

DISCUSSION OPEN ACCESS

Dietitians as System Builders: Advancing Equity, Sustainability and Health in Community Nutrition and Primary Care

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ABSTRACT

Diet-related challenges in primary care and community settings increasingly reflect the convergence of health, social and environmental pressures. Although dietitians routinely navigate this complexity, their system-level contributions often remain implicit. This paper proposes a conceptual framework that positions dietitians as system builders and synthesises insights from systems science, health promotion and ecological models to articulate this role. Three interconnected roles illustrate how dietitians influence system behaviour: as *integrators*, they embed nutrition within institutional routines, information flows and care pathways; as *connectors*, they strengthen relationships across health, social, education, and food system actors; and as *advocates*, they shape organisational priorities and policy agendas related to equity, sustainability, and health. The analysis identifies enabling conditions, including supportive organisational structures, intersectoral collaboration, relevant policy frameworks and enhanced competencies in systems thinking and equity. It also notes common constraints such as siloed systems, workload pressures and role overload. Several leverage points emerge where targeted action can exert significant system-level impact (e.g. through changes in care-pathway information flows or links to community food resources). Recognising and consolidating these system-building roles can enhance the visibility, legitimacy and effectiveness of dietitians' contributions. A systems-oriented professional identity, supported by education, practice environments and policy infrastructures, can strengthen the profession's ability to influence the conditions shaping dietary behaviour, equity and sustainability.

1 | Introduction

The “global syndemic” of obesity, undernutrition, and climate change [1] underscores the complexity of current nutrition-related health challenges. Currently, more than 2.5 billion adults are overweight or living with obesity, while around 735 million people face hunger, and food systems contribute to over one-third of global greenhouse gas emissions [2–4]. In community

settings and primary care, the implications of this “syndemic” are increasingly visible through rising multimorbidity, an ageing population, growing social complexity, and persistent inequalities in access to nutritious food, which are now a routine part of everyday dietetic practice [5–8].

Addressing these overlapping trends and crises demands responses that move beyond individualised dietary counselling

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Summary

- Systems thinking provides the foundation for systems-building practice, helping dietitians to act as integrators, connectors and advocates in addressing nutrition, equity and sustainability in their everyday practice.
- Dietitians act as system builders when they integrate services, connect stakeholders and advocate for structural changes that improve population health.
- Embedding systems-based competencies in dietetic practice strengthens collaboration across primary care, community settings and food systems, leading to more coherent and impactful interventions.

and siloed approaches [9, 10], recognising the interdependence of health, equity, and sustainability and acknowledging the structural contexts in which eating behaviour and food access are embedded. Models such as Whitehead and Dahlgren's [11] ecological framework of health determinants or Fanzo's food systems model [12] illustrate how personal choices are embedded within social, economic, and environmental conditions. These approaches invite us to look at the "causes of the causes" [13] and to recognize that the social determinants of health not only constrain or enable food access but also shape the possibilities for dietary behaviour and change [1, 14, 15].

While such a broader role for dietitians already exists in practice [16, 17] it remains emergent and largely implicit. Focusing on primary care and community contexts, this paper contends that dietitians already perform elements of system-building work. By making this role explicit and providing structured conceptual framing, the article aims to support its further development, consolidation, and recognition within the profession. Drawing on systems science and public health theory, it outlines three actionable roles and identifies the enablers, barriers and leverage points that shape their capacity to influence health, equity and sustainability across settings.

2 | Theoretical Foundations

2.1 | Primary Care and Community Nutrition

Primary care and community nutrition occupy a distinctive position within health systems because they operate at the intersection of individual care, population health, and the social and environmental conditions that shape everyday life [18]. Historically, these settings have been guided by principles articulated in public health milestones such as the Alma-Ata Declaration and the Ottawa Charter [19, 20]. The Alma-Ata Declaration (1978) established health as a fundamental human right and positioned primary health care as the central strategy for achieving "health for all." Its vision emphasized care that is essential, accessible, community-based, equitable, and participatory—principles that continue to guide public health practice today. Nutrition was part of this agenda, as a determinant of health, situated within a primary health care approach that integrates prevention, care and equity [18].

