Enhancing Culturally Competent Care for Obesity Among African Immigrants

ENHANCING CULTURALLY COMPETENT CARE FOR OBESITY AMONG AFRICAN IMMIGRANTS

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DEDICATION

For Dominic, my son

I dedicate this doctoral work to the glory of the Almighty God. I will keep on trusting Him for grace upon grace and blessing upon blessing in my life. Thank you, Lord

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ABSTRACT

Purpose: This DNP project examines the effectiveness of a brief educational presentation to improve cultural competency care for obesity among African Immigrants. This project focused on providers at southwestern urban primary care clinic to become culturally competent in caring for African immigrants with obesity. The findings and recommendations of this project also serve as resource for other providers locally and nation-wide who provide care for African immigrant population.

Method: Utilizing a purposeful sampling method, quantitative pre-test and post-test questionnaires were used to evaluate cultural knowledge and intended clinical practices of participants (N =5), feasibility and satisfaction of the educational activity. Aggregate data collected from the pre-and post-test questionnaires were analyzed and discussed through thematic and descriptive analysis.

Results: All participants demonstrated significant enhancement in cultural competency in knowledge in regard to nutrition, physical activity and linguistics/communication, body image perception and obesity management in African cultural context. Also, one hundred percent (n=5) of the participants recorded very high level of satisfaction of the intervention content and delivery.

Conclusion: The education intervention was successful in enhancing providers' cultural knowledge and competence in caring for African immigrants with obesity. It also serves as valuable initiative to further develop culturally competent care based on evidence-based practice to enhance the quality of care delivery for African immigrants as well as other vulnerable minority populations.

For the over two million African Immigrants in the United States, obesity and its related complications is a constant struggle for this minority population. Health disparities exist for all minority groups suffering from poverty in the US, and the immigrant population is at a higher risk for these disparities due to the slower rate of acculturation. The effort to address obesity among immigrants especially those of African descent is significantly influenced by providers' cultural knowledge, sensitivity and competency in healthcare delivery. This project outlines the development, implementation and evaluation of a brief PowerPoint presentation aiming to educate healthcare providers on cultural competency and appropriateness in caring for African Immigrants with obesity.

INTRODUCTION

Background

Overview of African Immigrants

The migration of Africans to the United States rose phenomenally between 1980 and 2009. Recent data from the Department of Homeland Security's Office of Immigration Statistics (OIS) (2010), places the population of African immigrants as 2.1 million, comprising a diverse group from different countries in Africa. Due to increased unrest in Africa, and the constriction of natural resources, the most recent data available from the U.S. Census Bureau (2012) and the American Community Survey (ACS, 2012). The American Immigration Council (AIC, 2012) claims that this number comprise of four percent of the immigrant population in the U.S, with most of the immigrants from Nigeria, Kenya, Ethiopia, Egypt and Ghana. This remarkable increase has been attributed to many factors, including work opportunities in the US, immigration through the diversity visa program and immigration as refugees and asylum seekers. Over half of the immigrants have come to the US through family relationships (Department of Homeland Security, 2010).

Recent studies show that immigrants in the United States who originating from these countries are at risk for obesity due to changes in dietary habits and socio-economic variables (Delavari, Sønderlund, Swinburn, Mellor, & Renzaho, 2013). African Immigrants often leave their countries of origin for better economic and educational opportunities in the US. Several studies document the prevalence of obesity in this demographic. Obesity is often associated with diet, culture, environment, physical activities and health issues (Barrington, Baquero, Borrell, & Crawford, 2010; Blanchard, 2009; McCubbin & Antonio, 2012; Oza-Frank & Narayan, 2010).

Key variables have been identified such as diet, physical activity, gender, socioeconomic status, level of education, and length of stay and concluded these factors contribute to the increase in obesity among African immigrants (Delavari, Sønderlund, Swinburn, Mellor, & Renzaho, 2013). Most meals and entrees served in several restaurants and exceed the U.S. Department of Agriculture's daily nutritional limit recommendations for calories and fat/saturated fat content which contributes greatly as a predictor of obesity (Wu and Sturm, 2013). Many African Immigrants are not familiar with servings and calorie counts and thus at risk of consuming more than the required daily nutrient recommendations. Another key risk factor for obesity is change in weather. The difference in climate between traditional and host countries may be obstacle to participating in exercise and/or physical activity in immigrant communities (Rothe et al. 2010). One study shows that 19% of African Immigrants have gender and cultural concerns requiring specific clothing especially for females to participate in any outdoor physical activities or having limited interaction with men who were not their spouses (Rothe et al., 2010).

Sociodemographic Challenges

There are numerous socioeconomic challenges confronting African Immigrant population in the United States. Five percent of the African Immigrant population is 65 years or older while 86 percent fall between the age range of 16 and 64 years old (U.S. Census Bureau, 2009). There are about fifty-six percent of men while about forty-four percent are women with half of the population of African Immigrants (48.5%) reported lacking literacy in English Language. In academic achievement, forty-one percent that are 25 years or older have a bachelor's degree while more than sixteen percent have higher university degrees (U.S. Census Bureau, 2009). Over sixty percent of African Immigrants are involved in the U.S civilian labor force working in

areas of construction, extraction and transportation and other services. Africans also participate in the management, business, and finance professions (12.5%) and others are involved in sales (10.7%). About fifteen percent of African Immigrants in the United States live above the federal poverty level while twenty-six percent are reported to be living below the poverty line. Fifty-nine percent falls within the middle class of American society (U.S. Census Bureau, 2009).

The major reason for migration is the pursuit for better life (Uwakweh et al. 2013). There are more economic opportunities in the U.S than in African countries. African Immigrants gained admission to the United States through temporary visas (visiting visas or student visas or other type of temporary visas), lawful permanent residence through family relationships, diversity visa program, and work/employment programs (U.S Census Bureau's 2013).

The other major reason is political due to widespread corruption in local and continental African governments. This is attributable to immigrants seeking political refugee or asylum from the various pressures of political, socio-economic and environmental exploitation going in their homeland. When these immigrants enter the US, they face a number of cultural, sociopolitical and healthcare issues. It has been reported that many African Immigrants do not have ready access to healthcare and face severe health disparities in comparison to other minority groups (Baundaoni, 2015).

Obesity Health Disparities

Venters and Gany (2011) conclude that upon arrival to the United States, African immigrants generally healthier than the native-born American population. However, with time, they acquire the health issues and diseases characteristic to the United States due to the nature of much of the processed food in the American diet. Venters and Gany (2011) have termed this the

"healthy immigrant paradox." Baundaoni, (2015) corroborates the findings of other studies (Lebrun & Dubay, 2010; Stevens and West-Wright, 2008; Derose et al.,2007; Prus,Tfaily and Lin, 2010). These studies report in general African Immigrants have the same access to healthcare relative to the general U.S population.

However, African Immigrants are less likely to use these services; this may be due to economic, cultural or religious reasons. Grey (2013) reports that African Immigrants "are less likely to have health insurance". The percentage of uninsured Africans in 2014 was about 14 percent of all African Immigrants (Grey, 2013). In comparison to the general US population, this percentage is low. However, it shows the limited access to healthcare by African Immigrants, which may be due to status of legal residency in the Unites States, lack of understanding of healthcare information or unfamiliarity with healthcare processes in the United states and/or lack of providers' sensitivity and competence to their respective culture at the point of care (Oza-Frank & Narayan, 2010).

Researchers Barrington, Baquero, Borrell, & Crawford (2010), Blanchard (2009), McCubbin & Antonio (2012), and Oza-Frank & Narayan (2010) associate obesity with issues such as culture, environment, physical activities, and inherent health issues. Research has also identified that migration-related stressors and life stressors can have an impact on dietary fat intake, contributing to obesity (Goldstein, 2009). In addition, lack of health education and access to care have been implicated to poor health practices among African Immigrants including making unhealthy food choices and reduction of physical activities and exercise, strong adherence to a cultural belief and perception that obesity is not a disease or condition but rather a sign of prosperity (Uwakweh et al. 2013).

Obesity Management

Definition

The Centre for Disease Control (CDC, 2012) defines obesity as a body mass index (BMI) greater than or equal to 30kg/m^2. The BMI, a key index for relating body weight to height, is a person's weight in kilograms (kg) divided by their height in meters (m) squared. Since the BMI describes the body weight relative to height, it correlates strongly (in adults) with the total body fat content. The CDC provides a BMI table or chat that can assist providers in screening for obesity (see appendix for BMI chat/table). In summary, when BMI is less than 18.5; it falls within the underweight range; BMI is 18.5 to <25, it falls within the normal; BMI is 25.0 to <30, it falls within the overweight range; BMI is 30.0 or higher, it falls within the obese range. More so, Obesity is frequently subdivided into categories:

Class 1: BMI of 30 to < 35
Class 2: BMI of 35 to < 40
Class 3: BMI of 40 or higher (sometimes classified as “extreme” or “severe” obesity)
(CDC, 2012).

Evidence-Based Recommendation

The American Heart Association, American College of Cardiology and the Obesity Society Clinical Practice Guideline recommend new practice guidelines to manage obesity. The guidelines emphasize lifestyle changes and developing individualized plan of care as essential steps to curb obesity (AHA/ACC/TOE, 2013). The new guidelines stemmed from current systemic evidence reviews and literature on the risks of obesity and benefits of weight loss. It provides an executive summary of knowledge on diets for weight loss, the efficacy and effectiveness of comprehensive lifestyle interventions on weight loss and weight loss maintenance and the benefits and risks of bariatric surgery (AHA/ACC/TOE, 2013).

The report recommends that healthcare providers calculate BMI at annual or routine visits and use the BMI values to identify individuals who may be at a higher risk of cardiovascular disease, diabetes, cerebral vascular disease or stroke resulting from overweight or obesity. The report reveals that the higher the BMI the greater the risk of stroke, diabetes, hypertension or heart disease and all-cause mortality or death from any cause (AHA/ACC/TOE, 2013). The new practice guideline urges healthcare providers create personalized weight loss plans that contain three key components – an averagely reduced calorie diet, a program of optimal physical activity and the use of behavioral strategies to help patients attain and maintain a healthy body weight. Hence, the practice guideline promotes comprehensive lifestyle programs and behavioral strategies that incorporate culturally tailored intervention to assist individuals with obesity or overweight in adhering to a lower calorie diet and in increasing physical activity (AHA/ACC/TOE, 2013).

