has been a speaker for several universities and national organizations within the United States, sharing about food, culture and social factors that impact healthcare in AA & NH/PI populations.

Janice Hey Yin Chow, MS, RD 鄒希妍
 Founder and Dietitian of The Mindful Chow

THE MINDFUL CHOW

Click the logo to be directed to "The Mindful Chow" website.

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Opening Remarks

The United States is a melting pot of different cultures and ethnicities, particularly with a growing population of Asian Americans, Native Hawaiians and Pacific Islanders (AA & NH/PI). These individuals come from over 30 countries, all with unique cultures and backgrounds. Despite the many contributions that AA & NH/PI communities have made to American society, they face a unique set of nutrition challenges that often go unnoticed. Information regarding health and nutrition-related disparities for AA & NH/PIs are not well understood. Formally documented differences in healthcare experiences by subgroup are also variable. Issues such as low acculturation, language barriers, and poverty play a role in higher food insecurity among the AA & NH/PI immigrant community in the United States.¹

Publicly available health data, particularly knowledge related to risk factors such as metabolism, body mass index, and dietary practices of AA & NH/PIs are often faulty and unreliable, especially within subgroups. This is partially due to discriminatory practices in research and healthcare delivery that have left AA & NH/PI populations grossly understudied in the U.S.

The story of Asian and Pacific Islander immigrants introducing new cuisines to American culture traces back as far back as the early 19th century. Today, those stories can be heard across all corners of the country - from Vietnamese shrimping boats in East Hollywood, to Pakistani grills in New Jersey.² Westernization and acculturation have caused a changing diet and lifestyle for Asian American, Native Hawaiian, and Pacific Islanders. Although some traditional foods and cookery have survived, colonization and the developments that followed have shaped the contemporary food culture for AA & NH/PI communities. Today, nutritional practices, food behaviors, and health outcomes are largely reflective of these systemic oppressions.

However, there is still a chance for AA & NH/PI communities to regain autonomy and food sovereignty. To address these challenges, culturally-competent interventions and programs should be developed to encourage health-promoting eating habits and provide education on nutrition-related issues within, and for, the AA & NH/PI community. This toolkit is designed to assist community agencies and healthcare professionals in developing culturally-competent nutrition programs for Asian American, Native Hawaiian, and Pacific Islanders.



Learning Objectives

Upon the conclusion of this toolkit, you will have the tools and resources needed to design and implement culturally-responsive health and nutrition programs for Asian American, Native Hawaiian and Pacific Islander (AA & NH/PI) communities. Here are some of the learning objectives:

- To understand the importance of cultural competence in the design and implementation of health and nutrition programs, particularly for AA & NH/PI communities.
- To explore best practices for engaging with AA & NH/PI communities in a culturally-responsive manner, including understanding cultural beliefs related to health and nutrition, and developing culturally-sensitive programs.
- To develop an action plan for incorporating cultural competence into nutrition programs, including strategies for working with community partners, gathering input and feedback, and measuring program impact and effectiveness.



Intended Usage

We designed this toolkit to be used to address a broad spectrum of nutrition concerns at the individual and community levels. Nutrition does not just refer to how we eat, but more importantly, the social determinants of health (SDOH) have a greater impact on nutritional outcomes. According to the World Health Organization, social determinants of health include non-medical factors that influence health outcomes.³ Research shows that individual behaviors (personal lifestyle factors) account for approximately 36% of our health, while 64% comes from things beyond our control, such as: 1) genetics, 2) lived experiences related to cultures and identities, 3) trauma from systemic oppression or individual traumatic events, 4) access to basic resources in our communities, and 5) the safety of our environment.

In Module 3, we will highlight additional considerations, specific to the nutritional outcomes within the AA & NH/PI communities. These factors all impact nutrition outcomes in different ways, and considerations of these factors can help with increased program efficacy and capacity building within the community.

The toolkit can be applied to support the following healthcare settings and priority areas:

CLINICAL:

- Hospitals, clinics, and health systems
- Patient health education
- Healthcare provider trainings
- Chronic disease management efforts
- Nutrition-based treatment plans

COMMUNITY INTERVENTIONS

- Community centers, non-profit organizations
- Grassroots initiatives focusing on improving nutrition and food access
- Health behavior change interventions
- Highlighting issues related to food, physical activities, and eating behaviors
- Public health advocacy and awareness efforts

RESEARCH & EDUCATION

- Academia
- Nutrition-related health metrics
- Community observations
- Policy development



Community Challenges

According to the 2020 U.S. Census, there are 25.6 million people who identify as Asian, Native Hawaiian, and Pacific Islander (alone or in combination), making up 7.7% of the nation's population. Between 2010 and 2020, the AA & NH/PI population grew 38%, making them one of the fastest growing groups of the U.S. population. Note that the AA & NH/PI diaspora is extremely diverse. These are individuals of ethnic origins from at least 30 different countries in East Asia, Southeast Asia, South Asia and Pacific Islands, who speak at least 100 different languages (written and spoken). Here are some of the challenges faced by AA & NH/PI communities:

Structural Factors

Systematic barriers that impact food access, such as income disparities, language barriers, and access to culturally-appropriate fruits and vegetables.^{4 5 6} For instance, people of Bhutanese descent had average hourly wages (\$15.36) that are just half the national average (\$29.95).⁷

Food Access

Limited access to culturally-competent nutrition professionals and in-language health education resources. Research shows that there is a high demand for culturally-competent nutrition education materials for the AA & NH/PI populations.⁸ Low-income AA & NH/PI communities often face barriers to accessing healthy food, including limited access to supermarkets and other food retailers, as well as higher food prices. Having culturally responsive foods at food banks is still rare. Per online search, there is only one initiative in the U.S. that has an extensive list of food items tailored to seven cultures living in the area.⁹

Co-morbidities

AA & NH/PIs have an increased risk of developing certain nutrition-related conditions, such as type 2 diabetes, hypertension, hepatitis B, and gastrointestinal cancers.¹⁰ Several studies show that Chinese, Filipinos, Japanese, Koreans, Cambodians, Vietnamese and Indians have higher prevalence of chronic diseases (pre-diabetes, diabetes, hypertension, and high cholesterol), compared to Caucasians.^{11 12}

Mental Illness

Intersectionality of mental health and nutrition, such as emotional eating, body image issues, and orthorexia.^{13 14} AA & NH/PI women have higher disordered eating rates compared with other women of color.¹⁵

Mobility Issues

Inadequate access to different types of physical movement which accommodate different ages, body sizes, and abilities.¹⁶ One study shows that there are many barriers to physical activities for individuals with intellectual disabilities, such as lack of adapted physical activity programs, and challenges with transportation.¹⁷ Another review reports that weight discrimination and internalizing weight stigma were associated with reduced physical activity.¹⁸

Cultural Competency



How does it relate to nutrition and wellness programs?

According to the National Prevention Information Network from the Centers for Disease Control and Prevention (CDC), cultural competence emphasizes the idea of effectively operating in different cultural contexts, and altering practices to reach different cultural groups.¹⁹

We know that different cultures have different needs and life contexts pertaining to their race, ethnicity, socioeconomic status, sexual orientation, age, gender, etc. This is true for the AA & NH/PI communities as well! For the success of any nutrition interventions, it is essential to enhance understanding of cultural nuances, and customize the approach to address the unique needs and challenges within each cultural group of the AA & NH/PI communities.

For the success of any nutrition interventions, it is essential to enhance understanding of cultural nuances, and customize the approach to address the unique needs and challenges within each cultural group of the AA & NH/PI communities. Culturally responsive health programs are important because:

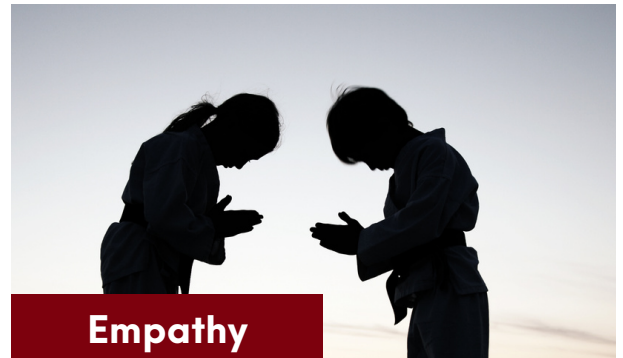
- They promote collaboration between target communities and providers
- They rebuild trust by encouraging more authentic connections with healthcare professionals
- They empower families and communities to create positive and sustainable changes

Cultural Competency

Empathy, compassion, and trust are the guiding elements within cultural competence, as they form the foundation for building positive relationships and creating an environment of understanding and support.



