Are You Talking to ME?

The Importance of Ethnicity and Culture in Childhood Obesity Prevention and Management

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Abstract

Childhood obesity is prevalent, is of consequence, and disproportionately affects racial/ethnic minority populations. By the pre-school years, racial/ethnic disparities in obesity prevalence and substantial differences in many risk factors for obesity are already present, suggesting that disparities in obesity prevalence have their origins in the earliest stages of life. The reasons for racial/ethnic variation in obesity are complex and may include differences in cultural beliefs and practices, level of acculturation, ethnicity-based differences in body image, and perceptions of media, sleep, and physical activity. In addition, racial/ethnic differences in obesity may evolve as a consequence of the socio- and environmental context in which families live. The primary care setting offers unique opportunities to intervene and alter the subsequent course of health and disease for children at risk for obesity. Regular visits during childhood allow both detection of elevated weight status and offer opportunities for prevention and treatment. Greater awareness of the behavioral, social-cultural, and environmental determinants of obesity among ethnic minority populations could assist clinicians in the treatment of obesity among diverse pediatric populations. Specific strategies include beginning prevention efforts early in life before obesity is present and recognizing and querying about ethnic- and culturally specific beliefs and practices, the role of the extended family in the household, and parents' beliefs of the causative factors related to their child's obesity. Efforts to provide culturally and linguistically appropriate care, family-based treatment programs, and support services that aim to uncouple socioeconomic factors from adverse health outcomes could improve obesity care for racial/ethnic minority children.

Prevalence and Racial/Ethnic Differences in Childhood Obesity and Obesity-Related Risk Factors

In the United States, approximately 32% of children ages 2–19 years are overweight (age- and sex-specific BMI 85th–94th percentile) or obese (BMI ≥95th percentile).¹ Even though US childhood obesity rates in some population subgroups, such as whites and those of higher socioeconomic status, may have peaked, overall rates remain stubbornly high, and racial/ethnic disparities appear to be widening.^{2–4} Racial/ethnic minority children bear a disproportionate share of the burden of obesity and its related comorbidities.⁵ According to the most recent national statistics, the prevalence of children ages 2–19 years having a BMI ≥95th percentile was 15.3% among non-Hispanic white children, 20.0% among non-Hispanic black children, and 20.8%

among Mexican-American children.¹

Research has shown that racial/ethnic and socioeconomic disparities exist across most known risk factors for childhood obesity, from the prenatal period through childhood. In a recent study by our research group,⁶ children from racial/ethnic minority groups were found to have a higher risk of various early life risk factors for obesity compared to their white counterparts. Several studies of older children have also found obesity-related risk factors to be more prevalent among racial/ethnic minority youth, including higher levels of television viewing and more televisions in bedrooms, higher consumption of sugar-sweetened beverages,⁷ increased fast food consumption,⁸ and lower levels of physical activity among black and Hispanic youth compared to white youth.^{9,10} These differences may help to explain racial/ethnic disparities in childhood obesity rates while justifying the need for early childhood interventions to prevent obesity.

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Contribution of Socio-Cultural and Environmental Context to Racial/Ethnic Differences in Obesity

Cultural beliefs and practices and levels of acculturation may contribute to racial/ethnic disparities in obesity. Culture may influence parental perceptions of their children's health status and behaviors. Ethnic minority mothers may have different perceptions of what they consider a "healthy" child. In some cultures, mothers may view thinness as a reflection of poor health and malnutrition,^{11–14} and some ethnic minority parents may have inaccurate perceptions of their child's weight or obesity status.^{15,16} Culturally defined perceptions of body image could influence parenting strategies and decisions regarding eating and physical activity habits. Accumulating evidence has also shown a change in health status with acculturation and more time spent in the United States. In particular, studies have shown changes in traditional diet components across generations.¹⁷ The neighborhoods racial/ethnic minority children live in may also be less conducive to reaching and maintaining a healthy weight.¹⁸ Neighborhood crime and safety, food marketing and transportation environments, access to recreational facilities, social capital and support, self-efficacy in overcoming barriers, parental activity levels, body image, and self-esteem could all influence nutrition and physical activity among racial/ethnic minority children and adolescents.¹⁹

