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PREFACE

This booklet is prepared by an enthusiastic and dedicated group of dietitians as a community service to the Indian Americans. The whole concept came up in my role as the chairman of the Public Health Committee of the American Association of Physicians of Indian Origin (AAPI) as a service to the community. I wanted to do this project and spoke to my sister-in-law Bansari Patel who is a registered dietitian and she introduced me to Rita Batheja also a registered dietitian and founder of the Indian American Dietetic Association (IADA). Rita as the co-chair and Padmini Balagopal as the chair got a team of writers and reviewers together. You, the reader will find the booklet brings together extra details and reference material on the subject of Indian cuisine and the management of diabetes. As you know India is a diverse country with hundreds and thousands of different foods. It is hoped that this booklet will help you understand the Indian cuisine and the concept of food exchanges so that with healthy eating, this cuisine can be enjoyed as much as it should be. This booklet has been sponsored as a guide to the community from AAPI. The President of AAPI, Dr. S. ‘Jay’ Jayasankar has been very helpful and instrumental in supporting this booklet and also with its free distribution (as long as the funding for this project lasts)

So, Bon Appetit!

T.G.Patel, MD, MACP
Chairman, Public Health Committee
AAPI
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Also I would like to thank all the reviewers: Padmini Balagopal, Rita (Shah) Batheja, Wahida Karmally, Karmen Kulkarni, Ranjita Misra, T G Patel, Sudha Raj and Nirmala Ramasubramanian for their time.

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Finally, Padmini Balagopal for the monumental task of getting the booklets printed in India and coordinating with Rita (Shah) Batheja to complete the project.

T. G. Patel, MD, MACP
FOREWORD

“Tell me what you eat, and I shall tell you what you are”
Antheime Brillat-Savarin

So many people ask me, “Why doesn’t the AAPI make available nutrition value information of Indian foods, so we can eat right.” The epidemic of diabetes and heart disease amongst us prods us to a healthy diet. The threshold levels of food groups and benefits and risks are undergoing constant refinement. Bewildering is the variety of Indian cuisine and scant is the nutritional analysis available.

So, when Dr. Thakor G. Patel, the Chair of the Public Health Committee offered to create this book, it was indeed a godsend. Thanks to the Herculean efforts by Dr. Patel, the outstanding task force and its chairs, Padmini Balagopal and Rita Batheja, and many others, here it is. I know everyone will want it for their kitchen. We hope to get enough sponsorship to make this available free widely.

This book complements the AAPI’s public health efforts in preventing the twin menaces of diabetes and heart disease among Indians as also, osteoporosis. Diet and activities are so central in all these conditions. As the leading ethnic medical society in the US and the standard bearer for the over 35,000 physician and 10,000 medical student and resident constituents (which is 1 out of 20 physicians and 1 out of 8 medical students in the US) and the nearly 1.7 million strong Indian American community and an effective Ambassador of India on this soil, the AAPI is proud to be of service.

S. ‘Jay’ Jayasankar, MD,
June 2002, Boston.
President, AAPI
American Association of Physicians of Indian Origin
INTRODUCTION

Since 1965 more than a million Indians have immigrated to the United States from the Asian sub-continent of India. Recent census report that their numbers have increased from 815,447 in 1980 to 1.6 million in 2000. Currently the community is ranked the third largest Asian American group in the United States after the Chinese and Filipinos. Thirty-five percent of the community lives in the North Eastern United States followed by 24% in the South, 23.1% in the West and 17.9% in the Mid-West. Indians make up approximately 2% of the population individually in the states of New Jersey, New York, California and Illinois. The community consists of academic and technical professionals, individuals who own and/or work in commercial establishments and dependents (spouses, children, siblings and elderly parents who visit from India for extended periods of time.

