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# Intercultural Competence for the Nutrition Professional

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# Intercultural Competence for the Nutrition Professional

**Abstract**

Diversity training for nutrition care professionals is essential in order to provide patients with culture-specific strategies that allow them to succeed with their health program. Nutritionists are faced with the challenge of understanding the dietary preferences of their cross-cultural patients, as well as appreciating a patient's religious beliefs regarding dietary selections by identify foods that will or won't support a prescribed nutritional program. Knowledge of intercultural nonverbal and verbal behaviors is becoming increasingly necessary, as is who ultimately makes medical decisions for the patient.

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Gary L. Evans

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INTERCULTURAL COMPETENCE FOR THE NUTRITION PROFESSIONAL

By

Cynthia S. Klement

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With Honors in Communication

Approved in Ypsilanti, Michigan on \_\_\_\_\_

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## **Honors Thesis**

### **ABSTRACT**

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## CHAPTER 1: INTRODUCTION

In order to provide excellent nutritional care to the growing number of culturally diverse members now living in the United States, the unique ethnicity of the population must be considered. Developing a working relationship with cross-cultural patients not only requires an understanding of the group's dietary preferences and food habits but a working knowledge of the nutritional composition of foods unfamiliar to the practitioner. The health practitioner must also possess an awareness of the role family members may play in health decisions, how religious beliefs may present roadblocks, and how nonverbal communication and behavior patterns can enhance or curtail the working relationship between practitioner and patient.

Foods common to a specific cultural group are part of their history and environment. For instance, cassava root is an important staple food in many parts of the world and accounts for a large part of the daily calories consumed. Cassava grows well in poor soil, requires little rain, and as a perennial plant it can protect against famine. Therefore this tuber is an important part of the history of the sub-Saharan Africans, and is supported environmentally by the climate found there. In the United States cassava flour is referred to as tapioca, something that most nutritional counselors are familiar with in the US.

Fried chitterlings, on the other hand, may sound a familiar ring to the practitioner but the nutritive composition of this customary soul food -- deep-fried porcine intestines -- may be unfamiliar. One cup of "chitlins" contains nearly 375 calories with 321 of those calories coming from fat, information of great importance when working with African Americans with heart disease or other health disparities commonly found in certain groups.

Regarding health decisions, the roles of family members widely differ among cultures. The patient may not even be included in the decision making process, as in the case of those from Pacific Island societies, as the patient's family is responsible for making decisions about treatments. Therefore, understanding that the family may need to be present during a counseling session is important information for the nutrition professional to have when scheduling meetings with a client.

Religious beliefs might hinder the health care process. When the patient's beliefs include the notion that they are ill largely because they have sinned against nature and cannot be well until they have made peace with nature, there may be less compliance to a nutritional program. Some foods are taboo because of religious beliefs. In order for the nutrition practitioner to build a successful diet plan they must have an understanding of these dietary restrictions. Practices, including fasting during Ramadan, will certainly matter to the health practitioner when developing a nutritional plan.

Both demonstrating and attaining respect requires an appreciation of the nonverbal messages that are as diverse as the cultures represented in the United States. Averted eye contact by the patient could indicate respect or shame, while direct eye contact by the practitioner can signal interest or disrespect, depending on

the cultures involved. Knowledge of the cultural norms in regards to eye contact, posture, touching, gesturing, space and time can allow the nutrition practitioner to achieve a mutual respect between patients and themselves.

Cultural distinctiveness must be taken into account by nutrition care professionals in order to cultivate rapport across the lines of dissimilarity. Competent communication skills can be achieved through cultural awareness and knowledge regarding the health practices and traditions of diverse cultures by understanding family roles, beliefs about health, authority, respect, and religious and nutritional patterns. Proficient cultural competence can enhance patient outcomes and help to diminish health disparities.

## CHAPTER 2: CULTURAL BELIEFS

Providing culturally competent nutritional intervention is both challenging and complex when the counselor does not have knowledge regarding the behaviors and health beliefs of members from other cultures. As both counselor and client hold a distinctive worldview, it's critical for nutritional professionals to recognize the differences but equally critical that they not participate in cultural stereotyping. There are many exceptions to the rule since people from the same ethnic group can have very different principles and customs. Therefore, obtaining information from the patient and family can ensure success in nutritional treatment plans.

## RELIGIOUS BELIEFS

While not every member of religious affiliations will follow all food prohibitions to the degree specified, it is nonetheless important to inquire as to any secular foods forbidden by the patient. Consider religions where caffeine, including other hot drinks, and alcohol are prohibited. Under the strictest of conditions even vanilla extract would be considered alcohol. Mixing meat and dairy in the same meal is considered taboo in some cultures and religions, while other cultures may not consume dairy products or meat at all. Pork, shellfish, duck, chicken, eggs, onions, garlic and yeasted breads may also be prohibited in some religions, and others may follow the nonreligious cultural restrictions of hot and cold foods or yin and yang foods they believe will restore balance to the body.

Fasting and abstinence are commonly practiced during particular religious holidays. These periods of abstinence from food can range from one day each week to an entire month. For a nutritional program to be effective and to ensure the patient will not be offended by including prohibited foods in their plan, knowledge and resources should be available to the counselor.

Depending on how strictly people follow religious restrictions, below are some general guidelines for religion and food culture. The nutrition professional must be careful in forming assumptions regarding a patient's beliefs and culture as they may widely differ. Generalizations follow regarding member's dietary adherence to religious guidelines. They are not intended to stereotype or suggest that all members in a specific religious affiliation adhere to these religious restrictions, prohibitions or guidelines.

Christianity – Catholics and Orthodox Christians may avoid meat on Ash Wednesday and Fridays during Lent. Seventh Day Adventists and Mormons do not consume alcohol, caffeinated beverages, or hot beverages such as tea. Some may not eat meat, pork, fish, shellfish or dairy products. There are approximately 2.1 billion Christians in the world practicing in 33,800 different denominations.

Islam – Foods forbidden are pork and products made from animal fat (such as lard). Other prohibited (haram) foods may include meat, shellfish, bread fermented with yeast, gelatin from pork used in making cheeses, alcohol, caffeinated beverages, and coffee. Baked goods made with vanilla extract are not allowed, unless the vanilla is alcohol-free. The month of Ramadan mandates fasting from dawn until dusk. Other religious observances may also require fasting. There are approximately 1.5 billion people practicing the Islamic faith around the world.

Hinduism - Common in those of Indian descent, vegetarianism is the norm but is not required. Beef is strictly forbidden, while other prohibited foods can range from other types of meat, eggs, pork, duck, fish or crab. Alcohol, turnips, leeks, mushrooms, red-colored foods (tomatoes, beets) onions, and garlic are sometimes avoided. Several days of fasting might also be observed. There are approximately 900 million people worldwide who practice Hinduism.

Confucianism and Taoism – These traditional Chinese religions do not impose dietary restrictions or prohibitions on adherents. There are approximately 394 million people who practice in the traditional Chinese religions.

Buddhism – Common in people from Southeast Asia. Many are vegetarians. Some avoid beef, while others may avoid all meat, fish, shellfish, eggs and dairy products. Approximately 376 million people are Buddhists around the world.

Judaism - Strictly forbidden foods are pork and shellfish. Meat and dairy products are not to be mixed or consumed at the same meal. Fasting may be observed on Yom Kippur, Rosh Hashanah and Passover, while certain foods may be avoided during Passover such as unleavened bread, wheat, barley, rye, oats, beans, peas, lentils, maize, millet and mustard. Some followers may adhere to keeping Kosher. There are approximately 14 million practicing Jews around the world.

## FAMILY ROLES

In some cultures family needs will take priority over the needs of the patient, and decisions regarding health concerns will be made by someone other than the patient. The husband will sometimes be the responsible party and in other cases it may be the eldest male, grandparent or eldest son who makes the decision, while in matrilineal cultures the eldest female might have the decision making power. It's important to ask patients if they are interested in consulting with other family members regarding nutritional protocols and having the decision maker present during the consultation.

## HEALTH BELIEFS

Some non-Western cultures may believe that health is mere good luck or that they are in harmony with nature and being rewarded. Some cultures view illness or malformation of limbs as a punishment. Three categories of beliefs help to differentiate how cultures differ in their understanding of illness. The first of these belief systems, known as the biomedical or Western approach, establishes illness as a deviation in the body's normally functioning processes or a dysfunction in the body's structure due to injury or aging. This belief system utilizes surgery, medication, nutrition, and other modalities to cure deterioration in the body. This system also supports injuries and removes obstructions, parasites, bacteria, and viruses. The principles of biomedicine are based on biology, physiology, and biochemistry.

The second belief system, known as the magico-religious or personalistic approach, ascertains illness is a result of punishment inflicted on the patient by other people or through supernatural forces and beings such as a god, deity, ghost or evil spirit. In personalistic medical systems, the cause of illness can be from a supernatural being placing foreign objects into the body and causing pain, or that the spirit of the patient has been possessed or damaged. The patient's spirit may also be lost due to the "evil eye" when a powerful person, either intentionally or unintentionally, harms the weaker person. Another cause of illness under the personalistic medical belief system is when the patient has been cast with a spell if a certain supernatural being breathes air on them.

The third belief system, known as the holistic or naturalistic approach, determines illness results when the body is out of harmony with nature or the elements of hot, cold, earth, fire, metal, water, wood, yin or yang. Other elements known as wind, cold, heat, dampness and dryness are also factors sometimes used to discover the reason for an illness. The reliance on using the elements to determine and heal the body is known as humoral pathology. Dr. Henry C. Lu's book, "The Chinese System of Food Cures," (Appendix A) categorizes foods into their elements and movements and is a valuable resource to nutritional professionals in need of guidance on this subject.

Armed with a better understanding of cross-cultural health beliefs, the nutrition professional can employ the use of multiple health care systems in developing treatment plans for their patients. Generalizations follow regarding health beliefs for specific cultural groups. They are not intended to stereotype or suggest that all members in the group adhere to the same beliefs. These generalizations are illustrated to aid the nutrition professional in understanding a client's cultural background and bring about an awareness of the groups they may be serving.

