

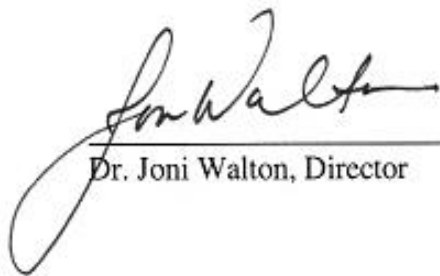
Nutrición Para La Vida

Sarah J. Potucek

Carroll College

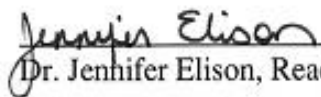
Signature Page

This thesis for honors recognition has been approved for the Department of Nursing and the Honors Scholars Program at Carroll College.



Dr. Joni Walton, Director

March 30, 2012
Date



Dr. Jennifer Alison, Reader

March 30, 2012
Date



Dr. Christopher Fuller, Reader

March 30, 2012
Date

Table of Contents

Signature Page.....2

Table of Contents.....3

Acknowledgements.....4

Dedication.....5

Abstract.....6

List of Figures.....7

Chapter I.....8

Chapter II.....20

Chapter III.....31

Chapter IV.....35

Chapter V.....44

Appendix.....51

References.....57

Acknowledgements

I am grateful to the volunteer participants in this research study for their willingness to share their insights into the world of nurses working with Latin American immigrants. Without graciously donating their time and insights, I could not have completed this honors thesis.

Additionally, I am sincerely grateful to Dr. Joni Walton. Dr. Walton's position as director of my honors thesis impacted not only the success of my honors thesis but also the enlightenment I gained as a researcher. I also thank my readers: Dr. Jennifer Elison, Chair of the Department of Nursing and Dr. Christopher Fuller, Director of the Honors Scholars Program. Their assistance was immeasurable throughout this multi-step research project. I would also like to express gratitude to Joan Stottlemeyer for her editorial assistance, which was crucial for the completion of my honors thesis. Lastly, I am grateful to Professor Alexis Rincón. *Gracias por alentarme a estudiar en el extranjero en la República Dominicana y apoyarme para terminar mis estudios de español. ¡Su familia se ha hecho mi propia familia latina en el Colegio de Carroll!*

Finally, I would also like to express my heartfelt gratitude and love towards my family for being supportive throughout this research project. This thesis is also in honor of my grandma who encouraged me to attend Carroll College; without her mentorship and friendship I would not be who I am today. My father has also played an instrumental part in supporting my academic pursuits and professional goals. I would also like to thank my fiancé, Don, for his unending words of encouragement, laughter, and love. I am so blessed to be marrying such a caring, compassionate, and loving person!

Dedication

I dedicate this thesis to my father, Edward. My father's love and support have allowed me to achieve success in so many ways. He has supported me through all of my passions in life: 4-H, traveling abroad, and volunteer service. One of my favorite memories as a child is sitting on our front porch, watching the summer sunset over the Snake River, talking about life. My dad and I would sit together for hours, sharing our family history, my future plans, and the world around us. My father has been the most amazing advisor a child could ask for on this life journey. I am deeply blessed to have a father who is my supporter, my mentor, and now, in adulthood, has become my dearest friend. Thank you, Dad, for your selfless love and dedication.

Abstract

The purpose of this research study was to explore the challenges faced by nurses working to enhance the nutritional status of Latin American immigrants working in Montana and Idaho. Classic grounded theory with constant comparative analysis was utilized to collect, code, and analyze the data. Three nurses working with Latin American immigrant populations in Montana and Idaho were interviewed regarding their perceptions of the challenges faced while working to enhance nutrition for Latin American populations. The core category of this study is *nutrición para la vida* with four supporting categories: living in poverty, overcoming language barriers, promoting healthy lifestyles, and eating nutritional ethnic foods. The findings of this study suggest that nurses believe that it is vital for this population to achieve and maintain a healthy nutritional status. The findings also suggest that nurses play an important role in providing culturally appropriate care to Latin American immigrants. This study provides an understanding of the challenges nurses encounter when providing nutrition education to Latin American immigrants working in Montana and Idaho.

List of Figures

See Appendix A: Figure 1.1 for an illustration of the challenges nurses encounter while trying to achieve *nutrición para la vida* for all of their Latin American immigrant clients.

CHAPTER I

Background

Over 27 percent of the Latin American immigrants and their children live in poverty. In 2008, the median income of Latin American immigrants living in the United States decreased by 66 percent, putting children of Latin American immigrants into the highest level of poverty, surpassing all other minority groups (Lopez & Velasco, 2011). The nutritional status of families living in poverty is a major concern to nurses who work to eliminate health disparities. The mission of the Office of Minority Health & Health Disparities of the Centers for Disease Control (CDC) “aims to accelerate the CDC’s health impact in the U.S population and to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified to be at-risk for health disparities” (2009, para. 1). Latin American immigrants are included in the vulnerable population, as defined above, based on financial status, language barriers, immigration status, health care access, and marginalization (Derose, Escarce, & Lurie, 2007).

In a partnership between the Office of Minority Health and Health Disparities of the Centers for Disease Control and the Healthy People 2020 government program, an action plan to reduce racial and ethnic health disparities has been established. The Department of Health and Human Services has selected six areas in which minorities experience health disparities. Cardiovascular disease, diabetes and immunizations were included in this list of six health disparity areas (CDC, 2009). As a result of the identified health disparity areas, “eliminating racial and ethnic disparities in health will require

enhanced efforts at preventing disease, promoting health and delivering appropriate care” (CDC, 2009, para. 4). Nutrition is vital to the prevention of illness and the promotion of wellness and will be the focus of this thesis.

Latin American Population in the United States

As of 2010, the U.S. Census Bureau estimated that there were “roughly 50.5 million Hispanics living in the United States, representing approximately 16.3 percent of the U.S. total population” (CDC, 2011a, para. 5). This is the largest minority population in the United States. To date, the United States has received more than 42 million immigrants from Latin America (U.S. Census Bureau, 2006). In addition, 20 percent of all children living in the United States between the ages of 1 and 5 have immigrant parents. For the purpose of clarification, the terms Hispanic, Latino and Latin American immigrants are defined as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race” (CDC, 2010a, para. 3). This thesis uses these terms interchangeably.

The total population in the United States increased by 13.2 percent from 1990 to 2000 while the Latin American population in the United States increased from 22.4 million to 35.3 million, which was a 57.9 percent increase (U.S. Census, 2001). Since 2000, the Latin American population has grown by 15.2 million individuals. This is a 43 percent increase in Latin Americans living in the United States since 2000 (U.S. Census, 2010). The U.S. Census Bureau reported that this increase accounted for “over half of the 27.3 million increase in the total population of the United States” (U.S. Census, 2010, p. 3). It is projected that by 2020, the Latin American population in the United States will reach an estimated 60.4 million individuals (Pew Hispanic Center, 2005). In addition,

there was a steady increase in the numbers of Latin Americans living in Montana from 2000 to 2009 (Pew Hispanic Center, 2011a).

Latin American Population in Montana

Currently, Latin Americans make up three percent of Montana's total population (Pew Hispanic Center, 2011a). In 2009, there were more than 28,000 Latin Americans living in Montana. Since the 2000 census, Montana has had a 58 percent increase in its Latin American immigrant population (*New York Times*, 2010). The Montana Latin American population accounted for more than half of Montana's non-English speakers (Pew Hispanic Center, 2011a).

The Montana Migrant Health Program reported that there were approximately 10,400 Latin American transient workers in Montana. Transient workers are also known as "migrant farmworkers." The Montana Migrant Health Program provides services to approximately 6,000 of its target population annually. According to the Montana Migrant Health Program (2011), it is difficult to provide healthcare to its target population of 10,400 for the following reasons:

The majority of our patients have poor housing or lack of housing, no running water or contaminated water sources, no money or insurance to pay for expensive medications and lack of transportation even though they may live in some of the most isolated locations. Often patients have no telephone, may move frequently and yet have to be kept in contact with and may not be able to comply with referral provider instructions because of language or cultural differences. (para. 5)

The various obstacles to healthcare delivery described above directly affect the healthcare of the transient seasonal Latin American migrant workers in Montana.

Latin American Population in Idaho

In comparison to Montana, Idaho has a much larger Latin American population. In 2009, there were 165,192 Latin Americans living in Idaho. This is an increase from the report of the 2000 census indicating 100,271 Latin American immigrants residing in Idaho. The Latin American population in Idaho is currently at 11 percent, a 73 percent increase from the 2000 census (*New York Times*, 2010). In addition, 34 percent of the Latin American population in Idaho does not have health insurance, and 34 percent of Latin Americans in Idaho live in poverty (Pew Hispanic Center, 2011b).

The main objective of the Idaho Partnership for Hispanic Health (2011) is to “decrease the risk of health disparities experienced by Hispanics in Southwest Idaho” (p. 1). Similar to Montana Migrant Health Program, Idaho Partnership for Hispanic Health assists in providing healthcare access to Latin American immigrants in Idaho. The mission statement for the Idaho Partnership for Hispanic Health contained the following statement:

The Idaho Partnership for Hispanic Health will research interventions to reduce health disparities experienced by the Hispanic population, particularly those identified as Mexican American. A community-based participatory research (CBPR) approach will meaningfully involve the Hispanic community in all phases of project partnership building, assessment, intervention design and implementation, evaluation, and communication of results. (Idaho Partnership for Hispanic Health, 2011, p. 1)

The Idaho Partnership for Hispanic Health works alongside Latin Americans in the community to develop programs and interventions that are sustainable and effective. This

program is a partnership and was developed by the Hispanic community. Adapting to new cultures and customs is challenging, and programs such as the Montana Migrant Health Program and the Idaho Partnership for Hispanic Health assists in transitioning to the healthcare system in the United States.

