

Preparing Dietetics Practitioners to Effectively Serve the Hispanic Population

It is critical that registered dietitians (RDs) who work with the Hispanic population are prepared to provide culturally and linguistically appropriate nutrition care to best serve the nutritional needs of this growing segment of the population. In addition, since the Hispanic population in the United States is growing (1), it is important to recruit more Hispanic individuals to the dietetics profession. This article discusses the issues of cultural competency, diversity, overcoming the language barrier, and what can be done to educate dietetics practitioners.

The Hispanic population comprises the largest minority group in the United States: currently about 12% of the population with a projection of 25% of the population by 2050 (1). Terminology referring to this ethnic

group can be confusing; the term *Hispanic* will be used in this article (2) according to the US Department of Health and Human Services.*

Hispanics are considered an underserved population in relation to health and nutrition care, with less access to nutritionally adequate and safe food compared to non-Hispanic whites. Hispanic households have a substantially higher rate of food insecurity (20.1%) compared to the national average of 11.1%, putting them at increased nutritional risk (3). Of great concern is that the prevalence of very low food security is higher in Hispanic households (6.6%) compared to the national average of 4.1% (3). Very low food security occurs when the food intake of household members is reduced and normal eating patterns are disrupted due to lack or resources for food (4). In addition to increased nutritional risk due to food insecurity, the Hispanic population has a high incidence of nutrition-related health problems, including diabetes, obesity, and cardiovascular disease. The Hispanic population in the United States has among the highest incidence of pre-diabetes (26.1%) and

diabetes (11.6%) of any ethnic group (5). Approximately 26.5% of Mexican-American boys and 17% of Mexican-American girls ages 6 to 11 years are overweight (compared to approximately 14% and 13% non-Hispanic white boys and girls, respectively) (6). The American Heart Association reported that over 70% of Hispanic adults were overweight (body mass index >25), with 28% of Hispanic men and 38% of Hispanic women classified as obese (body mass index >30) (6). Nutrition intervention and access to food assistance programs can be used to address the food security and health problems prevalent in the Hispanic population, resulting in better health outcomes, economic savings, and increased quality of life.

A DISPARITY IN HEALTH CARE

Despite the increased nutrition risk encountered by the Hispanic population, differences exist in treatment and health care outcomes based on race and ethnicity (7). The health care disparities are tied, in part, to a lack of multicultural tools and cultural sensitivity by the health care provider, language barriers, discrimination, stereotyping by health care practitioners, and the lack of diversity in the health care workforce.

Spanish-speaking residents of the United States have inadequate access to the health care system (8). Immigrants identify language and cultural differences as the biggest barriers to receiving health care (9). Compared to those who speak English fluently, individuals with limited English proficiency experience decreased access to acute care and longer hospital stays, express lower satisfaction with patient care, experience more misdiagnoses and medical errors, have more emergency room visits, and have poorer understanding of their care (10,11). Spanish-speaking residents of the United States are also

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**The terms Hispanic and Latino are often used interchangeably in the literature, and generally refer to persons of Spanish ancestry or descent. Latino is sometimes used to refer to individuals from Latin America, specifically. The term Chicano refers to individuals in the United States of Mexican descent. The terms do not indicate race; all races are represented in this ethnic group. Different specific definitions for each term exist, and the term commonly used varies by region of the United States. Hispanic will be used in this article and refers to a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture (2).*

less likely to receive preventive care such as immunizations, dental care, and breast and prostate screening than those who speak English (8). Once Spanish-speaking clients enter the health care system, communication barriers often produce anxiety, stress, fear, poor compliance, and problems with medications and treatment (11). Limited English proficiency has been identified as a barrier to the receipt of advice about diet among Hispanics (12).

Disparities in health care were addressed in the Healthy People 2010 initiative with a goal to eliminate health disparities among racial and ethnic minority groups by 2010, with specific emphasis on cultural competency among health care providers (13). The Healthy People 2010 Mid-course Review indicated some improvement in nutrition health care disparities with regard to the Hispanic population, but no progress in achieving the objective related to cultural competency (13).