A few years later, the Ottawa Charter for Health Promotion expanded this vision by reframing health as a resource for

everyday life rather than the mere absence of disease. It emphasized health in all policies, empowerment, and the importance of creating supportive environments through community action. Nutrition work in these settings has therefore long been situated within a broader understanding of health that extends beyond the clinical encounter, calling for collective action across sectors such as education, agriculture, and social protection [21–26].

In other words, the foundational principles articulated in these milestones anticipated what is now widely described as a systems perspective: an understanding that health outcomes arise from the dynamic interplay of social, environmental, and behavioural determinants, and that substantive, sustained progress requires coordinated multisectoral engagement rather than the isolated efforts of individual professions [9, 10].

Contemporary developments further reinforce the systemic nature of these environments. Primary care is increasingly characterised by multimorbidity, polypharmacy, and the ongoing management of chronic conditions whose trajectories are shaped by social and lifestyle determinants [27]. Community settings confront parallel challenges—food insecurity, social isolation, environmental injustice, and disparities in access to nutritious food—that require responses spanning health, social protection, education, and local food governance [28–30]. The convergence of these issues renders both settings inherently complex: professionals must navigate overlapping systems, reconcile diverse priorities, and attend simultaneously to immediate needs and underlying structural drivers.

Recent frameworks on complex interventions reaffirm this perspective. As Rutter et al. (2017) and other authors [21–26] argue, traditional linear approaches focused on single variables or short-term individual behaviour change have limited capacity to influence population health. Newer models call for integrative, adaptive, and context-sensitive approaches that acknowledge the dynamic nature of health systems, including their interactions with food, social and other systems. They stress the need for professionals who can navigate complexity, foster collaboration, and facilitate systemic change across multiple levels of action.

The structural organisation of primary care and community services also positions nutrition within a web of relationships rather than as a discrete professional domain. Primary care teams now commonly include social workers, physiotherapists, mental health professionals, and community link workers, integrating nutrition within team-based care to prevent and manage chronic disease, and connect clinical practice with social and environmental determinants of health [31, 32]. Increasingly, this work is guided by a three-level model of community orientation in primary care that frames action at the individual and family level—where nutritional care is shaped by context, social determinants, and personal assets; at the group level—where health education and food literacy initiatives are developed through meaningful, territory-specific learning; and at the collective level—where intersectoral community action is mobilised with local stakeholders [33]. In community settings, dietitians extend this work beyond clinic walls—collaborating with schools, local governments, and local food systems to build food literacy, promote sustainable diets, and create equitable, supportive environments [34–36]. Nutrition practice in these settings therefore naturally unfolds within

a landscape where health, social support, education, and food systems intersect.

2.2 | Systems Science Overview

Systems science provides a robust conceptual foundation for understanding the complexity inherent in food, nutrition, and health systems. In practice, this includes systems such as primary care and health services, community and social support structures, education settings, and food systems, which interact to shape dietary behaviour and health outcomes [37]. Rather than viewing dietary behavior as a sequence of isolated decisions made by individuals, systems science highlights that health outcomes emerge from the interactions among many elements acting simultaneously [38]. This orientation stems from general systems' theory, which posits that a system is an organized whole whose properties cannot be understood merely by examining its individual components [39].

Several theoretical traditions deepen this understanding and help articulate why dietetics must be situated within broader systems. Complexity theory, for example, emphasizes that many social and biological systems are dynamic, adaptive, and non-linear [9, 40]. In these systems, cause and effect do not operate in simple or predictable ways; small actions can produce disproportionately large consequences, and outcomes frequently emerge from interactions rather than from any single intervention [41]. This perspective helps explain why nutrition interventions sometimes succeed in one context but not another and why rigid or uniform approaches often fail when confronted with diverse social realities [9, 26]. Network perspectives add another layer by drawing attention to the structure of relationships within systems. Connections among actors—health professionals, families, community organizations, schools, and food providers—shape how knowledge, influence, resources, and opportunities flow [35]. Ecological models, long-established in public health, complement these perspectives by providing a layered view of the multiple influences on dietary behavior [11, 42, 43]. From a systems' perspective, ecological models underscore the importance of examining how these layers intersect and how structural conditions—such as food prices, housing stability, or access to transportation—shape dietary choices as profoundly as individual motivation or knowledge. Within this interconnected landscape, dietitians frequently occupy positions that allow them to bridge different parts of the system, connecting otherwise separate actors and facilitating the movement of information across professional or institutional boundaries [44, 45].