Latin American Poverty Rate

The current rate of poverty is 26.6 percent of the total Latin American population living in the United States (National Poverty Center, 2012, para. 10). This is the second highest poverty rate in an ethnic subgroup in the United States. According to the National Poverty Center (2012), “In 2010, 19.9 percent of foreign-born residents lived in poverty, compared to 14.4 percent of residents born in the United States. Foreign-born, non-citizens had an even higher incidence of poverty, at a rate of 26.7 percent” (para. 12).

Lopez and Velasco of the Pew Hispanic Center (2011) reported, “More Latino children are living in poverty—6.1 million in 2010—than children of any other racial or ethnic group. This marks the first time in U.S. history that the single largest group of poor children is not white” (para. 2). Lopez and Velasco continued to state, “Of the 6.1 million Latino children living in poverty, more than two-thirds (4.1 million) are the children of immigrant parents” (2011, para. 4). The U.S. Census Bureau measured poverty on family size and income. The levels of poverty are defined by an income threshold depending on family composition and the Consumer Price Index (Lopez & Velasco, 2011).

Nutritional Status and Health Disparities

According to the Centers for Disease Control and Prevention (CDC), “among Hispanics in 50 states and DC, the prevalence of obesity ranged from 21.0 percent to 36.7 percent, with 11 states having an obesity prevalence of ≥ 30 percent” (2011a, para. 3).

The terms overweight and obesity are “labels for ranges of weight that are greater than what is generally considered healthy for a given height. These terms also identify ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems” (CDC, 2010b, para. 1). In addition, many Hispanics lack healthcare insurance. According to the Centers for Disease Control and Prevention (2011), “private health insurance coverage among persons under age 65 was only 37.3 percent for Hispanics/Latinos in 2009, compared to 73.3 percent for non-Hispanic whites and 63.3 percent for the total population” (para. 11). Without health insurance, accessing healthcare and maintaining a healthy lifestyle can become difficult. A 2009 study conducted by Harvard Medical School and Cambridge Health Alliance found that a “lack of health insurance is associated with as many as 44,789 deaths per year in the United States” (Wilper, Woolhandler, Lasser, McCormick, Bor, & Himmelstein, 2009, p. 6).

The leading cause of disability and death in Latin American adults is cardiovascular disease (Tejero, 2010). With the presence of obesity, cardiovascular diseases, or diabetes mellitus II, there is an increased risk for the prevalence of the other diseases. Those with diabetes mellitus II are at a higher risk for experiencing a heart attack or stroke (CDC, 2011b, p. 9). However, cardiovascular diseases and diabetes mellitus II are somewhat preventable. According to the National Diabetes Education Program (2008), “studies show that people at high risk for diabetes can prevent or delay the onset of the disease by losing 5 to 7 percent of their weight, if they are overweight” (para. 4). Proper nutrition plays a key factor in preventing or delaying the onset of cardiovascular diseases and diabetes mellitus II.

Malnutrition is, according to the American Association for Clinical Chemistry (2009), “a disparity between the amount of food and other nutrients that the body needs and the amount that it is receiving” (para. 1). There are two forms of malnutrition: under-nutrition and over-nutrition. In underserved and developing nations, under-nutrition is most commonly experienced as a direct result of not receiving adequate food and clean water. In nations abundant with food and resources, over-nutrition is the predominant problem (American Association for Clinical Chemistry, 2009). Research suggested that healthy, low-calorie foods tend to cost more, according to Drewnowski, Director of the Center for Public Health and Nutrition for the University of Washington. Drewnowski stated:

Higher food costs represent both a real and perceived barrier to dietary change, especially for lower-income families, then the ability to adopt healthier diets may have less to do with psychosocial factors, self-efficacy, or readiness to change than with household economic resources and the food environment. Continuing to recommend costly diets to low-income families as a public health measure can only generate frustration and culpability among the poor and less-well educated. (Drewnowski, 2004, p. 154)

Drewnowski’s research suggested that all those living in poverty, not only Latin American immigrants living in poverty, tend to select higher caloric foods because it fits their financial budget.

Communication and Financial Barriers

Latin American immigrants face two barriers when accessing healthcare, whether the care is preventative or emergent. The two barriers are communication and finances

(Montana Primary Care Association, 2011). Language barriers have recently been reported as a major hindrance for Latin American immigrants seeking healthcare. Even when Latin Americans visit health services, too often they are not able to understand the information provided. This is either related to the lack of Spanish-speaking healthcare providers and nursing staff or the lack of translator services available for the Spanish speaking clients. According to an article written in the *American Journal of Medicine*, Cersosimo and Musi stated:

Further complicating access to healthcare is the fact that a significant number of Hispanics/Latinos do not speak English. Additionally, many Hispanics/Latinos prefer to conduct conversations in Spanish, although medical services are rarely provided in Spanish. This language barrier affects interactions with healthcare providers and, therefore, quality of care. (2011, p. 10)

The language barrier is felt by the nurses but the constant frustration is primarily experienced by the Spanish-speaking-only clients. According to an article by Llano in the *Stanford Journal of Public Health*, “language problems are cited by Hispanic parents in the US as the ‘single greatest barrier to healthcare’ for their children ahead of other barriers such as no medical insurance and difficulty paying medical bills” (2011, para. 20). According to Johnston (2011), “the complications and confusions that arise when concepts are lost in translation can be ‘devastating,’ resulting in poor care management or no care at all” (p. 49). Communication that is appropriate at the cultural and educational levels is crucial in providing healthcare to Latin American immigrants.

Financial barriers also affect the Latin American immigrants from accessing or receiving healthcare. Accessing healthcare is a time-consuming and expensive process, as confirmed by the below statement:

First of all, the client must have access to or a means of transportation. Next, the client must be able to afford the gas it takes to get to and from the clinic.

Ultimately, once the client arrives at the healthcare facility, they must be able to afford the care provided. (Johnstone, 2011, p. 53)

A healthcare provider must demonstrate culturally appropriate communication and financially feasible solutions for purchasing nutritional food. An example of demonstrating culturally appropriate care includes understanding that, according to Galanti, author of *Caring for Patients from Different Cultures* (2008), “[i]n most Hispanic families, the needs of the family take precedence over those of the individual and important decisions are made by the family, not the individual” (p. 94). When presenting information about nutrition, it is important to explain the benefit for the entire family such as decreasing the risk for obesity, cardiovascular disease, and diabetes mellitus type II.

Healthcare and Latin American Immigrant Clients

A primary clinical nursing implication for Latin Americans living in the United States may be the immigrants’ unfamiliarity with their new food choices. Living in a new country that does not have similar ethnic food selections may result in uncertainty while trying to select groceries at the supermarket (The European Food Information Council, 2005). Additionally, the Latin American immigrants’ nutritional status, as with all cultures, is directly affected by their food options and choices. Lastly, education in itself

does not directly correlate with comprehension on how to implement this knowledge when shopping at the grocery store and selecting nutritionally dense foods (The European Food Information Council, 2005).

Accessing healthcare is a vital step towards living a healthy lifestyle. Healthy People 2020 has identified the goal of improving “access to comprehensive, quality health care services” (2012a, p. 1). The venues available to reach this goal include mobilizing the migrant health clinics to reach the clients at their work location and also developing a financially feasible transportation system available for use by the Latin American immigrants. Culturally appropriate education continues to be an immeasurable necessity while creating incentives for follow-up appointments.

According to Healthy People 2020, accessible healthcare impacts “overall physical, social, and mental health status, prevention of disease and disability, detection and treatment of health conditions, quality of life, preventable death, and life expectancy” (2012a, p.1). This information suggested that by simply accessing health services, the overall health status of each individual could be maximized for the best benefit for the individual. In an article published in the *Mount Sinai Journal of Medicine*, health disparities were presented as multi-dimensional concepts:

Racial and ethnic disparities in health are multifactorial; they reflect differences in biological vulnerability to disease as well as differences in social resources, environmental factors, and health care interventions. Understanding and intervening in health inequity require an understanding of the disparate access to all of the personal resources and environmental conditions that are needed to generate and sustain health. (Richardson & Norris, 2010, para. 1)

Eliminating health disparities in the Latin American immigrant population will be challenging but intervening at this moment will not only affect the current generation but generations to come. According to Kochhar of the Pew Hispanic Center, the labor force will be primarily supported by Hispanics in the next decade:

Hispanics will account for three-quarters of the growth in the nation's labor force from 2010 to 2020, according to new projections from the Bureau of Labor Statistics. One major reason is that the Hispanic population is growing rapidly due to births and immigration. At the same time, the aging of the non-Hispanic white population is expected to reduce their numbers in the labor force. (Kochhar, 2012, para. 1)

As the Hispanic labor force increases, the need to access affordable healthcare is a necessity. Unintentional injuries, often related to work, are the third highest leading cause of death in Latin American populations (CDC, 2010a, para. 5).

