Asian American CalFresh Healthy Living Implementation Guide

September 2019

CalFresh HEALTHY LIVING

County of Los Angeles Public Health

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Background

The Supplemental Nutrition Assistance Program Education (SNAP-Ed), known in California as CalFresh Healthy Living, is a priority for the United States Department of Agriculture (USDA). Its goal is to increase the likelihood that individuals and families who are eligible for SNAP will make affordable healthy food choices and choose physically active lifestyles consistent with the current Dietary Guidelines for Americans (DGA) and Physical Activity Guidelines for Americans. CalFresh Healthy Living implements strategies to help the target audience establish healthy eating habits and a physically-active lifestyle, which can prevent or postpone the onset of nutrition-related chronic diseases such as obesity.

The Los Angeles County (LA County) Department of Public Health's (DPH) Nutrition and Physical Activity Program partners with universities, healthcare organizations, community-based organizations, and school districts to improve nutrition and physical activity opportunities among low-income residents who are eligible for SNAP-Ed. These agencies provide nutrition education and promote physical activity while implementing policy, systems and environmental change strategies to improve access to healthier foods and increase opportunities for physical activity in various settings. Evidence-based nutrition education curricula and physical-activity are utilized to improve the effectiveness of policy, systems, and environmental changes implemented throughout the county.

Introduction to the Asian American CalFresh Healthy Living Implementation Guide

PURPOSE AND TARGET AUDIENCE

The Asian American CalFresh Healthy Living Implementation Guide is intended to serve as a resource for SNAP-Ed funded partners in LA County, as well as other local health departments and/or organizations implementing SNAP-Ed with adult Asian

American populations. Working within the framework of the USDA SNAP-Ed Guidance, this guide builds on the evidence base and lessons learned from Asian Pacific Islander Forward Movement (APIFM), one of the SNAP-Ed funded partners in LA County. Paired with local trainings and translated nutrition education materials, this guide will promote *cultural responsiveness* in program delivery for Asian American audiences and help ensure program fidelity to existing curricula and resources.

LA County DPH's Nutrition and Physical Activity Program designed a Program Fidelity Assessment in 2017 to examine to what extent funded agencies demonstrated fidelity to SNAP-Ed guidelines. Results indicated that 44% of respondents frequently or very frequently encountered challenges and barriers to fulfilling curriculum fidelity requirements, one of which involved translating curricula to ensure linguistic and cultural competency and/or relevancy. From these results and input from community-based partners, LA County DPH's Nutrition and Physical Activity Program identified a need for translated materials and culturally-

responsive guidance to address this challenge, specifically for Asian American communities.

PREVALENCE OF DIET-RELATED CHRONIC DISEASES AMONG VARIOUS ASIAN AMERICAN COMMUNITIES

Studies suggest wide variation in dietary risk profiles depending on Asian American subgroups and call for disaggregating related data.[1] Data was recently published by Zheng, Guili, et al. on the prevalence of chronic diseases (prediabetes, diabetes, hypertension, and high cholesterol) among Asian Americans, including Chinese, Filipino, Korean, Japanese, Vietnamese and Asian Indians in Los Angeles County. Whereas diabetes has a frequency of 10% in the overall sample of all Asian American populations, data by subgroup showed that 20% of Filipinos, 15% of Taiwanese, and 4% of Chinese stated they had prediabetes.[2]

Several studies show that Filipinos, Japanese, Koreans, Cambodians, and other Asian American subgroups are at a higher risk for type 2 diabetes, and exhibit higher prevalence at lower BMI compared to whites.[3] One study focused on Asian American subgroups (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese) with considerable heterogeneity among individual subgroups. The study found these Asian American subgroups to have significantly higher prevalence of type 2 diabetes despite having a 5-8% higher treatment rate compared to whites.[4]

Ethnic-specific health disparities are also influenced by age. For hypertension, Chinese Americans aged 45-74 years old have the lowest incidence in the U.S., but the highest incidence among those aged 75-84 years.[5] Filipino Americans have the highest rate of hypertension among Asian American groups[6], and are 70% more likely to be obese compared to the other

Asian American sub-groups.[7] Although the prevalence of prediabetes among California adults varies between counties, among young adults (ages 18-39) 31% of Asian Americans compared to 29% of whites were estimated to have prediabetes. High rates among young adults are particularly concerning because the risk of complications from diabetes increases significantly the longer one has prediabetes.[8] Another study found that for older adults (ages 65+) in LA County, the prevalence of diabetes is 33.2% among Asian Americans compared to 16.9% among whites.[9]