The Indian community is diverse with regard to the region of origin in India and the religions they practice. India can be divided into four major regions-North, South, East and West. Each region has its distinctive language, dialects, customs and food practices. Hinduism is the predominant religion practiced by Indians followed by Islam, Buddhism, Jainism, Sikhism, Zoroastrainism, Christianity and Judaism. The followers of these different religions observe different dietary laws and codes for fasting, and feasting thereby influencing their eating patterns. Throughout history, the culture and cuisines of India have been influenced by other civilizations such as the Moghuls, the British and now the Americans. The neighboring nations of Pakistan, Nepal, Bhutan, Bangladesh and Sri Lanka on all four frontiers share many common features with regard to dietary habits and food practices despite their unique food specialities.

Health problems and nutritional status of Indians in the US

Some of the important health problems faced by Indian immigrants include chronic degenerative diseases such as diabetes, hypertension, cardio-vascular disease and complications arising from any of these conditions. In fact, Indian immigrants have a significantly higher risk of cardiovascular disease with heart disease rates estimated to be one and one half to four times greater than Whites. Research has shown that there is a susceptibility among us towards developing non-insulin dependent Type 2 diabetes. There are several reasons for this. Hereditary differences in lipid metabolism, excessive insulin resistance, increased glucose tolerance, increased abdominal fat, lifestyle changes such as lowered physical activity coupled with increasing stress are thought to enhance the risks for such diseases. Concerns also center around nutrition problems stemming from dietary changes such as altered vegetarian status, meal patterns, increased usage of fast and convenience foods, changes in the frequency of use of traditional Indian foods and the inclusion of other ethnic and American foods as substitutes for traditional foods. This results in the abandonment of a diet traditionally high in complex carbohydrates and low in fat to a diet that is high in saturated fat and animal protein and low in fiber.

What can you do?

Your nourishment does not depend on the selection of any one food. Instead it depends on the consistent and continuous selection of many different foods on a day to day basis. There is a section in this book in the Summary that gives you suggestions on how to plan your eating and what to avoid.
Purpose and organization of this booklet

In this book we have tried to present some practical guidelines for health professionals working with Indian clients and the clients themselves who wish to understand how to manage chronic disease conditions such as diabetes and cardiovascular disease.

In the first section we offer a primer on chronic degenerative diseases - their definitions, types and treatment modes.

In this booklet, we focus on the different regional cuisines of India. Within each region we provide background information to illuminate the cultural context from which the ethnic foods and food habits have evolved, popular dishes, meal patterns highlighting typical and modified meal patterns for clients with diabetes, tips for changes and suggestions for weekend and party planning and tips on how to modify a high-fat recipe into a more heart-healthy one. Every chapter talks about weekend eating as the two days of feasting and partying can undo many of the benefits of eating healthy throughout the week.

The section on food exchanges give you an idea of how much of a food item (like for example, a chapati) makes up a food exchange. The Glossary gives a list of some of the common foods and food items mentioned in the book as well as some of the more ingredients in this cuisine with its English equivalent.

Each section has been authored by a qualified professional in the field of nutrition (you will find a brief write-up of the writer at the end of each chapter) and has been further reviewed by qualified nutrition and medical professionals (listed on the inside of the cover page).

SECTION 1

Diabetes

Diabetes is a disease characterized by high blood glucose and either insufficient or ineffective insulin, depending on the type of diabetes.

Type 1 diabetes also known as insulin dependent diabetes or juvenile onset diabetes, occurs around the ages of 8 to 12 years but can occur at any age. The disease has a strong genetic link. The pancreas cannot synthesize insulin thereby altering the body’s metabolism. The person must be injected with insulin to assist the cells in taking up the needed fuels from the blood.