Compassion encourages kindness and acceptance for ourselves and others, and reduces judgment and self-blame. When individuals receive compassion from others and have compassion for themselves, they will have a higher capacity to cope during adversity; more patience to see their own progress through; and stronger motivation to make long-term behavior changes.



Empathy refers to the ability to understand and share the feelings of others, which helps individuals to see the world from another person's perspective. When our priority populations feel understood and validated, they are more likely to be open to new ideas and perspectives.



Trust builds relationships and creates a sense of security and comfort, which can encourage individuals to take risks and try new behaviors. Individuals are more likely to take action and make changes if they believe that the practitioner or organization offering support is trustworthy.

Practical Applications

Empathy

Validate feelings related to food, movements, eating behaviors and AA & NH/PI cultural practices.

Acknowledge the individual's knowledge based on their lived experiences.

Provide tailored advice instead of generalized recommendations, such as nutrition recommendations specifically for type 2 diabetes or other conditions, ethnicity, cultural food sources, income level, and physical ability.

Example

"I hear that you have mixed feelings regarding white rice."

"In your past experiences, doing acupuncture has helped with your pain relief in the long term. It's understandable why you prefer to do that over taking painkillers."

"White rice can still be part of your meal as a source of carbohydrate, even though you are monitoring your blood sugar levels. Let's look at how we can balance your meal with other components for blood sugar management."

Compassion

Provide a judgment-free space for an individual's lifestyle, actions and decisions, such as forms of movements, types of food and cultural norms.

Be aware of potentially unvoiced needs such as unresolved trauma from food and exercise, and inadequate access to food, cooking tools and healthcare.

Example

"I hear you. You are trying your best."

"It must be really hard to deal with this. It must be exhausting trying to find resources for yourself. What do you need now?"

Trust

Display a respectful attitude for all interactions, such as nutrition counseling sessions, educational workshops, social media posts/comments and emails.

Ask questions to confirm preferences and capabilities, such as preferred names and pronouns, education level, cultural and religious practices.

Offer a safe and welcoming space, such as providing special accommodations and maintaining confidentiality.

Example

Listen attentively!

"How do you prefer to be addressed? Who should I talk to regarding this?"

"Please let me know if you have any questions and require any special accommodations."

Module 1

Mission, Vision,
and Core Values

What is in this module?

Identifying Your Target Audience
Crafting Your Mission and Objectives
Determining Core Values

Module 1

Introduction

Defining your community or target audience is foundational to conducting a culturally-responsive program. It serves as the compass for the overall planning and intervention design. Having a clearly defined and representative audience, mission and objectives helps establish a solid foundation for future intervention activities. Too often, public health interventions are designed with a sole focus on changing the behaviors of an individual (e.g., the farmer, the patient, the mother, etc.,). This narrow-minded approach often yields unsustainable outcomes in the target audience because the social environment and community structures that influence healthy living are not fully acknowledged.

During this phase of your program design, it is important to examine the various definitions of ‘community’ and the processes by which we ‘diagnose’ or seek to understand the structural make up of different populations. In this module, we aim to help guide your program planning efforts to be conducive to what your community truly needs. By the end of this module, we hope your agency is equipped with the necessary tools to better understanding of how to identify your objectives, mission and core values.



Target Audience

Before crafting any objectives, it is important to ensure that there is an explicit understanding of who your program is trying to reach and what change or outcome it is trying to elicit.

Culturally-responsive programs with a clear and specific focus, such as "improving healthy food consumption amongst high-risk adults living in Oahu", bring about much higher rates of change. Broadly defined programs with objectives such as, "creating healthier communities" often lack a targeted audience, purposeful mission, and strategic direction. In this module, we will briefly describe some culturally-competent strategies to facilitate your program planning efforts. The examples below are some potential brainstorming practices to consider when trying to identify your target audience:

Your "target audience" should describe the specific community of people you want to impact and a justification for why an intervention is warranted.

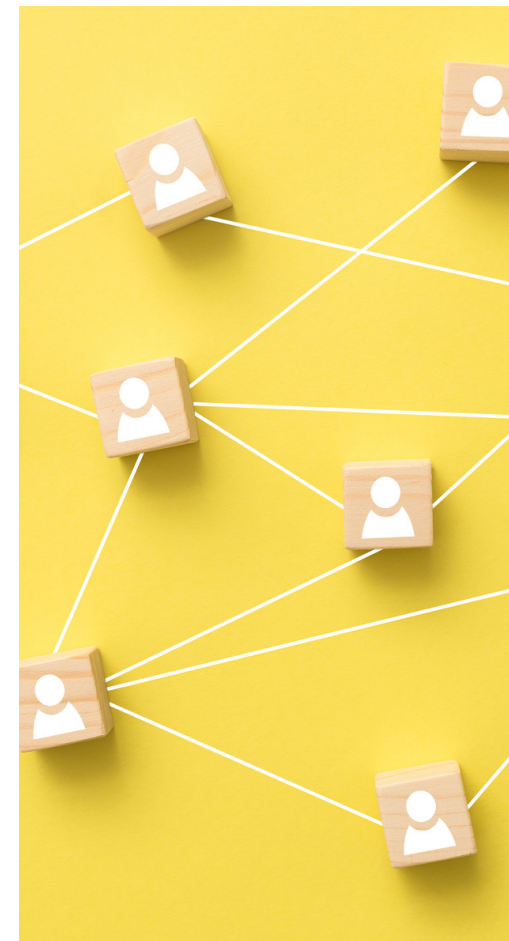
Example: First and second generation YYY immigrant communities living in XXX County have reported challenges with acquiring healthy and culturally-relevant food options to feed their families.

Identify the problem/issue you want to influence and how this community currently experiences it. What specific data sources (Figures 1A and 1B) support your claim of the problem/issue?

Example: According to a recent community survey, 30% of first and second generation YYY immigrants in XXX County report not having enough food to eat or not having enough money to buy food.

Why will this community be compelled by your mission?

Example: Having consistent and affordable food access is a basic survival need for human beings. Food security is linked to long-term health outcomes, economic stability, environmental sustainability and community empowerment. By improving food access for YYY immigrants in XXX County, we are supporting the long-term growth of this community.



Mission and Objectives

Goals and objectives must be clearly articulated from the start so that it is clear what the project is about, where it is headed, and what, specifically, will be measured to assess project progress and success. One way to ensure clarity is to remember to make your objectives SMART: Specific, Measurable, Attainable, Relevant, and Time-Based.

Using the answers from the previous page, reflect on what the best case scenario would be in the present moment. A mission statement should focus on what can be done today and how the program would facilitate that outcome. A mission statement describes “what the group is doing and why it’s going to do that.”²⁰ It should be concise, and also broad enough to encompass a wide range of outcomes. Mission statements can help remind your group what is important, offer a snapshot of what your group wants to accomplish and involve participants with a common purpose.

Examples of mission statements:

- “Food for People is working to eliminate hunger and improve the health and well-being of our community through access to healthy and nutritious foods, community education and advocacy.”²¹ – Food for People, The Food Bank for Humboldt County
- “SeekHer Foundation is on a mission to bridge the gap of mental health through advocacy, research, and support for emerging leaders who are impacting change in their local communities & beyond.”²² – SeekHer Foundation
- “To prevent and cure diabetes and to improve the lives of all people affected by diabetes.”²³– American Diabetes Association

Figure 1A

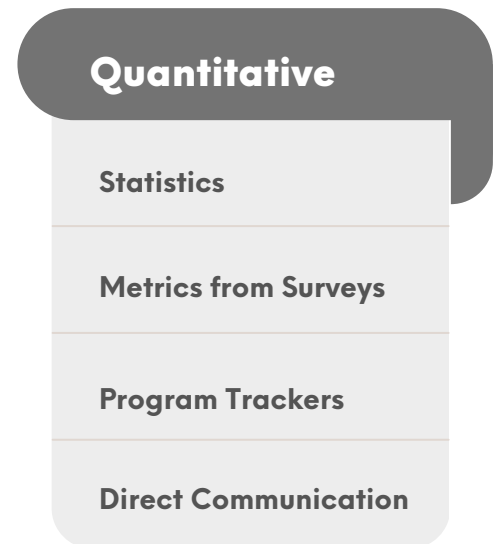
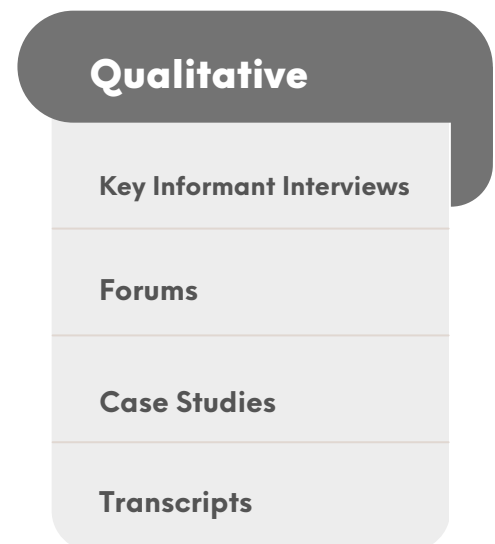


Figure 1A



Core Values

Your core values are what you stand for. More importantly, your target audience will also align with these values because they are living them, or they believe in the promise of these values and the work to get there. This simple exercise can help you determine your team’s core values so you can apply these values to your work.