Mexican Americans – Ascribe health as living according to God's will. Men may ignore pain for fear of being seen as weak or lacking masculinity. They may believe an evil eye can bring illness to or harm another person, or believe that powers a person obtains from evil can be directed at another and cause pain or illness. They may subscribe to the belief that illness results from disparity in one or more of the four humors: hot and wet, hot and dry, cold and wet, or cold and dry (see Appendix A). New mothers may delay breastfeeding for several days, as colostrum is perceived as being unacceptable for infants. There is also a belief that if the mother feels stress or anger and is nursing, she will produce milk that could make the infant ill.

African Americans – Beliefs vary from illness being the work of the devil, a spell that has been cast, God's punishment, or exposure to cold air. Often seen as essential for health, greens are frequently consumed. Literacy may be an issue if they refuse to sign a form. The family spokesperson is typically the eldest male or father of the family.

Native Americans – They believe health is attained through harmony with the environment, nature, family, and the community. Health is also viewed in a holistic approach by balancing the spiritual, mental and physical in one's being. They may be of the belief that powers a person obtains from evil can be directed at another and cause pain or illness, as can any supernatural interference. There may be a low compliance rate with diets as a slim body is associated with disease or illness. Native Americans believe talking about an illness can make it worse and may be reluctant to share information. Complaining of pain is viewed as a sign of weakness. Speaking the name of a deceased member could also bring illness or misfortune.

Chinese – Health is reliant on a balance between the elements of earth, fire, metal, water, wood and yin and yang. They may also believe illness can result from making their deceased ancestors angry. They believe a hospital is where one goes to die, and that when blood is drawn for serum testing it depletes the body's blood level. Family members should be involved in the treatment and present in the counseling sessions.

French Mediterranean - The French need to know that as patients they are appreciated, their values and spirituality will be respected, and that in the advising process the practitioner will recognize the family's distress over the patient's pain or illness. The patient may not confide in a family member when ill, so as not to upset them. Typically the male head of household is the health decision maker.

Filipino - Filipinos believe ill health is a result of an imbalance brought about by personal negligence or immorality and that caring for the body with rest, nutrition, exercise, and sleep will result in balance. Until the illness becomes advanced, typically they will not seek health care and tend to be stoic regarding pain. It's important to consult with family members in the decision making process. A belief in the hot and cold theory of healing persists among Filipinos (see Appendix A).

Adherence is common as they highly respect health practitioners and will not question the program. They believe life is controlled by supernatural forces, as well as by the will of God.

German - Illness is described as the inability to have energy to do things or to enjoy life, to congregate, or act the way in which they want to live. Illness can be attributed to God wanting them to suffer. Germans do believe in the germ theory and that stress can cause illness and disease. However, they also believe that environmental changes, such as drafts, can cause ill health. Stoic when it comes to pain, they may be reluctant to complain and avoid seeing doctors, unwilling to be in the sick role.

Vietnamese - The Vietnamese determine that health is dependent upon the number of good deeds executed by one's ancestors and how one behaved in their past lives. Pleasing good spirits can also have an impact on health and well being. They believe disease can be caused by gods, demons or deities who interfere with a patient's life. Family members should be regarded in all decisions made for the patient. They may adhere to the yin and yang theory of health, and if strict Buddhists may not consume meat, eggs, or drink milk.

Korean - They closely follow the Chinese principles of yin and yang, the five elements, and chi. Koreans also adhere to health beliefs regarding cold, damp, heat, and wind causing symptoms of ill health (see Appendix A). It is believed that the intervention of ancestors, the supernatural, or excessive emotions can also result in disease or illness. It is thought that a good appetite is an indicator of good health. The male head of household makes decisions regarding health care and should be present at appointments, but the entire family is also seen as being responsible for all its members. Family is highly valued and is viewed as more important than an individual's needs. Koreans are very close to their children and may fear being a burden to them.

Italian - They may keep illness a secret from family members, tending to blame themselves for their health problems. They may adhere to the belief that wind currents carry disease, but that other forms of illness also occur through heredity, supernatural or human causes, contamination, and psychosomatic dealings.

Russian - Relatives are involved in treatments. Be guarded yet positive about treatment plans as patients may overreact. They will not discuss mental illness or sexual history. These patients prefer alternative treatments. They may request hot, soft or warm foods when ill. The decision maker for the family is usually the member with the strongest personality. They may believe illness to be God testing their faith, punishment by God, or the will of God. To speed the healing process, a spiritual leader may be important to consider.

Arab - While the health care provider is expected to make decisions related to the care of the client, the family is involved in acting on decisions from the experts.

They may follow the hot/cold theory of health believing in an imbalance in hot, dry, cold and moist conditions in the body (see Appendix A). They ascribe health as living according to God's will and believe the evil eye can bring illness to or harm another person. They also believe that illness can be caused by germs, bad luck, stress in the family, sudden fear, drafts, and loss of personal objects. Women are subordinate to men. Conveying optimism in a treatment plan is very important.

South African – Balance with nature is stressed in their health belief system while also believing illness may befall a person from God, or nature, or malicious forces through the living or dead. They may believe the evil eye can bring illness to or harm another person and that powers a person obtains from evil can be directed at another and cause pain or illness. They may also be of the belief system that something they term "excess blood" (high blood pressure) is caused by eating beets, carrots and pork, or drinking grape juice or red wine. Likewise, they may believe "low blood" (anemia) can occur by including too many pickled foods, lemon juice or vinegar in the diet, and not eating enough red meat. "Bad blood" is caused by supernatural forces, contamination, or unclean blood that accumulates during the winter. Pica can also be an issue when nonnutritive objects are consumed, such as laundry starch or dirt.

Portuguese – Illness is believed to be associated with changes in the diet. Some folk medical practices still prevail in Portugal, where curers will use prayer, traditional and modern medicines, and religious paraphernalia.

Polish – Their definition of illness may simply be that they don't feel like doing what they usually do, or that something is wrong. They believe illness and disease are caused by poor diets, and possibly the evil eye. Other beliefs include having faith that God will protect them, and that fervent praying can heal them.

Japanese - Treatment decisions are made with the family, and the patient will want them present during appointments. Ask family members and patients more than once if they have questions. They may not ask until the third time.

Asian Indian – Illness may be viewed as being caused by God punishing someone for sin whether in the present life or past life. Dead ancestors or jealous living relatives can also cause illness. Illness can result from body imbalances, but can also wash away a person's sins. Some Indians may hold a strong belief in Ayurvedic medicine that classifies foods and conditions as pitta, kapha, or vata (see Appendix B, Ayurvedic Properties of Food). The decision maker in the Asian Indian family is typically the mother-in-law, grandmother, or eldest son. They may be stoic in regards to health conditions and not reveal all the facts. They believe spirituality is as important as rest and a good diet.

Greek – Some of their long-held conceptions concerning ill health include the impact certain foods will have on the system, the hot and cold theory (see Appendix A), wind damage, and emotional factors such as anxiety and envy.

## NONVERBAL COMMUNICATION

Nonverbal communication frequently correlates with verbal messages. By appreciating key cultural differences in nonverbal behavior, the nutrition professional can collect clues about underlying viewpoints and values. For example, some patients regard slouching as a mark of rudeness, or placing the hands into a pocket indicates a lack of respect. Nonverbal communication not only includes gesturing and body movements but also includes behaviors such as facial expressions, eye contact, and touch. Additionally, nonverbal messages are related through the placement of furniture or seating arrangements. People in some cultures may feel more comfortable sitting next to the counselor as opposed to facing them from across the desk. It is important in the counseling session to understand how much personal space is required for the patient to feel comfortable. Some cultures value closeness and warmth while others perceive distance as indicating respect and high regard.

Generalizations follow regarding beliefs for specific cultural groups. They are not intended to stereotype or suggest that all members in the group adhere to the same beliefs. These generalizations are illustrated to aid the nutrition professional in understanding barriers that may block effective communication.

Mexican Americans – Feel they are punctual even if they are 20 minutes late and view tardiness as a sign of respect. They shake hands forcefully and for longer periods of time, and may want to engage in extensive small talk before opening during their appointment. Asking them about their interests and families before beginning the session will create trust. The counselor will be viewed as an authority figure and will be expected to dress professionally. Once trust has been established they are likely to form a close bond. Interrupting the speaker is not considered impolite. Although Mexican Americans converse at close ranges and signs of affection are encouraged, they are uncomfortable with extended eye contact.

If complimenting a child touch them briefly, otherwise it may cause evil eye in the patient's belief system. Hispanics can appear loud, but are expressive and sensual and enjoy smelling and feeling things. They very much enjoy activity, sounds, bright colors and spicy food. They may not accept the invitation to ask questions until offered two or three times to do so. The soles of the feet or bottom of the shoe should not be shown, as it is perceived as being arrogant and rude to do so. The "OK" sign in the United States (made using the thumb and index finger) is an obscene gesture. The husband or father is responsible for making health decisions and should be included in the counseling session.

African Americans – Converse at close ranges and use significant amounts of hand gesturing when speaking. They maintain continuous eye contact while speaking, but broken eye contact while listening. They prefer indirect questions and equal turn taking during conversations, and believe it is entirely suitable to interrupt another. Touching the top of the head is a personal violation. They may feel a first

name basis infers disrespect, especially with elder patients, and prefer to be greeted by last name and respective title: Mr., Mrs., Ms. or Miss. Decisions regarding health issues will be viewed as a family responsibility. The head of the household, which is typically the female, should be involved in decision making.

Native Americans – Family takes precedence over an individual. Values include sharing, cooperation, and spirituality. Being a collective group with a present time orientation can make them late as a commitment to a family member or project could outweigh keeping their health appointment. In greeting, a smile and handshake are customary although a vigorous handshake can be perceived as an aggressive act. Elders are highly valued and respected and should be referred to as "grandmother" or "grandfather" in conversation. The relationship will be important between health provider and the Native American. They may want to engage in extensive small talk before opening up, and may believe the health professional should be able to deduce the problem through instinct. Their personal space is greater than other collective cultures, and they will shun direct eye contact as a symbol of respect. Nodding their head indicates they are listening but does not suggest an understanding of the message or that they are in agreement with what is being said. As it is deemed impolite to take notes, ask them to repeat what they have understood during the conversation. Patients speak for themselves and expect an unhurried conversation that is informal and interactive. They use silence as a sign of respect and believe that if they speak too quickly before silently contemplating their answer, they may be viewed as being immature. Comfortable with silence in order to compose their thoughts, they may take 90 seconds or more to respond to a question. The professional should speak in a normal volume, for loudness is considered disrespectful, as is pointing with the hands. "Yes" or "no" can be the complete answer to a question and should they not wish to discuss a matter they may say they "don't know."

