Health and Culture- Nutrition Implications in the Latino Community

The aim of this chapter is to provide some relief from the paradox: many Latino patients are passive during nutrition counseling, yet to succeed they need to be an active participant and at the center of the decision making. The origins of this passivity do not lie only within the patients, but in the way they are spoken to and dealt with by nutrition practitioners. Latinos are affected by disproportionate prevalence for chronic diseases, and have been identified as the largest and fastest growing population subgroup in the United States. Because of evident health disparities Latinos represent the minority group of most interest for public health. Nutrition related risk factors are associated to higher incidence rates for obesity and diabetes among Latinos, making cultural competent nutrition a fundamental component of effective health promotion/disease prevention efforts.

The intention of this chapter is to raise awareness about the implications of culture on health behaviors and dietary practices by exploring pertinent aspects of the Latino community. The chapter overviews the role of culture in nutrition and health, and proposes future implications of diversity and nutrition practice.

Which is the appropriate term Hispanic or Latino?

The federal government defines Hispanic or Latino as those who indicate their origin to be Mexican, Puerto Rican, Cuban, South or Central American (for example Dominican, Nicaraguan, Bolivian) or other Hispanic origin. This designation is made independently of racial classification. Furthermore, the term Latino by definition describes a person of Hispanic descent, especially from Latin American origin, often
living in the U.S. (Cambridge Dictionary, 2010). The term Latino encompasses a broader spectrum of ethnicities, including countries who speak Spanish, Portuguese and French. It is imperative not to assume a person's nationality or language preference by the sound of a name or by physical appearance. Hispanic or Latino are appropriate terms, they are often used interchangeably, and for this chapter the term Latino is preferred.

Why is it important to understand the Latino community in the US?

According to the U.S. Census Bureau, Latinos account for 15 percent of the population, that is around 46.9 million people. Latinos have the highest growth rate than any other ethnic group in the U.S. As depicted in figure 1, the growth rate from 1990 to 2006 was of 102 percent, and it is attributable mainly to high fertility rates. The projected Latino population of the U.S. for 2050 is 132.8 million people, this means that it will constitute 30 percent of the nation’s total population. Of the nation’s total Hispanic population, almost half lives in California or Texas (48 percent), with major concentrations residing in New York City, Los Angeles, Houston, and Chicago. In 2007, almost 64 percent of the U.S. Hispanic population was Mexican or Mexican-American; followed by 14 percent Central and South American, 9 percent Puerto Ricans, 3.1 percent Cubans, and the remaining were people from other Hispanic origins (U.S. Census Bureau, Facts for Features, 2009). Lifestyles practices and health beliefs will vary among Latinos of different backgrounds, and will also vary depending on the length of their history in the U.S.

Latinos and their descendants form the core of a union that matches relatively recent arrivals with long-time U.S. residents; English speaking with Spanish speaking, aliens with citizens; and documented with undocumented immigrants. As the nation’s
fastest growing minority, all indicators point to a heightened sense of awareness and receptivity among Latinos across ethnic and national lines, regarding a collective consciousness and historical role in the U.S. Recognizing such differences within the Latino population prevent undesired cultural insensitivity and foster an appropriate environment for education, especially when referring to things that may be linked to citizenship status. Some examples of undesired cultural insensitivity include assuming that most Mexican people are undocumented; another stereotypical example happens when Latinos are assumed to be of Mexican nationality. Both examples are common scenarios for most Latinos, and are popular assumptions made by many Americans.

