A NAZA HOLISTIC CHURCH FARM TEACHING DOCUMENT

FOOD IS THE FIRST MEDICINE

Diet, Disease, and the Structural War on Proper Human Nutrition

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Vincent Melqart Nazaright

Research and composition assisted by Claude (Anthropic)

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For education, not medical advice.

Come, Holy Spirit; come, Holy Ghost.

A Note on Knowing and Having Access

Before any discussion of what the proper human diet is, a word about the gap between knowing and being able to do. Tens of millions of Americans know the right things and cannot consistently afford to eat them. That is not a personal failure. It is a structural condition, and it is inseparable from the subject of this paper.

When a household is choosing between shampoo and vitamin C, when Peter is being robbed to pay Paul every month, the choice is not between ignorance and knowledge. It is between what you know and what the economic system has made available to you in your zip code at your price point. Poor diet causes disease. That is true. And poor people are systematically denied access to non-poor diets. That is also true. Both of these things must be held at once, or the analysis is dishonest.

The same economic forces that helped close the eclectic and botanical medical schools in the decades after the Flexner Report of 1910 also built a food system that makes cheap ultra-processed food ubiquitous in low-income neighborhoods while fresh vegetables are a luxury item. The pharmaceutical industry profits from chronic disease. The processed food industry helps manufacture it. These are not separate systems. They are integrated extraction infrastructure.

What follows is the knowledge layer. The structural critique and the practical work of access are inseparable from it and are treated alongside it. Knowing is the first step, and knowing well is worth doing even before you can fully act. The children we are planting trees for will need the knowledge and, God willing, the access.

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PART ONE: THE BASELINE — WHAT PROPER HUMAN NUTRITION IS

I. The Framework: Plants as Medicine, Animal Protein and Fat as Structural Nutrition

The framing that plants are medicine and quality animal protein and fat are structural nutrition is not a trendy diet philosophy. It is, in the reading offered here, the point where nutritional anthropology, ancestral-health research, and modern clinical dietetics most nearly converge. It resolves the false war between the plant-based and animal-based diet camps by understanding that they are not alternatives but complements serving different biological functions.

Animal protein and fat from quality sources (grass-fed and pasture-raised animals, wild fish, organ meats, eggs, full-fat fermented dairy) provide the structural materials the human body is built from: complete proteins containing all essential amino acids in bioavailable form; the fat-soluble vitamins A, D, E, and K2 in their most biologically active forms; omega-3 fatty acids, including the DHA and EPA critical for brain and nervous-system function; and heme iron, zinc, and B12, which plants supply poorly or not at all. These are not optional. The human body is substantially made of these things.

Plants provide a different category of biological input: phytonutrients, polyphenols, flavonoids, terpenoids, alkaloids, and other secondary metabolites that the plant produces for its own defense but that human biology has co-evolved to use as regulatory, anti-inflammatory, antimicrobial, and adaptogenic signals. This is herbalism at its most basic level. It is not mysticism and not placebo, but the recognition that plant chemistry and human physiology share a deep evolutionary relationship.

Fiber from plants feeds the gut microbiome, which works hand in hand with the gut's own nervous system (sometimes called the second brain) and has profound effects on immunity, mood, and metabolic function. Antioxidants from plants counter the oxidative stress that drives chronic disease.

The Mediterranean-keto synthesis that, on this reading, most closely reflects the optimal human dietary pattern pulls these together: high-quality animal protein and fat as the structural foundation, an abundant and varied plant intake for medicinal, microbial, and regulatory function, and refined carbohydrates, seed oils, ultra-processed foods, and added sugars minimized or eliminated. Not a diet in the popular sense. A return to the nutritional baseline the human body was built to run on.

II. Weston A. Price and the Anthropological Evidence

In the 1930s, Weston A. Price, a Cleveland dentist, carried out one of the most consequential, and most ignored, bodies of nutritional research in American history. Alarmed by the dental decay and physical degeneration he was seeing in his patients, Price spent much of the decade traveling the world to study fourteen isolated, non-industrialized groups who had not yet adopted the Western industrial diet: Swiss villagers, Gaelic islanders, Inuit, Indigenous peoples of North and South America, Melanesians, Polynesians, East Africans, and Australian Aborigines among them.

