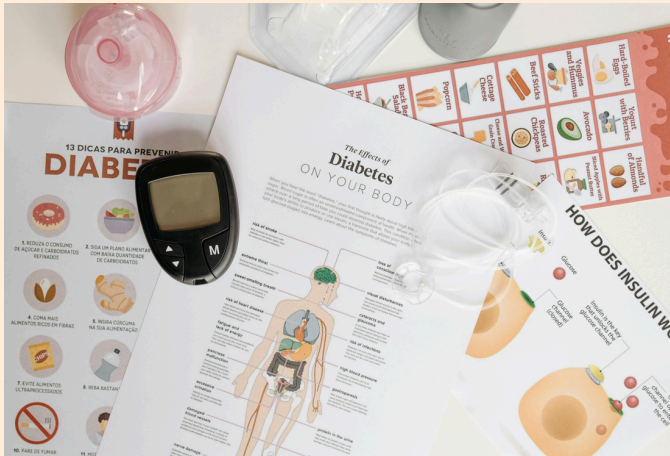


A close-up photograph of a person's hands chopping fresh green herbs on a wooden cutting board. The person is wearing a grey sleeveless top. The scene is lit with warm, golden light, creating strong shadows. In the foreground, there are several bowls: one with white rice, one with green jalapeños, and one with garlic. Two red onions are also visible on the cutting board.

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Cardiovascular Health Disparities in the Hispanic and Latino Communities



Cardiovascular disease (CVD) is the leading cause of death among Hispanic individuals in the U.S., with an overall prevalence of 8.2% including coronary artery disease, angina, and myocardial infarction. Other CVDs are also common, with stroke and heart failure affecting 2.4% of men and 1.7% of women, and peripheral artery disease carrying a lifetime risk of 22%. The prevalence of CVD can be attributed to health disparities within the population. Cardiovascular health disparities in the Hispanic population are characterized by increased prevalence of risk factors and co-morbid conditions such as hypertension, diabetes mellitus, obesity, and hypercholesterolemia. These factors are compounded with differences secondary to the country of origin, sex, and acculturation status. For example, Central American men have higher rates of hypercholesterolemia, while Mexican and Puerto Rican subgroups have higher rates of diabetes and obesity. Longer duration of residence in the United States, along with acculturation, creates a burden for risk factors, along with higher rates of heart disease and stroke. Barriers to the prevention of these conditions stem from limited access to healthcare, particularly for undocumented immigrants, lower insurance coverage rates, language barriers, and a lack of access to usual resources. Taken all together, they contribute to the undertreatment of the previously mentioned co-morbid conditions. Additionally, social determinants of health, including poverty, food insecurity, discrimination, and limited health literacy, further exacerbate these issues. The goal of physicians and other healthcare providers is to recognize these factors and avoid generalizations while providing culturally competent care.

Cardiovascular health disparities in the Hispanic and Latino communities are shaped by a complex interplay of biological, behavioral, and social risk factors that vary across subgroups. Data from the Hispanic Community Health Study highlights that hypercholesterolemia is the most prevalent risk factor among Hispanics, followed by obesity, smoking, and hypertension, compared to their non-Hispanic White counterparts. These conditions contribute to an overall prevalence of cardiovascular disease of 8.2 percent among Hispanic individuals in the United States, with an estimated annual healthcare cost of \$6025 per person. Importantly, risk profiles are not uniform across subgroups. For example, Puerto Rican adults report cigarette use at nearly three times the rate of Dominican adults. Prolonged residence in the United States has also been linked to worsening cardiometabolic risk factors, reflecting the influence of acculturation and dietary transitions, including increased consumption of fast food and sugar-sweetened beverages. Beyond individual behaviors, structural determinants such as immigration status, limited healthcare access, chronic stress, and systemic discrimination worsen disparities. Chronic stressors, including workplace inequities and exposure to COVID-19 as essential workers, have been shown to elevate rates of hypertension among Hispanic adults. Collectively, these findings underscore that cardiovascular disparities in these communities are not only a matter of biology but are deeply tied to socioeconomic, cultural, and structural inequities that demand multifaceted interventions.



The barriers that prevent Hispanic/Latino individuals from accessing care are multifactorial and complex. Political barriers, such as immigration policies and documentation status, pose a threat to achieving health equity, further deterring these communities from seeking medical attention when needed. Many individuals lack awareness of the common risk factors that lead to cardiovascular disease. Compared to non-Hispanic White individuals, Hispanic men and women rates of hypertension awareness, treatment, and control are lower. Factors such as language barriers, limited health literacy, lack of insurance, occupational exposures, nutrition, and cultural differences play a role in this discrepancy.

Focus groups aimed at discovering these barriers within these communities have found that there are large gaps in knowledge, belief, and attitude about CVD risks and prevention. Myths emphasized by culture, family, and social media further exacerbated the misinformation about CVD. Men within these communities also tend to exhibit the cultural norm of Machismo, the idea of appearing strong, leading them to often neglect their need for physical care. Nutritional factors also play a crucial role as a barrier to care, whether it be food scarcity, the lack of nutritional literacy, or the use of traditional cooking methods. Many communities lack access to healthy food options or are unable to afford their high costs. To truly combat these various barriers that the Hispanic and Latino communities encounter while trying to access prevention and care for cardiovascular disease, the implementation of community-based, culturally competent interventions is needed.



Healthcare providers can integrate discussions about well-balanced, nutrient-dense diets into patient encounters. The Dietary Approaches to Stop Hypertension (DASH) diet is a low-sodium, low-saturated fat eating plan that emphasizes vegetables, whole grains, and lean meats. In a meta-analysis conducted by Filippou et al., the DASH diet lowered systolic blood pressure by an average of 3.2 mmHg and diastolic blood pressure by an average of 2.5 mmHg. Patients with higher sodium intake before starting the diet experienced an even greater reduction in blood pressure. These benefits highlight the importance of encouraging patients to consider the DASH diet as part of managing their chronic conditions.

To ensure accessibility, healthcare providers should have patient education materials available in both English and Spanish. The National Institutes of Health (NIH) provides Spanish-language resources on the DASH diet, including guidance on getting started and a Heart Healthy Latino Recipes cookbook that can be shared with patients and clinic staff. Recognizing the cultural importance of traditional foods in Latino diets is essential to patient acceptance and long-term adoption of the DASH diet. Healthcare providers can start by encouraging simple modifications, such as substituting refried beans with whole beans or using whole-wheat tortillas instead of refined flour tortillas. These small changes allow patients to make traditional meals more DASH-friendly while continuing to enjoy the foods they cherish.

Reflection Questions

- What strategies can be used to adapt evidence-based dietary recommendations, like the DASH diet, to fit within the cultural and culinary traditions of my patients?
- How can recognizing the role of social determinants of health, such as acculturation and access to care, help healthcare providers provide more effective and culturally competent cardiovascular care for Hispanic patients?
- How can addressing structural barriers help reduce the burden of cardiovascular disease in the Hispanic and Latino communities?
- How can physicians and other healthcare professionals increase their understanding of the barriers to prevention and care faced by the Hispanic and Latino communities?

Helpful Links

- [Heart-Healthy Eating Latino Style](#)
- [Neighbor Health | Healthy Latino Cooking](#)
- [Latinos Living Healthy Nutrition](#)
- [NIH | Getting Started with DASH in Spanish](#)
- [NIH | Tips to Reduce Salt and Sodium in Spanish](#)
- [NIH | Why the DASH Eating Plan Works in Spanish](#)
- [NIH | Delicious Heart-Healthy Latino Recipes Book](#)
- [NIH | DASH Eating Plan](#)

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