Learning about how culture affects the patients decision making, allows for lifestyle plans to be individually tailored with nutrition recommendations that are realistic and achievable. Asking an individual to discontinue eating traditional foods, is insensitive and unrealistic. While establishing rapport or during the nutrition assessment phase of the encounter, the practitioner may gather useful information by asking simple questions, such as: Where are you from? How long have you lived here? Who buys the food in your house? What kind of foods do you eat every day? Do you worry about food? For patients with limited English language ability using food models, measuring cups, restaurant menus, food pictures or even sign language can be useful data gathering tools and shows the providers interest in understanding. Registered dietitians strive for best practice in clinical nutritional care, and can advocate for patients or clients by requesting interpreters when needed. The use of children for interpretation in clinical encounters is not recommended.
The Latino population in the U.S. is younger, less educated, economically disadvantaged, and more likely to live in larger households compared to non-Hispanic population. The before mentioned represent characteristics which lead to social segregation and discrimination. However, there are significant differences among the subgroups, with those of Mexican origin being relatively less advantaged and those of Cuban origin being relatively more advantaged in terms of education and income (Hobbs and Stoops, 2000). In the U.S., ethnicity is closely correlated with socioeconomic status. Adler and Ostrove (1999) define socioeconomic status as a combination of education, income, and occupation, which in addition to citizenship status, determines access to health knowledge and health resources. The Migration Information Source reported that 29 percent of foreign born individuals in 2004 were unauthorized migrants in the U.S, of which 57% were from Mexico and 24% from Central and South America.

What is the Latino health profile?

The Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (DHHS) compiled information from various sources describing socioeconomic characteristics of Latinos and other racial/ethnic minorities. Latino health related findings include:

- Language Fluency: Nationally, 12 percent of the population spoke Spanish at home in 2007. The number of Latinos who speak only English at home is 3.9 million for Mexicans, 763,875 for Puerto Ricans, 163,599 for Cubans and 1.8 million for other Latino groups. Whereas, the number of Latinos who speak Spanish at home is 14.5 million for Mexicans, 2.3 million for Puerto Ricans, 1 million for Cubans, and 6.7 million for other Hispanic groups.
- Educational Attainment: 61 percent of Hispanics in comparison to 89 percent non-Hispanic whites have a high school diploma; 12.5 percent of Hispanics in comparison to 30.5 percent of non-Hispanic whites have a bachelor’s degree.

- Economics: 21.5 percent of Hispanics in comparison to 8.2 percent of non-Hispanic whites were living at the poverty level; 24.4 percent of Hispanics, in comparison to 13.7 percent non-Hispanic whites, work within service occupations; 16.6 percent of Hispanics in comparison to 39.9 percent of non-whites work in managerial or professional occupations. Among full-time year-round workers, 55 percent of Hispanic households, in comparison to 68.2 percent of non-Hispanic White households earned $35,000 or more.

- Insurance Coverage: It is significant to note that Latinos have the highest uninsured rates of any racial or ethnic group within the United States. In 2007, 32.1 percent of the Hispanic population was not covered by health insurance, as compared to 10.4 percent of the non-Hispanic white population. Private insurance coverage among Latino subgroups varied as follows: 39.1 percent of Mexicans, 47.3 percent of Puerto Ricans, 57.9 percent of Cubans, 45.1 percent of other Hispanic and Latino groups. Medicaid coverage varied among Latino subgroups as well with 22.4 percent of Mexicans, 29.1 percent of Puerto Ricans, 17.9 of Cubans, and 20.8 percent of other Latino groups. Those without health insurance coverage varied among Hispanic subgroups: 37.6 percent of Mexicans, 20.4 percent of Puerto Ricans, 22.8 percent of Cubans and 32.3 percent of other Latino groups.

- Health: Latino health is often shaped by factors such as language barriers, low education level, citizenship status, lack of access to preventive care and lack of health insurance. The Centers for Disease Control and Prevention (CDC) has cited some of the leading causes of illness and death among Latinos, which include heart disease, cancer,
unintentional injuries, stroke, and diabetes. Some other health conditions and risk factors that significantly affect Latinos include asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease. Nutrition practitioners have a key role in the health promotion/disease efforts because Latinos have higher rates of obesity than non-Hispanic whites.

Disparities are not limited to minority versus non-minority populations; disparities among Latino subgroups also exist. According to the Office of Minority Health, while the rate of low birth weight infants is lower for the total Hispanic population in comparison to non-Hispanic whites, Puerto Ricans have a low birth weight rate that is 50 percent higher than the rate for non-Hispanic whites. Furthermore, Puerto Ricans suffer disproportionately from asthma, HIV/AIDS and infant mortality, whereas Mexican-Americans suffer disproportionately from diabetes.

