Cultural Beliefs About Healthy and Unhealthy Weight in Children 2 to 11 Years of Age Among Parents of Mexican Heritage

Nathalie Confiac

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CULTURAL BELIEFS ABOUT HEALTHY AND UNHEALTHY WEIGHT
IN CHILDREN 2 TO 11 YEARS OF AGE
AMONG PARENTS OF MEXICAN HERITAGE

A Dissertation
Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Nathalie Eve Veronique Confiac

May 2022
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IN CHILDREN 2 TO 11 YEARS OF AGE
AMONG PARENTS OF MEXICAN HERITAGE

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ABSTRACT

CULTURAL BELIEFS ABOUT HEALTHY AND UNHEALTHY WEIGHT IN CHILDREN 2 TO 11 YEARS OF AGE AMONG PARENTS OF MEXICAN HERITAGE

By
Nathalie Eve Veronique Confiac

May 2022

Dissertation supervised by Professor Melanie Turk

Introduction: Despite multisectoral preventive interventions, the obesity prevalence among children of Mexican heritage remains the highest of all ethnic groups in the US.

Methodology: Guided by Leininger’s Culture Care Diversity and Universality Theory, this study explored the culture care beliefs and practices of Mexican heritage parents about healthy and unhealthy weight in children 2-11 years of age using the ethnonursing research method. Eight key and 17 general informants were interviewed, and the four phases of ethnonursing data analysis guided analysis. Results: Twenty-six categories were identified which led to seven culture care patterns revealing four themes. Informants shared the cultural meaning of health as happiness, natural remedies and fresh food, and the desire of nursing concrete support on specific areas, such tracking of age-appropriate growth and culturally-appropriate healthy recipes. Discussion: Nurses should include Mexican heritage families’ cultural values and practices such as natural and collective care to provide more culturally congruent care.
DEDICATION

I would like to dedicate my dissertation to my mentor and friend Dr. Teresa Dodd-Butera, PhD, RN, DABAT who was instrumental in my pursuing a doctoral program. Thank you for believing in me, for your mentorship, love and support throughout this journey. I would also like to dedicate this dissertation to my family:

- To my mother Felly SEDECIAS, who has a passion for writing, encouraged me and always believed in me: I finally wrote my second book like you like to say. Thank you for inspiring me to always do my best and aim to #1. (J’ai finalement écrit mon deuxième livre comme tu le dis si souvent. Merci de m’avoir toujours inciter à être number 1)

- To my late great aunt and grandmother, Clotilde and Elizabeth SEDECIAS who made a lot of sacrifices to my studying nursing and gave us the hardworking family value.

- To my sister Danielle REMUS, who supported me throughout this journey. Thank you for our Sunday meetings. (Merci pour nos rendez-vous du Dimanche)

- And to my daughter Chloe Confiac who had to share her mommy time with doctoral time. Thank you mamy, your time is back and many kisses too.
ACKNOWLEDGEMENT

I would like to thank my dissertation committee for guidance and support during this journey, particularly my committee chair Dr. Melanie Turk, for countless hours of guidance, and encouragements, calm, kindness and patience. Then, many thanks to Dr. Zoucha for leading me towards qualitative research and ethnonursing mentoring. From a seed planted in qualitative practicum class, a dissertation proposal was born. Finally, I’d like to give special thanks to Dr. McFarland for her leadership in the transcultural nursing field as entrusted by Dr. Leininger. Her vision, guidance and support prepared me for the journey of transcultural nurse scholar. It was a true blessing and unique opportunity to work with such a knowledgeable and humble nurse and an honor to have Dr. McFarland as a committee member.

To continue, I would like to thank the community partners who assisted me during recruitment of study participants. This include CommUnify, Santa Barbara County Promotores Network, Promotoras y Promotores Foundation, and Health Linkages. I could not have done it without your precious help.

Then, I would like to acknowledge Sigma Theta Tau, Epsilon Phi Chapter who granted me an award that significantly contributed to informants’ incentives and Duquesne University School of Nursing for Scholarships which helped me carry on as a student during difficult times.

Finally special thanks to all informants. Thank you for opening your doors and sharing your stories and cultural expertise for better the health of all children of Mexican heritage.
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This dissertation will be presented in three parts. The first part consists of an integrative review of the literature, Mexican American Parental Knowledge and Perceptions of Childhood Obesity, published in Hispanic Healthcare International. It is presented below with the permission of Sage Publishing. The second part is the dissertation proposal. The third manuscript will include a complete presentation of the study including theoretical framework, methods, results, discussion and conclusion.
MANUSCRIPT #1: INTEGRATIVE REVIEW OF THE LITERATURE

Literature Review/Research

Mexican American Parental Knowledge and Perceptions of Childhood Obesity: An Integrative Review

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Abstract
Introduction: For the past two decades, childhood obesity has remained a national public health concern, particularly among Hispanic populations. Multiple cross-sectional obesity prevention strategies have been implemented yet remain unsuccessful in generating sustainable lifestyle changes. Method: The purpose of this integrative review, using the Whitemore and Knell method, was to examine the literature from 2009 to 2018 regarding Mexican American parental knowledge and perceptions of childhood obesity. The CINAHL, PubMed, PsychINFO, and ERIC databases were used to search the literature, and 13 peer-reviewed articles met the inclusion criteria. Results: Three main themes emerged from the literature synthesis: (1) parental misperception of child body weight and size, (2) influence of cultural health and growth beliefs on parental perception of child weight, and (3) parental perspectives of causes and consequences of childhood obesity and how to address it. However, cultural variations in parental perceptions were found; therefore, attempts to generalize Mexican Americans’ cultural practices should be avoided. Conclusion: Studies using qualitative approaches are needed to gain deeper insights about Mexican American culture regarding children’s health as it relates to body weight, the roles of different family members in the Mexican American child-rearing tradition, and the impact of their associated health beliefs.

Keywords: childhood obesity, Mexican Americans, cultural beliefs, integrative review

Introduction
For the past two decades, childhood obesity in the United States has been a public health concern with alarming consequences, such as increases in early onset of chronic diseases in children (diabetes, hypertension, hypercholesterolemia, cardiovascular disease; Centers for Disease Control and Prevention [CDC], 2015) and an overall shortening of life expectancy (Daniels, 2006). In addition, overweight and obese children are subject to psychological problems including depression, low self-esteem, bullying, and social stigmatization (CDC, 2015). The latest national trends indicate an overall obesity prevalence of 18.5% among youth 2 to 19 years of age, with higher rates among Hispanics—25.8%—compared with 22% in non-Hispanic Black, 14.1% in non-Hispanic White, and 11% in non-Hispanic Asian youth (Hales, Carroll, Fryar, & Ogden, 2017). The national census of 2010 revealed that 16.3% of the U.S. population was of Hispanic or Latino ethnicity of which 10.3%—the largest proportion—reported being of Mexican descent; hence, the need of examining their health (U.S. Census Bureau, n.d.). The health status of Hispanic Americans has been a focus at the national, state and local levels with the Healthy People 2020 goal to eliminate health disparities by addressing social determinants of health (U.S. Department of Health and Human Services, & Office of Disease Prevention and Health Promotion, 2017).

Problem Identification
Research has addressed multiple obesity prevention strategies including evidence-based interventions (Berger, Jenkins et al., 2014; Zeerob et al., 2013) and qualitative approaches (Lindsay et al., 2013; Martinez, Rhee, Blanco, & Beutelle, 2014) to better understand Hispanic families’ points of view about obesity. Long-term and short-term interventions targeting multiple age groups in various settings (primary care, home, school) have been implemented, yet remain unsuccessful in generating sustainable lifestyle changes (Ayala et al., 2010; Bender, Nader, Kennedy, & Gahagan, 2013; Boudreau, Karwowski, 2011)

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Gonzalez, Dimond, & Oreskovic, 2013; Hammond, Wiley, Fiese, & Tanen-Garcia, 2013; Zoorob et al., 2013). Moreover, much of the previous research has not specified subgroups among Hispanics despite significant differences, for example, children of Mexican descent have been found to be at a greater risk for obesity and its negative health consequences (Dominguez et al., 2015; Kammers, Kim, Yang, & Villarruel, 2011; Wojcicki, Schwartz, Jimenez-Cruz, Ricard-Guascon, & Heyman, 2012). Parents have been acknowledged as the main influence in children’s development (Skouteris, McCabe, Swallow, & Hill, 2010), and studies have found a positive relationship between parental perceptions and practices (feeding styles, role modeling) and children’s eating habits and weight status (Aguirre, 2016; Pesch, Harrell, Kaciroti, Rosenblum, & Lameng, 2011; Skouteris et al., 2010). Thus, examining Mexican American parental perceptions and beliefs with regard to childhood obesity causes, consequences, and preventive strategies is a necessary step (Skouteris et al., 2010).

In a review of the literature from 2000 to 2009, Sosa (2012) described the state of the science regarding Mexican American mothers’ knowledge and perceptions of childhood obesity, as well as maternal knowledge, perceptions, and role in childhood obesity prevention. A main finding was that Mexican American parents did not fully understand short-term consequences of childhood obesity and did not consider excess weight as a health concern to address in the moment. Additionally, parental ability to engage in childhood obesity preventive behaviors was affected by issues related to social determinants of health, such as lack of outdoor play area for activity. Furthermore, of the 22 articles in the systematic review, only 7 specifically included Mexican Americans as a subgroup in their sample. Information regarding Mexican American parental perspectives of childhood obesity is lacking. Therefore, there is a need to further explore the literature in this area.

Purpose

The purpose of this integrative review is to examine the current literature from 2009 to 2018 on Mexican American parents’ perceptions of childhood obesity, knowledge of causes and consequences of childhood obesity, and beliefs about the parental role in childhood obesity prevention in order to provide an update of the systematic review of Sosa (2012).

Method

Design

The literature was reviewed using the five-stage method for performing integrative reviews proposed by Whittemore and Knafli (2005), which includes the following: (1) the problem identification: clearly delineating the problem, study purpose, and variables of interest; (2) the literature search: ideally encompassing all relevant literature addressing the topic and/or identified problem; (3) the data evaluation: assessing the quality of the primary source of the review; (4) the data analysis: consisting of categorizing the primary sources; and (5) the presentation stage consisting of a synthesis of the evidence, limitations and implications for nursing practice.

Literature Search

The CINAHL, PubMed, PsycINFO, and ERIC databases were used to search the literature using combinations of key terms based on collaboration with a health sciences librarian. Search terms included the following: Mexican American(s), Chicano(a), parent, mother, father, parental perceptions, parental views, health knowledge, overweight, and obesity. These terms were further assessed through the controlled vocabulary features of each database to compose the most relevant syntax formula. Articles were reviewed for inclusion based on the following criteria: (1) peer-reviewed articles published in English between 2009 and 2018; (2) study sample included at least 50% Mexican American parents; (3) discussed parental perceptions of childhood obesity and its prevention; (4) discussed parental knowledge of childhood obesity including causes and consequences; (5) discussed parental involvement in childhood obesity preventive behaviors and/or perceived barriers to engage in such behaviors. For the purpose of this review, childhood obesity prevention behaviors include balancing food intake (portion control, quality of food, increase of fruits and vegetables consumption) decreasing sugary drinks, maintaining an active lifestyle, including decreased screen time (TV, computers, CDC, 2017). Additionally, children’s weight categories are defined by the CDC (2016) and Ogden and Flegal (2010); as such, a body mass index (BMI) between the 85th and 94th percentile on the BMI-for-age growth chart corresponds to the overweight weight category. BMI values at or above the 95th percentile are classified as obese. Also “Mexican-Americans” are defined as individuals of Mexican descent residing in the United States regardless of their place of birth and/or generation status.

Articles were first screened against inclusion criteria by looking at title contents. An article whose title seemed to match inclusion criteria was further assessed by reviewing the abstract. Full text review was also performed to confirm eligibility. In addition to the database searches, ancestry search was used as a secondary search strategy. Reference lists of selected articles from the primary search were reviewed for relevance to inclusion criteria. A total of 707 articles were identified. After duplicates were removed, 667 abstracts were screened, and 339 were excluded based on the eligibility criteria, leaving 68 articles for full text review. An additional 55 articles did not meet the criteria for inclusion after full text review. Thirteen articles were included in the final analysis (see Figure 1). Table 1 displays the details of the reviewed articles including authors, date of publication, study design, purpose, sample characteristics, methodology, major findings, and methodology quality rating.

Data Evaluation

The final articles included in the review were evaluated with a Methodological Quality Score (MQS) as used in previous reviews (Bali & Goodson, 2007; Chen & Goodson, 2007;
Sou, 2012). Criteria assessed study design, instrument(s) used, validity and reliability of instrument(s), sample size, sample characteristics, use of theoretical framework and data analysis. Scores range from 0 to 20. Studies with higher scores are considered to have a better methodological quality (Chen & Goodson, 2007). Table 2 displays the MQS criteria.

The MQSs ranged from 8 to 14. All seven quantitative studies were methodologically strong using validated tools. Five studies had large sample sizes ranging from 369 to 688 subjects (Kersey, Lipton, Quinn, & Lantos, 2010; Pasch et al., 2016; Rosas et al., 2010; Sadeghi et al., 2017; Su et al., 2014). Only two studies used theoretical frameworks (Bayles, 2016; Kersey et al., 2010). In spite of their relatively low scores (8 to 9), all 5 qualitative studies were methodologically sound, using valid qualitative methods and theoretical approaches (Gallagher, 2010; Guadarrama, Fernàndez, Nuéñez, & Fuentes-Afflick, 2010; Guerrero, Shauser, Barreto, Rosales, & Kao, 2011; Small, Melnyk, Anderson-Gifford, & Hamp, 2009; Zhang, Hurtado, Flores, Alba-Meraz, & Reicks, 2018). Finally, the mixed method study was methodologically sound but did not include a theoretical framework (Guadarrama et al., 2010). See Table 1 for each study’s score.

Data Analysis and Synthesis
To ensure all aspects of the integrative review’s purpose were addressed, analysis and synthesis of the data followed the
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<td>Value 1</td>
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<td>Value 3</td>
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<tr>
<td>Value 4</td>
<td>Value 5</td>
<td>Value 6</td>
</tr>
<tr>
<td>Value 7</td>
<td>Value 8</td>
<td>Value 9</td>
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*Table 1: Characteristics of Market Segments*
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(continued)
Table 2. Methodological Quality Score Criteria.