Problem and Purpose

The Centers for Disease Control and Prevention reported that cardiovascular disease was the leading cause of death for Hispanics and Latinos and diabetes was the fifth highest cause of death for the same demographic population (2010b). There are significant health disparities experienced in the Latin American immigrant populations in Montana, Idaho, and many other states within the United States. Nutritional status is an important factor when preventing disorders such as metabolic syndrome, obesity, malnutrition, hyperlipidemia, cardiovascular disease, and diabetes mellitus type II. Cardiovascular disease and diabetes are two diseases that are directly impacted by health and nutritional status. It is crucial for nurses to prevent, promote, and protect the clients at

risk for cardiovascular disease and diabetes through education and culturally appropriate interventions. There is a void of research related to education and interventions that facilitate health promotion in these populations. The purpose of this thesis was to explore the challenges faced by nurses working to enhance the nutritional status of Latin American immigrants working in Montana and Idaho.

Chapter II

Review of Literature

In qualitative research, a review of the literature may bias the researcher and influence the data analysis (Glaser & Strauss, 1967). For the purpose of this thesis, the literature review explores quality of life, nutritional status, eating disorders, self-esteem, gender-specific issues, age-specific issues, and acculturation of Latin American immigrants living in the United States.

Latin American View of Quality of Life

For Latin American families, interpersonal relationships and emotional well-being enhance the quality of life. Aznar and researchers (2005) reported that “quality of life is a concept that has meaning and structure which varies considerably from culture to culture” (p. 784). The study included 180 Latin American families in various socioeconomic classes. The 180 families were chosen from 12 different Latin American countries (Aznar & Castañón, 2005). The 18-month study resulted in determining several different factors that affect quality of life for Latin American families. The research resulted in the following findings for both quality of life and importance of each variable (2005): “interpersonal relations (27 percent), emotional well-being (23 percent), rights (11 percent), material well-being (10 percent), social inclusion (10 percent), self-determination (7 percent), personal development (7 percent) and physical well-being (4 percent)” (p. 785). Interpersonal relationships were important for Latin American families to have an enhanced quality of life. Healthcare providers can assist with this process by developing interpersonal relationships with their clients.

This process becomes especially important when clinics and hospitals receive clients who may be unfamiliar with the healthcare system and the roles of healthcare providers. In order for the healthcare workers to accurately assess the client, a trusting relationship allows the clients to express their anxieties, problems, and needs more comfortably and truthfully. Thus, it is vital for nurses and other members of the healthcare team to provide culturally competent care to Latin American immigrants.

In addition to culturally appropriate care, assessing emotional well-being of clients is important (Aznar & Castañón, 2005). Emotional well-being was the second most important factor when assessing Latin American immigrant quality of life. It is the responsibility of the nurse not only to provide culturally competent care but to constantly assess the emotional well-being of the client. As one of four determinants of overall health status, emotional well-being has the potential to greatly affect the overall health and wellness status of the client. Physical well-being was ranked as the least important factor when assessing Latin American immigrants' quality of life which could indicate a barrier of this study (Aznar & Castañón, 2005).

Latin American Immigrant Women

Gender can also affect the perception of quality of life and overall health (Aznar & Castañón, 2005). The life of an immigrant woman living in a new country, perhaps with a new language, trying to feed and protect her family can be very difficult. Identifying the basic social problems of immigrant women adjusting to life in the United States was the primary purpose of the Hrycak and Jakubec's (2006) study. Six women participated in this study which utilized a grounded theory methodology. The research process included interviews that were audio taped and later transcribed for a comparative

analysis to identify commonalities. Volunteer participants completed questionnaires about their lives in their original country in contrast to the United States, their new country of residence (Hrycak & Jakubec, 2006). It was found that Latin American immigrant women have a difficult time adapting to a new country. The adjustment phase that most immigrants experience can be tedious and frightening, and these emotions may be increased if the immigrants do not speak the language of their new country.

Transitioning for Latin American immigrants has proven to be challenging: “Adjustments to a new language and culture and encounters with a system of organization very different from what she knew were overwhelming” (Hrycak & Jakubec, 2006, p. 25).

These three factors, (a) a new language, (b) a new culture and (c) a different healthcare system, all prove to be difficult adjustment factors for Latin American immigrant women.

Hrycak and Jakubec stated, “When health-care professionals listen to the voices of refugee immigrant women, the individual and collective access to care for those women is enhanced” (p. 24). It is the role of nurses and the entire healthcare team to assess the needs of the Latin American immigrant women and appropriately implement interventions. Provision 1.1 of the American Nurses’ Association (ANA) code of ethics (2010) states that “a fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual. Nurses take into account the needs and values of all persons in all professional relationships” (ANA Code of Ethics, 2012, p. 4). It is the duty of the nurse to always promote human dignity, practice respect, and encourage client teaching.

Latin American Nutrition

Obesity and diabetes mellitus type II occur at a higher rate among the poor in numerous Latin American countries (Rivera, Barquera, Gonzalez-Cossio, Olaiz, & Sepulveda, 2004). According to Rivera and colleagues, “a growing number of studies are finding associations between low birth weight and obesity, diabetes, and coronary heart disease in adults” (p. 149). The study found that Latin American countries, especially Mexico, are experiencing health, nutrition, and demographic transitions. Also, the dietary intake has transitioned to a higher fat and refined carbohydrate intake in countries such as Brazil and Mexico.

Rivera and colleagues (2004) utilized a meta-analysis methodology and reviewed data from all of the countries included and then discussed the transitional characteristics from historical foods to high fat foods in each country. The conclusions developed from the findings of this meta-analysis study included (a) an increase in the prevalence of overweight and obese in Latin American populations, and (b) stunting continues to be a public health issue in Latin America and the Caribbean. As the Latin American immigrant population continues to expand in the United States, the American healthcare system may also witness an increase in obesity and stunting in Latin American immigrant populations.

Eating Disorders of Latin Americans

Although obesity has developed into an increased problem for Latin Americans, eating disorders have also become more prominent (Alegria, Woo, Cao, Torres, Meng, & Striegel-Moore, 2007). While Latin Americans have a low occurrence of anorexia nervosa, the findings from this study found that Latin Americans have an increased

prevalence of binge eating disorders (Alegria et al., 2007). The study utilized data from the National Latino and Asian American Study which is a national household survey of Latinos in the United States. The study supported the concept that the longer Latin America immigrants reside in the United States, the higher the risk for the development of certain eating disorders.

Severe obesity was correlated to lower levels of education. Also, the utilization of treatment, which included education on nutrition and eating disorders, was low. The research concluded that “standard eating disorder criteria may not be appropriate for understanding psychological morbidity of eating disorders for Latinos, particularly less acculturated Latinos, due to cultural differences in the presentation of eating disorder symptoms” (Alegria et al., 2007, p. 19). In addition, the research found that eating disorders such as binge-eating are of significant health concern in Latino populations (Alegria et al., 2007).

Acculturation

Acculturation is defined as the “process in which members of one cultural group adopt the beliefs and behaviors of another group” (Hispanic Center of Excellence, n.d., p. 1). Latin American immigrants experience acculturation at differing levels when they immigrate to the United States. Orientating to unfamiliar food selections, adjusting to a different economic availability, and experiencing different cultural patterns have all proven difficult for many Latin American immigrants (The European Food Information Council, 2005). According to Garland, an expert on international relations from the Elliot School of International Affairs at George Washington University (2007), “unlike other groups of immigrants in past centuries, Latinos keep their language and culture much

longer” (para. 8). Although the Latin American immigrants continue to utilize their original language and incorporate their culture for a longer period of time, numerous immigrants find themselves also incorporating themselves into American society.

In a recent research study that utilized a grounded theory methodology, various themes emerged from the perception of Latin American immigrants’ viewpoint. The immigrants focused on “acceptance of their culture, previous and current ethnic composition of their community, cultural values and behaviors underpinning interaction, and perceived pressures to maintain and change their culture” (Archuleta, 2011, p. 1). It was identified that the perceived pressure and discomfort experienced by Latin American immigrants often resulted in their acculturating to their new environment. According to Archuleta (2011), the “comfort and discomfort in interacting with other cultural groups often elicited pressure to change, suppress, or maintain one's culture” (p. 1). This often results in Latin immigrants consistently trying to balance their history, their present, and their future while also acculturating to a new country, which may include becoming proficient in a new language, adapting to a new culture, and perhaps learning new skills for a new occupation.

In a 2006 research study, Meyler and Stimpson suggested that “negative acculturation-health relationship found among younger immigrant adults may become a positive relationship in later life” (Meyler & Stimpson, 2006, p. 1). Acculturation occurs when one person adapts to the beliefs and social system of the new community he or she resides in. The purpose of this research was to compare the relationship between functional health and years of United States residency among Latin American immigrants. The data utilized for this study came from the Hispanic Established

Populations for the Epidemiologic Studies of the Elderly. The participants were 65 years of age or older and were from five United States southwestern states which included Arizona, California, Colorado, New Mexico, and Texas. The two main predictors of the study were nativity (country of origin) and years of United States residency. The study used controls for gender, marital status, age, and household income.

Self-Esteem

From a clinical perspective, nurses must be aware of the emotional well-being of their clients, as well as the physical well-being of their clients (Meyler & Stimpson, 2006). The results of this research concluded that Mexican American elders' self-esteem can benefit from language acculturation. Learning and understanding English while living in an English-dominated society increased self-esteem for Mexican Americans, according to the results of this study. Previously, acculturation was linked to depressive symptoms, but this research study suggested that acculturation impacts additional aspects of mental health. Social support is crucial for the mental health of Mexican Americans. Social support can be received from family members, friends, and community members, as well as the nurses themselves. Immigrant and non-immigrant older Mexican American adults reported comparable self-rated general health. In addition, it was found that among older Mexican American immigrants, longer United States residency contributed to improvement in functional health.

