

Part D. Chapter 8: Culturally Responsive Interventions to Improve Diet

Introduction

Culture—defined as the “shared values, norms, and belief systems that collectively shape a group’s attitudes, behaviors, and perceptions through their interactions with and within their environments”—plays an important role in an individual’s experiences with foods and beverages.¹ Culture informs the significance and the symbolic meanings that a person attaches to foods and beverages and guides their beliefs about the relationship between diet and health.¹ Dietary behaviors result from a complex interplay of psychological, sociological, economic, and sensory factors, all of which are influenced by culture.²⁻⁴ Foodways, which include the types of foods eaten, how they are prepared, and when and with whom they are consumed, are deeply woven into the social fabric of communities and are central to understanding dietary behaviors.²⁻⁴ Cultural oppression, in which a person’s cultural norms are marginalized or restricted, also plays a significant role in shaping dietary behaviors.^{5,6}

The U.S. population has become more racially and ethnically diverse—particularly among children—during the past decade,⁷ highlighting the need to ensure that the *Dietary Guidelines for Americans* are representative of the country’s diverse populations and their various nutritional needs and cultural preferences. Furthermore, marked racial, ethnic, and socioeconomic disparities in diet quality and related chronic disease outcomes have persisted despite modest improvements in overall dietary quality in the United States from 1999 to 2020.⁸

This chapter presents the rationale, methods, and results for the Committee’s evidence scan of culturally responsive (also referred to as culturally tailored) approaches to dietary interventions, which have garnered significant interest based on their promise for improving equitable access to healthcare and nutrition services and in supporting health behavior change ([Box D.8.1](#)). The chapter also discusses the results of the evidence scan and compares them to those from other reviews and provides the Committee’s advice to the Departments in terms of considerations for federal programs, future research, and further efforts to apply the *Dietary Guidelines* across a variety of cultural contexts.



Box D.8.1: Culturally Responsive Dietary Interventions

Culturally responsive dietary interventions are designed to align with specific cultural practices, beliefs, and preferences of the target population, with the aim of improving their diet quality and health outcomes. Different cultures have varied understandings of what constitutes a healthy diet based on their traditional knowledge, historical food practices, and external factors such as globalization, migration, and cultural exchange that impact groups as they transition across contexts. Nutrient-dense foods that align with the dietary patterns recommended by the *Dietary Guidelines for Americans* are present in all cultural diets, and a goal of culturally responsive dietary interventions is to identify and recognize such foods and how their preparation may promote health.

Context for the Committee's Evidence Scan

Previous reviews that examine the efficacy of cultural adaptations of dietary interventions have highlighted substantial areas for improvement, including lack of diversity among participants and inconsistency among study designs, intervention components, and measurement. A federal government-led workshop held in September 2023, titled “*Advancing Health Equity Through Culture-Centered Dietary Interventions to Address Chronic Diseases*,” addressed these topics as it identified gaps and opportunities for 1) research on the cultural tailoring and adaptation of evidence-based dietary approaches and 2) research on heritage foodways to prevent, manage, and treat diet-related diseases in culturally diverse populations and historically minoritized communities. Key takeaways from the workshop included the need to broaden the definition of culture to include a diverse array of shared values, knowledge, and practices that significantly influence perceptions about health and food, as well as the need to collaborate with community representatives to create dietary interventions to apply the *Dietary Guidelines* across a variety of cultural contexts.

For this evidence scan, the Committee considered the main takeaways of this workshop, as well as previous research experiences from Committee members, the public's comments, and recommendations from the 2020 Committee.

Rationale for Pursuing an Evidence Scan

An evidence scan is an exploratory evidence description project in which systematic methods are used to search for and describe the volume and characteristics of evidence available on a nutrition question or topic of public health importance.⁹ The Committee conducted an evidence scan for this topic because further definition of the scope of work was needed before moving forward with a systematic review. An evidence scan provides a basis for a future expert Committee to develop systematic review protocol(s).

