



Lack of Cultural and Language Concordant Nutrition Education for Hispanic/Latinx Individuals with CKD: A Call to Action

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LATINX INDIVIDUALS AND CKD

The Latinx (Hispanic, preferred nongender-based term for Latino/Latina) community is the largest racial and ethnic minority group in the United States, and they experience a disproportionate burden of CKD and a faster progression to kidney failure than non-Latinx White individuals.¹ Due to a variety of factors, including discordant care, Latinx individuals with CKD are less likely to receive predialysis nephrology care, which may lead to a lower likelihood of receiving predialysis nutritional education.² Dietary behaviors are important modifiable lifestyle factors that play a role in the management and progression of CKD and its associated comorbidities and complications. In addition to poor access to predialysis nutritional counseling, Latinx individuals with CKD receive nutritional educational materials or behavioral interventions that are not culture or language concordant.^{3,4} In this Perspective, we describe the lack of culture- and language-concordant nutritional education, food insecurity, and we propose a roadmap to improve clinical and patient-centered outcomes for Latinx with CKD.

THE DISTRESS FACED BY LATINX INDIVIDUALS WITH CKD

The start of kidney replacement therapy is a difficult period for patients and

their caregivers because of the disease- and treatment-associated life changes, which include rapid fluid fluctuations, symptom development, and adaptation to a new lifestyle centered around dialysis.³ For patients that did not receive predialysis nephrology care, they must adjust to these changes quickly and to a medical nutrition therapy (MNT) traditionally centered on restricting or limiting certain nutrients (phosphate, potassium, sodium, and protein), depending on their degree of kidney dysfunction and other comorbidities.⁵ Not surprisingly, this MNT has been described as one of the most complicated in clinical populations.⁵

The MNT provided to Latinx individuals may not be culturally tailored to the patient's food preferences. Latinx individuals may be advised to restrict foods traditionally consumed in their culture, because these foods may be good sources of potassium and phosphate, while the consumption of non-traditional US foods, which are not staples in their diet, is recommended.⁶ This advice may contribute to distress; a rejection of dietary recommendations; decreased nutrient-dense food intake; increased energy-dense food consumption containing sodium, phosphate, and potassium additives; and compromised nutritional status.

In addition to the lack of cultural concordance, language concordance is another challenge faced by Latinx individuals. The current materials available

online through national societies, foundations, and companies are verbatim translations without cultural adaptation to Spanish. Furthermore, healthcare staff may not be proficient in Spanish and fail to use a certified Spanish language interpreter. In a qualitative study, interdisciplinary dialysis center clinicians observed that patients who report limited English proficiency are often skipped during rounds; dialysis technicians reported they (or the patient's family) are asked to provide *ad hoc* language interpretation, which is discouraged and prohibited per Title VI of the Civil Rights Act of 1964.³ Therefore, the lack of culturally and language-concordant education may further contribute to the distress and limit dietary adherence in Latinx individuals with CKD. In fact, dietary restrictions have been depicted by Latinx individuals receiving hemodialysis as culturally isolating and the most distressing aspect of living with kidney failure: "All the food I had to let go... cause I like avocados, beans, tomatoes, tortillas... I can't handle that!"⁴

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Table 1. Barriers to language and cultural concordance among Latinx individuals with CKD

Problem	Barriers	Opportunities/Recommendations
Access to MNT	<ul style="list-style-type: none"> • Low referral rates • Underinsurance • Low awareness 	<ul style="list-style-type: none"> • Promote benefit awareness • Patient navigators • Community clinics • Partnership with local and national organizations to increase awareness • Promote stronger representation of Latinx individuals in research studies
Dietary adherence	<ul style="list-style-type: none"> • Dietary restrictions 	<ul style="list-style-type: none"> • Inclusion of fruits (e.g., avocados, bananas, papaya, cantaloupe) due to the nutrient content (dietary fiber, vitamins, and minerals), with education efforts focusing on portion control and frequency • Inclusion of vegetables (e.g., tomatoes and potatoes) due to the nutrient content (dietary fiber, vitamins, and minerals), focusing education efforts on portion control, frequency, and demineralization cooking techniques • Inclusion of legumes (e.g., beans and lentils) due to nutrient content (dietary fiber, vitamins, and minerals), focusing education efforts on demineralization cooking techniques, portion control, and frequency • Promote the use of Latinx seasoning substitutes and culinary techniques for their preparation (e.g., sofrito) • Consider the use of dietary patterns appropriate for the population (e.g., <i>dieta de la milpa</i> for Mexico and Central America)
Lack of language-/cultural-concordant materials	<ul style="list-style-type: none"> • Use of generic/nonadapted materials 	<ul style="list-style-type: none"> • Increase Latinx providers • Latinx educators/providers to develop concordant materials • Patient partnership for the development of materials • Promote studies showing the efficacy of language and cultural-concordant materials to improve outcomes in the Latinx CKD population