First Generation Mexican Americans

One of the most prominent recent demographic changes in the United States is the influx of Latin Americans migrating to the rural parts of the United States. Language barriers, unfamiliar cultures, climate changes, and alterations to routines all result in

increased stress levels for the Latin American immigrants. The stress is also increased if they arrive illegally, if family members are separated, or if work is unavailable (Hancock, 2005). In a 2005 study, Hancock utilized a meta-analysis methodology to gather common themes to determine what issues first generation Mexican Americans experienced. This research had several limitations. Primarily, the researcher did not thoroughly explain the methodology behind the research work. However, the information provided in this research was beneficial for healthcare providers to understand the worries and problems Latin American immigrants face when they enter the United States. By having a deeper understanding of their worries, the healthcare providers can offer firmer support and empathy (Hancock, 2005).

Elderly Mexican Americans

Researchers at the University of Texas at El Paso reported that elderly Mexican Americans felt that “the overall elderly health status was poor due to difficulty accessing services, lack of knowledge, social isolation, old age, and financial barriers” (Zunker, Rutt, & Meza, 2005, p. 54). This qualitative research study was done in Ciudad Juárez with the collaboration of the community centers of this city. The community centers were contacted and a suitable time and date were selected to schedule a focus group at each location. Colorful signs were posted within the centers so that their members would notice the signs. The two criteria established in this research included the following: a minimum age of 60 years old and maintained connections within the community centers. This could be through healthcare services, attending various programs, or uniting together for fellowship at the community centers. The sample included a total of 112 individuals (aged 60 or older) who participated in six focus groups at a hotel, church, and

four other community health centers throughout Ciudad Juárez, Chihuahua. The sample included participants separated by their socioeconomic class, from poverty to middle class. Ninety-three of the volunteer participants were female and 19 of the participants were male (Zunker et al., 2005). Each focus group consisted of 13 to 24 participants, lasted approximately an hour, and was audio taped (Zunker et al., 2005). Prior to the research, the Institutional Review Board of the University of Texas at El Paso approved this study.

The following common themes were developed from the focus groups. Elderly Mexican Americans, on reflection of their life, strongly believe that family is a key source of support. Participants believed that the family should provide physical and emotional support. *Familismo*, the cultural norm of taking care of family, is a major aspect of all Latin American cultures (Zunker et al., 2005). Family, according to this research, should assist the elderly with their basic and health needs. Elderly Mexican Americans also identified spirituality as being directly related to overall well-being. In addition, elderly Mexican Americans were appreciative of caring attitudes from healthcare professionals, including nurses.

In relation to nursing clinical implications, it is important for nurses to provide holistic and nurturing care to elderly Mexican Americans. The participants believed that their present health status was directly dependent on their previous lifestyle and their prior financial status related to their ability to buy food and medicine (Zunker et al., 2005). When requested to form a list identifying fewer than five common health problems of the older Mexican American population, diabetes was reported the most

frequently followed by hypertension, arthritis, depression, and osteoporosis (Zunker et al., 2005).

Horizontal Cooperation

Horizontal cooperation between healthcare professionals and residents in underprivileged communities can develop creative efforts to address health discrepancies in these underserved areas. Including direct and local involvement will always result in stronger support from the community that is receiving assistance. This research focused on the effectiveness of Venezuela's *Misión Barrio Adentro*, a program designed to increase healthcare access for the underserved in Venezuela's poor neighborhoods. The study included systematic observations as well as interviews with 221 residents, 41 healthcare professionals, and 28 government officials (Briggs & Mantini-Briggs, 2009). The results for this study indicated that several policymakers, clinicians, community workers, and residents designed *Misión Barrio Adentro* which resulted in its being a collaboration of many different opinions resulting in a program that is horizontal in nature. The research also found that if the nurses and healthcare providers were willing to work with and alongside the residents, greater success was achieved (Briggs & Mantini-Briggs).

In clinical practice, nurses and other healthcare providers need to be aware that working alongside their patient population will result in stronger acceptance of educational programs in Latin American communities in the United States (Briggs & Mantini-Briggs, 2009). In addition, trust is formed if the healthcare team listens to their Latin American patients as well as respects their cultural beliefs. Teamwork and a collaboration of healthcare providers, community workers, and residents will result in a

stronger educational program that is accepted more readily among Latin American communities.

Summary

There is an abundance of literature related to overall health and nutritional status for Latin American immigrants residing in the United States. In addition, research has included gender-specific and age-specific topics related to Latin American immigrants. Research specific to Montana and Idaho is only beginning to be conducted. There has been no research conducted to evaluate the challenges nurses encounter when trying to provide healthcare to Latin American immigrants working in Montana and Idaho. The purpose of this research is to assist with future studies in this topic area as well as assist with interventions implemented to solve the challenges nurses face while providing healthcare to Latin American immigrants working in Montana and Idaho. The review of literature suggested that nurses throughout the United States will provide care to Latin American immigrants at some point in during their practice.

CHAPTER III

Methodology

As the population of Latin American immigrants increases annually in the United States, it is crucial for nurses to gain a deeper understanding of the nutritional status of the Latin American immigrant population. The purpose of this research study was to explore the challenges faced by nurses working to enhance the nutritional status of Latin American immigrants working in Montana and Idaho. Grounded theory qualitative research methodology was utilized to “develop a theory that emerges from and is therefore connected to the reality” (Robert Wood Johnson Foundation, 2008, p. 1). Grounded theory is the “discovery of theory from data” (Glaser & Strauss, 1967, p. 4) and is a sensitive method to identify basic social processes that occur over time (also called the core category). Grounded theory produces a set of concepts, problems, and processes related to a core category generating theory that explains the behavior of the participants (Glaser, 2004). Thus grounded theory is a strong method for exploring the challenges faced by nurses improving the nutritional status of Latin American immigrants working in Montana and Idaho.

Sample and Setting

This purposeful sample included community health registered nurses working with Hispanic migrant workers in Montana or Idaho. The researcher recruited three public health registered nurses who have worked with Latin American immigrants. Volunteers interested in participating in an in-depth audio-taped interview contacted the researcher, and the interview took place in a mutually agreed upon private setting. The

sample included one male and two female nurses ages thirty to sixty. Each interview was approximately thirty minutes.

Protection of Human Participants

The Carroll College Institutional Review Board (IRB) approved this research project (see appendix C for IRB approval letter). The researcher obtained voluntary consent prior to beginning the research study. Participants were recruited through a flyer placed in a migrant health clinic. The researcher, to protect the privacy and anonymity of the participants, did not collect names or identifying data. Prior to conducting research, the researcher completed the National Institute for Health (NIH) Human Participants Protection Education for Research Teams online training course (see appendix B for NIH certificate of completion). Confidentiality was maintained throughout the entire research process by keeping client-sensitive information under protection through a personal password-protected computer. Once the study was concluded, the data collection from individuals was destroyed.

Data Collection

This qualitative grounded theory research study utilized both informal and formal interviewing (Fain, 2009). In addition, “the term grounded refers to the idea that the theory developed is based on or grounded in participants’ reality” (Macnee & McCabe, 2008, p. 207). The advantage of conducting a qualitative study is that “individual variation can be recorded in depth” (Fain, 2009, p. 126). The collection of data was accomplished through formal and in formal interview processes with open-ended interview questions (see Appendix E for interview script). The interviews were audio taped and transcribed for the use of the research.

Data Analysis

The researcher analyzed the data using classic grounded theory analysis by Glaser and Strauss (1967). Constant comparative method was used to code the data. The steps of this analysis included the following: (a) listening to the audio-taped transcript, (b) reading through the transcripts line by line, (c) open coding, (d) theoretical coding for concepts, processes, stages, or phases, (e) identifying similarities and differences, (f) discovery of categories, (g) constant comparison of each concept to identify relationships and build the categories, (h) identification of a core category, and (i) developing the categories by conceptualizing with literature. After data analysis, the researcher writes a theory that can fit clinical practice and be easily modified by others for implementation. To enhance the rigor of this study, the above steps were followed, and categories were developed with an experience grounded theory analyst.

Biases

This research design contained the potential for some biases to occur. The researcher has a passion and life purpose to eliminate health disparities and has worked in health clinics in the Dominican Republic and Honduras in impoverished conditions. The researcher believes that all humans deserve quality healthcare. The researcher worked with an experienced qualitative researcher (who may have also had biases) on data analysis to increase awareness of bias during data analysis.

Limitations

Primarily, the research study was limited by the sample size. Additionally, the public health registered nurses interviewed for this research study may not reflect the opinions of the majority of other registered nurses who provide healthcare to Latin

American immigrants outside of Montana and Idaho. Researcher bias could be a limitation of this study.

CHAPTER IV

Findings

Classic grounded theory analysis discovered the challenges faced by nurses working to improve the nutritional status of Latin American immigrants working in Montana and Idaho as well as the concerns of their clients. The core category of this study is *nutrición para la vida* which means “nutrition for life.” The supporting categories for *nutrición para la vida* are as follows: living in poverty, overcoming language barriers, promoting healthy lifestyles, and eating nutritional ethnic foods. Figure 1.1 is a theoretical model using a food pyramid as a symbol of nutrition and includes the themes of this study.