Application to Nutrition Practices: Core Values Exercise

(Adapted from Dr. Russ Harris²⁴ and TapRoot[®])²⁴

1

From the following list, choose and write down every core value that resonates with you and your team. If there is a value or concept you do not see here, write it down as well.

Acceptance	Calmness	Credibility	Ethics	Independence	Love	Persistence	Self-awareness	Usefulness
Accountability	Caring	Curiosity	Fairness	Innovation	Loyalty	Pleasure	Safety	Vision
Advocacy	Challenge	Daring	Flexibility	Inspiration	Mindfulness	Reciprocity	Self-awareness	Warmth
Assertiveness	Collaboration	Dedication	Freedom	Intuition	Motivation	Reliability	Self-care	Well-being
Authenticity	Commitment	Diversity	Growth	Joy	Observant	Resilience	Service	Wisdom
Autonomy	Compassion	Empathy	Happiness	Justice	Originality	Resourcefulness	Stability	Zeal
Balance	Connection	Encouragement	Honesty	Kindness	Passion	Respect	Supportiveness	
Benevolence	Consistency	Enthusiasm	Humility	Knowledge	Patience	Responsibility	Trust	
Boldness	Creativity	Equality	Inclusivity	Learning	Peace	Safety	Understanding	

2

From the list you created, group all the similar values together. Here is an example:

Acceptance	Challenge	Balance
Compassion	Growth	Joy
Empathy	Innovation	Well-being
Kindness	Passion	Mindfulness
Humility	Observant	

3

Choose one word from each group. These words will serve as the labels to your work.

Challenge	Acceptance	Balance
Growth	Compassion	Joy
Innovation	Empathy	Well-being
Passion	Kindness	Mindfulness
	Humility	Observant

4

Add a verb to each label and turn them into actionable phrases. Using the examples from above:

- Offer **compassion**.
- Encourage **growth**.
- Promote **well-being**.

5

Use these phrases as your references for creating mission and vision statements of your project or intervention.

Example – By improving food access for YYY immigrants in XXX County, we are supporting the long-term growth and well-being of this community.

Module 2

Assessing your Target Audience

An assessment is a systematic evaluation or examination of a program, project, or individual's skills or abilities. The purpose of an assessment is to gather data and information to make informed decisions, identify areas for improvement, and measure progress towards goals and objectives. The assessment process involves identifying, defining, and addressing the issue.

By the end of this module, you and your team should be able to go through the assessment process, find out what has and hasn't been done already, and determine what's missing.

What is in this module?

Identifying the Problem
Defining the Issue
Creating Solutions

Identifying the Problem

Identifying a problem means recognizing and acknowledging the existence of a challenge that needs to be addressed.²⁵ At this phase of the planning process, you should be examining the parameters in which the problem may exist by identifying what systems you need to assess and ultimately address. The aim here is to bring attention to a problem and initiate the process of changing its influence on the target population. As mentioned previously, this assessment should account for macro-level factors such as their geography, place, environment, and history, in addition to their social interactions, cultural values, and beliefs. These social systems might constitute cultural associations, family structures, roles and institutions. Macro-level influences would resemble aspects such as resources, access to healthcare, opportunity and wealth, in addition to political systems, like local leadership, and decision-making paradigms. In Module 1, we briefly talked about qualitative and quantitative methods for collecting information from your audience. Let's review a few of these examples and take a look at the pros and cons for each:

QUALITATIVE ASSESSMENTS

Figure 2A

	Focus Groups	Interviews	Field Observations
POSITIVES	<ul style="list-style-type: none"> Targets a specific audience Identifies the immediate impact of the program towards the community Fruitful and open-ended discussions 	<ul style="list-style-type: none"> Ability to capture lived experiences Easy to identify potential solutions Increased community engagement and involvement 	<ul style="list-style-type: none"> Comprehensive review of current issues on a specific topic Deeper understanding of the problem in the local context
NEGATIVES	<ul style="list-style-type: none"> Requires facilitation Conflict or strong opinions could affect the discussion 	<ul style="list-style-type: none"> Lengthy process to gather information Cognitive and explicit biases 	<ul style="list-style-type: none"> Cognitive and explicit biases Challenging to coordinate Requires extensive planning

QUANTITATIVE ASSESSMENTS

Figure 2B

	Population Data	Surveys	Validated Assessment Tools
POSITIVES	<ul style="list-style-type: none"> Readily available from existing resources (e.g. Census) Reduces bias 	<ul style="list-style-type: none"> Gathers large amount of data Low-threshold and multi-modal Able to track changes over time 	<ul style="list-style-type: none"> Ready to use Easy to administer Can track changes overtime
NEGATIVES	<ul style="list-style-type: none"> Data aggregation and generalization Exclusion of NH/PI populations 	<ul style="list-style-type: none"> Low participation rates Subject to human error Requires an assessment of its validity 	<ul style="list-style-type: none"> Validity might not be tested on AA & NH/PI groups Ethnic generalizations and misconceptions

Defining the Issue

Defining an issue specifies the problem or challenge that needs to be addressed. This step in the assessment process involves a thorough examination of the problem to understand its nature, scope, and root causes. The goal of defining an issue is to develop a clear and accurate understanding of the problem, so that appropriate actions can be taken to address it. This assessment will help you and your organization better understand your audience, their conditions, and any other contextual factors that may be influencing your communities health. In the development of culturally-responsive programs, make sure to articulate clearly what the problem is and the direct needs of the community.

Try to refrain from including solutions as part of the problem, as this may limit future opportunities and solutions. Avoid attributing bias and blame onto a specific group (this creates cognitive bias and limits exploration of other solutions). For example, too often, you will see program developers and health agencies manipulate their programs to reflect their own operational agendas. The proposed "needs" are then perceived to belong to the sponsor and not the actual community they are trying to reach. Making assumptions about "priority issues" without the input of your target population often leaves communities feeling the intervention was actually not designed to help them but to help the health workers meet a quota. As a result, you will find that community members will respond with little vigor or excitement due to their loss of agency or ownership. They will attribute any successes and/or failures to be the result of, as well as the responsibility of, the program developers themselves. Here are some additional recommendations to consider when trying to describe the needs of your priority populations.

List out the keywords for this specific problem you have identified. **For example:** "*Lack of food, low income, hunger within YYY immigrants.*" Avoid listing solutions when describing the problem. An example, would be to declare that: "YYY immigrants need more SNAP benefits." Focusing on the needs ensures the blame is placed on the problem and not the people. Instead, consider the following revision: "**Food access is limited for YYY immigrants within XXX County.**" As a group, make sure to give feedback on the language until an agreement is reached. Most importantly, make sure to consult with the target population to make sure they understand, endorse, and support the terminology in the problem statements.



Considerations

Reflect upon how you will be approaching the community before making contact.

It is important to give careful thought about the most appropriate methods for engaging with the individuals in the community you are targeting before making contact. Make sure that you use the evidence from your assessment to help inform your approach to community consultation. Be mindful of language barriers, cultural practices, and modes of communication. In many cases, extended family members, friends, cultural groups and faith leaders play a pivotal role in deciding when, where, and from whom to seek help or treatment. You should always consider the difficulties that local community members with jobs outside the area will have in attending daytime events. You should also consider the needs of caregivers and parents, seniors, those reliant on limited public transit and others for whom daytime meetings or events might be more accessible.

