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Cultural Diversity: Eating in America

Mexican-American

In the United States, Mexican-Americans comprise 64 percent of the Hispanic/Latino population, and 14.5 percent of the total U.S. population. Mexicans live predominately in California, Texas, Arizona, Illinois, Nevada, Colorado, and New Mexico. Today, while the majority of Mexican-Americans live in urban areas, significant numbers comprise the three agricultural migrant streams that flow from the south to the north across the United States, often twice annually.

A misconception is that all Spanish or Latino cultures are the same. The differences between Mexico, Puerto Rico, and other Latin American countries include 500 years of separate histories, native populations, and their specific customs that were present prior to their submission to the Spaniards. Although Spanish is the principal language spoken by most Hispanics/Latinos, regional pronunciations and dialects flavor their speech. Thus, the Mexican, Puerto Rican, and Latin American cultures each have different dietary patterns and what foods are called.

Food Habits and Their Relationship to Dietary Guidelines

The traditional Mexican-American diet is rich in a variety of foods and dishes that represent a blend of pre-Columbian, indigenous Indian, Spanish, French, and more recently, American culture. Traditional diets also reflect the geographic regions of Mexico and the availability of local fruits, vegetables, grains, dairy products, and protein sources.

Typically, the Mexican diet is rich in complex carbohydrates, which are provided mainly by corn and corn products (usually tortillas, present at almost every meal), beans, rice, and breads. This diet also contains an adequate amount of protein in the form of beans, eggs, fish and shellfish, and a variety of meats mostly including pork and poultry. *Chorizo*, a spicy pork sausage is served for breakfast with eggs. Popular fruits and vegetables are tomatoes, squash, sweet potato, avocado, mango, pineapple, papaya, and *aguas natuales* (fresh fruit blended with sugar and water). The nutrients most likely to be inadequately represented are calcium, iron, vitamins A and C, and folacin.

Food is often spicy (there are ninety varieties of chiles), but spicy sauces vary with the region of Mexico. Because of the extensive use of frying as a cooking method, the diet is also high in fat. Coffee with large amounts of milk and sugar is often preferred. *Atole* is a warm, milk-based beverage, flavored with chocolate, fruit, or nuts and thickened with finely ground *masa* (corn flour). Tap water is often unsafe in Mexico and Central America. New immigrants may need to be reassured that tap water in the United States is safe.

Eating Practices, Food Preferences, and Food Preparation Techniques

Traditionally, Mexicans ate four or five meals each day, but through their immigration to the United States, the three-meal pattern prevails. Mexican-American breakfast (*desayuno*) usually includes coffee, sweet rolls

(*pan dulce*), tortillas and beans, and occasionally eggs (*huevos rancheros*). Lunch (*comida*) is the main meal of the day, eaten between 1 and 3 p.m. It consists of soup, a meat dish, rice, tortillas, coffee, and dessert. *Cena*, supper, is typically a light meal eaten after 9 p.m. The specific foods chosen vary from factors such as income, education, urbanization, geographic region, and family customs. The degree of original culture varies according to the availability of traditional foods and the extent of assimilation into American society.

Healthy diet changes include a moderate increase in the consumption of milk, vegetables, and fruits, and also include a large decrease in the consumption of lard and Mexican cream (*crema*).

Unhealthy diet changes resulting from the introduction of salads and cooked vegetables include the increase of fats such as salad dressings, margarine, and butter. Other less healthy changes include an increase in high-sugar drinks in place of traditional fruit-based beverages. American acculturation has also decreased consumption of inexpensive healthy sources of complex carbohydrates such as beans and rice. Research also indicates that Mexicans in the United States eat more meat and saturated fats than Anglos, and use fewer low-fat dairy products. Mexicans also are less likely to recognize high-fat foods. These diet changes may be significantly economically based. For instance, Mexican-Americans comprise 12 percent of individuals in the United States below the poverty line. The desire for cheaper food items may have increased some of the unhealthy diet changes.