Certain parameters like body measurements (BMI or Body Mass Index>25 ) can put a person at risk for developing diabetes if there is a genetic predisposition. Formula to calculate BMI: wt. in kg divided by (ht. in meters)^2 BMI reference table has been included here for your use. Another guide is the waist-to-hip ratio:

Waist divided by Hip = should not be > 1 in men
Waist divided by Hip = should not be > .8 in women

Type 2 diabetes is characterized by high blood glucose and insulin resistance. This disease usually begins after age 20. However the widespread incidence of inactivity and obesity in our population is being shown to precipitate this condition even earlier. The mean age of diagnosis in children and adolescents is approximately 13.5 years with a majority diagnosed in mid puberty. Youths with Type 2 diabetes have a BMI of 25 Kg/m. In the initial stages the pancreas produces insulin. The person may actually have higher than average insulin levels but the cells respond less sensitively to it either because they have diminished in number or in function thus making the individual insulin resistant. Consequently the blood glucose levels rise stimulating the pancreas to produce insulin, exhausting the cells and reducing their ability to function. In
obesity, the higher body fat necessitates higher insulin production; however, insulin receptors are reduced in number and function resulting in insulin resistance. Age, diet, lifestyle and genetic factors have been implicated in the development of the disease. 

**Symptoms of Diabetes** include frequent urination, excessive thirst, extreme hunger, unusual weight loss, increased fatigue, irritability and blurred vision.

**Criteria for diagnosis**

- Symptoms of diabetes together with casual (any time of day) plasma glucose concentrations of $>200$ mg/dl.
- Fasting plasma glucose (At least 8 hours following no caloric intake) $>126$ /dl.
- Two hour plasma glucose $>200$ mg/dl during an oral glucose tolerance test.

**Criteria for Impaired Glucose levels**

- Fasting plasma glucose levels of $<126$ mg/dl can be considered to be in the Impaired blood glucose range.

**Complications of diabetes**

The accumulation of glucose in the blood leads to acute and chronic complications. Therefore early, aggressive treatment to control blood glucose significantly reduces the risk of long term diabetes related complications. Diabetes related complications include:

- diseases of large blood vessels such as atherosclerosis
- diseases of the small blood vessels resulting in loss of kidney function and retinal degeneration and blindness.
- diseases of the nerves resulting in loss of sensation, increased infections stemming from unnoticed injuries, and gastrointestinal problems.

**Recommendations for Type1**

Nutrition is an important part of the treatment regimen. Nutritional therapy focuses on maintaining optimal nutrition, educating clients about portion sizes, modifying recipes, controlling blood glucose and preventing and treating related complications. Focus is on meal intake patterns, consistency in carbohydrate intake to minimize glucose fluctuations.

**Recommendations for Type 2**

- Calories should be prescribed to maintain a reasonable body weight.
- Protein intake is recommended at 10-20% of caloric intake with a focus on lean meats, poultry, fish and the use of beans and cereal lentil combinations.
- Total fat and cholesterol intakes have to be tailored to meet individual requirements based on lipid profiles.
- Diet is designed to maintain consistent and evenly spaced carbohydrate intake throughout the day. In this respect carbohydrate counting and exchange lists as well the use of complex carbohydrates will help.
- Salt intake should be reduced in clients with hypertension.
- Persons with diabetes with elevated lipid levels need to monitor their fat intake as well.
Sudha Raj PhD RD is an Assistant Professor in the Department of Nutrition and Hospitality Management in the College for Human Services and Health Professions at Syracuse University in Syracuse New York.

References:

2. Ethnicity and type 2 Diabetes- Focus on Asian Indians. Journal of Diabetes and its complications
CAN NUTRITION AND EXERCISE IMPROVE CHOLESTEROL AND TRIGLYCERIDE AND PREVENT HEART DISEASE IN INDIANS?

A significant rise in heart disease among Indians could be due to inappropriate dietary habits and a lack of exercise. Some children may also be at a higher risk for developing dyslipidemia (high triglycerides and high LDL cholesterol).