He reported the same pattern across the groups he visited. Traditional populations eating their ancestral diets, which varied enormously in composition but were all whole, unprocessed, and nutrient-dense, showed excellent dental health (few cavities, straight teeth, wide palates, no crowding), robust skeletal structure, and, by his account, little of the chronic disease already common in Western industrial populations. When the same populations adopted the Western industrial diet of white flour, white sugar, vegetable oils, and canned goods, dental decay appeared within the first generation and physical degeneration followed.

Price reported that the traditional diets contained at least ten times the fat-soluble vitamins A and D of the average American diet of his day, mostly from animal sources: organ meats, seafood, fish liver oils, fermented dairy, and eggs from pastured animals. He also described a factor he called "Activator X," which later researchers have argued was vitamin K2, now recognized as an important co-factor in calcium metabolism, arterial health, and bone development, and one that is scarce in the modern industrial diet.

Price's work, published as *Nutrition and Physical Degeneration* (1939), remains one of the most ambitious field surveys of diet and health ever attempted by a single researcher. It is also largely absent from mainstream nutrition education. Its critics point out that it was observational, without controls or statistics in the modern sense; its defenders point out that no one has repeated it at that scale. Either way, its central observation deserves far more attention than it gets, and its conclusions sit badly with the processed food industry's business model.

III. What Modern Clinical Research Confirms

A. Ultra-Processed Foods and the Chronic Disease Epidemic

The research on ultra-processed foods (UPFs) is now extensive and remarkably consistent. By 2023, researchers had counted more than seventy long-term prospective studies linking UPF consumption to weight gain and chronic disease, and a three-part series in *The Lancet* in late 2025 drew on more than a hundred prospective studies, meta-analyses, randomized trials, and mechanistic studies covering

nearly every organ system. A 2024 umbrella review in *The BMJ* found UPF exposure associated with 32 health outcomes, with the strongest evidence for cardiovascular death, type 2 diabetes, and common mental disorders such as anxiety. UPF consumption is consistently associated with metabolic syndrome, inflammatory bowel disease, cardiovascular disease, type 2 diabetes, obesity, cerebrovascular disease, depression, dementia, and several cancers.

The mechanism is multifactorial. UPFs are characterized by high energy density, added sugars, refined carbohydrates, industrial seed oils high in omega-6 fatty acids, trans fats, sodium, and synthetic additives, while containing little fiber, micronutrients, phytonutrients, or essential fatty acids. This composition drives persistent low-grade chronic inflammation, a common upstream driver of many major non-communicable diseases, through gut microbiome dysbiosis, hormonal dysregulation, insulin resistance, damage to the lining of the blood vessels, and oxidative stress.

A particularly striking finding: in the large French NutriNet-Santé cohort, each 10 percent increase in the share of ultra-processed food in the diet was associated with a 12 percent higher risk of cardiovascular disease and a 12 percent higher risk of cancer overall. UPFs now make up more than half of daily calories in the United States and the United Kingdom. Most of this evidence is observational: it shows association, not proof of cause. But in 2019 a tightly controlled feeding trial at the National Institutes of Health found that people offered an ultra-processed diet, matched to an unprocessed one for calories, sugar, fat, fiber, and salt, ate about 500 more calories a day and gained weight, while on the unprocessed diet they lost it. The chronic disease epidemic is, in significant measure, an ultra-processed food epidemic. It is not a mystery, and the line from industrial food manufacturing to mass biological dysfunction is getting harder to deny.

B. The Mediterranean and Low-Carbohydrate Evidence for Disease Reversal

The clinical research on dietary intervention for disease reversal (not just management, but reversal) is stronger than most people know, largely because most people get their nutritional information from a medical system that is structurally incentivized to manage chronic disease with pharmaceuticals rather than eliminate it through lifestyle change.