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<td>Study design</td>
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<td>Cross-sectional</td>
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<tr>
<td>Descriptive design</td>
<td>2 points</td>
</tr>
<tr>
<td>Prospective design</td>
<td>3 points</td>
</tr>
<tr>
<td>Theoretical framework for quantitative studies</td>
<td></td>
</tr>
<tr>
<td>Study had no theory</td>
<td>0 point</td>
</tr>
<tr>
<td>Study was based on a implicit theory</td>
<td>1 point</td>
</tr>
<tr>
<td>Study was based on a specific theory</td>
<td>2 points</td>
</tr>
<tr>
<td>Theoretical framework for qualitative studies</td>
<td></td>
</tr>
<tr>
<td>Study neither built a theory nor linked its findings to a specific theory</td>
<td>0 point</td>
</tr>
<tr>
<td>Study linked its findings to a specific theory</td>
<td>1 point</td>
</tr>
<tr>
<td>The study developed a theory</td>
<td>2 points</td>
</tr>
<tr>
<td>Sample Size</td>
<td></td>
</tr>
<tr>
<td>Small sample (&lt;100)</td>
<td>1 point</td>
</tr>
<tr>
<td>Medium sample (100-390)</td>
<td>3 points</td>
</tr>
<tr>
<td>Large sample (&gt;390)</td>
<td>3 points</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td>0 points</td>
</tr>
<tr>
<td>Reported</td>
<td>1 point</td>
</tr>
<tr>
<td>Birthplace</td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td>0 points</td>
</tr>
<tr>
<td>Reported</td>
<td>1 point</td>
</tr>
<tr>
<td>Participants description</td>
<td></td>
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<tr>
<td>Parental perception and knowledge of mother only</td>
<td>1 point</td>
</tr>
<tr>
<td>Parental perception and knowledge of both parents</td>
<td>2 points</td>
</tr>
<tr>
<td>Measurement instrument(s)</td>
<td></td>
</tr>
<tr>
<td>Authors developed the instrument(s) to measure parental perception and/or knowledge</td>
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</tr>
<tr>
<td>Authors adopted a previously established instrument(s) to measure parental perception and/or knowledge</td>
<td>2 points</td>
</tr>
<tr>
<td>Data validity testing</td>
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</tr>
<tr>
<td>Reported</td>
<td>1 point</td>
</tr>
<tr>
<td>Data reliability testing</td>
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<tr>
<td>Not reported</td>
<td>0 points</td>
</tr>
<tr>
<td>Reported</td>
<td>1 point</td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
</tr>
<tr>
<td>Qualitative analysis (themistic analysis)</td>
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</tr>
<tr>
<td>Univariate statistics/descriptive analysis</td>
<td>1 point</td>
</tr>
<tr>
<td>Multivariate statistics (structural equation modeling)</td>
<td>4 points</td>
</tr>
<tr>
<td>Total</td>
<td>20 possible points</td>
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Note. ANOVA = analysis of variance; ANCOVA = analysis of covariance.

The researcher to highlight the main components of the studies and articles were examined for research methodology type. For example, all qualitative studies were examined together. This process facilitated visualization of patterns and associations across studies, which provided a starting place for interpretation of the data. Related findings were highlighted and clustered together to uncover similarities. The clusters were then organized by topic and arranged in categories. Similar categories were summarized and synthesized to determine patterns in the data, which lead to the identification of three major themes.

Results

Three main themes emerged from the data analysis: (1) parental misperception of child body weight and size, (2) influence of cultural health and growth beliefs on parental perception of child weight, (3) parental knowledge and perspectives of causes and consequences of childhood obesity and how to address it.

Parental Misperception of Child Body Weight and Size

A common theme among studies (8 out of 12) was parental underestimation of child weight and size (Bayles, 2010; Guendelman et al., 2010; Kersey et al., 2016; McLeod, Rojas, Heard, Bohmer, & Santiago, 2018; Pauch et al., 2016; Rosas et al., 2010; Sadeghi et al., 2017; Su et al., 2014). Studies used terms such as parental underestimation, parental misperceptions, and parental "obesity" (McLeod et al., 2018). The term "obesity" (Kaye, 2015) refers to a difficulty in identifying excess weight in their child due to a change in what is perceived as the norm for healthy weight, based on the national average weight and physical appearance of a child. Fathers were found to underestimate their child's weight to a greater extent (Kersey et al., 2016; Pauch et al., 2016; Su et al., 2014).

The level of misperception was substantial for all studies in which at least 50% of participants underestimated their child's weight, including binational studies (Guendelman et al., 2010; Rosas et al., 2010).

Bayles (2010) introduced a possible explanation for the misperception of children's weight. From participants' perspectives, the term "obesity" (overweight) corresponded to children in the 98th percentile for BMI on CDC growth chart; the term "peso normal" (normal weight) was at the 84th percentile; and "bajo de peso" (underweight) related to the 52nd percentile. The current CDC BMI-for-Age growth charts categorized children in the 85 to 94 BMI percentile range as overweight while children falling at and above the 95th percentile are considered obese. Children are not identified as underweight until they are below the 5th BMI percentile. Other possible associations with parental misperception include elevated maternal BMI, acculturation, parental preferred and ideal body size, and food insecurity (Bayles, 2010; Kersey et al., 2016; McLeod et al., 2018; Pauch et al., 2016; Rosas et al., 2010; Sadeghi et al., 2017).
Significant intercultural differences existed between parents in terms of perceptions that could not be linked to actual anthropometric results. Bayles (2010) explored intercultural consensus among Mexican American mothers who were asked to select photographs that best represented the healthiest children with the most appropriate body size for their age; mothers chose photographs of children with a BMI percentile ranging from the 17th to the 98th percentile. Similarly, Su et al. (2014) noted discrepancies between mothers’ and fathers’ perceptions of their child’s weight, hence, variations in parental perceptions exist within the Mexican American cultural group.

**Influence of Cultural Health and Growth Beliefs on Parental Perception of Child Weight**

One of the main findings regarding Mexican Americans’ beliefs and cultural perspectives of children’s health and growth, was that Mexican American parents did not associate children’s weight status with overall health. A healthy child was described as an active and happy child who plays well, eats well, is loved and does not have any limitations in their ability to function in activities of daily living (Guendelman et al., 2010; Guerrero et al., 2011; Small et al., 2009). Overweight was not viewed as a health issue, and parents referred to heavier bodies as healthy; younger children were believed to “outgrow their fat” (Guendelman et al., 2010). On the other hand, parents perceived this children as unhealthy and expressed more concerns about skinnier children than overweight or obese children (Davis, Cole, Reyes, McAuliffe, & Peterson, 2015; Guendelman et al., 2010; Small et al., 2009; Su et al., 2014). Some parents associated excess weight with deficient physical and mental health. This state would occur with poor self-care, which would subsequently lead to poor self-esteem (Small et al., 2009).

With respect to nutrition, parents perceived healthy foods as a way to prevent diseases (Gallagher, 2010; Guendelman et al., 2010). One interesting finding was the importance of the meaning of words: diet (“dieta”) for Mexican Americans relates to restriction of food intake, considered inappropriate for children’s growth (Gallagher, 2010). American foods were perceived as unhealthy because they were not natural or fresh (Davis, Cole, Reyes, McAuliffe, & Peterson, 2015; Gallagher, 2010; Guendelman et al., 2010). Discipline—eating at regular times—was described as a necessity to develop good eating habits. Physical activity considered essential to prevent disease, control weight and help children grow. Parents indicated that physical activity should be based on children’s age and development and could be as simple as play and dance (Gallagher, 2010; Guendelman et al., 2010; Zhang et al., 2014).

Mothers also expressed feelings of sadness, anguish, anxiety, hurt, despair and guilt when health care professionals identified their child as overweight or obese. They indicated feeling responsible for their child’s health and felt judged to be “bad mothers” (Davis, Cole, Reyes, McAuliffe, & Peterson, 2015; Small et al., 2009).

**Parental Knowledge and Perspectives of Causes and Consequences of Obesity and How to Address It**

The studies examined indicated that Mexican American parents are somewhat knowledgeable about the causes and consequences of obesity and have some strategies in place to address it. A large scale binomial study (N = 269) found that most participants could state at least one health consequence associated with obesity whether their child was overweight or not (Kersey et al., 2010). Parents identified practices around food intake as associated with excess weight. They viewed eating “too much food” and/or eating the “wrong foods” and dining out as potential causes of overweight (Gallagher, 2010; Guendelman et al., 2010; Guerrero et al., 2011; Zhang et al., 2010). Studies revealed that parents were managing excess weight issues by controlling the quantity and the quality of the food served, such as monitoring and using traditional dishes (Davis et al., 2015; Guendelman et al., 2010; Zhang et al., 2010). Fathers specified that, setting up diet and physical activity expectations could be a good strategy as well (Zhang et al., 2010). However, children’s resistance to decreasing the amount of food and/or modifying the type of food served was described as an obstacle. Furthermore, mothers indicated that those controlling practices were often a source of tension and arguments among family members. Grandparents, particularly, were in favor of maintaining cultural food traditions strictly (Davis et al., 2015; Guendelman et al., 2010; Guerrero et al., 2011). Additional causes of obesity included poor role modeling, poor self-care, and genetic predisposition. Study participants felt strongly about a mother’s responsibility for her child’s health including serving as a role model and feeding her children appropriate foods (Davis et al., 2015; Guendelman et al., 2010; Guerrero et al., 2011; Small et al., 2009). Last, parents indicated that, unless a medical provider brought it to their attention, they would not know how and where to obtain information regarding children with health issues associated with unhealthy weight (Small et al., 2009; Su et al., 2014).

**Discussion**

The purpose of this review was to examine the current literature on Mexican American parental knowledge and perceptions of childhood obesity. Studies assessed in this review confirmed some of the previous findings from the literature and revealed new knowledge specific to Mexican Americans. First, misperceptions of children’s weight as underestimation of the actual weight was a common finding. However, differences among parental perceptions of child weight were revealed, and no significant correlations were found among studies in terms of rationale for misperceptions. Parents’ perspectives of a child’s ideal body size was found to be considerably different from current medical expectations, and acculturation—the process of social, psychological, and cultural changes occurring in immigrants adapting to a new culture—might play a determining role (Berry, 2003). In fact, research has demonstrated that acculturation was associated with a change in ideal body size.
for Mexican Americans of later generations, who had an ideal
body size and weight that was smaller than first generations
from Mexico (McLeod et al., 2018; Rosas et al., 2016). Con-
versely, acculturation also lead to a change in food habits with
families eating larger portions and less fruits and vegetables
than in Mexico (Guendelman et al., 2010). Although this is not
completely new information, the binational studies brought to
light that maternal perceptions of children’s body size did not
vary by country of residence. While mothers living in Califor-
nia had a smaller ideal body size than mothers living in Mexico,
all had a preference for larger babies (Guendelman et al., 2010;
Rosas et al., 2010).

Only five studies included fathers in their samples, of which
one (Zhang et al., 2018) addressed the cultural meaning of
paternal roles in the Mexican American culture. The role and
place of fathers needs to be further assessed and discussed to
evaluate how they can support mothers in implementing a
healthy lifestyle for the entire family. This is one of the main
differences with Sosa’s review (2012), which highlighted tra-
tional gender role differences in Mexican American parents,
with the mother being the main caregiver. The assumption,
based on Bandura’s social cognitive theory including self-
efficacy, was that mothers who perceive childhood obesity as
a health issue would be more likely to engage into preventive
behaviors (Bandura, 2004). Similarly, the extended family,
particularly the impact of grandparents, and the possible cul-
tural pressure they exert, should be further examined.

One novel aspect highlighted in this review was the fact that
parental misperception of child’s weight might not be specific
to Mexican Americans. Societal factors, such as the current
rational norms for children’s weight might play a decisive role
in parental perceptions as outlined by the concept of obes-
ity by Katz (2015). Few qualitative studies (n = 5) addressed
Mexican American perceptions of childhood obesity and how
to prevent it from a cultural perspective. This indicates a need
for subsequent qualitative research to gain a deeper understand-
ing of Mexican Americans’ cultural perspectives on this theme
of misperception.

In regard to the cultural perspective, the review did uncover
a major Mexican American cultural difference—the fact that
health did not relate to weight, and excess weight was generally
not considered a health problem. The studies portrayed a hol-
istic Mexican American concept of health. Body and mind
were equally important. Good health was part of one’s success.
Nevertheless, parents were genuinely concerned about their
child’s health.

Contrary to Sosa (2012), this review showed that parents did
understand the causes and consequences of obesity although
they might not always grasp the immediate impact. There was a
disconnect between parents’ knowledge and the way they con-
nected this information with their own children. Parents fre-
quently did not associate this health problem with their children
or thought it did not apply to their children. Yet, studies also
showed that parents felt responsible for their child’s health and
considered the good health of their children a part of their
parental success. These notions require health care

professionals’ attention. Particularly, mothers’ perception of
being considered “bad mothers” when health care professionals
discuss their children’s overweight status must be taken into
consideration during appointments. Also, Gallagher (2010)
highlighted the importance of terminology and how it can
affect parental motivation and understanding about counseling
for weight management. Mexican American parents did not
follow recommendations for a healthier diet if it meant (food
restrictions (“dieta”), considered inappropriate for children.
Additional studies are needed to examine these issues within
the context of the Mexican American culture.

Implications for Nursing Practice and Research

Public health nurses (PHNs) attend to underserved populations,
via home visits, group teaching, outreach, and partnering with
multi-disciplinary agencies. The findings of this review can
assist PHNs in providing culturally congruent care to Mexican
American families and gaining a deeper understanding of fam-
ilies’ obstacles and commitments to healthy lifestyles. With
childhood obesity being a public health focus, PHNs have an
opportunity to develop, implement and lead culturally tailored
obesity prevention interventions. Raising awareness among
providers and community partners about Mexican Americans’
cultural health beliefs and perspectives about childhood obesity
is crucial in tackling this epidemic.

Limitations

Although these findings expanded current knowledge about
Mexican Americans perspectives on children’s health, several
limitations to this review were noted.

The findings cannot be generalized to all Mexican Amer-
icans as intracultural variations were found among parents
(Bayles, 2010; Su et al., 2014). Also, the number of qualitative
studies was low at 5 out of 13 when, traditionally, qualitative
methods are preferred to capture insights into a phenomenon
(Creswell & Creswell, 2014). Finally, the MCA used by Sosa,
2012) to assess study quality and utilized here for consistency,
shows a bias toward quantitative studies because the methodo-
logical characteristics evaluated relate more to qualitative
studies than qualitative ones. Similarly, there are no specific
criteria for evaluating mixed methods studies.