Core Category: Nutrición para la Vida

Nutrición para la vida implies a movement by nurses to improve the overall nutritional health for Latin American immigrants and their families. It includes the challenges faced day-to-day by Latin American immigrants living in poverty who are experiencing difficulties overcoming language barriers when communicating with nurses. *Nutrición para la vida* involves an unspoken partnership between Latin American families and their nurses to learn about nutritional food choices, identify and avoid traditional foods high in calories and low nutritional value, and commit to lifestyle changes for themselves and their families.

Supporting Category: Living in Poverty

Nurses reported that Latin American immigrants working in Montana and Idaho are continuously transient throughout the Northwest United States. This population is dependent on seasonal farm work for employment, and income is often unreliable.

Climate impacts harvest seasons which may cause unpredictable periods of unemployment for seasonal farmworkers. Food, clothing, healthcare, transportation, and money for car and gas become scarce resources. A nurse participant working in a migrant clinic stated:

When you live any place else, you don't think about nutrition; you are thinking about survival. You just want to put food on the table; you don't think about nutrition. You just want to have food on the table to survive, to feed your children.

Nurse participants explained that during periods of unemployment, Latin American farmworkers center their efforts around finding affordable food to eat. This also stems from their country of origin, immigration, and their transient lifestyle. Food insecurities develop from this unpredictable cycle of feast and famine. Long periods of minimal food during unemployment are followed by periods of relative overabundance leading to indulgence of foods low in nutritional value and high in carbohydrates to obtain a feeling of being full or *satisfecho*. A nurse explained:

They have a tendency to overeat because it is so affordable. If you came from a place where money is scarce and suddenly you arrive here and you get a job and the food is cheap, what is your response; it is to hoard it or eat a lot. If you used to just eat two times a day and now you are eating four or five times a day because it is so affordable. If you came from a place, like Latin America, where food is not as cheap, you overindulge when you can afford it which is human nature.

Compared to Latin American countries, the United States has an abundance of food.

Often, the cheaper food does tend to be frozen or processed with higher fat content. As

another nurse reported, “I think our population of migrant farm workers, with little available money, usually use the lower, cheaper cuts of meat. I think that the lower cuts of meat have a higher fat content.” The Latin American clients know that protein is important but when selecting meat, they often select meat that is more economically feasible rather than higher in nutritional value.

When facing financial challenges, Latin American immigrant families compromise on nutritional food choices to ensure that they feel full or *lleno*. As this nurse explained, “You don’t get full when you don’t eat starch because you aren’t used to not eating starch. You have to add rice.” For people living in extreme poverty, nurses focus teaching on balanced food choices. Another nurse stated, “I am a provider and overall the nutritional status is one of abundance, overconsumption of calories that are calorically dense and nutritionally sparse, lower in vitamins and minerals and higher in fat and simple carbohydrates.” As reported by the nurses, a balance between nutritionally dense food, financially appropriate options and education is crucial.

Supporting Category: Overcoming Language Barriers

Nurse participants in this study identified that there were often problems with client nutritional education related to language barriers while Spanish continues to be the primary language of most of the Latin American immigrants working in Montana and Idaho. Nurses in this study spoke only English, and if they did comprehend Spanish, it was at a very minimal level. This often results in the need for both the nurses and the Latin American immigrants to overcome language barriers. This may include utilizing a translator, a family member or merely through nonverbal communication. A nurse with minimal understanding of the Spanish language stated:

From my experience, when I do education about diabetes or diet and nutrition education or exercise, I am worried that the translation may not be getting through to the point where they are comprehending or understanding the education as well as I want them to.

The nurses approaching the Latin American immigrant clients are unsure of the English-speaking ability of their clients, so the nurses must include a language assessment prior to beginning care. In addition, the need for a translator is also unpredictable and changes with each client. As one nurse reported:

The biggest challenge is the language barrier. You don't know how accurate the translation is. The things that I am advising the patient depends on the understanding of the translator. I don't know what transpired or if the message is received as accurate as I want it.

When attempting to educate their clients, the nurses often struggle with not only the translation itself but also wonder how accurate the translation is from a translator. This becomes incredibly important when the translation includes education about diet and food choices. One nurse stated:

I think a lot of them don't understand the benefits of eating a whole grain diet. Of course you are aware that they eat a lot of flour tortillas. I do a lot of emphasis education on trying to switch their diet to eating more whole grains, fresh fruits, vegetables, and leaner cuts of meat.

Language barriers were a common struggle in the practice of all of the nurses included in this study. Although the level of English and Spanish was not equivalent in every

situation, the nurses struggled to educate their clients on the importance of incorporating healthy foods into their ethnic food habits.

Supporting Category: Eating Nutritional Ethnic Foods

Many Latin American immigrants prepare and eat their ethnic food even after they have moved to the United States. Their culture is tied closely not only to their language but also to their ethnic foods. This can develop a problem of calorie intake versus calorie use. In addition, Latin American immigrants are reluctant to incorporate more whole grains into their meals, which would require replacing the traditional flour tortillas and tamales.

One nurse stated, “The Latin American diet is a high calorie, relatively high fat diet. Often there are multiple tortillas, or similar, consumed at every meal. Calorie and portion control are often abstract concepts and are difficult to translate effectively into Hispanic culture.” Their ethnic food includes high calories which becomes a very present problem when they do not understand portion control.

Their ethnic food is not the only source of high calorie foods they ingest. One nurse also identified problems in the fast food they eat before or after work. Combining a high calorie diet of traditional foods with a high calorie diet of fast food only increases the problem of nutritionally dense foods versus calorie dense foods. One nurse reported:

They have their ethnic food. The Mexican ethnic food is very high in starch and fat. Probably because, in the States, the price of food is cheaper and they can afford it and there is a lot of fast food if they're in a hurry to get to work. They have an abundance of calories, tortillas, pork and pop.

As a result of their ethnic food and eating fast food, utilizing the abundance of calories consumed each day is difficult. Learning about nutritional values, adapting their ethnic foods to include healthier options and incorporating more whole grains are the changes needed to become healthier. Another nurse included in the study reported:

Based on their culture and their food... it is kind of hard for them to change, to want to eat more of the whole grain tortillas. As far as their high increased risk of diabetes, it is hard for them to grasp that eating more of the whole grain type stuff would be better. I also tell them to eat more corn which is a little bit better, the corn tortillas.

Changing their ethnic foods to include selections that are higher in nutritional value, and lower in calories and carbohydrates will decrease their already increased risk for diabetes. Through changing their eating habits to include more whole grains and better protein, they will be able to live healthier lifestyles. From a nurse's perspective, promoting a healthy lifestyle is key to preventing the healthcare disparities experienced by Latin American immigrants.

Supporting Category: Promoting Healthy Lifestyles

Promoting healthy lifestyles is a role that nurses incorporate into their practice regardless of their nursing specialty. For nurses with Latin American immigrant clients, promoting healthy lifestyles becomes an important aspect of their role as a healthcare provider. A healthy lifestyle includes a balance of nutritionally dense and calorically dense foods. In addition, a healthy lifestyle also incorporates exercise and rest. Lastly, a healthy lifestyle also includes family support. One of the nurses from the study reported:

The problem is there is also the convenience here that transportation is available so probably these people that are farm workers that used to walk from their residence to their place of work now just ride. So there is less burning of calories; there is more intake of calories but the burning is less so that has created an issue. With a lifestyle that is decreasing the amount of exercise Latin American immigrants receive, a balancing issue ensues. With this imbalance of exercise, nutrition, and intake one nurse reported:

We have a high incidence of adult Hispanic both male and female that do have kind of a high incidence of an elevated A1C. So I think, maybe with the high incidence of them having a predisposition of having diabetes, nutritional education is very important and also diabetes education.

A1C is the average blood sugar level over a two to three month period of time. A higher A1C level is indicative of an uncontrolled blood sugar level which then means uncontrolled diabetes. However, diabetes is not alone in challenging a healthy lifestyle. One nurse discussed the “tired trap”:

The first thing they go for is pizza or McDonald’s. They are so tired they don’t have time to cook. They will just go for fast food because it is so cheap and they don’t have to cook. When you are tired, you don’t have time to think about logical things. You fall into the tired trap.

Many Latin American immigrants spend long days working, so when they are on their way home, stopping for pizza or McDonald’s becomes an easy way to feed their family without having to prepare a meal.

Promoting a healthy lifestyle can result in success and with dedication from the clients, often does. One nurse reported that “most of the males like their beer. When they gave that up, they were surprised that they lost a lot of weight.” Through education and dedication, Latin American clients can live healthy lifestyles that maintain a balance among their traditional foods, whole grains, and exercise. Promoting a healthy lifestyle also incorporates educating clients about the importance of exercise. A nurse reported:

We also told them that work is not exercise; it is an activity. It means that even if you are working, you still need to do some type of exercise regime. With exercise, if they partner with their wife or significant other, they have more success. If they do it by themselves but the rest of the family is eating whatever they want, then you, as a person that wants to eat better and lose some weight, will not have as much success because the food served on the table will not have the nutritional value needed. If there is family support, it works because the Hispanic population is a close-knit family so whatever the family says affects the family decision. You must make the whole family involved.

Latin American immigrants receive much of their support and care from their family members. Thus, when one person in the family wants to lose weight, it is important for the entire family to unite and lose weight together. This will result in maintained weight loss and a healthy lifestyle change for the entire family. Incorporating a balance of nutritionally dense foods, calorically dense foods, and exercise, a healthy lifestyle can emerge.