Although Asian Americans experience a lower prevalence of overweight and obesity than other ethnic groups (blacks, Latinos, and whites), they are at higher risk of developing chronic diseases than whites at the same BMI. The proportion of Asian Americans with risk factors for type 2 diabetes and cardiovascular disease is substantial even below the BMI cutoff of 25 kg/m^2, a BMI that typically indicates increasing, but acceptable risk for disease development for other ethnic groups.[10]

Currently, most nutrition and physical activity evidenced-based curricula are not culturally and/or linguistically adapted to meet the needs of the diverse population that exists in the United States. This may contribute to health disparities, especially in ethnic minority communities, where the effectiveness of interventions and ability to access health care may be compromised due to cultural or linguistic barriers. Therefore, cultural adaptation and translations are important to improving the responsiveness to behavioral interventions in LA County.[11]

The Diversity of Asian American Cultures, Histories, and Food Practices

ASIAN AMERICAN COMMUNITIES AND HEALTH ACCESS BARRIERS: LANGUAGE, IMMIGRATION HISTORY, SOCIOECONOMIC STATUS

The term "Asian American" encompasses a broad diversity of ethnic subgroups, each with their own intragroup diversity[12] in terms of regional heritage, language, dialect, immigration history, and other categories informing culture and identity. The following are some, but not all, categories of Asian American diversity that may inform how nutrition education can be adapted toward cultural responsiveness.

LANGUAGE DIVERSITY

Over eleven different Asian languages are spoken in LA county. Of these eleven, five languages are in the top ten most frequently spoken languages countywide: Chinese, Tagalog, Korean, Vietnamese, and Japanese.[13] Nationally, 51% of Vietnamese, 46% of Chinese, 23% of Filipinos, and 21% Asian Indians are not fluent in English. In 2015, 75.5% of Asian Americans spoke a language other than English at home.[7] Therefore, it is a priority to provide nutrition education in the same languages spoken by Asian American communities.

IMMIGRATION HISTORY DIVERSITY

Immigration that has established Asian American communities has occurred in waves, starting in the late 1700s with Filipinos. In the mid-1800s, Chinese immigration began to fill manual labor and other low skill jobs, but this migration flow was cut off in 1882 due to the Chinese Exclusion Act. The 1965 Immigration Act allowed for another wave of immigration limited primarily to skilled laborers. The political climate has impacted immigration and cultural identity, where Japanese American communities were significantly impacted by forced internment during World War II. Since 1975, refugees from Cambodia and Vietnam have immigrated as well. Constraints on who could enter at different points (e.g., based on skill level, refugee status, etc.) had and continue to have a considerable influence on socioeconomic status and access to opportunity.

SOCIOECONOMIC DIVERSITY

Due to varying immigration circumstances, policy landscapes, and other contexts, each subgroup has

a different profile when it comes to poverty rates, employment, and other factors affecting access to resources and economic well-being resulting in socioeconomic diversity.

Studies have shown that youth in low-socioeconomic status Asian groups, especially Southeast Asian and Vietnamese, bear a disproportionate burden of health and social problems, including chronic health conditions such as hypertension and overweight/obesity.[14] Moreover, 8 out of 19 Asian groups had poverty rates higher than the U.S. average with Burmese (35%), Bhutanese (33.3%), and Hmong (28.3%) holding the highest poverty rates according to an analysis conducted in 2017.[15]

In a 2018 California study, the highest prevalence of food insecurity was found among Vietnamese (16.4%) and the lowest prevalence among Japanese (2.28%), and a significant relationship was noted between food insecurity prevalence and low acculturation for Chinese, Korean, and Vietnamese subgroups.[16]

Culturally-Specific Understanding of Food, Eating and Health, Food Practices

EATING PRACTICE AND TRADITIONS DIVERSITY

Environmental and socioeconomic factors affecting access to health influences health behaviors, including dietary patterns. Food practices vary by culture, age, immigrant generation, location, acculturation and other various factors, however it is important to recognize cultural approaches to eating that are interwoven into Asian traditions.