Strategies To Aid Clinicians in the Prevention and Management of Obesity among Ethnic Minorities and Diverse Pediatric Populations

The primary care setting offers unique opportunities to intervene and alter the subsequent course of health and disease for children at risk for obesity. Every year, about 80% of children and adolescents visit a physician, with an estimated 76 million annual contacts.²⁰ Regular contacts during childhood allow both detection of elevated weight status and offer opportunities for prevention and treatment. Greater awareness of the behavioral, social-cultural, and environmental determinants of obesity among ethnic minority populations could assist clinicians in the treatment of obesity among diverse pediatric populations. Several strategies can aid clinicians in the treatment of overweight among underserved, diverse pediatric populations:

Begin Prevention Efforts Early

Evidence suggests that racial/ethnic minority children have higher rates of early life risk factors for obesity. Thus, early childhood seems particularly promising for health promotion interventions to prevent obesity among

minority children. Habits and tastes develop early in children, and so establishing the tastes for a variety of foods, enjoying active play, and developing motor skills and good sleep habits are all critical for future healthy behavioral patterns. Clinicians, in particular, can play a crucial role in preventing and addressing childhood obesity by discussing prenatal risk factors known to be more prevalent among racial/ethnic minorities. Clinicians can counsel expecting mothers on early determinants of obesity and promote optimal gestational weight gain and smoking cessation. During infancy and childhood, clinicians should look for early signs of excess gains in weight-for-length or BMI in children and counter the commonly held belief that a chubby baby is a healthier baby. They should also encourage healthy diets, reduced television viewing, increased physical activity, and limited sugar-sweetened beverage intake. Early education and intervention can serve to not only prevent children from becoming obese but also serve a role in secondary prevention of disease progression among high-risk children.

Recognition and Query of Ethnic- and Culturally Specific Beliefs and Practices

Parents enter medical encounters with their own ethnic- and culturally specific beliefs and practices of their child's health and care. Culturally defined perceptions of health may influence how parents view and respond to their child's body size. If health is primarily perceived as the absence of illness,²¹ parents may not recognize childhood obesity as a health risk. Parents who perceive their overweight or obese children as healthy may then be less motivated to modify the child's environment and behavior. Clinicians should query about the parents' view of the long-term control and consequences of childhood obesity. For example, in a study of African-American mothers,²² many reported that a child's size is due to a fixed inherited growth pattern with little that can be done to prevent excess weight gain. In other studies of Latina and African-American mothers, some expressed that a child would eventually "grow out of" obesity.^{11,21,22}

Querying about child-feeding practices may help clinicians further understand the parents' beliefs and may have implications for childhood obesity prevention. For instance, a recent focus group study in Mexico City²³ revealed several parental perceptions and practices related to childhood obesity, including parents' use of junk or *chatarra* foods as a reward and a negotiation strategy for good behavior. This practice suggested that pleasing children is a major motivator of parental feeding behaviors, which may outweigh perceived negative attributes of "unhealthy" foods. This study illustrates the utility of asking parents' beliefs when formulating a management plan for obese children.

Inquiring about these beliefs and practices may help clinicians better understand the parents' perspective and effectively communicate health issues sensitively and respectfully. Specific queries can help clinicians better

understand the role of ethnicity and culture in influencing obesity development and the context in which racial/ethnic minority families are making decisions about behavior change. These include assessing:

1. General ethnographic questions and indicators of socioeconomic status.²⁴
2. Knowledge, beliefs, and perceptions of child health and disease. Assess parental explanatory models of health and disease as well as barriers and facilitators to maintaining healthful nutrition and physical activity practices in their family. Managing a child's obesity involves merging the perspectives of parents and healthcare providers. The parents' explanatory model highlights their beliefs regarding obesity while helping to identify any potential barriers to treatment. Discussing the explanatory model also provides an opportunity to gauge parents' knowledge of healthy lifestyle choices and to clarify any misconceptions.
3. Psychosocial and societal stressors influencing obesity-related behaviors in childhood. This includes an assessment of social support,²⁵ existing social networks, family roles and responsibilities, and parent's perceived confidence and readiness to change.²⁶
4. Perceptions of and influences on early feeding choices. Assess mothers' knowledge of and perceptions of infant hunger and satiety cues; cultural beliefs related to breastfeeding, bottle feeding, and adding solids to bottles; and maternal attitudes toward children's body size.
5. Emergence of parental attitudes towards diet, sleep, media, and physical activity patterns in childhood. Assess parents' understanding of "healthful" diet patterns, including sugar-sweetened beverage, juice, and sweet solid food consumption, and the role and perceptions of television viewing and children's sleep.
6. Acceptability and cultural appropriateness of potential clinical strategies for obesity prevention including food and beverage substitutions. Assess awareness by parents and other household members of the quality of the carbohydrates and beverages they consume and explore acceptability of substitutions to improve carbohydrate and beverage quality.

