The Need for Culturally Relevant Community Nutrition Education
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Health educators have documented the failure of current nutrition education interventions in communities of color (Whitman 2000; Price 2001; Minkler 2003; CLOCC 2004). Despite ten years of research by the medical community documenting the fattening of America, weight gain persists, and incidence rates of Type II Diabetes among African American and Latino adolescents continues to rise (CLOCC, 2004). At the same time, there is an increasing rate of eating disorders in middle class African American suburban girls, who are influenced by super thin models in magazines and other media.

Davis and others (Davis and Northington 2000; Price 2001; Minkler 2003; Devine, Farrell et al. 2005) discuss the need for people from their own communities to be able to address obesity and its medical consequences, while incorporating positive elements of cultural views and practices.

A public conversation between representatives of the American Public Health Association and the American Dietetic Association identified the need for nutrition educators to “view the world more broadly by putting the focus on the community as well as the individual” (Johnson, Eaton et al. 2001, p. 530). Food insecurity and hunger, particularly among children have increasingly become a focus of community nutrition educators (Hamm and Bellows 2003).

Culture and family context are well recognized as the most important factors in determining nutritional practices (Davis & Northington, 2000). Cultural insensitivity can be a huge barrier to providing appropriate nutrition education for clients (Price, 2001). The use of paraprofessional has been one solution proposed to provide culturally sensitive community nutrition education (Divine, Farrell, & Hartman, 2005).
According to recent surveys the health gap between minority and non-minority populations in the United States has increased (Richards and Lowe 2003). In 1960, African American men had an average life expectancy of 61 years compared to 67 years for white men. In 1996, the respective numbers were 55 and 74 (Hogue 2000). According to the CDC (2000) the ten leading causes of death in the U.S. include seven chronic diseases with heart disease, cancer, diabetes, and stroke leading the morbidity cause lists. CDC findings have indicated that the prevalence of diabetes is 70% higher in African Americans as compared to their white counterparts. They also reported that the five-year survival rate for African Americans diagnosed with cancer was 40% as compared to 59% for whites.

Phillips, Cohen and Trazian (2001) identified barriers cited by African American women to breast cancer treatment. Their findings pointed to the distrust African American women have of health care delivery system and the need for a holistic approach to health maintenance. Historical incidences of inhumanity experienced by African Americans have lead to the current mistrust of the health care system. Experimentation on slaves, African American prisoners and members of the military, including the infamous Tuskegee syphilis study, are part of this history of oppression. Berger (1988) also looked at views of African Americans of the health care system. Berger points to abuses from sickle cell screening and minority focused sterilization initiatives in the 1970s which are viewed as a form of genocide by many Latino and African Americans (Murray 1992). Murray also found in focus group discussions that African Americans are more likely to believe that hospitals and physicians have a profit motive in treatment choices and minority patients risk having organs stolen for transplant purposes.
Family presence is perceived as necessary protection against physicians’ mistreatment and family members often remain in the hospital with patients.

A national telephone survey conducted by the Kaiser Family Foundation in 2000 found that of almost 4,000 individuals surveyed, 36% of Latinos and 35% of African Americans compared to 15% of whites felt they were treated unfairly in the health care system in the past, based on their race and ethnicity (Foundation 1999). When asked about future treatment, 65% of African Americans, compared to 22% of whites reported fear of future unfair treatment. In contrast, physicians (mainly white) reported that the health care system “never” (14%) or “rarely” (55%) treats people unfairly based on race/ethnicity (Foundation 2002).

Disparity in Health Treatment

Reports have identified less aggressive treatment of African Americans, regardless of socioeconomic status in relation to heart disease and childhood asthma (Kleinpell 2000; Crawford 2001). In their research regarding culture, ethnicity and health care, Fox and Kleinman (1997) reported disparities regarding access to health care. The study identified a failure of the medical profession to both address disadvantages experienced by poorer Americans, and to recognize the impact of cultural influences on disease. Gornick (2001) looked at the relationship between race and ethnicity in relation to U.S. health statistics. African Americans can expect to have good health up to 56 years old, as compared to whites who have good health up to an average of 64 years of age (Gornick 2001).

Schulman et al. (1999) studied disparity in physician recommendations. Physicians were asked to watch a video of a simulated patient with symptoms of coronary artery disease and to answer questions regarding care recommendations. The study demonstrated that physicians were less likely to recommend cardiac catheterization for women and African Americans (and
particularly African American women) than for white subjects with identical clinical presentations.