- In Chinese American culture, some approach food according to forces of Yin and Yang, or cold and hot, respectively. A balance of cold/Yin foods and hot/Yang foods is valued to maintain good health.[17] Some studies have found a low consumption of dairy products in Chinese American communities.[18, 19]
- Studies have shown that for Korean Americans and Chinese Americans, intake of meat, fruits, milk, fat, and sugary foods and beverages increased after immigration or with acculturation. [20, 21]
- Studies have pointed to increased consumption of traditional "festival foods" (that tend to be higher in sodium, saturated fat, and cholesterol) after immigration in Asian subgroups such as Asian Indians, Filipinos, and Koreans.[22]

GENERAL TIPS FOR WORKING WITH ASIAN AMERICAN COMMUNITIES

- Conduct a community needs assessment that includes survey questions about what language respondents speak at home. Use census[23] demographic research and key informant interviews to identify possible oral interpreters, ensure the reading level is appropriate, and determine what languages and dialects are most common in the community.
- Integrate ice-breakers or discussion time that encourages participants to share where their families are from, and how their families' immigration stories connect to food and health.
- Be attuned to potential fears or concerns surrounding immigrant status.
- Connect with local service providers that specifically assist immigrant community members and explore pairing programs with referrals or guest presentations on how to access services and resources with different immigrant statuses.[24]

Learning *From* and *With* the Asian American Communities Served – Common Questions and Discussion Topics

- LA County DPH's Nutrition and Physical Activity Program examined Asian American perceptions and practices according to the recommendations from the SNAP-Ed curriculum and resource guidelines, including Choose MyPlate, Rethink Your Drink, and

physical activity. Partnering with APIFM, LA County DPH captured the perspectives of various Asian American communities served within LA County by distributing surveys and conducting focus groups in English and the following six languages: Chinese, Japanese, Korean, Vietnamese, Cambodian, and Tagalog.

- Data collection methods included distributing and collecting surveys over the span of 2 months during the winter of 2019. Surveys were distributed via paper or electronically and facilitated by APIFM at their community classes/events or by going into the community. A total of 349 respondents were surveyed. All subjects were recruited from communities served by APIFM and their partner organizations. The survey included nine demographic questions and ten SNAP-Ed curricula focused questions outlining various aspects of the MyPlate recommendations and evaluating health behaviors of respondents.

- Focus group interviews were conducted to explore Asian American perspectives and recurrent themes toward the SNAP-Ed curricula within a greater familial and community context. Each focus group interview was 90 minutes and aimed to include 6-8 participants. A 13-question focus group interview guide was developed to evaluate Asian American perceptions and focus on strategies to improve cultural responsiveness in program delivery of SNAP-Ed to Asian American audiences.

Findings

HEALTHY EATING

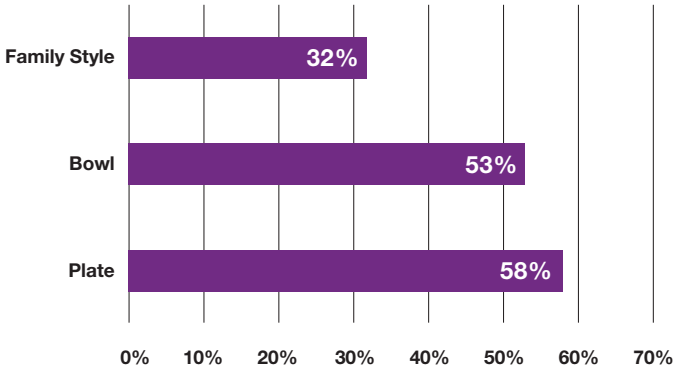
Balance and eating plant-based foods was indicated throughout Asian American cultures, however formal nutrition education was not mentioned as something that influences familial and community approaches to healthy eating. Among Asian Americans, generation and acculturation factors influence ties to cultural traditions and practices of Traditional Chinese Medicine (TCM). A component of TCM promotes specific eating practices. A Vietnamese respondent noted it is undesirable to have “too much hot energy in your body,” a concept which classifies foods as hot or cold where a balance of energies from hot or cold foods factors into whether consuming too much or too little of a food is healthy.

MyPlate recommended portions of fruits and vegetables were not regularly reported at meals among respondents. An emergent theme showed that fruit was not perceived as a staple part of every meal. Fruit is often consumed separately from the meal as a snack or dessert, which was particularly noted among Filipinos. Fruit may be perceived as a sweet food that is supplemented outside of meals and that can replace other sweet foods or sugar-based items. Addressing cultural norms associated with foods establishes an open dialogue to health that emphasizes the totality of balanced dietary practices and minimizes focus away from the Americanized view of fruit portions consumed at every meal.