Unfortunately, despite the enormous amount of attention focused on the problem of obesity in recent years, the systematic and literature reviews revealed that obesity researchers have yet to develop a set of evidence-based practices or an "absolute remedy" or universal practice guidelines effectively addressing obesity among African Immigrants (AHA/ACC/TOE, 2013). Still, evidence-based research reveal close connection between culture and dietary habits from which individualized care plan and effective interventions for obese and overweight target population can be developed. Culturally tailored interventions have been to be effective among Mexican population, but precision education and implementation is needed to begin to correctly address the endemic of obesity for the entire US population (AHA/ACC/TOE, 2013).

In a pilot study of cultural adaptation with eighty-six Mexican immigrant women, culturally-appropriate behavioral lifestyle interventions for obesity shows positive outcome with an average loss of 11.7lb within 6 months, and 15.8lb within 12 months, and a mean reduction of 3.2 kg/m2 in BMI (Limber et al, 2013). More so, in a randomized controlled study to evaluate the efficacy of a culturally designed intervention for obesity intervention among Latino youths and children (Familias Activas y Saludables, or Active and Healthy Families- AHF), Child BMI (kg/m^2) decreased (-0.50) in the AHF group and increased with about +0.32 in the control group, leading to an adjusted difference in change of -0.78 (95% confidence interval of -1.28,-0.27 (Falbe et al, 2015). Similar success was achieved in a randomized study engaged in culturally modified anti-obesity intervention of "Mindful Eating" behavior skills among Latino Females; the study shows significant decrease in body-mass index (BMI) and continuous weight lost by 1.1kg/m (2) to 1.4kg/m (2) in a 10-week period (Daly, Pace, Berg, Menon, & Szalacha, 2016). Contemporary research recommends culturally competent providers geared with the knowledge and skill set to provide culturally designed interventions that will improve outcome among immigrant populations particularly of African origin as this target group are at high risk for obesity (Lutfiyya, Garcia, Dankwa, Young, & Lipsky, 2008)

Cultural Considerations

A mixture of social and cultural factors are predictors of obesity in African Immigrants. The cultural factors include values about body image perception, connection of food/dinning together and family unity, and religious beliefs about body weight as obesity/overweight is linked to prosperity, "good health and wellness", sign of successfulness and so on. These social factors include sex/gender, age/life stage, employment, occupation, income, education,

household size, marital status, parenthood, residential density, and region (Goldstein, 2009). Though perception of body image varies from culture to culture, many African communities place great significance on body image and obesity. For the purpose of this DNP proposal the notion of "body image" perception will be expanded. Paradoxically, obesity is a welcoming concept as a manifestation of well-nourished and successful achievements in life as well as a factor to determine marital union and, in contrast, being lean is perceived as a sign of "ill-health", sickness, malnourishment and poverty (Ogunjimi, et al, 2010). In some African cultures especially among the Afik and Ibibio of west African, the community provide dieting program that helps young females to gain weight and become obese so that men would find them well-nourished, healthy and attractive for marriage (Ogunjimi, et al., 2010). Hence, it is not surprising that upon migration to the United States individuals from these communities are very reluctant to appreciate the need of obesity prevention and management.

Cultural Competency

Cultural competent practice involves a combination of knowledge, congruence of diverse cultural practices and perspectives, contemplative self-awareness of own cultural perspective, approach about cultural differences, and skills in trans-cultural assessment and communications (Anderson et al., 2010; Andrews, 1992; Campinha-Bacote, 2010; Lipson, Dibble, & Minarik, 2005). Cultural Competence refers to a proficient demonstration of cultural awareness, knowledge and skill and applies these components as he/she interface with patients, co-workers, and customers. Culturally competent individual operates from a platform of respect for others and adjusts to the changing and difficult opportunities in remaining culturally aware and effective.

There are four key elements of cultural competence relevant to this research project namely, cultural awareness or cultural humility, cultural knowledge/education, cultural skills & practice and cultural desire & encounter. Cultural humility is a life-long process of conscious awareness or sensitivity in recognizing the dynamic interaction among various cultures, recognizing one's own assumptions, biases and prejudices and how these might influence cross-cultural interactions and healthcare delivery (Schuessler et al., 2012). It is also the acknowledgement of the similarities and difference in various cultures without attributing values to them as positive or negative, right or wrong, good or bad (Oza-Frank, 2010). The second element is cultural knowledge which is a process of seeking and acquiring veritable and reliable education or information about African immigrants, their world-view and perspective toward healthcare and management of obesity (Campinha-Bacote, 2007). The third component of cultural competency is cultural skill which refers to the ability to collect important cultural data regarding the patient's presenting problem, as well as accurately perform a culturally based, physical assessment in a culturally sensitive manner (Campinha-Bacote, 2007). The fourth component is cultural encounter indicating the interaction between healthcare professionals and members of different cultures. The fifth component is cultural desire, which is the motivation to become culturally educated, skilled, competent in cultural diversity. These components of cultural competency involve a lifelong commitment to self-critique and developing mutually respect and openness across cultures. Cultural competency concepts enable providers to reject any discourse or notion that one cultural worldviews or practices is superior over another but attest the diversity and uniqueness of each cultural and how it impacts lifestyle and health practices (Oza-Frank, 2010).

Evidence-based studies and literature reviews have shown that African Immigrants tend to visit or would prefer to receive healthcare services from providers and healthcare centres that apply elements of cultural values familiar to this population (Oza-Frank, 2010). Thus, cultural competency promotes access to healthcare services as well as good health practices, improving overall health outcomes for this at-risk demographic.

Local Problem

This project was conducted in the Metropolitan city of Las Vegas, Nevada. The city of Las Vegas has a population of 1.9 million people and African and Black population include about 300,000 of this number and about 11% of the whole population are of African origin or immigrants (City of Las Vegas, 2013). About 20% of this number of Africans do not have health insurance coverage therefore, their access to health facilities is limited (Uwakweh et al. 2013). There is no readily available data on the percentage of obese patients with no access to healthcare.

This project was conducted at VIP Primary Care Clinic in Las Vegas Nevada. It is a group practice with specialization in General Practice. These providers have been treating diabetes, hypertension, obesity and other chronic conditions among Africans for more than a decade. The setting was chosen for this project because the providers are conversant with the health issues of the African Immigrant community in Las Vegas, caring for a significant proportion of this population, and thus appropriate for this study. However, during my clinical rotation, I noticed that the standard procedure and practice employed by many of these primary care providers for treating obesity among African Immigrants frequently lacked the cultural context to it, which imparted patient compliance and outcome.

Also, there is lack of culturally specific strategies to promote effective weight loss among obese immigrants in Las Vegas. VIP primary care clinic is the only known healthcare center that provides comprehensive care to significant number of African Immigrants in Las Vegas through the concept of "small change" approach. This approach involves a 12-week weight-loss program which participants would complete daily food and pedometer logs assisted by four sessions of (five-minutes per session) weight-loss counseling. The assumption behind this approach is that some changes in physical activity level and/or dietary changes can significantly decrease body mass index and rate of obesity as well as improve overall health outcome (Damschroder et al. (2009). Though the principle of "small change" approach seems credible, it lacks the cultural context and appropriateness of care for African Immigrants with obesity that would significantly improve quality of care for this population. It is for this reason, that this project identifies the opportunity to conduct this project at VIP primary care clinic that enhance clinical practice in caring for African immigrants with obesity.

Purpose of Study

This is a pilot project to assess the effectiveness of a short educational presentation to improve cultural competency of obesity care for African Immigrants. The presentation with a pre-test and post-test aims to determine change in providers' knowledge and intended practice behavior as well as to evaluate the feasibility and satisfaction of this activity. The goal is to enhance cultural competency which is significant because African culture influences these immigrants thought patterns, behavior and health practices in ways which must be understood for health care goals to be met with trust between provider and patient. Cultural competent providers may be more likely to improve health outcomes and decrease the alarming rate of obesity and its

related outcome among this population. This project is geared toward using the findings therein to help providers at VIP primary care clinic to become culturally competent in caring for African Immigrants with obesity. In addition, it is important to note that if the intervention of this project proves successful at VIP primary care clinic, the findings and recommendations of this project could be used as resource for other providers locally and nation-wide who provide care for African Immigrant population.

Specific Aims

This project aims to assess the effectiveness of a brief educational intervention to improve primary care providers' cultural competency in providing obesity among African Immigrants living in the United States, this project attempts to answer following questions:

Q1. Does a brief educational intervention improve providers' knowledge, skills and intended clinical practice behavior in caring for African Immigrants with obesity?

Q2: Are participants satisfied with the content and presentation of a brief PowerPoint educational intervention?

THEORETICAL FRAMEWORK

Campinha-Bacote's Model of Cultural Competence in Healthcare Delivery

The theoretical framework is the Model of Cultural Competence Process in Healthcare Delivery (CCHS) developed by Campinha-Bacote. This model popularly known as "cultural competency in the delivery of healthcare services," considers cultural competence as an ongoing process (Campinha-Bacote, 2012). The concept of cultural competence can be described as a process in which healthcare providers' endeavor to enhance proficiency or efficiency in delivering quality care to individual(s) in a culturally diverse environment or context (Campinha-

Bacote, 2012). The process of achieving cultural competence entails five essential components namely cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.

The first concept of Campinha-Bacote theoretical model is cultural awareness which is a process in which healthcare professionals consciously acknowledge their own cultural backgrounds, which helps them avoid biases toward other cultures. The second component is cultural skill, which is the ability to acquire relevant information in a culturally-accepted approach and physical assessment from patients. The third component is cultural knowledge, a process in which healthcare professionals dispose themselves to understanding variations in cultural and ethnic characteristics in relation to patient attitudes toward illness and health. The fourth component is cultural encounter during which conventional images are avoided through the interaction between healthcare professionals and members of various cultures. During this process, over reliance on conventional views are discouraged. The fifth and last component is cultural desire, which is the impetus to getting educated, skilled, competent, and becoming familiar of culture; it also presuppose a willingness to have transcultural interactions (Campinha-Bacote, 2011). These cultural competence process have been shown to help improve health outcomes related to various comorbidities including chronic conditions like diabetes, hypertension, arthritis, cardiovascular diseases and obesity among minority ethnic groups (Campinha-Bacote, 2008). This model can appropriately be used to enhance providers' knowledge and competency in caring for African immigrants with obesity

Campinha-Bacote's competence model has been utilized in many healthcare settings across the globe. For instance, in Saudi Arabia and South Africa where the healthcare systems

are staffed mainly by expatriate providers from diverse linguistic and socio-cultural backgrounds applied the above mentioned model to effectively manage and improve quality of patient care in such multicultural environment (Almutairi, McCarthy and Gardner, 2015). Using the Inventory to Access the Process of Cultural Competency - Revised (IAPCC-R) cultural competence questionnaire from eight critical care units in a public hospital in KwaZulu-Natal Province, South Africa, it was determined that healthcare providers need cultural competence in the management of patients within a cultural context in order to improve comprehensive patient centered care and decrease health disparities (Sullivan, Forsythe and Sniffen, 2015).