Building on these theoretical foundations, several system properties become particularly relevant for dietetic practice. *Feedback loops*, a central concept in systems thinking [46], illustrate how actions within a system generate responses that either reinforce or counteract change and action. For example, investments in healthier and more sustainable community food environments can strengthen institutional and consumer demand for nutritious foods over time, creating reinforcing cycles that sustain improvements in diet quality (e.g. [47]). *Interdependence* captures the idea that shifts in one part of the system inevitably influence others. Rising housing and energy costs reduce disposable income available for food and, combined with increasing food prices, drive greater reliance on low-cost, low nutritional density products and shaping the nutrition-related conditions—such as poorly

controlled diabetes—that primary care teams must manage (e.g. [48, 49]). *Adaptation* reflects the capacity of systems to evolve in response to pressures or opportunities (e.g. [50]), successful interventions are those that remain flexible and responsive rather than fixed or prescriptive (e.g. [41]). Last, *emergence* shows how dietary patterns arise from intersecting social and environmental pressures. Heatwaves, heavy rains, floods and biological hazards can force community food programmes to reorient their sourcing or delivery models (e.g. [51–53]).

Within this framing, systems science also foregrounds *leverage points*—strategic places within a system where targeted action can produce amplified effects [54]. These may involve altering information flows, for example by dietitians conducting joint consultations with nurses, social workers or midwives, which creates new channels for shared decision-making and cross-disciplinary learning [55, 56]. Others relate to changing routines and mindsets, such as embedding sustainability into everyday counselling by recommending affordable, culturally relevant plant-forward or seasonal options [34], or normalising the use of social-determinants language, including terms such as structural barriers, food environments or time poverty, which shifts team mental models towards equity-oriented interpretations of dietary challenges [57, 58]. Additional leverage points arise from building informal connections with community assets—for example linking patients to community gardens, cooking classes, walking groups or cultural food networks—actions that expand the reach of dietetic practice beyond the clinic without requiring formal governance structures [59, 60]. Acting on these practitioner-led leverage points can contribute to influencing system behaviour from within their current roles, especially where organisational, collaborative and policy conditions are supportive.

Altogether, these perspectives make systems science both a theoretical lens and a practical guide for dietetic practice. They help reframe nutrition work from focusing solely on individual counselling to understanding and influencing the interconnected, adaptive, and multi-layered systems that shape dietary behavior and health outcomes. They invite dietitians to consider how their actions modify relationships, flows, and structures within complex systems, and how, through these mechanisms, they can contribute to building systems that are more coherent, equitable, and sustainable.

2.3 | Framing Dietitians as System Builders in Primary Care and Community Nutrition

Building on the systems principles outlined above, the question becomes not whether dietitians work within complex systems, but how they influence them in practice. Although dietitians' core expertise in nutrition remains essential, their daily practice in primary care and community settings has long extended beyond individual counselling. Much of this systems-facing contribution, however, remains implicit.

To substantiate this framing, we draw on the Ottawa Charter for Health Promotion [19], which remains a foundational reference for health promotion. Its five action areas—building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services—remain directly relevant to contemporary nutrition practice, as do its core strategies of

enabling, mediating and advocating. Interpreted through this lens, dietitians can be understood as system builders who bridge health, food, education and social domains.