CHOOSE MYPLATE

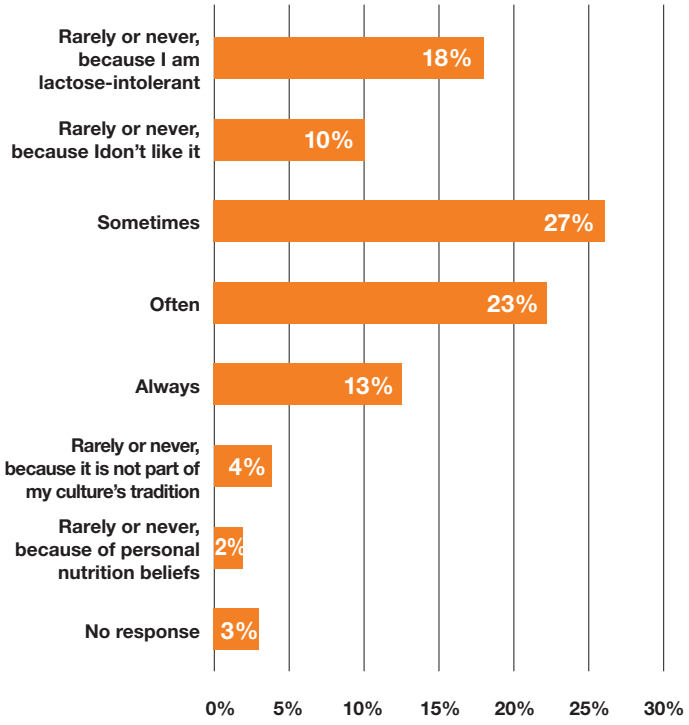
Within Asian American communities, eating food out of a bowl is a common practice that often coincides with participating in family style meals, where the family communally shares food. Cognizance of the cultural eating practices within the Asian American community is critical to understanding the relevancy of curriculum and building cultural responsiveness to nutrition education.

Figure 1. How do you usually eat your meals?



Among Chinese respondents, it was noted that, "main food dishes are put on plates, but eating is done with the bowl." Facilitators and health educators working with Asian American populations should be mindful that the MyPlate visual may not translate the same health message to Asian American communities and culturally sensitive approaches to eating styles should be considered when serving an Asian American audience.

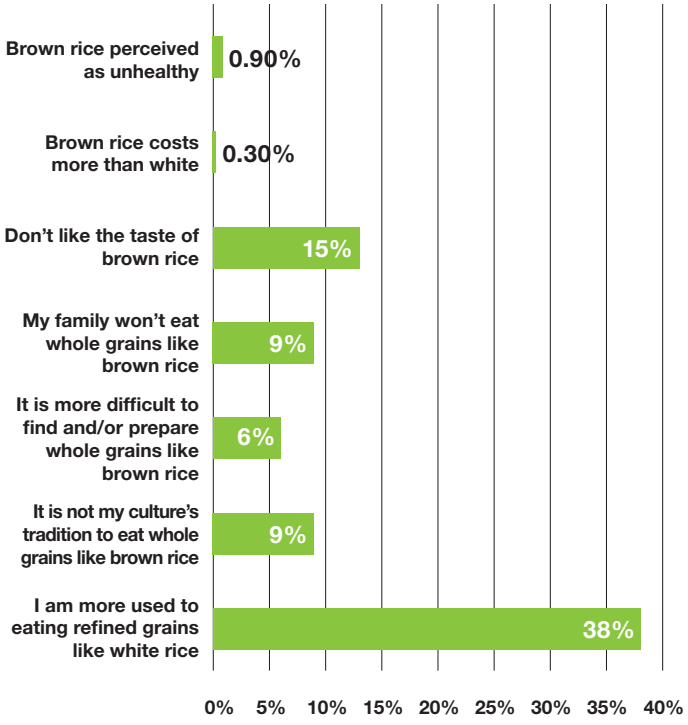
Figure 2: MyPlate recommends that you choose low-fat or fat-free milk or yogurt. How often do you choose low-fat or fat-free milk or yogurt?



