

Providing Nutrition Guidance to a Multicultural Population: The Importance of Cultural Competency

An important challenge for today's nutrition professionals is communicating effectively with an increasingly diverse US population. It is well established that culture has a strong influence on an individual's food intake, attitudes and behaviors. Demonstrating multicultural competence requires sensitivity to cultural differences between ourselves and those of different gender, age, religion, race or ethnicity, education or income. For nutrition professionals, this requires knowledge of culturally relevant foods and food habits and the ability to incorporate this into interventions and communications that promote desirable health and behavior changes. Showing knowledge of and respect for an individual's food practices and customs and building a trusting relationship can help nutrition professionals facilitate healthful changes in the eating and exercise patterns of all their patients and clients.

Demographic Trends

The 2000 Census revealed that minorities comprised about 28% of the US population. (Note: This calculation did not include the Commonwealth of Puerto Rico and the US Island Areas.)¹ The following are findings for several population groups: Hispanics accounted for 12.5% of the US population (of this, Mexicans represented 7.3%, Puerto Ricans 1.2%, Cubans 0.4% and other Hispanics 3.6%); African-Americans 12.3% and Asians 3.6%. By 2030, it is projected that these groups will comprise 40% of the population, with Hispanics accounting for almost half of the entire minority population.²

Health Disparities

Not all people living in the US are benefiting equally from advancements in health care. For example, health disparities among racial and ethnic groups may include differences in mortality rates and incidence of chronic diseases, as well as in quality of and access to care. Many circumstances, including socioeconomic or environmental factors, language barriers and/or cultural attitudes regarding medical care, may contribute to these differences.

In the late 1990's, the US Department of Health and Human Services launched a major initiative to eliminate disparities in health as part of Healthy People 2010. The initiative focuses on six of the most important health areas affecting racial and ethnic groups: diabetes, immunizations, HIV/AIDS, cardiovascular disease, cancer and perinatal care. These priorities represent health issues that affect individuals across the life span and account for a significant portion of disease, but that are also

amenable to improvement. Attention to this initiative is key for nutrition professionals because certain dietary changes can be a means to reduce some of these health disparities.

Dietary Acculturation

Immigration to a new country often leads to a substantial shift in a person's lifestyle and environment as he or she becomes acculturated. Some anthropologists define *acculturation*, which includes dietary adaptations, as the exchange of cultural habits that results when groups come into continuous contact. Both cultures change, but each group remains distinct.³

Access to the abundant food supply and adoption of US eating patterns may result in dietary choices higher in protein, fat and/or calories and potentially lower in fruits and vegetables than traditional eating patterns in some other countries. This may result in increased risk for chronic diseases. A recent study suggests that, for immigrants, number of years of residence in the US is associated with higher body mass index beginning after 10 years.⁴ Nutrition professionals can play an important role in the acculturation process by determining the degree to which lifestyle interventions should focus on maintaining traditional healthful eating habits, adopting healthful aspects of eating in America and promoting adequate levels of physical activity to help prevent weight gain and chronic disease.⁵

Multicultural Training

While it may be ideal for health professionals and clients to be culturally matched, evidence suggests most health care providers can learn to address the needs of specific cultural groups.⁶ Health care professionals who receive multicultural training can overcome cultural barriers to treat clients more effectively.

Training may include self-study or a course or workshop on multicultural foods (including selection, preparation and storage), food habits, customs, health behaviors and language, including body language. Training should focus on increasing awareness of the cultural experience and background of those being served. For example, many people in the US may benefit from information on nutrition topics such as serving sizes and reading food labels. Research suggests that developing programs and materials specifically for churches, neighborhood grocery stores and local restaurants is an effective way to reach African-Americans.⁷ Finding appropriate distribution channels within local communities may be a way to deliver culturally relevant nutrition and health information to other consumers, as well.