Drawing from these examples, this project endeavors to apply the concepts of Campinha-Bacote's competence model to how improve providers care for African Immigrants with obesity. Using the concept of cultural awareness, the educational intervention of this project will enhance providers' awareness and self-examination to recognize their respective biases, if any, toward this minority group and toward obese individuals in general. Through cultural knowledge, providers can ask cultural appropriate acquire information regarding health-related beliefs practices and cultural values, disease incidence and prevalence, and treatment efficacy of obesity among African Immigrants. Through cultural skills, providers develop enhanced cultural assessment approach to explore the patient's explanation of his or her illness. Cultural skills help providers to engage in open-ended questions with patients to elicit details during an encounter. Examples of such questions include: How do you perceive your problem? What name does it have in your culture? What are the treatment options should you receive? What are the most important results that you hoped for in this treatment? Through the application of the concepts of this cultural competent model, this project aimed to help providers in VIP primary clinic to

established a pattern of quality healthcare services, safety and efficacy for obesity management among African Immigrants within a cultural context.

SYNTHESIS OF EVIDENCE

A literature search was conducted using current and relevant peer-reviewed articles, form the following databases: Medline, PubMed, the Cumulative Index to Nursing and Allied Health (CINAHL), the National Guideline Clearinghouse databases, ScienceDirect database and the National Guideline Clearinghouse databases. To optimize the search results, I used the following keywords as search strings: Obesity AND Disease management; African Immigrants AND obesity AND diet; Obesity and nutrition practices AND African immigrants; African Immigrants AND obesity AND education; Obese immigrants AND increased physical activity; African Immigrants AND obesity AND socioeconomic status; African Immigrants AND obesity AND length of stay; Cultural sensitive care, obesity AND African Immigrants" Cultural tailored obesity teaching AND African Immigrants, Obese African immigrants AND cultural beliefs AND knowledge deficit.

The above searches yielded a total of 192 articles. However, after a review of these articles for relevancy, eleven articles that met inclusion criteria were selected for this project. The published articles are organized based on the theoretical framework that guided this study and the following key factors associated with providers' care delivery for obesity among African Immigrant populations. Four articles reviewed used Campinha-Bacote's Process of Cultural Competence Model as the theoretical framework to assess the need for providers' cultural competence care among immigrants based using cultural practices and nutrition/dieting habits as key factors (Aponte, 2009; Ingram, 2012; Matteliano & Street, 2012; Singleton & Krause, 2009).

Two article focused on the predicators of obesity and significance of providers' communication skills in providing care for African Immigrants in the United States (Obisesan, 2015), and three articles and peer reviews studied the significance of cultural competent care for prevention and management of Type 2 Diabetes among African Immigrants and the implication of environment, physical activity and length of stay (Abioye-Akanji, 2015). Two articles provided descriptive analysis of body image perception among African immigrants and how it affects care of obesity in this cohort population (Ndiaye, 2009, Uwakweh et al. 2013).

Perception of Obesity

Cultural practices greatly influence perception of body image and obesity. In general, Africans and African Immigrants do not perceive overweight and obesity as a disease, but rather as a sign of success, riches or wealth, good fortunes, wellness and health and a physical quality worth emulation (Uwakweh et al. 2013; McGuigan, 2010; Ndiaye, 2009). Indeed, perception of obesity as "unhealthy" state of being or a risk factor for chronic conditions remain foreign to many African immigrants and cause undue stress to African Immigrants with obesity (Abioye-Akanji, 2013; McGuigan, 2010; Owens, Piccinin, & Lai, 2009). Cultural practices may also affect an individual's weight and BMI due to cultural beliefs or preferences. A pilot study conduct among the Ibibos of west African shows that many females desire to gain excessive weight or increased BMI as this is socially acceptable or preferable because it is the ideal body image for marital union (Ceballos & Czyzewska, 2010). The concept of BMI is not widely accepted by African Immigrants and thus are less likely to know what their normal weight recommendations are or endeavor to seek healthcare services regarding their weight (Lopez et al., 2014).

Nutrition and Cultural Practices

Again, cultural practices influence diet choices and eating habits. Most traditional African food are mainly high complex carbohydrates and spices such as white rice, yam, cassava, banku, muufa. Two descriptive quantitative studies show that most Africans and African Immigrants nutritional intake lack the concept of counting calories or carbohydrates as well as other nutrients contents (Abioye-Akanji, 2013; Oniang et al. 2003). In addition, African Immigrants often adhere to traditional eating habits, finding ingredients from back home in specialty African stores or substitutes in American grocery as well as limited knowledge about food portion sizes contributing to obstacles in preventing and managing obesity (Abioye-Akanji, 2013; Ndiaye, 2009). Studies performed to collate dietary information from the Eritrean, Ethiopian and Somalia communities showed scanty vegetable intake from these African Immigrants in the U.S. because of lack of familiarity of the various vegetables grown in the U.S. and for fear of contracting infections from pesticide (McGuigan, 2010; Haq, 2003).

Linguistics and Communication

Language is an intrinsic and vital part of culture. It is an essential tool for communication and interaction that greatly have impact on all aspects of life including health practices, disease prevention and health promotion (Drummond et al., 2011). Three literature reviews show that most African immigrants are sensitive to gestural communications such as eye contact, facial expressions, body language, spacial distancing practices, touch and familiar greetings; even at the point of healthcare services (Drummond et al., 2011). Many primary care providers lack such cultural skills or fail to apply it in their practices and thus decrease patient's adherence or access to healthcare services especially among minority ethnic populations like African Immigrant

groups (Drummond et al., 2011). Studies show that immigrants are less likely to return to primary provider with a perceived lack of effective communication (Drummond et al., 2011).

Environment and Physical Activity

In a study conducted in 2013, evidence shows that many African cultures do not recognize recreational activities such as participation in physical activity as an integral part of good health and well-being; thus, walking for recreation and participation in any physical activities are viewed as a waste of time (Uwakweh, Rotich, & Okpala, 2013). Though physical activity, especially walking, has been reported as a normal part of everyday life in Africa, walking is viewed as a means of transportation in Africa rather than health promotion activity. It is a common practice to walk to friends and relatives' houses to visit and walk to the shopping centers or walk to gather food menus from the grocery stores performed at one's leisure rather that a therapeutic recommendation to manage health conditions like obesity (Uwakweh et al. 2013). In addition, two studies conducted among Somalian Immigrants reveal that extreme cold or hot weather, lack of safe sidewalks, fear of walking alone and busy work schedules are other barriers have been reported by African Immigrants in the U.S. which all contributed to the increase sedentary lifestyle and obesity among this population (Abioye-Akanji, 2013; McGuigan, 2010). Also, it shows that cultural concerns that hinged on females requiring specific clothing to participate in any outdoor physical activities or having limited interaction with men who were not their spouses are major barriers to physical activities participation and thus increase the rate of obesity among African immigrants (Rothe et al., 2010).

METHODOLOGY

Design

This project evaluated the effectiveness and satisfaction of a brief educational intervention to enhance cultural competence at VIP primary care clinic that cares for African Immigrants with obesity. The educational intervention was delivered in PowerPoint format and focus on cultural competency of obesity care for African Immigrant patients. A quantitative pre-post-test design was used to evaluate cultural knowledge and practices of the participants and offer recommendation to improve quality of care to this minority group locally and nationwide.

Setting

The setting for this project was the VIP Primary Care Clinic in Las Vegas Nevada, a group primary care practice that provides care for a large number of African immigrant patients. At present this practice has two physicians, three advanced practice registered nurses (APRNs) and three medical assistants, one receptionist, billing and coding staff and an RN case manager. These providers have been treating obesity among Africans for more than a decade. Many African immigrants in the state of Nevada especially in Clark County attend this clinic for health issues such as diabetes, hypertension and obesity. The setting was chosen for this research because the providers were conversant with the health issues of the African immigrant community in Las Vegas and thus appropriate for this project and the participating providers.

Sample

All licensed clinicians at VIP primary care clinic were invited to participate in the educational intervention. This included registered nurses (RNs), advanced practice registered nurses (APRNs), physicians (MDs, DOs) and RN case managers. Currently there were no Physician Assistants (PAs) at the clinic, but they would also be eligible to participate. The

inclusion criteria for this study include the participants must: (1) be healthcare providers or nurses currently employed at the target healthcare facility (VIP Clinic) and (2) complete a signed ethical disclosure form. Five participants were estimated to be eligible for the study. This study had a small sample size but utilized all healthcare providers available at VIP primary care clinic Las Vegas, Nevada. The small population sample size for this study allowed for only a descriptive analysis from the findings and recommendations would be provided thereafter.

Intervention

The approximate 15-minute PowerPoint presentation reviewed key elements of cultural competence education, including:

i. *Significance of communication among African Immigrants*: Effective cultural communication clearly shows respect, dignity, and the conservation of human rights (Miller et al., 2008). Communication breakdown can be misrepresented as prejudice, bias or stereotyping and evidently decrease healthcare quality delivery (Leininger & McFarland, 2006). Language and communication defects may result to patient dissatisfaction, poor understanding and low quality of care. Communication includes concepts associated to the ruling and local language; circumstantial usage of language; and paralanguage variations such as voice volume, tone, intonations, reflections, and willingness to share thoughts and feelings (Miller et al., 2008). Gestural communications such as eye contact, facial expressions, body language, spacial distancing practices, and general greetings; and the use of names are also important communication variables (Drummond et al., 2011). Research studies show that Immigrants are less likely to return to primary provider as a result of ineffective

communication lack of effective communication (Drummond et al., 2011). This study provides cultural competence skills that could enhance effective communication in dealing with African Immigrants

ii. *Nutrition and cultural practices among African Immigrants*: includes significance of having adequate food for satisfying hunger; the meaning of food; food choices, rituals, and taboos; and how food and food substances are used for health promotion and wellness and during illness (Drummond et al., 2011). Post-migration trends among African Immigrants reveals dietary acculturation to a western, calorie-dense diet (Wa¨ndell, 2013). With constrained access to their cultural basic foods and little financial resources, the attraction of comparatively cheap, easily attainable fast foods often lead in a diet change that promote obesity; some African Immigrants also encounter dietary naturalization because of the pressure to associate with the culture of the host country (Association for Psychological Science, 2011).

iii. *Obesity and body image perception among African Immigrant*: how certain part of African perceived being "obese" as a sign of prosperity, good health, wealth and being divinely blessed or favored. Obesity is not typically considered as a health condition requiring medication but as a socially acceptable or preferable image to be emulated. Indeed, among the ibibios of Western Africa uphold a cultural belief of "fattening" a bride prior to marriage as obese females are perceived as attractive, beautiful, healthy and not malnourished.

iv. *Socioeconomic status of African Immigrants*: Socioeconomic status can be a risk factor for obesity especially among minority groups like African Immigrants

(Caramota, 2012). Due to the relatively high cost of healthy foods, there is a tendency for poorer people to avoid healthy foods and to lean more towards purchasing cheaper refined/processed foods that contain higher concentrations of sugar and saturated fat (Food Research and Action Center, 2010).

v. *Exercise/physical activity practices among African Immigrants*: There is certain misperception about exercise and physical activity among African Immigrants which contributes greatly to the adoption of sedentary lifestyle. Drummond et al. (2011) points out certain misconceptions and cultural beliefs among African Immigrants that costly equipment was essential requirement to be active physically; that exercise was only for young people, and that one has to undergo through some rigor and pain in exercise as well as physical activities in order to achieve any meaningful purpose. The study also identified time constraint, fear of pain, difficulty in transportation or appropriate exercise clothing and equipment as obstacles to engage in exercise and physical activity in among many African Immigrants living (Drummond et al., 2011).