Within Chinese culture, whole milk is often used with young kids as it was noted, "if you have younger kids, you choose whole milk and if you are older, you can use low fat or fat free." For Asian American families, education should focus on highlighting the American Academy of Pediatrics recommendations for milk fat content by age group for children to inform healthier dairy choices in children above 2 years of age.

Moreover, many traditional Asian diets consume little to no dairy, therefore consuming dairy may not be a regular practice in Asian American communities.[25] To meet the nutrient needs that dairy based foods provide the diet, education on alternative food sources of calcium and vitamin D should be available to Asian American audiences.

Figure 3: What are the barriers, if any, to eating whole grains such as brown rice?



Whole grains were not reported to be consumed regularly in most of the respondents. By focusing on Asian American perceptions on brown rice, it was revealed that overall consumption is low and utilizing brown rice as a substitution for white rice is not a common practice among respondents. For Japanese respondents taste has the greatest impact. A respondent said , "I understand that brown rice is good for me, but white rice tastes better. Brown rice was very popular, but I tried it and it doesn't taste good. I got tired." The consumption of white rice contains a deeply intertwined traditional, cultural, and culinary history that holds a greater context beyond the MyPlate recommendations. To encourage whole grain consumption, educators should focus on highlighting whole grain foods that maintain cultural relevance.

Among Koreans, whole grain alternatives are options noting that the community can "substitute brown rice for options [they] can digest well… including mung bean, black eyed peas, and purple or black rice." Moreover, it is important to contextualize Asian American dietary habits by the makeup of Asian American families, which often is multi-generational. The practices of the elderly generations have been reported to dictate the dietary practices of the entire family. Education should incorporate multi-generational strategies to target various practices and perspectives that may be present in one household.

RETHINK YOUR DRINK

Water or unsweetened beverages are regularly consumed instead of sugary drinks. Using fruits to naturally sweeten water is also a practice reported in Asian American families with children. Milk tea and boba drinks are sugary beverages that are popular among Asian Americans and should be included in Rethink Your Drink conversations to facilitate knowledge regarding the sugar content of beverages popularly consumed in Asian American cultures.

PHYSICAL ACTIVITY

Overall, respondents within the Japanese, Vietnamese, and Cambodian focus groups perceived that they currently meet these guidelines. A respondent noted, "In general Asian culture we do emphasize exercise. We go to parks in the morning. There are old people doing Tai Chi and walking. So, I don't feel like exercise is that big of a problem for us." Asian American

perceptions on health integrate concepts of physical and mental well-being, which reflect the influence of TCM components in Asian approaches to exercise. Differences across ages should be acknowledged in Asian American populations, as these focus groups' viewpoints may reflect a more traditional perspective existing amongst older Asian generations. Respondents noted that their kids and younger Asian Americans enjoy playing sports and engaging in similar high intensity activities, therefore physical activity messages should be mindful to the age demographic of the Asian American population.

BEST PRACTICES AND RECOMMENDATIONS

Based on findings from the survey responses provided from the focus group interviews, the following recommendations are important for addressing cultural responsiveness in Asian American populations.

USING MYPLATE AS A TEACHING TOOL

The findings indicate that modifications may facilitate a more culturally relevant delivery of MyPlate messaging. Results show that it is common practice to eat from a bowl or family style, therefore the focus of MyPlate recommendations should:

- Highlight how to eat appropriate portion sizes of foods using multiple techniques, such as the 'hands as portion sizes' method, as a visual reference.
- Minimize emphasis on the need to use a plate to portion a meal, which will make the message more relatable to an Asian American audience with diverse eating styles.
- Promote vegetable consumption by making half of the plate vegetables during meals, since results indicated that fruit is not a main meal component.
- Emphasize the importance of integrating fruit as snacks or desserts, at times that are outside of main meals.
- Focus on the importance of balanced eating throughout the day and avoid only focusing on the traditional 3 meals- breakfast, lunch, and dinner.
- In lessons regarding food resource management, create opportunities for participants to share where they find healthy, traditional foods and ingredients at lower costs.
- Become familiar with the grocery stores and establishments frequented by participants, and collect relevant ingredients, coupons, and other materials for nutrition education purposes.

FOCUSING ON CULTURALLY APPROPRIATE SOURCES OF WHOLE GRAINS

Findings demonstrate that utilization of brown rice as a whole grain substitute for white rice is limited by taste and not widely used.