In general, individuals without the financial resources to afford preventive medical care tend to also have lower levels of education. In the case of many Latinos, scarce financial resources, deficient language skills, and unstable living conditions, hinder compliance to recommendations resulting in greater disparities. Interestingly, Iceland and Wilkes provide evidence that ethnic minorities in the U.S. are disproportionately overrepresented among those with lower socioeconomic status (Iceland and Wilkes, 2006). The authors argue that language barriers and lower health literacy can interfere with the ability to understand and follow instructions, independent of financial resources. Availability of nutrition education materials such as handouts in Spanish and English written at a low literacy level (images and few words) along tridimensional food models can minimize obstacles and enhance the learning experience.
Health disparities are believed to be the result of the complex interaction among generic variations, environmental factors, and specific health behaviors (Livingston et al., 2008). The term ‘disparity’ may connote a difference that is inequitable, unjust or unacceptable. The Institute of Medicine (IOM) of the National Academies reported that minorities are less likely than whites to receive health services, including clinically necessary procedures, even when controlling for insurance status, patient income, and other access-related factors. The Agency for Health Care Research and Quality (AHRQ) of U.S. DHHS revealed that about 30 percent of Latinos lack a usual source of health care compared with less than 16 percent whites, and Latino children are 3 times as likely as non-Hispanic children to have no usual source of health care. Central Americans, South Americans, and Mexicans, for instance, are notably less likely to have insurance than Puerto Ricans and Cubans (Kaiser Family Foundation, 2003), and this is thought to be related mainly to migration status. Evidence shows that racial and ethnic minorities in the U.S. often receive a lower quality of care than their white counterparts (Livingston et al., 2008). Results indicate that disparities are found even when socioeconomic status and health insurance is comparable to their white counterpart; reflecting an unacceptable reality for people of color in the U.S.

Although, Latinos generally have lower mortality rates but higher morbidity rates compared with the overall U.S. population, morbidity and deficient chronic disease management are areas of great public health concern. Nutrition interventions dealing with the Latino population are particularly significant not just because multiple chronic
diseases are diet related, but because medical nutrition therapy has been shown to be a cost-effective intervention addressing chronic disease prevention and management.

**How does Nutrition fit in the efforts to battle health disparities?**

Current disparities in health care impact the most vulnerable population sectors across the nation, specifically races of color with Latinos at the center. Cultural competence is a tool that can be used by nutrition providers to reduce these health disparities, and to provide more effective care to minority patients. Nutrition educators are and will be evaluated in their ability to produce desirable behavioral changes in patients (Curry, 2000). Consequently, nutrition educators who are aware of their personal sensitivity to cultural differences, as well as, able to recognize the degree of sensitivity in others is an essential aspect for nutrition practice in their ability to produce positive behavior change.

Cultural competence is composed of “specific cognitive, affective, and psychomotor skills that are necessary for the facilitation of cultural congruence between providers and patient” (Alexander, 2008). Cultural competency models suited for nutrition education are available, though cultural competency training in dietetic programs is not yet widely implemented. The American Dietetic Association has released position statements regarding cultural diversity in nutrition, and provides a series of health disparity tip sheets for nutrition practitioners of various fields (food service management, public health and community nutrition, clinical nutrition, and others. The Health Resource and Service Administration (HRSA) is a federal agency for improving access to health care services for people who are uninsured or medically vulnerable. The agency offers open-access self-assessments tools and training resources. Despite the good
intentions of cultural competency advocates to lead efforts toward eliminating disparities in health care, it is evident that resistance remains.

*Melting pot or a chunky stew?*

The process of acculturation among Latinos in the context of the U.S. mainstream culture provides a good example of the complexity and multidirectional nature of the phenomenon. Among Latinos it is associated to inadequate dietary choices including lack of breast feeding, low intake of fruits and vegetables, and a higher consumption of refined sugars.

Acculturation is often defined as the process by which immigrants adopt the attitudes, values, customs, beliefs, and behaviors of a new culture. The Multidirectional Model of Acculturation described by Beck (2006) acknowledges that Latinos can acculturate into mainstream culture retaining or not their cultural roots. Perez-Escamilla and Putnik (2007) propose that the acculturation process can take Latinos into at least one of four different paths:

1) Assimilated: Following the ‘melting pot’ social concept, Latinos may give up their Hispanic culture and assimilate.