Eating in America: A Look at Culturally Diverse Populations

The following table highlights some food practices, health issues, dietary concerns and strategies for three key minority groups in the US.⁸⁻¹⁰

Cultural Group	Food Practices	Diet Related Health Issues	Dietary Concerns	Strategies
African American	Traditional foods include: collard greens, other leafy green and yellow vegetables, beans, legumes, rice and potatoes; starches and vegetables are often seasoned with fat, such as bacon, ham hocks or salt pork; meats are often fried or barbecued and served with sauce or gravy; home-baked cakes and pies.	High incidence of diabetes, hypertension, heart disease, obesity and some types of cancer; lactose intolerance	Overall diet may be low in fiber, calcium and potassium, and high in fat and sodium	<ul style="list-style-type: none"> ▪ Encourage continued intake of leafy greens, vegetables, legumes, rice and potatoes. ▪ Offer tips for modifying food preparation methods to reduce fat and sodium. ▪ Encourage increased intake of fruits. ▪ Suggest ways to include low-fat dairy foods.
Asian	Traditional diets vary widely by country and region of origin. Some common elements include: diet largely composed of rice, vegetables and fruits; low intake of dairy foods except for ice cream or some yogurt; protein is primarily from fish, pork and poultry, as well as nuts, legumes and/or tofu; food is prepared by stir-frying, steaming, grilling, deep-frying, baking or boiling.	Some types of cancer, osteoporosis and stroke; lactose intolerance; risk for heart disease, diabetes and obesity increases with dietary acculturation	Overall diet may be low in calcium and high in carbohydrates and sodium.	<ul style="list-style-type: none"> ▪ Encourage continued variety. ▪ Evaluate calcium intake and suggest other food sources of calcium if inadequate. ▪ Provide tips for reducing sodium intake.
Hispanic	Traditional diets vary by country and region of origin. Often the same foods are prepared and/or integrated into meal patterns in different ways. Common elements include: beans, rice, breads and, for some, corn and corn products; protein sources include legumes, eggs, shellfish, fish and a variety of meats and poultry; minimal use of low-fat dairy foods; foods are mainly fried or baked; with acculturation, increased intake of milk, certain vegetables and fruits, fats and sugars.	High incidence of obesity, diabetes, heart disease, hypertension, dental caries and both over and under nutrition	Overall diet is high in fat and low in calcium, iron, folic acid and vitamins A and C.	<ul style="list-style-type: none"> ▪ Preserve healthy cultural food practices, such as continued use of complex carbohydrates. ▪ Suggest modifications of traditional dishes to lower intake of fat and sodium. ▪ Encourage intake of low-fat dairy foods, lean meats, fresh vegetables and fruits. ▪ Reduce intake of soft drinks and sweetened beverages.

Overcoming Cultural Barriers

There is a frequent perception that advice to “eat healthfully” will mean giving up familiar or traditional foods and trying to conform to the eating patterns of the dominant culture. Nutrition professionals are charged with overcoming this barrier, which involves making nutrition communications culturally relevant while assisting individuals in adopting healthful food habits. Often this means adapting nutrition messages and developing flexible approaches for nutrition education and counseling.

Food guidance tools, such as food guide graphics developed or adapted by various countries, organizations or ethnic groups, can be very useful in nutrition communications (see *Resources* section). These education tools recognize ethnic foods and/or various dietary patterns (e.g., vegetarian diets) while demonstrating how the overall diet can be assembled to achieve health goals. Providing practical tips for making small changes in food selection and preparation that allow individuals to retain

food practices from their culture can greatly improve acceptance and the likelihood of positive health behaviors and outcomes.¹¹

In addition to resistance to modifying food habits, there are often cultural barriers to exercise. Health professionals can encourage clients to get recommended amounts of physical activity by assessing their interests and suggesting culturally relevant pursuits. For example, being familiar with local community resources, including classes, events and facilities, is one way to overcome barriers such as cost, language and a sense of unfamiliarity.

Strategies to overcome linguistic and cultural barriers to care can include the use of bilingual providers, bilingual/bicultural community health workers, interpreters and translated print materials.¹² Certain strategies may work best in a particular setting, while others have wide application and can be useful in all settings.

Cultural Competence: Checklist for Nutritional Professionals

This checklist is intended to heighten awareness and sensitivity to the importance of cultural and linguistic competence. If you frequently respond "A" to the statements that follow, you demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within your practice setting.

Select A, B or C for each item listed below:

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

___ I display pictures, books, brochures, posters and use videos, films or other media resources that reflect the cultures and ethnic backgrounds of clients that I serve.

___ I ensure that printed information takes into account the average literacy levels of individuals and families receiving services.

___ When interacting with individuals and families who have limited English proficiency, I keep in mind that limited English fluency is in no way a reflection of people's intellectual functioning or ability to communicate effectively in their language of origin.