Diabetes affects about one in ten Americans, nearly all of it type 2, and mainstream medicine has long described type 2 diabetes as progressive and irreversible. In many people it can be put into remission, which is to say reversed for as long as the remission holds. A 2024 systematic review of 52 studies found that a low-carbohydrate Mediterranean diet was more effective than low-fat approaches at producing type 2 diabetes remission, particularly in newly diagnosed patients; the same review found that diets high in plant protein also produced remission, with less weight loss needed. The Diabetes Remission Clinical Trial (DiRECT), published in *The Lancet* in 2018, put 46 percent of its intervention group into remission at one year, and 36 percent were still in remission at two years. Its method was blunt: about three months of a liquid formula diet of roughly 850 calories a day, then a gradual return to food with support to keep the weight off. Very low-carbohydrate ketogenic approaches have shown strong results of their own: in an Indiana University trial, about 60 percent of participants on the ketogenic diet who had been using insulin stopped needing it entirely, as University of Michigan researcher Laura Saslow summarized in a 2024 review of the evidence for both approaches.

Alzheimer's disease, increasingly understood as having a strong metabolic dimension and sometimes called "type 3 diabetes," also shows signs of responding to diet. A 2025 study in *Communications Medicine*, a Nature Portfolio journal, analyzed blood samples from a small randomized crossover trial of 20 older adults and found that a modified Mediterranean ketogenic diet (MMKD) shifted blood

lipids in the direction opposite to the pattern seen in Alzheimer's disease. The researchers concluded that MMKD could be a promising approach for prevention or early symptomatic treatment, noting its "low risk and cost." The study is small and early, and worth watching.

Cardiovascular disease, high blood pressure, fatty liver disease, and polycystic ovary syndrome all show research evidence of improvement, and in some cases reversal, through diet; autoimmune conditions and some cancers show early evidence that diet can modify their course. The pattern is consistent: remove the UPFs, reduce refined carbohydrates and industrial seed oils, restore nutrient density through whole animal and plant foods, and chronic inflammatory disease retreats. This is not alternative medicine. It is peer-reviewed clinical research, published in journals such as *The Lancet*, *The BMJ*, and the Nature family.

C. The Mediterranean-Keto Synthesis — Why This Specific Combination

The Mediterranean diet and the ketogenic diet are often presented as alternatives or even opposites. They are better understood as complementary frameworks addressing different aspects of the same nutritional problem.

The Mediterranean diet's core strengths: abundant vegetables, legumes, and whole fruits; olive oil as the primary fat; regular fish and seafood; moderate fermented dairy; moderate poultry and eggs; little red meat and almost no processed meat; minimal added sugar; herbs and spices as functional medicine. Its research base for cardiovascular protection, longevity, and cognitive preservation is among the strongest in nutritional science.

The ketogenic framework's core strengths: elimination of refined carbohydrates and added sugars, and a metabolic shift to fat-burning (ketosis) that reduces insulin resistance, lowers systemic inflammation, improves mitochondrial function, and gives the brain ketone bodies, a fuel some researchers consider more efficient than glucose (of particular interest for neurological and psychiatric conditions). It is also especially effective as a rapid metabolic reset in cases of severe insulin resistance.

Their synthesis, a low-carbohydrate Mediterranean diet emphasizing quality animal protein and fat, abundant non-starchy vegetables, olive oil, herbs, fermented foods, and minimal refined carbohydrates, captures the strengths of both frameworks. It is ancestrally coherent (far closer to pre-industrial eating than to the modern supermarket diet), clinically supported for multiple disease categories, and structurally consistent with the plants-as-medicine, animal-protein-as-structure framework.

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PART TWO: THE MECHANISM — HOW POOR DIET CAUSES DISEASE

IV. Chronic Inflammation: The Common Thread

Most chronic diseases (heart disease, type 2 diabetes, Alzheimer's, most cancers, autoimmune conditions, depression, metabolic syndrome) share, by a growing body of evidence, a common upstream driver: chronic low-grade systemic inflammation. This is not the acute inflammation of an infection or wound, which is the body's appropriate and necessary defense, but a persistent, low-level inflammatory state that gradually degrades tissue, disrupts hormonal signaling, damages blood vessels, impairs mitochondrial function, and creates the conditions in which chronic disease establishes itself.