Here are some reflective questions to consider before approaching the community:

- What languages are spoken in this community?
- How can I make sure that printed or digital communication are accessible to my audience?
- What physical barriers might prevent the community from participating in focus group opportunities?
- What is the best location for a meeting or event? Is it well-known and accessible by public transit?
- What is the best time of day to hold an event?

Listen actively. Listen patiently. Listen to learn, not to lecture.

Conducting focus groups, public forums, key informant interviews, town halls, or panel discussions are great ways to obtain information about the lived experiences, perceived barriers, and proposed solutions to a communities challenges. However, make sure that you remain impartial when observing and collecting this information.

Take the time to build a connection with the community first.

An appreciation of community similarities and differences is necessary so that we do not fall into the trap of designing one-size-fits-all interventions. We need to recognize that no matter how a community might be viewed, we can find strengths and capacities for improvement in each community. Identifying community capacities and resources is the first step in facilitating community change, as well as the need for communities to participate in the design, implementation and evaluation of that intervention.²⁶ It is very important that the planning process is inclusive. What other established organizations in the community can help encourage people to participate in these focus groups or can help facilitate a community event? Seek champions, gatekeepers, and leaders to become active participants in your efforts.

Creating Solutions

As you gather information from the communities, you will move into the problem solving process.²⁶ This is a process of understanding every aspect of the problem by answering the “what”, “why”, “who”, “when”, “where” and “how”, and helps to create potential solutions for the issues you've identified.

Figure 3A

WHAT	What is the problem?	<i>This is your problem statement.</i>
WHY	Why does the problem exist?	<i>This considers any constraining and driving factors that cause the problem. Consider structural and system oppression (laws, access to care, education, employment) and cultural differences (beliefs, eating practices, community expectations) when approaching this question.</i>
WHO	Who is affected by the problem? Who is causing the problem? Who else?	<i>This helps you to list out the obvious causes (those with direct connection/impact right now) and the hidden causes (those with indirect impact who might be missing from the current conversations).</i>
WHEN	When did the problem first start? When did it become significant?	<i>This offers background context for the problem. You might not be able to go back in time to make changes, but you can use the "when" to track future progresses.</i>
WHERE	Where does this problem take place? Where can you create change?	<i>This helps to pinpoint the root of the issue. Consider these levels to create change: personal (individual behaviors, beliefs, ability), community (engagement efforts, collective healing) or environmental (policies, infrastructure). Prioritize issues that make the most impact with current resources.</i>
HOW	How many people are affected? How significant is the problem? How are things being done now?	<i>This allows for open-ended answers.</i>

Module 3

Cultural Considerations

As you prepare to design your programs, note that there are many considerations specific to the needs of AA & NH/PI communities. In this module, we will highlight ones that impact health and nutrition outcomes.

What is in this module?

Culturally Competent Health Education
Trauma-Informed Care
Gathering Insights

Cultural Competency in Health and Nutrition Education

Nutrition education refers to the process of providing information and training to individuals or groups about nutrients, dietary practices, metabolism and eating behaviors. The goal of nutrition education is to equip individuals and communities with knowledge related to nutrition, empowering them to make informed choices that promote their overall well-being.

Behavior change theories and models, which have been validated within the field of dietetics, provide structured explanations for changes in nutrition-related behaviors. These theories and models are essential to the nutrition care process as they guide nutrition assessment, intervention, and outcome evaluation, including Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).^{27 28} Research prior to 2010 has shown that combining Motivational Interviewing with CBT is a highly effective counseling strategy for nutrition. Effective strategies for improving nutrition and dietary behaviors include goal setting, problem solving, and social support.

Cultural competence in nutrition education refers to the ability of health professionals and educators to understand and appreciate the cultural and dietary practices of diverse populations, and to use this understanding to effectively communicate information about nutrition, dietary patterns and eating habits.²⁹

With the increased awareness of cultural nuances in the U.S. and around the world, cultural competence has become a critical aspect of nutrition education. A culturally-competent approach to nutrition education recognizes the unique needs and perspectives of different cultural groups and seeks to address these in a way that is inclusive, respectful, and effective.



Lomi-Lomi (Salmon Salad)



Haupia (Coconut Pudding)



Paia (Fresh Pounded Taro)

Cultural Competency (cont...)

Evaluate the validity of the information.

are nutrition research and guidelines of interest being developed in a culturally-competent way?

Identify what is included in the data.

Is the data disaggregated to reveal the disparities within the AA & NH/PI communities?

Determine the appropriate platforms to share educational resources.

Are they shared on platforms that are most commonly used by the specific AA & NH/PI communities that you are seeking to reach?

Food for Thought #1

MyPlate is one of the most popular food education tools developed by the U.S. Department of Agriculture.³⁰ Some AA & NH/PI cultures do not eat from plates, use forks, drink dairy, or consider fruit as part of a meal. We should be mindful that the MyPlate may not translate the same health message when serving the AA & NH/PI communities.

Also, lobbying efforts from the food and beverage industry highly influenced the process of developing these guidelines,³¹ so it is important to check for sources of funding and partnerships.

Food for Thought #2

Aggregated data in health, education, and other areas perpetuate the model minority myth within AA & NH/PI communities, by not allowing for a deeper dive into the differences within subgroups. When data is disaggregated, a much more complex story emerges.

During your research, it is best to go through the disaggregated data through research (search for specific ethnic population), government sources (U.S. Census) and community-led sites (AAPI Data³²).

Food for Thought #3

Social media use made it easier for misinformation to spread, especially within the Asian American communities, and affected their health behaviors. When studying misinformation related to the COVID-19 pandemic, Chong and colleagues³³ found that many Asian Americans tend to use social media platforms that enable communication in their native languages. Likewise, different generations prefer different platforms and channels of receiving information (newspaper and radio).

For example, Chinese communities might use WeChat, Douyin and XiaoHongShu (Chinese from certain regions might use WhatsApp and LINE); South Korean communities like to use Kakaotalk, LINE and Naver; Indian communities like to use WhatsApp.

Cultural Competency (cont...)



How does it relate to nutrition and wellness programs?

Offer linguistic and cultural assistance.

Is the information offered in different written and oral languages? Is the context of the information tailored to specific cultures and cultural practices?

Include the support of culturally-competent experts

Are there any Registered Dietitians, Licensed Therapists, and other health providers in your area who have knowledge on providing care to AA & NH/PI communities? If not, is there a way to increase access to these professionals

Food for Thought #4

There are so many languages and dialects within the AA & NH/PI diasporas. Some languages might not have written forms, and some languages accommodate people with certain needs (e.g. American Sign Language, braille, etc.). Moreover, there could be intersectionality of identities and needs - for example, a deaf Indian immigrant who is not English-proficient may require assistance in Indian Sign Language.

Food for Thought #5

According to the Commission to Dietetic Registration, only 5-6% of Registered Dietitians in the U.S. are of Asian and Pacific Islander descent.³³ The AA & NH/PI Registered Dietitian to AA & NH/PI individual ratio is 1:4200, meaning one Registered Dietitian serves 4200 individuals — that's not enough practitioners! While being of AA & NH/PI descent does not guarantee cultural competence, there is a need to diversify the field to support the increasingly diverse demographics in the U.S. Additionally, National Asian Pacific Center for Aging recommends partnering with local AA & NH/PI community leaders for additional support on culturally-appropriate care.³⁴

Cultural Competency (cont...)



How does it relate to nutrition and wellness programs?

Assess the needs of the community

What information is your community looking for? What are their burning questions?

Draw reflections from the current state

what opportunities are there to address misinformation and navigate cultural beliefs sensitively?

Food for Thought #6

Assessment tools will help to provide data-driven insights that can be used to identify areas for improvement. Different tools are developed to screen for specific health conditions or risks, so there is not a one-size-fits-all nutrition assessment tool. For example, the Dietary Screener Questionnaire (DSQ) captures dietary patterns; the Malnutrition Screening Tool (MST) is used to identify patients at risk for malnutrition, and the Eating Attitude Test (EAT-26) provides an indication of concerns with eating attitudes and behaviors.

Food for Thought #7

Some of my patients incorporate alternative medicine into their dietary intake. For example, the concept of health and how food interacts with our bodies can be very different in Traditional Chinese Medicine (TCM) and Ayurveda practices, compared to Western medicine. Be mindful of our own implicit biases and judgements,³⁵ and how that impacts different cultural beliefs or preferences. Learn about these approaches. Respect that these approaches have their own values, and an individual's choice to engage with their health using different approaches. At the end of Module 4, we will discuss more details on performing a nutrition assessment.