The goal of the evidence scan was to better understand the breadth and depth of the diverse body of evidence on culturally responsive dietary intervention studies. Such studies emphasize how cultural considerations have been incorporated into interventions to address the needs of a given population and explore the impact of culture on dietary intake and health. The Committee refined the scope of the evidence scan to include studies conducted in the United States and Canada, establishing a focus on interventions with cultural relevance to the U.S. population and recognizing the importance of being inclusive of Indigenous peoples. The evidence scan recorded each included study's population of interest (including key characteristics such as age, gender, race, ethnicity, and geographic location) and outcomes assessed (diet-related psychosocial factors, dietary intake, diet quality, and health outcomes). This evidence scan also identified strengths and gaps in the literature.

Key Considerations Guiding the Evidence Scan

For purposes of the evidence scan, the Committee chose a broad definition of culture to ensure inclusivity of diverse interpretations and definitions of culture, allowing for a comprehensive understanding of how cultural factors influence dietary behaviors and health outcomes.

The Committee's decisions about which outcomes to examine in the evidence scan were informed by results from its data analysis findings on dietary intake and prevalence of nutrition-related chronic health conditions. For example, dietary intakes of food groups vary by racial and/or ethnic group, such that certain groups are more or less likely to achieve recommended intakes. Variation also exists among racial and/or ethnic groups in the food categories and subcategories that contribute to food group intakes. Similarly, prevalence varies by race and/or ethnicity for several nutrition-related chronic health conditions examined, including obesity, diabetes, hypertension, and stroke. The disparities that are apparent in these findings underscore the role of culturally responsive dietary interventions that address dietary intakes and specific health outcomes in various population groups. See **Part D. Chapter 1: Current Dietary Intakes and Prevalence of Nutrition-Related Chronic Health Conditions** for details of the Committee's data analyses.

The evidence scan also explored intervention opportunities, emphasizing the potential for social, economic, and environmental strategies to improve overall diet and diet quality among populations disproportionately affected by health disparities. Such interventions could significantly enhance health outcomes by addressing the root causes of poor dietary habits.

Community engagement throughout the research process is one way to create and implement interventions that are responsive to the community's needs. These types of collaborations, including community-based participatory research (CBPR) approaches, were an important consideration and target for information-gathering in this evidence scan. In addition, previous studies have identified gaps in funding for community-engaged health disparities research and as a result, the Committee was interested in gaining a better understanding of the funding sources for articles in this evidence scan.^{10,11}

Culturally Responsive Classification Systems

A wide range of methodologies and theoretical frameworks have been used to examine cultural factors in the design, implementation, and evaluation of interventions in nutrition research. The Committee applied concepts from 2 such frameworks to categorize the culturally responsive intervention strategies in the literature it described: 5 types of cultural targeting/tailoring intervention strategies¹² and dimensions of cultural sensitivity,¹² both of which provide approaches describing how dietary interventions can be adapted to meet the unique cultural needs of diverse U.S. populations. The Committee applied concepts from 2 such frameworks to categorize the culturally responsive intervention strategies in the literature it described: 5 types of cultural targeting/tailoring intervention strategies¹³ and dimensions of cultural sensitivity,¹² both of which provide approaches describing how dietary interventions can be adapted to meet the unique cultural needs of diverse U.S. populations. Integrating the concepts from these 2 frameworks provided a theoretical and practical foundation for the Committee to classify the intervention components within the evidence scan and interpret the scan's results within the broader context of the literature. The following sections briefly describe the 2 frameworks.

Culturally Targeting/Tailoring Intervention Strategies

Kreuter and colleagues¹³ provide a comprehensive overview of 5 strategies commonly used to develop or adapt health promotion programs for culturally defined groups. The 5 strategies, described in [Table D.8.1](#), emphasize use of cultural targeting (e.g., designing health interventions aimed at a particular cultural group by incorporating shared characteristics such as common values, beliefs, and experiences that are broadly representative of that group) and tailoring (considering broader shared cultural characteristics while customizing the intervention to the specific cultural, psychosocial, and behavioral traits of an individual) to improve acceptance and efficacy of dietary interventions.