Data Collection

The project was initiated with a brief presentation of the purpose, process and scope of study. Data collection was conducted during a medical staff meeting held every first Monday of each month at 0800. A paper survey tool was used for data collection in the form of pre-test and post-test. The pre-test lasted for about 7-10 minutes to determine the knowledge of healthcare providers in the area of cultural competency and clinical practice behavior. The pre-test was followed by a brief 15-minutes PowerPoint presentation on cultural competent care for obesity among African Immigrants. After the PowerPoint presentation, the post-test was distributed to

and completed by participants to determine the effectiveness, feasibility and satisfaction of this activity. The completion of the post-test questions lasted for about 7-10 minutes. The data gathered from this educational activity was entered into an Excel spread sheet and analyzed to show aggregated impact of the educational intervention.

Prior to the presentation, a disclosure form was given to each participant that described the purpose, process and summary of the project. Participants were made aware that by completing the pre-test, post-test, and/or viewing the presentation, they were consenting to participate in the study. It was important to emphasize that participation was voluntary and participants could stop partaking in the study at any given time. More importantly, before the actual conduction of this study, the researcher obtained IRB review from the University of Arizona and site approval. Participants were also informed that the data gathered from this educational activity and cultural competency tests (pre- and post-tests) would be entered in an Excel spread sheet and analyzed and only aggregated results would be shared to the medical staff.

Pre-Test

The Pre-Test (Appendix A) took approximately 7-10 minutes to complete. The pre-test questions were formulated based on the (1) theoretical framework of Campinha-Bacote's process of cultural competence for healthcare providers and (2) literature reviews on cultural competence care of obesity for African Immigrants, knowing that diverse interactions between various African cultures is essential to established quality holistic care. The pre-test covered the following categories:

i. **Socio-demographic questions** of participants (e.g., years of clinical experience)

ii. **Awareness questions-** helps to recognize and examine personal values, perceptions, biases and prejudice toward other culture as well as the disposition to appreciate the similarities and differences between one's culture and other cultures.

iii. **Knowledge and education question** which assess how knowledgeable are in cultural diversity, sensitivity and competency (how much they know about African culture and obesity; what competency they have)

iv. **Skills and practice questions** which determines how skillful and how comfortable providers are in dealing with sociocultural issues in the areas of patient care particularly with regard to obesity

v. **Desire and encounter questions** helps to illuminate the predisposition and biases, if any, of providers toward other cultures as well as the desire and openness to appreciate other cultures in caring for diverse ethnic population especially of African origin.

Post Test

The post-test questions (Appendix B) were developed on the basis of the (1) theoretical framework of Campinha-Bacote's process of cultural competence for healthcare providers and knowing that diverse interactions between various African cultures is essential to established comprehensive quality cultural sensitive care (2) literature reviews on cultural competence care of obesity for African Immigrants and (3) evidence based guidelines to manage obesity. The post-test covered the following categories:

i. **Awareness Questions-** helps to recognize and examine personal values,

perceptions, biases and prejudice toward other culture as well as the disposition to appreciate the similarities and differences between one's culture and other cultures.

ii. **Knowledge and Education Questions** which assess how knowledgeable and training providers have in cultural diversity, sensitivity and competency (how much providers now know about African culture; what competency they have)

iii. **Skills and Practice Questions** which determines how skillful and how comfortable providers are in dealing with sociocultural issues in the areas of patient care particularly with regard to obesity

iv. **Desire and Encounter Questions** helps to illuminate the predisposition and biases, if any, of providers toward other cultures as well as the desire and preparedness to care for diverse cultural ethnic population especially of African origin

v. **Content/Delivery Question** which gives feedbacks and appraisals of content after presentation delivery.

To substantiate the suitability of the data collection instruments and process, expert reviews was conducted for the content of pre-test and post-test to determine appropriateness and objectivity. One professional expert was from the committee of this project and the other was an external expert with background on cultural sensitivity/competence and clinical practice in managing chronic condition like diabetes, hypertension, cardiovascular disease and obesity.

A data assessment instrument namely Inventory for Assessing the Process of Cultural Competence among Healthcare Professional Revised (IAPCC-R) was used as an instrument to

measure providers' cultural competence (Campinha-Bacote, 2002). The test scores aim to assess providers' functional levels of cultural proficiency, cultural competence, cultural awareness, or cultural incompetence (Fitzgerald, Cronin, & Campinha-Bacote, 2009). The instrument is based on Dr. Campinha-Bacote's culturally competent model of care with scores ranging from twenty-five to hundred (25 - 100). For the purpose of this study, the IAPCC-R instruments used a Likert-scale format of twenty questions to determine perceived cultural competence of providers. The survey within this tool were distributed into Socio-demographic, Awareness, Knowledge/Education, Skills and Practice and Desire and Encounter questions**.** The validity and Reliability of IAPCC-R has been established by multiple literature reviews and studies; the instrument IAPPC-R has been extensively used in healthcare research and evidence-based studies on national and international levels (Fitzgerald and Cronin, 2009). Approval to use the IAPCC- R tool was given to the principal research or investigator of this project in the form of a written permission (Appendix F and tables below).

In addition to the IAPCC-R tool, a socio-demographic survey was utilized to gather descriptive and demographic data on study participants' age, sex/gender, ethnicity, race, education status, level of transcultural training, clinical experience and exposure to African cultures. The instruments of data collection were administered on paper on the site of study.

Ethical Consideration

There were several ethical considerations in the design of this project. In this study, only aggregate data were given to medical director and staff of the study institution, VIP clinic, to protect participant confidentiality. Participation was voluntary and no identifying data was recorded. Each participant was assigned a numerical code (i.e., "1," "2," "3," …etc.) to help

distinguish data collection and permit comparison of pre and posttests. Participation was voluntary and risk of harm was minimal. Prior to initiating this DNP project, review was obtained from the University of Arizona Institutional Review Board (IRB) in collaboration with the College of Nursing, University of Arizona as well as VIP site approval (Appendix D & F). An appraisal and approval from IRB was required to make sure that participants are safe and participants'' personal information are kept confidential and private.

RESULTS

The key findings of this DNP project were driven by the specific aims and purpose of the study which was to assesses the effectiveness and satisfaction of an educational intervention to improve providers' cultural competence with particular emphasis for quality delivery of obesity care among African immigrants. The results analysis was collected through purposeful pre-test and post-test questionnaires and demographic survey of participants. The quantitative pre-test and posttests questions as well as the socio-demographic data were all scored according to Dr. Campihna-Bacote's IAPCC-R Scoring Keys in Figure 1 with corresponding scores outlined in Table 2.

Sample Demographic Characteristics

Five (5) providers (n = 5) from VIP Primary Care clinic completed the pre- and post-tests and educational intervention tool. Table 1 outlines the demographic data of study participants.

TABLE 1. *Demographic Characteristics of Study Participants (n=5)*

Characteristic	**N**	**%**
Gender		
Male	2	40
Female	3	60
Education & Specialty		
DNP/FNP	2	40
MSN/FNP	1	20
MD/DO	2	40
Language Fluency Besides		
English	5	100
French	3	60
Spanish	3	60
Italian	1	20
African Language		
Swahili	2	40
Hausa	1	20
Igbo	1	20
Somali	1	20
Ashante Twi	1	20
Year of Clinical Practice		
5-10	2	40
11-15	2	40
16-20	1	20
Practice Experience with African Immigrants		
1-5 yrs.	3	60
6-10 yrs.	2	40
11-15 yrs.	0	0

Over half of the participants were Nurse Practitioners (60%), the majority of which were doctorally prepared. All participants had at least five years of clinical experience, with one participant with more than 20 years of experience. However, most (60%) had 5 years of experience of less working with the African Immigrant population. Participants all have fluency in, at least, three languages other than English language. Greater than 80% are bilingually fluent in European or African Languages. Swahili have the highest percentage (40%) of fluency for the African language compared to the other four African languages. Two participants were born in

Africa and are both descendants of the Hausa nomadic ethnic group. All participants reported having zero (0) difficulty providing care for African immigrants of either gender (male or female). Only one participating provider stated to have previously attended a culturally designed intervention for African Immigrants with hypertension.