___ For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them.

___ I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

___ I understand and accept that family is defined differently by different cultures and ethnic groups, and respect that male-female roles may vary significantly among different cultures and ethnic groups.

___ I understand that customs regarding touching, gestures, eye contact and spatial relationships vary tremendously among cultures, and I attempt to send nonverbal messages consistent with my verbal messages.

___ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and support that impacts their lives.

___ I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures, and that religion and other beliefs may influence how individuals and their families respond to illness, disease and death.

___ I keep abreast of the major health concerns and issues, including socio-economic and environmental risk factors that contribute to health disparities, and/or major health problems, for ethnically and racially diverse client populations residing in the geographic locale that I serve.

___ I am well versed in the most current and proven practices, treatments and interventions for major health care problems among ethnically and racially diverse groups.

___ I take part in professional development and training to enhance my knowledge and skills in the provision of services and support to culturally, ethnically, racially and linguistically diverse groups.

Adapted from:

Goode TD. Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health Care Services. National Center for Cultural Competency, 2002. Available at: <http://gucchd.georgetown.edu/nccc/nccc11.html>. Accessed December 12, 2004.

References

1. US Census Bureau. Overview of race and Hispanic origin. Available at: <http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf>. Accessed December 11, 2004.
2. Collins, Hall, Neuhaus. U.S. Minority Health: A Chart Book, 1999.
3. Kottak CP. Cultural Anthropology. New York: McGraw-Hill Inc. 1994.
4. Goel MS, McCarthy EP, Phillips RS, Wee CC. Obesity among U.S. immigrant subgroups by duration of residence. *JAMA*. 2004; 292:2860-7.
5. Satia-Abouta J, Patterson RE, Neuhaus ML, Elder J. Dietary acculturation: Applications to nutrition research and dietetics. *J Am Diet Assoc*. 2002; 102:1105-18.
6. University of Florida. Cultural training increases competence of nonminority psychologists. January 21, 2004. Available at: <http://www.namimass.org/news/news04/ad0201c.htm>
7. James DC. Factors influencing food choices, dietary intake, and nutrition-related attitudes among African Americans: Application of a culturally sensitive model. *Ethn Health*. 2004 Nov; 9(4):349-67.
8. Kittler PG, Sucher KP. Food and Culture in America: A Nutrition Handbook. Albany, NY: West/Wadsworth Publishing, 1998.
9. The American Dietetic Association. American Diabetes Association. Ethnic and Regional Food Practices: A Series (Soul and Traditional Southern, Mexican American, Chinese American). Chicago: American Dietetic Association, 1995-98.
10. Ohio State University Extension. Fact Sheets: Cultural Diversity: Eating in America: African-American, Asian, Mexican-American. Available at: <http://ohioline.osu.edu/hyg-fact/5000/>. Accessed December 13, 2004.
11. Painter J, Rah JH, Lee YK. Comparison of international food guide pictorial representations. *J Am Diet Assoc*. 2002; 102:483-9.
12. HHS Fact Sheet: Eliminating Minority Health Disparities. The Initiative to Eliminate Racial and Ethnic Disparities in Health. U.S. Department of Health and Human Services. <http://www.omhrc.gov/rah/index.htm>. Accessed December 13, 2004.

Additional Resources

- The American Dietetic Association. Diversity Resource List—Food Guide Pyramids. http://www.eatright.org/Public/85_20351.cfm.
- Stein K. Cultural literacy in health care. *J Am Diet Assoc*. 2004; 104:1657-9.
- Food and Nutrition Information Center, U.S. Department of Agriculture. Cultural and Ethnic Food and Nutrition Education Materials: A Resource List for Educators. August 2001. <http://www.nal.usda.gov/fnic/pubs/bibs/gen/ethnic.html#11>.
- Food and Nutrition Information Center. U.S. Department of Agriculture. Ethnic/Cultural Food Guide Pyramids. <http://www.nal.usda.gov/fnic/etext/000023.html>.
- Healthy People 2010. U.S. Department of Health and Human Services. <http://www.healthypeople.gov>
- Multicultural Health Clearinghouse. University of Illinois at Urbana-Champaign. <http://www.mckinley.uiuc.edu/multiculturalhealth/index.html>.
- National Center for Cultural Competence. <http://gucchd.georgetown.edu/nccc/>.