The industrial diet is, in its composition, an almost perfectly designed inflammation machine. Refined carbohydrates and added sugars drive repeated insulin spikes that promote systemic inflammation and insulin resistance. Industrial seed oils (soybean, corn, canola, cottonseed) are extraordinarily high in omega-6 polyunsaturated fats, which in excess, many researchers argue, shift the body's balance toward a pro-inflammatory state. That point is contested: other researchers cite trials in which these oils did not raise inflammatory markers. The case made here is about excess, and about imbalance against omega-3. Some emulsifiers have been shown in animal studies to thin the gut's protective mucus layer and provoke immune activation, and an early human trial found troubling changes as well. Trans fats are linked to damage of the cells lining the blood vessels. The combination is chronically and cumulatively harmful.

Conversely, the nutrient-dense whole-food diet is anti-inflammatory by composition. Omega-3 fatty acids from wild fish, grass-fed animal products, and certain plants balance the omega-6 load and actively help resolve inflammation. Polyphenols from herbs, vegetables, and fruits modulate inflammatory pathways down to the level of gene expression. Fiber from whole plant foods feeds beneficial gut bacteria that produce short-chain fatty acids with anti-inflammatory effects throughout the body. Vitamins A and D help regulate immune function. This is not supplementation. This is food doing what it is biologically designed to do.

V. The Gut Microbiome: The Second System

One of the most significant scientific developments of the past two decades is the emerging understanding of the gut microbiome, roughly 38 trillion bacteria by one widely used estimate, living mostly in the colon, as a system with effects far beyond digestion. By common estimate, around 70 percent of the body's immune tissue sits in and around the gut. More than 90 percent of the body's serotonin is made in the gut, and gut bacteria help regulate that production. The microbiome communicates with the brain through the vagus nerve, metabolizes hormones, and produces vitamins. Its disruption, called dysbiosis, has been linked, with varying strength of evidence, to inflammatory bowel disease, autoimmunity, depression, anxiety, Alzheimer's, autism spectrum conditions, obesity, and metabolic syndrome.

The industrial diet is hard on the microbiome. Routine antibiotic use in industrial livestock breeds drug-resistant bacteria that can reach people through food. Laboratory and animal studies suggest that

glyphosate, the most widely used herbicide, can harm some beneficial gut bacteria more than some harmful ones; what residue levels in food do to people is still being studied. Some emulsifiers and artificial sweeteners have been shown to shift the microbial community in unhealthy directions. Lack of dietary fiber starves beneficial bacteria. The result is a progressively degraded microbiome that contributes to systemic disease.

The fermented food tradition in virtually every pre-industrial culture (sauerkraut, kimchi, kefir, yogurt, kombucha, miso, tempeh, traditional sourdough, fermented meats and fish) was intuitive microbiome medicine. These cultures arrived at the practice of feeding and diversifying gut bacteria through fermentation long before anyone had a framework for understanding why it worked. Modern research is catching up: in a 2021 Stanford trial, healthy adults who ate several servings of fermented foods a day for ten weeks saw the diversity of their gut microbes rise and their markers of inflammation fall. The eclectic physicians who documented traditional plant medicines were likely observing, in part, effects carried through the microbiome (the gut-brain axis, the gut-immune axis) without the vocabulary to name the mechanism. The vocabulary now exists.

VI. Nutrient Deficiency as Disease Generator

Modern chronic disease is at once a disease of caloric excess and of nutritional deficiency. People eating thousands of calories of industrial food can be obese and profoundly short of the micronutrients their bodies need to function. The industrial diet is calorically dense and nutritionally near-empty.

Vitamin D deficiency is widespread: one analysis of national survey data found about 42 percent of American adults deficient by a common cutoff, with far higher rates among Black and Hispanic Americans, though estimates vary with the cutoff used. Low vitamin D is associated with immune dysfunction, depression, cardiovascular disease, autoimmunity, and weaker resistance to cancer. Magnesium is a co-factor in more than 300 enzyme systems, including those behind protein synthesis, energy production, and muscle and nerve function, and dietary surveys consistently find that many Americans, by some estimates around half, take in less than recommended. Low omega-3 intake is common in populations eating industrial diets, with consequences for brain function, cardiovascular health, and inflammatory regulation. Shortfalls in zinc, iodine, vitamin K2, choline, and B12 are common among people eating industrial diets, and each of these nutrients plays a role whose absence drives recognizable disease.