2) Integrated or bicultural: Latinos may retain Hispanic heritage at the same time that they fully integrate into mainstream culture, also referred as ‘stew’.

3) Separated or segregated: Living in ‘ghetto or barrio’ environments, Latinos may chose to retain their Hispanic heritage without attempting to integrate in the mainstream culture becoming segregated from society.
4) Marginalized: Latinos may end up losing their Hispanic ethnicity without seeking integration into the mainstream society, becoming ‘invisible’ with little or no sense of belonging to any culture.

For Latinos, as it is for other migrant groups, the process of acculturation to the U.S. mainstream culture is perceived to lead to deterioration in dietary patterns and health status. Beck (2006) describes the acculturation process as complex and multidirectional because it involves learning and adopting aspects of the new culture while modifying facets of the culture of origin. Furthermore, nutrition providers who are familiar with the concept of acculturation and understand the implications it has in nutrition and health, have a greater opportunity to generate positive health outcomes by tailoring realistic and achievable behavior change plans.

Even though, acculturation is often associated with negative health behaviors among Latinos, there is evidence of positive associations as well. Either way, research findings have been found to be inconsistent across acculturation indicators and appear to be strongly modified by Latino subgroups (Perez-Escamilla & Putnik, 2007). Variations in acculturation indicators diminish any association between cultural and nutritional constructs.

*How vital is to know traditional Latino health beliefs?*

Latino culture tends to view health from a more synergistic point of view, expressed as the continuum of body, mind, and spirit. According with a Robert Wood Johnson Foundation Report (2009), nearly 70 percent of Latinos believe that spiritual healing is very important in maintaining health and well being. The values that guide
Latino culture and people in general, influence the type of interaction that individuals have with one another, and the health care system.

Heightened awareness of cultural differences improves communication between the provider and the patient, augmenting patient compliance to the treatment plan. The Rhode Island Department of Health presents a multitude of cultural information surrounding Latino health, including health beliefs and practices, as a resource to health care personal. Nutrition providers can capitalize from predominant Latino social interactions, such as:

- Involvement of family or ‘la familia’ is often critical in the health care of the patient. Traditionally, Latinos include many people in their extended families- not only parents and siblings but also grandparents, aunts, uncles, cousins, godparents, and close family friends.

- Respect or ‘respeto’ implies a mutual and reciprocal reverence. Respect dictates appropriate deferential behavior toward others based on age, sex, social position, economic status, and authority. Older adults expect respect from those who are younger, men from women, adults from children, teachers from students, employers from employees, doctors from patients, and so on.

- Latinos tend to stress the importance of personal relationships or ‘personalismo’, which explains why many Latinos rely on community-based clinics for their primary care, rather than large hospitals. Latinos expect health care providers to be warm and friendly, and to show legitimate interest in their patient.
Some Latinos, particularly those who are older or who are recent arrivals in the U.S. may have traditional syndromes, symptoms, behaviors, or illnesses that are unfamiliar to most Americans. Depending on the patients’ country of origin, different terms exist to describe such illnesses, for example:

- ‘Empacho’ presents lack of appetite, stomachache, diarrhea, vomiting; thought to be caused by poorly digested or uncooked food. The symptoms overlap with those of several biomedical conditions, such as gastroenteritis, formula sensitivity, milk allergy, even bowel obstruction. Traditional treatment includes dietary restrictions, herbal teas, or abdominal massage with warm oil. Parents may take a child with ‘empacho’ to a traditional healer before seeking medical care.

- ‘Bilis’ includes vomiting, headaches, dizziness, migraine, nightmare, loss of appetite, or inability to urinate. It is believed to stem from bile pouring into the blood stream in response to strong emotion, rage, or revenge fantasies.

- ‘Ataque’ is a severe expression of shock, anxiety, or sadness, which may result in illness. For instance, diabetes is often perceived to result from an ‘ataque’.