Dyslipidemia defined as high cholesterol and/or high triglyceride can be lowered with a healthful diet. Indians may have a condition called insulin resistance or “metabolic syndrome”. The primary cause of an increase in heart disease in Indians is due to the metabolic syndrome described as high triglyceride levels and low HDL (good cholesterol) levels. These levels are also associated with upper body (waist) obesity and high insulin levels in the blood. Metabolic syndrome includes dyslipidemia (high triglyceride levels, small LDL particles or pattern B, and low HDL levels), high blood pressure, a moderate increase in blood sugar or diabetes. Accompanied by a small weight loss (if overweight), consistent daily aerobic exercise for a minimum of 30 minutes to an hour e.g. walking can increase the good HDL cholesterol and lower triglyceride, lower blood pressure and lower blood sugar. In fact life style changes including exercise and weight loss (if overweight) can reverse insulin resistance and the metabolic syndrome in many people. The question we should ask is not whether one should exercise. The question we should be asking is whether we can afford NOT to exercise. A high level of homocysteine and lipoprotein (a) are also risk factors for heart disease. Ask your doctor if you should have these blood tests.

Lowering your triglyceride levels

Triglycerides are the blood fats strongly associated with diet and weight. Being overweight, excessive sweets consumption and excessive alcohol intake can increase the triglyceride levels in the blood. The best level of triglyceride is 150 mg/dl or less, however, some lab slips indicate levels up to 250 mg/dl as normal. An increase in triglycerides can suggest changes in the lipoprotein patterns that are not healthy. This unhealthy change is referred to as Pattern B. Eating a high carbohydrate diet can cause triglycerides to increase. Both what you eat and the amount of food you eat can change triglyceride levels. If your overeating causes you to gain weight this will also raise your triglyceride. Alcohol can also increase triglyceride levels in the blood. Eating fatty fish e.g. salmon, mackerel and trout once or twice a week may help lower triglycerides as these are high in omega-3 fatty acids. Flax seeds may also be beneficial on a heart healthy diet although they do not have the two essential fatty acids EPA & DHA that fish does.

Fitting Fats and Oils into your daily diet

Fat is an important nutrient because the body cannot produce its own and must get it from the diet. A low fat diet accompanied by weight reduction will lower triglycerides. Eating too little fat but enough food to maintain your weight usually results in your triglycerides going up and your HDL going down. Although your triglyceride may stay in the lab normal range (<150 mg/dl) you do not want your triglyceride to go over 100 mg/dl. If your triglyceride levels go above 100 mg/dl your HDL will usually go down. Obviously, you do not want to do anything to lower your HDL. A healthy HDL for men is at least 45 mg/dl and for women is 55 mg/dl. Sometimes, reducing your fat intake will allow you to lose some weight. During active weight loss, HDL is reduced.
Moderation - the key to a healthful diet

The appropriate diet you should eat to lower your triglycerides is one that is moderate in fat. A typical woman can daily consume 3-4 Tablespoons (45-50 g/day) of oils/fats and a typical man 5-6 Tablespoons of oils/fats (75 g/day), but the fat should be primarily from monounsaturated sources. Monounsaturated fats are the fats found in olive oil and canola oil. Avoid foods made with saturated fat (fat that is solid at room temperature). To reduce the LDL (bad) cholesterol in your blood, saturated fat and dietary cholesterol should be reduced in the diet. Saturated fats have the most dramatic effect on raising LDL cholesterol. These are butter, ghee, lard, shortening, coconut and the fat in meat including chicken. They are solid at room temperature. They are also found in baked goods (pastry, kulf, rasmalai, pies, cakes and cookies) and prepared foods made with these fats such as in restaurants (fried appetizers, marinated entrees, butter and cream based sauces). To lower your cholesterol you would choose as little saturated fat as possible and lose weight if you are overweight.

All fats are not created equal

You can eat other types of fat. It is simply not true that “no fat in the diet is better than any fat in the diet”. One type of fat that is thought to be “good” is called monounsaturated fat. This is the type of fat in olives and olive oil, canola oil and peanut oil. By using canola and olive oil in food preparation you can improve your cholesterol levels. If you have a weight problem you will want to limit the intake of all oils including the monounsaturated oils. You can use these in cooking and on food such as salad dressings. There are a few margarines and mayonnaise made with monounsaturated fat. Read your labels carefully looking for canola or olive oil or that list more of these (monounsaturated fat) than other fats on the label. The new margarines made from plant cholesterol e.g. “Benecol” and “Take Control” can also lower LDL cholesterol levels.