Conclusion

This integrative review examined the current state of the sci-
ence about Mexican American parental knowledge and percep-
tions of childhood obesity. A previously recognized finding,
parental understimation of children’s weight and a preference
for larger size as the ideal was confirmed. However, cultural
variations in parental perceptions existed. These results suggest
that many aspects of the Mexican American culture regarding
children’s health as it relates to body weight have not been fully
examined. Particularly, the roles of different family members
in the Mexican American childrearing tradition and the impact
of their associated health beliefs remain largely unknown. Studies using qualitative approaches are needed to provide deeper insights into these concepts. Societal factors and acculturation should be considered when designing obesity prevention interventions, and caution should be used when attempting to generalize Mexican Americans’ cultural practices. These findings represent only a small part of Mexican American perspectives on childhood obesity. The identified themes provide avenues that further expand scientific knowledge on how to tailor obesity prevention and reduction strategies for Mexican American children based on parental perspectives and cultural beliefs.

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References


DISSERTATION PROPOSAL

Specific Aims

Childhood obesity, assessed by a child’s Body Mass Index (BMI) and BMI-for-age percentile based on the Center for Disease Control and Prevention (CDC) growth charts, has been identified as a national concern due to its negative health impacts and a continuous prevalence increase over the past decades (Centers for Disease Control and Prevention, 2015). An increase in physiological and psychological chronic diseases, such as early onset diabetes, asthma, cardio-vascular disease, low self-esteem, and depression, are associated with excess weight in younger children (Centers for Disease Control and Prevention, 2015). Research has shown that children who were overweight or obese were most likely to remain obese through adulthood and experienced more severe health issues with a projected risk of decreased life expectancy (Bass & Eneli, 2015; Daniels, 2006; Gordon-Larsen, The, & Adair, 2010; Hales, Carroll, Fryar, & Ogden, 2017; Office of Minority Health, 2017; Ogden, Carroll, Lawman, Fryar, et al., 2016). Latest national trends showed an overall childhood obesity prevalence of 18.5% in children (1 in 6) 2 to 19 years of age (Centers for Disease Control and Prevention, 2015; Hales et al., 2017; Ogden, Carroll, Lawman, Fryar, et al., 2016).

Particular attention has been given to the Hispanic/Latino population because disparities were found among ethnic groups, with Hispanics children and youth showing higher rates than other groups (25.8%) (Hales et al., 2017). When looking at age categories, the highest rate among Hispanics was the 6–11-year-old age category with a rate of 25% (2 times the non-Hispanic Whites—13.6% and 2.5 times higher than Non-Hispanic Asian—9.8%). The 2-5 year-old category for Hispanic children revealed a prevalence of 15.6%, 3 times greater than non-
Hispanic Whites and Non-Hispanic Asians (5.2% and 5%, respectively) (Ogden, Carroll, Lawman, Fryar, et al., 2016)

Although substantial differences have been found between Hispanic ethnic subgroups, few studies focus on Mexican Americans as a subgroup (Bayles, 2010; Davis, Cole, Reyes, McKenney-Shubert, & Peterson, 2015; Gallagher, 2010; Guendelman, Fernald, Neufeld, & Fuentes-Afflick, 2010; Kersey, Lipton, Quinn, & Lantos, 2010; Pasch et al., 2016; Rosas et al., 2010; Sadeghi et al., 2017; Small, Melnyk, Anderson-Gifford, & Hampl, 2009; Su et al., 2014). Despite the fact that Mexican-American children were found to be at greater risk for obesity (Dominguez et al., 2015; Guendelman et al., 2010; Kornides, Kitsantas, Yang, & Villarruel, 2011; Pasch et al., 2016; Wojcicki, Schwartz, Jiménez-Cruz, Bacardi-Gascon, & Heyman, 2012), obesity prevention strategies and interventions have been unsuccessful in improving childhood obesity prevalence among Mexican American children (Ayala et al., 2010; Bender, Nader, Kennedy, & Gahagan, 2013; Boudreau, Kurowski, Gonzalez, Dimond, & Oreskovic, 2013; Hammons, Wiley, Fiese, & Teran-Garcia, 2013; Zoorob et al., 2013). Studies that examine environmental factors and social determinants of health utilized quantitative methods, but few studies have looked at the problem from a qualitative perspective (Boudreau et al., 2013; Ochoa & Berge, 2017; Wojcicki et al., 2012; Zoorob et al., 2013). Thus, a more comprehensive understanding of this complex problem from a cultural perspective is lacking. Precisely, an in-depth inquiry of both mothers’ and fathers’ insights regarding childhood obesity in the age range reflective of its highest national prevalence (2-11 years) is needed.

The purpose of this qualitative study, following Madeleine Leininger’s Culture Care Diversity and Universality theory (CCT) is to (1) examine Mexican Americans’ cultural beliefs regarding healthy and unhealthy weight in children 2 to 11 years of age; (2) explore Mexican
American parents’ knowledge of negative health outcomes caused by childhood obesity and a potential risk for their child; (3) unveil barriers Mexican American parents may face in trying to adopt obesity prevention behaviors; (4) learn about the type of support and resources Mexican Americans parents would be interested in to maintain a healthy weight for their 2-11 year old children; (5) explore the role healthcare providers and nurses could play in enhancing and sustaining a healthy lifestyle and weight in 2-11 year old Mexican-American children. The underlying long-term goal is for nurses to provide the culturally congruent care that Mexican American families need to sustain healthy weight and lifestyle over time.

Significance

Research has shown that children who were overweight or obese were more likely to remain obese through adulthood and experienced more severe health issues with a projected risk of decreased life expectancy (Bass & Eneli, 2015; Daniels, 2006; Gordon-Larsen et al., 2010; Office of Minority Health, 2017; Ogden, Carroll, Lawman, Fryar, et al., 2016). Although the literature discussing childhood obesity in Hispanics is extensive, research addressing Hispanic subgroups such as Mexican Americans is scarce, even though Mexican American children are one of the highest-risk populations in regard to obesity and its consequences (Dominguez et al., 2015; Office of Minority Health, 2017). Parental perceptions and practices such as feeding styles or role modeling have been associated with children’s eating habits and weight status (Aguirre, 2010; Pesch, Harrell, Kaciroti, Rosenblum, & Lumeng, 2011; Skouteris, McCabe, Swinburn, & Hill, 2010). Furthermore, it has been recognized that parents are the main influence in children’s social, emotional and physical development. Thus, examining Mexican-American parental perceptions and beliefs in regard to children’s weight status, childhood obesity causes, consequences and preventive strategies seems to be an appropriate and necessary step (Skouteris
et al., 2010). The following section discusses the state of the literature regarding Mexican American parental cultural perspectives of childhood obesity, parental knowledge and role in childhood obesity prevention as well as current outcomes of childhood obesity prevention strategies and interventions, to provide rationale for the proposed qualitative study.

**Mexican American Cultural Perspective of Childhood Obesity**

**Perception of child body weight and size.** A common concern discussed in the literature examining Mexican American parental perceptions of child weight is the significant and persistent underestimation of children weight and size (Bayles, 2010; Guendelman et al., 2010; Kersey et al., 2010; McLeod, Bates, Heard, Bohnert, & Santiago, 2017; Pasch et al., 2016; Rosas et al., 2010; Sadeghi et al., 2017; Su et al., 2014). This finding was present even in large scale binational studies, which showed that while mothers living in California had a smaller ideal body size for their child than mothers living in Mexico, all had a preference for larger babies (Guendelman et al., 2010; Rosas et al., 2010). Although various factors were considered, including maternal elevated BMI, acculturation, parental preferred and ideal body size, food insecurity, and parental oblivobesity, no significant commonalities were found among studies to explain the underestimation of children’s weight and size (Bayles, 2010; Kersey et al., 2010; McLeod et al., 2017; Pasch et al., 2016; Rosas et al., 2010; Sadeghi et al., 2017). The term and concept of “oblivobesity”, coined by Katz (2015), refers to the difficulty for parents to identify excess weight in their child due to a change in perception of what constitutes the norm for a healthy weight child, based on the current national average weight and physical appearance of children.

Important differences among parental perceptions of child weight were revealed that could not be explained by anthropometric results. For instance, when Mexican American
mothers \((N = 61)\) were asked to select 3 photographs that best represented their ideal healthiest children and most appropriate body size for their age, they chose a wide array of photographs of children with a corresponding BMI percentile ranging from the 17th to the 98th percentile (Bayles, 2010). Additionally, from these participants’ points of view, a difference in terminology that might further explain the misperception of children was discovered: the term “sobrepeso” (overweight) corresponded to children on the 98th percentile per CDC growth chart; the term “peso normal” (normal weight) was at the 84th percentile; and “bajo de peso” (underweight) related to the 52th percentile. Fathers were found to underestimate their child’s weight to a greater extent (Kersey et al., 2010; Pasch et al., 2016; Su et al., 2014). Studies were not able to find rationale for these differences in perceptions, which justifies a need for further in-depth analysis of Mexican American parental cultural beliefs of weight and health.

**Mexican Americans’ cultural beliefs of health and growth.** Mexican American parents have not associated children’s weight status with overall health. A healthy child was described as an active and happy child who plays well, eats well and is loved (Guerrero, Slusser, Barreto, Rosales, & Kuo, 2011; Small et al., 2009). Moreover, parents indicated that the healthy child did not have any limitations in his/her ability to function in activities of daily living (Guendelman et al., 2010; Guerrero et al., 2011; Small et al., 2009). Parents did not consider overweight and obesity weight status as a health issue. They considered heavier or chubby babies as healthy babies with the belief that younger children outgrow their fat, especially babies (Guendelman et al., 2010). On the other hand, parents perceived skinny or thin children as unhealthy and expressed more concerns about skinnier children than overweight or obese children (Davis et al., 2015; Guendelman et al., 2010; Small et al., 2009; Su et al., 2014). Parents shared that they
Knowledge of causes and consequences of obesity and how to address it. Articles found in the literature seem to indicate that Mexican American parents are somewhat knowledgeable about the causes and consequences of obesity and have some strategies in place to address it. The factors they identified associated with excess weight included eating “too much food” and/or eating the “wrong foods”, and dining out, as potential causes of overweight (Gallagher, 2010; Guendelman et al., 2010; Guerrero et al., 2011). Mothers managed excess weight issues by controlling the food intake in terms of quantity and quality of the food served. For instance, they indicated that monitoring the use of lard in traditional dishes could be an efficient practice (Davis et al., 2015; Guendelman et al., 2010). Nevertheless, mothers believed that maintaining Mexican traditions, including the type of food consumed and how it is prepared, the Spanish language, the childrearing traditions, and the family values and beliefs, were crucial to assure children’s well-being and success at school and later in life. Healthy foods were perceived as a way to prevent diseases (Gallagher, 2010; Guendelman et al., 2010). Discipline—eating at regular times—was explained as a necessity to develop good eating habits, and physical activity was considered essential for body and mind (Gallagher, 2010; Guendelman et al., 2010). Despite some comprehension of the causes and consequences of excess weight and perceived knowledge of how to address it, further exploration of parents’ understanding is warranted because of the persistent high rates of obesity in Mexican American young children.

Parental perceptions of obstacles to healthy behavior change. One of the obstacles mothers described was children’s resistance to their decreasing the amount of food served and/or modifying the type of food served. Additionally, they indicated that this controlling practice was
often a source of tension and arguments among family members. Mothers talked about grandparents interfering and wanting to maintain traditions strictly and use a softer discipline approach for children (Davis et al., 2015; Guendelman et al., 2010; Guerrero et al., 2011). They also talked about how stress caused by family separation or depression could affect a mother’s ability to provide the right environment for healthy growth including providing the right foods (Davis et al., 2015; Guendelman et al., 2010).

Another obstacle examined in the literature was the impact of healthcare providers discussing weight issues with mothers. Mothers expressed feelings of sadness, anguish, anxiety, hurt, despair and guilt when healthcare professionals identified and labeled their child as overweight or obese. They indicated feeling responsible for their child’s health and felt judged and considered as “bad mothers” (Davis et al., 2015; Small et al., 2009). The proposed study purpose will further explore these findings. The ethnonursing systematic method of inquiry with open-ended questions will provide an opportunity for informants to explain their perceptions and beliefs regarding potential weight issues in children and the type of support they would want to assist them in helping their family.

**Language Barrier.** Language was also identified as a barrier. For instance the word diet, commonly used in clinical practice and translated as *dieta* in Spanish, refers to restriction of food consumption for Mexican Americans, which they consider inappropriate for children’s growth (Gallagher, 2010). In Spanish, the words *overweight* and *obese* do not relate to health concerns for children. The terms *fat* and *obese* were found to be offensive to Hispanic families (Knierim et al., 2015). The only term that was found to be inoffensive and motivating was *demasiado peso para su salud* (too much weight for his or her health). Bi-lingual families had mixed feelings about the terms healthy and/or unhealthy weight finding them motivating, confusing or insulting...
Parents also reported the term BMI and the use of growth charts confusing. They shared that associating children’s weight to health risks, such as diabetes, was the most pertinent and motivating (Knierim et al., 2015).

