Over the past 10 years there has been a threefold increase in the rates of child and adolescent overweight (OW) and obesity (OB) in the United States (Hedley, Ogden, Johnson, Carroll, Curtin, & Flegal, 2004; Ogden, Carroll, Curtin, Lamb, & Flegal, 2010). During the 2007-2008 National Health and Nutrition Examination Survey (NHANES), the prevalence of OB among children aged 2-19 years was reported to be 16.9% (Ogden & Carroll, 2010). Ogden, et al. (2010) found that 31.7% of 2-19 year old children and adolescents were at or above the 85th percentile for body mass index (BMI) for age during the 2007-2008 NHANES survey.

These concerning statistics have captured the public attention and have led to the development of programs to prevent childhood OB. For example, First Lady Michelle Obama initiated the Let’s Move initiative in response to the concerning rise in the rates of childhood OW and OB (White House Task Force on Childhood Obesity, 2010). Family-based weight management programs, especially parent-focused programs, are one effective approach to combat the growing rates of childhood OW and OB (Birch & Ven-
The purpose of this paper is to discuss and to discover the process of achieving cultural competent care when conducting family weight management strategies.

There is evidence of socioeconomic disparities in the national rates of childhood OW and OB. The prevalence of OW and OB among 2-19 year olds is higher among Hispanic (41.4-42.6%) and Non-Hispanic Black (37.6-41.1%) children and adolescents than among Non-Hispanic Caucasian children and adolescents (26.8-34.5%) (Bethell, Simpson, Strumbo, Carle, & Gombojav, 2010; Ogden, et al., 2010). Ogden and Carroll (2010) found the highest rates of OB among Mexican-American boys (26.8%), and Non-Hispanic Black girls (29.2%). Bethell et al. (2010) reported higher rates of childhood OW and OB among children from lower income families and families enrolled in public insurance programs.

The increasing rates of childhood OW and OB in the author’s home state of Georgia are a public health concern. Using data from the 2009 Pediatric Nutrition Surveillance System (PedNSS), researchers from the Centers for Disease Control and Prevention (CDC) found that 14.2% of 2-5 year old Georgia children are at or above the 95th percentile for BMI for age (Polhamus, Dalenius, Mackintosh, Smith, & Grummer-Strawn, 2011). Polhamus et al. found the highest prevalence of childhood OB in Georgia among Hispanic children (17.9%), as compared to Non-Hispanic Caucasian (12.9%), and Non-Hispanic Black children (11.9%).

Similar to other states, Georgia is experiencing an increase in the numbers of Hispanic/Latino residents. In the 2010 census survey, the U.S. Census Bureau (2011) reported that 30.5% of the population in Georgia is Non-Hispanic Black/African American, and 8.8% are Hispanic/Latino. The Georgia Hispanic/Latino population increased in numbers by 96.1% during the last census period (U.S. Census Bureau, 2011).

In response to the rising rates of childhood OW and OB in Georgia, the Georgia Department of Human Resources [GDHR] (2005) launched a 10 year strategic plan to prevent OB and OB-related chronic diseases. Using a socio-ecologic approach, the major goals of the initiative include encouraging healthy eating, increasing physical activity, and reducing television and screen time. The strategic plan specifically targets children, low income families, and Hispanic and Non-Hispanic Black individuals, due to noted socioeconomic disparities in OB rates in Georgia.

To this end, the implementation of interventions aimed at improving healthy eating, increasing physical activity, and reducing television and screen time among ethnically and socioeconomically diverse families is paramount. Understanding parents’ health-related values, beliefs, and practices is an important first step in implementing culturally competent programs that meet the needs of the population served. The process of achieving cultural competency when conducting family weight management interventions will be discussed. Specifically, the author’s experience using the Ways to Enhance Children’s Activity and Nutrition (We Can!) program with a group of diverse parents in Georgia will be highlighted. The paper will conclude with specific lessons learned about cultural competency when delivering the We Can! program.

Cultural Competency

Leininger (1967) was the first nursing scholar to formally define the concept of culture as an essential component of nursing care. As a nurse-ethnologist and psychiatric nurse, Leininger brought to the discipline of public health and mental health the universality and importance
of culture when working with the public around health issues. Leininger (2002) asserts that there are elements of culture that are diverse and some that are universal; the role of nurse is to provide care that addresses an individual’s unique sociocultural needs. Cultural competence is defined as the ability of a clinician to understand and respect the values, attitudes, beliefs that differ across cultures, while simultaneously considering and attending to these differences in planning, implementing, and evaluating care (Luquis & Perez, 2003).