Indeed, culture is a major determinant of lifestyle and health status. A diverse nutrition encounter encompasses the assessment and incorporation of health beliefs and dietary practices into the nutrition care plan to ensure favoring results. It is vital to know about health beliefs and traditional practices of different ethnic populations in order to diminish the slightest opportunity of prejudice or discrimination to occur.
Basic considerations for a successful cultural nutrition encounter

By respecting the patient’s culture and showing personal interest, the nutrition provider can expect to earn a patient’s trust. When there is trust or ‘confianza’, Latinos value the time they spend talking to their provider and are more likely to adhere to the recommendations. To Latinos, ‘confianza’ means the provider has the patients’ best interest at heart. Forms, posters and written education materials in Spanish, availability of food models representing ordinary staples or other three dimensional objects, and a bilingual dictionary are likely to validate an effort for best care. The recommendation is to request interpreter services if considered necessary, and to properly document the visit by including at least information regarding language skills, intervention implemented, and the patients perceived understanding of the encounter. Non-verbal communication is a significant component of the interaction, and may positively influence the encounter with a Latino patient. For example, during an encounter the nutritionist may: 1) sit closer than with patients of other cultures; 2) lean forward when speaking or listening; 3) give a comforting pat on the shoulder or gesture of interest; 4) shake hands, and 5) be sensitive to non-verbal messages like eye contact. To avoid misjudgments during a cultural encounter, the nutrition provider should understand and accept that many Latinos have a broad definition of health. The Latino definition of health combines respect for the benefits of mainstream medicine and traditional healing, along with a strong religious component in daily life. The evidence that Latino individuals do not depend on doctors most of their care is substantial, and words like ‘medicine’, ‘nurse’, ‘doctor’ or even ‘dietitian’ tend to be associated with death and disease, not necessarily health promotion.
Surprising to the world is that hunger and poverty are extensive and persistent challenges in the U.S. According to a U.S. Department of Agriculture (USDA), in 2007 approximately 36 million Americans worried about how they will provide enough food for themselves or their families on a daily basis, let alone healthy and nourishing food. Why is more than 40% of those 36 million hungry Americans Latino or African-American? The answer to the question is complex, although it is simple to conclude that the unequal access to food in a nation of abundance and human rights is inexcusable.

Diet-related disparities can be defined as differences in dietary intake, dietary behaviors, and in dietary patterns in different segments of the population. Nutrition-related disparities result in poorer dietary quality and inferior health outcomes. For racial and ethnic minority groups (acknowledged as African American, Hispanic, Asian, and American Indian/Alaska Native) the burden in terms of disease incidence, morbidity, mortality, survival, and quality of life is notoriously unequal. In a commentary article in the Journal of the American Dietetic Association, the author portrays diet related disparities as diets high in fat, particularly saturated fat; low in fruits, vegetables and whole grains, and high in salt (Satia, 2009), which reflect the distinctions in diet and disease between and within minority subgroups. Consequently, the tendency of ethnic minorities to have poorer nutrient profiles and dietary behaviors relative to whites is visible across national social and health outcomes.

A significant aspect of diet-related disparities in ethnic minorities is food insecurity. The US Department of Agriculture (USDA) defines food insecurity as “limited or uncertain availability of nutritionally adequate and safe food or uncertain
ability to acquire acceptable foods in socially acceptable ways”. In the U.S. food insecurity is prevalent among low-income Latino households (Nord et al., 2007), it is associated to increased risk of obesity (Buscemi and Beech, 2009; Kaiser, 2007), and it affects most those that are Spanish speaking at home (Kaiser, 2004; Aldrich, 2000). Some would argue the U.S. food supply of relative abundance and low-cost today is largely dependent on labor inputs from migrant farm workers, who often do not have proper documentation, who are underpaid for seasonal work, and live with the contrast threat of deportation.