TABLE D.8.1
INTERVENTION STRATEGIES

Intervention Strategy	Description
Peripheral	Seek to give programs or materials the appearance of cultural appropriateness by packaging them in ways likely to appeal to a given group
Evidential	Seek to enhance the perceived relevance of a health issue for a given group by presenting evidence of its impact on that group
Linguistic	Seek to make health education programs and materials more accessible by providing them in the dominant or native language of the target group
Constituent Involving	Draw directly on the experience of members of the target group
Sociocultural	Discuss health-related issues in the context of broader social and/or cultural values and characteristics of the intended audience

Source: Kreuter et al., 2003¹³

Dimensions of Cultural Sensitivity

Resnicow and colleagues¹² drew on concepts introduced in ethnic and linguistic studies and proposed application of cultural sensitivity in developing and/or adapting interventions to be more responsive to

cultural context, including resonating with the cultural beliefs and practices of the study population. They defined cultural sensitivity using 2 dimensions: surface-structure and deep-structure ([Table D.8.2](#)).

TABLE D.8.2
DIMENSIONS OF CULTURAL SENSITIVITY

Surface-Structure	Deep-Structure
Addresses observable, “superficial” characteristics of a population	Requires understanding the cultural, social, historical, environmental, and psychological forces that influence target health behavior in target population
Employs audio/visual materials, channels, and settings appropriate for intervention delivery	Includes perceptions of how religion, family, society, and economics may influence the target behavior

Source: Resnicow et al., 1999¹²

Question

1. What evidence has been published on the relationship between culturally tailored dietary interventions and diet-related psychosocial factors, dietary intake, diet quality, and health outcomes?¹⁴



View the full evidence scan, including details on the methodology and the evidence underlying the review of the science, at https://nesr.usda.gov/2025-dietary-guidelines-advisory-committee-systematic-reviews/evidence-scan_culturally-tailored-dietary-interventions

Review of the Science

What evidence has been published on the relationship between culturally tailored dietary interventions and diet-related psychosocial factors, dietary intake, diet quality, and health outcomes?

Approach to Answering Question: Evidence Scan

Description of the Evidence

The body of published evidence identified in the evidence scan included 178 articles (139 randomized controlled trials, 39 non-randomized controlled trials). Seven articles were published from 1980 through 2000; the remainder were published between 2001 and September 2023. Beginning with the 5-year time frame of 2001 through 2005, the number of articles published per 5-year cycle increased over time, reaching an apex of 53 articles published from 2016 through 2020. Nearly all studies were conducted in the United States (172 articles), and 6 articles were from studies conducted in Canada.

Population

Analytic sample sizes ranged from n=20 to n=4,333. Most studies were in adults only (104 articles), and 22 articles enrolled or randomized adults and children and/or adolescents. In total, 67 articles included children and/or adolescents. Six articles were in pregnant or postpartum populations. Most articles (127 articles) included both men and women, although in many cases these participant populations were

predominantly female. Forty-five articles included only women, while 1 article included only men, and 1 article in adults did not report the gender of participants. Three articles included mother-child dyads and 1 article included father-child dyads. The evidence scan protocol was inclusive of studies with gender-expansive participants; however, no articles in these populations were present in the final body of evidence.

The most common racial and/or ethnic groups (as reported in the articles and defined in this scan as having ≥ 20 percent of participants from a given racial and/or ethnic group) in the study populations were Black, African American, or of African Descent (78 articles), and Hispanic or Latinx (71 articles), followed by American Indian, Alaska Native, or Indigenous (27 articles), White (16 articles), Asian (11 articles), and Native Hawaiian or Pacific Islander (3 articles).

Interventions and Intervention Strategies

Intervention duration ranged from a single session (e.g., watching an educational video) to 5 years. Most studies (141 articles) reported use of an underlying theoretical framework when designing the intervention tested. Of those, most (84 articles) used 2 or more frameworks, while 57 articles cited a single framework. Eighty-four articles cited use of social cognitive theory to inform intervention development. The interventions in 24 articles (from 21 studies) were modeled after the CDC's Diabetes Prevention Program.

Most articles reported either a high level of community involvement (71 articles) or at least some community involvement (58 articles) in designing the intervention. Fifty-three articles specifically mentioned using a CBPR model to guide their research. Forty-nine articles did not involve community members in the intervention design or did not report doing so in the publication. During the publication date range of January 1980 to September 2023, the proportion of articles reporting a high degree of community involvement grew over time.