Case Study Example



Application to Nutritional Practice

**Names and identifying details have been changed to protect the privacy of individuals.*

Grace* is a 38-year-old East Asian cisgender woman who recently found out that she has high cholesterol and high blood pressure. Concerned about her health, she received a referral from her doctor to consult a Registered Dietitian for nutrition education.

Her first encounter with a dietitian didn't go as well as expected. With her background as East Asian, she grew up eating white rice and various kinds of Asian vegetables. However, the dietitian didn't take her cultural upbringing into considerations before making suggestions such as switching to brown rice and consuming other non-Asian leafy greens. Grace didn't feel heard and came out of the session not very motivated to make any changes. Then her doctor referred her to see me.

When she came to my practice, she was skeptical at first. It turned out that she continued to work with me for the next six months, and we were able to see improvement in her blood pressure and cholesterol levels. I interviewed Grace at our final session – what did I do differently as a nutrition practitioner that made her want to keep working with me?

- I included questions that asked about her upbringing, foods/cuisines she grew up eating, practices that influenced her beliefs, behaviors, and sources of health information.
- I remained curious and compassionate of her lived experiences and trauma.
- I took the time to educate myself on ingredients and food practices that I am not familiar with.
- My recommendations were tailored to suit her preferences on food, such as incorporating high fiber Asian food sources to lower her cholesterol and exploring different Asian spices and ingredients to season her food.
- My handouts were adapted to show different AA & NH/PI food sources.
- In addition to analyzing her dietary intake, we investigated other factors that may be contributing to her high cholesterol and blood pressure, helping her gain a comprehensive understanding of her overall health.
- I made sure she felt heard and respected for who she is.

In the end, cultural competence helps to build trust and satisfaction between individuals and healthcare providers. When individuals feel that their healthcare provider or support system has their best interests at heart and genuinely cares about their well-being, they may be more motivated to make positive changes in their behavior to achieve better health outcomes.

Trauma-Informed Care

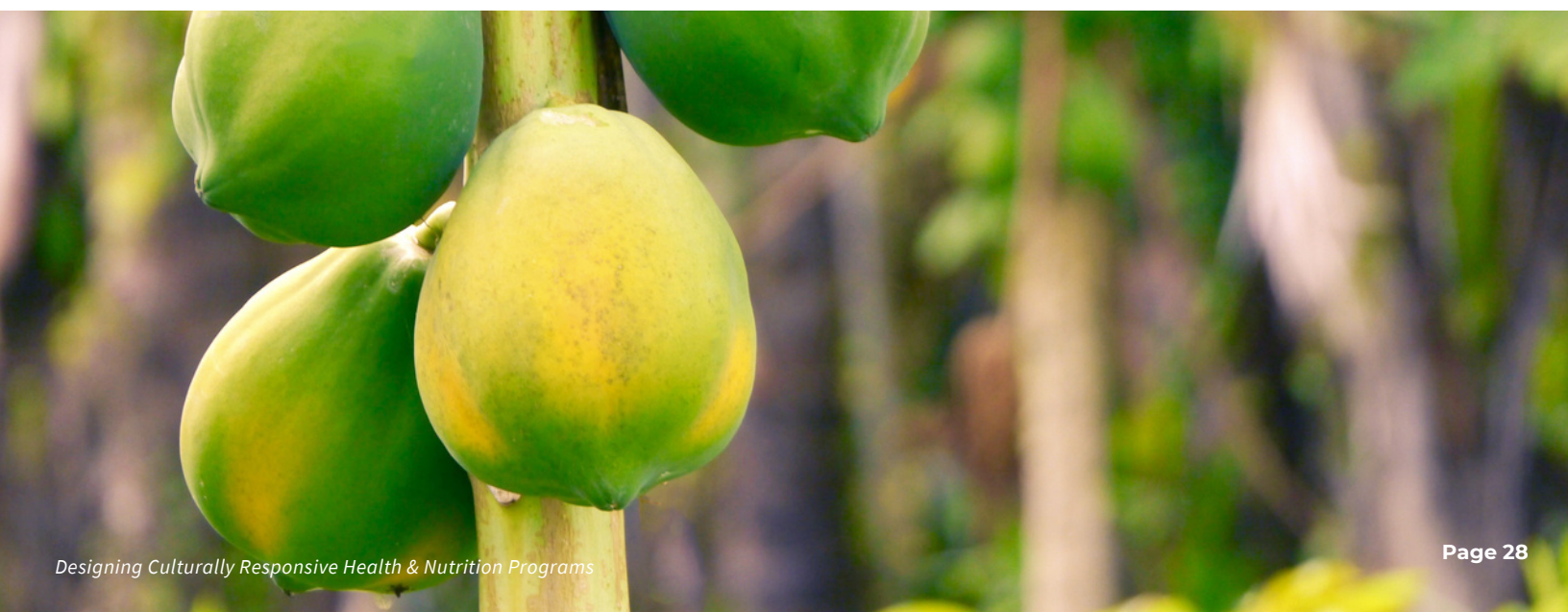
Trauma comes in different forms, and it affects how individuals connect with the world, and live their lives on a daily basis. Examples of nutrition outcomes include:

- Trauma related to body size or weight³⁶
 - (e.g. stigmatization of larger bodies, body shame from weight gain)
- Post-migration trauma³⁷
 - (e.g. barriers to food access, health literacy, changes in cooking and eating)
- Acculturation trauma³⁸
 - (e.g. adjusting to completely different cultures and new foods)
- Intergenerational trauma³⁹
 - (e.g. trauma that changes eating behaviors and food beliefs through the generations)

Trauma-Informed Care is an approach developed to respond to trauma at all levels.⁴⁰

It has the potential to improve patient engagement, treatment adherence, and health outcomes. It follows five guiding principles that serve as a framework for how service providers and systems of care can work to reduce the likelihood of re-traumatization:

- Safety (physical and emotional safety)
- Choice (individual's autonomy)
- Collaboration (shared decision making)
- Trustworthiness (clear and consistent boundaries)
- Empowerment (skill building).



Trauma Related to Food & Nutrition

Be mindful of nutritional stigmas (e.g., racism, fatphobia, sexism, healthism).

What assumptions do we make about “healthy” behaviors or body sizes? What beliefs do we hold on certain types of foods or ways of eating? Who are we hurting during this process?

Determine the barriers to care and support.

Is there any fear about disclosing information, such as immigration status or financial status? Are we looking at “what’s wrong” instead of “what’s happening”?

Identify sources of harm and their impact.

How did colonialism change cultural beliefs and practices in regards to health and food? How could we provide support as communities are still healing from intergenerational trauma? What are other sources of harm in the modern days?

Eureka Effect #1

One example to reflect biases in the nutrition realm is diet culture. Diet culture promotes thinness and weight loss, encourages certain ways of eating, and most importantly, reinforces healthism.⁴¹ We highly encourage you to read more about the Health At Every Size® approach,⁴² and consider how anti-diet culture efforts work in the dietetics world.⁴³

Eureka Effect #2

Here are some common barriers to care, according to my own experience and previous health assessments done on AA & NH/PI communities:⁴⁴

- Anxiety over health care costs
- Lack of insurance coverage
- Legal consequences for signing up for food assistance programs
- Lack of reliable transportation to get to grocery stores or food banks

Eureka Effect #3

Colonization disrupts the intergenerational connection of ‘āina (land) to health for Native Hawaiians,⁴⁵ and serves as a reminder of what's lost in the food culture of Pacific Islanders.⁴⁶ In the modern world, Eurocentric foods are still promoted as the gold standard of health and that excludes food options that have been part of cultures for hundreds and thousands of years.⁴⁷

Data Collection

Data aggregation is a major issue when studying AA & NH/PI communities in the U.S. In recent years, there has been an increased awareness and call for data disaggregation. Here are some of the best practices in collecting data for AA & NH/PI communities:

Offer incentives to increase survey participation.

Monetary incentives⁴⁸ or stipends⁴⁹ are particularly attractive to East Asian populations. Another study in 2017 showed that frequent incentives help to recruit and retain study participants.⁵⁰

Obtain key opinions on culturally-appropriate social media platforms.

As previously mentioned, different ethnic groups prefer to use different social media platforms. When obtaining key opinions or following up on surveys, it's helpful to use the platforms that are most convenient and frequently used by your target audience.

Create a welcoming space for underrepresented identities.