FOOD INSECURITY IS AN ADDITIONAL BARRIER IN LATINX INDIVIDUALS WITH CKD

Education and counseling may not be sufficient to overcome the high food insecurity affecting the CKD Latinx community. National Health and Nutrition Examination Survey data reported that, although Mexican American adults represented 23% of the US population, approximately 54% had food insecurity.^{7,8} Food insecurity is associated with CKD and contributes to poor diet and health in various ways, such as reductions in nutrient-dense foods and increases in ultra-processed foods.⁷ In the Latinx population, this may translate to being unable to afford minimally processed foods or healthy substitutes for those with CKD. This may further exacerbate mineral and bone disorder, cardiovascular disease, and disordered glucose metabolism in the Latinx population already at risk for increased diabetes—a primary contributor to CKD among Latinx individuals.

BREAKING THE CYCLE: COMMUNITY-BASED INTERVENTIONS TO MITIGATE FOOD INSECURITY AND ELIMINATE INEQUITIES IN LATINX INDIVIDUALS WITH CKD

There is a critical need to create educational materials that are culturally and language concordant, provide nutritional education that does not eliminate foods that are traditional for Latinx communities, and consider community-based

The message should shift away from avoiding foods important to the Latinx community and instead look for ways to incorporate them

strategies (Table 1). Educational materials that are culturally and language concordant should incorporate, at the very minimum, foods traditionally consumed by Latinx individuals to reduce the feeling of isolation and distress (Table 1). Whereas several of the currently available materials have overwhelmingly excluded foods

important to Latinx individuals, a lack of evidence exists between dietary potassium intake and hyperkalemia. Furthermore, plant-based foods that naturally contain potassium or phosphate may be incorporated in the dietary advice, given the differences in nutrient bioaccessibility.⁵ In other words, the message should shift away from avoiding foods important to the Latinx community and instead look for ways to incorporate them. Some strategies to achieve this include appropriate portion control, frequency, and taking

advantage of culinary techniques (e.g., demineralization) to include vegetables and legumes (Table 1).⁹ Another strategy is to identify a substitution to lower the amount of potassium and phosphate, such as replacing commercial spices or sauces with homemade versions, using the appropriate modifications. A strategy

for supporting individuals to increase their intake of fresh or plant-based foods is to provide these foods, such as fruits, vegetables, and legumes, as has been shown through community-based interventions by Banerjee *et al.*⁷

Importantly, we need more Latinx healthcare providers who can provide culturally and language-concordant care and Latinx researchers who can build trust and encourage increased participation in research. While we work to diversify the healthcare workforce, patient navigators (*i.e.*, community health workers or *promotoras*) can serve as a bridge to healthcare providers. Community-based dietary interventions that employ navigators could also incorporate family and faith, which are highlighted as important values for Latinx individuals. All of these individuals can further promote dietary cultural and language concordance. Additionally, Latinx individuals face discrimination and are hesitant to seek healthcare; navigators can help reduce the work needed to build trust with Latinx individuals and provide education in safe locations, such as churches.¹⁰ Finally, increased language and cultural concordance can facilitate the advancement of research in the Latinx community to develop better approaches to the remaining challenges.

CONCLUSION

The Latinx CKD community faces distress through overly restrictive nutritional prescriptions, lack of culturally and language-concordant care, and a

lack of Latinx providers. In collaboration with healthcare providers and researchers, patient navigators can work together to develop materials and interventions that are culturally and language appropriate to reduce discordant care, health inequities, and disparities in the Latinx CKD community.

DISCLOSURES

A. Biruete reports serving in an advisory or leadership role for the Academy of Nutrition and Dietetics (as an expert work-group member of the Augment Trial) and the *Journal of Renal Nutrition* (on the editorial board); receiving honoraria from Amgen; and receiving research funding from Keryx Pharmaceuticals. L.M. Perez has nothing to disclose.

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AUTHOR CONTRIBUTIONS

A. Biruete and L.M. Perez conceptualized the study, wrote the original draft, and reviewed and edited the manuscript.

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