Level of Competence

Dr. Campinha-Bacote's cultural competence model provided the framework to assess participants' level of cultural competence in caring for African Immigrants with obesity. Using Campinha-Bacote's construct including, Awareness, Knowledge/Education, Skills (& Practice), Desire and Encounters, a quantitative descriptive comparison of pre and posttest cultural competency scores was performed to determine cultural competency of participants from VIP primary care clinic. Table 2 outlines the scoring key used for each item. Aggregate score for each participant reflect level of cultural competency: incompetent to proficient (Figure 1)

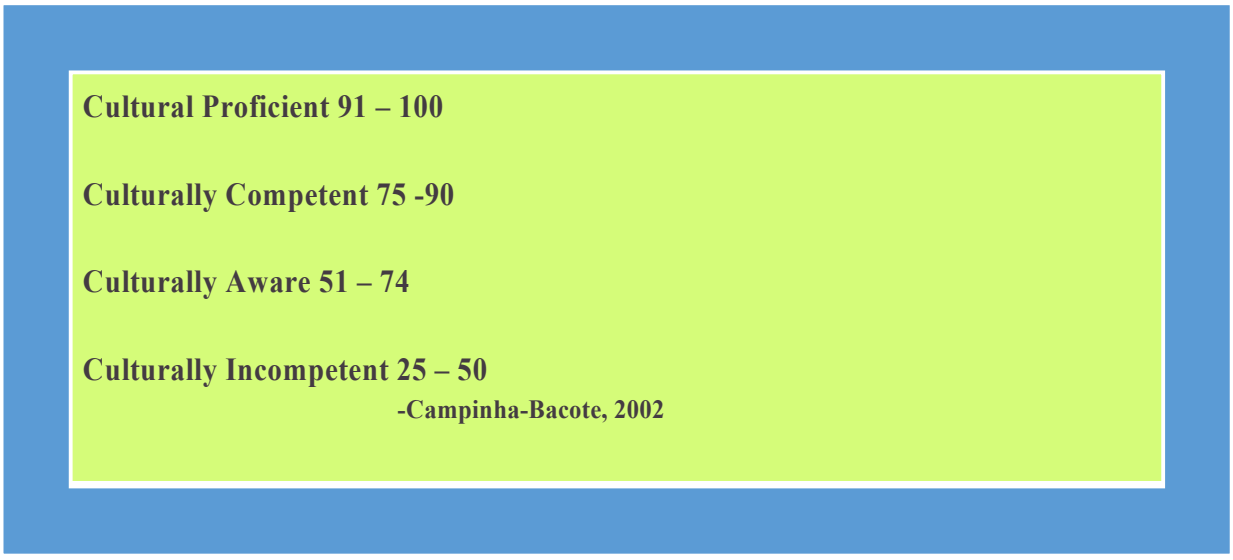


FIGURE 1. Level of Cultural Competency

TABLE 2. *IAPCC-R Scoring Key*

ITEMS: Skill/ Practice Questions
4 pts. = Strongly Agree
3 pts. = Agree
2 pts. = Disagree
1 pt. = Strongly Disagree

ITEMS: Knowledge/Education Questions
4 pts. =Very Knowledgeable
3 pts. = Knowledgeable
2 pts. = Somewhat Knowledgeable
1 pt. = Not Knowledgeable

ITEMS: Encounter Questions
4 pts. = Very Comfortable
3 pts. = Comfortable
2 pts. = Somewhat Comfortable
1 pt. = Not Comfortable

ITEMS: Desire Questions
4 pts. = Very Involved
3 pts. = Involved
2 pts. = Somewhat Involved
1 pt. = Not Involved

ITEMS: Awareness Questions
4 pts. = Strongly Agree
3 pts. = Agree
2 pts. = Disagree
1 pt. = Strongly Disagree

-Campinha-Bacote, 2002

Using Camphina-Bacote's Inventory for Assessing the Process of Cultural Competence Revised (IAPCC-R), pre and post test scores measured providers' cultural competence. Pre-test and post-test cultural competency scores are listed in Table 3.

TABLE 3. *Cultural Competency Pre-Test and Post-Test Scores (n=5)*

	Total Scores	Minimum	Maximum	Mean	Standard Deviation
Awareness pre-test scores	56	15	36	5.5	2.103
Awareness post-test scores	84	19	80	16	5.43
Knowledge/Education pre-test scores	37	3	15	6.167	1.602
Knowledge/Education post-test scores	82	3	35	17.000	2.608
Skills & Practice Pre-test Scores	55	3	15	6.875	1.727
Skills & Practice Post-test Scores	85	9	75	18.125	1.959
Desire & Encounters Pre-test Scores	47	7	10	7.333	3.011
Desire & Encounters Post-test Scores	88	15	70	0.500	0.567

In the pre-tests participants' knowledge and competence is at an overall level of *cultural awareness* with a score of 56%. While the post-test scores show improvement with participants at a level of cultural competence with a total score of 84%. Only 6% of the total pre-test scores reflect participants' possession of clinical proficiency in regard to cultural competence when providing care for African immigrants with obesity. Table 3 shows greater than 35% increment from pre-test to posttest scores for each construct. Following the data presented in Figure 2, it shows that participants from VIP clinics had a significant gap in the continuum of cultural competency with a trend away from cultural proficiency or competency, prior to educational intervention.

There was an increase in cultural competency following the educational intervention (Figure 2). The post-tests reflect a higher score in the construct of cultural competence with a total of 84% score than other constructs as presented in figure 2. This shows a change in trend of level of cultural competence after the educational presentation. Participants scores suggest an increase in knowledge, skills and intended practice beyond the level of cultural impotence and awareness to higher construct level of cultural competence and proficiency. Again, a comparative analysis presented in the charts below (Figure 2) indicates the effectiveness of a brief education intervention outlined in this project, enhances provider's knowledge, practice and cultural competence in caring for African immigrants with obesity.

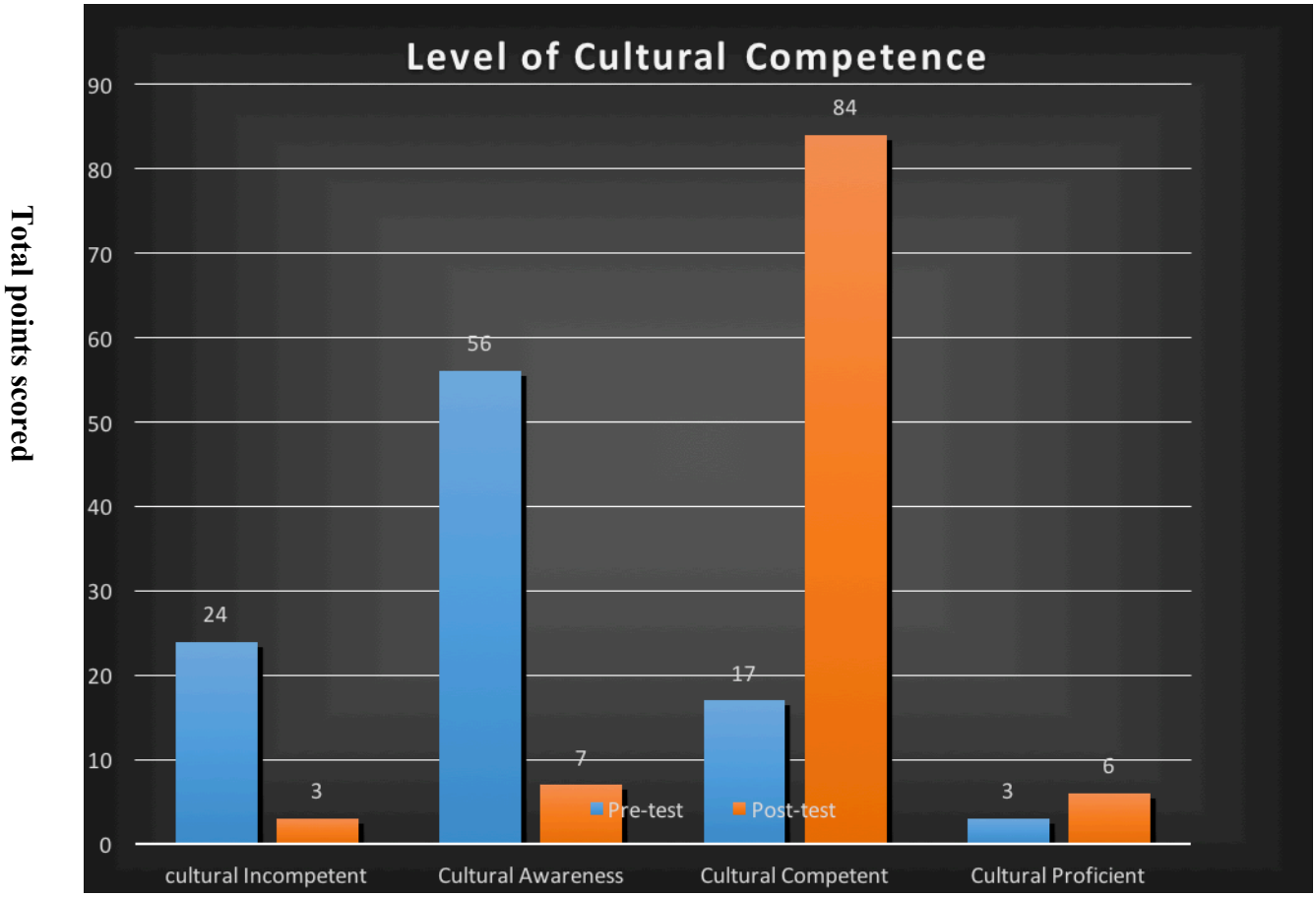


FIGURE 2. Level of Participants' Competence for Pre- and Post-Test

Content Delivery

Upon completion of the education intervention, a post-test survey was conducted to determine participants' satisfaction and acceptability as well as feasibility of content delivery. The survey questionnaire was scored on a 100% basis as presented on Table 4. The scores show that all participants strongly agree with 100% satisfaction and acceptability of content delivery of this educational intervention that enhanced providers' cultural competence for obesity care among African Immigrants with obesity.

TABLE 4. *Content Delivery Scores*

	Strongly Disagree %	**Disagree%**	**Neither Agree or Disagree %**	**Agree %**	**Strongly Agree %**
Content and delivery of presentation well-organized					100
Environment and length of presentation was appropriate for my learning needs					100
I prefer the on-site mode of presentation.					100
I prefer on-line mode of presentation	100				
Content and education interventions valuable for my practice and improve my knowledge on cultural competent care for obesity among African immigrants					100
Presentation content and knowledge provides new perspective and communication approach in dealing with minority African Immigrant population with obesity					100
I learned new and effective approach to care for obese individuals with diverse cultural practices that influence healthcare behaviors and practices.					100
I wish presentation is longer					100
I will like more sessions of topic in future					100
I would recommend presentation and intervention					100

DISCUSSION

The hypothesis or assumption guiding this project was that providers who received brief cultural competence education will have enhanced knowledge and change in intended clinical practice to delivery high quality care to African Immigrants with obesity as defined by the constructs of social demographics, cultural awareness/humility, knowledge, skill & practice, and desire & encounters. Guided by Campinha-Bacote cultural competency model that provides the framework for this project. The data for outcome variables or constructs was obtained through

scoring pre-test and post-test to evaluate participants'/providers' level of competence and content satisfaction. Pre- and post-intervention surveys were scored according to the Likert scale format (1-4 scale with 1 indicating strongly disagree, not involved, not knowledgeable or not comfortable. While 4 represents strongly agreed, very comfortable and very knowledgeable). The scores are reported in percentiles - on percentage basis- with 100% being the highest (perfect) score, and 0% being the lowest. The test questions for knowledge/education was an eight-item questionnaire; the skill and practice questions included a seven-item questionnaire, and for desire & encounter questions was a five-item questionnaire while the content and delivery questions consisted of a twelve-item questionnaire. However, due to the small sample size, statistical analyses was not performed; a descriptive analysis from the pre-test and post-test scores were conducted, analyzed and discussed. Finally, assessment of satisfaction with the activity content and presentation was performed using descriptive analysis of participants' feedback. Participants' responses to open ended feedback were summarized and presented herein.