**Obesity prevention interventions unsuccessful in generating lifestyle changes overtime.**

Research has addressed multiple obesity prevention strategies including experimental interventions using evidence-based (Berger-Jenkins et al., 2014; Olvera & Power, 2010; Zoorob et al., 2013), long term and short term interventions targeting multiple age groups in various settings (primary care, home, school) (Wojcicki et al., 2012) as well as qualitative approaches to better understand Hispanic children, youth and their families’ point of view (Lindsay et al., 2012; Martinez, Rhee, Blanco, & Boutelle, 2014). Obesity prevention strategies have been implemented but yet remain unsuccessful in generating sustainable lifestyle changes in Mexican American children (Boudreau et al., 2013; Bender et al., 2013; Hammons et al., 2013; Zoorob, 2013). For instance, in a study conducted by Boudreau et al. (2013), 9- to 12-year-old Mexican-American children with a BMI above the 85th percentile and their caregivers received 6 weeks of interactive nutrition education and physical activity group classes followed by monthly culturally appropriate coaching face-to-face or by phone for 6 months. The purpose of the coaching was to assist families in applying the healthy lifestyle they learned while examining family and social barriers to making changes. Yet, no significant changes in lifestyle behaviors were observed between the intervention group and the control group 6 months post intervention. The initial sample included 41 mother-child dyads (23 intervention, 18 control) while the final sample included 26 dyads (14 intervention, 12 control). Similarly, Bender et al. (2013) used a community engagement approach to implement a 9-month culturally and linguistically tailored intervention in a southern Californian urban health center. The purpose of the study was to
improve health behaviors in low-income Mexican mothers and their 3- to 5-year-old children (N = 33 mother-child dyads). Using a one-group, pretest–posttest design, changes in children’s consumption of sugar-sweetened beverages (SSB), mothers’ pedometer steps, and BMI were assessed at the time of intervention, post-intervention (9 months) and then 6 months post-intervention (15 months). The study revealed that, while at post-intervention a significant decrease in children’s consumption of soda and other sugary drinks had been observed, children’s soda and juice consumption reverted to baseline at 6 months post-intervention. However, the children’s consumption of water and milk did remain higher. Finally, Hall et al. (2016), implemented a 12-month intervention (4-month intensive phase consisting of eight classes and an 8-month reinforcement phase with monthly mail/telephone contact) with the purpose of promoting healthy eating behaviors, increased physical activity, and decreased sedentary behavior with a particular focus on parental role modeling and experiential learning for children. The researchers used a two-group, cluster randomized trial design with 136 families assigned to the intervention and 136 families to the control group; they analyzed children’s body mass index z-score (BMI-Z). They reported that the BMI-Z growth rate did not differ between intervention and control groups at 6 months short-term follow-up or long-term follow-up (16 months).

Despite the disappointing results of the above studies, a recent analysis demonstrated significant positive results for childhood obesity in the following four communities: Anchorage, Alaska; Granville County, North Carolina; New York, New York; and Philadelphia, Pennsylvania. A decline in childhood obesity was observed between 2003 and 2012. The success was attributed to a multi-level, cross-sectorial approach following a socio-ecological model for preventing childhood obesity. Part of the strategy was to focus directly on the children, providing
them with nutrition and physical activity interventions in environments where they spend most of their time. Although these results appear encouraging, the communities receiving these interventions included a low percentage of Hispanics (7.5% for Anchorage, 11.6% for Granville and 28.4% for New York). Additionally, ethnic subgroups such as Mexican Americans were unspecified in the Hispanic study sample (Ottley et al., 2018).

There are few qualitative studies discussing Mexican Americans’ cultural perspective of childhood obesity (Gallagher, 2010; Guendelman et al., 2010; Guerrero et al., 2011; Small et al., 2009). Most of them discussed interventions rather than in depth cultural knowledge. Guerrero et al. (2011) did explore mothers’ perspectives on child weight status, beliefs regarding causes of overweight and perceptions of physicians’ role and weight measurements while Small et al. (2009) studied the beliefs of Mexican mothers regarding weight and health. Both of these studies’ data collection methods were focus groups with recommendations for further studies to conduct individual interviews. Gallagher (2010) did use ethnographic individual interviews to explore Mexican American mothers’ point of views about the lifestyle habits of food/nutrition, physical activity, and televisions but the sample only included 9 mothers. Guendelman et al. (2010) who conducted a mixed methods study particularly evaluated maternal perceptions of children current and ideal body size. The method of data collection for the qualitative data was also focus groups. These qualitative studies results highlighted findings similar to quantitative studies. Guendelman et al. (2010) concluded that obesity prevention information particularly weight management strategies should be presented in a culturally acceptable way. Guerrero et al. (2011) made the same recommendations to the attention of healthcare providers. Therefore, current studies, regardless of the research methodology, did not fully uncover the cultural meaning of children’s health, growth, healthy and unhealthy weight from a parental perspective.
Further qualitative research using individual interviews is needed. Specifically, fathers’ perspective has not been completely addressed and is rarely discussed.

**Fathers place and role**

Few studies have included fathers in their participant samples (Kersey et al., 2010; Lora, Cheney, & Branscum, 2017b; Pasch et al., 2016; Penilla et al., 2017; Shears, Furman, & Negi, 2007; Su et al., 2014; Tschann et al., 2015b; Turner, Navuluri, Winkler, Vale, & Finley, 2014). Perhaps assuming that traditional gender roles existed among Mexican American parents with the mother being the main caregiver, Sosa (2012), who reviewed the literature for Mexican American mothers’ knowledge and perceptions of childhood obesity and perceptions and role in obesity prevention, did not include fathers in his systematic review. Yet, fathers were found to underestimate their child’s weight to a greater extent (Kersey et al., 2010; Pasch et al., 2016; Su et al., 2014). Furthermore, concerns were raised by Su et al. (2014) about the discrepancies found between mothers’ and fathers’ perceptions of their child’s weight; hence, a recommendation was made to further assess these discrepancies using qualitative methods. This is consistent with recent literature examining the impact of Mexican American fathers’ involvement in childrearing practices. For instance, Penilla et al. (2017) studied the association between fathers’ feeding practices and children’s weight status. They found that fathers’ pressure to eat and use of food to control behaviors were associated with lower BMI scores regardless of mothers’ involvement, because fathers tended to adjust their control behaviors based on their child weight status.

Tschann et al. (2015) revealed similar evidence and recommended inclusion of fathers in studies addressing Mexican American parental feeding practice and childhood obesity prevention strategies. Fathers did specify that they wanted to be involved in their children’s lifestyle even when they appeared to negatively affect children’s weight outcomes (Lora et al., 2017b; Shears
et al., 2007; Turner et al., 2014). It is important to note that these studies all used quantitative methods and did not address the cultural meaning of paternal roles in the Mexican-American culture regarding childhood obesity prevention. These outcomes provide evidence for the need to further assess the role and place of Mexican American fathers in supporting children’s healthy lifestyle.

**Gaps**

As previously discussed, childhood obesity, a national public health concern, is still on the rise (Bass & Eneli, 2015; Hales et al., 2017), and latest national trends have shown that obesity prevalence among 2-11 year old Mexican American children continues to escalate in addition to being 2 to 3 times higher than most ethnic groups (Hales et al., 2017; Ogden, Carroll, Lawman, & et al., 2016). Previous childhood obesity prevention strategies have not been successful in generating significant and sustainable life behavior changes to prevent childhood obesity in Mexican American families and reverse the current increasing trend. Previous quantitative and qualitative studies have provided a beginning of understanding of the Mexican American culture. However, the cultural meaning of children’s health, growth, healthy and unhealthy weight from a parental perspective has not been fully addressed. Precisely, most previous qualitative studies used focus groups to collect data. Recommendations were made to use individual interviews, which the proposed study will employ, to gain a deeper understanding of Mexican American parental perspective on children’s overall health and childhood obesity (Guerrero et al., 2011; Small et al., 2009). Specifically, fathers’ perspectives are rarely discussed. One of the main questions remaining is why Mexican American parents do not associate the knowledge of the negative health outcomes caused by childhood obesity that they seem to understand and are committed to address, with the potential risk for their own child.
Using Leininger’s culturally focused holistic CCT theory and ethnonursing research method to gain an in-depth discovery of this phenomenon seems indicated and timely.

**Implications to health and nursing**

Although the proposed study aims to enhance nursing practices in a variety of settings, the study findings could particularly benefit Public Health Nurses (PHNs). With childhood obesity being a national public health concern, PHNs are involved in developing, implementing, monitoring and evaluating childhood obesity prevention interventions as part of the 10 essentials public health services (Center for Disease Control and Prevention, 2017). Population based services are provided within a public health lead program, or in partnership with community-based organizations, schools, managed care plans and/or any other agencies involved in such mission. Intervention outcomes are critical for funding and are continuously monitored. Gaining a better understanding of the cultural meaning of healthy and unhealthy weight in children for Mexican Americans can assist PHNs in better answering these families’ needs. Furthermore, this information could also be beneficial to nurse practitioners leading group interventions in primary care settings, school nurses, home health nurses and any other community agency working with Mexican American families.

**Theoretical framework guiding the research**

The proposed study will be conducted using Dr. Madeleine Leininger’s Culture Care Diversity and Universality Theory (CCT) (Leininger, 1991). Developed in the 1960’s, the CCT aims to gain an in-depth knowledge of care and culture concepts as it relates to health, well-being, disability and death through methodologic research with the goal of delivering care in a meaningful and culturally appropriate, congruent way (Leininger, 2002a).
Dr. Leininger viewed human care as an essential part of humanity, what motivates humans to seek health, be concerned about each other’s health and lend a hand to the sick. She also emphasized that curing could not take place without caring. Caring represents the actions, behaviors, and practices to help others heal and maintain wellbeing. Culture is “the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally” (McFarland & Wehbe-Alamah, 2014, p.10). Dr. Leininger predicted that, in order to answer client needs, both culture and care needed to be fully grasped. She believed that rethinking care from a cultural based research approach was the essence of nursing.

Dr. Leininger designed the CCT as a guide for nurses to enhance caring practices by increasing cultural knowledge via cultural care research from informants of the related studied culture. Dr. Leininger called the type of care resulting from such approach, culturally congruent care and made it the major goal of the CCT. Part of this process includes uncovering similarities (universal/common) and differences (diversity) between and among cultures using the emic (folk) and etic (professional) concepts. The term emic has to do with the indigenous or insider’s cultural knowledge or view point of a cultural phenomenon, in other words the folk perspective. In contrast, the etic relates to outsiders’ or strangers’ point of view and is frequently associated with health professional and/or institutions’ perspective on a cultural phenomenon. These two concepts are strongly related to the major constructs of the CCT: Care Diversity: “differences or variabilities among human beings with respect to culture care meanings, patterns, values, lifeways, symbols or other features related to providing beneficial care to clients of a designated culture” (Leininger, 1995, 1997a; Leininger & McFarland, 2002). Culture Care Universality is commonly shared or similar culture care phenomena features of human beings or a group with
recurrant meanings, patterns, values, lifeways, or symbols that serve as a guide for caregivers to provide assistive, supportive, facilitative, or enabling people care for healthy outcomes (Leininger, 1995).

Three other essential concepts are important to describe: Health is seen as the state of well-being as learned in individuals’ cultural context. The Worldview is the broad perspective of individuals on the universe that influences how they envision wellbeing, care, disability and death. It also affects individuals’ caring practices. Similarly, the Environment or Environmental Context is taken into consideration. It is viewed as a multidimensional concept that goes beyond geophysical space. This aspect will be discussed further in relationship to enablers (McFarland & Wehbe-Alamah, 2014).

The Domain of Inquiry (DOI) from this theory is the specific aspects the nurse researcher wants to know more about from a cultural perspective to provide congruent care for the area of concern. For this proposed study, the DOI is the cultural meaning of healthy and unhealthy weight for Mexican American parents regarding children 2 to 11 years of age. As discussed previously, the number of qualitative studies addressing childhood obesity in Mexican Americans as a subculture is limited. Dr. Leininger viewed subcultures as “subgroups who deviate in certain ways from a dominant culture in values, beliefs, norms, moral codes, and ways of living with some distinctive features that characterize their unique lifeways” (Leininger, 2002b). In other words, subcultures or subgroups are related to main cultures but are specific enough to include significant variances. This justifies the need to differentiate Mexican Americans from Hispanics and the reason why the proposed study specifically focuses on Mexican Americans.
To assist researchers in implementing the CCT, Dr. Leininger developed ethnonursing, a qualitative research method following the CCT constructs and providing researchers with a step-by-step discovery process to obtain the utmost in depth data about their Domain of Inquiry (DOI) using enablers to guide the research. The proposed study will explore the Mexican American CCT constructs of health, care and culture. It will identify what universal/diverse practices, and beliefs exist in caring for children 2 to 11 years of age from an emic (informant’s traditional, learned and transmitted caring practices and beliefs) and etic (researcher’s professional knowledge) perspectives based on Mexican Americans’ worldview and informants’ environmental context. The ultimate goal of the study is to increase nursing knowledge about the Mexican American cultural perspective on overall childrearing and health concerns associated with childhood obesity to be able to provide culturally congruent and safe care.

The proposed study will use the ethnonursing research method with several of the recommended enablers including 1) the Sunrise enabler, 2) Leininger’s Semi-Structured Inquiry Guide Enabler to assess Culture Care and Health, 3) the Stranger to Trusted-Friend enabler, 4) Leininger’s Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways and 5) Leininger’s Phases of Ethnonursing Data Analysis Enabler for Qualitative Data. Details about these enablers will be discussed in the approach section that follows.

**Innovation**

**Specific ways in which the dissertation is innovative**

One of the novel aspects proposed in this study is the inclusion of fathers in the study sample. Shears et al. (2007) revealed that a significant number of self-identified Mexican American fathers wanted to be involved in their children’s day to day lives. They valued
spending time with their children, being role models and were committed to adopting health promoting behaviors for their children. In contrast, other studies have indicated that Mexican Americans perceived fathers as a hindrance to healthy lifestyles, particularly feeding choices. More specifically, fathers voiced the importance of healthy eating and active living while continuing to be permissive, bringing high calorie foods in the home, using sweet and savory foods to regulate children’s social emotional behaviors and disagreeing with mothers’ meals choices (Lora, Cheney, & Branscum, 2017a; Turner et al., 2014). Fathers tended to be more involved in physical activities than mothers (Turner et al., 2014). Additional studies have discussed the impact of Mexican American fathers’ feeding practices on children’s weight status and the importance of including them in study samples (Penilla et al., 2017; Tschann et al., 2015a). Consequently, capturing Mexican American fathers’ insight to gain a better understanding of their role in caring for their children seems appropriate and fits the holistic approach associated with the CCT.

To date, there are no studies using ethnonursing as a research method for this domain of inquiry (DOI). There are few qualitative studies regarding childhood obesity focusing on Mexican Americans as a subgroup (Gallagher, 2010; Guendelman et al., 2010; Guerrero et al., 2011; Small et al., 2009). Most of them discussed interventions rather than in depth cultural knowledge. Traditionally, qualitative methods are used to explore and understand the meaning of a human phenomenon, which allows for a flexible ability to adjust questions and observations in the field to understand the phenomenon from participants usually referred to as informants (Creswell & Creswell, 2014; Polit & Beck, 2008). Ethnonursing is an evidenced-based research method that provides a systematic approach leading to an in-depth discovery of the studied culture’s worldview and DOI (McFarland & Wehbe-Alamah, 2015, pp. 35-66). What makes
ethnonursing unique and interesting for the proposed study DOI is not only that it was designed to work with a the CCT, but also the components of the method and Leininger’s method of data analysis can lead to an expansion of the theory or a new theory.