Chinese – Chinese are not time conscious and may arrive late to the meeting. The first word in their name is family name, the second word is their middle name, and the last one or two words are their given name. They usually prefer being addressed by their family name along with Mr. or Mrs., but the health professional should ask the client how they would like to be addressed. Upon greeting, they may not smile but rather nod their head or bow slightly. Handshaking may or may not be appropriate so it is best to wait for an extended hand. Touching is uncommon in this culture.

In conversation settings, they prefer to sit next to someone vs. across the desk or table. Less personal space is preferred, sitting and standing closer to the counselor albeit avoiding eye contact. They may want to engage in extensive small talk before opening up. Nodding of the head indicates they are listening but does not suggest an understanding of the message or that they are in agreement. Ask them to repeat the information. Silence is a form of respect, rather than a lack of desire to continue the conversation, and it is best not to interrupt their process. They will expect a quiet and unhurried conversation with a simple treatment plan, which includes terms they understand, and a detailed explanation. They will also need the health

professional to maintain a positive outlook on the results of following their treatment plan. Asking questions can be seen as a sign of disrespect, so they may need to be asked several times if they do not understand something. When the nutrition professional asks questions, to save face the Chinese patient may say "yes" to avoid any confrontation even if their answer is "no."

Do not gesture with hands while talking as it may make them feel uncomfortable. Pointing with the index finger is regarded as ill mannered, thus any directional pointing should be done so with an open hand. Expressing emotion is regarded as immature and also violates the cultural value of saving face, so they may restrain their true feelings. However, if they are uncomfortable or surprised they may noisily suck in air to express their negative emotion. Seldom will they publicly show physical contact, and touching the top of their head is a violation. The soles of the feet or shoes should not be shown as it is perceived as being arrogant and rude, and therefore the nutrition counselor should be conscious of how crossing the legs may appear. Good posture is important to them. Of those who do speak English, 50% do not use the language at home.

French Mediterranean – Shaking of hands when being introduced and conversing at close ranges is the norm. They may shake hands before and after a meeting, or upon entering or leaving a room. However they do not engage in full eye contact, as brief contact appears more friendly. The use of titles is important to address those not on a first name basis, such as Monsieur for men, Madame for women, and Mademoiselle for young women. An exaggeration of emotions, such as grief or sadness, is not looked down upon and even men will cry in public. They read silence as a form of agreement among parties. To swear or promise something, the hand is placed flat on top of the head. They do not chew gum in public.

Filipino – Men may find discomfort working with a female health figure and will refrain from maintaining prolonged eye contact, as it is impolite to stare at people. In avoiding conflict and saving face, emotions are pent up and the patient will appear polite and cooperative. They are extremely sensitive to social slights so preventing embarrassment in the meeting is paramount, as is pointing out any positive efforts on the patient's part. Giggling or smiling can indicate discomfort or interest. They are comfortable with silence and require a greater personal space. The use of first names should be avoided when greeting adults who are older. The middle name is the mother's maiden name, and the last name is the father's name. The practitioner should be conscious of attire worn at meetings and dress professionally.

German – Obsessed with punctuality, they will arrive for the appointment on time or early. They shake hands firmly upon greeting, but will require more personal space when conversing. The use of title is important in addressing new clients. They will engage in very direct eye contact and use loud tones when speaking to convey self-confidence and authority. Silence in conversation is viewed as negative. Disinclined to complain, they tend to act quite stoic and may even avoid seeking care to

emphasize self-reliance. They feel uncomfortable when people gesture with their hands while speaking and seldom show physical contact publicly. Slouching is considered impolite and a mark of poor manners. Good manners are expected of the health practitioner, and the professional's education and knowledge will be respected.

Vietnamese - May arrive late to their appointment. By avoiding direct eye contact they are indicating respect. They will require more personal space than other cultures with strangers. The family name is written first, the middle name is next, with the first name listed last. They usually prefer their first name along with Mr. or Mrs. A patriarchal culture, men will not be accustomed to working with women in the health care setting. Men will shake hands, but it is respectful to wait for a woman to offer her hand first. Expressing their emotions and feelings is not something they are accustomed to doing and consider it a weakness that interferes with self-control. Negative emotions may be expressed by silence, as they believe a blunt no might offend others or create disharmony. To avoid conflict, smiling is a common reaction. Explain the program as accurately and as simply as possible and ask them to repeat what they've understood, for nodding of the head does not necessarily indicate approval or understanding. The head is considered sacred and must not be touched. Feet, being the lowest part of the body, are offensive and should not be shown.

Korean – Direct eye contact demonstrates sincerity and attentiveness, and is expected. Withholding emotions, they can appear cold and distant. Too much smiling is viewed as the mark of a superficial person. Very little touching occurs in public, although a light introductory handshake is typical. When rising to shake hands in greeting an elder, it is customary to touch the palm of the left hand to the elbow of the right arm. This gesture is also traditionally employed in passing items. In seating arrangements, the seat to the right is regarded as one of honor. Crossing legs after sitting down is taboo. Quiet and nonassertive, they view loudness or laughing as impolite. Emotions are quietly suppressed. They are hesitant to say "no," but will indicate disagreement by tipping the head and sucking air in through their teeth. The "OK" sign using the thumb and index finger in the United States indicates money to Koreans.

Italian – May arrive up to two hours late for an appointment and think nothing of it, as Italians move at a slower pace. Nothing is more important than family so if a relative needs something their need will override being punctual. When arriving and leaving make sure to shake hands firmly. Touching is acceptable, as well as direct eye contact. Close personal contact between 18" and 24" is common. The Italians use dramatic gesturing while speaking, but moving a finger behind the ear can refer to someone as a homosexual. Their communication is characterized by loud voices and they will express more stress and emotional tension than any other cultural group. They will be willing and open to sharing detailed symptoms if the health professional is empathetic and warm, as they scorn arrogance. Business

cards should be treated with respect for they are an important part of the culture. The male head of household makes the decisions regarding health care.

Russian – In greetings, a handshake is used or three quick kisses on the cheek. They expect formality and save first name usage for those close to them. Russians maintain direct eye contact and view silence as an agreement between parties. They consider it rude to sit with the legs spread wide or outward, or if the ankle rests on the knee.

Arab – May run up to 30-60 minutes late for an appointment, as they are a slower-paced culture. At the beginning and end of each visit, shake hands less firmly but longer than usual. However, do not touch members of the opposite sex or extend a hand to an Arab female unless she instigates the handshake first. Smile and greet in order of seniority, but males are always greeted first. They prefer to be addressed using a title and their first name. Eye contact is important and is both long in duration and direct. They may resist the pressure to achieve too much at the first meeting and will want to spend time with small talk before opening up. The counselor can gain trust by sharing a bit of personal information with them. Coffee or tea should be offered at least three times. The appointment should remain unhurried. Looking at your watch suggests they aren't worthy of your time. They use direct body orientation when engaged in conversation and are communicative, animated, and speak with volume to denote strength. Responding with silence in conversation is viewed as negative, while interrupting the speaker is not considered impolite. Nodding the head indicates they are listening but does not suggest an understanding of the message or that they are in agreement.

Refrain from bright colors in dress, and avoid cologne or perfume, as they believe a person's bodily smell is important. Do not pass objects with the left hand as it is considered unclean. Good posture when standing and sitting shows respect and proper manners. When the "OK" sign is accompanied by exposing teeth, it indicates hostility. Do not show the bottom of the foot or point with the index finger as it is considered rude. The Arab patient will not actively take part in decision-making, but see their role as cooperating with the program that has been outlined for them.

South African – A handshake is the most common form of greeting. They converse at close ranges but may evade eye contact as a mark of respect. The male head of household makes the decisions regarding health care. Afrikaners will not want the meeting to follow a set agenda, but rather be a warm and friendly, folksy-type meeting. They can be rather blunt in expressing their opinions and do not view this as disrespectful.

Portuguese – Although they may arrive 15-30 minutes late for a meeting, they will expect you to be on time. Business dress is very important to the Portuguese. In greeting patients, shaking hands with everyone present is customary – whether men, women, or children. Refrain from demonstrative hand gesturing or body language, and don't use your fingers to point. Shake hands with everyone again when the meeting has concluded.

Polish – Shake hands upon greeting. Maintain direct eye contact and smile. They will ask questions but not freely offer information. The Polish are expressive in conversation, will lean closer or even touch an arm to gain attention. They may be quite loud in order to be heard. However, they may voice fewer concerns and worries, which can lead to less effective communication. Friendly conversation is welcomed when business is finished as a way to bond with the practitioner and build a relationship. Do not put your hands in your pocket and do not show the bottom of the foot. They do not chew gum in public.

Japanese – They are "fashionably late" to events. In order to demonstrate respect, they should not be addressed on a first-name basis. A light handshake is customary. They prefer an unhurried meeting and may want to engage in long periods of conversation before getting to the agenda of their appointment. Silence is used when considering something and also can indicate respect, rather than a lack of desire to continue the conversation. Criticism leads to embarrassment and a halt in the communication flow. Waving a hand with palm facing outward in front of the face signals "I don't know." They may inhale breath to signal respect while communicating with others. They do not verbalize emotion and may hide anger or sorrow by smiling and laughing. Displays of emotion are considered rude and lacking in control, and seldom will physical contact be shown in public. Downcast or closed eyes indicate attentiveness and agreement. Direct eye contact is regarded as discourteous, intimidating, and disrespectful. They feel uncomfortable when people gesture with their hands while speaking. Even the slightest gesture could have meaning and therefore it is best to refrain from broad hand or body gestures. They relate status and authority to dress more so than anywhere else in the world. Good posture is highly regarded.