Based on the 2 frameworks that the Committee used to classify intervention components,^{13,12} the most frequently used approaches were constituent-involving strategies (161 articles), followed by sociocultural (150 articles), peripheral (100 articles), linguistic (83 articles), and evidential (18 articles) strategies. All peripheral and evidential strategies used were considered to be surface-structure, as were all but 1 of the linguistic strategies. Constituent-involving strategies encompassed a range of surface- and deep-structure levels of cultural sensitivity, with 42 articles including both levels of sensitivity in their constituent-involving techniques. All sociocultural strategies employed were considered to be deep-structure. Most articles reported using between 2 to 4 strategies (164 articles); 7 articles used all 5 strategies, and 7 articles used 1 strategy.

Outcomes

The most commonly reported outcomes were growth, body composition, and risk of obesity (GBCO) (117 articles) and dietary intake (109 articles). Fewer articles assessed risk of cardiovascular disease (52 articles), diet-related psychosocial factors (50 articles), energy intake (38 articles), risk of type 2 diabetes (35 articles), diet quality (23 articles), and postpartum weight change (4 articles). No articles examined gestational weight gain as an outcome. A greater proportion of articles conducted only in children and/or adolescents included GBCO outcomes compared with articles conducted only in adults (76 percent and 60

percent of articles, respectively). Higher proportions of articles in adults included outcomes related to risk of cardiovascular disease and type 2 diabetes, compared with articles in children and/or adolescents. Similar proportions of articles in each life stage included outcomes of dietary intake, diet-related psychosocial factors, energy intake, and diet quality.

The frequency of strategy use was generally consistent across outcomes. Sociocultural and constituent-involving strategies were the most frequently used for each outcome, with linguistic strategies included about half as often. The use of peripheral strategies tended to be either equal to or somewhat higher than linguistic strategies for each outcome, with the exception of type 2 diabetes, for which linguistic strategies were used in a greater number of articles compared to peripheral strategies. This observation can be at least partly explained by the fact that a larger proportion of articles assessed type 2 diabetes outcomes in Hispanic or Latino populations, which was also the group for which linguistic strategies—such as translations or intervention delivery in Spanish—were employed more often than any other type of strategy.

Funding Sources

As noted earlier in the chapter, the Committee’s awareness of funding gaps for community-engaged health disparities research led to its interest in describing the funding sources for culturally responsive interventions. Most studies were funded by the U.S. or Canadian government (144 articles). Other sources of funding included nonprofit organizations (31 articles), academic institutions (27 articles), state governments (4 articles), the food industry (3 articles), and a variety of other sources (e.g., hospital systems, private funding, or professional associations; 15 articles). Ten articles did not report funding sources, and 2 articles reported receiving no funding.

Application of the Frameworks: An Example

To illustrate how the Committee used the frameworks to classify intervention components, this section describes a comprehensive example from an intervention included in its evidence scan, Kwon et al.’s Project RICE ([Table D.8.3](#)).¹⁵

This intervention was developed for Korean American adults at risk for type 2 diabetes in the metropolitan New York City area using the CDC’s Diabetes Prevention Program as a model. First, the researchers employed a peripheral intervention strategy by incorporating culturally appropriate images and photos of typical Korean foods into their program. This surface-structure approach ensured that the materials resonated with Korean American participants by reflecting familiar and culturally relevant dietary elements. By using visuals with which participants could easily identify, the intervention became more engaging and relatable, potentially increasing the program’s effectiveness in promoting dietary changes and diabetes prevention.

Second, Kwon and colleagues used an evidential strategy by incorporating specific educational content into the diabetes prevention sessions. This strategy involved discussing the prevalence of diabetes and the increased risk faced by Asian American communities, providing an explanation of body mass index (BMI), and highlighting the at-risk BMI thresholds specific to Asian populations. Additionally, the authors

addressed and dispelled common cultural misconceptions about diabetes. By presenting evidence-based information that was directly relevant to the participants' cultural context, the intervention aimed to enhance understanding and awareness, thereby empowering participants to make informed health decisions. This surface-structure approach ensured that the content was not only informative but also culturally meaningful and applicable.

Third, the researchers applied a linguistic approach by ensuring all curriculum materials were accessible to Korean-speaking participants. Initially developed in English, these materials were translated into Korean and reviewed by bilingual study staff to ensure accuracy and cultural relevance. This surface-structure strategy helped to eliminate language barriers, making the content accessible to participants who were more comfortable with Korean than with English. Additionally, the session topics were translated into Korean through a collaborative process involving a community-academic partnership. This collaboration ensured that the translations were not only linguistically accurate but also culturally appropriate. Before the translated sessions were implemented in the study, they were piloted to test their effectiveness and comprehension. By involving community partners in the translation process, Kwon and colleagues enhanced the cultural and linguistic resonance of the materials, thereby improving participant engagement and understanding.