Data from the Census Bureau revealed that between 2007 and 2008, the poverty rate for Hispanic Americans increased and income fell, a reality that parallels the decline on economic wellbeing experienced by many Americans who were also affected by the current recession. While poverty rose for Americans overall, Latinos and Blacks are nearly three times as likely to live in poverty relative to whites. The poverty rate in 2008 was 23.2% for Latinos, 24.7% for blacks, and 8.6% for whites. The latest recession has erased ten years of economic progress among Latinos, as in any crisis the recession affects children the most. Is pertinent for the nutrition practitioner to understand how race today still plays a role in determining why some people have greater access to healthy foods and other are merely subsisting.
Latinos and their children have been particularly affected by the growing prevalence of overweight and obesity. According to the CDC, at least one in four Hispanic adults living in the U.S. was obese in 2007, and the trend continues among the young. As Latino children make up 22 percent of all children in the U.S. under the age of 18, they represent a significant portion of the obese or overweight children in the country. In recognition to Mrs. Obama for her health advocacy efforts, solutions to the widespread problem of childhood obesity are becoming part of the national strategy to reduce health disparities. The opportunities for nutrition providers to take part in the health care reform process are enormous and with a wide spectrum for contribution.

According to the National Diabetes Information Clearinghouse (NDIC), the prevalence of type 2 diabetes mellitus is two to three times higher in Latinos than in non-Hispanic whites, with an estimated 10 percent of adults over the age of twenty and 25 to 30 percent of those over the age of fifty are affected. The process of acculturation and the changing nature of the Latino diet have serious implications on health. Diabetes prevalence is especially high among Mexican Americans and Puerto Ricans. Compared to non-diabetic individuals, those with the disease are also at two to four times higher risk of developing cardiovascular disease (NIDDK, 2007), recognized as the leading cause of death in the country. Along this increased risk of diabetes and the marked increase in the risk of obesity, is the presence of poverty and food insecurity amid Latinos.

It is important to note that the majority of the national data measuring prevalence of overweight and obesity, as well as in scientific findings, the Mexican American subgroup is overrepresented. While national data and research findings are used to note
trends among Latinos, they do not reflect the full diversity continuum of this population in the U.S. It is the responsibility of the nutrition provider to gain knowledge of the racial, ethnic, and religious background of the community they serve.

**Overview of Latino dietary practices**

Just as Latinos have altered the American cuisine, American culture has also altered the Latino diet. As with many other migrant groups in the U.S., the lifestyle of Latinos is undergoing a transition away from traditional values and customs of their ancestry as they begin to adopt the values and behaviors of their adopted country. With regard to health behaviors, the process of acculturation is typically characterized by a more sedentary lifestyle and changes in dietary patterns (Abraido-Lanza et al., 2005; Kaiser, 2007). Evidence of the effects of acculturation on the Latino diet show that Latinos who continue to use Spanish as a primary language eat somewhat more healthful diets than those who use English as a primary language (Aldrich, 2000). These healthier food choices include lower consumption of fat, saturated fat, and cholesterol. Interestingly, additional analysis of the data revealed that these dietary differences did not appear to be the result of greater nutritional knowledge or greater awareness of food-disease relationships. Higher retention of traditional practices such as home cooking, are believed to be the reason for these dietary differences.

Dietary differences appear to be attributed to the degradation of diet quality that occurs as Latinos become acculturated into the mainstream U.S. population may occur in the context of improvements of economic status. For instance, Guendelman and Abrams (1995) reported that first-generation Mexican-American women, despite of lower socioeconomic status than second-generation Mexican American or non-Hispanic white
women, tend to have higher intakes of protein, vitamins A and C, folic acid, and calcium than these other groups. The authors concluded that the diets of second-generation Mexican American women more closely resemble those of non-Hispanic white women of similar socioeconomic status.

Regardless of the heterogeneous ancestral backgrounds of Latinos, many still retain core elements of the traditional diet. The Latino Nutrition Coalition, describes traditional dietary practices as customary food preparation and family meals with a reliance on grains and beans, fresh fruits and vegetables. Depicted in figure 2, The Latin American Diet Pyramid developed by Oldways, embodies a fine representation of traditional Latin lifestyle, and foods. This pyramid was developed with the intention to provide the basis for preservation and revitalization of modern American lifestyle with Latin traditions that contribute to health in addition to wellbeing. In other words, by capitalizing on traditions it promotes the integration of both cultures for healthier Latino dietary practices.