In addition, the current clinical paradigm for childhood obesity focuses on interventions based on risk factors and social determinants of health, assessed from a quantitative perspective. For instance, a particular emphasis has been placed on environmental factors. A cross sectional approach involving policy implication and evidence-based interventions following the Ecological Model of Childhood Obesity has been used (Brown, Halvorson, Cohen, Lazorick, & Skelton, 2015). Although this multi-sectorial strategy has helped in making progress with childhood obesity prevention, treatment and health promotion practices were often implemented without fully exploring the cultural relevance for Hispanic families or related Hispanic subgroups, such as Mexican Americans. Thus, using a qualitative inductive approach challenges the trend of a “one size fits all” approach that tends to persist in childhood obesity prevention and/or treatment practices.

**Approach**

**Mexican Americans Mini-study**

In the spring of 2016, this investigator conducted a qualitative mini-study entitled: “Mexican Americans Cultural Beliefs of Healthy and Unhealthy Weight in Children 3-5 years of age”. The purpose of the mini-study was to examine the cultural beliefs of Mexican Americans in regard to healthy and unhealthy weight in children 3-5 years of age and also to help refine the semi-structured interview/open-inquiry guide for further studies. The initial research questions included (1) What are the cultural beliefs of Mexican Americans regarding healthy weight in children 3 to 5 years age? (2) What are the cultural beliefs of Mexican Americans regarding
unhealthy weight in children 3 to 5 years age? and (3) What is the role of the nurse in promoting healthy weight in children 3 to 5 years age? Informants were recruited from state pre-school, elementary schools, after school programs, work environment, word of mouth from the Santa Barbara County Office of Education partners, from Santa Barbara County promotores de salud coalition (network), and Ventura County Public health partners. Potential informants were introduced to the study at pre-established meetings or by word of mouth from an informant to other potential informants.

The mini study was conducted using Leininger’s ethnonursing research method with the purpose of discovering the cultural meaning of healthy and unhealthy weight for Mexican Americans regarding children 3 to 5 years of age. The Sunrise enabler was used to obtain a holistic perspective of the study informants’ circumstances of life and to examine how they related to the phenomenon of obesity in children 3 to 5 years of age. Data were collected using investigator fields notes, interviews following a semi structured interview guide and a demographic form. Interviews were conducted in English at the informant’s location of choice. Data were analyzed using Leininger’s four phases of ethnonursing analysis for qualitative data.

Six female informants agreed to participate in the study. Participants’ ages ranged from 19 to 54 years. Three were born in Mexico and had been leaving in the US for at least 13 years with 54 years being the longest. Participants were from various generations in regard to immigration status. Five were mothers and one was an aunt. Most of them were married with household sizes ranging from 4 to 7 individuals.

Some of the themes from preliminary findings included:
• Healthy child: All participants indicated that a healthy child was an active and happy child, who interacts well with others and peers. In contrast, an unhealthy child was described as a less active or inactive child, sad, pale, skinny who does not interact well with others or peers.

• Healthy weight and growth charts: Participants stated that they understood and were familiar with the growth charts but did not trust them fully especially when their child/relative was categorized as overweight or obese, and this did not match their perception of an unhealthy child.

• Perception and value of doctors and professionals: Doctors were trusted, and their advice sought. Informants respected doctors even when they disagreed with them.

• Nurses are viewed as health information providers and health trackers. Informants indicated that they needed a professional to tell them what was happening with their child and what was the next steps.

• Programs: When asked about what could be useful if they felt that their child was perceived as unhealthy, informants indicated that they would be interested in programs involving both parents and children. They specified that they would want a program that demonstrated to the children the benefits of being healthy. They also voiced that they would want the program in English to ensure the children understand it well in the American context and additional translations in Spanish for the parents.

• Community Resources: most of the informants did not know where to go for information about maintaining a healthy weight. When they did, resources often did not meet their needs.

These initial findings differed significantly from this author’s knowledge and assumptions about the Mexican American culture used in practice to provide care and education to Mexican American families. This mini-study that only included 6 informants revealed a
different understanding of the culture; thus, additional exploration of these preliminary themes is needed to help inform future interventions that incorporate in-depth cultural knowledge. This led to the development of the proposed study.

**Dissertation Research Design**

The proposed study will follow the Dr. Leininger’s Culture Care Diversity and Universality Theory (CCT) as a guiding framework with the purpose of gaining an in-depth understanding of the cultural meaning of healthy and unhealthy weight for Mexican American parents regarding children 2 to 11 years of age using Ethnonursing. Ethnonursing is “a qualitative research method as an open discovery process using diverse strategies and enablers to document, describe, and understand people’s experiences, care meanings, and symbols of care related to their beliefs, values, health, and cultural lifeways” (Leininger, 2005). This method was designed by Dr. Leininger to assist researchers in addressing all constructs of the CCT while gathering emic data (perspective from the community member expert in the studied culture or generic/folk) and etic data (information coming from professional and institutional settings).

What is specific about ethnonursing is that this method offers possibilities to uncover the studied culture’s informants’ worldviews and cultural practices in a systematic way, within the scope of human caring which constitutes the essence of nursing as defined in the CCT ((McFarland & Wehbe-Alamah, 2014, p.23-24; 41-42). To ensure researchers address all constructs of the CCT and facilitate open-inquiry, Dr. Leininger created enablers, concrete tools to guide the research. Five enablers will be used for this research study: 1) the Sunrise enabler, 2) Leininger’s Semi-Structured Inquiry Guide Enabler to assess Culture Care and Health, 3) the Stranger to Trusted-Friend enabler, 4) Leininger’s Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways and 5) Leininger’s Phases of Ethnonursing
Data Analysis Enabler for Qualitative Data. The purpose and role of these enablers will be discussed further in the Instrument section.

Setting

Informants will be recruited in Santa Barbara and Ventura County agencies involved with Mexican American parents and children. Some of the potential sites will include sites such as Head Starts, Neighborhood For Learning (NFLs), Family Resources Centers (FRCs), Women Infants and Children (WIC) sites, preschools, elementary schools, after school programs and medical offices. Head Starts are federally and state funded programs that support low income children from birth to five years to enhance their growth and development through a comprehensive set of services. Head start services are provided throughout both counties.

Neighborhoods For Learning (NFLs) are community targeted centers serving children and their families from the prenatal period to age five. NFLs are community support strength-based points of resource providing services such as high-quality pre-school, parent/child education, and support to access healthcare and dental services. There are 11 NFLs throughout Ventura County.

Similarly, there is a network of Family Resource Centers throughout Santa Barbara County serving children, The focus is on strengthening not only the families’ well-being but also the community in which they live at large. The Women, Infants, and Children (WIC) program is a federally-funded program that provides supplemental nutrition, health care referrals and nutrition education to low income pregnant and post-partum woman and their children until they turn 5.

The principal investigator is a public health nurse working in a preventive community program targeting children from birth to 21 years of age. Part of her duties involves working closely with primary care medical offices and community agencies, which leads to privileged relationship and partnerships. The investigator plans to capitalize on these relationships and seek
authorizations through proper channels and work with agency representatives to identify opportunities from existing events to introduce the study to potential participants. The researcher will provide preliminary information including study purpose, modalities and consent procedures. She will obtain consents and offer thorough information to interested candidates. Additionally, snow ball sampling which consists of prospective informant referrals by current study participants (http://www.statisticshowto.com/snowball-sampling/) will be used. If data saturation cannot be met from the previously cited strategies, the researcher will reach out to *promotores de salud* to increase recruitment. In fact, both of these approaches have been proven effective strategies in increasing recruitment (Heckathorn, 2011).

**Population sample**

The researcher will seek out a minimum of 10 to 12 key informants and 20 to 24 Mexican general informants as established and recommended by Dr. Leininger. Key informants are individuals purposefully designated by the researcher or members of the studied culture because of their in-depth knowledge about the values, norms, beliefs, customs, practices and general lifeways of the studied culture; they are interested in the domain of inquiry and willing to participate in the study. For this study, key informants might be parents or grandparents residing with the 2–11-year-old children and significantly involved in their life. General informants, although not as knowledgeable as key informants, usually have an interest and a good understanding of the DOI, are familiar with the studied culture and are willing to share their point of views about the DOI (Leininger & McFarland, 2006). General informants in this study setting might be Head Start or school staff, or medical staff very familiar with the Mexican American culture. Dr. Leininger stressed the importance for the investigator to actively listen during field observations in the community to determine which individuals could potentially be
key or general informants; this could be accomplished by participating to community events where this population is present. Furthermore, the investigator is involved with the promotores de salud network coalition and could seek opportunities to interact with the Mexican American community through these connections.

Dr. Leininger established the number of key and general informants based on her many years of research with the essential idea that the emphasis should be placed on gathering exhaustive knowledge rather than the number of informants. The depth and accuracy of the information collected are associated with the time spent during interviews and the ability of the researcher to verify the information with key informants (Mc Farland et al., 2014, p. 54-55). Dr. Leininger explained that 3 to 5 encounters of 1 to 2 hours per study participant are necessary to gain in depth information from informants. She specified that interviews with general informants are typically shorter. For this proposed study, informants will include Mexican American parents of 2 to 11-year-old children who are English or Spanish speakers (key informants) or any Mexican American English or Spanish speaker over the age of 18 (general informants).

**Description of enablers and how they would be used**

The Ethnonursing method’s general principles established by Dr. Leininger emphasize the ability of the researcher to actively listen, be open to learning from the informants and to participate in providing meaning to the lived experience after confirming accuracy with the informants (McFarland, Mixer, Webhe-Alamah, & Burk, 2012). To accomplish this, the researcher must maintain field notes from direct observations and interactions with the informants and must conduct individual interviews using a semi-structured interview guide. Dr. Leininger recommended the use of enablers that she developed to facilitate the researcher’s immersion in the informants’ worldview. The Sunrise enabler, shown in Appendix A, portrays a
variety of factors that can affect culture care. It is used to capture a holistic perspective of informants’ lifeways, worldview, environmental context and cultural practices as it relates to human care and to the phenomenon of obesity in Mexican American children 2 to 11 years of age. Designed to be used with the Sunrise enabler, Leininger’s Semi-Structured Inquiry Guide Enabler to assess Culture Care and Health includes suggested open-ended questions in the 12 domains pictured in the sunrise enabler, to be adapted to the researcher’s DOI. The purpose of this enabler, similarly to the sunrise enabler, is to discover the worldview of informants using open-ended questions to capture the maximum amount of information. For the proposed study, the enabler is used to refine the semi-structured interview-guide.

Because the population of this study might include immigrants from different generations, Leininger’s Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways will be used to assist the researcher in evaluating whether informants are traditionally or non-traditionally oriented to their culture. This enabler includes indicators addressing worldview, language, cultural values, kinship, religion, politics, technology, education, environment to be rated based on informants’ behaviors using a 5-points Likert scale from mainly traditional to mainly nontraditional. The values are then plotted on a summary sheet allowing the researcher to create a profile for each informant in regard to their traditional and nontraditional orientation. It is important to understand that this tool is not meant to be used as an instrument of data collection for quantitative data but rather as a mean to explain informants’ qualitative data.

The Stranger to Trusted-Friend enabler will also be used for this study. As indicated in the name, this enabler was developed to allow researchers to move from a distrusted stranger’s position to a trusted friend position by using a reflective guide to consciously evaluate their
behaviors, feelings and reactions to interactions with informants. Finally, the Leininger’s Phases of Ethnonursing Data Analysis Enabler for Qualitative Data will be used for the data analysis (described further in next section).

**Procedures for data collection and plans for data analysis**

Following the ethnonursing principles, the aim of the study is to capture the Mexican American cultural context and traditions associated with overall, healthy and unhealthy weight among children 2 to 11 years of age by using field notes from direct observations and semi-structured individual interviews with key and general informants in their home or an agreed up quiet environment. After permission is received from the informant, the interviews will be recorded then transcribed using software such as Verbatim. All data including field notes, interviews and transcriptions will be managed using qualitative or mixed methods data analysis software (MAXQDA professional or NVIVO 11). All written and recorded materials will be stored in a locked file in the researcher's home. Electronic files will be encrypted and kept in an external drive in the locked filed mentioned previously. All data will be destroyed 3 years after completion of the study.

The data will be analyzed using Leininger’s four phases of ethnonursing analysis for qualitative data (McFarland & Wehbe-Alamah, 2014). Dr. Leininger developed an enabler to facilitate this process. The first phase consists of accumulating, compiling, gathering and describing all raw data from observations, field notes, enablers and interviews. The investigator should start analyzing the data and reflect on it in relation to the DOI from the first day of data collection. In the second phase, the investigator will start to organize the data in categories (coding) related to the DOI, establishing descriptors and indicators from the raw data. During the third phase, the investigator scrupulously reviews the data and looks for possible patterns of
values, beliefs and practices and/or contextual explanations in relationship to the DOI. The last phase is a synthesis and interpretation phase. The investigator refines the research findings and identifies the major themes and dominant care patterns of practice in link to the DOI. He or she may define study limitations and can make recommendations, then this phase leads to the revelation of new knowledge and theoretical formulations (Leininger & Mc Farland, 2006). The process includes ongoing confirmation of data accuracy with informants. This can be done by returning to the informants and clarifying any themes and/or statements that are not fully understood.

**Study Limitations**

Although this is not a true limitation for qualitative studies, the data/findings from the interviews will be self-reported from Mexican Americans or informants familiar with the Mexican American culture. This relates to the credibility of the study, or the truth in the study’s findings (Ryan, Coughlan, & Cronin, 2007). However, Leininger’s phases of ethnonursing data analysis enablers for qualitative data address credibility by the level of data immersion of the investigator, the collaboration with a ethnonursing expert mentor and the clarification of findings with informants as described in the previous section (member checking). Additionally, the number of mothers and fathers who participate may not be even; since most previous studies’ samples have often included mothers only, fathers might not be as willing to participate as mothers.

The principal investigator is not Mexican American therefore, per Dr. Leininger’s CCT, has a more etic perspective. Nevertheless, the investigator has been working in the community with Mexican American families has a public health nurse for more than 15 years and has
established a trusting relationship with promotores de salud and several communities of both Santa Barbara and Ventura counties.