Participants highest overall score in desire & encounter construct was 88%, participants overall highest score of 85% was in the knowledge construct. Participants scored 55% in cultural skills/practice pre-test survey. This low score reflects survey questions regarding cultural sensitive health assessment and appropriate therapeutic interventions for obesity care among African Immigrant population. The low score of 37% falls within the construct of cultural awareness and knowledge/education during pre-test while 82% score falls within same constructs after the post-tests. The mean scores show about 45% improvement on providers'

knowledge constructs and cultural competence for obesity care Among African Immigrant population after education intervention was delivered.

As the U.S. population becomes increasingly more diverse, health care providers must consider the provision of safe and appropriate cross-cultural competent care. This project evaluated the impact and satisfaction of a brief educational intervention to improve clinical practice as well as providers' cultural competency in caring for African Immigrant communities. Five providers from a Las Vegas primary clinic who care for African Immigrants participated in this educational intervention and completed pre-test and post-tests. Participants demonstrated marked improvement in cultural competency scores after participating in the educational activity.

The scores as outlined in the tables above were greatly affected by the knowledge acquired during the educational intervention presented in the educational intervention to enhance provider's knowledge, skills, competency and intended practice in caring for African Immigrants with obesity. For instance, a list of healthy food substitutes for typical African foods and appropriate physical activity/exercise approach were provided during the educational presentation that improves providers' knowledge, guidance and health assessment skills in relation to dieting habits, communication skills and achievable BMI for African Immigrants with obesity. The study intervention enhanced providers' survey scores, cultural competent knowledge, desire, intended practice and skills in caring for this minority immigrant population.

Participants scored 88% in the desire construct which Dr. Campinha-Bacote described as a yearning to learn, understand and actively engage with others from different cultures as well as to negotiate suitable plans that incorporate pertinent cultural values (Campinha-Bacote, 2002). Participants high scores in this cultural construct is logical for their keen interest to impact their

clinical practice with sound foundation of cultural competent knowledge and skills in caring for vulnerable population like African Immigrants with obesity. On the other hand, the lowest score in the post-test is cultural knowledge construct. Although an overall score of 85% in the knowledge construct was obtained, it reflects an ongoing process of searching for and acquiring sound foundation of knowledge about cultural and ethnic diversity (Campinha-Bacote, 2002). It can be inferred that participants were keenly interested and enthusiastic to engage in educational activity, as the intervention in this project, to enhance their knowledge and competency in providing quality care for minority immigrant population of African origin.

The intervention covers essential cultural tenets common among many African communities and African Immigrants in the United States. These key cultural elements cover areas in cultural sensitive communication/linguistics, nutrition and cultural practices, body image perception and physical activities. Through the educational activity, providers become knowledgeable and competent in applying culturally modified anti-obesity intervention of "Mindful Eating" behavior skills to help African Immigrants with obesity achieve negotiable BMI goals (Daly, Pace, Berg, Menon, & Szalacha, 2016).

This DNP educational intervention is driven by the theoretical framework of Dr. Campinha-Bacote's cultural competency constructs of cultural awareness, cultural knowledge, cultural skill and cultural encounters and desire summarized in the mnemonic "ASKED" (A=awareness, S = skill, K = knowledge, E = encounter, D = desire). The "ASKED" helps providers to examine their respective level of cultural competence as presented in figure 5. This process of determining the level of cultural competence was expanded using the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised

(IAPCC-R). The IAPCC-R provides a description of how the scores obtained in the pre-test and post-tests may be categorized: culturally incompetent (scores = 25-50); culturally aware (scores = 51-74); culturally competent (scores = 75-90); and culturally proficient (scores = 91 -100); the higher the score reflects higher level of cultural competence (Campinha-Bacote, 2003). The post-tests survey scores reflect increase in the mean scores for each construct in comparison with the pre-test survey scores. This is indicative that effected outcome of the education intervention to enhance improving providers' knowledge and skills for intended clinical practice in caring for African Immigrants with obesity was achieved.

AWARENESS: Do you recognizing your own cultural disposition, beliefs and values? Do you notice differences between your culture and other cultures?

SKILL: Do you have the skills and ability to perform cultural competent healthcare assessment and cultural sensitive intervention?

KNOWLEDGE: Do you know about different cultural world views? How knowledgeable are you in providing care for people of different cultures?

ENCOUNTER: Do you have encounters with people and different cultures than yours. Are you committed to providing cross-cultural care?

DESIRE: Do you want to be Culturally Competent? Are you motivated to engage to become culturally competent?

-Campinha-Bacote, 2002

FIGURE 3. "Asked" Framework

Participant Satisfaction

The culturally designed obesity educational intervention for African Immigrants received active participation and appreciation from all providers who participated. The responses received from participants indicated 100% satisfaction and a need to have more of such culturally tailored education to enhance providers' competence in caring for such minority group. All participates

recommended the intervention to other healthcare providers and a broader mode of dissemination via online modules, YouTube and other social media to expand participation. Participants indicated they enjoyed the presentation and will inform other providers outside VIP clinic who care for both African and non-African Immigrant populations. Upon completion of the presentation, some providers affiliated to VIP clinic who heard about the program but who did not attend the presentation called to inquire more about it and the next time it will be held.

All responses and feedbacks from participants were exceedingly positive. Participants overwhelmingly indicated 100% that they learned so much from the educational intervention, particularly information regarding body image perception, non-verbal/gestural communication and unhealthy traditional food alternatives commonly acceptable among African Immigrant population as well as the concept of physical exercise as a component of every living than a strenuous activity with set goals. Furthermore, participants stated that they feel culturally empowered and competent to provide quality healthcare services to African Immigrants with obesity.

Summary

Providers in this sample achieved a total pre-test mean score of 59.75 on the Inventory for Assessing the Process of Cultural Competence in the Delivery of Healthcare Services, revised (IAPCC-R) indicated a level of cultural awareness and a total post-test mean score of 85.33 determined as culturally competent as defined by Campinha-Bacote (2002). With 85.33% of total post-test mean scores on competency of the participants, it can be implied that the brief educational intervention did improve providers' knowledge to cultural competency in relation to caring for African Immigrants with obesity-which invariable is considered an upgrade from

cultural awareness. This awareness was enriched and elevated to a level of cultural intelligence (CI) and competence through the culturally designed intervention of this study that is focused in enhancing providers' knowledge and intended practice on cultural sensitive healthy dieting, use of verbal and non-verbal communication and linguistics, physical activity and exercise as well as body image perception among African immigrants with obesity (Abioye-Akanji, 2013; McGuigan, 2010; Ndiaye, 2009; Uwakweh et al. 2013).

Furthermore, a lack of appropriate cultural competency, providers run the risk of misinterpreting the reason for African Immigrants' non-adherence to care plans especially in areas of dieting and physical activity which, thus, may lead to decrease in health outcome. In general, Africans and African Immigrants do not perceive overweight and obesity as a disease. Obesity is rather considered as a sign of success, prosperity, wealth, good fortunes, being divinely blessed or favored, good health and a physical quality worth emulation (Uwakweh et al. 2013; McGuigan, 2010; Ndiaye, 2009). Indeed, certain part of African culture particularly among the Ibibos of West Africa, observe a cultural belief of "fattening" a bride prior to marriage. Females desire to gain excessive weight as this is socially acceptable or preferable since it reflects the "ideal" body image for marital union (Ceballos & Czyzewska, 2010; Uwakweh et al. 2013).

Also functioning at the level of cultural awareness puts providers at risk of delivery low quality care as providers are likely to engaged in cultural blindness or cultural impositions, which implies inappropriately placing their own respective cultural dispositions, values, beliefs upon others particularly vulnerable minority groups like African Immigrants (Campinha-Bacote, 2002). The need to achieve the level of cultural competence cannot be over-emphasized as the

preceding levels in the continuum of cultural competence (cultural incompetence and awareness) do not go far enough in attaining cultural proficiency which is a requirement for healthcare professionals to deliver safe, effective and comprehensive care for culturally diverse groups and minority population (Wells, 2000). A significant benefit of this project's intervention was helping participants to advance from the level of cultural awareness to cultural competency, thus helping providers from VIP primary care clinic improve in cultural knowledge, skills and intended practice to deliver high quality cultural competent care for the many African Immigrants within the areas of their practice.

Strength and Limitation of Study

The major strength to this study include that it was specific to the VIP primary care clinic and therefore permits evidence-based recommendations that offers unique solution in providing providers' culturally competent care for African Immigrant patients with obesity at this primary care clinic. This project was not designed to be generalizable and was limited to the small number of providers at the clinic, which did include a diverse range. Also, this study was able to give live presentation of the educational intervention which provided the opportunity for interactions with providers as well as to provide answers to questions directly to participants during the study.

While the theoretical framework demonstrates cultural competence for providers caring for obesity individuals among African Immigrants, it does not demonstrate a causal relationship between culturally competent nursing care and increase/decrease rate of obesity. Future research should expand on these exploratory studies by comparing various models of cultural

competence, directly measuring the effects of culturally competent of obesity and other chronic condition in various immigrant groups.

CONCLUSION AND RECOMMENDATIONS

Despite the lack of a single strategy or a universal remedy to the obesity problem affecting African Immigrant communities, cultural competent intervention is a promising approach to enhance the quality of obesity care among this minority population. Providing healthcare professionals with appropriate competency becomes paramount in advancing the quality of care for African Immigrant communities. This project shows that through a brief cultural competent educational intervention, there was improvement in providers' cultural knowledge, skills and intended clinical practice in caring for African Immigrants with obesity.

Healthcare providers' cultural competence in clinical practice is the cornerstone for delivering equal and quality cultural sensitive care locally and nation-wide. In order to improve providers' competency and minimize health disparity for African Immigrant population, healthcare professionals require appropriate culturally tailored education in areas connected to the roots of the problems. Central to the root of the problem include communication/linguistics, nutrition practices, perception of body image and physical activities unique to African Immigrant population. The findings of this study shows effectiveness of a brief educational intervention that improves providers' competency in these areas and thus enhances intended clinical practices and health outcome of African Immigrant population with obesity. Based on the findings of this study, the researcher offers the following recommendation for VIP primary care clinic and other healthcare professionals involve in care delivery for African Immigrants with obesity.