*The Need to Improve Community Healthcare*

A number of studies have addressed challenges involved regarding the improvement of healthcare for people of color. Yancy, Kumanyika and Ponce (2004) published a review of interventions regarding obesity in communities of color. They claimed “There is a paucity of high-quality data on sustained chronic disease or obesity risk reduction from interventions targeting or including meaningful numbers of people of color or people from low-income backgrounds. This gap in the literature represents a major obstacle in developing effective policies and programs” (p.9). The authors continued “It is sobering to note that as of 2001 (so few) participants have been studied to control obesity and reduce chronic disease risk among 100 million persons of color – more than one third of Americans….and data derived from ethnically inclusive studies are not widely disseminated” ( p. 9).

In March 2002, the Institute of Medicine (IOM) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care published their findings (Nelson 2003). This study reported that the quality of care in this country is generally lower for people perceived as coming from communities of ethnic minority than that provided to the majority population. Racial and ethnic disparities were associated with worse health outcomes (Betancourt, Maina et al. 2005). The inequality was consistent with persistent racial and ethnic discrimination in many sectors of American life and “bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers” (p.341).
The Committee recommended reducing the variation around best practices, placing incentives to improve quality and reduce errors, and improving the quality of communication within the delivery system (Betencourt, Maina et al. 2005). Also recommended was an increase in the proportion of underrepresented minorities in the health care workforce. Betancourt et. al reported that only 3.5% of physicians with disclosed race and ethnicity are Hispanic, while only 2.6% are African American. Minorities represent only 4.2% of medical school faculty, with 20% located at three historically black medical schools and in schools in Puerto Rico. In 2001, medical school graduates from African American, Latino and Native American backgrounds represented only 10% of the total graduates. Half of the minority graduates reported plans to practice in underserved communities, highlighting the need for increased emphasis on recruitment, retention and promotion.

Cohen and Northridge (2000) point to the structural roots of racial disparity in healthcare.

Nutrition, clothing, shelter and primary medical care cannot be reliably obtained with substandard income…Barriers to health resources are all but insurmountable where inferior education and compromised social networks limit dissemination and implementation. Racism and other forms of group oppression aggravate all of these situations and in themselves are sources of substantial, unrelenting stress (p.841).

_Culture and Nutrition_

There are few human activities more culturally defined than eating. Every culture, based upon their environment and socio-political history, has developed its own traditions around food. Withholding food has historically even been used as a political weapon of oppression. Currently, within dietetics there is a view of a correct “diet” and body image that reflect that of the dominant white culture. Many people have been alienated from their natural instincts of eating, growth and physical movement. This cultural imposition has increased resistance to medical intervention and often rendered health providers ineffective {Kumanyika, 2006 #48}. There is a
need for people of color to define healthy eating, fitness and body size within a historical cultural
context. Unfortunately, there is a lack of representatives from communities of color, informing
the field of dietetics. One might ask is this lacking in the profession by accident or by design.

The distrust of the medical community carries over to the recommendations made by
dietitians in the name of “medical nutritional therapy.” Many recommendations are ignored, as
discussed by Berger (1998) below:

Culture, meals and food preparations have profound social meaning in most cultures. Among African Americans ‘soul food’ is defined both by the social context of eating (where and with whom) as well as the specific foods eaten. Culturally determined eating habits may conflict with optimal health. Compliance with recommended health
promotive dietary restrictions has been problematic among many African Americans. African Americans’ sociohistorical memory is one of deprivation, so foods rich in
calories take on a particular meaning. Additionally, African American culture is present
oriented. Therefore, medically indicated diets are seen as a form of austerity at variance
with the struggle of having to do without and may conflict with established patterns of
social and family behavior. Medically determined target body weights may be culturally
irrelevant. African American women tend to hold a higher body weight as ideal and are
more likely to consider themselves attractive at a body weight unacceptable to white
women. (p. 2086)

The lack of people of color in the field of dietetics has rendered the profession ineffective
in many communities.

The Field of Dietetics and Diversity

Cultural sensitivity has been shown to be an extremely important aspect of health and
nutrition education. Yet the field of dietetics remains controlled by a dominant race, class and
culture {Suarez, 2002 #182}. In addition, as a profession comprised predominantly of women,
dietitians have remained underpaid for the amount of education and responsibility required in
most positions.

There is a history of African American women who have entered nutrition-related
professions, such as home economics, food service management, and public health. But less
than 3% of Registered Dietitians come from the African American community (Byrk & Soto, 1999). The lack of African American dietitians has had an effect on students coming into the field as well as on how the African American community is informed about the connection between nutrition and related diseases.

In their 2002 Annual Report (Jarratt, 2002), it was acknowledged that diversity within the ADA continues to lag demographic changes within the U.S. population. The ADA called for greater efforts to work cross-culturally (Jarratt, 2002).