Potential Problems with the Proposed Procedures and Strategies to Address Them

The first anticipated problem might be recruitment. One strategy to improve success would be to seek informants in multiple settings where Mexican American parents of 2 to 11-year-old children can be found. Another strategy would be to have written contact information and consents available at the time of study introduction to recruit immediately, if potential informants are showing interests. At the time the investigator conducted the mini-study, no deadline or timeline was specified to community/agency partners or prospective informants that had expressed interest in joining the study. This seemed to have affected the timeframes in which agency partners and potential study participants provided available times. For this study, the investigator will establish a timeline and specific deadlines for the recruitment period. The other problems might be delays in conducting interviews due to possible scheduling difficulties between principal investigators and informants’ schedules in relationship to the time needed to reach data saturation. To decrease this issue, when approached by an informant, the principal investigator will offer different days and times to facilitate scheduling.

Protection of research participants

The study will include a convenience sample of male and female Mexican-American parents of 2 to 11 years old children or any other Mexican American individual, English or Spanish speakers, over the age of 18 regardless of religion, sexual orientation, family type and educational background. Informants may also include any individual familiar with the Mexican American culture, English or Spanish speaker, over the age of 18 regardless of religion, sexual orientation, family type and educational background.
The study will not include any invasive procedures or any procedures leading to potential physical harm. Informants will be treated with respect and interviewed in their home or alternate quiet setting of their choice after consent is obtained. Confidentiality will be respected. Informants’ names will never appear on any survey or research instruments. No links to informants’ identity will be made in the data analysis. All written, recorded and transcribed materials including consent forms will be stored in a locked file in the researcher's home. All materials will be destroyed three years after completion of the research. Prospective informants will be under no obligation to participate in the research. Informants who have previously agreed to participate in the study will be free to withdraw their consent to participate at any time and without any consequences. This information will be clearly delineated in the consent form.
References


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Figure 1. Sunrise enabler
Introduction

Despite decades of multisectoral efforts, childhood obesity remains a significant public health concern in the US. Overweight and obese children are more likely to remain obese in adulthood with increased risk of long-term chronic diseases such as diabetes, hypertension, coronary disease, stroke, cancer, and asthma, leading to a shortening of life expectancy (Bass & Eneli, 2015; Deal et al., 2020; Goran, 2016). Moreover, overweight and obese children are subject to teasing, bullying and discrimination due to stigma and bias associated with obesity (Centers for Disease Control and Prevention, 2021; Goran, 2016) contributing to depression, low self-esteem and low academic performance (Centers for Disease Control and Prevention, 2021). National data showed an obesity prevalence of 19.7% in children and adolescents 2-19 years of age (Fryar Cheryl D. et al., 2020). Hispanic children, as part of the second largest racial/ethnic group of the US population (62% of which reported being of Mexican descent), have the highest prevalence at 26.2%, compared to other ethnic groups, e.g., 24.8% for Non-Hispanic Black, 16.6% for non-Hispanic white, and 9% non-Hispanic Asian children (Krogstad & Luis, 2021; Stierman et al., 2021; United States Census Bureau, 2022).

Significant variations in health have been identified among Hispanic subgroups (Quader Zerleen S. et al., 2019; Zoucha & Zamarripa-Zoucha, 2021). For instance, obesity prevalence among children of Mexican heritage was the highest (26.9 %) (Dominguez et al., 2015; Ogden et al., 2020), yet few studies have focused on ethnic subgroups (Flórez et al., 2021; Fryar Cheryl D. et al., 2020). To date, most obesity prevention strategies and interventions remain unsuccessful in improving childhood
obesity prevalence among children of Mexican heritage (Davis et al., 2017; Heerman et al., 2019; Tamayo et al., 2021).

Environmental factors and social determinants of health among Hispanic populations have been examined in studies utilizing quantitative methods (Arauz Boudreau et al., 2013; Lindsay, Wallington, Lees, et al., 2018; Ochoa & Berge, 2017). Additionally, research has found a correlation between children’s eating habits and weight status, and parental perceptions and practices (feeding styles, role modeling) (Brambila-Paz et al., 2021; Davis et al., 2015; Tschann et al., 2015), but only a few studies have tried to gain a deeper understanding of the problem from a qualitative perspective (Chatham & Mixer, 2019; Hammons et al., 2021; Ochoa & Berge, 2017). Studies addressing childhood obesity prevention and exploring the cultural perspective and relevance for families of Mexican descent are simply lacking, and in-depth knowledge regarding Mexican heritage parental perspectives of childhood obesity is needed. Therefore, the purpose of this study, was to examine the culture care meaning of healthy and unhealthy weight for parents of Mexican heritage regarding children 2 to 11 years of age.

**Review of the literature**

A comprehensive integrative review of the literature has previously summarized the state of knowledge regarding Mexican heritage parental knowledge and perceptions of childhood obesity (Confiac et al., 2020). Primarily, studies found a common parental underestimation of child body weight and size (Ávila-Ortiz et al., 2017; Hidalgo-Mendez et al., 2019; McLeod et al., 2018) attributed to cultural perception, parental preferred/ideal body size (Eyambe et al., 2016; Martinez et al., 2017; Pasch et al., 2016)
and misinterpretation of traditional Centers for Disease Control and Prevention (CDC) Body Mass Index (BMI) categories (Bayles, 2010). In that regard, Garcia et al. (2020) found that using silhouette scales might assist parents to better estimate their child’s weight. Acculturation and related stress, food insecurity and maternal BMI were also identified as possible reasons for parental misperception (Eyambe et al., 2016; McLeod et al., 2018; Sadeghi et al., 2017). Mojica et al. (2019) found that maternal cultural perspective might vary with acculturation: parental concerns about healthy weight seems to be higher in families who are more acculturated compared to others that are not. Sadeghi et al. (2017) and Brambila-Paz et al. (2021) particularly discussed parental elevated BMI, describing it as a good predictor of childhood obesity. Brambila-Paz et al. (2021) longitudinal study, conducted in Mexico, focused on the transitions from normal weight, to overweight and obese status and established that there was a systematic transition of parental obesity to the children; children gained weight as their parents did. Ochoa and Berge (2017) still consider parental elevated BMI and the effect on children’s BMI as part of home environmental factors.

Researchers also looked at Mexican heritage individuals’ beliefs and cultural perspectives of children’s health and growth and found that parents of Mexican descent did not associate children’s weight status with their own children’s health status (Kersey et al., 2010). Furthermore, overweight and obese were not regarded as health concerns whereas perceived skinnier children were thought to be unhealthy and brought parental concerns (Davis et al., 2015; Guendelman et al., 2010; Su et al., 2014). Parents believed that excess weight is outgrown as a child grows up (Ávila-Ortiz et al., 2017; Eyambe et al., 2016) and considered children healthy when they were happy and active, ate well and
carried out their daily activities including playing (Guerrero et al., 2011). Healthy food and physical activity have been described as playing a role in disease prevention measures (Gallagher, 2010; Zhang et al., 2018). Parents labeled American foods as unhealthy, noting that such food is often not natural or fresh (Davis et al., 2015; Gallagher, 2010).

Among other strategies, focusing on the quantity and the quality of the food served while maintaining tradition was cited (Davis et al., 2015; Guendelman et al., 2010; Zhang et al., 2018). As for parental knowledge and perspectives of causes and consequences of childhood obesity, studies have indicated that parents did have some knowledge about both causes and consequences of childhood obesity and could speak about strategies to address it (Gallagher, 2010; Guerrero et al., 2011; Zhang et al., 2018). At the same time, parents stated that they might not have been able to find information and resources about health effects of childhood obesity if healthcare professionals did not mention it to them (Small et al., 2009; Su et al., 2014).

Fathers’ involvement, particularly in leading physical activities, was also mentioned (Greder et al., 2021; Morgan et al., 2017; Penilla et al., 2017). Children’s and other family members’ opposition to diet changes was identified by mothers as a source of conflict and a barrier to healthy eating (Davis et al., 2015; Guerrero et al., 2011; Hammons et al., 2021). Mothers strongly and proudly acknowledged their perceived role and responsibility in assuring their children’s health by providing the right foods and behaving as a role model (Davis et al., 2015; Jones, 2015). In relation to this role, mothers reported feeling like “bad mothers” and experienced negative feelings (sadness,
guilt, despair) when told by a health care professional that their children were overweight or obese (Davis et al., 2015; Small et al., 2009).

**Theoretical Framework**

The purpose of this study was to examine Mexican Heritage families’ cultural beliefs regarding healthy and unhealthy weight in children 2 to 11 years of age. This study was guided by Dr. Madeleine Leininger’s Culture Care Diversity and Universality Theory (CCT) (Leininger, 1991). The CCT aims to gain an in-depth knowledge of care and culture concepts as they relate to health, well-being, disability and death through methodological research with the goal of delivering care in a culturally appropriate, congruent way (Leininger, 2002). Leininger specified that culture and care needed to be fully and deeply understood to allow nurses to meet clients’ needs. This study explored the CCT constructs of health, care, and culture to reveal the care practices and beliefs related to weight and excess weight for Mexican heritage parents in caring for their 2 to 11 years of age children from an emic (informant’s traditional, learned and transmitted caring practices and beliefs) and etic (researcher’s professional knowledge) perspective based on their worldview and environmental context. The Domain of Inquiry (DOI) is the culture care meaning of healthy and unhealthy weight for parents of Mexican descent regarding their 2 to 11 years of age children. The ultimate goal of the study is to increase nursing knowledge about the cultural care diversity of Mexican heritage parents about childhood obesity, to allow nurses to provide culturally congruent and safe care.
METHODS

The study followed ethnonursing: “a qualitative nursing research method focused on naturalistic, an open discovery and largely inductive (emic) modes and processes with diverse strategies, techniques and enabling guides to document, describe, explain and interpret people’s worldview, meanings, symbols, life experiences and other related aspects as they bear on actual or potential nursing care phenomena” (Wehbe-Alamah & McFarland, 2015, p. 37). General principles of the ethnonursing method emphasize the ability of the researcher to actively listen, be open to learning from the informants, and to discover their culture care values, beliefs and practices about healthy childhood weight and obesity participate in providing meaning to the after confirming accuracy with the informants. To accomplish this, the researcher maintained field notes from direct observations and interactions with the informants and conducted individual interviews using a semi-structured interview guide which was guided by Leininger’s Semi-Structured Inquiry Guide Enabler to assess Culture Care and Health as described below (Wehbe-Alamah & McFarland, 2020).

Dr. Leininger developed enablers to guide researchers in the discovery of informants’ cultural views via storytelling and narratives to gather in-depth holistic data in relationship to the Domain of Inquiry (DOI) (Wehbe-Alamah & McFarland, 2020). The Sunrise enabler portrays a variety of factors that can affect culture care and was used to capture a holistic perspective of informants’ lifeways, worldview, environmental context, and cultural practices as they relate to human care and the DOI. Designed to work with the Sunrise enabler, Leininger’s Semi-Structured Inquiry Guide Enabler to assess Culture Care and Health was used to develop a semi-structured interview with
open-ended questions to capture the maximum amount of data in the enabler’s 12 domains to answer the following research questions:

1) What are the culture care beliefs of Mexican heritage parents regarding health and weight, (healthy and unhealthy) in children 2 to 11 years of age?

2) What knowledge of childhood obesity health outcomes and potential risk for their child do parents of Mexican heritage parents have?

3) What barriers do parents of Mexican heritage potentially face in trying to adopt obesity prevention behaviors?

4) What type of support and resources would parents of Mexican heritage be interested in to maintain a healthy weight for their 2- to 11-year-old children?

5) What role can nurses play in promoting a healthy lifestyle and weight in 2- to 11-year old children of Mexican heritage?

Following institutional review board approval, the study was conducted in Santa Barbara and Ventura Counties, California. Informants were recruited from Head Start programs, state preschools, and a federally and state funded program in which the principal investigator was working. The researcher used her partnerships with these community agencies to introduce the study to potential participants during existing events. She introduced the study to agency representatives and provided them with copies of the consent form in English and Spanish so that families could contact her if they were interested. In addition, she worked with the Santa Barbara County Promotores Network and Promotoras y Promotores Foundation (Ventura County) for referrals. Promotores de
salud are trusted individuals of a community who are working to bridge gaps between their community members and professional organizations (etic) by educating themselves on topics and available resources addressing their community needs.

Finally, snowball sampling, which consists of prospective informants’ referrals by current study participants was used as well (Holloway & Galvin, 2016). Individuals interested in participating contacted the principal investigator or indicated their interest to the agency representatives by providing contact information. Prior to the time of the interview, informed consent was obtained.

Informants included key informants as defined by Dr. Leininger as individuals with in-depth knowledge about the values, norms, beliefs, customs, practices and general lifeways of the studied culture and interested in the DOI. Informants also included general informants, individuals not as knowledgeable as key informants, but who have a good understanding of the DOI and are familiar with the studied culture (Leininger & McFarland, 2006). Informants were asked a variety of questions regarding children’s’ health, weight and growth.

**Data Collection**

Twenty-five informants consented to participate to the study. Eight participants were identified as key informants, and 17 were identified as general informants. A total of 28 interviews (24 initial and 4 confirmatory) took place in the informants’ home or a quiet location of their choice and lasted 70 to 130 minutes. One interview was conducted with a grandmother and grandfather at the same time. Ten interviews were carried out in English and 18 in Spanish, per informant choice.
Due to the COVID 19 pandemic, in-person interviewing was suspended per an Institutional Review Board (IRB) requirement for safety reasons. The COVID pandemic significantly affected recruitment and study progression after February 2020. An amendment was obtained from the IRB to continue interviews virtually using Zoom®. Despite this opportunity, recruitment and data collection remained challenging. Informants who participated to the study during this period electronically signed the consent form allowing the investigator to record the video sessions. Ten interviews were conducted via Zoom®. Confidentiality was maintained per study protocol. All Interviews were audiotaped or videotaped then transcribed verbatim.

Spanish interviews were translated to English by the primary investigator or professional translation services. To ensure accurate understanding throughout the interview process, the principal investigator repeated back informants’ answers to them and summarized the main points they wanted to convey at the end of each interview. Interviews were conducted and informants were recruited until data saturation occurred. Informants received a $30 gift card or e-gift card incentive per completed interview. All data including field notes, interviews and transcriptions were managed using the qualitative data analysis software, NVIVO 12.

**Data Analysis**

Data analysis and data collection occurred concurrently using Dr. Leininger’s Four Phases of Ethnonursing Data Analysis Enabler for Qualitative Data (Wehbe-Alamah & McFarland, 2020, pp. 66-67). During the first phase, the principal investigator accumulated, compiled, gathered and described all raw data from observations, field notes, and interviews in relation to the DOI and uploaded them to NVIVO. During the
second phase, the research team organized the data in categories (coding process). During the third phase, the principal investigator scrupulously reviewed the data and looked for possible patterns of care values, beliefs, and practices and/or contextual explanations in relationship to the research questions and informants’ beliefs about children’s health, growth, and healthy and unhealthy weight. The research team identified seven dominant care patterns. In the last phase, the research team synthesized and interpreted the data from the patterns to reveal four major themes.