We articulate this contribution through three complementary roles—integrators, connectors and advocates—that capture how dietitians influence processes, relationships and priorities across systems. These roles were derived by synthesising insights from some of the previously discussed references on systems science [54], health promotion frameworks [11, 19] and documented areas of dietetic practice [14, 17], and reflect three distinct but inter-related modes of system influence: shaping structures and routines (integration), strengthening relationships and coordination (connection), and influencing norms, priorities and decision-making (advocacy) [19]. Each role is rooted in daily practice and illustrates mechanisms through which dietitians help shape health, equity and sustainability beyond the clinical encounter.

Figure 1 synthesises the conceptual framing proposed in this paper by illustrating how dietitians operate as system builders within and across interconnected systems. The diagram highlights three overarching system goals (equity, sustainability and health) and situates dietitians at their intersection through three complementary roles: integrators, connectors and advocates. These roles influence system structures, relationships and priorities, and interact with key system properties such as feedback loops, interdependence, adaptation and leverage points.

2.3.1 | Dietitians as Integrators: Creating Coherence Across Systems

Dietitians act as integrators when they reshape how nutrition is embedded in the routines, structures and decision-making processes of institutions such as primary care organisations,

hospitals, community health services, schools and food-service providers. Integration occurs when nutrition is not a discrete service but part of the system's information flows, care pathways and resource allocation. In primary care, this includes co-designing referral criteria linked to biomarkers (such as HbA1c or malnutrition risk), embedding standardised prompts and documentation within electronic records, and contributing to shared care plans for chronic disease management and prevention. These integrative practices help create more coherent care trajectories: nutritional assessments inform treatment decisions; follow-up data feed into monitoring processes; and communication between providers reduces fragmentation. Evidence shows that such integration is associated with more consistent engagement, better alignment between lifestyle and clinical management, and improved system responsiveness to prevention and chronic disease needs [61, 62]. In systems terms, dietitians function as integrators by reshaping information flows (automatic referrals and documentation), rules (protocols and care standards that embed nutrition), and resource allocation (co-located or team-based delivery) [16].

Integration also extends beyond clinical care. In food-service settings, dietitians align procurement, menu planning and sustainability initiatives so that nutritional and sustainability goals inform institutional decision-making over time [15, 34, 35, 63]. In education, they integrate food literacy and nutrition competencies across age groups and disciplines, ensuring coherence between evidence, curricula and professional practice [64]. Within social care, integration means connecting clinical assessment with the realities of daily life—building referral pathways to income support, food programmes and community assets that strengthen the system's ability to respond to social determinants of health [53, 65]. Across these