The ADA commissioned a study to determine the obstacles to increasing non-white representation within the field. Dr. Greenwald (2000) surveyed dietitians (RDs) and dietetic technicians (DTRs) of color as well as 20 education program directors to elicit their views about the barriers to more people entering the field. The RDs and DTRs identified lack of visibility of the profession in communities, the difficulty of the program prerequisites being met and gender bias (lack of males) leading to low salaries. The need for more flexible, affordable programs was proposed as the solution. Many study respondents gave examples of struggles they had encountered with discrimination issues during their internships. The program directors claimed the barriers were poor science background of students, low salaries, high cost of training programs, and lack of internships.

Racial Disparity in Education in the U.S.

The inequity in education for students of color in the United States has been well documented (Hallinan, 2001). It is obvious to anyone who has visited schools in an urban versus suburban area. The facilities, resources, programs, and even cleanliness are obviously different.

Students from the dominant culture, who are raised in environments of privilege, score higher on standardized examinations…many of these students are perceived as
superior...and are considered to exhibit mentally gifted abilities, while the majority of students of color are stigmatized and shamed by assignments into basic and remedial classes. [This] has then been used as a justifiable rationale for appropriating additional resources to the already privileged – a group that just happens to include very few working-class students of color. (Darder, Baltonano, & Torres, 2003, p.331)

Even when students of color attend racially integrated high schools, they do not test as high on SAT scores as white students; they obtain lower grades and are more likely to fail a class (Hallinan, 2001). There is often a “glass ceiling” in these schools. The students of color are allowed to attend but are put in lower ability groupings and are not valued for the contributions and culture they represent (DeCuir & Dixson, 2004). Teachers are reported as having lower expectations of students of color and assume they come from a disadvantaged economic circumstance (Hallinan, 2001). Cunningham (1991) pointed out that diversity means difference, not necessarily deficiency. Negative stereotyping by teachers has a proven negative effect on students (Steele, 1999).

The college drop-out rate for African Americans has been 20 to 25 % higher than whites (Steele, 1999). In a study done of undergraduate African American males, Steele demonstrated that underperformance could be greatly reduced through the development of a support program: “For the greatest portion of black students…the degree of racial trust they feel in their campus life, rather than a few ticks on a standardized test, may be the key to their success” (p. 54). His study looked at the effect negative stereotyping had on students and found that sometimes the strongest students often performed badly due to anticipation of mistreatment (Steele, 1999).
Racism in Professional Health Education

Dating back almost forty years to 1969, Dr. Victor Sidel, Chief of the Division of Social Medicine at Albert Einstein College of Medicine, was asked to address the topic, “Can More Physicians Be Attracted to Ghetto Practice?” (Norman, 1969). In his opening remarks, he stated,

It has not to my knowledge been demonstrated that it would be better for …quality of life to attract physicians into rather than to transport people out of the ghetto…it has not to my knowledge been demonstrated that a white, middle-class physician has much to contribute to a solution of the problem (Norman, 1969, p.171)

His primary recommendation was a change in medical education and the selection of candidates so that communities that need services are represented.

Education of healthcare professionals includes the same class, race and gender institutional biases found in most of higher education (Cunningham, 1991). When jobs become scarce, those who are privileged are less willing to share opportunities with people who have been marginalized.

Reyes and Gutierrez (1997) have looked at overt vs. covert racism in higher education, which was also reported by African American dietetic interns (Greenwald, 2000). Students of color described an atmosphere of discomfort in which they felt isolated and silenced, which is associated with retention problems (Reyes & Gutierrez, 1997).

Hill Collins (2000) wrote about the need for a safe space for African American professional women to gather, validate and empower themselves to survive and thrive, despite daily racial insult in US society. Alfred (2001) described the burden on people of color to adapt the majority culture in order to be successful in education and careers. They must develop a
“bicultural framework, whereby women of color develop competencies to meet expectations in white organizational cultures…and access the power of their bicultural life to maintain these careers”(p. 110). She also identified the need for strong self-definition and a safe space to recoup from constant interaction in a white-dominated culture. She exposed the existence of unwritten rules and information that people of color must learn for themselves because it is not always overt or shared. This is particularly true in medical settings, where language and terminology are intentional barriers constructed by health providers against clients. For novice students, just reading medical charts can be overwhelming. There are many unwritten professional behavioral and clinical expectations that are only learned through mentorship. Nursing, for example, is known for “eating its own,” a tradition that new nurses are expected to endure to prove themselves.