Summary

Nutrición para la vida is the commitment of nurse participants working to improve the nutritional status of Latin American immigrants. These nurses are challenged by language barriers and their clients' living in poverty. In addition, the nurses are dedicated to identifying culturally sensitive teaching strategies to educate on healthy lifestyle changes and choosing nutritionally healthy ethnic foods.

CHAPTER V

Discussion

The purpose of this research study was to explore the challenges faced by nurses working to enhance the nutritional status of Latin American immigrants working in Montana and Idaho. The challenges described by nurses were described in the core category: *nutrición para la vida*. Living in poverty, overcoming language barriers, promoting healthy lifestyles, and eating nutritionally ethnic foods describe the primary obstacles that are faced by Latin American immigrants and thus the challenges that nurse face when educating clients on nutrition and long-term lifestyle changes. Nurses are dedicated to educating their clients about long-term changes for healthier, longer lives. It is vital for the nurses to incorporate culturally sensitive environment and demonstrate respect for the diverse ethnic backgrounds. Healthy People 2020 reports that it is important to “create social and physical environments that promote good health for all” (2012a, p. 1). Johnstone (2012) identified that nurses who are able to “establish common ground” with Latin American immigrants have more success in developing mutually agreed upon plans of care that support lifestyle changes.

Living in Poverty

In the research presented, nurses explained that Latin American immigrants’ main focus is to provide food for their families. In turn, the food selected is based on price rather than nutritional value. For nurses, this is a challenge because they are trying to educate their Latin American immigrant clients about nutritional choices while also being sensitive to a life of poverty. According to the Weight-Control Information Network of the National Institutes of Health (2008), “social factors including poverty and a lower

level of education have been linked to obesity” (para. 19). Participants reported that when Latin families have to decide between nutritionally dense foods at a higher cost versus calorically high foods at a cheaper cost, families will select the cheaper food for economic purposes.

Survival is of the utmost importance for the Latin families, and it is food that comforts and gives the feeling of *satisfecho* (satisfied) that is more important than nutritional value at a time of financial need. Impoverished families often experience food insecurities. However, when finances are available, an overabundance of calories occurs. Latin American immigrants ingest an abundance of calories when finances are available because in their countries of origin, utilizing the opportunities presented is key to survival. As one nurse explained, “If you came from a place where money is scarce and suddenly you arrive here and you get a job and the food is cheap, what is your response; it is to hoard it or eat a lot.” The cyclical poverty experienced by Latin American immigrants results in a constant struggle with high caloric, financially cheap food selections to achieve a feeling of *lleno* (full) and over-abundant food consumption.

Ethnic Foods

Latin American ethnic food tends to be higher in calories and fat and lower in nutritional value. However, ethnic food is a very important aspect of Latin American culture. In addition, family gatherings tend to develop around the importance of mealtime. Educating Latin Americans on the need to alter food preparation methods used to assist in decreasing the fat content of the Latin American meals is a difficult concept for Latin American immigrants to adopt into practice. Calorie counting is an uncommon practice for Latin Americans and has been challenging for the nurses to teach and

implement. As one nurse reported, “Calorie and portion control are often abstract concepts and are difficult to translate effectively into Hispanic culture.” The Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services published *La Buena Vida*, the good life, a new bilingual booklet developed to guide Latin American families toward living a healthy lifestyle. The booklet contains information on portion sizes, calories, maintaining a healthy weight and food safety (Health and Human Services Department, Office of Disease Prevention and Health Promotion, 2008).

Access to Healthcare

Accessing healthcare is important for a longer, healthier life. For Latin American immigrants, transportation to appointments is often dependent on taking unpaid time off from work and spending money on gas when other necessities may not be getting met. Latin American immigrants would rather forgo accessing healthcare to receive a larger paycheck to ensure that food is being placed on the table for their families. Follow-up appointments are often inconsistent and not deemed as crucial. Nurses included in this research study expressed the challenges they faced while trying to arrange for follow-up appointments. One nurse explained that organizing family appointments so the entire family comes as one unit has helped.

Language Barriers

Overcoming the barrier of two different languages is a challenge commonly experienced by nurses working with Latin American immigrants. Many of the nurses are concerned that the education they are providing is not comprehended by Latin American immigrant clients. One nurse described the challenge of overcoming a language barrier

when trying to provide education, “[w]hen I do education about diabetes or diet and nutrition education or exercise, I am worried that the translation may not be getting through to the point where they are comprehending or understanding the education.” For one nurse, the language barrier is the biggest challenge faced by nurses working with Latin American immigrants.

Kale and Syed, in an article included in the *Patient Education and Counseling* journal, identified “a key area for further improvement is the process of raising awareness among health-care providers and institutions regarding the legal responsibility they have to ensure the sufficient level of communication with their patients/clients” (2010, para. 5). A language barrier is much more than an inconvenience or frustration on the part of the nurse or the client. There is a legal obligation that nurses, and other members of the healthcare team, provide accurate information to their clients. If a language barrier is identified, the nurse must request a translator or find another solution to ensure that the information received is correct and that the education provided is comprehended.

The need to eliminate this barrier should be a prime concern for all nurses, nursing schools, and public health organizations. Language barriers are modifiable, and with education and resources, this barrier could be eliminated.

Clinical Implications

Acquiring knowledge of the healthcare disparities specific to Latin American populations will assist nurses in completing the four-step nursing process: assess, plan, implement, and evaluate. In addition, the nurses will be able to practice their skills at the highest level of capability while caring for Latin American immigrants. The category of language barriers including translation problems with interpreters must be addressed by

nursing programs throughout the United States. The recommendations for clinical practice include mandating Spanish health care courses for nursing students as well as providing clinical opportunities in Latin American community health centers. Clinical simulations could also include basic Spanish competencies with Spanish-speaking clients. The Robert Wood Johnson Foundation, in partnership with the Institute of Medicine, released a report in 2011 titled *The Future of Nursing: Leading Change, Advancing Health*. In this report, five evolving healthcare challenges were identified. Of these five challenges, three of these challenges relates to Latin American immigrant populations; diverse population, health disparities, and limited English proficiency. This report also stated that, in regards to limited English proficiency, “[t]o be effective, care and health information must be accessible and offered in a manner that is understandable, as well as culturally relevant” (2012, p. 2-2). As a result of this main issue identified, nurses should obtain knowledge of Spanish for the increasing percentage of Spanish speakers in the United States.

Future Nursing Research

The need for nursing research in regards to Latin American immigrants is crucial for nurses to understand the situations that Latin American immigrants encounter while trying to access healthcare and implement healthy lifestyle changes. Currently, there are three topics identified that would greatly benefit from nursing research.

The first topic of research is comparing client outcomes of Latin American immigrants with Spanish-speaking nurses versus Latin American immigrant clients that had English-only-speaking nurses. Incorporated in this research could be the education provided, the education comprehended, and the client adherence that resulted from this

knowledge. Would the research show that Latin American immigrants achieve outcomes more quickly when the nurses utilize translators at all times versus when a nurse has a background in Spanish? It would be beneficial for nurses to understand the most effective way to advocate for their clients.

An important topic for nursing research would be to compare seasonal food selections of Latin American immigrants. Analyzing when Latin American immigrants select certain fruits and vegetables throughout the year would assist the nurses in understanding what foods they need to encourage at different times of the year. In addition, the research could focus on what would the benefits be in educating Latin American immigrants about fruits and vegetables that may be new to them culturally but are nutritionally dense and available during times when their familiar foods are not available.

Another nursing research topic that could prove beneficial for nurses would be to compare seasonal income with access to healthcare. The research could determine when Latin American immigrants are accessing healthcare: whether it is during the summer months when they are busy yet have a stable income or during the winter, when they have more time available but finances are stricter. Through establishing when Latin American immigrants are accessing healthcare, nurses can develop plans to promote Latin American immigrants to access health services.

All three of these research studies would prove beneficial for nurses, the healthcare field, and Latin American immigrants. The role of nurses is to advocate for their clients, maintain human dignity, and promote best practice. The three research topics identified above have the potential to impact nursing practice on all levels.

Conclusions

The nurses who participated in this research study found several challenges while improving the nutrition of Latin American immigrant clients. Of these challenges, language and poverty proved to be the most significant to making lifestyle changes and choosing nutritional ethnic foods for *nutrición para la vida*. With the increasing population of Latin American immigrants living in the United States, nurse must face the challenges to help improve the nutrition of Latin American immigrants.