Understanding individual and family values, beliefs, and health-related practices is essential in order to recognize the context in which health behavior changes will take place (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). The notion of cultural tailoring, or tailoring information directly to an individual’s assessed needs, has been cited as a way to increase cultural competency in health promotion strategies (Kreuter, et al.). Cultural tailoring helps to prevent one-size-fits-all approaches to modifying health behaviors.

Health promotion interventions have historically been designed with the cultural values of the majority of the population in mind, and empirically tested with middle class Non-Hispanic Caucasian participants (Hodge, Jackson, & Vaughn, 2010). This lack of cultural sensitivity in developed health promotion programs requires that researchers and clinicians adapt materials and delivery methods prior to use. Two examples of culturally competent adaptation techniques are linguistic strategies (translation) and involving individuals of a similar cultural background to the group (Kreuter, et al., 2003). Meir, Ory, and Medina (2010) assert that delivering interventions in the native language by an individual familiar with the culture is one way to meet cultural needs, along with a comprehensive understanding of the degree in which cultural values and beliefs (i.e. familism) impact health behaviors. Hodge et al. noted that there are two components to delivering culturally competent health promotion programs: 1) sensitivity to individual values and beliefs and 2) the level of cultural competence of the researcher. As the demographics of the country continue to shift, it is essential that researchers tailor interventions to individual and family needs, values, beliefs, and practices.

Understanding this need, the author will discuss her experiences using the We Can! program. The program will be described in depth, followed by a discussion of the positive and negative aspects of the program as they relate to cultural competency. The paper will conclude by summarizing particular lessons learned using the program, including ways the materials were tailored and delivered to a population of diverse parents in Georgia.

**Description of the We Can! Program**

The Ways to Enhance Children’s Activity and Nutrition (We Can!) program, developed by the National Heart Lung Blood Institute (NHLBI) is the program the author used with a group of 11 parents in North Georgia (all mothers). The participants ranged in age from 25 to 60 years (M = 39.6). A majority identified themselves as Black or African American (63.6%), followed by Hispanic/Latino (27.3%), and Caucasian (9.1%). Nearly all (91.9%) possessed at least a high school education. Almost half (45.5%) were single-parent families.

We Can! was designed to educate parents on modifiable lifestyle factors (NHLBI, 2007). The program has several foci: increasing knowledge about healthy eating and physical activity, changing attitudes and behaviors, and helping parents to develop self-efficacy in making family lifestyle changes. All of the materials are available to download or order on the website:

[www.ojccnh.org](http://www.ojccnh.org)
http://www.wecan.org. The website also features articles and resources for individuals, communities, and healthcare providers. The author liked the curriculum immediately due to the short length (five weekly sessions), ease of delivery, family focus (specifically to the parents), and positive message about becoming a healthier family.

We Can! has a set curriculum called *We Can! Energize our Families: Curriculum for Parents and Caregivers* (NHLBI, 2007). The program addresses four key areas: 1) increasing the availability of healthy foods in the home and understanding correct portion sizes 2) understanding food labels and limiting high fat, high sugar, and calorie-dense foods 3) increasing family physical activity and 4) reducing family screen time (both television and computer time) (NHLBI, 2007). As part of the curriculum each participant receives the publication “Families Finding a Balance: The Parent Handbook” which summarizes and reinforces key lessons from the curriculum (NHLBI, 2008). The parent handbook is available in both English and Spanish from the NHLBI. During the program, the participants learn how to incorporate new healthy lifestyle skills, along with strategies to help with successful implementation. The participants are encouraged to try the new strategies at home and the group dialogues about successes and barriers at the weekly sessions.

The original testing of the We Can! program occurred between 2005 and 2006 at 14 test sites across the United States (NHLBI, 2007). One-hundred seventy four parents (87% female mean age 36) participated in the program testing. A majority of the participants identified themselves as Caucasian (73%), followed by Hispanic (22%), and African-American (15%). The NHLBI reported significant increases in parental knowledge, attitudes, and behaviors of energy balance, portion sizes, healthy eating, healthy foods, physical activity, and screen time after the parents completed the program.