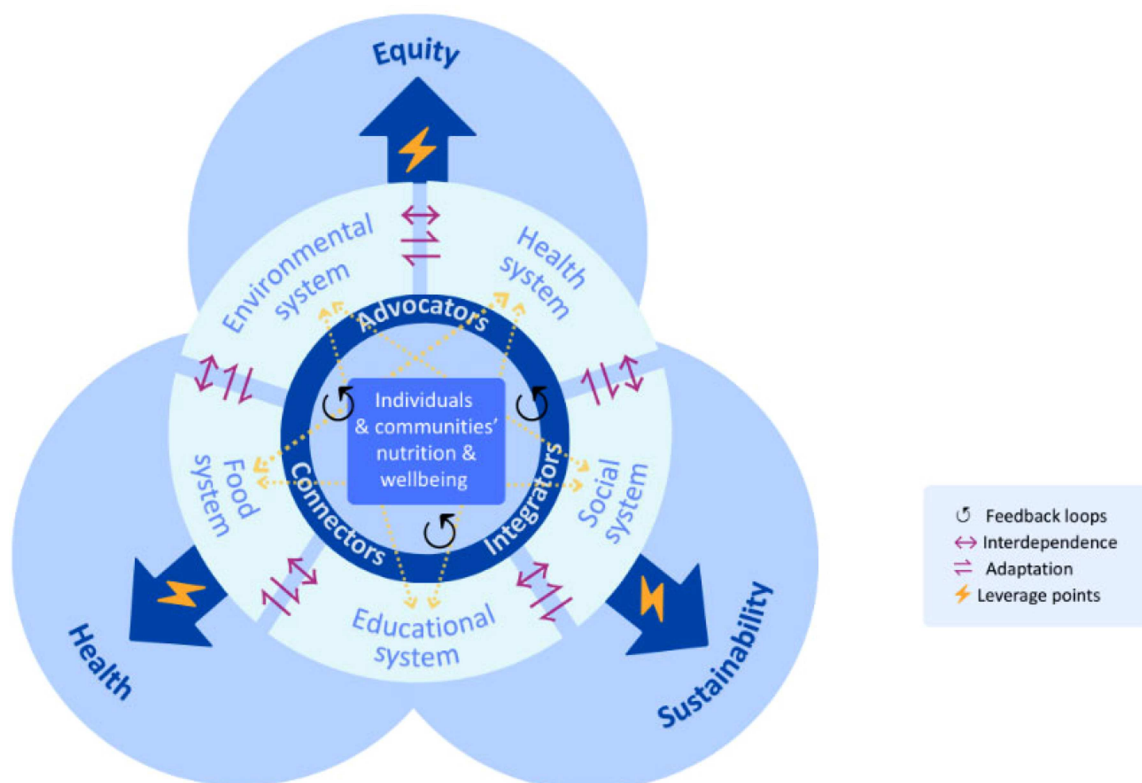


FIGURE 1 | Conceptual framing of dietitians as system builders across interconnected systems.

domains, integrators primarily reshape processes—how information flows, how decisions are taken and how services fit together—thereby enhancing the adaptive and preventive potential of the broader system.

2.3.2 | *Dietitians as Connectors: Building Networks and Bridging Relationships*

If integrators work primarily through structures and processes, connectors work through relationships. Dietitians function as connectors by strengthening the relational and institutional ties that allow health, food, education and social systems to operate coherently. From a network perspective, they act as “bridging nodes” linking actors who otherwise work in parallel [66]. In primary care, this includes close collaboration with physicians, nurses, physiotherapists and social workers to coordinate prevention, chronic-disease management and patient follow-up [60]. In childhood obesity prevention and oral health initiatives, dietitians broker knowledge between families, schools, community organisations and clinical teams, ensuring coherence across the environments in which dietary practices develop [32, 67, 68].

This connective function is particularly visible in equity-oriented programmes. Clinic–community models for food-insecure adults with diabetes show how dietitians link nutrition education, monitoring and food provision through shared infrastructures [69]. In homeless services, disability care and community health centres, they align fragmented services by coordinating efforts among clinical teams, caregivers and community organisations [70, 71]. Beyond health care, dietitians connect research, pedagogy and sustainability efforts. They mediate between evidence, curriculum design and inter-professional education [36] and help coordinate sustainability strategies across food procurement, environmental teams and community food initiatives [72, 73]. Through contexts, this role focuses on relationships—cultivating trust, coordination and multi-directional exchange that strengthen system cohesion and adaptive capacity. Dietitians’ training in communication, empathy and person-centred care underpins this connective work, enabling them to build trust and facilitate collaboration across professional, community and institutional boundaries [63, 74].

2.3.3 | *Dietitians as Advocates: Shaping Systems and Policies*

Dietitians act as advocates when they shape the norms, priorities and rules that influence how systems respond to nutrition, equity and sustainability. Advocacy operates at key leverage points: reframing problems, altering information flows and influencing institutional or policy-level decision-making [54]. In health care, this includes integrating food insecurity screening into routine practice, promoting non-stigmatising approaches to obesity care and advancing justice-oriented models for people with severe mental illness [53, 75, 76]. Advocacy also supports equity and inclusion. Initiatives such as culturally safe practice standards, decolonising curricula, and “nutritional ecology” frameworks, which conceptualise nutrition as emerging from the interaction between biological, social, cultural and environmental systems, call for services that adapt to context rather than rely on uniform protocols, thereby strengthening systems’ long-term capacity to respond to diverse lived realities [77, 78]. For example, evidence from transgender health and South Asian diasporic communities highlights the need for accessible, linguistically appropriate and

structurally competent services—priorities advanced through dietitians’ advocacy [79, 80].