- Increase awareness of other whole grain options that are more commonly found in Asian American cooking, such as buckwheat noodles, black or purple rice, and barley, etc.

- Provide education on appropriate portion sizes of white rice.

HIGHLIGHTING NON-DAIRY FOODS THAT ARE HIGH IN CALCIUM

Dairy is not commonly consumed in Asian American communities, as there is a high prevalence of lactose intolerance.

- Emphasize alternative food sources of calcium in Asian cooking, including green leafy vegetables, broccoli, tofu, etc.
- Encourage the consumption of plant-based milks as a source of vitamin D and focus on messaging highlighting unsweetened, fortified forms.
- Provide education on how to find calcium and Vitamin D on a food label.

EMPHASIZING THE CONSUMPTION OF LEAN MEATS AND PLANT-BASED PROTEINS

According to the focus groups, several language groups enjoy consuming high fat meats, including chicken skin, beef, and pork belly. Provide tips and guidance on how to prepare lean meats with more flavor, like:

- Cooking meat in the skin and removing before consuming.
- Marinating or adding flavors using garlic, ginger, etc.
- Preparing meals with culturally appropriate plant-based proteins like tofu.

DEMONSTRATING UNDERSTANDING OF EXISTING CULTURAL PRACTICES

Concepts of Traditional Chinese Medicine (TCM) were interwoven into several health beliefs noted in the focus groups. Many diverse Asian American communities may follow principles from TCM. Consider the following:

- Maintain and engage in an open dialogue about TCM and how it is practiced within the specific Asian American population.
- Facilitate conversations that respect and integrate deeply embedded cultural practices.

HIGHLIGHTING COMMONLY CONSUMED FOODS DURING CLASSES FOCUSED ON READING THE NUTRITION FACTS LABEL

Asian American audiences with limited English proficiency are interested in the Nutrition Facts Label, but may face barriers in understanding it. During food label reading education:

- Be aware that Asian Americans may purchase the same Asian foods out of habit without reading the Nutrition Facts Label or fully understanding what is in the food product.
- Encourage individuals to bring in food items they use often and walk them through how to read the food label of their favorite household food items.
- Highlight nutrients that are relevant to the chronic conditions that greatly affect Asian American communities, specifically focusing on sodium and sugar content.

- Nutrition Facts Labels used as nutrition education tools should be translated into the preferred language of participants in Asian American immigrant communities.

CONSIDERING AGE AND GENERATIONAL DIFFERENCES

The analyses also indicated that age related practices and generational differences exist within Asian American families and communities. Familial dynamics within Asian American households must be considered because:

- One household may include several generations beyond the nuclear family.
- The perspective of Asian American youth has a different lens than older Asian Americans, due to age and cultural exposure.
    - In the survey data, certain health themes emerged indicating a difference between the belief that "eating more meat is healthy" versus "eating less meat is healthy". The average age of respondents who noted "eating more meat is healthy" was 26 years old, compared to respondents who noted "eating less meat is healthy" whose average age was 51 years.
- It is important to be aware that the Asian American health lens is not only dictated by ethnic culture, but also by personal experience, age, and acculturation factors.

CONSIDERING AGE WHEN PROMOTING PHYSICAL ACTIVITY

Physical activity reported among the focus groups highlighted two important factors. Older Asian Americans prefer to engage in exercise that integrates into their daily activities.

- Recommend activities such as walking, tai chi, household chores, and gardening as low impact activities that have a mind and body focus and can be integrated into daily lifestyle activities.

CHAMPION STORY FROM CALFRESH HEALTHY LIVING PARTICIPANT

Jessie Sanchez immigrated to California from the Philippines in 1988. Now 70 years old, she lives in the Los Angeles neighborhood of Eagle Rock, where she is an active member of her church community. She frequents her local farmers market every week. There she makes use of Market Match program to get double her EBT food dollars to buy more produce. Like an increasing number of Filipino Americans, Jessie has struggled with diabetes and other chronic health issues related to diet. "My health practitioner told me a lot about what I cannot eat," Jessie shared, "then I came to a CalFresh Healthy Living class and I realized what I could eat." She consistently attended CalFresh Healthy Living classes in both LA's Chinatown and Historic Filipinotown for over a year, and shared that the program had a significant impact:

> "The classes taught me how much sugar and sodium I can have. I started learning how to mix fruits and vegetables in my cooking. I didn't eat them before because I wasn't familiar with them. I also use herbs now. Before I didn't use them, just what I need for Filipino Adobo. Now I use

a lot of herbs instead of salt. I can taste it right away if something is too salty or sweet. I don't drink sugary drinks anymore. I learned to eat by portion size. I've been drinking a lot of almond milk—before I only drank milk during breakfast. Now I have it almost every meal. And I cook my own meals.