How do diversity, cultural competence and nutrition relate?

Efforts to reduce the burden of health disparities have demonstrated that lifestyle interventions such as diet and moderate physical activity have a significant public health impact in reducing chronic disease risk (Jacobs-van der Bruggem et al., 2007; Berg and Wadhaw, 2002; DPP, 2002). Much of the increased risk of diabetes experienced by Latin Americans is believed to be attributable to the changing lifestyle that accompanies the acculturation process. Consequently, change in quality of the diet and the adoption of a more sedentary lifestyle result higher obesity prevalence (Kaiser, 2007; Ogden C, 2006).
These trends, in addition to an escalating poverty rate, are occurring across all segments of vulnerable populations. Though, the extent of the changes related to poverty is more pronounced in some subgroups than others, for example documented versus undocumented. Cultural competent nutrition education is a fundamental constituent of health promotion/disease prevention interventions. The Nutrition Care Process (NCP) is a systematic approach to providing high quality nutrition care. The model consists of four interrelated steps; nutrition assessment, diagnosis, intervention, and monitoring/evaluation, which provide a standardized framework for nutrition providers to tailor individualized plans. Because nutrition interventions involve forecasting the individuals’ or the groups’ clinical risk factors, cultural and religious background, language proficiency and literacy level, health beliefs and values, dietary practices and food access, as well as other information, the NCP facilitates and promotes the conveyance of quality nutrition care using the best available evidence to make decisions.

**Future perspectives for nutrition practice**

Nutrition education is defined by Edelstein as “a process of learning that influences the knowledge, beliefs, attitudes, and behavior of an individual or a community and allows them to make more intelligent decisions regarding dietary choices in order to improve health and reduce the risk of developing chronic diet-related disorders, such as obesity, diabetes, heart disease, hypertension, and osteoporosis” (Edelstein, 2006). The author further suggests that a variety of health professionals can provide nutrition education by studying-nutrition related health problems and interventions, such as organizing and implementing educational programs. Registered dietitians are best suited to lead nutrition education efforts, because they are uniquely
qualified to conduct medical nutrition therapy and counseling. Thus, cultural competency training for registered dietitians as well as for other health providers is increasing in popularity as a response to the vast demand of an increasingly diverse U.S. population.

To confront diversity within the Latino population, comprehensive approaches require input from multiple disciplines and levels. The development and implementation of effective individual and community-wide interventions to increase access to healthcare require policy support from all stakeholders involved in this cause. Dietetic professionals are uniquely prepared to lead health promotion/disease prevention efforts, and can enhance their scope of practice by capitalizing in proficiencies such as use of the NCP, cultural competency and counseling skills, and information technology.

Today, health and nutrition-related diseases are becoming more global, as is the dietetics profession. Along with passion, innovation and creativity, dietetic professionals can become valued players in the national quest of improved health outcomes, and esteemed contributors to the shared desire to ultimately reduce Latino health disparities in the United States.

*Example of an innovative approach to battle hunger and food disparities*

Share Our Strength is a national organization that works to make sure that ‘no kid in America grows up hungry’. Through a network of community groups, activists, the culinary industry and food programs, it is able to surround low-income children and their families with nutritious foods and comforting educational environment. Operation Frontline is one of their nutrition education programs helping low-income families by teaching them how to prepare healthy-low cost meals. Courses are offered in English and
Spanish, and the curriculums are developed recognizing and incorporating culture. This wonderful organization is recognized by the USDA.

Discussion questions

Explain how socio-economic status is associated to Latino health issues and explain how it relates to acculturation.

List 3 differences between Latino subgroups, and explain how they affect health outcomes.

Give an example, such as a case scenario, for each of the four paths described in the Multidirectional Model of Acculturation, and propose strategies to address them.

What questions can you ask a Latino client/patient to help you understand their dietary practices and health beliefs?

How can you become more cultural competent?
APPENDIX

Figure 1.

Figure 2.

The Latino Diet Pyramid created by © 2009 Oldways Preservation & Exchange Trust,
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