Asian Indian – In greeting, acknowledge the husband first. He may also be the spokesperson for his wife. Very little physical contact is shown although a handshake may work. They will be soft-spoken, courteous, and polite. Asian Indian women will not be comfortable with male counselors and will not maintain eye contact. Direct eye contact between women and men is avoided for reasons of modesty and religious laws. However, men may engage in direct eye contact and will be highly respectful of health professionals. They will not expect to be rushed in the meeting and will engage in significant small talk. The meeting should be leisurely or they will perceive the practitioner as rude. It is impolite to point with

the foot as it is regarded as the filthiest part of the body. Do not cross the leg and show the bottom of the foot, either. Touching the head should be avoided, as well as any sign of affection or touching. The left hand is never used for social purposes such as shaking hands or passing items.

Greek – They prefer a personal relationship with health providers. When greeting, shake hands firmly, maintain direct eye contact and smile. Female patients will want to discuss their health concerns with a female and, likewise, men will want to work with another male. A high level of physical contact is natural to them and they want to sit and stand close. Direct eye contact is very important. They can be loud and will want to express themselves. To indicate "no" Greeks lift their face and jerk the head back, or fervently bring one or both hands to shoulder height, or raise and lower the eyebrows once. "Nay" indicates "yes." It is important to communicate with the patient's family, as they are a vital support system. The thumbs-up gesture is regarded as an obscene sexual gesture, and a wave of the palm with fingers extended (as in a friendly hello) is a critical insult to the Greek.

### CHAPTER 3: FOOD, NUTRITION AND HEALTH PROBLEMS BY CULTURE

This chapter provides information on the common core staple foods for each culture, followed by a description of a typical day's meal plan. The leading causes of death for each ethnicity are presented, accompanied by the statistics on obesity rates for the country. Lastly, dietary recommendations and other health information are listed.

#### MEXICAN AMERICANS (43 Million Non-English Speaking US Residents)

The most abundant staple food in the Mexican diet is grains. Nearly 239 pounds of grains are consumed per person per capita with much of that total consisting of corn. Meat includes poultry, pork, goat, sausage, beef and fish totaling 150 pounds consumed per person annually. Meats are typically heavily spiced and rolled into wraps made from corn or wheat, such as tacos, flautas, tamales, enchiladas, burritos or quesadillas. In small amounts, vegetables such as chili peppers and sweet peppers, onions, tomatoes and tomatillos most commonly accompany these meat wraps, which are then typically fried in lard. Eggs are also commonly added to the wraps, with approximately 198 eggs eaten per person yearly. Mexicans consume only 40 pounds of vegetables during the year. Total dietary consumption of legumes is 49 pounds per person. Legumes and rice are commonly combined for complementary proteins, while corn, cactus, jicama, potatoes, greens, squash and avocado are popular staples. Hot chocolate milk is a popular beverage for those Mexicans who are not lactose intolerant. The average Mexican will consume 31 gallons of milk per year, but will also consume 33 gallons of soda, 7 gallons of alcohol and over 13 pounds of sugar per person annually.

Breakfast can consist of tortillas, eggs, fried beans, meat, fruit, cereal or sweet bread, coffee or hot chocolate. Lunch is the largest meal of the day and might include tortilla wraps, fried beans and rice, meat, or soup and sandwich. Snacking is frequent and can include cookies, cake, sweet rolls, hot chocolate, and coffee. Dinner resembles lunch with another tortilla wrap, fried beans and rice, meat stews, and dessert. A snack before bedtime would include sweet rolls or leftovers.

The diet is high in fat from fried foods (see Appendix C for the food composition of typical Mexican foods) while few vegetables are included. Mexicans suffer from diabetes, heart disease, stroke, and liver diseases. 67.9% of the women are overweight (of which 34.3% are obese). 15% of the children between the ages of 3 and 7 are overweight (of which 6.3% are obese) and 68.4% of the men are overweight, which includes 24% who are obese.

Diabetes is the most pressing health concern for Mexican Americans and is the leading cause of death. 11.3% of the men and 14.2% of the women have been diagnosed with Type II Diabetes. Estimates present 28.5% of the men and 23.6% of the women are pre-diabetic. The Mexican Food Pyramid (see Appendix D) suggests a daily consumption of 6-11 servings of grains, 3-5 servings of vegetables, 2-4 servings of fruit, 2-3 servings of both meat and dairy, and suggests using fats and sweets sparingly. The Mexican diet is deficient in calcium, riboflavin and Vitamin A. Those with limited dairy intake could be low in protein or iron (see Appendix E for food sources of these nutrients.) Knowledge of the hot-cold system may be beneficial when counseling the Mexican American client (see Appendix A). See also Appendix E for information on bilingual patient resources for diabetes care and prevention.

#### AFRICAN AMERICANS (38 Million US Residents)

Foods staple to the African American diet include fried chicken, pork with gravy, pork back, chitlins (fried hog intestines), barbecued spare ribs, fried fish, ham hocks, fried eggs, legumes, greens, yams, sweet potatoes, turnips, squash, grits, corn bread and dumplings. Many of the soul food recipes were originally created using scraps slave owners gave away to their slaves, as in the case of a sausage called scrapple that is made from pork scraps. The typical African American breakfast can consist of grits and butter, eggs, sausage, biscuits and gravy, or bacon, pancakes, hash browns and corned beef hash. Fried meat sandwiches with beans, ham, and cornbread is an average lunch. For dinner additional fried meat, greens with fat back, hush puppies, and beans with ham hocks is common, especially for African Americans living in the South. Most meals are centered around meat (which is typically fried), rather than vegetables. Very little dairy is consumed as approximately 75% of African Americans are lactose intolerant, although those who can consume dairy are known to drink clabbered milk, something similar to plain yogurt.

African Americans suffer from heart disease, stroke, cancer, diabetes and respiratory disorders. Hypertension is also a major health concern, so dietary recommendations should include advice to reduce or eliminate salt (see Appendix E for the DASH Eating Plan), as well as educating the patient on the health advantages of a low fat diet.

The African American diet is low in calcium (see Appendix E for food sources of this nutrient) due to the inability to use dairy products. However, the diet is very high in fat and clients should be counseled on ways to prevent heart disease and obesity. (See Appendix E for "On the Move to Better Heart Health for African Americans.") Appendix C contains a food composition table for Soul Food to better educate the health counselor on the nutritional aspects of staple foods in the diet. In addition to heart health and diabetes prevention, efforts to educate the patient on obesity should also be included. 79.8% of African American women are overweight, of which 30.7% are obese and 57.9% of African American men are overweight, of which 34.5% are obese. Obesity rates for African Americans are the highest for any culture. The African American food pyramid recommends a daily intake of 6-11 servings of grains, 3-5 servings of vegetables, 2-4 servings of fruits, 2-3 servings of dairy, and 2-3 servings of meat. (See Appendix D for the African American Soul Food Pyramid.)

#### NATIVE AMERICANS (3.4 Million US Residents)

Perhaps no other food practices have changed as dramatically as the Native American diet, and possibly more so than any other cultural group in the United States. Traditionally, the Native American Indian's diet is calculated to have contained a mere 3-5% carbohydrates, as their diet was very rich in buffalo, wild game, fish, organ meats, turkey, deer, rabbits, elk, moose, bears, eggs, and sheep, with the brains being a delicacy. As hunters and gatherers living off the land, they grilled, stewed, dried and smoked their meats to preserve them. Corn, squash and legumes were also staples in their diet, as were other vegetables such as groundnut (wild potatoes), breadroot (wild turnip), artichokes, sweet potatoes, peppers, and pumpkin. They also consumed a wide variety of nuts, seeds, acorns, and fruits, wild rice, honey and maple syrup. As a lactose-intolerant group, very little dairy was consumed in their diets.

Meat was highly valued and considered healthful and was the central ingredient to any meal. Customarily, two large meals were consumed daily. The first meal was taken at sunrise and the second meal after sunset. A diet very high in meats and antioxidant fruits and vegetables kept them lean and strong; in fact, the Dakota tribesmen reached six feet tall. A study done in the late 1990s in California, however, found that Native Americans have moved quite far from their hunter-gatherer diet. Results of the study concluded 60% of those interviewed had not eaten fruit and 28% had not consumed vegetables in the prior day.

Transitioning to the Standard American Diet of highly refined carbohydrates and much less protein has created an obesity crisis in the Native American Indians with 33.7% of the men overweight (including 18.8% who are obese), and 40.3% of the women overweight (of which 16.6% are obese). The leading causes of death are heart disease and diabetes. In the Pima tribe alone, 50% of the adults have Type II diabetes, the highest rate anywhere in the world. Cancer is another leading cause of death, as is chronic liver disease resulting from alcohol abuse.

Typically unwilling to change the diet, these patients are more open to considering different ways to prepare foods. The National Heart, Blood and Lung Institute (NHBLI) has created a flyer (see Appendix E for American Indian and Alaskan Native People) featuring tips for making better food preparation choices while using both the Native American Food Pyramid and the Traditional Navajo Food Pyramid (see Appendix D.) Unfortunately, Native American Indians are four times more likely than any other group in the United States to suffer from food insecurity. The United States Department of Agriculture has developed a "American Indians and Alaska Natives Guide to USDA Programs" (see Appendix E) with programs available for obtaining both food and medical care and is a very extensive guide for the nutrition professional to have. (Also, see Appendix C for food composition tables for Alaskan Native Foods.)

#### CHINESE (2.5 Million Non-English Speaking Residents)

The National Bureau of Statistics of the People's Republic of China distinguishes the per capita consumption of major food items between those living in the urban areas and those residents living in rural areas, as their diets vastly differ. Urban Chinese consume only 17 pounds of grains per person per year, whereas rural Chinese consume approximately 490 pounds annually. Vegetables are preferred slightly unripe or pickled and consumption is closer in range between urban and rural areas at 261 pounds and 237 pounds, respectively. Pork, beef, sheep, poultry and aquatic products consumed in urban areas are 101 pounds per capita and 50 pounds in rural areas. Fruit consumption also vastly differs with 127 pounds consumed per person annually in urban areas and 39 pounds for rural members. In urban areas, approximately 210 eggs and the equivalent of 5.5 gallons of milk and milk products are consumed compared to 85 eggs and no milk products included in the rural diet.