In their study examining racism and social justice in professions, Jeris and McDowell (2003) discussed how deeply white supremacy is ingrained in institutions so that it creates an “invisible norm.” Ogbu (1978) wrote about minority education and caste systems which overtly and covertly track students into certain professions. African American nutrition students have often been advised toward food service management rather than clinical dietetics, which requires more science and lab courses to qualify for internship application. Some students are not even advised that they will not be eligible to be registered dietitians after just completing a bachelor’s degree in nutrition. Shaw (1998) described the problems first-generation students experience trying to successfully navigate hidden agendas within educational systems. In dietetics, for example, there are a lot of unwritten, extracurricular expectations, such as volunteer hospital experiences, that students are supposed to include when competing for internships.
Students within a program are often competing against each other for entrance to the same internships and might not even help each other.

*Racism in Dietetic Education*

In a sociohistorical study of African American women in dietetics at Tuskegee Institute, Burley (2005) examined the model by which faculty transformed an industrial education program into one that met the criteria for professional credentialing by the nearly all-white American Dietetic Association in the 1950s.

By looking at the institutional, local and national circumstances that influenced African American women’s professionalization experiences, this study examined the tensions brought about by race, gender and class differences to show the driving forces behind the motives and the methods by which professionalization occurred. (Burley, p. 1)

Because of institutionalized segregation, African American women were not allowed to train inside white hospitals and were forced to set up parallel education and clinical experiences.

Unfortunately, fifty years later, despite the ADA’s declarations calling for the need for extraordinary efforts to “reflect the beliefs and values of a more diverse society within its leadership and membership” (Jarratt, 2002, p. S1824), inclusion is not only unrealized, it’s not even prioritized in the current educational recommendations (HOD, 2006).

*Community Nutrition Education in Dietetics*

In her book *Slim Down Sister*, Weaver (2000), an African American nurse, described from a very personal perspective the struggle for African American women to maintain balance between a positive body image, health needs and a love of food. Using a colloquial, conversational format, she interspersed suggestions and solutions to problems raised while addressing food, exercise and health issues. She provided a very practical approach to adapting recipes, incorporating movement into daily life and reinforcing feeling beautiful about oneself.
Since Clinton signed the so-called Personal Responsibility Act of 1996 (welfare reform) the Institute for Food Development and Policy (IDFP, 2002) estimated from 1995 to 2000 the number of households with children receiving food stamps dropped from 6.4 to 4 million, resulting in a 50% higher risk of infants and children being hungry. The demand for emergency feeding programs continues to escalate (Hamm & Bellows, 2003). Of the 23.3 million people seeking emergency food, more than one-third are children under the age of 18 (IDFP, 2002). According to a report of the Chicago Urban League, of the fifteen neighborhoods in Chicago characterized as having “deep child poverty,” twelve of them are over 90% African American and increasingly dependent upon free lunch programs, emergency food pantries and food subsidies programs to access food.

Greenwall-Arnold, Lapido, Nguyen, Nkinda-Chaiban, and Olson (2001) reviewed seventeen Food Stamp Nutrition Education Programs seeking approaches in nutrition education that would foster client self-sufficiency. The authors proposed a program utilizing peer educators to improve clients’ knowledge and skills and to develop social support linking individuals to the community. Skills that recipients identified as valuable to share included shopping, gardening, cooking, canning, and infant feeding strategies.

Another study attempted to assess the educational needs of households with food insecurity through focus groups held at nine locations throughout Washington State (Hoisington, Shultz, & Butkus, 2002). The recipients identified barriers to coping strategies such as non-acceptance of food stamps at bargain stores and selected shopping and stretching food dollars as the topic they would most like to discuss (Hoisington et al.). The authors recommended nutrition educators become involved in empowerment processes, both for teaching individuals and communities, with a priority ensuring that families with children have access to food (Hoisington
et al.) A study done by Cason, Cox, Wenrich, Poole, and Burney (2002) demonstrated that without education, nutrient intake and food-related behaviors of recipients are not improved, even with food assistance.

**History of Home Economics**

Home economics as a field of study was first introduced in the U.S. before the Civil War in a curriculum of female seminars by advocates of women’s higher education (Nerad, 1999). It was developed as a form of education to prepare women for their family and community roles in nurturing life and morality. By the turn of the century, the Home Economics Movement incorporated science and technology of the times and was viewed as a reform movement. “If husbands were fed and children raised according to scientific principles, if purity and fresh air swept through every corner of the house, then the nation could triumph over disease, poverty, and social decay” (Nerad, 1999, p.5).

As a field of academic study, home economics was shaped by a series of conferences held from 1899 to 1908 in Placid, NY, with the original meeting including eight women and over two hundred attendees in 1908 (Nerad, 1999). In 1914 the Smith Lever Act was passed, which institutionalized home economics in schools and land grant colleges and funded teacher training as public schools began to require all girls to study home economics.