Recognition of the Role of the Extended Family in Obesity Prevention and Management

The extended family plays an important role in Latino and African-American families. In many racial/ethnic minority families, grandparents or other extended family members are typically involved in the upbringing and care of children and may influence parenting strategies and beliefs.^{14,27} Extended family may also influence children's eating and physical activity behaviors.²⁸ An understanding of who is involved in caring for the child, especially who prepares the child's meals, who lives with the child, and who cares for the child during working

hours, can help clinicians better understand the child's environmental context and levers of influence.

Provide Culturally and Linguistically Appropriate Care

As the population in the United States continues to grow and become more ethnically diverse, providers must consider linguistic and cultural barriers in providing care. Language and culture play a role on many levels of healthcare, including families' ability to recognize illness, seek care, give relevant and accurate histories, understand diagnoses, and comply with treatment and follow-up.^{29,30} In regard to childhood obesity, healthcare providers should pay special attention to traditional ethnic cuisine and eating customs. Culturally appropriate care could entail nutritional counseling that provides alternatives within families' cultural framework. For example, African-American families may be counseled regarding healthier alternatives in traditional soul food preparations, *i.e.*, using skim or low-fat milk in recipes or replacing carbohydrates on their plates with greens like spinach or collards that are prepared with small amounts of healthy oils. Among Mexican-American families, clinicians could discuss opting for brown rice instead of white rice to accompany meals, reducing the portions of rice and replacing them with beans, using whole-grain or corn tortillas for flour tortillas, and not adding sugar to children's foods or beverages. Among Caribbean families, additional culturally appropriate dietary substitutions may include baking instead of frying plantains and using olive or extra virgin coconut oil instead of lard for stewing beef or other meats.³¹ Likewise, recommendations for physical activity could incorporate culturally based activities that appeal to diverse groups, such as Zumba, traditional Latin or folk dance, and sports teams.

Overcoming language barriers requires that healthcare providers be familiar with using trained interpreters in clinical settings. Clinics should also be equipped with adequate communication services that supplement in-person interpreters. In addition, any health literature provided should be translated in the patient's language. This would include educational handouts, consent forms, and prescriptions. Providing culturally and linguistically appropriate care builds a foundation for establishing rapport with families.

Provide Coordinated Services or Family-Based Treatment

Family-centered care may help to extend the reach of clinical efforts to manage childhood obesity. For instance, providing adult obesity management for parents helps create a supportive environment for the child. Affordable, family-oriented physical activities would further promote a healthy lifestyle. Multidisciplinary providers, including nutritionists, social workers, and behavioral psychologists, could additionally help to provide comprehensive care in one setting. Coordinated services allow obesity management to become a priority for the entire family.

Provide Health Services that Aim to Uncouple Socioeconomic Factors from Adverse Health Outcomes

Healthcare providers should actively counteract socioeconomic factors that negatively influence obesity management. For instance, families who have difficulties commuting to appointments may be provided with travel vouchers. Clinics should be mindful of working parents' availability and try to appropriately accommodate their schedules. Clinics could also provide social service support for families needing assistance with food, child care, utility bills, or housing. Addressing these social factors in a healthcare setting may help to eliminate barriers to treatment.

Conclusions

Greater awareness of the behavioral, social-cultural, and environmental determinants of obesity among ethnic minority populations and provision of care that recognizes the importance of ethnicity and culture in childhood obesity management could assist clinicians in the treatment of obesity among diverse pediatric populations. Ethnically and culturally appropriate strategies in primary care may very well open up new avenues for preventing childhood obesity in the very segments of the US population that need it most.

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