This is where the plants-as-medicine framework meets clinical pharmacology. Many of the herbal preparations documented in *King's American Dispensatory* were addressing micronutrient deficiencies, antimicrobial needs, and inflammatory conditions through concentrated plant chemistry. Its authors were often right about the effects even when they lacked the vocabulary for the mechanisms. Echinacea's effects on the immune system, elderberry's antiviral activity, the anti-inflammatory action of curcumin from turmeric, and garlic's antimicrobial compounds are all documented in the laboratory and under active study in people, where the results range from promising to mixed. The folk tradition pointed at real chemistry. Modern pharmacology is still confirming the pointing.

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PART THREE: THE STRUCTURAL PROBLEM

VII. The Political Economy of Disease — Why the System Produces Sick People

The chronic disease epidemic is not an accident. It is the predictable output of an economic system in which the industries that profit from chronic disease (pharmaceutical, processed food, hospital systems) have vastly more political power than the individuals and communities being made chronically ill. Understanding the dietary science without understanding the political economy of food is like understanding that mercury poisoning is killing people without asking who is dumping the mercury.

The processed food industry spent decades shaping nutrition research in ways that obscured the harms of sugar by attributing cardiovascular disease to saturated fat. This is a documented case of industry manipulation of science, brought to light in 2016 when researchers published internal industry documents showing that the Sugar Research Foundation had funded and shaped a 1967 review that played down sugar's role in heart disease and pointed at fat instead. That episode helped tilt decades of research and policy toward the low-fat dietary guidelines that dominated American nutrition from the late 1970s through the 2000s, which in turn drove the boom in low-fat processed foods loaded with sugar and refined carbohydrates, a shift many researchers link to the obesity and type 2 diabetes epidemics.

The pharmaceutical industry's incentive structure runs perpendicular to healing. A patient whose type 2 diabetes is reversed through diet is a lost revenue stream. A patient managed on metformin and insulin for thirty years is a profit center. The FDA approval process, the medical school curriculum, continuing medical education funded by pharmaceutical companies, and clinical guidelines written by professional associations with industry ties all, in the argument made here, tilt medical care toward pharmaceutical management and away from dietary reversal, not because dietary reversal doesn't work but because it doesn't pay.

VIII. Food Deserts and the Geography of Malnutrition

The gap between knowing the right diet and being able to afford and reach it is not randomly distributed. It maps closely onto the geography of poverty, race, and disinvestment. Using a 2019 directory of food stores, the USDA's Economic Research Service found that about 12.8 percent of U.S. census tracts were both low-income and low-access, meaning that a substantial number or share of residents lived more than a mile from a supermarket in a city, or more than ten miles in the country. By a wider half-mile measure, the agency's Food Access Research Atlas counts some 53.6 million Americans, about 17 percent of the population, living in such tracts. These food deserts are not the result of individual dietary choices. They are the result of urban planning decisions, supermarket location strategies, transportation infrastructure, and economic disinvestment in low-income communities.

Where supermarkets are scarce, corner stores and fast-food outlets fill the gap, and what they sell runs heavy on sugar, salt, and industrial fats, the very categories most strongly linked to chronic disease, while fresh vegetables, quality protein, and whole foods are scarce, expensive, or missing. Public health

researchers report higher rates of preventable chronic illness in these communities: obesity, heart disease, type 2 diabetes, vitamin and mineral deficiencies, and everything that follows from them.

Food insecurity, the condition of not having reliable access to enough affordable, nutritious food, is associated with poor diet quality and a higher risk of diet-related disease, including cardiovascular disease, diabetes, and certain cancers. People of lower income and racial and ethnic minority groups experience higher rates of food insecurity and bear the greatest burden of diet-related chronic disease. This is structural, not incidental.

Blaming individuals for poor dietary choices when they live in communities where healthy food is systematically out of reach is not only scientifically inaccurate; it is the preferred framing of the industries that profit from the situation. Personal responsibility is a real value. Structural conditions are also real. A complete analysis holds both.

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PART FOUR: THE VISION — FOOD, MEDICINE, AND THE NEXT GENERATION

IX. The Proper Human Diet: A Practical Summary

What follows is a practical synthesis of the ancestral, Mediterranean, and clinical evidence for the human dietary baseline. It is not a prescriptive protocol. It is the outline of what the body is built to run on and what the research consistently supports for disease prevention and reversal. Individual variation exists and matters. Context (economic, geographic, cultural, clinical) shapes what is achievable. The ideal is worth knowing even when it is imperfectly realized.