In *The Academic Kitchen*, Nerad (1999) told the story of the development of the Berkeley Department, under the leadership of Agnes Fay Morgan, who became chair of the Household Science Division of the department in 1918. Despite a doctorate in organic chemistry from the University of Chicago, because of her gender, Morgan was never allowed a position in male-dominated scientific research departments. For over 36 years, Morgan’s leadership helped supervise 31 doctorates and 165 master’s degrees despite a continuous struggle for resources and
status. It was not until after her death (and the succession of her position by a man) that the department name was changed to Nutritional Science (Nerad, 1999).

Burley (2005) documented many of the first African American women seeking to become professionals chose home economics as a career. They were motivated by economic conditions to look for vocational education. But they also had a strong sense of responsibility to the community. In a study done by Shaw (1996) on professional African American women, she described women who chose home economics:

[They] reinforced the traditional public and private female roles by working as domestics and by pursuing feminized professions, but formal education and vocational goals kept them from internalizing an inferior status. They had learned that even though they were working within the limited feminized professions, they had social and political opportunities and obligations. (p.2)

Due to segregation, African American women could not intern in white hospitals. The first accredited dietetic internship program was developed at Howard University in 1946 (Burley, 2005; South 1993). Burley’s (2005) study traces the development of the dietetics program at Tuskegee University within a larger historical context of professionalization of African American women:

Tuskegee dietetics education evolved in response to socioeconomic and political conditions brought about by the post-Reconstruction era, the Great Depression, World War II and the early desegregation era. Along with professionalization continuum there was aggressive seeking of new opportunities in dietetics on the part of the faculty members and students with a declining emphasis on industrialism and practical skill development. With advancement, institutional and individual notions of profession changed. (p.18)

In the post-Reconstruction era through the mid-1930s, Tuskegee focused on preparing women to be teachers or developing skills regarding home and family life (Burley, 2005). In 1936 Tuskegee created a commercial dietetics program which
was attended by mostly males. In 1942 they expanded into a second major area: institutional management. This program attracted more females and was comparable to the dietetics curricula offered at white public and private colleges and universities. It continued into the mid-1950s, but following World War II there was rapid development in the field of food and nutrition and demand for credentialed dietetics professionals increased. Tuskegee faculty developed an internship program with local African American hospitals because “access for black women to predominantly white internship programs was limited” (Burley, 2005, p.21).

The History of Paraprofessional Community Health Educators

In 1972, Wingert, Grubbs, Lenoski, and Friedman (1975) looked at the effectiveness of utilizing paraprofessional community health aides to assist families in coordinating their health needs in a pediatric outpatient clinic in Los Angeles County. The aides received two months of training, after which they were expected within twelve months to affect the family’s social conditions, income, employment, environment, education, and patterns of seeking emergency care. The authors admitted that the study did not have realistic expectations given the pervasive poverty and problems of these families (Wingert et al., 1975).

In her chapter “Indigenous Community Health Workers in the 1960s and Beyond,” Doris Wilkinson (1992) attempted to synthesize pertinent literature documenting the effectiveness of community health workers in the African American communities, as measured by patient outcomes. The first studies, done with a New York tuberculosis program, demonstrated effectiveness. It was recognized that the more autonomy the workers had in problem solving, the more effective they could be. She conducted an interview study in a Baltimore hypertension project to examine the role, obligations, activities and social placement of health aides within the professional status hierarchy. She found that much more information was relayed between
clients and community health workers than between clients and professionals. Clients were able to communicate the life problems that related to their treatment more easily to people they recognized as peers than to the professional health providers.

A detailed case study described the use of paraprofessionals recruited from their own community for prenatal intervention with migrant farm workers. (Meister, Warrick, Zapien, & Wood, 1992). The project utilized a scripted Spanish-language prenatal curriculum, with an instructor’s guide that had been developed for lay teachers. The peer educators (promotoras) received two months of training for four hours a week. Classes were described as both didactic and experiential, including trips to a hospital maternity wing, county health department, and migrant health center. The results exceeded the planners’ expectation. Classes become a center for all kinds of family needs and the promotoras request more information and education for themselves. An accompanying study, evaluated the status within the community of the women who became promotoras and their relationship with the medical community. The cultural sensitivity of the curriculum was reported as contributing to the success of this program.

Following a series of focus groups of young Hispanic mothers of preschool children and community leaders in 12 counties of southern Colorado, La Cocina Saludable (the Healthy Kitchen) program was developed to address nutrition education needs of this at-risk population (Taylor, Serrano, & Anderson, 2001). Abuelas (grandmothers) were recruited as peer educators and trained with a bilingual curriculum guide that included a script, background information, and presentation tools. Peer educators indicated they were motivated by a desire to work with the community and learn about nutrition.

