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Targeting Minority Groups in Community Nutrition

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by

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INTRODUCTION

A community nutritionist takes on the immense task of "improving the nutrition, and . . . health of individuals and groups within communities" (1). These objectives are generally met by private sector sponsors such as health care facilities, work-site wellness programs and food banks. If the arena of public health is included, then the dietitian's scope is enlarged to include federally-funded agencies designed to improve public health and disease prevention (1). Skills required of these community dietitians not only include clinical knowledge and assessment skills, but marketing, education, and research competencies. The challenges of community nutrition range from counseling an individual on a gluten-free diet to investigating the dietary patterns of an ethnically-diverse population. The variety of having to shift from the specific scope of an individual's needs to the epidemiologic patterns within the state or country not only is one of the most difficult aspects of this career, but the most charming trait as well.

The U.S. Census Bureau reported that in 1990, minorities comprised 27% of the nation's population. One third of this minority population was of Hispanic origin and comprised 8.8% of the total U.S. population (2). They now form the second-largest and fastest growing minority group in the United States. Although African-Americans currently compose the largest minority group, the Hispanic segment is growing at such an accelerated rate that by the 21st century this group will have surpassed the African-

American population in size (3). By the year 2025, it is projected that the Hispanic population will double in California and be substantially larger in all areas of the country (2). Ramifications of such population shifts are bound to be felt in every business and professional sector. The field of nutrition is no exception. Community nutritionists throughout the country must keep abreast of minority projections such as these, and act accordingly to better serve all community residents.

In order to achieve the goal of health promotion and disease prevention through community nutrition, dietitians must be able to define the nutrition-related problem specific to their community and then conduct a needs assessment (1). These steps will be outlined with specific application to targeting the Hispanic population using the case study of the Cache Valley Community Health Clinic as an example.

DEFINING THE PROBLEM

Similar to the action of a catalyst in a chemical reaction, some type of stimulus must instigate the nutrition evaluation process in a community setting (1). The importance of this stimulus lies not in its specific identity but in its mere existence. Whether the catalyst be published research results, feedback from individuals, or first-hand observation of a need or problem, the effect is the same: it motivates action. The first step to be taken in this action is a formal definition of the problem. In Logan, Utah, the coordinated dietetics program director became aware of the existence of a non-profit, volunteer-operated community health clinic that was not yet providing any type of nutrition education to its clientele.

Through further research, it became apparent that the participants of this clinic must be uninsured to qualify. Many of the clients belong to the low-income portion of the population with Hispanic individuals making up the majority. Because certain high-risk nutrition states such as obesity and hunger are more prevalent in Hispanics when compared to non-Hispanics (4,5), access to nutrition education would be greatly needed in this group. Although the WIC program continues to be remarkably effective in providing nutrition intervention and education to low-income women and children through age five (6), there is a lack of nutrition-based programs for the men, older children, adolescents and elderly in this category. In most cases, this clinic was the sole source of health care for these individuals. Subsequently they had little or no access to a source of reliable nutrition information. Thus, the problem was identified as a lack of access to nutrition information specifically for clients of this community health clinic.

COMMUNITY NEEDS ASSESSMENT

Identifying the relevant characteristics of community can be accomplished by defining the following: 1) purpose and goals of the assessment, 2) sources of information, 3) the community, and 4) the target group within the community (1).

Purpose and Goals

The purpose of the needs assessment was to increase the amount of nutrition information available to the public and subsequently improve the health of the community. Goals included: 1) greater access to reliable nutrition information for at-risk groups, 2) provision of nutrition education to CVCHC participants, and 3) improve the health of the target population through preventive nutrition measures.

Informational Resources

Gathering data from a variety of sources will enable the dietitian to effectively conduct a community assessment. Sources such as websites for Centers of Disease Control and U.S. Census not only contain valuable information, but also provide links to other relevant sources. Local home pages for the area may list some helpful information, however, the Chamber of Commerce and the office of Workforce Services can provide much more detailed information.

The Community

A community can be defined by geographical area such as a county, or common characteristics such as school-age children, or Hispanic immigrants. In this case, the Cache Valley Community Health Clinic (CVCHC) helped define the community through its established regulation of serving only Cache Valley residents. Relevant characteristics of the community should be researched to better understand the background and context of the potential nutrition intervention recipients.

General demographics for Cache Valley revealed that in 1994, 8% of the population belonged to a minority group, with a further breakdown of 3.6% Hispanic, 2.9% Asian and Pacific Islander, 0.8% American Indian, and 0.3% Black (7). As of 1990, the elderly population was slightly lower at 10% than the U.S. average of 13%, while those under 18 years Cache Valley made up 36% of the population whereas the U.S. average was 26% (7). Also, the average household size for this community was 3.29 persons in comparison to the nation's average of 2.63 persons per household (7). A greater percentage of individuals over 25 had completed high school and attended 4 or more years of college when compared to the U.S. average (7). Although the poverty rate

in Cache Valley was similar to the national rate, per capita income and median household income was substantially lower than the nation as a whole (7).

The Target Population

This community-specific information should be used to narrow your objectives to a specific target population. The participants of the CVCHC were selected as the target population, due to the lack of nutrition education offered to this group. In addition, the Hispanic population was selected as a particular target subset. For information regarding the ethnicity of clinic participants, see Figure 1. Risks specific to your target population should be researched, enabling the nutritionist to tailor the education for relevancy to the group.