CULTURAL SENSITIVITY

Certainly, nutrition assistance programs are available to the general population in the United States, including the Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), among others (14). But do these programs effectively serve the Hispanic population? To develop and implement effective nutrition programs for this population, RDs need to have knowledge of and sensitivity toward the Hispanic culture, including dietary patterns and practices. It is also important to know and understand cultural idioms of how symptoms are explained and how they cause disease (9). With over 40% of Hispanics being foreign-born, cultural values, attitudes, and practices related to health and nutrition persist in the United States (1). RDs must be sensitive to the different societal, cultural, and economic factors that influence food choices and eating behaviors of the

Hispanic population in order to most effectively intervene in health promotion and treatment efforts (15). Malena Perdomo, MS, RD, CDE, a bilingual RD practicing in Denver, states, "A good example is when the RD needs to accommodate the family as part of the nutrition counseling and allow time during the nutrition interview to gain trust and get to know the client and family." One example of cultural influence on health and eating behaviors in the Hispanic population is the influence of Catholicism, including the practice of Lent, which often includes abstinence of certain foods, and abstinence from meat on Fridays. Another is the practice of *curanderismo*, a form of folk healing that includes prayer, herbal medicine, healing rituals, and spiritualism common in some Hispanic communities (16).

RDs must keep in mind, however, that much diversity exists within the Hispanic population. Because foods typically consumed, eating habits, and health practices and beliefs vary

so much within a culture and by region, it is highly unlikely that an RD can achieve true “cultural competence” regarding the Hispanic population. Country of origin, extent of continuing contact with country of origin, socioeconomic status, generation status, language, and level of acculturation are factors that vary widely among this population (17). RDs must be aware that eating habits and health behaviors of Hispanics cannot be stereotyped, and thus a careful assessment of eating behaviors and health beliefs/practices must be performed for individuals or communities. “Even as a bilingual Latina RD, I had to learn all of the different ethnic dishes that are traditional of other countries. Mixed dishes are common and names of foods vary from country to country,” says Perdomo, who is a native of the Republic of Panama. “For example, I didn’t know what ‘nopales’ and ‘burritos’ were until I started to help Mexican-American clients.”

Acceptance of health recommendations and compliance to dietary recommendations is much greater when

cultural food traditions, preferences, and beliefs are honored. Caballero found that cultural and language barriers were significant factors that led to noncompliance with insulin regimens by Hispanic patients with diabetes (18). The author concluded that increased cultural awareness and competence and increased use of Spanish-speaking diabetes educators (including RDs and other health professionals) would result in better diabetic control in the Hispanic patient population. These conclusions are supported by a recent study, which underscores the effectiveness of a culturally sensitive nutrition education program (19). Eight weekly 1-hour classes taught in Spanish in the community resulted in low attrition during the program (two drop-outs) and significant improvements in dietary and exercise behaviors in Latina women with low acculturation scores (19).

In addition to community and health care settings, RDs in the foodservice industry need to be culturally competent. RDs as foodservice managers and directors are responsible for the production and delivery of safe and nutritious food and meals in hospital, school, prison, and restaurant settings. RDs in foodservice are also responsible for the supervision and training of staff. An estimated 20% of foodservice workers are Hispanic, with varying degrees of English proficiency (20). Increasing the cultural awareness of RDs in foodservice, as well as increasing the number of Hispanic RDs in foodservice management positions, will enable them to be more effective in leading a large segment of their employees.