**Evaluation of the data**

The research team used six criteria for evaluation of qualitative data (McFarland & Wehbe-Alamah, 2018), which include credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. Credibility, which relates to accuracy and trustworthiness of informants’ shared experiences with the DOI, was maintained by verifying understanding of informants’ answers during and at the end of interviews. Verbatim data was organized through the NVIVO coding process allowing for methodic review. Confirmability was ensured during the interview process as the principal investigator explored further and verify repeated information with each interview. Furthermore, at least four confirmatory interviews were conducted to assess final themes. Meaning-in-context was confirmed by the use of targeted categories in the semi-structured interview guides and confirmatory interviews. Recurrent patterning was identified during the process of analysis as comparable information regarding the DOI and research questions were traced. Saturation was determined when no new information arose from interviews and the information about the DOI became similar. Regarding
transferability, although many of this study findings might transfer to other Hispanic subgroups, the level of transferability is unknown at this time.

Results

The study total sample size was $N=25$, including 24 females and 1 male. Informants’ ages ranged from 19 to 68 years. All informants were of Mexican descent from northern or central Mexico and identified as Mexican rather than Mexican American. Nearly half of the participants ($n=12$) were first generation immigrants. All informants were parents except for two grandparents and one aunt. Children ages ranged from 9 months to 17 years of age; some informants had multiple children beyond the age range of the study. Eighty four percent ($n=21$) were Catholic. See Table 1 for demographic data.

Themes

As part of the systematic data analysis, 26 categories were identified through the coding process, which led to seven culture care patterns. Further analysis of the culture care patterns revealed four themes (see Table 2).

**Theme 1: A Healthy Child is One Who is Active, Happy, Eats Well, and Plays with Peers, Regardless of Body Weight and/or Appearance.**

Informants shared their cultural perspectives on what they considered healthy and unhealthy children; healthy and unhealthy weight; and the intentional actions they took as a family to remain healthy. Informants stated a healthy child does not relate to the child’s body weight. Health is related to the child’s happiness, his ability to perform daily activities and interact with peers, and his level of energy. For instance, a mom shared, “If I see a child who is jumping, who is smiling, who is leaping, it means that child could be
healthy.” Other informants shared that a healthy child is, “well, active, that plays, healthy, that jumps over here and runs over there;” and “full of energy from the time they get up in the morning till the time they go to bed.”

Additionally, informants talked about the type and the amount of food a child might eat, for example, “the little girl, she may be in good health because she eats everything, she eats beans, eats lentils that has a lot of iron” and “a child …using up energy and eating as much as they can on the plate, fruits and veggies.” In opposition, informants described an unhealthy child as quiet, sad, not interacting with peers, and unable to run. They described a child that is tired and refuses to play or go outside. A child who is not eating well was perceived as sick. It is interesting to note the reference to weight and use of both “gordo,” which translates to “chubby,” and “delgado,” the term for “skinny,” when informants were describing what they perceived as an unhealthy child. One informant explained, “a child who is chubby. I think is not healthy. Therefore, when you are obese, you are not. When you look at him and he is chubby, very agitated and he can’t breathe well.” Another mom stated, “a child who is very obese, or sometimes too skinny or tired.”

Informants conveyed that it was the responsibility of parents to ensure that their child remained healthy and grew adequately. For example, “You're looking at each child's problem, and I think it depends a lot on parents to keep their child healthy”; “…like with my daughters I have the responsibility to take care of them to try to keep them the healthiest.” Another informant stated, “you can't teach by telling him, but you can teach him or her like with your example;” and “If the parents aren't trying to change for their kids, you know, it's not going to happen. Should the child decide to change the
way they eat. The parents need to support them.” They spoke about taking the children to the pediatrician for their regular well child visits as part of parental responsibility to maintain the child’s health. A mom shared, “I take them to their physical checkups, and I'm reassured because they check them out, and they're well.” Mothers felt strongly about their responsibility for all aspects of feeding their child. Two mothers stated, “I consider my daughter healthy… because I'm making sure she has her fruits and vegetables and proteins and doesn't drink a lot of carbonated sodas.” “A healthy child means for me to have her food balanced and to do activities with the children, routine checkups.” Another informant shared, “in order for a child who is obese to stop being obese, the dad and the mom have to start a different diet at home and exercise.”

**Theme 2: Parents Expressed a Preference for a Collective, Familial Approach to Care Using Natural Remedies and Food as Primary Methods.**

Natural remedies and food were described as primary methods of care. Informants favored non-pharmacological approaches of care for their child and family, not only to treat illness but also as a method to ensure wellness. More than beliefs, these care practices are cultural and family values transmitted from one generation to the next. One informant shared, “We do the natural remedies of our grandmothers… if your stomach hurts, a tea of mint, a chamomile tea, and you’re better. If you're bad in your eyes, clean yourself with an egg because your eyes are red, and it works.” Informants described the importance of discussing care options with close and extended family when someone gets sick and turned to family for advice about home remedies prior to deciding to take their children to the doctor. When asked about who they would turn to first if they had health concerns for their children, one mom said, “I would say, my sister-in-law and then my
mom for guidance, and then if it continues, then I would make a doctor’s appointment.”
Another shared, “‘grandma, the girls have this’…. ‘daughter, give them this tea… they are suffocated…put some butter with bicarbonate, and you will see the air go away’….and it works.”

**Té de los abuelas.** Informants described the recipes and use of teas as cultural traditions, an art passed on to them by grandmothers, mothers and great aunts. Many informants referred to them as “té de los abuelos” (our grandparents’ teas) or “té de los abuelitas” (our grandmothers’ teas). Teas were cited as the first level of care for most illnesses (cold, stomach pain, headaches and other pain) or to decrease complications of chronic diseases, fight fatigue and decrease anxiety. Some of the plants mentioned included, “Yerba Buena” (mint), “Epazote,” “Estafiate” (prairie sage), “Yerba Sueca,” “Ruda” (Rue, Herb-of-Grace), “la Sábila” (Aloe Vera), and arnica. A mom provided these examples: “Chamomile tea, if you have children with lots of sleepy dust in their eyes, drops of chamomile tea to wash their eyes… or drops of breast milk in their eyes to fight infection. Aloe vera for when one gets burn…these are not harmful because they are natural.”

**Association of food to wellness.** Food categorized as healthy or unhealthy. Healthy food included fruits, vegetables, legumes (beans, lentils, chickpeas), nopales (cactus), papayas, guavas, cinnamon, lemon, garlic, ginger, onions, oregano, and natural honey. Many informants spoke about the importance of fresh food and the difference between food in the US compared to food in Mexico. They shared that when they lived in Mexico they knew exactly where the food came from; fruits and vegetables came from their garden, field, or their neighbors. Chicken, pork, beef had just been slaughtered and
were fresh. Everything they ate was fresh and not processed. One informant shared, “we cultivated what we eat.” Thus, informants perceived food in the US as unhealthy because food is often processed and frozen. One informant stated, “the meat is not good, it is frozen, not good, it has a lot of things that they put in it…lots of chemicals.” Eating outside the home (comida de la calle or food from the street) was also considered an unhealthy practice contrary to home cooked meals.

**Other traditional care practices.** Sobadores (masseurs), massages, and prayers are common care practices among study participants. For instance, “[I] massage the stomach with ointments and acai.” One particular massage called “empacho,” helps regulate bowel movements. One mom shared, “for example my daughters say, ‘mom, my back hurts, a massage… mom, my head hurts. Are you going to give me a massage?’” Sobadors are trusted traditional practitioners. Faith is transmitted from generation to generation and important to Mexican families. Prayers are an additional way to seek physical and mental health. One mom shared, “if she wakes up at night crying, they do say to pray for her with an egg, kind of take the bad vibes away from her into the egg.” Another stated, “when you have sick children, you ask God to help”; “…God protects me, he looks after my children, my family.”

One element that stood out from this study’s results is informants’ identity. Out of the 25 informants, only 3 identified themselves as Mexican-American. To the question, “which culture do you identify with?” they answered with pride “Mexican” and provided details about the region from which they came. Nurses and health care professionals may want to consider a different term than Mexican-American, which might not be relevant to some individuals.
**Theme 3: Environmental, Socio-cultural, and Economic Circumstances are the Main Barriers and Stressors to Healthy Weight Promotion.**

When asked about causes and consequences of childhood obesity, informants all provided at least two examples of related causes and/or consequences based on established evidence. Lack-of-knowledge concerns were only shared by two informants and related to the process of food absorption in the body. Barriers to a healthy weight that informants discussed can be summed up in two categories: parental barriers and child barriers.

**Parental barriers.** Informants shared several concerns parents might face in trying to keep their children at a healthy weight. Time was frequently cited since many parents must work several jobs to make ends meet due to the high cost of living in California. Parents are exhausted after work and do not have time to attend educational programs, exercise or cook. As a result, they tend to buy fast food or pizza to ensure children are fed. Also, certain healthy foods are not affordable. For instance, one informant stated, “I never had blueberries as a kid. How far you are going to get with a little box for four kids? Two blueberries each?” Unhealthy foods are cheaper for large families. Informants also noticed that it was easier to access unhealthy foods in the US, for example, “In Mexico if we had a soda, it was to share with everyone, but here no, because we have the ease of having one right here.” Furthermore, many families can only afford to share an apartment, which means limited time in the kitchen, with each family taking a turn. Lack of money also translated into inability to afford physical activity programs for the children.
Other barriers informants shared about had to do with childrearing ways. Caregivers’ (parents, grandparents, extended family members, babysitters) parenting styles differed regarding what foods or feeding behaviors are allowed for the child; this was identified as a major source of conflict. These conflicts also related to discipline in regard to physical activity and screen time. Informants also conveyed concerns about culturally inappropriate advice or foods offered by food banks or other organizations, including items their children would never eat. One mom stated, “I would probably speak to a professional, like a dietitian that gives me healthy recipes, but at the same time that my child will eat.” Another informant spoke about how a doctor had asked her to remove tamales from her diet and how offended and powerless she felt. Following this idea, many also stated that traditional cooking could be a barrier due to the richness of the food, such as the use of lard. In addition, there is a cultural difference in perception of healthy weight and overall health which makes it challenging for informants to fully adhere to healthcare professional assessments, for example, “According to America they want skinny children. According to my country, the children are thin, they need to eat more.” Informants shared that they would rather not hear about their children excess weight if it is presented in a judgmental way. They would feel offended.

**Child barriers.** Informants shared barriers coming from children’s behaviors, including children who refuse to eat certain healthy foods or to eat regular meals. One mom shared “the girl doesn’t eat beans, she doesn’t eat lentils, she doesn’t eat eggs, she doesn’t eat. That girl eats nothing else than pasta, chicken, noodles and potatoes.” Some children were described as picky eaters or children who do not want to eat all, “Ella no come (she does not eat).” Another issue had to do with portion sizes, children who never
have enough and feel hungry all the time. A mom stated, “This is difficult for eating when the children want more. It’s hard. They feel they are not full, and they want a lot more.” Parents pointed out children experiencing peer pressure and wanting to eat the same as their friends, whether it is healthy or unhealthy foods. Informants highlighted the challenges of technology. They specified that many children prefer to watch TV and play video games rather than going for a walk or playing outside, for instance, “My girl, when she arrives from school, she … is on TV, phone or computer….there are times that I’m talking and talking, and let’s go, and let’s go, and then they don’t stand up.”

**Resource access.** Finally, informants discussed a few access issues, namely health insurance, transportation, and community resources. Some informants did not know where to find community resources. One mom stated, “it goes back to money so, there's a lot of activities, but rarely are they free or affordable.” Spanish only speaking informants shared that they could not access some of the existing resources due to a language barrier. One mom shared, “Just because they don’t speak or want to speak Spanish, they asked you what you said, they say they don’t understand… they say, ‘we don’t speak Spanish.’” Others did not take advantage of programs like Medi-Cal (Medicaid), Women Infants and Children (WIC), or food stamps, because they feared being deported or losing their opportunity to become a US citizen. One mom explained, “We're in the process of applying for citizenship, for my husband, so I can't ask for any government assistance… for instance, I didn't apply for WIC because it would affect our case for immigration.” One community resource informants valued was the community gardens, but obtaining a piece of land is difficult. Therefore, many do not attempt to
apply for one. Instead, they grow their own plants and veggies whenever possible or find ways to buy them.

**Theme 4: Parents Desire that Nurses Embrace their Cultural ways and Provide Education and Advocacy for Heathy Weight Promotion.**

Informants had great respect for health care professionals. Some even felt uncomfortable when asked if they had any culturally congruent suggestions or advice for health care professionals working with children who had gained excess weight. They expressed their desire to be taken care of by nurses who are physically, mentally and spiritually healthy; nurses who are sensitive to human pain and what one is going through. One informant shared, “What could help is they get at peace with themselves and are patient with us when we are sick.” They described how they would like to be supported by a nurse in multiple areas. They would like nurses to build programs working directly with children in English, in a non-judgmental way, teaching them how to differentiate healthy and unhealthy foods so they can make their own choices. For instance, an informant voiced, “Letting the kids know that eating unhealthy can result in child diabetes. Overweight. And it can continue with them throughout their adult life. But at the same time, educating the parents because the parents can help the kids.”

Informants would like nurses to provide them with information about child health and growth in Spanish, particularly about how to keep tract on age-appropriate growth and development. Other topics brought up included culturally relevant healthy meals, portion sizes, food groups, discipline, how the body absorbs foods, and dangerous chemicals found in foods. Moms spoke about, “a resource guide where I could go to look for healthy meal options;” “information about healthy meals to eat, because sometimes,
one does not have many recipes.” Informants specified that they would appreciate nurses taking the time to explain the information. One mom explained: “the recommendation is to explain to them… in a good format. Don't tell them: ‘your child is too fat; you need to stop feeding him’... Because if you tell a dad your son is too fat, that is, in the form that you're scolding them. Look, he's too chubby, try to do this…”

Additionally, informants indicated that they wanted nurses to be more involved with their faith, to not only understand the cultural importance of their faith but also to share their beliefs and pray with them. For example, one informant stated, “nurses also have to pray for the sick; for the sick to heal.” “When a nurse enters a sick person’s room, they entrust themselves to God, and that God will pour out the spirit so that they do things right.” They also spoke about the advocacy role a nurse could play among the medical team. For instance, the nurse could advocate for them to have qualified interpreters able to explain well in Spanish. Then, nurses should consider their cultural beliefs and respect their desire to first use natural remedies prior to Western medicine. In summary, informants spoke of seeking support from nurses to help them remain healthy within the context of their culture and faith.