Positive Aspects of the We Can! Program

We Can! Has several positive aspects. First, We Can! is a family-focused program that acknowledges the role of parents as the key agents of change in the family system. Familism is important to address in weight management interventions; focusing on the needs of the family and social support systems are vital. The second positive aspect is the group delivery of the material. This delivery method allowed each participant the opportunity to share personal experiences and to dialogue with other parents in the group. As an additional benefit, the author was able to quickly ascertain differences between the curriculum materials and the cultural values and beliefs of the participants. Although We Can! has a set curriculum, each session included at least one group discussion period. These discussion periods allowed enough flexibility to address the specific concerns and questions of the participants, as well as to deliver the materials in a more culturally competent manner. A standing flipchart and marker were used to take notes during the discussions. This culminated in a summary of specific needs discussed with the participants (Table 1).

Negative Aspects of the We Can! Program

Although We Can! is an easily accessible, inexpensive intervention, there are a few aspects to make sure and address if you plan to use this program. The first and most pressing concern is the lack of course materials available in Spanish. The parent handbook is available in Spanish, but almost all other course materials are written in English. All of the participants in the pilot program were literate, but three of the mothers spoke Spanish as their primary language. A native South American Spanish-speaking inter-
A interpreter was hired to assist with interpretation during the sessions. Each session was delivered in both English and Spanish. The interpreter sat near the Spanish-speaking participants and was able to translate the materials presented. She also translated back their questions and comments to the group so that an active dialogue was created.

As more materials become available in Spanish from We Can! this will become less of a concern. We Can! questionnaires were used in the pilot study, and a native Spanish-speaker translated them from English to Spanish. The translator then translated the materials back to English to ensure accuracy. Re-translation is an important step. In addition, it may be wise to pilot test the translated questionnaires with a small group of participants.

Two important aspects not addressed in the program are cultural variations in food choices and sensitivity toward the availability and affordability of suggested healthy foods. For example, the author educated the group about 100 calorie snack options, which included a few snack ideas like graham crackers, strawberries, and mozzarella string cheese. After sharing the ideas, a few of the mothers spoke up about their concern with the cost and/or availability of the

<table>
<thead>
<tr>
<th>Week/Session</th>
<th>We Can! Topic/Activities</th>
<th>Summary of Group Discussion</th>
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<tbody>
<tr>
<td>Week 1/Session 0</td>
<td>Introduction We Can!</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Week 2/Session 1</td>
<td>Childhood overweight/obesity rates</td>
<td>Healthy ways to cook</td>
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<td></td>
<td>Introduction to energy balance</td>
<td>Healthy preparation of fish/chicken</td>
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<td>Tips to eat well and more mover</td>
<td>Iron-rich foods</td>
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<td>Easy activities for kids</td>
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<td>Limit setting for television</td>
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<tr>
<td>Week 3/Session 2</td>
<td>Understanding body mass index</td>
<td>Barriers to a healthy lifestyle</td>
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<td>Portion control/service sizes</td>
<td>Overcoming barriers</td>
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<td>Healthy cooking practices</td>
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<td>Physical activity ideas</td>
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<td>Fat percent in ground meat</td>
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<td>Fat percent in milk</td>
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<td>Role modeling and change process</td>
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<td>Week 4/Session 3</td>
<td>Reducing fat/sugar in the diet</td>
<td>Saving money on healthy foods</td>
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<td>Slow, Whoa, and Go foods</td>
<td>Healthy substitutions for fats/sugar</td>
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<tr>
<td></td>
<td>Recipe alternatives</td>
<td>Ways to reduce calories</td>
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<tr>
<td></td>
<td></td>
<td>Amount of sugar in drinks</td>
</tr>
<tr>
<td>Week 5/Session 4</td>
<td>Incorporating physical activity</td>
<td>More healthy substitutions</td>
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<tr>
<td></td>
<td>Ways to limit family screen time</td>
<td>Limit setting on television</td>
</tr>
<tr>
<td></td>
<td>Limit-setting/family goals</td>
<td>Family physical activity ideas</td>
</tr>
</tbody>
</table>

Table 1: Weekly Topics and Group Discussion Points - We Can!
snacks in their local markets or grocery stores. The participants used this opportunity to share ideas for 100 calorie snacks that were within the means of the group, available in their area, and would meet their personal idea of a healthy snack. The author also brought healthy snack examples each week. One week, the author brought hummus (a Mediterranean chickpea dip), baby carrots, and celery sticks for the participants. Other than one mother who helped herself to a full plate, the snacks went untouched. Hummus costs between three and five dollars for a small container in North Georgia, and was an unfamiliar food to most of the participants. While exposure to new healthy foods can be beneficial, more attention to cultural variations in food preference and the cost of suggested foods was warranted.