Fourth, Kwon and colleagues employed a constituent-involving approach by forming a coalition that included community partners, researchers, health providers, and community health workers (CHWs) as active and equal partners throughout the research process. This deep-structure strategy ensured that the research was grounded in the community's needs and perspectives, fostering a sense of ownership and collaboration among all stakeholders involved. The coalition was strengthened by the active involvement of CHWs and staff from a Korean American-serving community-based organization. These members served as vital sources of community knowledge, offering valuable input and guidance during all phases of the study, from design and implementation to evaluation. Their involvement ensured that the intervention was culturally and contextually appropriate, aligning with the community's unique characteristics and needs. Furthermore, the intervention was led by a bilingual Korean American CHW, which was a crucial aspect of the constituent-involving approach. This leadership role not only facilitated effective communication and trust-building with participants but also ensured that the intervention was delivered in a culturally sensitive and linguistically appropriate manner. By deeply involving constituents in every aspect of the research, Kwon and colleagues were able to create an effective, relevant, and sustainable intervention.

Finally, Kwon and colleagues integrated a sociocultural approach by incorporating findings from formative research to enhance the curriculum with culturally relevant topics and strategies, addressing the deep-structure needs of the Korean American community with whom they worked. This approach ensured that the intervention was not only linguistically accessible but also culturally meaningful and effective.

The curriculum was enriched with discussions on several culturally pertinent topics:

- **Traditional Korean dietary practices:** The authors explored traditional practices such as eating fruits as alternatives to high-fat desserts, aligning dietary recommendations with familiar cultural habits to encourage healthier choices without abandoning cultural preferences.
- **Korean cuisine and health:** By identifying healthy elements within traditional Korean cooking and discussing Korean foods that may have an adverse effect on blood glucose levels, the curriculum provided participants with practical guidance for maintaining cultural eating habits while managing health risks.
- **Dining practices:** The use of small plates typical of Korean dining was related to the Plate Method, a common portion control strategy, making it easier for participants to apply this strategy to a culturally relevant context.
- **Cultural expectations and social dining:** The curriculum addressed the challenge of managing cultural expectations when eating in other homes, providing strategies for navigating social situations while adhering to dietary recommendations.
- **Emotional and family dynamics:** Discussions included the emotional aspect of food-related guilt tied to family expectations and perceived shortcomings with regard to traditional dietary practices, acknowledging the psychological and social dimensions of dietary behaviors.
- **Community resources:** A list of community resources and providers was included, offering participants culturally and linguistically appropriate support options.

By embedding these culturally specific topics into the curriculum, Kwon and colleagues ensured that the intervention was not only informative but also resonated deeply with participants' cultural identities and everyday experiences. This sociocultural approach helped facilitate greater acceptance and adherence to the health recommendations provided.

TABLE D.8.3
CLASSIFICATION OF INTERVENTION COMPONENTS: KWON ET AL., 2022

Intervention Component	Use in Kwon et al., 2022	Dimension of Cultural Sensitivity
Peripheral	Use of culturally appropriate images and photos of typical Korean foods.	Surface-Structure
Evidential	Discussion topics during diabetes prevention sessions included diabetes prevalence and increased risk of diabetes in Asian American communities, explanation of BMI and at-risk BMI thresholds in Asian communities, and dispelling common cultural misconceptions regarding diabetes.	Surface-Structure
Linguistic	All curriculum materials developed in English, translated into Korean, and reviewed by bilingual study staff.	Surface-Structure