A LANGUAGE BARRIER

Language is an important part of cultural competency. As mentioned previously, language barriers can adversely affect nutrition care (21). According to a Pew Hispanic Center study, only 23% of first-generation and 88% of second-generation Hispanics in the United States said they were able to speak English very well (22). RDs can use interpreters when working with patients, clients, or employees who speak Spanish only. However, interpreters are not always available, and when interpreters are used translation is dependent on the interpreter’s understanding of what

the RD or client is trying to convey. In other words, the RD’s or client’s message may be lost in translation. Perdomo indicates, “A good example is when Mexican Americans say that they eat around 9:00 AM an ‘almuerzo,’ which is literally translated as lunch. In reality, this is breakfast, not lunch. The assessment could be that they are skipping breakfast; therefore, a possible recommendation would be to eat breakfast, which will be culturally translated as a recommendation to eat more.”

Even with trained interpreters, some practitioners find it difficult to obtain accurate information and explain treatment options to clients. Interpreters are often unfamiliar with medical/nutrition terminology, tend to explain responses according to their own perceptions, and can be a barrier in developing rapport with a client (23). In addition, interpreters may interfere with communication because they are viewed as an outsider to a private consultation (9). Translated hand-outs may be an option, but the client will not be able to have questions that arise from the hand-outs answered. Moreover, in some cases, clients may not be able to read due to vision or literacy problems. Use of family members is also problematic as some clients feel loss of control over making their own decisions or may feel uncomfortable revealing important information in front of family members (11).

Care by Spanish-speaking medical providers is rated by clients with higher satisfaction than care by non-Spanish-speaking providers, even when the Spanish ability of the provider was less than perfect (9,24,25). Service from bilingual health care providers results in improved access to care and treatment, better participation by the client, and overall improved satisfaction with care (11,23).

While even limited Spanish speaking ability by the provider may improve rapport with a client, limited fluency can result in miscommunication about important health issues. Levels of fluency in Spanish or any language vary greatly (26,27). Level of fluency can have a significant impact on the clarity and completeness of communication between an RD and client. RDs need to know more than names of foods and simple phrases such as “What did you eat yesterday?”

Clients need to be able to explain their food behaviors as well as barriers to change to the RD. This leads to better nutritional care and greater probability that the client will follow through on changes. RDs working with monolingual Spanish populations should, therefore, be trained well beyond beginning levels of Spanish and have knowledge of specific vocabulary and cultural constructs related to diet. Ideally, standardized tests should be used by programs teaching Spanish to health practitioners to evaluate when specific and appropriate proficiency has been achieved (27).

Thus, the ideal is for the RD working with a Spanish-speaking population to be fluent in Spanish. Laura McNally, MS, RD, Public Health/Community Nutrition dietetic practice group chair, contends that language training of RDs needs to begin with undergraduate education (if not sooner) (21). Cecelia Pozo-Fileti, MS, RD, FADA, president of Latino Health Communications, also advocates cultural immersion so that the RD can connect to the cultural food and preparation methods (21).

In the foodservice setting, RDs must be able to communicate effectively with Hispanic employees to ensure understanding of policies and procedures for food storage, preparation, and delivery. Knowledge of the importance of special diets is particularly important in health care settings, and training in food safety is vital in all foodservice settings. A language barrier during training and supervision has the potential to result in harm to the general public.

A PROFESSIONAL DIVERSITY ISSUE

Although the public generally relates better to health practitioners with a similar ethnic background, over 90% of RDs are non-Hispanic whites, and only 3% of RDs are Hispanic (28). According to Fitz and Mitchell, “perceived ethnic and social differences with health care providers often discourage consumers from seeking care or sharing intimate information required for appropriate treatment” (29). Thus, greater recruitment of Hispanics into the profession of dietetics and increased cultural competency of non-Hispanic RDs would better serve this population. One example of

a federally funded program in particular that would benefit from Spanish-speaking and culturally competent RDs is the WIC program. WIC is a federally funded food assistance, health care referral, and nutrition education program for low-income pregnant and breastfeeding women and children. Hispanics make up 41.2% of WIC participants, and trends indicate the percentage is rising (14).