Sisters in Health represented an attempt to increase fruit and vegetable consumption among low-income women through a series of weekly meetings facilitated by community
nutrition paraprofessionals (Devine, Farrell, & Hartman, 2005). The program’s impact was evaluated in a sample of 269 low-income adults in 32 interventions. Results indicated group support and food skill experience were effective for increasing fruit and vegetable consumption in this population.

This review did find a history of paraprofessional educators in healthcare in general, and specifically, some involved in community nutrition education. People from communities have been recruited to serve as a bridge between healthcare professionals or researchers. The programs have often contained scripted teaching modules prepared by the professionals. The paraprofessional education or training described was generally limited to a few sessions or weeks and confined to the specific material. Several studies raised the issue of the changing relationship of the paraprofessionals to their community as a result of their position as educators and involvement with professionals. In some cases this also raised conflict with professional staff but definitely created a desire in the paraprofessionals for increased education and economic status. The nutrition education studies were very much geared towards improving the shopping and food selection behaviors of people with limited access to food and income. The most successful programs described were those that allowed the most autonomy and flexibility to the paraprofessionals.

The Study “Hearing the Voices: African American Nutrition Educators”

Less than 4% of Registered Dietitians in the US are African American. This study analyzed the impact of white dominance in the field of dietetics (White, 2007). Nineteen African American women who practice nutrition education in the African American community were interviewed regarding their own educational experiences, their practice, and their perception of
the profession of dietetics. They were also asked to give their opinions regarding changes that need to take place.

Cultural insensitivity can be a huge barrier to providing appropriate nutrition education for clients (9). This study attempted to give voice to those who have experienced exclusion or marginalization in the Field of Dietetics by examining the structural factors that contribute to exclusion and cultural insensitivity. Critical Race Theory provided a lens for the study.

*Critical Race Theory*

Over the past 10 to 15 years, scholars and researchers have used CRT to examine and challenge ways that racism shape schooling structures and practices (10). CRT centralizes race and racism, but also focuses on intersection with other forms of subordination (gender, class, sexuality, language, surname, etc.) (11). CRT challenges claims that the educational system offers objectivity, meritocracy, color-blindness, race neutrality and equal opportunity. It questions approaches to schooling that pretend to be neutral or standardized while implicitly privileging white, U.S.-born, monolingual, English-speaking students. Acknowledging that schools are political places, CRT views education as a tool to transform society. Critical race research draws on the lived experiences of Students of Color and views this knowledge as strength. CRT researchers draw on multiple methods to listen to and learn from those knowledges otherwise silenced by popular discourse and academic research (11).

*Findings and Discussion*

**Participants as African American Nutrition Students**

The participants described a number of issues that affected their access to school and careers. These included segregation, their economic situation and family history, including being first generation college students.
One of the older participants discussed her experiences with segregation and education.

“I go to apply at (two hospitals) here in Chicago. They said ‘we’d be glad to have you. Send your application and send your picture’. When I send my picture, well I’m Black. Each one of them said, ‘Oh, you have to do your internship at Freeman Hospital in Washington D.C., all Black’. I said ‘my, my, my. I’m in the North and I’m getting segregation. I had it in the South, I expected it’. So I applied to Freeman for my internship.”- Eve, retired Administrative RD

A number of participants discussed the difficulties of being first generation in their family to go to college, particularly regarding financial aid information.

“My mother couldn’t afford it at the time. I was basically on my own as far as picking colleges. I wasn’t knowledgeable about filling out college applications and my mother wasn’t either. I tried to get help but I couldn’t get any. I was in a family with no knowledge of it.”- Chris, DTR, BA Finance, currently working on verification to become RD eligible

CRT argues that white dominant culture in education maintains and sustains exclusion and privilege, even while purporting integration or multiculturalism (15). Black students often come to the university in the role of intruders—who have been granted special permission to be there (10).

“There were no Black people in Nutrition and no Black bench scientists there was no Black people in my classes. People wouldn’t pick me to be their lab partner. I was basically socially isolated in my classes. your self identity is in that. In the Black world I was very popular. All of a sudden ...I am an 18 year old in college away from home and all of a sudden nobody likes me.” - Ora PhD Nutrition, Community Researcher

The women in this study felt they were held to a higher standard of qualification than other students. Eve put it this way “You have got to have more credentials than the others in order to prove yourself and for them to decide that you’re qualified. You got to be overqualified”. Women told of a number of incidences where they had to prove papers had been written, assignments met, pre-qualifications to courses documented, above and beyond their white counterparts. Debra found out that white students in her program were given options to
test out of courses required for program completion while African American students were never given that opportunity.