**Lessons Learned from We Can!**

Specific lessons learned from We Can! will be discussed as well as personal experiences. I found that utilizing the We Can! program with a group of diverse parents in Georgia was feasible. The parents who attended were ready to make healthy changes for their families, and were receptive to education on increasing healthy foods, decreasing calorie-dense foods, increasing physical activity, and setting limits on television and screen time. Based on my experiences in using the program, it can be adapted to a variety of cultural groups with some preparation and attention to the unique cultural needs of the participants. I offer the following recommendations as lessons learned from my experience using We Can!

**Lesson 1 – Get to Know Your Group**

The first step is to understand the unique cultural needs of your population, which can be accomplished by conducting a focus group. The focus group can serve as both a way of getting to know the participants, as well as an opportunity to explore the parents’ perceptions of assets and barriers to making lifestyle changes. During the pilot study I did this informally during the first session, before we began the curriculum. This allowed me to understand the participants’ most pressing questions and needs. I could then tailor the discussions to the most pertinent needs of the group. I would consider formalizing this process before my next intervention using We Can!

**Lesson 2 – Get to Know the Neighborhood and Surrounding Community**

Another preliminary step is to get to know the neighborhood the participants live in, as well as the surrounding community. I conducted a windshield survey of the neighborhood with special attention to safe places for physical activities, and types of grocery stores and restaurants in the area. Next time I would consider taking a tour of local grocery stores to assess for types of foods available and food prices. This would allow the opportunity to discuss healthy options available in the participants’ neighborhood(s) and communities, as well as tips to save money while shopping. I would also consider assessing for surrounding farmer’s markets or other places to buy produce at reasonable prices.

**Lesson 3 – Language and Literacy**

Attending to the literacy level and primary language needs of the group is essential before initiating an intervention. Mier et al. (2010) suggest that intervention facilitators be bicultural (or multicultural), and that program materials are written in the language and at the literacy level of the participants. Back translation is an important step, and, as mentioned previously, piloting translated materials can ensure that the materials or research instruments are sensitive to the unique cultural values of the participants.
I hired both a translator and an interpreter for my pilot study. The interpreter, who was from the same country as my Spanish-speaking participants, was invaluable in helping to overcome language barriers. Although there were a few moments of difficulty in delivering the class in both English and Spanish, having a native Spanish-speaking interpreter allowed each participant to have a voice during the discussions.

Lesson 4 – Cultural Values

It is imperative to have a comprehensive understanding of your participants’ values and beliefs about body weight, foods, physical activity, and television/screen behaviors. It is difficult to achieve cultural competency in weight management programs without acknowledging the universal cultural values and the unique cultural values of the group. A mixed methods approach to research may help to meet this goal, and conducting focus groups is a good way to start.

If the intervention involves delivering education on health behaviors, it is worthwhile to think of ways to adapt the materials prior to each session. For example, I prepared for the sessions by remaking participant recipes with healthier ingredients, coming up with creative physical activity ideas around the participants’ apartment complex, and thinking of healthy substitutions at the closest fast food restaurant to the apartment complex. I could draw on these ideas and examples during our discussions in order to meet the needs of the participants. Encouraging group dialogue and idea sharing also helps with this process. One example of this is when the group addressed limit setting on television. One mother was having difficulty setting limits on television time with her son. The group began brainstorming ideas about how to handle the situation (e.g. removing the television from his bedroom). Group social support and idea sharing was a serendipitous enhancement to the intervention.

Lesson 5 – Understand Socioeconomic Barriers

The final lesson I learned through my experience is to have a thorough understanding of the socioeconomic barriers to making family lifestyle changes. With the exception of one participant who was unemployed, the mothers in my group were employed part time or full time. All of the mothers struggled with their personal finances. This came up frequently when we discussed grocery shopping and food preparation. As part of the group dialogue we came up with ways to save money at the market, while still purchasing healthy foods. For example, one participant bought regular carrots, peeled, and cut them into sticks instead of buying the more expensive prepackaged baby carrots. We also used the group dialogue to discussed no-cost family physical activities in their area. The group came up with playing basketball (there was a court at their apartment complex) and taking a family walk around the track at the elementary school.

Conclusion

Achieving cultural competency in delivering family weight management interventions can be a challenge for researchers and clinicians. Despite challenges, interventions can be adapted or tailored to the unique cultural values and beliefs of the participants. Understanding the cultural values and beliefs of the group, ensuring that materials are in the primary language, engaging facilitators familiar with the participants’ culture, and tailoring course materials to the socioeconomic level of the participants are a few ways to meet cultural needs. As the nation continues to become more diverse, it is imperative that researchers and clinicians build, test, and refine family weight management interventions to meet the unique needs of families.
References