

## African Americans and Diabetes — Educate to Eliminate Disparities Among Minorities

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Educate is the operative word here—educate not only your patients but also yourselves, recognizing African Americans' barriers to proper care and learning ways to best help them overcome these obstacles.

Compared with the general population, African Americans are disproportionately affected by diabetes. Specifically, they are 1.6 times more likely to have type 2 diabetes than non-Hispanic whites.



While there are no definitive answers as to why this is, in 1962, geneticist James Neel hypothesized that a gene that once helped African Americans survive periods of starvation was contributing to the diabetes epidemic among that population. This so-called thrifty gene may have enabled African ancestors to store more fat and use energy more efficiently when food was scarce. But the idea is that today, without that “feast or famine” cycle, the body still efficiently stores fat. Other reasons for the disproportion may include the increasing obesity rate among this population and other genetic risk factors.

Regardless of the reasons, the fact is that nearly 15% of all African Americans aged 20 and older—approximately 3.7 million people—have been diagnosed with diabetes. African Americans also may be more likely to experience diabetes-related complications. For instance, according to the American Diabetes Association, this group is 2.7 times as likely to have lower limb amputations and 2.5 to 5.6 times as likely to develop kidney disease, with more than 4,000 new cases of end-stage renal disease (ESRD) each year. Mari Somerville, RD, who works for DaVita, a dialysis company in California, says, “I work with a largely inner-city population, and ethnic minorities make up the majority of my patient population, with African Americans being the largest minority group. Most of my patients develop ESRD as a result of uncontrolled or untreated diabetes or hypertension.”

Somerville says her patients' limited access to information and care, as well as their lack of financial resources, is a large part of the problem. “Many of my patients don't even know what kidney failure is,” she says. “It's such a gradual and slow process that they don't realize what's

happening. And since they aren't getting regular, or any, treatment, it's often too late when they're finally seen."

Somerville says the solution is early education, and the first step is knowledge for the educator. "A lot of educators know a lot about blood sugar, cholesterol, and related dietary changes, but they don't know a whole lot about kidney function," she says. "Educating the educators is important. Diabetes educators should really understand kidney disease and how it can be prevented."

Focusing education on the feet is also important to prevent additional complications, adds Barbara Capozzi, DO, clinical systems coordinator for Touro College of Osteopathic Medicine and a certified nutrition specialist. Because diabetes can cause peripheral polyneuropathy and eliminate sensation in the feet, small problems such as ill-fitting shoes can be big problems for those at higher risk. "Even just a tiny break in the skin can end up leading to an amputation if it's not cared for right away," says Capozzi. "Patients need to know the importance of these seemingly small, everyday problems. Educate them to cut their toenails straight across, avoiding any jagged cuts that could potentially break the skin. Small steps like this can lead to prevention."

### Rethinking the Food Pyramid

Diet changes, of course, are a major component of preventing or managing diabetes. But one of the bigger challenges that diabetes educators may face when working with clients of a different ethnic background is being understanding of and sensitive to food preferences. People may include certain foods in their diet for cultural reasons, and clients may be unwilling to forgo them. "Clients trying to fix their diet but also stay true to their cultural values is one of the biggest challenges," says Maria Collazo-Clavell, MD, a specialist in the Mayo Clinic's division of endocrinology, metabolism, diabetes, nutrition, and internal medicine and the medical editor-in-chief of Mayo Clinic: The Essential Diabetes Book. "The diabetes educator not only needs to educate but be educated. They need to learn more about what's in these meals and how they can be improved while still allowing that client to maintain their cultural background."

That is the primary reason why Roniece Weaver, MS, RD, LD, author of four soul food cookbooks and founding partner and executive director of Orlando, Fla.-based Hebni Nutrition Consultants, Inc, a nonprofit organization, helped develop the original Soul Food Pyramid. This revised version of the traditional pyramid is a culturally sensitive food guide. "It's not only helped consumers but also many healthcare providers," she says. "It's especially helped dietitians who don't look like me but have a population of clients that do. When their clients see the Soul Food Pyramid, they really get it, and it gives the dietitian more leverage to help that client change their eating habits."

Constance Brown-Riggs, MEd, RD, CDE, CDN, author of *Eating Soulfully and Healthfully With Diabetes* and owner of CBR Nutrition Enterprises in Massapequa, N.Y., also uses a revised food pyramid that she calls the Diabetes Soul Food Pyramid. "So many of the African American clients I saw would make comments that they don't see any traditional foods from the South on the regular food pyramid," she says. "These southern foods are ones they are used to preparing, like collard greens, chitterlings, or ham hocks."