APPENDIX A

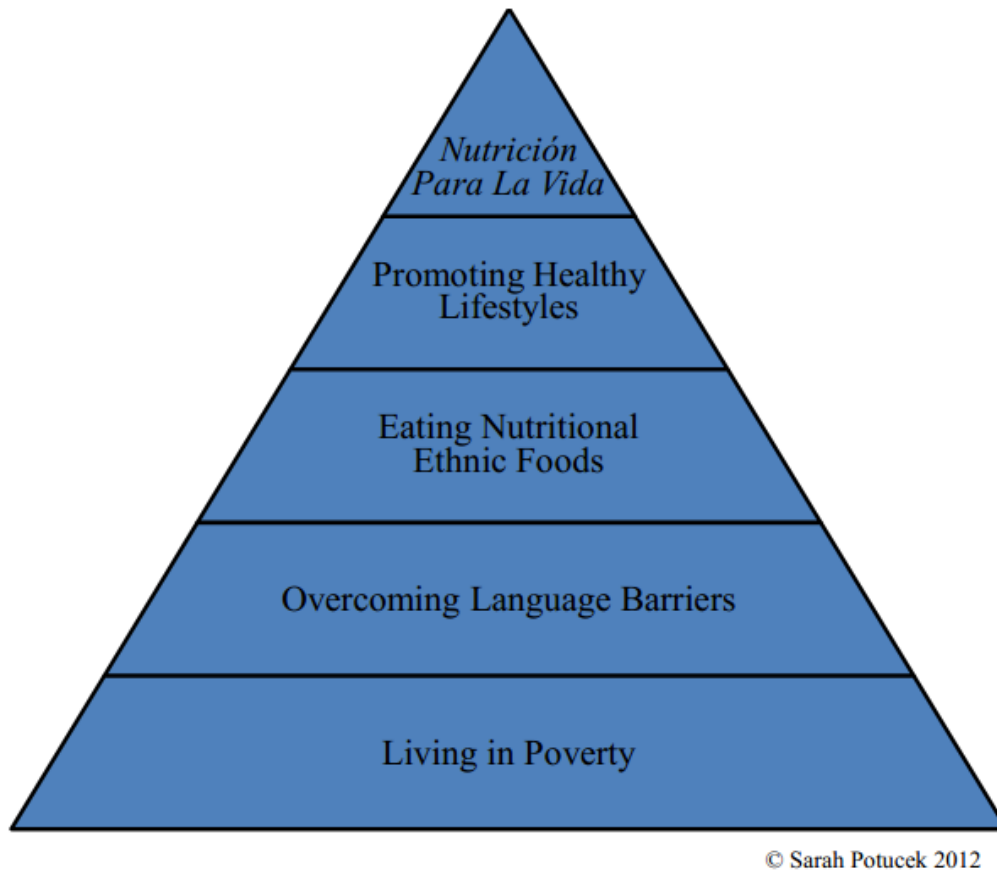
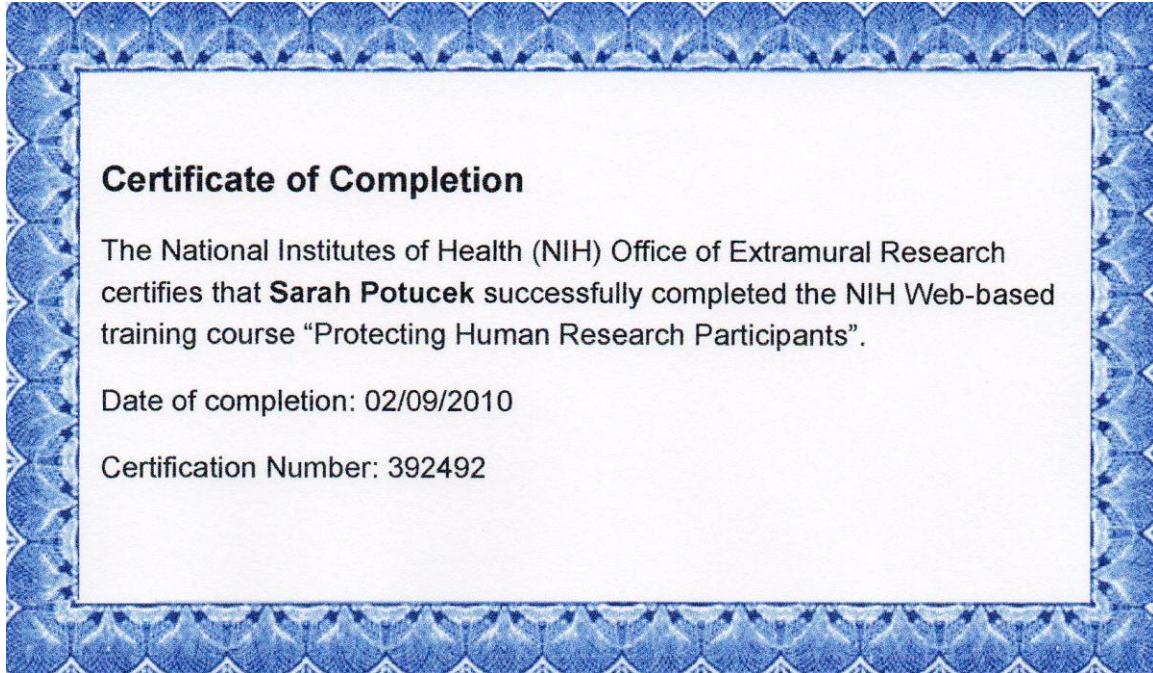


Figure 1.1 by Potucek, 2012, illustrates the challenges nurses encounter while trying to achieve *nutrición para la vida* for all of their Latin American immigrant clients.

APPENDIX B



APPENDIX C

**Institutional Review Board**

April 13, 2011

Sarah Potucek
1030 #A Butte Ave.
Helena, MT 59601

Dear Sarah Potucek:

Your research proposal, "Exploring the Nutritional Status of Latin American Immigrants Living in Montana," has been reviewed by the IRB and has been approved with a few stipulations. You may begin your research project after you address these stipulations in writing to the IRB and receive confirmation from the IRB that you have met these stipulations.

- 1) Explain to what degree Jennifer Elison and Murphy Fox will have access to subjects or identifiable data.
- 2) Confirm that your flyer is free of errors.
- 3) Include Jamie Dolan's phone number on your consent form: 406-447-4969.
- 4) Acknowledge on page 2 of your application that you may in fact be working with a vulnerable population in terms of economic or educational disadvantages.

As a courtesy, we also offer the following for you to consider:

- 1) Your title about "living in Montana" may be problematic as many of the migrant workers are transient through several states.

Please keep the following in mind once your project is under way:

- The Carroll College IRB Policy & Procedures Manual is available online at <http://www.carroll.edu/academics/research/irb/index.cc> and will serve as an invaluable reference source. Also, feel free to contact your research advisor or the IRB chair, Dr. Jamie Dolan, with questions.
- Should you discover that your project requires significant modifications (e.g. changes in protocol or informed consent documentation), those changes must be approved by the IRB before they are initiated.
- Unanticipated problems or serious adverse effects must be reported to the IRB as outlined in the Carroll College IRB Policy & Procedures Manual.

Approval of this project is valid until April 13, 2012. If this project will not be completed before this date, please apply for continuing review as outlined in the Carroll College IRB Policy & Procedures Manual.

Thank you for your submission, and best of luck with your research.

Carroll College 1601 N. Benton Ave., Helena, MT 59625-0002 406.447.4300 406.447.4533 fax www.carroll.edu



Sincerely,

A handwritten signature in black ink that reads "Jamie Dolan". The signature is written in a cursive, flowing style.

Jamie Dolan, Chair
Institutional Review Board for Human Participants in Research

Cc: IRB Members
Paula McNutt, Academic Affairs VP

APPENDIX D

**Carroll College
Subject Consent Form
For Participation in Human Research**

Title of Study: Exploring the challenges faced by nurses working to improve the nutritional status of Latin American immigrants working in Montana and Idaho.

You are being asked to participate in a research study about the nutritional status of Latin American immigrants working in Montana and/or Idaho. From this study, the investigator hopes to learn the challenges faced by nurses working to improve the nutritional status of Latin American immigrants working in Montana and Idaho.

You have been selected to participate in this study because the research study needs 3 nurses working in Montana. If you agree to participate, you will be asked to participate in an in-depth interview. The study is expected to involve 3 nurse volunteer participants and will include one in-depth interview.

Participation in this study may involve certain risks, including emotional distress but otherwise, no physical risks. The study is of no benefit to you.

Funding for this study will be provided by the researcher, Sarah Potucek. If you choose to participate, the cost to you will be based on time for the interviews and gas/driving to meet the researcher.

Confidentiality of records identifying you will be maintained by the researcher, Sarah Potucek.

Carroll College cannot be held responsible for injury, accidents, or expenses that may occur as a result of your participation in this project. In addition, Carroll College cannot be held responsible for injury, accidents, or expenses that may occur as a result of traveling to and from the site.

Further information about this research study may be obtained by calling Sarah Potucek at 208/590-4944. Additional questions about the rights of human subjects can be answered by the Chairman of the Institutional Review Board, Dr. Jamie Dolan at 406/447-4969

I, _____(name of subject), agree to participate in this research. The investigator has thoroughly explained the nature and process of this research to me. I have read the above and understand the discomforts, inconvenience and risk of this study. I understand that I have the right to refuse to participate in this study and that refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled. I also understand that I may withdraw from the study at any time without penalty or loss of benefits to which I am otherwise entitled. To the best of my knowledge I have no physical or mental condition that would be adversely affected by my participation. I have received a copy of this consent form for my own records.

Signature of Participant

Date

Printed Name of Participant

Signature of Witness

Date

Printed Name of Witness

APPENDIX E

**Sample Questions
RN Volunteer Participants**

1. Do I, the researcher, have your permission to audio record this interview to be used later, anonymously, for research in the field of nursing?
2. Are you a registered nurse working with a Latin American immigrant population either in Montana or Idaho?
3. Explanation of research and purpose.
4. What do you perceive to be the biggest health challenge to adult Latin American immigrants working in either Montana or Idaho (depending on your residency)?
5. What are the most commonly diagnosed diseases/illnesses that you perceive in adult Latin American immigrants working in Montana or Idaho (depending on your residency)?
6. In your experience working with adult Latin American immigrants working in Montana or Idaho, what do you perceive to be the relationship between the commonly diagnosed diseases/illnesses in Latin American immigrants and food choices?
7. What do you perceive to be the biggest challenges for nutrition in Latin American immigrants working in Montana or Idaho?
8. Do you feel that Latin American immigrants working in Montana or Idaho have a good nutritional status, and what does this mean to you as a nurse?
9. What is the most challenging aspect of working with this population of Latin American immigrants?