The American Dietetic Association (ADA) recognizes the need for diversity within the profession to serve an increasingly diverse population in the United States. The 2006 ADA Environmental Scan acknowledged the increase in the Hispanic population, and identified the need for greater cultural awareness of the health problems faced by ethnic groups, including language skills and cultural sensitivity (30). Increasing the number of Hispanic students in dietetics programs will not only result in a larger number of RDs familiar with the culture, but also, non-Hispanic dietetics students will learn about the culture from being in classes with Hispanic students and, thus, become more culturally competent through interaction with classmates.

ADA created a Diversity Philosophy Statement that is posted on the organization’s Web site, which states, in part, “ADA’s mission and vision are most effectively realized through the promotion of a diverse membership that reflects cultural, ethnic, gender, racial, religious, sexual orientation, socioeconomic, geographical, political, educational, experiential and philosophical characteristics of the public it serves” (31). In addition, ADA’s 2008 Strategic Plan includes addressing health disparities and providing relevant and valued products and services for a diverse population (32). Unfortunately, a lack of diversity in the profession is still an issue, as the Report on the American Dietetic Association/Commission on Dietetic Registration 2008 Needs Assessment indicated that the percentage of RDs who referred to themselves as “white” was 84%, with 3% indicating they were Hispanic (28).

WHAT CAN BE DONE

The need for RDs who can speak Spanish and are culturally competent with regard to the Hispanic popula-

tion is obvious. To educate RDs to be better prepared to serve this growing yet underserved segment of the population, programs that provide opportunities for dietetics students and practitioners to learn about Hispanic food practices and culture and increase Spanish speaking proficiency would be helpful. For example, Metropolitan State College of Denver offers a summer cultural immersion experience in which students spend 4 to 6 weeks in Cuernavaca, Mexico, taking intensive Spanish classes at Kukulcan Spanish Language School as well as courses in community nutrition and food and culture. Spanish proficiency will be directed toward learning dietetic-related Spanish that can be used in nutrition programs and health care settings. Classroom discussion will role play use of dietetic Spanish in simulated nutrition situations. Actual practice in the community will also be included once some level of proficiency is acquired. Collaboration with the Hispanic community is vital to providing opportunities for dietetic students to gain exposure to Hispanic culture, including food practices and health beliefs.

Recruiting Hispanic individuals to the dietetics profession is also key to better serve the Hispanic population. Didactic Programs in Dietetics and Dietetic Internship Programs need to develop strategies to increase interest and enrollment of Hispanic individuals in dietetics programs. The ADA has made efforts to increase diversity in the profession (33), and currently provides awards and grants to individuals and projects that promote diversity. A diversity mentoring toolkit is also available through ADA that includes training materials and advice to recruit K-12 students to the profession (34). In addition, the ADA has media spokespersons who specialize in Latino Nutrition, including Ximena Jimenez, MS, RD, LD, and Malena Perdomo, MS, RD, CDE, who is also an adjunct faculty member at Metropolitan State College of Denver. Despite ADA’s efforts, Hispanics remain underrepresented in the profession (28). Crucial to the development of effective recruitment strategies is an understanding of the reasons Hispanics do or do not consider the profession, and the barriers to educational access. Faculty at Metro State are also conducting surveys to under-

stand why Hispanic students tend to avoid dietetics as a profession.

The ability to receive high-quality health care in a culturally and linguistically appropriate environment is a matter of social justice and good public health. It also makes economic sense. People who receive culturally appropriate health care and nutrition counseling in a language that allows for good communication are better able to make changes in their lives to achieve excellent health. Increasing the number of RDs with Spanish language skills and increasing knowledge of Hispanic food and health traditions will allow RDs to better serve this population. Recruitment efforts to increase the number of Hispanic RDs is encouraged to increase diversity in the profession. Future research related to dietary compliance of Hispanic clients when working with Hispanic vs non-Hispanic RDs is also recommended to determine the impact of Hispanic RDs on nutrition care of this important and growing segment of the US population.

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