> **A word of care.** This paper is for education, not medical advice. If you take medicine for diabetes or blood pressure, talk with your clinician before cutting carbohydrates sharply: doses often need to come down quickly, and low blood sugar is dangerous. Herbs are medicine too, and some interact with prescription drugs, so ask a pharmacist before adding them. Anyone pregnant, nursing, or living with kidney disease should get personal guidance before a big change in diet.

FOUNDATION: QUALITY ANIMAL PROTEIN AND FAT

Grass-fed and pasture-raised beef, lamb, and bison, including organ meats (liver especially, among the most nutrient-dense foods there are). Wild-caught fish and seafood, emphasizing fatty fish (salmon, sardines, mackerel, herring) for omega-3 density. Pasture-raised eggs. Full-fat fermented dairy (yogurt, kefir, hard cheeses, butter from grass-fed animals). Poultry from quality sources. These provide complete proteins, the fat-soluble vitamins A, D, and K2, heme iron, zinc, B12, DHA, EPA, and choline: the structural and neurological building blocks of human biology.

MEDICINE: ABUNDANT AND VARIED PLANT FOODS

Non-starchy vegetables as the primary carbohydrate source: leafy greens, cruciferous vegetables (broccoli, cauliflower, cabbage, Brussels sprouts), alliums (garlic, onions, leeks), root vegetables, peppers, tomatoes, cucumbers, zucchini. Low-sugar fruits, especially berries, which are among the richest in polyphenols. Herbs and spices as daily medicinal practice (turmeric, ginger, garlic, rosemary, thyme, oregano, cinnamon), not as flavoring alone but as active agents used every day. Legumes in moderation for those who tolerate them, preferably soaked or fermented. Nuts and seeds for mineral density and beneficial fats.

FATS: THE RIGHT OILS

Extra-virgin olive oil as the primary cooking and dressing fat; it is among the most extensively researched single foods in the cardiovascular literature. Coconut oil and ghee for high-heat cooking. Animal fats (tallow, lard) from quality sources. Eliminate industrial seed oils (soybean, corn, canola, cottonseed, sunflower, safflower): they are the main source of the omega-6 excess described in Section IV, and, as industrially refined oils, they were not part of any traditional human food system.

CARBOHYDRATES: CONTEXT-DEPENDENT

Eliminate refined carbohydrates and added sugars categorically: white flour products, white rice, white sugar, high-fructose corn syrup, and everything containing them. They are empty calories at best and inflammatory at worst. Whole grains in limited quantities for those without metabolic disease, properly prepared (soaked, sprouted, or fermented, as traditional cultures did). Sweet potatoes and

other starchy tubers as whole-food carbohydrate sources for those with higher activity levels or without significant insulin resistance.

FERMENTED FOODS: DAILY MICROBIOME MEDICINE

Traditional fermented foods belong in daily practice: lacto-fermented vegetables (sauerkraut, kimchi, pickles in brine), kefir, yogurt, miso, traditional sourdough. They are the cheapest and most accessible way to restore and maintain the microbiome, and they continue the food culture that pre-industrial communities kept intuitively. The knowledge to make them is freely available and the ingredients are minimal.

WATER AND HERBAL TEAS: THE PRIMARY BEVERAGES

Filtered water as the baseline. Herbal teas as daily medicine, in their traditional uses: echinacea for immune support during illness, elderberry for its antiviral activity, chamomile as an anti-inflammatory and calming nervine, nettle for minerals, dandelion root for the liver and as prebiotic fiber, ginger for digestion and inflammation, rose hip for vitamin C. These are not supplements in the pharmaceutical sense. They are food.

WHAT TO ELIMINATE

Ultra-processed foods of all categories. Industrial seed oils. Refined sugar and high-fructose corn syrup. Refined grain products. Conventionally raised factory-farmed meat, for reasons of both nutrient density and antibiotic use. Artificial sweeteners, colorings, preservatives, and emulsifiers. Fast food as a regular pattern.