Allow study participants to self-identify their identities, preferences, and needs.⁵¹

Build trust with your target populations.

Having trust and feeling respected is key for AA & NH/PI communities when recruiting participants for interviews, surveys, focus groups, and community forums. According to several research studies, word-of-mouth referrals from a trusted organization, individual, or community member is the most effective way to obtain data and recruit study participants within the ethnic Chinese,⁵² Filipino,⁵³ Maori,⁵⁴ and South Asian populations.⁵⁵

Module 4

Creating an Action Plan

After going through these considerations and refining the proposed nutrition interventions, the last step is to solidify your action plan.

An action plan is a vital tool for turning goals and objectives into concrete, achievable steps. It provides a roadmap for achieving a specific outcome. A well-designed action plan provides structure and organization, enables efficient use of resources, and improves the chances of successfully achieving the desired outcome.

By the end of this module, you will be able to create a comprehensive action plan, including key considerations, best practices, and tools for making your interventions a reality.

What is in this module?

- Finalizing Interventions
- Developing a Monitoring & Evaluation Plan
- Piloting Your Interventions

Step 1: Finalize the Intervention

Your interventions should focus on these three areas: relevance (objectives met), feasibility (adequate funding, skills and time for implementation) and sustainability (ability to have ongoing impact). In any health and nutrition intervention, there should be clear and measurable goals, specific tasks and responsibilities, estimated timelines or deadlines, and resources needed to implement the plan successfully.

Individual Nutrition Counseling

Based on the information obtained during assessment, a practitioner or counselor can reflect on these questions to figure out the appropriate health and nutrition interventions:

“What does the patient want to know?”

Potential interventions: Educating on specific health and nutrition topics; teaching them hands-on skills (such as cooking, reading labels, gardening).

“What existing knowledge does the patient have? Which area requires education or clarification?”

Potential interventions: Clarifying misconceptions on diseases/nutrients/eating behaviors; expanding education efforts based on what they already know.

“What is the patient’s ability and capability?”

Potential interventions: Tailoring current education materials to their abilities and preferences; encouraging patients to set their own specific and measurable goals.

“What are the current barriers to care? What additional support do they need? Who else can we collaborate with?”

Potential interventions: Identifying any support they need from other healthcare providers (such as access to endocrinologists for diabetes management) and socioeconomic resources (such as Supplemental Nutrition Assistance Program); connecting patients with the appropriate partners/organizations to facilitate support.

Community Nutrition Programs

Based on the findings from population data, surveys and key opinions from the community, your team can use these questions to figure out the appropriate health and nutrition interventions:

“What do community members want to know?”

Potential interventions: Connecting them to health and nutrition educators; hosting educational workshops; creating town halls and forums.

“Who is missing from the conversations?”

Potential interventions: Creating new resources and initiatives from needs assessments.

“What are the current barriers to care? What additional support do they need?”

Potential interventions: Connecting them to existing health and nutrition resources; assisting them in finding financial support; helping with linguistic support; advocating for policy and environmental changes (such as public spaces for recreation).



Step 1: Finalize the Intervention

Nutritional Considerations

When drafting interventions related to food and nutrition, it's important to incorporate staple foods, cooking and eating practices that AA & NH/PI communities are most familiar with. Some common eating practices and cooking methods include:

Eating Practices

- Tools for eating food - chopsticks, hands, forks, spoons, knives
- Containers - bowls, plates, leaves, containers carved out from fruits/plants
- Eating styles - shared (family-style), buffet, individual portions

Cooking Methods

- Grilling
- Boiling
- Steaming
- Stir-frying
- Stewing
- Cooking with underground heat
- Preserving with salt, vinegar or alcohol
- Fermenting

Figure 4A

Regions	Staple Foods	Spices, Herbs & Seasonings	Dishes
Central Asia 56	sheep, mutton, yogurt, millet, rice, wheat, barley, turnips, parsnips, tomatoes, radishes, onions, red peppers, cucumbers, figs, melons	turmeric, saffron, coriander, caraway, sesame, red and black bitter pepper, dried tomatoes, paprika, sweet peas, cloves, barberry	rice pilaf, manti soup, tandyr flatbreads, kebabs, noodles
East Asia 57 58	tofu, pork, beef, poultry, fish, seafood, rice, wheat, soy beans, mung beans, bok choy, Napa cabbages, seaweed, mushrooms, bamboo shoots, longans, starfruits, pears	star anise, chili pepper, ginger, garlic, scallions, bay leaves, soy sauce, vinegar, fermented bean paste, dried seafood	ramen, rice noodles, porridges, steamed fish, kimchi stew, dumplings, stir-fry bok choy
Pacific Islands 59 60 61 62	pork, chicken, fish, octopus, taro, sweet potato, sugarcane, breadfruit, coconut, banana, guava, seaweed	ginger, garlic, onion, coconut cream, coconut milk, fish sauce,	poi, cooked breadfruit, boiled butterfish, seasoned seaweed
Southeast Asia 58 63	tofu, pork, chicken, beef, fish, rice, bananas, mangoes, pineapples, durians, mangosteens, rambutans	lemongrass, bird's eye chili peppers, galangal, Thai basil, kaffir lime leaves, torch ginger flower, mint, tamarind, pandan leaves, curry leaves, fish sauce, coconut milk, shrimp paste, sambal	laksa noodles, pho, Thai curry, sinigang, gado-gado, momo, mohinga, fish amok
South Asia 58 64	chicken, lamb, lentils, chickpeas, rice, paneer, ghee, yogurt, mangoes, grapes, apples, apricots, oranges, banana, avocados, guava, lychee, papaya, sapota, watermelons	chili, black pepper, cloves, turmeric, coriander, cumin, garam masala, cardamom, mustard seeds, ginger	naan, dosa, curries, biryani, kebabs, chutneys,

Solution Analysis

After generating a list of possible interventions, the next step is to create specific criteria for choosing the final options. Developing specific criteria is an essential step in the intervention selection process. It helps to eliminate unrealistic options and evaluate different solutions objectively. The Solution Analysis is a valuable tool to identify and prioritize the criteria to consider when selecting the final interventions.⁶⁵

To evaluate your problem and possible solutions, here are the steps:

- Create a table with your problem and potential solutions listed on the left-hand side.
- Along the top of the table, list the criteria you have identified to evaluate the solutions.
- Using a scale of 1 to 10, rate each solution on each criterion, where 1 represents a poor outcome and 10 represents the most positive outcome. For example, for the criterion of initial cost, 1 would represent the most expensive solution, and 10 would represent the least expensive.
- Once you have completed this process for all your solutions and criteria, add up the numbers in each row to determine a total score for each solution. The solution with the highest total score represents the most appropriate choice based on your criteria.

Figure 5A

Problem Area:	Proposed Solutions	Criteria 1: Cost	Criteria 2: IM Impact <small>IM = Immediate</small>	Criteria 3: LT Impact <small>LT = Long-Term</small>	Total Score:
<i>YYY immigrants in XXX County have limited access to food.</i>	<i>Connect them to food assistance programs</i>	9	10	8	27
	<i>Build more grocery stores</i>	1	5	10	16

In this example, connecting YYY immigrants to food assistance programs is a more appropriate solution after comparison. The template for this tool can be found in Appendix A.

Step 2: Develop a Monitoring and Evaluation Process (M&E)

Monitoring and Evaluation (M&E) is important to measure and ensure the success of an activity, intervention or program. Measurable indicators are often used to track progress over time in a quantifiable way. When performing an evaluation, it is also important to consider the cultural context in which the intervention operated and create an evaluation design that is responsive to it. Honoring and acknowledging the cultural environments of your program participants should remain a critical component in your evaluation plan. Evaluations are considered culturally responsive if they purposefully and deliberately account for the cultural context of the populations that are being evaluated.⁶⁶ The monitoring and evaluation design is therefore conceived to assess both the immediate and long term impacts and outcomes of a particular project through the lenses of the target population being considered. Culturally responsive evaluators honor the cultural context in which an evaluation takes place by bringing much needed, lived experiences, and insights to the evaluation activities.⁶⁶ It is imperative that persons undergoing these M&E processes reflect on how their own cultural preferences, biases, and predispositions might influence their assessments. Competent evaluators need to be able to listen to the community when they express their needs, when they talk about their limitations, and when they talk about their hopes and desires.