It can be difficult to describe the Chinese diet as foods not only include regional variations but are also divided into five culinary categories based on flavor and whether or not the food is commonly eaten in the north or in the south. Traditional foods include white and polished long-grain rice and rice bean thread pasta, black bean and shrimp pastes, bok choy, Chinese eggplant, long beans, lotus root, bitter melon, mushrooms, water chestnuts, and congee (a rice porridge). Egg rolls, spring rolls and wontons (fried, steamed or in soup) with meat and vegetable fillings are common. Due to lactose intolerance, the soybean is used to make soymilk, soy cheese and tofu. (As a note, 75% of Chinese are lactose intolerant, although cheese

that has been aged over 60 days is tolerated as the lactose is converted in the aging process to lactic acid.) Hoisin, oyster and soy sauces are traditional seasonings. Meat and fish is preferred salted and dried. Fruits include persimmons, pomegranates, tangerines and dates. The Chinese balance yin and yang foods with hot, cold, warm and cool foods (see Appendix A for The Chinese System of Food Cures).

Breakfast can consist of rice gruel, millet and small amounts of animal proteins, or deep-fried crullers or dumplings. Hot steamed bread or noodles can also be included as breakfast foods. Lunch is a smaller version of dinner that includes soup, rice or wheat, fish or meat, vegetables and sliced fruit. Beverages include alcohol made from rice and bamboo leaf, and tea.

Several dietary deficiencies are common in the Chinese diet: vitamin A and C deficiencies are found in some areas, iron, zinc, iodine and calcium are also common deficiencies (see Appendix E for food sources of these nutrients). Calcium sources for Chinese include calcium-set tofu and consuming small bones in fish and poultry. With a diet high in sodium, hypertension is a common health issue (see Appendix E for The DASH Eating Plan). Stroke, heart disease, stomach and liver cancer top the list of leading causes of death. 24.7% of the women are overweight (with 1.9% of them obese) and 33.1% of the men (and 1.6% obese.) Two versions of the Chinese Food Pyramid are found in Appendix D. The Chinese Food Guide Pagoda recommends daily consumption of 11-18oz. of grains, 14-18 oz. of vegetables, 4-7 ounces of fruit, 2 oz. of legumes, 1 ½ -3 oz. of meat and 2 oz. of fish, ½ to 1 egg, and 2 tablespoons of fat.

#### FRENCH MEDITERRANEAN (1.4 Million Non-English Speaking US Residents)

Meat is the central part of a meal in France, whether veal, horse, lamb, beef, poultry, pork, goat, rabbit, sheep, goose, sausage, liver pate, organ meat or fish and shellfish. The French consume 220 pounds of meat per person per annum. Bread is another staple in their diet. They consume 138 pounds of bread, 38 pounds of cheese and 17 gallons of milk (mostly as cream), which is used to make their rich sauces. In addition, the French will consume ½ gallon of olive oil in a year's time. Vegetables considered staple foods include garlic, shallots, onions, leeks, carrots, potatoes, cabbage, beets, turnips, celery, radish, spinach and other fresh greens, cauliflower, green peas, zucchini, asparagus, green beans, sweet peppers, eggplant, fennel, mushrooms (including truffles), pumpkins, tomatoes, fava beans and chick peas. Fruits common to the diet are apples, quinces, pears, peaches, apricots, cherries, nectarines, raspberries, strawberries, prunes, blueberries, grapes, figs, watermelon, oranges, lemons, pomegranates, olives and avocados. Grains include rice, couscous, bulgur wheat, buckwheat, barley, and pasta. Walnuts, almonds, filberts, chestnuts, pine nuts and pistachios also are common in the diet. Unlike the Koreans, sweet and sour are never mixed in a meal. All vegetables are cooked unless served in a salad.

A French meal is leisurely. It is common for the French to have coffee or cocoa with hot milk for breakfast with toast and jam or a croissant. Because the breakfast is so light, a morning snack of bread and cheese or a small meat sandwich or fruit may be eaten. A typical lunch might start with a pate appetizer, then a meat, fish or egg dish with cooked vegetables and bread, an open-face meat and cheese sandwich, quiche, salad, or a cheese filled pancake. Wine is served with the meal and coffee after the meal. Dinner could start with vegetables and cold cuts, meat, pureed vegetables, bread, salad and cheese, or a dinner may resemble chicken in a cream sauce with a baguette, cheese, a green salad and wine.

Heart disease, stroke, and lower respiratory cancer are the leading causes of death in France. Although heart disease is their number one killer, their rate of heart disease is lower than in any other country worldwide, even with a high fat diet that is very low in complex carbohydrates. Resveratrol is an antioxidant found in the skins of red grapes, and it is believed that in consuming 54 liters of red wine per person annually, the resveratrol is responsible for this low heart disease ratio. As for weight, 34.7% of the women are overweight (of which 6.6% are obese) and 45.6% of the men (with 7.8% of them obese). "The Seven Keys of Change" from the French food pyramid suggests 50% of a meal should consist of vegetables and 25% of lean meats. Specific suggestions are 6-11 servings of vegetables and fruits daily, 3-5 servings of whole grains, 2-3 servings of low fat dairy or meat. (See the French Food Pyramid in the Appendix D.)

#### FILIPINO (1.4 Million Non-Speaking US Residents)

Rice is the most important staple food in the Filipino diet. It is the basis of a meal and is eaten at breakfast, lunch and dinner as well as featured in many of the desserts. Rice is served with meat and vegetables; salted or smoked fish and vegetables; or with coconut milk, ginger and chili peppers. Rice dishes are flavored with soy sauce, fish sauces, garlic, and vinegar. With most Filipinos lactose intolerant, seafood is the most important protein eaten although poultry and pork are available. All parts of the animal are eaten in the Philippines, with approximately 68 pounds of meat being consumed per person annually. Few records exist on grain, fruit and vegetable, egg or cheese consumption. Vegetables common to the Philippines include sweet potatoes, tomatoes, eggplant, chili peppers, mung beans, corn, hearts of palm, seaweeds, greens, garlic and ginger. Fruits include papaya, coconut, jackfruit, limes, mango, bananas, and pineapple. Pickled fruits and vegetables are common staples as are peanuts. Rice noodles, wraps, wheat and mung bean pastas are also popular. Shrimp paste and anchovy sauces add flavor to dishes.

Breakfast may include rice and vegetables with meat or fish and coffee, hot chocolate or juice, or rice fried with garlic, an egg and bits of fish, meat or sausage. On occasion, bread or cheese rolls will be substituted for rice. Lunch is the heaviest meal of the day and may include pork liver soup, egg rolls or turnovers, steamed rice with vegetables and meat, or stew made with chicken, pork, shrimp or ham, and

fruit for dessert. Dinner is similar. Snacks may be in the form of rice cakes, yams or bananas.

The leading causes of death in the Philippines are lower respiratory infections, heart disease, and tuberculosis. 28.5% of the women are overweight (with 3.7% of them obese), and 21.9% of the men (of which 1.1% are obese.) A diet high in rice, vegetables and fish results in both an iron deficiency (resulting in anemia) and a zinc deficiency. (See Appendix E for food sources of these nutrients.) Other health issues include diabetes and gout.

The Food and Nutrition Research Institute of the Philippines has designed Food Pyramids for multiple age groups. There is a pyramid for children ages 1-5, another for those age 7-12, a teen pyramid, a pyramid for those ages 20-39, two pyramids for pregnancy and lactation, and a final pyramid for those 60-69, which is presented in the Appendix D, along with the a link to the other pyramids used in the Philippines.

#### GERMAN (1.2 Million Non-English Speaking US Residents)

Next to meat in the German diet, bread (especially pumpernickel and rye) is most important. Germans eat about 134 pounds of bread per person per year, with 180 pounds of meat and 67 pounds of sausage, bratwurst and liverwurst on top of that. Nearly every type of meat is eaten: beef, pork, veal, lamb, goat, wild game, poultry, liver, kidneys, lungs, tripe (stomach lining), and sweetbreads (thymus gland). Snails and fish (pickled, smoked, or salted) are also included. Another staple are dairy products: Germans consume 21 gallons of milk per person per capita in the form of buttermilk, sour cream, fresh cream, milk and whipped cream (which is consumed daily in coffee); 42 pounds of cheese (especially strong cheeses like Limburger); and 15 pounds of butter each year. In addition, 290 eggs are consumed in the German diet annually. Needless to say the German diet is very high in protein and cholesterol.

In addition to protein foods, an average of 154 pounds of potatoes and another 220 pounds of other vegetables are consumed annually per person, along with 253 pounds of fruit. At 38 gallons per person per year, Germans consume more beer than any other nation in the world.

Breakfast consists of any combination of bread, butter, jam, honey, soft boiled eggs, cheese, ham, sausage, cold cuts, sweet pastries, cereal and milk. Mid-morning snacks can range from bread, fruit, meat sandwiches and beer to coffee and pastries. Lunch is the main meal of the day and may consist of soup with dumplings, one or two meat or fish dishes and vegetables, or sometimes a one pot meal or stew. Dinner is the lightest meal of the day where sandwiches, cheese, yogurt, cold cuts, pickled or smoked fish is eaten with bread.

The leading causes of death are heart disease, stroke and lower respiratory cancers. Germans also suffer from digestive problems and arthritis. 55.1% of the women are overweight (of which 20.4% are obese) and 56.1% of the men are overweight (including 21% who are obese.) 15% of the children between the ages of 3 and 7 are overweight and 6.3% are obese. The German Nutrition Circle recommends daily consumption of: 9-12 oz. of bread or 7-9 oz. of rice or 9-11 oz. of potatoes; 7 oz. of vegetables and 3 ½ oz. of legumes; 9-11 oz. of fruit; 8 oz. of low fat milk or 3 oz. of low fat cheese; 5-11 oz. of fish weekly; 11-21 oz. of meat weekly; 3 eggs weekly; and less than 3 tablespoons of fat daily. (See the German Food Pyramid in the Appendix D.)

#### VIETNAMESE (1.2 Million Non-English Speaking US Residents)

Rice is the staple food in Vietnam, sometimes simmering on the stove during the entire day. Approximately 63 pounds of meat is consumed per person per annum in Vietnam, including pork, chicken, fresh and fermented fish, fish sauces, and shellfish. Tofu is another source of protein for Vietnamese, as are soymilk and eggs, while dog meat is considered a delicacy. Vegetables common to the diet include chili peppers, asparagus, potatoes, cabbage, carrots, radishes, cucumbers, jicama, green beans, and bean sprouts. Fruits include oranges, coconut and coconut milk, jackfruit, bananas, guavas, mangoes, pineapple, grapefruit, limes, plantains, star fruit, mangosteen fruit, apples, lemon, melon, and the tropical fruits soursop and durian. White bread, noodles and pastries are also consumed.