1. **Intervention Content:** Given that this education is evidence-based and the gross significant improvement of providers' post intervention scores that demonstrates enhancement in cultural knowledge, skills and desire to advance cultural competent practice for Obesity Care Among African Immigrants, the content and delivery of this education activity would remain unchanged.
2. **Requirement for VIP Clinic Staff education:** In order to promote and sustain cultural competency at VIP Primary care clinic, planned educational intervention will be shared with VIP primary care clinic administrative and clinical director and staff; education intervention will be conducted at the clinic periodically through on-site presentation and/or as asynchronized online module or hybrid combination of on-site & on-line format, for continuous education requirement for both seasoned new providers as well as all clinical staff (Physician Assistants, Dentists, Registered Nurses, Physical Therapist, Medical Assistants, Registered Case Managers, Registered Dietitians and so on).
3. **Presentation at local conference:** As an effort to promote cultural competent care for African Immigrants with obesity, planned presentation at the bi-annual conference of Nevada Association of Advanced Nurse Practitioners will be conducted. In addition, similar presentation of this intervention is planned to be held at other clinics providing similar care for African Immigrants. With permission from VIP clinic, the findings of the intervention will be shared via webinars, health journal publications for applications into other similar practice setting, locally and nationally, to improve care, as well as future research. In this way, more and more providers will become aware of the need and

significance of cultural competency when providing care to minority population like African Immigrants with obesity.

Relevance for Clinical Practice

Effective Cultural Sensitive Communication

Providers can effectively deliver cultural competent care through the use of cultural sensitivity communication including skills in negotiation and attention to non-verbal communication specific Among Africans and African Immigrants. Africans and African Immigrants give deep meaning to gestures and non-verbal communications. For example, handshakes and embrace are considered as "formal friendliness". While eye contact can be interpreted as intimidation, rudeness or challenge. People of this culture do not appreciate certain familiarity like looking directly into the eyes but appreciate physical touch by providers or verbal casual use of first names as it is perceived as benign, friendliness, mutuality, and a sign of trust and 'close' familiarity (Uwakweh et al. 2013). Also contrary to popular opinion, nodding or shaking of the head is *not* typically conceived in many African communities as malignant or connoting negativity; in fact, it may represent a deep sense of understanding, agreement to something or an expression of empathy/sympathy and/or appreciation of a situation with profound grievousness or excitement (Uwakweh et al. 2013). With the skills learned from the cultural encounter constructs presented in the intervention of this study, providers are encouraged to warmly greet African Immigrants with gestures of handshakes, embrace, a touch on the shoulder or forearms and call them by first names if known. This goes a long way to provide a sense of "warm welcome" to the individual of African origin with a deep intuition/knowledge that guarantees a reception of cultural competent care from the provider(s).

Another important linguistic consideration in providing care for African Immigrants involve 'labeling'. Appropriate use of cultural sensitive nomination to describe obesity is significant in caring for this population. In general, many African communities do not consider obesity as a disease or health condition but rather as a sign of good health, wealth, prosperity, abundance, good fortunes and divine blessing (Uwakweh et al., 2013). Hence it would seem futile and an effort to de-value their cultural perception when attempting to inform African Immigrants that obesity is a significant health risk with multiple health complications. However, African Immigrants perceive tenets of obesity (LDL, cholesterol, triglyceride) as unhealthy and unsafe for daily consumption (McGuigan, 2010; Ndiaye, 2009; Uwakweh et al. 2013). Thus, in caring for African Immigrant population, providers can also effectively provide patient teaching through the use of words like "cholesterol" or "triglyceride" rather than "fat", "fatty food" or obesity as the later terms or "labeling" does connotes positive meaning instead of health risk factors. Immigrant African communities can thus be educated to make healthier food choices with less cholesterol, triglyceride, LDL and high HDL which all contribute to decrease of obesity and related health conditions (McGuigan, 2010; Ndiaye, 2009; Uwakweh et al. 2013).

Providing Healthy Food Substitute and Using Culturally Based 'Mindful Eating'

Most traditional African food are mainly high complex carbohydrates and spices such as white rice, yam, cassava, banku, muufa and so on. More so, African Immigrant nutritional intake lacks the concept counting carbohydrates and calories as well as lack familiarity with American grocery stores; therefore, African Immigrants are uninformed about the health risks of foods high in calories and low in nutrients (Van Hook & Baker, 2010). Again, the transition from the nutrition of the heritage culture to the nutrition of the host culture has proven be challenging and

sometimes lead to unhealthy food choices and obesity among African Immigrants (Delisle, 2010).

Culturally competent healthcare providers can help African Immigrants overcome the above challenges by providing a list of health food substitute to African diets and can negotiate with patients to develop a customized culturally mindful dieting plan that centers on the quality rather than quantity of food consumed. In this way, satiety and the required daily body nutrients as stipulated by the FDA is achieve without consumption on unwanted calories and increase fat intake. It is important to remember that developing a customized cultural dieting plan is negotiable and providers may respect inputs of individuals as to promote achievement of desired body mass index (BMI) for African Immigrant with obesity.

Promoting Physical Activity

African Immigrants typically conceive exercise in the form of walking, running, sports, and domestic chores as a way of life rather than a "task" to stay healthy. It is therefore important to determine what kind of physical activity that is performed by an African Immigrant in country of origin and assess for feasibility of continuation of such physical activity/exercise in host country. Providers can educate and expand knowledge of the benefits of a physical exercise and perception of health risk associated with obesity by sharing the benefits of active physical activities like reduction in blood pressure, decrease in level stress and blood glucose as well as maintaining good body posture and physique that helps to increase expected life-span (McGuigan, 2010). In this way, cultural competent providers can help African Immigrants become more physically active and optimize health outcome.

Utilizing Leaders of African Immigrants and Religious Leaders

Engaging leaders of African communities and religious groups have shown to be powerful means to effect change among African Immigrant population. Many African Immigrants conceive faith and church as central in understanding illness and health among this minority population. Hence, community and religious network are considered as foundation for obesity prevention and management as well as to develop a health promotion and awareness strategy. Cultural competent providers should endeavor to ask clients/patients if they are affiliated to any religious or faith denomination or/and organized ethnic groups as well as who the leaders of such affiliations are and if they wished to be contacted regarding health promotion and disease prevention activities. Once identified, providers should endeavor to develop and maintain networking with the leaders of the religious and community groups and allow contributions in developing care plans for African Immigrants, with their respective permission. In this way, clients/patients can receive profound support from the affiliated religious groups or ethnic communities to achieve desired set goals to curb obesity and maximize health outcome.

Relevance for Education of Providers

The cultural competency score becomes evident that more attention will undoubtedly be focused onto the education of Physicians, Nurses, Clinicians, Physician Assistants and other healthcare professionals to achieving cultural proficiency. The nursing profession seem to have pioneered the way of educating future providers to become culturally competent. The two accrediting bodies for Schools of Nursing, the Commission on Collegiate Nursing Education and the National League for Nurses, require that cultural competency content be incorporated into nursing curricula. Recent research found significant relationships between cross-cultural training

and cultural competence scores for nurses and nursing students, which account for accreditation requirements for cross-cultural care education in nursing programs (Brathwaite, 2005; Kawashima, 2008; Seright,2007; Starr and Wallace 2009), which would be appropriate for the training and education of a range of healthcare providers and clinicians.

Relevance for Healthcare Policy

More so, the recommendation for this project extends beyond VIP clinic as organization to other health care facilities and government legislation in developing and enacting healthcare policies and strategies that meet the cultural needs of minority groups like African Immigrant communities in curbing obesity. Also, national healthcare organizations like the National Institute of Health and the Institute of Medicine should endorse culturally designed intervention rooted in evidence-based practice that would provide standardize guidelines for delivering culturally competent care for minority groups like African Immigrants. An important aspect of healthcare policy would include funding research endeavors and supporting agencies engaged in enhancing cultural competent care for this vulnerable minority groups. This would significantly help to increase healthcare access and services to this population, decreasing health disparities and optimizing health outcome.

Relevance for Future Study

This project study focuses on the effectiveness of short PowerPoint educational intervention to enhance providers cultural competent at VIP primary care clinic who deliver healthcare services to African Immigrant population with obesity. However, there seem to lack substantial research study on this topic. There is also the urgent need to develop standardize guidelines with the most effective and efficient strategies of implementing cultural competent

care for minority groups like African Immigrant population with obesity (Ayala et al., 2010). Although the study in this project demonstrated effectiveness of improving providers' competence at VIP primary care clinic using on-site presentation, a comparative study with other healthcare facilities should be conducted using online or asynchronous approach in order to identify which mode of intervention or a hybrid of both approach would produce the best outcome with more participants' satisfaction and feasibility.

APPENDIX A:

PRE-TEST CULTURAL COMPETENCY QUESTIONNAIRE

Socio-Demographic Questions of Providers

Sex: Male _____ Female _____
Race/Ethnicity (please select all that apply)

African American/Black
American Indian/Alaska Native
Asian American
Latino/Hispanic
Native Hawaiian/Other Pacific Islander Caucasian
Other

Have you ever visited or lived in any countries outside the United States? Yes _____ No _____ If Yes, please specify _____

Do you speak any languages other than English? Yes _____ No _____ If Yes, please specify _____

School Attended: United States _____ International _____

Areas of Clinical Practice:

Urban____
Suburban _____
Rural (<50,000) ____
Underserved _____

Years of Clinical Practice___ (<1, 1-4, 5-10, >10)

Specialty of Practice___ (MD/DO, NP, PA, RN, Other)

Years of Experience Practice caring for African Immigrants___ (<1, 1-4, 5-10, >10)

Experience working with health care professionals from culturally diverse backgrounds ____ (Not involved/somewhat involved/Involved/Very involved)

Awareness Questions: How much awareness do you have on the following:

	1 –Strongly disagree)	2 – Disagree	3 – Agreed	4- Strongly Agreed
Aware of my own cultural values, beliefs, bias and opinions of other cultures				
Imposition of my beliefs, values and perceptions which may conflict with other ethnicity or cultural groups				
Knowingly or unknowingly made culturally insensitive jokes, comments or behaviors towards others with different cultural beliefs and values.				
Limitation in proficiency of English Language does not represent level of literacy or intellectual capabilities of African Immigrants				
African Immigrants and cultures may use or prefer other forms of communication than written English Language				
Gender, age and life factors are essential considerations when caring from African Immigrants (e.g. decisions of religious and ethnic or family carry high importance)				
Religion and faith is a major determinant on how African Immigrants perceive and respond to healthcare practices, diseases and death.				
Importance to learn how to care for African Immigrants with different cultures				
I make available to professionally enhance my knowledge, skills and competence in caring for culturally and linguistically and diversely group like African Immigrants with obesity.				