Intervention Component	Use in Kwon et al., 2022	Dimension of Cultural Sensitivity
	Session topics translated into Korean using a collaborative process with community-academic partnership; translated sessions piloted before study.	
Constituent Involving	<p>Coalition of community partners, researchers, health providers, and community health workers (CHWs) engaged as active and equal partners in the research process.</p> <p>CHW and staff at Korean American-serving community-based organization were active members of coalition and a source of community knowledge, providing input and guidance during all study phases.</p> <p>Intervention was led by bilingual Korean American CHW.</p>	Deep-Structure
Sociocultural	<p>Findings from formative research were used to add culturally relevant topics and strategies to curriculum.</p> <p>Discussions involved:</p> <ul style="list-style-type: none"> • Traditional Korean practice to eat fruits as alternative to high-fat desserts • Healthy elements in traditional Korean cooking; Korean foods that may have an adverse effect on blood glucose levels • Small plates typical of Korean dining in relation to the Plate Method • Managing cultural expectations for eating in other homes when invited as a guest • Food-related guilt with respect to family member expectations and perceived shortcomings around dietary practices <p>List of community resources and providers offered culturally and linguistically appropriate support options.</p>	Deep-Structure

Source: Kwon et al., 2022¹⁵

Discussion

Comparisons to Other Reviews and Frameworks

Vincze and colleagues¹⁶ used a similar integration of the Resnicow et al.¹² and Kreuter et al.¹³ classification systems to conduct a scoping review of culturally adapted health interventions for Indigenous peoples. They identified 66 unique intervention studies targeting Indigenous populations in the United States, Canada, and Australia, most of which focused on type 2 diabetes prevention or management. As with the current evidence scan, the most common strategy reported was visual adaptation (which could be defined as a peripheral intervention strategy). Most studies applied more than 1 strategy to culturally tailor the intervention, combining surface- and deep-structure adaptation approaches. However, fewer than half of the interventions in this scoping review involved Indigenous constituents on a deep-structure level.

Another systematic review of behavioral interventions with culturally adapted strategies to improve diet and weight outcomes in African American women was conducted by Kong and colleagues.¹⁷ Among the 28 interventions included in the review, the most frequently identified strategies were sociocultural and

constituent-involving. The studies that had significant findings for improving diet and weight commonly reported constituent-involving strategies during the formative phases of the intervention. This work underscores the critical role of cultural adaptation in enhancing the efficacy of dietary interventions.

Considerations and Limitations of the Evidence Scan

This evidence scan demonstrated that many diverse culturally responsive dietary interventions have been conducted in the United States and Canada to improve diet and energy intake as well as various health outcomes such as growth, body composition, risk of obesity, and risk of cardiovascular disease and type 2 diabetes. None of the studies included in the evidence scan addressed gestational weight gain as an outcome and only a few addressed postpartum weight change. Although the evidence scan yielded 10,579 search results, only the 178 articles that met the inclusion criteria were included in the body of evidence that the Committee described. These articles do not represent the absolute number of published articles on this topic. Refining search strategies in future systematic reviews will be key to comprehensively identify the existing evidence.

The Committee's application of the Resnicow et al.¹² framework to evaluate the level of cultural sensitivity integrated into dietary interventions, and its application of the Kreuter et al.¹³ framework to classify how the 5 strategies were used to design/implement the culturally responsive intervention, enabled a comprehensive assessment of the type and extent of cultural tailoring within the body of evidence examined. Most interventions reported either a high level or some level of community involvement when designing the intervention. In addition, most used constituent-involving, sociocultural, and peripheral strategies, while linguistic and evidential strategies were used less often. Nevertheless, information provided in the included studies may be incomplete. This is because the scan relied on information included in the published articles, but some articles may not have described all of their intervention's methods. This could be due to the word limits imposed by most journals or the lack of use of these types of frameworks when reporting intervention components.

Committee discussion also underscored the chronic underfunding of health disparities research, which impacts the availability and quality of literature included in the evidence scan. Such underfunding limits both the development of effective interventions and the understanding of health disparities, emphasizing the need for increased investment in this area.

Committee's Considerations for the Departments

Based on the results of its evidence scan on culturally responsive dietary interventions, the Committee suggests the following considerations to the Departments as they develop the *Dietary Guidelines for Americans, 2025-2030*.

Considerations for Federal Programs

This evidence scan on culturally responsive interventions may provide insights as to the importance of allowing for flexibilities around dietary patterns to be more culturally responsive. (See **Part E. Chapter 1: Overarching Advice to the Departments** for details of this Committee's proposed dietary pattern).