Vegetarian alternatives including use of Soy

Tofu is an excellent choice for protein especially in place of “Paneer”. Unlike “Paneer” which is high in saturated fat, the fat in tofu is preferable to unsaturated fat. Legumes (dried beans and lentils) including “daal” are naturally low in fat, high in protein and carbohydrate and in fiber. Soy milk like tofu is available in low fat varieties. Soy milk usually has a beany taste which most people find quite pleasant. Try using soy milk with fresh fruit to make delicious smoothies. Soy yogurt and soy cheese is available. Check the fat content as these can be high in fat. One egg three times per week is quite acceptable in an otherwise low fat diet. Nuts and seeds, avocados and olives are considered good fats because they are high in monounsaturated (good) fat. Be aware that these good fats are also high in calories and can cause a weight problem. Vegetarian burger patties can be convenient and nutritious alternative to the meat patties. Two or three servings (2 or 3 oz each) of protein foods and two or three servings (8 fl oz) of low fat or non fat milk or buttermilk or yogurt is recommended daily. Also recommended are 6 to 11 servings of grains and 5 servings of fruits and vegetables daily. Use of whole milk in the preparation of “chai” and desserts during the Hindu festivals e.g. ‘peda’ can add saturated fat in the diet. Though such items can be worked into occasional use on an exchange basis, they can contribute to high cholesterol and/or high triglyceride levels.

For more information

A registered dietitian can help you develop a customized meal plan while taking your personal food preferences and medical history and lab reports into account. This is referred to as medical nutrition therapy (MNT) by a registered dietitian (RD).
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References

NORTH INDIAN CUISINE

North Indian cuisine typically represents foods of Punjab, Delhi, Uttar Pradesh, and Rajasthan area. All the states north of Maharashtra are often clumped together in this generalization. Each state has its own specialties but it is the similarities that classify the food of this region. North Indian food is often called “Punjabi food”. North Indian food is the most popular food in restaurants and is often understood to represent Indian food.

Wheat is the staple food of this region. “Basmati” rice is grown in the northern plains and is often the rice of choice for pulaos and biryanis. Variety of dals or beans such as garbanzo, kidney, urad as well as moong and toor dal are used. Milk, butter and ghee are used extensively. Chicken and mutton are the most popular meats eaten in this region. Most of the cooking is done on the stovetop using the roasting and frying method.

Punjabis popularized tandoori food (that gets its name from the tandoor clay oven in which the food is cooked) in this region. Today most Indian restaurants around the world serve tandoori dishes and typically Punjabi food.

North Indian food is a mix of simple to very elegant vegetarian and non-vegetarian fare. A simple vegetarian meal may consist of moong dal, subjji and phulka (thin fat-less roti). The food is seasoned with asafoetida, cumin, turmeric, coriander powder and garam masala. Other Indians often refer to Garam masala as a north Indian spice blend. Onion and garlic may or may not be used. Then there are the non-vegetarian favorites like chicken and lamb dishes heavily seasoned with spices, onion, ginger and garlic. Foods like stuffed parathas, saag and makki ki roti, chole and bhature, kofta, rogan josh, tandoori chicken, biryanies and pulao’s are very popular here. North Indian desserts like barfies, laddus, and gulab jamun are extremely popular throughout India.

North Indian food is often described as “rich”. The food is often fried, and a fair amount of ghee, butter and nuts may be is used. The food is seasoned heavily with onion, ginger, garlic and spices like cardamom, cinnamon and cloves that give the food a “rich” color and flavor.

Nutritionally speaking north Indian meals with plenty of whole grains, green vegetables, beans and lean meats (poultry without skin) are high in complex carbohydrates, fiber, vitamins and minerals. The overall fat and saturated fat content of traditional meals may be high due to extensive use of milk, butter, ghee and oil. This is where the meals can be modified in fat content by using small amount of oil to season the food. Also substitute low fat or fat free milk wherever possible and use butter and ghee sparingly.