The Vietnamese do not differentiate between breakfast foods or dinner foods, so meals typically include all of the same foods. Soup is served at every meal. Breakfast might be soup with meat or poultry and rice noodles; a sweet potato with peanuts and coconut; or pickled vegetables, bread and a boiled egg with meat. Lunch would also include rice with meat and broth and a vegetable dish or pickled vegetables. Dinner may be a soup made from fresh vegetables and meat, grilled meat, or stir-fried tofu and vegetables with rice. Breakfast is a light meal, but lunch and dinner are substantial. Strong coffee can also be served at meals. Snacks include watermelon and peanut seeds

Heart disease and stroke are the leading causes of death. Tuberculosis and hepatitis also create health issues for the Vietnamese. Obesity rates are extremely low in Vietnam. Only 8.7% of the women are overweight and 4.1% of the men. Obesity is not an issue. In fact, underweight is found in 13.3% of the population. The diet is low in iron, calcium, and zinc (see Appendix E for food sources of these nutrients) while high in sodium. The Vietnamese pyramid suggests a monthly intake of 3 ½ pounds of fish, 4 ½ pounds of meat, 26 ½ pounds of vegetables or as many vegetables as one can eat, and less than 10 ounces of butter. See Appendix D for the Vietnamese Food Pyramid.

#### KOREAN (1 Million Non-English Speaking Residents)

Grains and vegetables comprise over one half of the Korean diet. 279 pounds of grains and cereal, and 228 pounds of vegetables and another 29 pounds of potatoes are consumed per person per year. Other plant sources are 6 pounds of seaweed and 158 pounds of fruit consumed per person, per capita. Protein foods include 25 pounds of legumes, 109 pounds of meat, poultry and fish, 144 eggs per person annually, and approximately 6 pounds of fats and oils. Dairy is generally not consumed due to 90% of the population being lactose intolerant.

Food staples include grains, spicy vegetables, meat, poultry and fish, with short-grain rice being the foundation in their diet. Millet, barley, and noodles made from buckwheat, mung bean and wheat are also common. Vegetables are eaten at every meal, especially cabbage, eggplant, radishes, cucumbers, winter melons, sweet potatoes, bean sprouts and seaweeds. Vegetables are mostly eaten pickled or fermented, and in soups. Fruits common in the diet are Asian pears, cherries, red dates, apples, grapes, persimmons, melons and tangerines. Fish is eaten dried, salted, and in fermented fish sauces. Chili peppers and chili paste are also customary.

There is an emphasis on combining the tastes of sweet, hot, sour, bitter, and salty foods in meals (see Appendix A), as well as including the colors black, red, green, white and yellow. Rice is served at every meal. Breakfast is considered a main meal and will consist of soup and rice with eggs, meat or fish and vegetables and seaweed, flavored with sauces. Lunch consists of noodles with meat or fish and their broth with vegetables. Dinner resembles breakfast.

Stroke, cancer and heart disease are the leading causes of death among Koreans. Stomach cancer, hypertension and hepatitis B are also common among Koreans. 43.8% of the women are overweight (of which 10.1% are obese) and 40.2% of the men are overweight (of which 4.1% are obese). Their diet is low in vitamins A, C, and riboflavin, and the minerals phosphorus and calcium (see Appendix E for food sources of these nutrients). The Korean Food Guide Pagoda recommends daily consumption of 4-5 servings of grains, 6-7 servings of fruits and vegetables, 1 serving of milk, 4-5 servings of meat, and 1 egg. (See Appendix D for the Korean Pagoda.)

#### ITALIAN (.8 Million Non-English Speaking US Residents)

Italians eat 207 pounds of meat each year in the form of veal, lamb, pork, chicken, seafood, sausage, horse, sheep, beef, goat, turkey, rabbit, duck, goose, pigeon, and other wild game. Few parts of the animal go to waste as Italians enjoy pig's feet, head, tongue, and oxtail, along with the brain, sweetbreads, liver, spleen, hearts, lungs, kidneys and the testicles of animals. Eating bread at every meal, Italians consume 162 pounds per capita per annum and 79 pounds rice, corn and wheat. Wheat is enjoyed in the form of couscous, pasta with tomato sauce, stuffed with meat and topped with cream sauce, and in other wheat items such as pizza,

calzones, and breadsticks. Polenta from corn is also a staple in their diet. Olive oil is eaten with bread, pasta, and vegetables, and butter is another commonly used fat.

Although eggs are rarely eaten alone, over 200 eggs per person are consumed annually in the form of egg noodles and pasta made from eggs. The equivalent of 19 gallons of milk is consumed in hot coffee drinks and hot chocolate, as well as the base for most cream sauces. Also eaten with pasta is cheese – around 29 pounds per person. Vegetables common in the diet are chickpeas, fava beans, mushrooms, tomatoes, leeks, garlic, asparagus, onions, potatoes, zucchini, cucumbers, fennel, bell peppers, eggplant, artichoke, pickled vegetables, and pesto nut paste. Staple fruits include fresh figs, melon, pears, apples, apricots, tangerines, oranges, strawberries, cherries, peaches, plums, watermelon, persimmons, grapes, medlars and olives. Nuts include chestnuts, walnuts, pine nuts, hazelnuts, peanuts, and pistachios.

Breakfast resembles that of most European countries. It is kept light with strong coffee and milk or hot chocolate and a roll, croissant, biscotti, or bread with honey or jam. Fresh fruit is eaten at the end of most meals, and especially consumed after breakfast. A mid-morning snack would include another strong coffee drink, such as espresso or cappuccino, with a pastry or fruit. Lunch can be substantial: pasta with sauce; meat with vegetables, lentils and salad; or sausage with pickled vegetables and olives followed by soup and pasta or risotto. Dinner is a lighter version of lunch and could begin with pasta or soup, followed by a meat or fish dish and vegetables. Bread and coffee are consumed at every meal, and fruit with cheese is served at the end of each meal.

Anemia is common in Italy while heart disease, stroke, and stomach cancer are the leading causes of death. 38.3% of the women are overweight (of which 12.6% are obese) and 52.7% of the men are overweight (with 12.9% obese.) The Italian Food Pyramid (see Appendix D) suggests a daily intake of 6-11 servings of grains, 3-5 servings of vegetables, 2-4 servings of fruit, 2-3 servings of milk, and 2-3 servings of meat.

#### RUSSIAN (.8 Million Non-English Speaking US Residents)

Bread and potatoes are the two most important food staples in the Russian diet, with 244 pounds of bread and 207 pounds of potatoes consumed per person per year. Protein foods consumed include 91 pounds of cheese, 48 gallons of milk, and 199 eggs. Russians eat about 103 pounds of meat annually, but unlike the German and Polish their meat is prepared well done. They also include jellied meats in their diet along with sausage, beef, pork, poultry and sheep. 28 pounds of fresh, smoked or pickled fish and caviar are common in the diet. Aside from potatoes, an additional 178 pounds of cabbage, cucumbers, mushrooms, and root vegetables are included. Fruit consumption is low at just 48 pounds per person per capita. With 22 pounds of fats and oils consumed along with 61 pounds of sugar, the Russian diet is quite high in saturated fats and sugar.

Breakfast is typically bread, cheese and weak black tea. The mid-morning snack can include sweet rolls and tea or a meat sandwich. Lunch consists of soup or salad, meat and starches, and more tea. Dinner starts with cold appetizers of meat, smoked fish, pickled vegetables or caviar, followed by soup or cabbage, meat and potatoes. Iced cold vodka can be consumed at this meal. Along with weak black tea that is drunk throughout the day, Russians also drink Kvas, a non-alcoholic beverage resembling beer and made from dark bread.

With a diet high in saturated fat, sodium and sugar, the most common causes of death for Russians are heart disease and stroke. 31% of the women are overweight (which includes 25% of them obese) and 35% of the men are overweight (and 10% of them obese.) The Russian Food Pyramid suggests the daily diet should include 6-11 servings of grains, 3-5 servings of vegetables, 2-4 servings of fruit, 2-3 servings of milk and cheese, 2-3 servings of meat, fish, poultry, sausage, eggs or ham, and to consume fats, oils and sweets sparingly. See the Russian Food Pyramid in the Appendix D.

#### ARAB (.7 Million Non-English Speaking US Residents)

There are very little records kept in the United Arab Emirates regarding food consumption per capita or food composition tables. What is known, per the World Resources Institute, is that Arabs consume 164 pounds of meat (from lamb, goat, beef, chicken and camel) and the equivalent of 30 gallons of milk in dairy products, although there is a trend toward lactose intolerance. All parts of the animal are included in the diet (brains, chitterlings, head and feet) and are considered delicacies. Staple foods include wheat kernels, bulgur wheat, fava beans, chickpeas, dates, apricots, mango, papaya, citrus, figs, guava, melon, bananas, tomatoes, spinach, cucumbers, grape leaves, olive oil, yogurt, and dark pita flatbread which is eaten at every meal.

Breakfast is light and may consist of bread or croissants with jam and yogurt and tea. Flatbread with olive oil is another common breakfast. Lunch is the main meal. Legumes with olive oil, garlic and lemon may be served, or a lentil soup. Salad and meat, rice, lentils, bread, and cooked vegetables are also common. Dinner is the lightest meal and will consist of the same foods eaten at lunch.

The Arab diet is low in fruits and vegetables. Heart disease is the leading cause of death. There are also problems with infectious diseases, anemia, and parasites. Health and strength are associated with being overweight so, unfortunately, 69.7% of the women are overweight (of which 39.4% are obese), and 66.9% of the men are overweight (of which 24.5% are obese.) The Arab Food Pyramid (see Appendix D) suggests a daily intake of 6-11 servings of grains, 3-5 servings of vegetables, 2-4 servings of fruit, 2-3 servings of milk, and 2-3 servings of meat.