Clinical studies have consistently reported a high prevalence of obesity, cardiovascular disease, dental caries, and over/under-nutrition in the Mexican-American population. Diabetes in Hispanic Americans is a serious health challenge because of the increased prevalence of diabetes in this population, the greater number of risk factors for diabetes in Hispanics, the greater incidence of several diabetes complications, and the growing number of people of Hispanic ethnicity in the United States. Specifically, after adjusting for population age differences, 2004–2006 national survey data for people aged 20 years or older indicate that 11.9% of Mexican-Americans had diagnosed diabetes. About three-fourths of Mexican adult men and women are overweight, with 30 percent obese males and 42 percent obese females. Children have “felt the weight” as well. Twenty-eight percent of boys and 20 percent of girls ages 6–11 are overweight. These overwhelmingly high numbers are indicators that

a shifted diet may be a factor to the increased weight gain of this culture.

Teaching Implications

Health care providers need to understand Hispanic culture, beliefs, norms, food practices, and terminology to assist clients. In addition, providers need to support and stimulate the preservation of healthy cultural food practices among Mexican-American clientele so as to preserve their culture. When appropriate, suggest modifications of traditional dishes that are high in sodium, fat, and sugar with lower fat, lower sugar, and more whole grain options. Increase clients’ knowledge of healthy food selections from typical American fare. Gain support from clients’ families to enhance their acceptability of the diet.

Diets of many pregnant Mexican-American women of marginal social and economic standing are deficient in dietary iron, vitamin A, and calcium. Encourage the consumption of low-fat cheeses, lean red meat, and fresh fruits and vegetables. Monitor beverage intake, as carbonated soft drinks and pre-sweetened drinks are widely consumed. Breastfeeding is widely practiced in Mexico, although most Mexican-Americans use infant formula. Weaning children from the bottle at one year of age is not widely practiced. Baby bottle tooth decay is common in toddlers, suggesting that the child is put to bed with a bottle.

Customs and Family Traditions that May Affect Health Care

The family unit is the single most important social unit in the life of Hispanics. Family responsibilities come before all other responsibilities. Gender differentiation and male dominance are issues to consider while working with Hispanic families. The father is the leader of the family, while the mother runs the household, shops, and prepares the food. However, with increased acculturation to American society, the traditional concepts of manhood and womanhood appear to be changing toward a more egalitarian model. Mexican-Americans value *Personalismo*, or personal rather than impersonal relations, especially showing *respeto*, or respect, and *familialismo*, or emphasis on the value of, and reliance on the family.

Religious beliefs are important to acknowledge when interacting with Mexican-Americans. The majority of Mexicans are Roman Catholic. The Protestant Evangelical Christian movement is making major in-roads in the

Latino population. The church is often part of daily family and community life and plays an even greater role in times of illness.

Summary

Health care providers may intervene with Hispanic clients and communities in culturally sensitive ways, which include viewing culture as an enabler rather than a resistant force, incorporating cultural beliefs into the plans of care, stressing familism, and taking time for pleasant conversation. Understanding cultural values and beliefs can facilitate better health care interactions and outcomes, can be used to reduce risk behaviors and can potentially reduce health disparities.

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Cultural diversity must be studied to fully understand the dietary patterns of one culture's assimilation into the American lifestyle. This fact sheet is one of nine in a series developed to address cultural diversity in American eating.

“Culture” encompasses many attributes of a society including socioeconomic status, religion, age, education, social class, location, length of time in the United States, location of origin, and of course food habits, or dietary patterns. All of these influences are important to understanding the educational information to provide to a group. The goal of this fact sheet is to assist the educator in reducing any cultural barriers that may inhibit education. It is important for cultures to keep their customary food practices but to also incorporate healthier alternatives.

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Additional resources addressing cultural diversity in nutrition education:

- *Cross-Cultural Counseling: A Guide for Nutrition and Health Counselors* (FNS250). (1989). U.S. Department of Agriculture and U.S. Department of Health and Human Services.
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