North Indian food can be easily incorporated in a healthy lifestyle. If you have diabetes it is important to watch the carbohydrate content of each meal. Plan balanced meals of roti, dal, meat (if non-vegetarian) non-starchy vegetables and salad. A typical ‘thaali’ meal (proportioned out foods in small cups served on a large plate or ‘thaali’) with balance of nutrients, flavors and textures may work well with diabetes and a healthy diet. The amount of carbohydrate in each meal is individualized based on needs. Portion size of foods is important to determine the actual carbohydrate intake. Remember within reason most foods can fit into a diet for a person managing his/her diabetes. See sample menu below.

Sample Menu

A sample menu of a typical vegetarian and non-vegetarian meal with an improved sample of the same is given below. A typical meal as mentioned earlier is high in carbohydrate and fat. By some modification in the amount of oil and ghee used, substituting low fat and low
carbohydrate vegetables as well as cutting down on portions will help in cutting down in carbohydrate and fat content and therefore the total calorie intake. Consult a dietitian for an individualized meal plan.

Typical Vegetarian Meal with Non-vegetarian options

**Breakfast**
1 cup Chai (Tea) with whole milk
3 teaspoon sugar
2 Potato Parathas
Pickle

**Lunch**
2 Roti with 2 teaspoons ghee
1 cup Rajmah (or Chicken Curry)
1 cup spinach and potato subj
1 cup rice
½ cup Dahi (whole milk yogurt)
Onion and Cucumber salad
1 Roasted Papad
(4 teaspoon vegetable oil in cooking)

**Tea Time**
1 cup Chai with whole milk
3 tsp regular sugar
1 cup Namkeen (fried snack)
1 Laddu (sweet)

**Dinner**
4 Parathas (8-10 tsp oil)
(1 cup Kheema)
1-2 cups potato and pea subj
½ cup Dahi (whole milk yogurt)

**Snack**
1 ½ cups Kheer

Above menu modified to yield a lower range of fats and carbohydrates

**Breakfast**
1 cup Chai with skim milk
no calorie sweetener
2 Whole wheat toast
1 teaspoon margarine
1 cup skim milk

**Lunch**
2 Roti-no ghee
1 cup low fat Rajmah (or low fat Chicken Curry)
1 cup spinach subj
½ cup rice
½ cup Dahi (fat free yogurt)
Onion and cucumber salad
1 Roasted Papad
(2 teaspoon vegetable oil in cooking)
**Tea Time**
1 cup Chai with skim milk
no calorie sweetener
½ cup roasted Chana and Murmura
1 Banana

**Dinner**
3 Roti-no ghee
½ cup Chole (½ cup Kheema, low fat)
1 cup cauliflower subji
½ cup Dahi (fat free yogurt)

**Snack**
1 Orange
1 cup Skim milk

**Weekends and Parties**
There is often a distinct difference in our eating between weekdays and weekends. On weekdays we are bound by time and schedules and it is easier to control the types and amounts of foods we eat. People will often say they do so well Monday to Friday implying that they make good choices in their meal selection. But come weekends (starting Friday night) we lose all restraints in our food selection. Indians love to party, as it is our way of socializing and connecting with our culture. Socializing is associated with special occasion foods of puri, chole, pakore, and not to mention kheer and halwa (generally high-fat foods). Portion control is a good tool to use here. If you are the host, plan your parties to balance meals and incorporate some lower fat foods like vegetable trays as appetizers and use less fat in your dishes. If you are the guest at a party and everything you see is high in fat and calories watch your portion sizes, enjoy the company and thank the hosts for a wonderful evening. You will be much happier on Monday morning!

**Typical Party Menu**
Samose or pakore with chutney
Puri
Chole
Chicken curry (non-vegetarian)
Potato Pea subji
Cauliflower with potato subji
Kofta
Onion, cucumber, radish salad
Boondi Raita
Matar Pulao
Chai
Gulab Jamun

**Suggestions for person with diabetes**
(Remember you have to watch your total carbohydrate intake to avoid elevated blood sugar after the meal)
1 Samosa
1 Puri