In food and education systems, dietitians advocate for sustainability-oriented procurement standards, food waste reduction policies, and curricula that embed equity and systems thinking [37, 72, 81]. At the policy interface, they act as boundary spanners, linking evidence, practice and societal goals, contributing to guidelines and frameworks that balance health, environmental sustainability, and cultural relevance [15, 37, 82, 83]. Across these domains, advocates shape system goals—the deepest and most enduring leverage points—thereby strengthening coherence, accountability and long-term sustainability within the nutrition ecosystem. While these advocacy roles are increasingly visible in practice, their enactment is shaped by institutional mandates, resource constraints and professional boundaries, which may limit the scope and pace of change. These constraints are discussed further in Section 3.2.

3 | **Enablers, Leverage Points and the Way Forward**

Viewing dietitians through a systems lens highlights emerging opportunities for practice, education and intersectoral collaboration. Such a perspective shifts attention from the constraints that have traditionally shaped the profession to the conditions that make system-building roles possible—namely, the environments, partnerships and competencies that support integrative, connective and advocacy-oriented work. At the same time, examining the factors that enable or constrain system-building practice, and identifying the leverage points where well-targeted action can exert disproportionate influence, provides a basis for consolidating and scaling the profession’s systemic contribution [17, 84–86].

3.1 | **Enablers and Leverage Points for System-Building Practice**

A central enabler is the reframing of dietitians’ value proposition. This process must begin within the profession itself: systems thinking, intersectoral collaboration and policy literacy should be embedded in core competencies rather than positioned at the margins. Strengthening these competencies through pre-service education and continuing professional development equips practitioners with the analytical and relational skills required to understand system dynamics and translate evidence across contexts. At the same time, external reframing is necessary to ensure that dietitians’ system-level contributions are visible and understood across sectors. Clearer articulation of this role in professional standards, public communication and cross-sector collaborations can enhance recognition of dietitians as system builders. Such external visibility is further reinforced when institutional and policy frameworks—many of which already emphasise equity, sustainability and multisectoral action—are leveraged to legitimise and support this expanded professional identity. This reframing aligns with literature on professional role evolution and systems-oriented health work, which highlights the importance of competencies, institutional recognition and cross-sector legitimacy in enabling systemic practice [87–90].

Policy frameworks such as Health in All Policies, One Health, sustainable food strategies and global initiatives led by the World Health Organization (WHO) and the International Confederation of Dietetic Associations (ICDA) provide additional levers for fostering more systemic environments [43, 91, 92]. These frameworks already emphasise multisectoral action, equity, sustainability and the integration of health considerations across domains such as education, agriculture, social protection and local governance. By aligning their work with these established agendas, dietitians can position their system-building contributions within widely recognised policy discourses, strengthening the legitimacy of integrative and preventive approaches. Engaging with these frameworks—through participation in local implementation processes, adaptation of guidelines to practice settings, and contribution to cross-sector planning—helps create environments where system-oriented dietetic practice is not only visible but structurally supported.

Within supportive environments, dietitians can act at leverage points—strategic places in a system where small, well-targeted actions can produce disproportionately large effects [54]. Embedding equity metrics into planning and evaluation is one such point, shifting equity from an aspirational principle to a decision-making criterion that guides resource distribution and shapes institutional priorities [93, 94]. Another leverage point is the redesign of procurement systems to prioritise healthy, sustainable and ethically sourced foods, enabling nutrition standards, environmental goals and economic decisions to reinforce one another [15, 95, 96]. A third involves adapting clinical guidelines and care protocols to incorporate systems thinking and social determinants, reframing nutrition interventions as responses to structural contexts rather than solely individual behaviours. Evidence shows that such structurally informed approaches in dietetic and health care settings can improve relevance, engagement and continuity of care, and that frameworks for applying systems thinking to food and nutrition strategy can support this integration in policy and practice [97]. Recent empirical work further demonstrates how these approaches influence clinical and organisational decision-making, particularly in settings where social determinants shape health outcomes [98].