Figure 1. Ethnic Profile of Clinic Participants

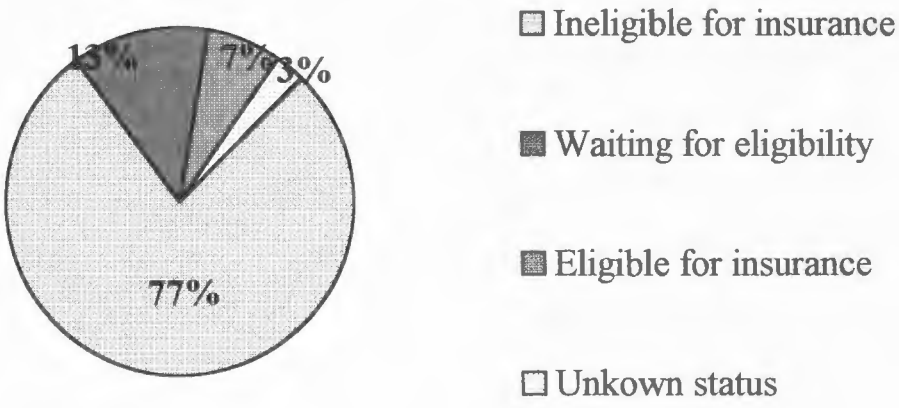
Regulations of the CVCHC mandated that university students were excluded from clinic participation due to the availability of student health services on campus. This non-student characteristic increases the nutrition risk of the group since the rate of certain

nutrition-related chronic illness is higher in non-students compared to those having received a college education (8). Individuals that did not attend college have also been found to show less response to health promotion messages (8) which provides an extra challenge for the dietitian. This correlation between higher education and healthier diets may be further explained by the fact that lower education levels indicate decreased financial resources and limited food-related skill such as cooking and shopping (9). For individuals with low incomes, nutrition or a healthy diet may not be a high priority due to other more pressing concerns (9).

For the Hispanic subset of this target population, many of the aforementioned risks are intensified. Hispanics are the second poorest minority in the U.S. and thus have less resources available for nutrition products and services (3). Of all minority groups, Hispanics have the least access to health care and are the least insured (3). Information from the 1993 Arizona Women's Health Survey (10) found that 32% of Hispanic women couldn't afford medical services compared to 13% of non-Hispanic women, and rates of uninsurance in Hispanics were double that of non-Hispanics (10). Ironically, this population has the greatest needs for such services since they are at greater risk for health problems than the general population (3). Risks related to low income and low education are of more concern in this minority since level of education achieved and income rates are lower than the general population (2).

Another defining characteristic of the target group arises from the clinic regulation of serving *only* uninsured persons. While the majority of participants do not have insurance, there are those which are either waiting to be eligible for insurance, or choose not to accept the insurance plan offered (see Figure 2).

Figure 2. Insurance Status of Clinic Participants



In cases where the individual is eligible but chooses not to accept insurance, they are seen that day only and are informed they will be unable to visit the clinic due to their eligible status. An uninsured status implies little or no contact with health professionals including dietitians. The brief visits of these individuals at the clinic provide a unique opportunity to increase nutrition awareness and answer any food or nutrition questions they might have.

CVCHC ACTION PLAN

As mentioned earlier, something must stimulate the awareness of a problem within the community. Likewise, simply labeling the problems and needs of your community is merely the beginning. A community needs assessment must in turn serve as a catalyst of action to arrest the community problem and reverse its detrimental effects.

Out of approximately 100 volunteers at the time of this assessment, there were no nutrition professionals contributing service (see Table 1).

Table 1. Volunteer Profile of CVCHC

Type of volunteer	**Number participating at CVCHC**
Physicians	35
Dentists	10+
Nurses	20+
Clerical:	27+
Interpreters	14
Clerks	7
Receptionists	6
Total:	**92 +**

The obvious first step was to make a nutrition presence known and obvious at the clinic. After proper permission was obtained, junior dietetic students from USU began to provide nutrition education once each week at the clinic. The process has evolved from informal interviews in the waiting room, to the development of a screening tool in English and Spanish that is given to each patient to fill out when they sign-in. This questionnaire is constantly under revision as more input is gained from students and patients alike.

As part of their community nutrition experience, the dietetic students are also encouraged to formulate an education material to be used as a handout at the clinic. This facilitates the counseling sessions normally held with the patient in the waiting room or

exam room while waiting to see the doctor. The majority of information provided deals with the food guide pyramid, 5-a-day, feeding toddlers and teens, and weight loss. Many individuals enjoy learning more about food and their health and welcome the opportunity to speak with a nutritionist. Although the nutrition education program at the CVCHC has a long way to go and a lot of evolution ahead, it has provided benefits to the students as well as the clientele.

APPLICATIONS

There is a great need to increase the availability and clarity of nutrition education to all individuals regardless of health, ethnic, or financial status. As the nation moves health care toward prevention, this need increases steadily. In addition, as our "melting pot" society becomes more diverse, the challenge of disseminating correct information to all sub-groups of the populous increases in importance. When community nutritionists take a proactive role in identifying the problems and assessing their communities, action will follow. It is imperative that every dietitian evaluate his/her role and influence in the community whether it be passive or proactive. In every area of the country, programs need to be proposed, implemented and continually evaluated. Dietitians are equal to the task of positively shaping this country's food and health choices. It is only through grassroots nutrition via community efforts nationwide, that effective health promotion and disease prevention will occur.

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