Suggested strategies to consider when designing your M&E plan:

- Determine outcomes and technical expertise required.
- Use data collection methods that fit the needs of beneficiaries and the skills of your employees.
- Use outcomes that are relevant for your beneficiaries and try to motivate beneficiaries to provide data at key intervals.
- Inform partners, focus population and key stakeholders of results.
- Ensure that your dissemination plan is culturally-appropriate and reflective of the community.
- Seek champions, gatekeepers, and leaders to become active participants in your dissemination efforts. Stakeholders play a critical role in providing sound advice from the beginning (framing questions) to the end (disseminating the evaluation results).



Step 3: Pilot Testing

According to the Capacity Building Center for States,⁶⁷ pilot testing helps to:

- Identify challenges and allow for adjustments to the intervention plan prior to implementation
- Provide an opportunity to gauge the target audience’s reaction to the intervention.
- Make decisions on time and resource allocation.
- Refine the monitoring and evaluation process.

The following steps can be followed to pilot test your nutrition interventions:

- Choose a pilot site or setting that is representative of the target community and has the resources and support to implement the program. Consider available funding and capacity of staff/volunteers involved.
- Recruit potential participants by developing specific criteria for screening, and marketing through different channels such as local community centers, clinics, places of worship, culturally-appropriate social media channels, and news channels.
- Provide necessary training to personnel involved, such as healthcare providers, patient navigators, and community leaders.
- Examples: training on counseling skills, interviewing/facilitating strategies and implicit bias.
- Set a clear timeline for when pilot testing starts and ends and test out your M&E indicators by having timely evaluations.
- Collect feedback from participants and personnel involved in the pilot program. As mentioned above, consider offering incentives and providing different channels (e.g. surveys, focus groups).
- Make necessary adjustments based on evaluation.

On the next page, we will share examples of individual and community indicators commonly used for nutrition assessments, and examples of M&E questions.



Step 3: Pilot Testing (cont...)

Examples of Nutrition Indicators:

Individual Indicators

- Biochemical markers (labs, tests, procedures)
- Physical cues (symptoms, hunger/fullness cues)
- Dietary patterns (food frequency, nutrient intake, food recall)
- Physical movements (minutes of movements, types of movements)
- Sleep (sleep quality, hours of sleep)
- Stress (levels of anxiety and depression, emotional eating)

Community Indicators

- Periodical nutrition surveys on health practices
- Feedback questionnaires after education workshops or counseling sessions
- Service provision and utilization data
- Program coverage data
- Food security analysis

Examples of Evaluation Questions

Descriptive Questions

What happened? What was the context? What was done by the intervention and what changes in conditions occurred? These questions can be answered through questionnaires, measurements, video recordings, and other qualitative methods.

Causal Questions

What produced or contributed to these changes? Usually requires a research design that addresses attribution (to determine if the changes in outcomes occurred because of the intervention/program) as well as contribution (the program only partially caused or contributed to the changes). Finding causal links is very challenging, especially because programs and Interventions are complex, multifaceted, and intersectional. It is hard to find true causal links in programs with so many moving pieces.

Evaluative Questions

What was the overall merit or value of the program? To what degree did the target population engage with or adopt the intervention activities into their own lives?



A Story from the Author: Janice Chow

When I decided to set up my private practice, I had gone through the same process of intervention development: finding my mission and values, identifying my target audience and their pain points, and determining the most appropriate solutions to achieve the desirable outcome. Before I share how I conduct pilot testing and finalizing interventions in my work, let me give you some background context to my private practice:

Mission, Values & Target Audience

As a Chinese immigrant, I experienced challenges navigating through the complex healthcare systems when I moved to the U.S. My personal experience and education made me realize that there weren't many nutrition professionals who mainly serve Asian Americans, Native Hawaiians and Pacific Islanders. Throughout my 10-year career, a lot of patients have expressed the needs and wants for more culturally-appropriate resources and support. During this time, I also learned about the Health At Every Size® approach. That opened my eyes to systemic factors that impact nutrition outcomes and existing oppression against people with different skin colors, body sizes and health statuses. This sparked my interest to offer weight-inclusive nutrition counseling specifically for AA & NH/PI communities.

Needs Assessment

During my research process, I created a survey for friends, families and ex-coworkers of AA & NH/PI descent, and asked them what they know about Registered Dietitians, what support they need and what would be the most helpful way to reach them (this was my mini "needs assessment"). I also compiled my observations from AA & NH/PI patients in my previous jobs.

Potential Interventions

The needs assessment helped me decide on setting up a virtual practice, where clients could see me online instead of in-person, because I would be able to reach more people online.

Moreover, it prompted the creation of my own education materials, where I include images and descriptions of AA & NH/PI cultural foods. Lastly, the most feasible way is to offer nutrition counseling and tailored nutrition recommendations, which is my area of expertise.

After developing all the "essentials" (business license, website setup, EHR setup), then it came to "pilot testing".

Pilot Testing

Given that it was the beginning of COVID-19 pandemic, I chose to do pilot testing on only two clients. After many rounds of emailing and reaching out to different communities, I was able to find the test clients. Then I created pre- and post-session surveys and asked them to give feedback on the overall experience, ease of use and content received. Clients were able to give qualitative feedback (free text response), as well as quantitative metrics (M&E indicators). The measurable indicators for evaluation included: (a) how comfortable and safe they feel during sessions, (b) my education and communication ability, (c) change in dietary pattern over time, (d) change in physical movements over time, (e) frequency of nutrition-related symptoms and (f) ability to acknowledge cultural preferences. These indicators are developed with the interest of the AA & NH/PI population in mind. With the feedback and ratings gathered, I was able to make adjustment to the following areas:

- Improved time management during sessions.
- Adjusted my communication styles.
- Provided new ideas for additional education materials.
- Identified areas for continuing education.
- Initiated collaboration with other healthcare providers (psychotherapists, psychiatrists and primary care providers).
- Determined areas to reduce costs (use free online tools instead of paid tools).

I hope it's helpful for you to see how intervention development goes through my own story!

Step 4: Launching Your Intervention

After pilot-testing your intervention and making necessary adjustments, the next step is to launch it. Here are some of the proposed steps and considerations:

Develop a Communication Plan

Develop a communication plan to inform the target audience about the intervention, its goals and objectives, and how it will benefit them. Consider the following areas for training: review cultural practices of the target group, utilize translated terminologies/phrases, refine skills on educating, counseling, interviewing and facilitating.

Secure the Necessary Funds

Identify and secure the necessary funding/resources to support the full-scale implementation, particularly government fundings or grants that are geared towards AA & NH/PI efforts.

Hire Staff and Recruit Volunteers

Hire the necessary staff or recruit volunteers to implement the program. Note for any linguistic needs.

Tips and Takeaways

Usually there are recommended timelines to recheck labs for each nutrition-related diagnosis. For example, patients at risk of developing type 2 diabetes (pre-diabetes) are encouraged to recheck their A1C every year. You could consider checking A1C every 3 to 6 months for more “real time” feedback. For optimal effectiveness when targeting changes in dietary patterns or health behaviors, most guidelines and research studies suggest offering weekly or monthly interventions for at least 6 to 12 months.⁶⁸ In summary, creating an action plan requires a comprehensive overview. It serves as a roadmap, providing direction and focus to guide individuals or organizations towards their desired outcomes. By having a well-defined action plan, individuals and organizations can enhance the efficacy of the interventions and promote collaboration and engagement.

Follow the Implementation Plan

Develop a comprehensive plan for the full-scale implementation of the program, including timelines, budget, and responsibilities staff and volunteers. Once you've drafted these strategies ensure to execute according to the plan and procedures. Ensure that personnel who will be implementing the program are adequately trained to perform their expected duties. Consider the following factors: media and social media sources (e.g., news, newspaper, radio, instant messaging apps, social media apps), gathering locations (e.g., places of worship, interest groups, community centers), forms of communication (e.g., verbal, written, multimedia)

Modify, Monitor, and Evaluate

Consistently evaluate the program's progress by collecting data and feedback from all constituents. Consider incentivizing feedback by offering incentives or providing various platforms for staff and participants to provide feedback (e.g., focus groups, surveys). Based on the evaluation, make adjustments and changes to the intervention as necessary to ensure its effectiveness.

Creating An Individualized Nutrition Intervention for AA & NH/PI Patients

Nutrition Care Process (NCP)⁶⁹ is a standardized model to guide Registered Dietitians (RD) in providing nutrition care. There are four steps in the NCP process: nutrition assessment, diagnosis, intervention, monitoring and evaluation. Here, I will share how Registered Dietitians apply NCP process to clients:

Nutrition Assessment

The Registered Dietitian (RD) collects and documents information such as food or nutrition-related history; biochemical data, medical tests and procedures; anthropometric measurements, nutrition-focused physical findings and client history.