The support systems that each woman reported helped to sustain and motivate them to continue their educational pursuits included family and friends, educators and supervisors.

“It’s challenging because I am a single mother...balancing going to work and going to school, that was challenging, tiresome and takes a lot of energy and focus and support group and people to talk to you. Me...I had to have a support group through family, friends and some of the students.” - Ruth, GED, former DT student, Peer Educator

Critical Race Theory shifts the center of focus from valuing the middle class cultural capital to recognizing the margins as a place of resistance and as a strategy for survival (10).

The motivation to get into the nutrition field expressed by the women included positive experiences with food in their background, an interest in health and science, or career advancement. Chris, DTR, stated, “I am from the community so I want people to get the services that they need. To me that is what community means”. Rosé, a 62 year old Dietetic Intern was motivated to become a dietitian by the needs of diabetic patients she saw working in an endocrinologist office. “White dietitians had no understanding of our seniors or their economic situation, nor how we ate.”

**Participants as African American Nutrition Educators**

The women discussed their perception of the benefit of having African American educators address African American clients. They described what they perceived as effective teaching experiences in the community. They commented on their perception of the government recommended Dietary Guidelines. Finally, participants discussed their roles as mentors for potential nutrition educators.
Participants talked about the importance they felt of clients being able to identify with the nutrition educator. Ann, MPH, former WIC nutritionist described her perspective of clients’ attitude “You look like someone I know, you look like my sister, you look like my cousin. I can sit and talk with you. I can tell you the truth”.

“See it, feel it, touch it, eat it and understand how it relates to the larger world” is how Lynn, BA, LD Nutritionist with a community program characterized her perspective.

“*You have to show excitement of presenting the food. It’s all in how you speak to them in kindness, in warmth...it’s not like’ hey, I’m the big nutrition educator’. I go in as a friend..we all here to learn from each other...so that works.*” – Ruth, Peer Educator

CRT has the perspective that communities of color are places with multiple strengths in contrast to deficit scholars who place value judgments on communities who do not have access to white, middle or upper class resources (16). Using understandable language and relating directly to people was a commented on many times. “You can walk in and talk all this high fallutin’ stuff, but what does it mean really? If you can’t get what it means really down to their understanding, then you haven’t talked” stated Lucy, DTR, and MS Education, who taught culinary programs for homeless women, ex-prisoners and urban high school students.

Women gave many examples of using cooking and eating, games and interacting experientially as the most effective method for teaching in a community setting.

Participants responded to questions regarding the relevance and usefulness of USDA Dietary Guidelines in the African American community. The lack of access to healthy foods in the community was raised (17).

“*When you are trying to help someone and teach them that kind of stuff that they know they can’t afford in the first place, they just shut the door on you...and you’re just talking but it’s not going any place, because they already know they can’t afford this.*” – Betty, RD
An additional concern was that foods provided by the supplemental government food programs were not healthy. “The other thing I have seen with the community programs is the food we are actually providing people is not good.”, stated Debra, RD, WIC nutrition education coordinator.

Participants as African Americans in the Profession

Four themes emerged in the interviews of women regarding their perception of African Americans in the profession of Dietetics. The first theme centered on the obstacles to becoming a Registered Dietitian. The second theme discussed the women’s reported relationships to the American Dietetic Association. The third theme reflected an alternative network that developed through the Illinois African American Dietetic Association. Fourth, the women gave examples of how they experienced racism on their jobs.

The women commented that Dietetics as a field is not known about in the African American community. Burley’s study (18) of the history of Dietetics at Tuskegee Institute cited a difference in relationship to the medical profession between white and African American women, which remains today.

The professionalization experiences of African American women stand in stark contrast to the selectivity, isolation and separation characteristics of traditional medical education. While medicine established public identity through standardized training, African American women established their identity as professionals through their effectiveness as African American community leaders. (18) p.57)

The women also talked about the fact that often African Americans interested in careers in nutrition are often tracked into food service management, rather than clinical dietetics.

“(Counselor said) ‘Do you really want to go into dietetics because it is really, really hard?’ And I said, ‘Yes, I’m sure I want to do this’. She said, ‘Do you want to maybe consider hotel and restaurant management which is also in our department?’ I said, ‘No, I don’t want to be a hotel or restaurant manager. I want to be a dietitian’.”- Cathy, RD
Women discussed strategic and costly errors they made while trying to access the process to become RD’s. They expressed the perception that “you have to know somebody to get in”.

Debra, who was already the director of a food service department in a hospital, but wanted to get her RD, said “I applied to several internships. I was having issues there because I am a single woman, gainfully employed. I work every day in the field of nutrition; I supervise dietitians…why do I have to quit my job to do an internship? I refused to do it.”