Dietary Pattern.) The evidence scan also could serve as a springboard for future, more targeted systematic reviews that assess the effectiveness of the interventions on outcomes of interest. Although this evidence scan, by design, did not provide results on how these culturally responsive interventions affected diet or related health outcomes, cultural adaptations may be a welcome component across federal nutrition assistance programs such as the Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the National School Lunch Program (NSLP) and School Breakfast Program (SBP), among others. Ensuring that federal food and nutrition programs apply culturally responsive strategies and foods may help promote adequate nutrient intakes and food security by providing individuals with foods that align with their cultural practices and preferences. For example, incorporation of certain cultural foods (e.g., Beans, Peas, Lentils, and Dark-Green Vegetables) could help individuals from all cultures meet dietary recommendations and enhance dietary variety. In turn, this may promote higher program acceptability and utilization rates, improve adherence to the *Dietary Guidelines*, and offer a stronger connection to participants' heritage, ultimately contributing to overall health and well-being, especially within diverse communities.

Considerations for Future Research

- Develop a classification system and checklist similar to tools such as Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Equity¹⁸ or Consolidated Standards of Reporting Trials (CONSORT)¹⁹ for researchers to submit as an attachment when publishing manuscripts describing culturally responsive dietary interventions. This checklist would include the details of how the culturally responsive dietary interventions were developed and implemented, using the frameworks highlighted in this report ([Tables D.8.1](#) and [D.8.2](#)).
- Address social determinants of health when tailoring interventions to enhance the effectiveness and equity of dietary interventions across diverse populations. The Nutrition Equity Framework, introduced by Nisbett and colleagues²⁰ conceptually illustrates how addressing sociopolitical determinants of nutrition is essential for sustainable improvement in nutrition equity and can provide a broader context for understanding the fundamental and sustainable ways to enhance nutrition equity, reinforcing the importance of culturally responsive dietary interventions.
- Diversify search terms and use an iterative process to better understand and incorporate common terminology relevant to the interventions of interest when conducting future systematic reviews or similar research efforts. Further, expand the range of search databases to provide a more comprehensive view of the available literature. For specific populations of interest such as pregnant populations, consider additional relevant outcomes, such as nutritional adequacy, to ensure that the research addresses the most pertinent health concerns of these groups. By adopting these strategies, the content of systematic reviews or related projects can be more effectively tailored to better understand the diverse needs of various communities and populations.
- Allocate sufficient funding for culturally responsive research given that these types of interventions take extended time to develop and implement, due in part to the process of

building trusted relationships with community members and authentically engaging them in all stages of the intervention. These essential activities enhance the relevance and effectiveness of interventions and contributes to their sustainability.

- Revise funding mechanisms to allow extended time to develop the trusting relationships that are critical for culturally responsive research. The current standard of 5 years of research funding should be lengthened as investigators build partnerships that engage community-based organizations in driving the research agenda and co-creating research questions and methods.
- Communicate plans for community involvement and intervention sustainability in academic and professional publications; for example, details about use of the community-based participatory research approach.
- Tailor interventions not only to racial and/or ethnic group considerations but also to other relevant characteristics such as time spent in the United States or country of birth. It is equally important to apply this tailored approach across all levels of research (design, implementation, and evaluation), ensuring that the lived experiences of leadership and staff at the community and research team are reflected.
- To further strengthen the body of evidence on culturally responsive interventions, the Committee recommends more research to fully elucidate the effect of cultural tailoring on program acceptability and effectiveness for health outcomes.

Considerations for Future Committees

- Conduct a systematic review on the effectiveness of culturally responsive interventions for improving diet and health outcomes and use this evidence scan to inform the population, intervention, comparator, and outcome(s) outlined in the systematic review protocol (i.e., the PICO elements).
- Consider factors beyond racial and/or ethnic group categorizations in future reviews, such as time spent in the United States, geographic location of residence, and income, which can significantly influence community needs and responses to interventions.
- Use an intersectional approach when considering the population of interest. It is also important to consider that many discrete categories can shape cultural identity and dietary behaviors and intakes, such as race, ethnicity, gender, income, and geography. This lens could be applied when designing the PICO table.
- Expand evidence-gathering efforts to include qualitative studies, which may enable recognition of the potential for diverse interventions to be effective in different communities and identify barriers and facilitators that explain the outcomes. This may also help address the evolving changes in culture between generations of immigrants, with second generation becoming more acculturated to the dominant culture, communities with several different cultures residing

together, and differences of culture within ethnicities (e.g., Caribbean vs. Central America vs. South America).

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