Obtain the following information from your client for assessment:

- Chewing and swallowing functions
- Eating behaviors - food intake, avoidance of food and timing of meals
- Socioeconomic factors - cooking, grocery shopping, education level and financial status
- Cultural observations - food beliefs and practices, linguistic preferences, religious practices and other sources of influence
- Physical activities - frequency, types of activities, likes and dislikes
- Sleep - quality and duration
- Mental health status - stress, anxiety and body image
- Client's current concerns - medical diagnoses, any signs and symptoms
- Existing knowledge on their diagnoses and sources of knowledge - family, friends, religious/spiritual leaders, mentors and media
- Personal and family health history
- Current medications, supplements and herbal remedies
- Biochemical data - blood work, medical tests and exploratory procedures
- Food recall - food, beverages and others
- Gastrointestinal issues
- Allergies and intolerances to foods or nutrients

Nutrition Diagnosis

Nutrition diagnosis comes after nutrition assessment. The goal is to address a client's nutritional needs by naming the specific problem. It is important to note that nutrition diagnoses are distinct from medical diagnoses, and require a thorough analysis of nutrition assessment data using standardized terminology, such as the Nutrition Care Process Terminology (NCPT).

This allows for a systematic approach to labeling nutrition diagnoses that includes the defined problem, etiology/causes, and signs or symptoms identified. It is essential that nutrition diagnoses are made only by Registered Dietitians, using the NCPT reference list, to ensure accuracy and consistency in the assessment and diagnosis process.

Example: *Inadequate fiber intake (problem) as related to low fiber intake (etiology) as evidenced by constipation (signs/symptoms).*



Creating An Individualized Nutrition Intervention for AA & NH/PI Patients

Nutrition Intervention

Nutrition Intervention is the key step in addressing the nutrition diagnosis(es) by altering or eliminating the underlying nutrition etiology(ies), and may also aim to relieve the signs and symptoms of the nutrition problem.

- Prioritize interventions that are more urgent (symptoms are causing more harm or physical discomfort) or based on client's preferences (what they want to work on).
- Identify potential education topics.
- If the client agrees, communicate the client's progress and current care plan with their healthcare providers to create a care team.
- Define clear goals potentially including time and frequency of care, intensity and duration.

Example: For a client experiencing constipation, we identified that the client did not have any prior education about fiber, significance of its intake and fiber sources. RD provided education on these topics and asked how the client wanted to proceed with this new information. Client decided to eat more vegetables, and RD collaborated with the client to craft a specific and measurable goal: the client will eat at least 1 cup of vegetables at lunch and dinner for 4 days per week.

Nutrition Monitoring/Evaluation

The final step of the process is monitoring and evaluation, which the RD uses to determine the client's progress, review any challenges and adjust planned goals.

Here are some tips during the monitoring/evaluation process:

- Encourage patient feedback and response, through active listening.
- Offer positive reinforcement for any progress based on planned goals.
- Explore setbacks with empathy and compassion.
- Identify any new sources of barriers.
- Modify the plan to fit their needs.

Example: During the follow-up session, the client reported a consistent intake of one cup of vegetables with dinner every day. The Registered Dietitian (RD) provided positive feedback on the progress made and probed about the client's experience at lunch, asking if any additional challenges had arisen. The client explained that there were not many vegetable options available during lunchtime at work. The RD empathetically acknowledged the client's experience and suggested other sources of fiber to be added to the lunch or other ways, such as fluid intake, that might help relieve their symptom (constipation). Together with the client, RD guides the client to change their goals on fiber intake and add a new goal to increase fluid intake during the day.

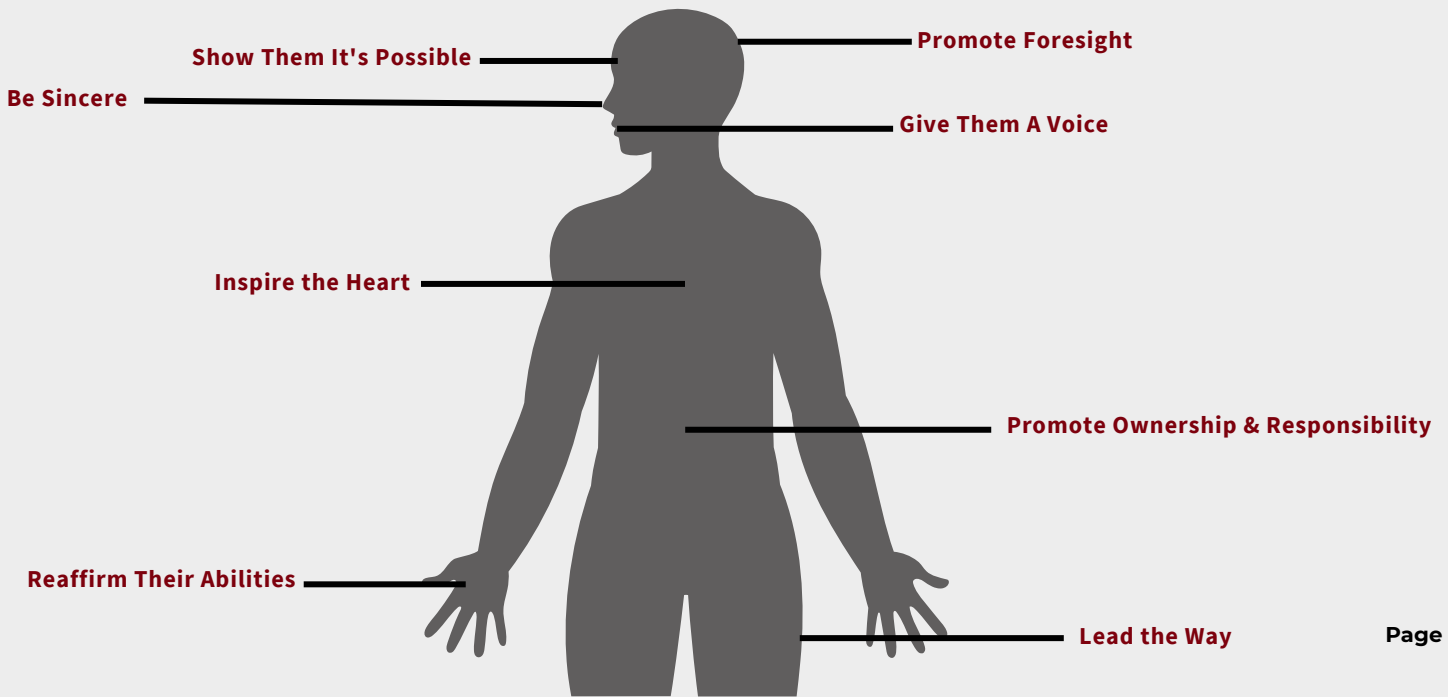
Final Remarks

Developing a culturally responsive nutrition program that effectively addresses the needs of a specific population requires a comprehensive approach that includes careful planning, implementation, and evaluation. By utilizing evidence-based research, collaborating with key stakeholders, and tailoring the program to meet the cultural and linguistic needs of the target population, nutrition programs can improve health outcomes and promote positive behavior change. There is no formula for creating change, but you have an opportunity to create that formula using your voice, the tools disposable to you, the strength of your communities, and the will to create change. Your contribution to this fight is imperative. Each of you, regardless of locality or specialty area, play a role in this paradigm.

Key Takeaways

- Conduct a thorough needs assessment to identify the unique nutritional needs and challenges.
- Tailor the program to meet the cultural and linguistic needs of the target population.
- Develop clear and measurable program objectives that align with the identified needs.
- Use evidence-based research and disaggregated data, specifically for AA & NH/PI communities, to guide intervention development and implementation.
- Collaborate with key stakeholders, including individuals, healthcare providers and community partners.
- Implement effective communication strategies to engage and empower participants - trust and compassion is key.
- Regularly monitor and evaluate the program to identify areas for improvement and measure impact.
- Encourage a mutual ownership with community members by developing interventions that supports their existing beliefs and cultural identities.

Figure 6A





Submit Your Feedback!

Please take a couple minutes to enter your thoughts about the resource. Your input is extremely important to us and the continued success of this learning program!

Click the "take survey" icon to submit your entry.

TAKE SURVEY



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