#### SOUTH AFRICAN (.7 Million Non-English Speaking US Residents)

South Africans average an annual consumption of 273 pounds of grain, 447 pounds of vegetables and legumes, 42 pounds of meat, 9 gallons of sour milk and 137 eggs per person. Staple foods in the diet are corn, greens, and pork and pork products. Corn polenta is eaten with meals much like bread and rice are in other cultures. Pork is barbecued, smoked, and dried into jerky, pig's feet are pickled or roasted, and the ears and intestines are fried. Loaves of meat are made using the pig's head. Salt pork is used in cooking greens such as chard, kale, mustard greens, spinach, turnip greens, and collard. Sheep, lamb, beef, goat, chicken, opossum, raccoon, and fish are also common, as is eating mopane worms. Curdled milk is consumed in small amounts.

Vegetables include pumpkin, squash, sweet potato, cucumbers, carrots, turnip, tomatoes, yams, green pepper, chili peppers, eggplant, cassava, okra, onions, and legumes such as lentils, lima beans, black beans, pinto beans, white beans, kidney beans, peanuts, black-eyed peas and green peas. Fruits include plantains, coconut, apricots, grapes, quinces, tangerines and grapefruit. Fruits are preserved by drying, or in the form of fruit leather, preserves or jams. Other grains common in the South African diet are rice, millet, wheat, barley and sorghum. A home-brewed beer considered food is made from sorghum. It contains B vitamins and is very low in alcohol content.

Breakfast is substantial consisting of grits, fried sweet potatoes, biscuits, ham or bacon and eggs. Lunch is a main meal and may include legumes with ham and greens, potatoes, vegetables, and bread or biscuits. A baked item is included for dessert. Supper is also substantial and could include ham hocks and black-eyed peas, vegetables and potatoes or sweet potatoes, greens, and fried corn meal.

67.2% of the women are overweight (including 35.2% who are obese) and 39.5% of the men are overweight (of which 6.7% are obese.) The leading cause of death in South Africa is HIV/AIDS. The diet in South Africa can be deficient in protein, iodine, calcium (for those who are lactose intolerant), iron, magnesium, zinc and vitamins A, D, E, C, niacin, folate, and pantothenic acid (see Appendix E for food sources of these nutrients). The Nutrition Society of South Africa has published the "South African Guidelines for Healthy Eating" which link can be found in the Appendix E.

#### PORTUGUESE (.6 Million Non-English Speaking US Residents)

The people of Portugal consume 201 pounds of meat per person annually with fresh, dried and salted fish and sardines dominating. Roasted pig's hearts and liver, beef (the preferred meat) and beef liver, smoked ham and sausage is commonly consumed in Portugal. The Portuguese eat 112 pounds of bread and 59 pounds of other grains per person per capita, with rice and cornmeal most common. Very little cheese is included in the diet with just 15 pounds consumed along with 21 gallons of milk. Bread, potatoes, and rice are staples. Guava, mango, papaya, bananas, passion fruit, pineapple, cherimoya, avocado, and yams are frequently eaten, and olive oil is

generously used. Their diet closely resembles the dietary intake of those living in Spain.

Breakfast is either light or can be a full meal. If it's light it consists of coffee and cream, hot chocolate, bread, fried dough pastry or cornmeal boiled with a small amount of lard. A second breakfast will then be eaten consisting of breakfast sausage, fried squid or omelets with bread or tomatoes. When a full breakfast is consumed it resembles the dinner meal. Lunch consists of soup, salad, fish or meat with fruit and cheese. Dinner can be sardines in a vegetable and tomato sauce served with beans or potatoes; soups and stews featuring pigs liver or hearts, cabbage, kale or potatoes; or liver fried in olive oil with beans, rice, vegetables or fried potatoes. Bread and wine are always served with the main meal and soup can be served before or after the main course. A typical snack is cold cuts, olives or cheese.

Stroke and heart disease are the leading causes of death in Portugal. 49.2% of the women are overweight (of which 16.1% are obese) and 58.5% of the men are overweight (with 13.8% obese.) The Portuguese Food Pyramid (see Appendix D) suggests 6-11 servings of grains daily, along with 3-5 servings of vegetables, 2-4 servings of fruit, 2-3 servings of both the meat, nuts, and legume category as well as the milk and cheese category.

#### POLISH (.6 Million Non-English Speaking US Residents)

The most abundant food staples in the Polish diet are grains and bread. The Polish consume approximately 331 pounds of grain and another 250 pounds of bread per capita. Secondly most abundant in their diet is produce, with 308 pounds of vegetables and 105 pounds of fruit consumed per person per year. Protein sources include 101 pounds of meat (in the form of kielbasa, pork, liver, beef, tripe, raw tartar and smoked meats), 29 pounds of poultry, 249 eggs, and the equivalent of 56 gallons of milk. Their diet also includes an enormous 87 pounds of sugar per person annually.

Breakfast is either hearty or light. If it is hearty it will consist of ham, sausage or other cured meats with bread, and perhaps onion, and tomato and pickled cucumber. This meal would be followed by a light lunch consisting of soup, and then followed by a hearty meal of at least two courses in the evening. If a lighter breakfast was eaten, "second breakfast" is very common and will replace lunch if dinner is eaten early between 3:00 and 5:00 in the afternoon. Sandwiches made with cheese, sour cream, radishes and cucumber are a likely late-morning or second breakfast snack, as is cake.

The Polish have a propensity toward heart disease, stroke and cancer. 44.3% of the women are overweight (of which 18% are obese) and 50.7% of the men are overweight (including 12.9% as obese). Dietary guidelines from the United Nation's Food and Agricultural Organization suggest the Polish diet should include 5-6

servings of vegetables and fruits daily, 5-6 servings of bread and potatoes, 1-2 servings of meat and fish, 3-4 servings of dairy, and 2 servings of fat. (See the Polish Food Pyramid in Appendix D.)

#### JAPANESE (.5 Million Non-Speaking US Residents)

With 204 pounds of vegetables consumed per person per year in Japan, it is second only to seafood, which is consumed in the amount of 233 pounds per person annually. Rice, another mainstay, has a consumption rate of 154 pounds per capita per year with short-grain and japonica varieties being most preferred. Japanese consume 346 eggs per person each year with meat consumption at 95 pounds. Protein from dairy is extremely low: 4 gallons of milk, 1.5 pounds of butter, 1.5 pounds of cheese, and 1.4 pounds of skim milk powder. Fruit intake is about 96 pounds per person each year.

Staple foods include soybeans and soy products (soy sauce, edamame beans, tofu, soy milk, miso paste), millet, sweet potatoes, taro, yams, Japanese eggplant, daikon radishes, winter squash, shitake mushrooms, pickled vegetables, and large amounts of seaweed and algae. Beef, poultry, dried sardines, raw fish and shellfish are also staples, along with sesame seeds and walnuts. Udon, somen, ramen and soba noodles are also common in the diet.

Rice is consumed at every meal and three meals a day are generally eaten. Breakfast may be a salty-sour umeboshi plum with rice and seaweed, soup, pickled vegetables or eggs with rice. Lunches can include rice with leftovers, or noodles with eggs and vegetables. Dinner consists of soup, raw fish, sushi, and rice with vegetables either grilled, simmered, steamed or fried. Green tea is drunk with meals. A balance between sweet, sour, pungent, bitter and salty comprises most meals (see Appendix A).

With an aversion to oily tastes and lactose intolerance as the norm, the Japanese diet is low in saturated fats and in calcium but remains high in sodium. Hypertension, stroke and stomach cancer are the leading causes of death in Japan, along with lower respiratory infections. 18.1% of the women are overweight (including 1.5% obese) and 27% of the men are overweight (1.8% obese.) Daily recommendations from the Japanese Food Guide suggest 2 servings of fruit daily, 2 servings of milk (or soy), 3-5 servings of fish and meat dishes, 5-6 servings of vegetable dishes and 5-7 servings of grain dishes daily. (See the Japanese Food Guide Spinning Top and the Okinawa Pyramid in Appendix D.)

#### ASIAN INDIAN (.5 Million Non-English Speaking US Residents)

The average Asian Indian consumes 173 pounds of rice, 185 pounds of vegetables, 48 eggs, 10 pounds of fish and 11 pounds of meat per person annually. Meat, in the form of beef, goat, sheep, lamb and chicken are protein sources for those Indians who are not vegetarians. 32 pounds of legumes are also consumed, more than in

any other culture. Staple foods are rice and unleavened bread. Wheat, barley, corn, lentils, peas, chick peas and beans are also staples in the Indian diet as well as cashews, walnuts, peanuts, pistachios and almonds. Cultured and fermented dairy foods such as clabbered milk, buttermilk, yogurt and cheese are a large part of the diet, as well. Vegetables include white potato, eggplant, mustard greens, onion, taro, bitter melons, gourds, yams, white radishes, lotus roots and green beans. Fruits common to the diet include coconuts, lemons, limes, oranges, bananas, Indian gooseberries, papaya, mango, star fruit, jackfruit and guava. Fruits and vegetables are commonly pickled, dried or made into chutney. Preferred fats include clarified butter (ghee), peanut oil or coconut oil.

Two meals are typically consumed during the day with snacks. Breakfast may be coffee with milk and sugar, pickled vegetables or fruit, stews with lentils, or stuffed rice pockets that have been fermented or boiled. The main meal consists of curried vegetables and rice with legumes or meat, another vegetable side dish, pickled vegetables or fruit, Indian bread, and yogurt. It could also include deep-fried cheese or turnovers stuffed with peas and potatoes and served with rice or lentil purees, vegetable curry, chutney, flat bread and yogurt. Rice is eaten daily with the average Asian consuming approximately ½ pound per day. A balance between six tastes may be used to create the meal: astringent, pungent, bitter, salty, sour and sweet (see Appendix E).

15.2% of the women are overweight (of which 1.4% are obese) and 16.8% of the men are overweight (1.1% of which are obese.) Heart disease, stroke, lower respiratory infections and diarrheal diseases are the leading causes of death. Deficiencies of protein and iron are common, as well as Vitamin B12 (see Appendix E for food sources of these nutrients) and some of the essential amino acids in the case of the vegan or vegetarian Indian. The Asian Indian Food Pyramid (see Appendix D) suggests a daily intake of 6-11 servings of grains, 3-5 servings of vegetables, 2-4 servings of fruit, 2-3 servings of milk and 2-3 servings of meat.