X. The Accessibility Problem and the Path Forward

An honest reckoning with the dietary ideal has to include an honest reckoning with what it costs and who can afford it. Grass-fed beef costs more than factory-farmed beef. Wild salmon costs more than frozen fish sticks. Organic vegetables cost more than whatever is on the convenience store shelf. The gap between the optimal diet and the accessible diet in food desert conditions is real.

But the gap is not as absolute as it is often presented, and knowing the cost-effective ways in matters enormously for anyone working within a tight budget. Eggs, pasture-raised when you can get them, are among the most nutrient-dense and affordable proteins available, more so than most cuts of commercial meat. Canned sardines and mackerel are affordable, wild-caught, and among the densest omega-3 sources there are. Chicken livers are cheap, extraordinarily nutrient-dense, and widely available. Dried legumes (lentils, black beans, chickpeas) are inexpensive and nutritionally solid when properly prepared. Cabbage, carrots, onions, garlic, and frozen vegetables are affordable and nutritionally respectable. Dried herbs and spices bought in quantity (turmeric, ginger, oregano, cinnamon) cost very little and deliver real medicinal value. Lacto-fermented vegetables, made from a head of cabbage and salt, cost nearly nothing and deliver the live cultures that probiotic supplements charge a premium for.

The bigger structural interventions (community gardens, food co-ops, farmers market access programs, local food sovereignty policy) are the systemic answers to the systemic problem. A community garden producing herbs, vegetables, and medicinal plants in a food desert neighborhood is at once food access work, holistic medicine work, and community sovereignty work. It is the direct continuation of what Sylvester Graham was trying to do, what Ellen White was trying to do, and what

the eclectic physicians were trying to do: restoring the ordinary household's relationship with the food and plant medicines that the Creator put on the earth for human flourishing.

XI. The Thesis: What We Are Actually Saying

> *The proper human diet is not a fad. It is not a pharmaceutical product. It is a biological reality documented across anthropology, clinical medicine, and nutritional science: quality animal protein and fat as structural nutrition, abundant and varied plant foods as medicine, fermented foods as microbiome maintenance, herbs and spices as daily pharmacological practice, and the elimination of industrial food chemistry that the human body was not designed to metabolize. The chronic disease epidemic is substantially a dietary epidemic, manufactured by the same capital forces that suppressed botanical medicine, engineered the processed food system, and profit from the illness they helped create. The knowledge to reverse this is available. The structural barriers to accessing it are real and must be named and fought as political problems, not treated as personal failures. The children of tomorrow deserve both the knowledge and the access. The work of building both is the work of our generation.*

A companion compendium, plant by plant and condition by condition, is the next phase of this work.

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Come, Holy Spirit; come, Holy Ghost.

About this edition

This public edition carries the pen name. The personal note that opened the June draft has been replaced with a general one. Every study and figure was checked against its source in November 2026, and the bibliography now lists what was actually found.

Corrected citations: the 2022 Lancet Gastroenterology & Hepatology review is by Srour, Kordahi, Bonazzi, Deschasaux-Tanguy, Touvier and Chassaing (7:1128–1140); the 2024 remission review appeared in Diabetes & Metabolic Syndrome, not Diabetes & Metabolism; the University of Michigan piece is a June 2024 expert Q&A; the Alzheimer's study by Neth and colleagues appeared in January 2025 and was a post-hoc analysis of 20 adults; the American Journal of Clinical Nutrition paper is by Odoms-Young and colleagues (2024); the review of ultra-processed food, heart disease and cancer appeared in Aspects of Molecular Medicine. The USDA figure of 12.8 percent is the share of census tracts in 2019 (published 2022), not the share of the population in a 2025 report. A 2026 Frontiers in Nutrition citation could not be found and was removed, and the count of "48 prospective studies as of 2022" could not be traced and was replaced with the counts in Touvier et al. (2023) and the 2025 Lancet Series.

Claims stated more carefully than in the draft: Price's findings are reported as his; the link between Activator X and vitamin K2 is given as a later argument; the seed-oil question is marked as contested; glyphosate, antibiotic and emulsifier effects are stated at the strength the evidence supports; serotonin is described as made in the gut with bacteria helping to regulate it; the evidence for the herbs is described as promising to mixed; and the ultra-processed food evidence is described as mostly observational, with the 2019 NIH feeding trial added. A short note of care was added to Section IX.