3.2 | Constraints, Risks and Unintended Consequences

Despite these opportunities, system-building occurs within settings marked by several persistent constraints. Limited exposure to systems thinking, policy literacy and cross-sector collaboration within pre-service education and continuing professional development can constrain practitioners' ability to recognise and act on system dynamics in practice [86]. High workloads, limited consultation time, fragmented referral pathways and under-investment in prevention restrict dietitians' capacity to engage beyond the clinical encounter. Sectoral silos—between health-care, social services, education, agriculture, or environmental sectors—continue to discourage integrative practice, especially when mandates, funding structures or performance indicators reinforce separation. These conditions create a risk of role overload: as expectations expand to include systems thinking, sustainability and equity, dietitians may face responsibilities that exceed available time, training or organisational support.

System inertia poses an additional challenge. Established routines, hierarchical structures and narrow success metrics can inhibit innovation or limit the sustainability of integrative initiatives. Moreover, systems approaches may produce unintended consequences if not explicitly equity-oriented [99, 100]. Interventions that rely on digital literacy, community assets or volunteer capacity may inadvertently benefit more advantaged populations. Sustainability policies that shift costs to households or reduce choice without structural supports risk exacerbating inequities [101, 102]. Recognising these risks is essential to developing systems approaches that are not only complex but also just by embedding equity in their design and preventing the reinforcement of existing inequalities.

3.3 | Opportunities and Future Directions

Advancing system-building practice requires focusing on opportunities that dietitians can meaningfully enact within their professional environments. We frame these opportunities in relation to the three complementary roles—integrators, connectors and advocates—through which dietitians influence systems (Figure 1). A priority, closely linked to the connector role, is to strengthen participatory and community-informed approaches in day-to-day primary care and community nutrition practice.

This is essential because system-building depends on dietitians' ability to work across boundaries, align interventions with lived realities, and build legitimacy within the social systems that shape food access and dietary practices. Without meaningful participation, system-level interventions risk being poorly adapted, weakly adopted or inequitable in their effects. Dietitians are well-positioned to contribute to local governance and decision-making structures—such as community health boards, cross-sector committees, food policy councils, or municipal health plans—where community priorities and territorial strategies are developed [103, 104]. Entering these existing structures, rather than creating new ones, allows dietitians to map ongoing processes, join as technical contributors and build credibility through early, small-scale collaborations with social services, municipal health promotion teams, schools or local food organisations. As trust develops, they can engage more fully in co-design, participatory assessments and community-based research, ensuring that interventions reflect lived realities and are responsive to local social, cultural and material conditions.

However, such processes are inherently time-intensive, relationally demanding and often non-linear, particularly in under-resourced or marginalised communities. A growing body of work on co-production and community engagement in food systems highlights the complexity, uncertainty and contested dynamics involved in participatory approaches, while also demonstrating their importance for equitable and sustainable systems transformation [105]. Integrating intercultural and decolonial perspectives further strengthens the system relevance of community dietetics. These approaches recognise that food practices and nutritional norms are shaped by cultural, historical and political contexts, and that sustainable change requires culturally grounded, reciprocal and non-universalising interventions [78, 106]. Embedding such perspectives can support more equitable and resilient systems transformation.

A second priority relates to the integrator role, by focusing on the expansion of the professional and organisational capacities necessary for system-building. Integration depends on dietitians' ability to embed nutrition within existing structures, routines and decision-making processes across health and community systems. This, in turn, requires competencies that go beyond technical nutrition expertise, including systems thinking, policy literacy, intersectoral collaboration and equity-oriented analysis.