References

- Alegria, M., Woo M., Cao, Z., Torres, M., Meng, X., & Striegel-Moore, R. (2007). Prevalence and correlates of eating disorders in Latinos in the United States. *International Journal of Eating Disorders*. 40:15-21.
- American Association for Clinical Chemistry. (2009). *Malnutrition*. Retrieved from <http://www.labtestsonline.org/understanding/conditions/malnutrition.html>
- American Nurses Association. (2012). Code of ethics for nurses with *interpretive statements*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf>
- Andrade, F. (2009). Estimating diabetes and diabetes-free life expectancy in Mexico and seven major cities in Latin America and the Caribbean. *Salud Publica*. 26(1):9-16.
- Aznar, A., & Castañón, D. (2005). Quality of life from the point of view of Latin American families: A participative research study. *Journal of Intellectual Disability Research*. 49(10):784-788.
- Briggs, C. & Mantini-Briggs, C. (2009). Confronting health disparities: Latin American social medicine in Venezuela. *American Journal of Public Health*. 99(3):549-555.
- Centers for Disease Control and Prevention. (2009). *Eliminating Racial & Ethnic Health Disparities*. Retrieved <http://www.cdc.gov/omhd/About/disparities.htm>
- Centers for Disease Control and Prevention. (2010a). *Hispanic or Latino populations*. Retrieved from <http://www.cdc.gov/omhd/populations/HL/hl.htm#high>

Centers for Disease Control and Prevention. (2010b). *Defining overweight and obesity*.

Retrieved from <http://www.cdc.gov/obesity/defining.html>

Centers for Disease Control and Prevention. (2011a). *Hispanic/Latino heritage*. Retrieved

from <http://www.cdc.gov/Features/HispanicHeritageMonth/>

Centers for Disease Control and Prevention. (2011b). *National diabetes fact sheet, 2011*.

Retrieved from http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

Center for Immigration Studies. (2003). *Where immigrants live: An examination of state*

residency of the foreign born by country of origin in 1990 and 2000. Retrieved

from <http://www.cis.org/articles/2003/back1203.html>

Cersosimo, E., & Musi, N. (2011). Improving treatment in hispanic/latino patients.

American Journal of Medicine, 124 (10), S16-S21.

Chilton, M., Black, M., Berkowitz, C., Casey, P., Cook, J., Cutts, D., Jacobs, R., Heeren,

T., Ettinger, S., Coleman, S., Meyers, A., & Frank, D. (2009). Food insecurity and

risk of poor health among US-born children of immigrants. *American Journal of*

Public Health. 99(3):556-562.

Coffman, M., Shobe, M., Dmochowski, J., & Fox, S. (2007). Health care access and

utilization among Latino immigrants. *Hispanic Health Care International 5:73-80*.

Derose, K., Escarce, J., & Lurie, N. (2007). Immigrants and health care: Sources of

vulnerability. Retrieved from

<http://content.healthaffairs.org/content/26/5/1258.full.pdf>

Drewnowski, A. (2004). Obesity and the food environment: Dietary energy density and

diet costs. *American Journal of Preventative Medicine, 27(3), 154-162*.

- Fain, J. (2004). *Reading, understanding, and applying nursing research*. Philadelphia: F.A. Davis Company.
- Galanti, G. (2008). *Caring for patients from different cultures*. Philadelphia: University of Pennsylvania Press.
- Glaser, B. (2004). Remodeling grounded theory. *Forum: Qualitative Social Research*, 5(2) retrieved from: <http://www.qualitative-research.net/index.php/fqs/article/view/607/1315#g34>
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New Jersey: Transaction Publishers.
- Garland, E. (2007). Latinos in America's cultural laboratory: Immigrating for diverse reasons, Latinos complicate U.S. policy choices. *The Futurist*, 41.1. Retrieved from Academic One File with Full Text database.
- González, H., Ceballos, M., Tarraf, W., West, B., Bowen, M., & Vega, W. (2009). The health of older Mexican Americans in the long run. *American Journal of Public Health*, 99(10), 1879-1885. Retrieved from CINAHL Plus with Full Text database.
- Health and Human Services Department. (2008). *Healthy food choices for Hispanics/Latinos and their families*. Retrieved from <http://bookstore.gpo.gov/collections/healthyhispanics.jsp>
- HealthyPeople.gov. (2012a). *Access to health services*. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1>
- HealthyPeople.gov. (2012b). *Social determinants of health*. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>

- Hrycak, N., & Jakubec, S. (2006). Listening to different voices. *Canadian Nurse*, 102:24-28.
- Institute of Medicine. (2011). *The Future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press.
- Johnstone, J. (2011). Challenges of providing healthcare to Montana migrant workers (Honors Thesis). Montana: Carroll College Department of Nursing.
- Kale, E., & Syed, H. (2010). Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Education and Counseling*, 81 (2), 187-191.
- Kochhar, R. (2012). *Labor force growth slows, Hispanic share grows*. Retrieved from <http://www.pewhispanic.org/2012/02/13/labor-force-growth-slows-hispanic-share-grows/>
- Llano, R. (2011). Immigrants and barriers to healthcare: Comparing policies in the United States and the United Kingdom. Retrieved from <http://www.stanford.edu/group/sjph/cgi-bin/sjphsite/2011/06/immigrants-and-barriers-to-healthcare-comparing-policies-in-the-united-states-and-the-united-kingdom/>
- Lopez, M., & Velasco, G. (2011). *Childhood poverty among Hispanics sets record, leads nation*. Retrieved from <http://www.pewhispanic.org/2011/09/28/childhood-poverty-among-hispanics-sets-record-leads-nation/>
- Macdonald, J., Brevard, P., Lee, R., & Wagner, T. (2009). Link between diet and cardiovascular disease in Latin America and the Caribbean using geographic information systems. *Salud Publica*. 26(4):290-298.

Montana Primary Care Association, Inc. (2011). Montana Migrant Health Program.

Retrieved November 3, 2011 from <http://www.mtpca.org/mtmigrant.htm>

Meyler, D., Stimpson, J., & Peek, M. (2006). Acculturation and self-esteem among older

Mexican Americans. *Aging & Mental Health*, 10(2), 182-186. Retrieved from

CINAHL Plus with Full Text database.

National Poverty Center. (2012). *Poverty in the United States*. Retrieved from [http://](http://www.npc.umich.edu/poverty/)

www.npc.umich.edu/poverty/

Palitza, K. (2009). *No quick fix for malnutrition and hungry*. Retrieved from

<http://www.globalpolicy.org/component/content/article/217/46260.html>

Pew Hispanic Center. (2005). Hispanics: A people in motion. Retrieved November 1,

2011, from <http://pewhispanic.org/files/reports/40.pdf>

Pew Hispanic Center. (2011a). Demographic profile of Hispanics in Montana, 2009.

Retrieved November 1, 2011, <http://pewhispanic.org/states/?stateid=MT>

Pew Hispanic Center. (2011b). Demographic profile of Hispanics in Idaho, 2009.

Retrieved November 3, 2011, from <http://pewhispanic.org/states/?stateid=ID>

Power Y., Power L., & Canadas, M. (2008). Low socioeconomic status predicts

abnormal eating attitudes in Latin American female adolescents. *Eating*

Disorders. 16:136-145.

Richardson, L. & Norris, M. (2010). Access to health and health care: How race and

ethnicity matter. *Mount Sinai Journal of Medicine*, 77: 166–177.

doi: 10.1002/msj.20174

- Rivera, J., Barquera, S., Gonzalez-Cossio, T., Olaiz, G., & Sepulveda, J. (2004). Nutrition transition in Mexico and other Latin American countries. *Nutrition Reviews*, 62:149-157.
- Robert Wood Johnson Foundation. (2008). Constant comparative method: Grounded theory. Retrieved from <http://www.qualres.org/HomeCons-3824.html>
- Tejero, M.E. (2010). Cardiovascular disease in Latin American women. *Nutrition, Metabolism, Cardiovascular Disease*, 20(6):405-411.
- U.S. Census Bureau. (2001). The Hispanic Population. Retrieved from <http://www.census.gov/prod/2001pubs/c2kbr01-3.pdf>
- U.S. Census Bureau. (2006). Immigrants. Retrieved from <http://www.census.gov/PressRelease/www/releases/archives/population/006808.html>
- U.S. Census Bureau. (2010). Overview of Race and Hispanic Origin: 2010. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>
- Weight-control Information Network. (2008). Understanding adult obesity. Retrieved from <http://win.niddk.nih.gov/publications/understanding.htm#environmental>
- Wilper, A., Woolhandler, S., Lasser, K., McCormick, D., Bor, D., & Himmelstein, D. (2009). Health insurance and mortality in US adults. Retrieved from <http://pnhp.org/excessdeaths/health-insurance-and-mortality-in-US-adults.pdf>
- Zunker, C., Rutt, C., & Meza, G. (2005). Perceived Health Needs of Elderly Mexicans Living on the U.S.-Mexico Border. *Journal of Transcultural Nursing*. 16:50-56.