

# Culturally-Responsive Food Strategies



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## **Introduction**

The following report is an exploration of a narrow field within the broad context of health and human services work. It is not an exhaustive treatment of all effective programs or approaches within the field, but rather a narrow investigation of a topic of interest.

The subject matter of this paper does not necessarily represent an area of financial investment, grant funding, or other programmatic pursuit for United Way of Olmsted County. Rather, this report reflects on a specific type of intervention that allows individuals to reach their full potential, and presents related research.

There may be a wide variety of programs or services that address individual and community needs, and this report is not designed to enumerate all possibilities. United Way of Olmsted County hopes that readers will think creatively about the ways in which the ideas and experiences contained within the report might inform programs, services, and community changes in Olmsted County.

## **What Is Culturally-Responsive Food Provision?**

*Culturally-responsive* or *culturally-relevant* are terms made popular by Dr. Gloria Ladson-Billings in the early 1990s, and are most often seen in reference to teaching and classroom environments. Culturally-responsive teaching “empowers students to maintain cultural integrity, while succeeding academically (Ladson-Billings, 1995).” United Way has adopted this phrase to refer to food provision, such that ‘culturally-responsive food provision empowers individuals to maintain cultural integrity while accessing nutritional supports.’

Culturally responsiveness in food provision can manifest itself in various ways: the provision of culture-specific foods, culturally-responsive distribution methods, or even culture-specific education around food. Often, this is carried out by making adaptations to existing services, though it can sometimes include the launch of new service areas.

## **Why is it Important**

From a systems perspective, programs that provide food-based interventions are more efficient if the food is consumed by the individuals receiving it. If the food being provided is not culturally relevant or acceptable – due to personal taste preference, knowledge on how to prepare the food, dietary restrictions, or religious restrictions – individuals may not use the food provided to them and will instead seek out more preferred food by other means. This redirects household resources that may have gone to other expenses had the food intervention been culturally relevant.

Food distribution and intake methods that are not culturally responsive may also disincline potential clients from enrolling in or fully utilizing a food support. For example,

individuals from high-context<sup>1</sup> cultures may not desire to participate in a program in which distribution is public or screening is intrusive (Koc & Welsch, 2001), and individuals from cultures with a large stigma on accepting outside assistance may be reluctant to participate in food provision programs at all.<sup>2</sup> Under the Trump administration, many immigrants have begun to decline food assistance for fear that the intake process will lead to deportation (Fessler, 2017).

As Americans become increasingly diverse, cultural competency becomes more important to ensuring that social and human services are optimized to serve their client population. In the year 2000, 11% of the US population was foreign-born (US Census Bureau, 2000), compared with an estimated 14% in the year 2016 (US Census Bureau, 2016a). Locally, 60% of Rochester's population growth between 2000 and 2010 has been persons of color or Hispanics, and 97% of net migration since 2000 has been international (Wheeler, 2013).

Poverty disproportionately affects minorities, with 39% of African-Americans and 20% of Latinos living in poverty in Olmsted County (US Census Bureau, 2015). Because food insecurity is so intricately linked to income, minority and non-native populations are disproportionately food-insecure. On the national level, African Americans and Hispanics have higher than average rates of food insecurity (Coleman-Jensen, Nord, Andrews, & Carlson, 2012). According to a survey of Minnesota food shelf and on-site meal program clients, American-Indian, African-American/Black, and Hispanic/Latino individuals are over-represented when compared to US Census Bureau population estimates (Chase & Schauben, 2006). Locally, over 50% of food shelf users are identified as non-white (according to program-level reporting), compared to US Census Bureau estimates of 18% in Olmsted County (US Census Bureau, 2016b). In Olmsted County, non-US born residents are twice as likely as their native-born counterparts to worry about running out of food (Olmsted County Public Health Services, Olmsted Medical Center, Mayo Clinic Rochester, 2016). While many of these are estimates based on race, culture is often tied to race. In order to best serve the populations that are facing food insecurity and are utilizing food resources, it seems ideal to adopt approaches that are culturally-relevant to these populations.

### **Maintaining the Healthy Immigrant Effect**

Upon arrival, immigrants usually have fewer chronic conditions compared to the native-born population (Sanou et al., 2014). This is widely attributed to selection effects – immigrants must undergo medical screening, and those with major health problems generally do not emigrate. However, immigrants tend to experience deteriorating health

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<sup>1</sup> Cultures that rely heavily on context and in which meanings are implied. Direct questions, especially those of a sensitive nature (here, regarding financial instability), can often be uncomfortable for individuals from high-context cultures.