At the educational level, pre-service training and continuing professional development need to more fully incorporate systems science, sustainability, policy literacy and equity competencies so that dietitians are equipped to collaborate across sectors, interpret system dynamics and influence institutional decision-making. Equally important are organisational conditions that enable integrative practice to be enacted and sustained. Embedded care pathways, aligned information systems, co-located or team-based service delivery, and leadership committed to prevention and equity provide the structural scaffolding through which integrator roles become feasible in everyday practice. Without such conditions, expectations for system-building risk remaining aspirational, placing the burden of integration on individual practitioners rather than on the systems within which they work. In addition to formal education reform, mentorship, supervision and workplace-based learning are critical for supporting both new graduates and experienced practitioners in developing systems-thinking competencies, particularly where prior training has been limited. Together, educational preparation and organisational support create the enabling conditions for dietitians to function as integrators—reshaping information flows, routines and resource allocation in ways that enhance coherence, prevention and adaptive capacity across health and community systems.

A third opportunity relates to strengthening the capacity of dietetic practice to influence agendas, norms and decision-making processes across food and health systems. Advocacy operates within complex governance environments shaped by institutional mandates, commercial interests and competing social priorities [22, 82]. As public health and food policy scholarship has long noted, advocacy is not a purely technical extension of expertise but a relational and political practice that shapes how problems are framed, which issues gain legitimacy and how responsibilities are distributed across sectors [38]. For dietitians, this means engaging with leverage points that extend beyond individual care encounters—such as contributing to guideline development, embedding food insecurity screening into routine systems, informing procurement standards, or participating in cross-sector policy processes. In this sense, advocacy is best understood as a structured professional contribution embedded within institutional contexts, through which dietitians help align health, equity and sustainability objectives. Strengthening this capacity requires not only individual competencies in policy literacy and systems thinking, but also organisational and professional support that legitimises engagement at these deeper system levels.

Taken together, these priorities highlight that advancing system-building practice is less about adding new tasks to dietitians' roles than about creating the conditions under which integrative, connective and advocacy-oriented work can be enacted and sustained. Such work is shaped by contextual constraints,

including political feasibility, institutional mandates and power dynamics across sectors. Acknowledging these conditions helps avoid overly idealised expectations and supports forms of action that are strategic, context-sensitive and aligned with scope of practice. Here, professional bodies and regulatory organisations play a critical role in enabling and legitimising system-building as a core professional function. Through standards, position statements, guidance and engagement with policy actors, they can articulate shared priorities, reduce the burden on individual practitioners and strengthen the collective voice of the profession, situating integrative, connective and advocacy-oriented work within professional mandates rather than relying on individual initiative alone.

Finally, the integrator–connector–advocate framework represents a theoretically informed synthesis that warrants empirical examination in local primary care and community contexts. Framework validation in complex health systems is increasingly guided by approaches to complex interventions and systems evaluation, which emphasise iterative refinement, contextual sensitivity and examination of mechanisms rather than linear testing alone [10, 21, 26]. Co-creation and participatory research—widely used in community health and food systems transformation [24, 105]—offer appropriate strategies for assessing how these roles operate in practice and under what conditions. Such context-sensitive validation would strengthen the framework's theoretical robustness while supporting its meaningful integration into education, policy and professional standards.

4 | Conclusions

Viewed through the lens of the Ottawa Charter, the system-building roles described in this paper can be understood as contemporary expressions of enabling, mediating and advocating for health within complex food and health systems. Rather than marking a departure from professional foundations, they reinterpret core public health principles for contexts in which dietary behaviour and food access are shaped by structural, relational and policy dynamics. Although dietitians already engage in this systems-oriented work, it often remains implicit or undervalued within predominantly individual-focused models of care. Making this dimension visible reframes the profession's contribution, positioning dietitians not only as providers of nutrition expertise but as active shapers of the environments, institutions and policies that influence health. In doing so, the profession becomes better aligned with the complexity of contemporary food systems and more capable of contributing to healthier, more equitable and more sustainable outcomes.

Author Contributions

Elena Carrillo-Alvarez contributed to conceptualization, writing—original draft, writing—review and editing, and supervision. Yael Puyol-Martin, and Mariona Rigau-Sabadell contributed to writing—original draft and writing—review and editing. Aina Camps, Míriam Rodríguez-Monforte, Sofia Berlanga-Fernandez, and Júlia Muñoz-Martinez contributed to writing—review and editing. All authors have agreed to the final submitted version.

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The authors declare no conflicts of interest.

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