Several described the disappointment of the lack of financial benefits of becoming a dietitian after all the sacrifice.

“So it was really, really, rough and it’s very disappointing to have to go through all that and still not get paid the amount you should get paid to have all this education. I have about the same amount of student loans if I had went ahead and become a doctor. Close to $100,000 dollars!” – Cathy, RD

The general perception of the American Dietetic Association expressed by the participants in study was one of marginalization. Lucy, MSRD, a state nutrition administrative coordinator and leader in several organizations stated “historically I feel like African Americans have not been able to make the connections, have not felt the connections in ADA”. They described a perceived hierarchy in dietetics, which puts people who work in food service at the bottom and scientists at the top.

“I noticed right off that food service people are completely marginalized. Food service people, community nutritionist, clinical dietetics, nutritional biochemistry… So early on I peeped that structure. So where do Black people go, food service. Where do they only allow Black people in.. food service, then community. WIC, you know, not dietitians, but people who could do community nutrition without an RD.” – Ora, PhD, Community Nutrition Researcher

Critical Race scholars take the position that the margins can be viewed as both sites of oppression and sites of resistance, empowerment and transformation (19). Finding themselves
ignored and on the fringes of ADA, several women in this study participated in founding an organization that gave them an alternative “voice” in the profession. The Illinois African American Dietetic Association. The organization drew in not only RDs, but was open to all African Americans working in Nutrition. This association was looking to elevate its members and the profession, to be of service to the community and a model for other young women who were entering the field.

CRT talks about how racism so permeates society in the United States that it looks ordinary and natural and is, in fact, considered normal (20).

“There had not been a Black dietitian on that floor as a teaching dietitian before. When it was announced the doctors were all like, What! Oh they tried me. They would come into the office...I had a white intern of course, and my desk was at the front of the room...and the intern was at the back....and the doctor would walk straight past me to her to ask their questions. And she would have to send them back to me. And then they come back with this little silly grin on their face.” Betty, RD

Some talked about disparity in salary.

“Sometimes I accidentally will become privileged to somebody else’s salary and I’ll ask about it. Because for every job evaluation I have ever had it’s always been excellent. One time I questioned my supervisor about my compensation with the current company and they were forced to give me 7% increase at one time, maybe 8%, to compensate me for what was lacking.”- Pam, Dialysis RD in African American Community

Needed Changes Expressed for the Field of Dietetics
Changes that were expressed by the participants centered on four themes including; accessing the educational process, the need for a multicultural curriculum, mentoring, and salaries.

The women spoke of the need for more exposure of the profession in high school career programs to familiarize and recruit students of color to the field. They raised the need for nontraditional routes for students to return to school.
The women commented on the need for dietetic students to be exposed to cultures and develop sensitivity.

“Because food is very important, it is very private. It’s special to people, especially those who are in need, who don’t have a whole lot. Dietitians can’t understand the importance of food if you don’t have a lot. Like ‘why, if you are so poor or you are having health crisis or stress in your life, why are you turning to food. It’s going to make it worse’. I think if you can understand why they turn to food, you can deal with it better.” - Lynn, LD, Nutritionist Community Program

The women talked about their views of themselves as mentors.

“It has also become my desire to reach back to find other black girls, or girls of color who have an interest in science to let them know this is a profession of diversity. It is not just your skinny, white, blond, celery eating profession, looking to marry a doctor, type of profession. I can influence the dietetic profession in a manner that really can put a light on this profession. Also just given this epidemic with childhood and adult obesity I want to give this care, I want to represent this profession.” – Chris, DTR, Dietetics Student

A low salary in comparison to the sacrifice of so much schooling has been identified as an obstacle for people of color to come into the field.

“I think that people encourage their children to go after jobs that pay a lot of money, doctor or lawyer, if you have the skills. People gear their children towards careers they know about. But if they feel like I am going to take out all these loans and it doesn’t pay well, why would you” – Cass, BA Home Economics, MS Education, Culinary Arts Coordinator for Public School.

Conclusions

The lack of African American dietitians has had an effect on students coming into the field, as well as on how the African American community is informed about the connection between nutrition and related diseases. In a model proposed to increase diversity in the professions, Kachingwe included three components (21). One was multiculturalism, which includes a respect and education for differences. This needs to be incorporated throughout dietetic curriculum.
The second component is diversity of the people themselves (21). The obstacles to accessing dietetics education must be addressed. Finally, Kachingwe stated that ultimately, motivation, the desire to have diversity, must come from the leadership of the profession and the educational leaders within the profession (21). It is up to those of us who have already crossed over to reach back and make away.


REFERENCES