As I kept going to classes, I learned more information about healthy eating and exercise. And I wanted to share what I was learning with my friends and family. I go home from the classes and cook food for everyone in my building. I give the healthy recipe books to my friends at church. The classes give me something to look forward to. It feels like I'm going to school again. Another thing I like about the class is that I can always ask questions regarding food. Now that I've changed how I eat, and I exercise more, my doctor told me my sugar [level] is under control. So now I don't have to take diabetic medication anymore."
- Jessie Sanchez

Stories like Jessie Sanchez's illustrate the impact of nutrition education and physical activity promotion to facilitate healthy behavior change. Jessie's story represents many that have experienced similar positive health changes from gaining access to education in their local communities. Currently, approximately 1.7 million individuals of Asian descent live in LA County.[26] Ensuring that cultural responsiveness is a cornerstone of the diverse work with Asian American populations, public health efforts can make significant impacts to advance the health of these communities and diminish health disparities.

Acronyms and Definition of Terms

DGA – Dietary Guidelines for Americans

DPH – Department of Public Health

FNS – Food and Nutrition Service

LA County – Los Angeles County

SNAP-Ed – Supplemental Nutrition Assistance Program Education

SNAP – Supplemental Nutrition Assistance Program

USDA – United States Department of Agriculture

Behavior indicates action rather than knowledge or attitudes.

CalFresh, known federally as the Supplemental Nutrition Assistance Program or SNAP, provides monthly food benefits to individuals and families with low-income and provides economic benefits to communities. CalFresh is the largest food program in California and provides an essential hunger safety net. CalFresh is federally mandated and in California, is state-supervised and county-operated.

CalFresh benefits can help buy nutritious foods for a better diet. CalFresh benefits stretch food budgets, allowing individuals and families to afford nutritious food, including more fruit, vegetables and other healthy foods. The amount of benefits a household receives is dependent on household size, countable income, and monthly expenses, such as housing and utilities. The program issues monthly benefits on an Electronic Benefit Transfer (EBT) card. Food may be purchased at any grocery store or farmers market that accepts EBT cards.

CalFresh Healthy Living is the new brand identity for Supplemental Nutrition Assistance Program Education in California, formally known as Champions for Change.

Effectiveness is the extent to which pre-established objectives are attained as a result of program activity, as indicated by performance measures.

Evidence-Based Approach for nutrition education and obesity prevention is defined as the integration of the best research evidence with the best available practice-based evidence. The best research evidence refers to relevant rigorous nutrition and public health

nutrition research including systematically reviewed scientific evidence.

Health Disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. In addition, health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

Market Match is California's healthy food incentive program, which matches customers' federal nutrition assistance benefits, like CalFresh and WIC, at farmers' markets.

Rethink Your Drink is a public health initiative led by the California Department of Public Health and administered by local health departments. The goals of the campaign are to: educate Californians about healthy drink options; help identify drinks with added sugar, and; make the link between consumption of sugar-sweetened drinks and health risks.

Supplemental Nutrition Assistance Program Education (SNAP-Ed): A federal/state partnership that provides nutrition education for individuals who are enrolled in or are eligible to enroll in SNAP, which is known as CalFresh in California. The SNAP-Ed target audience includes SNAP participants, low-income individuals eligible to receive benefits under SNAP or other means-tested Federal assistance programs, and individuals residing in communities with a significant (50 percent or greater) low-income population.

General Resources

EXAMPLES OF CULTURALLY RELEVANT OR MODIFIED RECIPES

https://eatfresh.org/recipe/filter-cuisine/asian-pacific-islander-10006/filter-cuisine/asian-392

https://snaped.fns.usda.gov/nutrition-education/healthy-thrifty-holiday-menus/chinese-new-year

SNAP-ED APPROVED CURRICULA IN VARIOUS ASIAN LANGUAGES

http://publichealth.lacounty.gov/nut/nutrition-and-physical-activity-curricula.htm

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