<sup>2</sup> Seniors and the working poor are two populations that significantly underutilize food assistance, and the USDA speculates that these two groups are especially susceptible to stigma (Kauff et al., 2014). Even though these are not culture-based populations, it may be relevant if one considers intersections of identity that are particularly susceptible to underutilization of food resources.

status after settling in a new country. Some of this can be traced to dietary changes – many traditional diets contain fewer carbohydrates (Pomerlou, Ostbye, & Bright-See, 1998), rely more heavily on fruit and vegetables (Satia et al., 2001), and contain healthier sources of protein (Dhaliwal, 2002) than typical Western diets. The extent to which culture-specific food and cooking equipment are available can be barriers to maintaining a traditional diet (Johnson & Garcia, 2003), as can an individual's socioeconomic status (Delisle, 2010; Satia et al., 2001) – fresh fruits and vegetable, as well as imported ethnic foods, tend to be more expensive than processed and shelf-stable Western food. In many instances (depending on the cuisine in question), immigrants who maintain their traditional cuisine continue to have better health outcomes than their native-born peers (Satia et al., 2001).

### **Maintaining Cultural Identity in Poverty**

Food is a major component of one's cultural identity. Specific foods carry meaning with them, such as a Thanksgiving turkey or Ramadan dates. Gathering around food is common across cultures – we see this with summer cookouts, s'mores over campfires, and Passover Seder. There are fasting traditions across numerous religions, along with religion- and culture-based food taboos. There are even social norms based around food, such as bringing hot food to the recently bereaved. When someone lives in poverty, these cultural practices can be lost. Specialty foods may be unavailable or unaffordable. Community kitchen and meal times may fall during times traditionally reserved for fasting. Even daily food traditions become disrupted with poverty – individuals working long or late hours often find that they are unable to eat at traditional times or spend the time and effort needed to cook traditional meals. In many cultures, there are important aspects to the production, sale, and consumption of food that are lost in the Western tradition of shopping in supermarkets and preparing food for a single family. When food provision is culturally-responsive, these identity markers can remain in place for both individuals and communities.

## **Successful models**

**Sacramento Native American Health Center** is a community-owned and operated nonprofit located in downtown Sacramento. The organization serves more than 5,000 patients representing over 200 tribal nations. The center uses a multigenerational approach and collaborates with American Indian owned business and community partners to offer community and home gardens. The initiative views culture and prevention, and traditional eating as health. Historical trauma and its relationship to food choices, as well as the utilization of traditional planting and harvesting methods put culture in the center of the work (“Healthy Active Native Communities,” 2017).

**Syrian Supper Club**, in which Muslim refugees women from Syria and Iraq prepare elaborate feasts for American hosts. When the participants come together to eat the meal, the result is part cultural exchange, part fundraiser. Each dinner guest pays \$50 which covers the cost of the meal, with the remainder going to the cooks. The refugee women use the dinners as opportunities to meet their new neighbors, learn more about American culture, and boost their household income at a time when resources are scarce. For the American participants, the event is largely about cultural exchange and contributing to a cause important to them (“Syrian Supper Club,” 2016).

**Vida Saludable** was a two-phase intervention delivered over 9 months to low-income Hispanic mother-child pairs. The first part of the project was educating the mothers on healthy drink choices for their children, the importance of physical activity for both mother and child, and the importance of providing a health role model for their children. The second part of the project involved bringing the mothers together in community settings to reinforce healthy behaviors, including visits to grocery stores, fast food restaurants, a park, a community walk, and a cooking class. The education and community components were delivered bilingually and designed to be culturally-relevant. Healthy behaviors were adopted readily by the group, and the majority continued those behaviors in follow-ups (Bender, Nader, Kennedy, & Gahagan, 2013).

## **Sources**

Initial interest in the healthy immigrant effect came from 2017 Office of Health Disparities Research Retreat Keynote Address by David R. Williams, Ph. D. This presentation was on September 22<sup>nd</sup>, 2017 at Mayo Clinic in Rochester Minnesota. The presentation and slides can be viewed at:

<https://healthdisparitiesresearchblog.mayo.edu/2017/09/22/2017-retreat-keynote-address-by-david-r-williams-phd-now-available-for-viewing/>

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