As a result of those observations, Brown-Riggs created her own food pyramid with diabetes patients in mind. By incorporating traditional foods that many African Americans are accustomed to preparing, she says her clients are able to better understand which foods are very high in fat and which food group they would fall under. Once clients are better educated about what they're eating, Brown-Riggs says she helps them with healthy substitutes. "It's really a matter of the food preparation that needs to change," she says. "For instance, with collard greens, I suggest using smoked turkey breast, which has less fat. Of course, for some of the highest fat items, it may mean limiting those foods to special occasions only."

The benefit, says Brown-Riggs, is that making an effort to work with clients' food preferences makes them more likely to adhere to a new diet plan. Simply instructing clients to give up certain foods, especially those with cultural links, may dissuade them from even attempting to make changes. Weaver agrees: "Instead of making your clients feel like you're just taking everything away from them, those clients will understand you're just trying to give them some healthier alternatives. It's a much more effective approach to the situation."

Brown-Riggs offers a caution when using educational tools such as a soul food pyramid. While recognizing food differences is crucial, don't be too quick to make assumptions, or you risk alienating your clients rather than connecting with them. "You can't lump all African Americans together and just assume you know what they eat," she says. "Just like you can't assume your clients eat foods from the traditional food pyramid, you can't assume they eat soul foods either. Some African Americans may be from the Caribbean and eat traditional foods from their homeland. Or maybe it's a client that was raised in the South but eats foods that are from the Caribbean. The bottom line is that you really can't assume anything. Instead, go into it with questions, and take the time to figure out what your client's diet is really like."

And once you see how your clients are eating and what they are willing to substitute, it'll be easier to take action and come up with effective changes. "Many African Americans eat too much meat, so it's important to focus on portion control," suggests Weaver. "That's why Hebni Nutrition Consultants developed the Hand Jive method. It teaches people how to eat with their hands, using their hands as a way of measuring sizes. Meat should be no larger than the size of the palm of your hand, butter should be the size of your thumbnail, and a piece of cheese should be no larger than the size of your thumb."

#### Addressing Other Barriers to Care

Of course, food preference is not the only barrier to care for African Americans and other minority groups. Other barriers include language and communication differences. If the patient and healthcare provider speak a different language or have a strong dialect on either end, information could be poorly communicated. "For instance, I'm African American, but my doctor may be Indian," says Weaver. "A doctor with a strong dialect may be a barrier for some patients."

"Communication barriers could also include health literacy," she continues. "When dealing with handouts, literature, or even a prescription, someone with a lower level of literacy may not understand what they're supposed to do."

For some minorities, transportation is a potential barrier. How easily can they get to a physician or a nutrition specialist? Even if they are getting care, access to available resources could also be an issue that prevents them from following the healthcare provider's advice. "If you tell a patient they have to be more physically active, take the time to find out if they have exercise equipment or access to a gym," says Collazo-Clavell. "Otherwise, you might be giving them recommendations that are not doable. You don't want them to walk out the door feeling like the plan they've been given is something they can't do. So maybe you need to come up with some physical activities that don't require equipment, or be aware of local community centers you can recommend that don't require a fee. Open options for your patients so they can feel like they can succeed."

Keeping the recommendations realistic is key, adds Capozzi. If your clients are unwilling to make a drastic change to their lifestyle, suggest some ways to modify what they already do. "If it's a client that eats at fast-food restaurants a lot—whether it's because it's cheap or because it's convenient—then give them some of the healthy choices they can make there," says Capozzi. "For instance, McDonald's has a fruit and yogurt parfait that's pretty affordable and definitely a healthier choice."

Diabetes educators and dietitians can also overcome barriers of access to care by making their services more available. Weaver says that Hebni Nutrition Consultants has brought its services to communities that may have otherwise lacked access to nutritional information and care. Since 1995, she and her partners at Hebni have been organizing a health seminar called "Sisters: Take Charge!" which presents practical information about eating healthy foods in an ethnically comfortable setting. Two hundred African American women attended the first seminar, and the numbers continue to rise each year, with more than 1,500 women attending more recent seminars.

Weaver also reports that she's about to open a brand-new office, including a kitchen, where she can teach people how to cook soul food in a healthy way. It will also include an Internet corner where people can access free health information. "We're basically bringing the education to the neighborhood," she says. "It will be hands-on learning that even includes cooking instruction. And it's in a Florida zip code that has one of the highest rates of diabetes, heart disease, and obesity. By implementing this facility, we're taking away the excuses. This neighborhood may not have had access to a dietitian in the past, but now that I'm here, I'll tell them there's no excuse not to make those necessary changes."

Early intervention is vital, adds Somerville. "The first time patients are getting a thorough diabetes education shouldn't be when they wind up in a dialysis center and have already suffered complications," she says. "Often, doctors don't refer patients to a nutritional professional soon enough, even if they are in the early stages of a condition like diabetes. So make yourself available—whether that's doing events in a grocery store or participating in local health fairs, community centers, or churches. Bring education to the people who need it most. Don't wait for them to come to you."

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