**Discussion**

This study provided both confirmatory information and novel knowledge regarding the cultural meaning of health, growth and childhood obesity in families of Mexican heritage with the unveiling of four themes: 1) A healthy child is one who is active, happy, eats well, and plays with peers, regardless of body weight and/or appearance, 2) Parents favor a collective, familial approach to care using natural remedies and food as primary methods, 3) Environmental, socio-cultural, and economic
circumstances are the main barriers and stressors to healthy weight promotion, 4) Parents desire that nurses embrace their cultural ways and provide education and advocacy for healthy weight promotion.

Like the findings presented here, previous studies have pointed out the underestimation of child body size and weight (Ávila-Ortiz et al., 2017; Hidalgo-Mendez et al., 2019; McLeod et al., 2018). However, no identified study has addressed the relationship between families of Mexican descent’s cultural beliefs of the healthy and unhealthy child and perception of excess weight that could explain why families might not respond to traditional approaches to managing childhood obesity. A meta-analysis by Janicke et al. (2021) argued that published quantitative trials addressing lifestyle behavior changes in families of Mexican heritage over the past 5 years were scarce and scored as low in regard to quality of the evidence (study designs and small sample sizes).

Qualitatively, others have examined the cultural perceptions of healthy eating in children of Mexican heritage and revealed that 1 to 13-year-old children associated healthy food to traditional cultural food and the feeling of joy it brought to them (Ribar et al., 2021). Eyambe et al. (2016, p. 220) discussed the importance of food and the beauty of chubby babies as cultural factors but did not address the in-depth cultural meaning of food and how changing it to the traditional American way can be perceived negatively by families.

Another major point from this study to be considered for childhood obesity prevention interventions is the fundamental cultural meaning of natural care for families of Mexican heritage, which includes both natural remedies and fresh food. Regardless of health insurance status, level of education and immigration generation status, informants shared that they prefer use of natural remedies, particularly herbal teas to care for their
children and themselves. Similarly, Fowler et al. (2022) found that 83% of Hispanic participants (N=200) had used cultural (home) remedies while only 15% had shared these practices with their healthcare provider. Food and related rituals were identified as a way to maintain healthy lifeways and improve healthy eating in Hispanic population (Chatham & Mixer, 2019; Coe et al., 2018). This vital culture care need to follow traditions in using natural remedies has also been discussed by Crocker and Gonzales (2021), labelled as “authoritative healing knowledge” (p.4) and described as a survival mode to migration. All these findings have in common the fact that these diverse culture care practices and preferences are somewhat ignored by medical professionals, which can be responsible for gaps in services for this population. Previous studies had discussed the importance of three essential cultural concepts to facilitate congruent care in families of Mexican heritage: trust (confianza) that nurses could establish by approaching families with a caring and friendly attitude, personal connection (personalismo) which shows openness, and respect (respeto) (Jones, 2015; Sobel & Metzler Sawin, 2016; Zoucha & Zamarripa-Zoucha, 2021). Furthermore, family, already identified as a CCT caring construct, was also acknowledged by the current study informants as a central element for care (McFarland & Wehbe-Alamah, 2018, pp. 42-46). The role of the mother as responsible for the children’s health was confirmed as well (Reifsnider et al., 2020; Sadeghi et al., 2017). Healthcare professionals should consider the cultural concepts and cultural value of natural remedies and include it to the overall care of Mexican patients or at least offer opportunities for families to speak about it without fear (Martinez et al., 2017).
One novel finding from this study is that the main barrier to behavior and lifestyle changes might not be primarily related to a lack of knowledge. Informants in this study understood childhood obesity’s negative health outcomes, but the need to modify lifeways might not make sense from a cultural standpoint if the overweight child is happy and active. Similar to what others discussed previously, informants in the current study knew about causes and consequences of childhood obesity but did not believe that these applied to their children (Flores et al., 2012; Kersey et al., 2010; Zhang et al., 2018). Yet, childhood obesity prevention interventions tend to have a one-size-fits-all idea that families’ issues with weight are related to a lack of knowledge (Martinez et al., 2017; Tamayo et al., 2021). Yet, informants indicated they would like health information and support from nurses to help them keep their children healthy but within the context of their culture and faith.

**Implications For Practice and Research**

The cultural information shared by informants in this study will assist nurses and other healthcare professionals in various fields to provide individualized, culturally congruent care to families of Mexican descent. Findings could improve all areas of childhood obesity prevention including how the child’s excess weight is presented to the family, the medical follow-ups, prevention education, and interventions offered. Dr. Leininger envisioned three culture care decision and action modes nurses and healthcare professionals can use to provide culturally congruent care (McFarland & Wehbe-Alamah, 2018, p. 49).

**Culture care preservation and/or maintenance** relates to any professional action/decision to support, maintain, and preserve an individuals’ cultural beliefs and
values. Knowledge about Mexican families’ concept of health, use of natural remedies and fresh food as part of their healing and health promotion strategies should inform nurses approach and decisions in planning for care of Mexican overweight and obese children. Nurses should provide opportunities for individuals to share their emic expertise in traditional natural home remedies. Public Health Nurses (PHNs) could provide resources about where to grow fresh food or could advocate in multisectoral coalitions/initiatives to expand community gardens. Overall, nurses should work to maintain and preserve the culture care values of Mexican heritage families whenever possible.

**Culture care accommodation and/or negotiation** has to do with professional care action and/or decision that helps cultures adapt or negotiate care in a culturally congruent way for the benefit of their health and wellness. Studies have shown that Mexican Americans value trust (confianza) (Jones, 2015; Zoucha & Reeves, 1999). PHNs could work with promotores de salud, trusted members of the community, to share health information or discuss culturally appropriate ways to address obesity prevention. Informants shared the mother is primarily responsible for the child’s health and diet. Nurses can work with mothers to adapt recipes in a culturally appropriate manner so that the children can eat the food as well as the rest of the family. This study showed that fathers, although invited, did not participate to the study with the exception of one grandfather. As already stated, in recent studies, fathers’ perspective on children’s obesity has not fully been explored (Greder et al., 2021; Lindsay, Wallington, Muñoz, et al., 2018; Morgan et al., 2017). Further studies should address father’s cultural perspective maybe by limiting the inclusion criteria to men.
Culture care repatterning and/or restructuring is about mutual actions and decisions leading to modifications and restructuring of cultures lifeways for improved health outcomes. These actions would be in continuation or ongoing actions from the two previous modes. PHNs could offer opportunities for collective care and participatory action, through gatherings with families and extended families to discuss the benefits of monitoring weight and tracking excess weight overtime. The tracking methods could be developed jointly to address both Mexican Heritage families’ cultural lifeways and healthcare professionals’ etic ways for continued family support in working towards and/or maintaining their children’s healthy weight. Since informants did not connect the consequences of excess weight to their own children, PHNs could engage parents in designing preventive solutions that meet their cultural views of long-term health and happiness while acknowledging real-life barriers to healthy weight promotion. Further qualitative studies should explore ongoing partnerships with families (collaborative and collective care) to maintain emic perspectives of care while ensuring progress towards healthy weight for children (McFarland & Wehbe-Alamah, 2018, pp. 42-43).

Study Strengths and Limitations

Strengths

The study used the CCT and ethnonursing, a qualitative research method, which was designed to gain in depth knowledge of phenomenon from a cultural perspective following a rigorous evidenced-based model. The use of the Sunrise and Semi-Structured Inquiry Guide to assess Culture Care and Health enablers provided opportunities for in-depth exploration to uncover transcultural care meanings in the context of the DOI. Other strengths included the sample size and the variety of informants in terms of age, number
of children and experiences and the four confirmatory interviews that substantiate the study themes.

**Limitations**

The study took place during the COVID-19 pandemic, which required alternate ways to conduct interviews and did not allow for full observation of the informants’ environmental context for the 10 informants who were interviewed via Zoom®. Also, although the principal investigator was well accepted, involved with the informants’ communities, and spoke Spanish fluently and proficiently, she and the other investigators for this study were not of Mexican descent. Informants might have shared different information with a promotora or a family friend. Furthermore, translation accuracy while performed mostly by the principal investigator and professional translation agencies, might have been affected by linguistic and cultural untranslatability with some words/expressions not absolutely conveying the same meaning or tone in English.

**Conclusion**

This study expanded understanding of Mexican heritage families’ cultural beliefs about weight, health, and growth in children 2 to 11 years of age. Findings revealed that the cultural meaning of a healthy child is not absolutely associated with the idea of healthy weight like it is in the etic view but with happiness and the child’s ability to perform his or her daily activities. Informants reported being responsible for their child’s health, and expressed a cultural care preference for natural remedies (teas, massages) and fresh food as primary methods of care and health promotion, particularly transmitted by grandmothers. Family is a core value of the Mexican culture, hence health care decisions for children are made after consultation with the entire,
extended family. Barriers to healthy weight are multi-factorial including parental time restrictions and children’s resistance to change. The study found that families of Mexican heritage have knowledge about causes and consequences of childhood obesity but do not perceive excess weight as a problem for their children and therefore do not relate to health care professionals' methods and tools to discuss excess weight.

Parents value caring nurses who are open to their culture and faith. The findings of this study will help nurses and other health care practitioners provide more culturally congruent care by using cultural humility and working to preserve Mexican heritage families’ values in the care they provide. Nurses, particularly PHNs, have a unique opportunity to address this gap through culture care repatterning and restructuring mode of actions, such as increasing families’ awareness of their child current health status and assisting them in finding preventive methods that meet their cultural care values and perspectives of long-term health and happiness.
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[https://doi.org/10.1017/S1368980016002962](https://doi.org/10.1017/S1368980016002962)


Children [Article]. *Pediatric Nursing, 35*(6), 357-368.


[Record #248 is using a reference type undefined in this output style.]


### Table 1. Informants Demographics ($N = 25$)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>$n$ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>19-30 y</td>
<td>4 (16)</td>
</tr>
<tr>
<td>31-40 y</td>
<td>10 (40)</td>
</tr>
<tr>
<td>41 and above</td>
<td>9 (36)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (8)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Female</td>
<td>24 (96)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4 (16)</td>
</tr>
<tr>
<td>Married</td>
<td>17 (68)</td>
</tr>
<tr>
<td>Divorced</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (4)</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>12 (48)</td>
</tr>
<tr>
<td>3-4</td>
<td>12 (48)</td>
</tr>
<tr>
<td>5 and more</td>
<td>1 (4)</td>
</tr>
<tr>
<td><strong>Children’ age</strong></td>
<td>$N = 54$ children in the household (100)</td>
</tr>
<tr>
<td>0-5</td>
<td>21 (39)</td>
</tr>
<tr>
<td>6-11</td>
<td>14 (26)</td>
</tr>
<tr>
<td>12-15</td>
<td>11 (20)</td>
</tr>
<tr>
<td>16 and above</td>
<td>8 (15)</td>
</tr>
<tr>
<td><strong>Country of Birth</strong></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>3 (12)</td>
</tr>
<tr>
<td>West and South Central</td>
<td>15 (60)</td>
</tr>
<tr>
<td>South</td>
<td>1 (4)</td>
</tr>
<tr>
<td>USA</td>
<td>6 (24)</td>
</tr>
<tr>
<td><strong>Immigration Generation Status</strong></td>
<td></td>
</tr>
<tr>
<td>1st generation</td>
<td>12 (48)</td>
</tr>
<tr>
<td>2nd generation</td>
<td>10 (40)</td>
</tr>
<tr>
<td>3rd generation</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (8)</td>
</tr>
<tr>
<td><strong>Length of time in the US</strong></td>
<td></td>
</tr>
<tr>
<td>5-10 y</td>
<td>4 (16)</td>
</tr>
<tr>
<td>11-20 y</td>
<td>8 (32)</td>
</tr>
<tr>
<td>21-30 y</td>
<td>7 (28)</td>
</tr>
<tr>
<td>40 y and more</td>
<td>6 (24)</td>
</tr>
<tr>
<td><strong>Primary language spoken in the home:</strong></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>4 (16)</td>
</tr>
<tr>
<td>Spanish</td>
<td>13 (52)</td>
</tr>
<tr>
<td>Both</td>
<td>8 (32)</td>
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<tr>
<td>Religion</td>
<td>Count</td>
</tr>
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<tr>
<td>Catholic</td>
<td>22 (88)</td>
</tr>
<tr>
<td>Christian</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Atheist</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Themes</td>
<td>Patterns</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A healthy child is one who is active, happy, eats well, and plays with peers, regardless of body weight and/or appearance.</td>
<td>A pattern of common perceptions for what a healthy child is.</td>
</tr>
<tr>
<td>Parents favor a collective, familial approach to care using natural remedies and food as primary methods.</td>
<td>A pattern of parents’ responsibility for their child's health</td>
</tr>
<tr>
<td>Environmental, socio-cultural, and economic circumstances are the main barriers and stressors to healthy weight promotion.</td>
<td>A pattern of use of natural remedies and food as cultural care practices</td>
</tr>
<tr>
<td>Parents desire that nurses embrace their cultural ways and provide education and advocacy for healthy weight promotion.</td>
<td>A pattern of respect for family influence in caring for the child</td>
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<td></td>
<td>A pattern of barriers and stressors to healthy weight promotion and maintenance</td>
</tr>
<tr>
<td></td>
<td>A pattern of desired assistance from nurses related to health information and support</td>
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<tr>
<td></td>
<td>A pattern of pride in identifying as a person of Mexican heritage</td>
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</tbody>
</table>
Leininger's Sunrise Enabler to Discover Culture Care

Focus: Individuals, Families, Groups, Communities, or Institutions in Diverse Health Contexts of

Generic (Folk) Care
Integrative Care Practices
Professional Care—Cure Practices

Three Modes of Care Decisions & Actions

Culture Care Preservation and/or Maintenance
Culture Care Accommodation and/or Negotiation
Culture Care Repatterning and/or Restructuring

Code: ↔ (Influencers)


Culturally Congruent Care for Holistic Health, Wellbeing, Disability, Illness, Dying, and Death