#### GREEK (.3 Million Non-English Speaking US Residents)

The people of Greece eat 173 pounds of meat (mostly as lamb), 134 pounds of bread, 29 pounds of grains, and consume 63 pounds of cheese and 18 gallons of milk per person annually. Leavened loaves of bread are consumed at every meal. Staple foods in the Grecian diet are olives, olive oil, feta cheese, yogurt, almonds, walnuts, sesame seeds, rice, pasta, bulgur wheat, fish, seafood, lamb, legumes, lemons, apples, grapes, figs, quinces, plums, strawberries, cherries, apricots, peaches, melons, tomatoes, carrots, potatoes, beets, eggplant and zucchini.

A traditional breakfast would be bread with jam, cheese, kalamata olives, or a roll, fruit and yogurt, and coffee or tea. Lunch is considered the main meal of the day and may start with appetizers such as baba ganoush, hummus, grape leaves stuffed with rice and lamb, phyllo dough stuffed with cheese and eggs, or caviar with olive oil and bread. A dish featuring grilled meat or beans is served with a salad, and yogurt or

cheese, and fruit for dessert. A glass of ouzo may be served. Dinner is light and may feature soup with beans and vegetables and pita bread, spinach and cheese pastry or cucumbers in yogurt with garlic. A Greek salad is common with tomato, cucumbers, onion, green pepper, olives and feta cheese.

The leading causes of death for the Greek are stroke and heart disease. 61.3% of the women are overweight (of which 24.5% are obese) and 75.7% of the men are overweight (with 27.7% of them obese). The Supreme Scientific Health Council's daily recommendations for a Mediterranean diet include 8 servings of non-refined grains, 3 servings of fruit, 6 servings of vegetables, and olive oil as the main fat. A weekly consumption of 5-6 servings of fish, 4 of poultry, 3 servings of potatoes, 3 eggs, and 3-4 servings of olives, legumes or nuts. 4 servings of meat are suggested for the entire month. See the Greek Pyramid in Appendix D.

#### CHAPTER 4: CONCLUSION

Considerable challenges face nutrition professionals with the growing increase in diverse populations. Nutritional counseling matters require not only sensitivity to the cultural differences, but a vast knowledge regarding the powerful influence culture has on an individual's food choices, attitudes, beliefs and behaviors.

Nutrition professionals will gain the trust of their patients and clients, write better programs and find better patient compliance when they are familiar with possible food restrictions and religious dietary regulations. Understanding a patient's food intolerances, health disparities, and nutritional deficiencies is paramount to successful counseling. Familiarizing themselves with historical foods and diets of these cultural groups, nutrition professionals will gain the necessary knowledge to help patients acclimate to a healthier diet.

The health professional should know who is ultimately responsible for making decisions for the patient, and which physical setting will provide comfort for the people of a specific culture. Professionals should not only be aware of the time orientation and greeting customs but possess empathy while teaching clients one new concept at a time. Exploring the culture's background prior to the appointment will provide insight into how the patient would like to be addressed or where they would like to sit.

Not only are obesity rates skyrocketing, having everything to do with food choices and inactivity, but death from diabetes, heart disease and other health disparities are constantly on the rise as illustrated in the following charts from the Center for Disease Control. The faces of Americans are changing. By the year 2050 Latinos will be the largest minority group in the US, while the population of the ethnic subpopulation groups is projected to be 47.5%. Multicultural competence is no longer an inessential skill to obtain; it is a requirement for those in the health professions. With the national demographics constantly changing, providing culturally competent care is not only an ethical necessity but must be essential for

further agency accreditation. Cross-cultural health care will be commonplace in the not too distant future.

## CHAPTER 5: RESOURCES

In working with clients where language barriers prevent the complete communication exchange process, providing materials to the patient in their native language can support and clarify information conveyed in the meeting. Most of this information is free, and immediately downloadable from a computer.

The National Heart, Lung and Blood Institute (NHLBI) provides bi-lingual Latino resources on cardiovascular risk factors, such as "Lower Your Blood Cholesterol," or "Prevent High Blood Pressure," as well as other health publications. The US Department of Health and Human Services publishes a booklet for African Americans on heart health, while the National Institutes of Health (NIH) provides hundreds of materials in the Chinese, Filipino, Vietnamese, Korean, Japanese, and Asian Indian languages.

Medline, also a part of the National Institutes of Health provides extensive publications in the French, German, Italian and Portuguese languages; and the Public Health Division of Seattle, Washington likewise offers wide-ranging publications in Vietnamese, Korean, Russian and Chinese.

Wayne State University offers a broad range of publications in Arabic, and Stanford University provides multilingual health information in Greek, Polish and 57 other languages. Georgia State University provides bilingual diabetes handouts in 36 languages, and the New South Wales Government provides numerous publications in Greek.

Training nutritional professionals is also an important step in cultural competence. Free training online through the University of Alabama at Birmingham, funded by the NIH and NHLBI, offers learning through both the patient's perspective and the provider's. Another online training course that includes videos and assessment tools is through Diversity Rx and sponsored by The National Conference of State Legislatures, Resources for Cultural Health Care, and the Henry J. Kaiser Family Foundation. The Association of American Medical Colleges provides resource

guides and tools for assessing cultural competence training. There are numerous universities offering online training. Simply Google "cultural competency training."

Window links captured for each of the above-mentioned resources follow.

<http://www.nhlbi.nih.gov/health/healthdisp/aa.htm>

Other links to Health Materials in Languages other than English:

National Network of Libraries of Medicine

Multi-Cultural Resources for Health Information  
<http://sis.nlm.nih.gov/outreach/multicultural.html#a3>

Consumer Health Information in Many Languages Resources  
<http://nnlm.gov/outreach/consumer/multi.html#A6>

Health information in Many Languages  
<http://www.nlm.nih.gov/medlineplus/languages/languages.html>

Cultured Med  
<http://culturedmed.binghamton.edu/index.php/multilingual-health-materials>

Georgetown University Non-English Materials and Resources  
<http://www.mchlibrary.info/nonenglish.html>

Health Education Resource Exchange  
<http://here.doh.wa.gov/search-by-language>

Eurasia Health Knowledge Network  
<http://www.eurasiahealth.org/eng/health/resources/82169/>

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[http://factfinder.census.gov/servlet/SAFFPeople?\\_event=&geo\\_id=01000US&\\_geoContext=01000US&\\_street=&\\_county=&\\_cityTown=&\\_state=&\\_zip=&\\_lang=en&\\_sse=on&ActiveGeoDiv=&\\_useEV=&pctxt=fph&pgsl=010&\\_submenuId=people\\_8&ds\\_name=null&\\_ci\\_nbr=null&qr\\_name=null&reg=null%3Anull&\\_keyword=&\\_industry=](http://factfinder.census.gov/servlet/SAFFPeople?_event=&geo_id=01000US&_geoContext=01000US&_street=&_county=&_cityTown=&_state=&_zip=&_lang=en&_sse=on&ActiveGeoDiv=&_useEV=&pctxt=fph&pgsl=010&_submenuId=people_8&ds_name=null&_ci_nbr=null&qr_name=null&reg=null%3Anull&_keyword=&_industry=)

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#### GREEK FOOD COMPOSITION TABLES

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#### AFRICAN AMERICAN SOUL FOOD COMPOSITION TABLES

#### MEXICAN FOOD COMPOSITION TABLES

#### ADDITIONAL FOOD COMPOSITION TABLE RESOURCES:

NATIVE AMERICAN – available online at the link provided below:  
Nutrient Value of Alaska Native Foods – 44 pgs.  
[consortiumlibrary.org/aml/publications/akfood.pdf](http://consortiumlibrary.org/aml/publications/akfood.pdf)

CHINA – not currently available online  
China Food Composition 2002  
Institute of Nutrition and Food Safety  
China CDC, Beijing  
2002\* 393 pp (Chinese & English)

FRANCE – not currently available online  
Répertoire général des aliments: Tome 2--Table de composition des Produits  
Laitiers  
M Feinberg, JC Favier, J Ireland-Ripert Fondation Française pour la Nutrition (FFN)  
and Centre Informatique sur la Qualité des Aliments (CIQUAL) Technique et  
Documentation-Lavoisier, 11, rue Lavoisier, F 75384 Paris Cedex 08 1987\* 231  
pp (French with English)

PHILIPPINES – not currently available online  
Food Composition Tables - Recommended for Use in the Philippines  
Food and Nutrition Institute, Department of Science and Technology, Manila  
Draft update, 1996 (English)

GERMANY – not currently available online  
Food Composition and Nutrition Tables 2000  
SW Souci, W Fachmann, H Kraut mbH, Stuttgart  
2000\* 1182 pp (English, German, French)  
Contact: 2000 Medpharm GmbH Scientific Publisher,  
Birkenwaldstrasse 4470191, Stuttgart, Germany, and CRC Press.

VIETNAM – not currently available online  
Thành Phần Dinh Dưỡng Thức Ăn Việt Nam,  
Food Products in Vietnam, Composition and Nutritive Value  
NHÁ XUẤT BAN Y HỌC  
National Institute of Nutrition, Ministry of Health, Medicine Publisher, Hanoi,  
1995\* 555pp (Vietnamese with English)

KOREA – not currently available online  
Food Composition Table  
National Rural Living Science Institute  
Rural Development Administration, Suwon  
6th ed I & II 2001\* I(439 pp) & II(545 pp) (Korean with English)

ITALY – not currently available online

Tabelle Sinottiche di Composizione degli Alimenti [Synoptic Food  
Composition Tables]

P Cok, B de Bernard, O Radillo, MP Francescato Dipartimento di Biochimica, Biofisica  
e Chimica delle Macromolcole, Università di Trieste Piccin Nuova Libreria, SpA, Via  
Altinate, 107, 35121 Padova  
1987\*, xix + 442 pp (Italian and English)

RUSSIA – not currently available online, and in Russian only

Tables of Chemical Composition and Nutritive Value of Food Products  
AI Stenberg, GM Heller, EF Kacpsak (TE Boldyrev, OP Molcanova, ed)  
Medgiz (State Medical Literature Publ), Moscow  
1954, 236 pp (Russian)

ARABIAN STATES – not currently online

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FOOD SOURCES OF VITAMIN B3 (NIACIN)

FOOD SOURCES OF VITAMIN B5

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