Knowledge and Education Questions: How much training/education have you had on the following:

	1 - None (Not knowledgeable)	2 – Somewhat (somewhat knowledgeable)	3 – Above Average (knowledgeable)	4 – A lot (Very knowledgeable)
Cultural diversity?				
Demographics of diverse ethnic groups and dialects of African Immigrants?				
Health risks and health disparities experienced by African Immigrants?				
Health Promotion/Disease Prevention strategies or practices among African Immigrants?				
Cultural significance of body image perception and Obesity				
Variations in Traditional medical and health practices (traditional healing practices, reliance on folk remedies and herbal therapy, Ayurvedic Medicine etc.)				

Skills and Practice Questions: Are you skillful in the following areas?

	1 –Strongly disagree	2 – Disagree	3 – Agreed	4- Strongly Agreed
Determining how patients or families from different cultures want to be treated?				
Effectively communicate and express greetings to African Immigrant individuals in a culturally sensitive manner?				
Attentive to nonverbal cues or the use of culturally specific gestures that might have different meanings in different cultures?				
Gathering information about use of herbal therapy and folk remedies and/or other alternative of non-orthodox healing approach				
Conducting culturally sensitive physical examination for obesity among African Immigrants				
Identifying cultural (religious and non-religious) customs that might affect care				
Developing treatment plans and providing culturally sensitive therapy for obesity among African Immigrants				
Providing culturally sensitive clinical preventive care and education				

Desire & Encounters Questions: How comfortable are you in the following areas?

	1-Never (Not comfortable)	2 - Seldom (somewhat comfortable)	3 - Usually (comfortable)	4- Always (Very comfortable)
Dealing with African Immigrants with obesity problems				
Caring for individuals with limited English proficiency				
Caring for ethnic groups who insists on using or seeking folk healers or alternative therapies				
Identifying beliefs that are not expressed by African Immigrants but might interfere with the treatment regimen				
Providing cultural competent care for obesity among African Immigrants?				
A schedule that includes a culturally diverse patients				

APPENDIX B:

POST-TEST CULTURAL COMPETENCY QUESTIONNAIRE

Awareness Questions: How much awareness do you have on the following:

	1 –Strongly disagree)	2 – Disagree	3 – Agreed	4- Strongly Agreed
Aware of my own cultural values, beliefs, bias and opinions of other cultures				
Imposition of my beliefs, values and perceptions which may conflict with other ethnicity or cultural groups				
Knowingly or unknowingly made culturally insensitive jokes, comments or behaviors towards others with different cultural beliefs and values.				
Limitation in proficiency of English Language does not represent level of literacy or intellectual capabilities of African Immigrants				
African Immigrants and cultures may use or prefer other forms of communication than written English language				
Gender, age and life factors are essential considerations when caring from African immigrants (e.g. decisions of religious and ethnic or family carry high importance)				
Religion and faith is a major determinant on how African Immigrants perceive and respond to healthcare practices, diseases and death.				
Importance to learn how to care for African immigrants with different cultures				
I make available to professionally enhance my knowledge, skills and competence in caring for culturally and linguistically and diversely group like African Immigrants with obesity.				

Knowledge and Education Questions: How much training/education have you had on the following:

	1 - None (Not knowledgeable)	2 – Somewhat (somewhat knowledgeable)	3 – Above Average (knowledgeable)	4 – A lot (Very knowledgeable)
Cultural diversity?				
Demographics of diverse ethnic groups and dialects of African Immigrants?				
Health risks and health disparities experienced by African Immigrants?				
Health Promotion/Disease Prevention strategies or practices among African Immigrants?				
Cultural significance of body image perception and Obesity				

Skills and Practice Questions: Are you skillful in the following area

	1 –Strongly disagree	2 – Disagree	3 – Agreed	4- Strongly Agreed
Determining how patients or families from different cultures want to be treated?				
Effectively communicate and express greetings to African Immigrant individuals in a culturally sensitive manner?				
Attentive to nonverbal cues or the use of culturally specific gestures that might have different meanings in different cultures?				
Gathering information about use of herbal therapy and folk remedies and/or other alternative of non-orthodox healing approach				
Conducting culturally sensitive physical examination for obesity among African Immigrants				
Identifying cultural (religious and non-religious) customs that might affect care				
Developing treatment plans and providing culturally sensitive therapy for obesity among African Immigrants				
Providing culturally sensitive clinical preventive care and education				

Desire & Encounters Questions: How comfortable are you in the following areas?

	1-Never (Not comfortable)	2 - Seldom (somewhat comfortable)	3 - Usually (comfortable)	4- Always (Very comfortable)
Dealing with African Immigrants with obesity problems				
Caring for individuals with limited English proficiency				
Caring for ethnic groups who insists on using or seeking folk healers or alternative therapies				
Identifying beliefs that are not expressed by African immigrants but might interfere with the treatment regimen				
Providing cultural competent care for obesity among African Immigrants?				
A schedule that includes a culturally diverse patients				

Content- Delivery Questions: Please rate your learning and satisfaction level for each category:

	1- strongly disagree	2 - disagree	3 - neither agree or disagree	4 - agree	5 - strongly agree
Content and delivery of Presentation well-organized					
Environment and length of presentation was appropriate for my learning needs					
I prefer the on-site mode of presentation.					
I prefer on-line mode of presentation					
Content and education interventions valuable for my practice and improve my knowledge on cultural competent care for obesity among African Immigrants					
Presentation content and knowledge provides new perspective and communication approach in dealing with minority African Immigrant population with obesity					
I learned new and effective approach to care for obese individuals with diverse cultural practices that influence healthcare behaviors and practices.					
I wish presentation is longer					
I will like more sessions of topic in future					
I would recommend presentation and intervention					

What other information would you like covered in the presentation:
Comment:

APPENDIX C:

POWERPOINT PRESENTATION OUTLINE

POWERPOINT PRESENTATION OUTLINE

i. **Introduction**
ii. **Cultural Competence Pre-test.**
iii. **Objectives**
iv. **Description of Key concepts:**
    - Obesity
    - Cultural competence
    - African Immigrants
    - Continuum of cultural competency
v. **Cultural Tailored Interventions for African Immigrants with obesity**
    - Linguistics – using cultural sensitivity mode of communication
    - Nutrition – providing healthy food equivalents for African immigrants
    - Physical activity/Exercise as a way of life rather than a "task" to stay health
    - Body Image Perception - African Immigrant Perspective
    - Utilizing engaging leaders of African immigrant groups, communities and religious resources to help in decreasing the rate of obesity.
vi. **Conclusion**
vii. **Open Forum for Questions and Answers**
viii. **Post-test Cultural Competence.**

APPENDIX D:

AUTHORIZATION TO CONDUCT STUDY AT VIP PRIMARY CARE CLINIC

VIP Primary Care Clinic & ABBA Urgent Care 4903 Vegas Drive
Las Vegas, NV 89108

August22, 2017

University of Arizona
Human Subjects Protection Program
1615 E Helen St
P.O Box 245137 Tucson
AZ85724

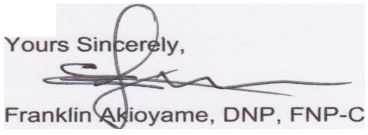
Dear Human Subject Protection Program Members

This is to certify that Solomon Joshua, RN has permission to perform a brief educational study and evaluation entitled "Culturally Competent Care For Obesity Among African Immigrants" at the VIP Primary Care Clinic in partial fulfillment of the requirements for the Doctor of Nursing Practice at the University of Arizona College of Nursing.

Mr. Joshua will be conducting a brief educational PowerPoint presentation with pre and post-test for VIP Primary Clinic providers. This study will be physically conducted at our primary clinic during a staff meeting conference at VIP Primary Care Clinic in Las Vegas, Nevada, and is expected to occur during the Fall or Winter 2017.

I understand that Mr. Joshua will be conducting this program evaluation with IRB approval from the University of Arizona.

I Will be glade to answer any question or address any concerns. I can be reached on 702-808-6501



Medical and Administrative Director

APPENDIX E:

DISCLOSURE STATEMENT

Primary Investigator's Name: Solomon Joshua, RN, FNP-DNP student

Institution: College of Nursing, University of Arizona

Title: Enhancing Culturally Competent Care for Obesity among African Immigrants

INTRODUCTION

You are being asked to participate in a study that is being conducted to assess the effectiveness of a short educational intervention on cultural competent care for obesity among African immigrants in the United States of America with particular focus at VIP primary care clinic, Las Vegas, Nevada. This is study is part of the requirement for my graduate education, Doctor of Nursing Practice program at the University of Arizona. This study has three parts as listed below in the following order:

1. Completion of a pre-test survey (7-10 minutes)
2. Brief PowerPoint presentation (12-15 minutes)
3. Completion of Posttest survey (5-7 minutes)

Upon completion of this study, only aggregate information would be shared and recommendations based on the findings will be presented to the medical director and staff in an executive summary and presentation, if desired. No identifying or personal information would be recorded all through the study. In addition to ensure protection of privacy and confidentiality of participants, the University of Arizona IRB committee will review and approve the tools, methods and process of gathering information and matters that concerns human subject in this project.

It is important to bring to inform you that participation in this study is voluntary and you may choose to discontinue your participation at any time as you wish without any penalty or risk of loss of benefits to which you are otherwise entitled. Though we encourage

full participation for the validity of the study, should you choose not to participate or discontinue your participation, please inform the investigator.

Know that your participation is voluntary and therefore the is no monetary or non-monetary incentives to be awarded for participation. This academic project with clinical implication is a non-profit endeavor and is not funded by any agency. This project is purely for academic purposes and participants' integrity will be upheld all through the study.

For concerns and questions regarding this project, please contact the following:

1. Mr. Solomon Joshua (Investigator) at joshual@email.arizona.edu
2. Dr. Christy Pacheco (Committee Chair) at christyp@email.arizona.edu
3. University of Arizona Institutional Review Board (IRB) at (520) 626-5859 or VPRIRB@email.arizona.edu

By completing the surveys and /or observing the presentation, you are consenting to participate in the study

APPENDIX F”

THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD (IRB) LETTER OF APPROVAL

Research
Office for Research & Discovery

Human Subjects Protection Program

1618 E. Helen St.
P.O. Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
http://rgw.arizona.edu/compliance/home

Date: September 12, 2017
Principal Investigator: Solomon Joshua
Protocol Number: 1709788432

Protocol Title:	Enhancing Culturally Competent Care For Obesity Among African Immigrants
Determination:	Human Subjects Review not Required

The project listed above does not require oversight by the University of Arizona because the project does not meet the definition of 'research' and/or 'human subject'.

- **Not Research as defined by 45 CFR 46.102(d):** As presented, the activities described above do not meet the definition of research as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "research means a systematic investigation, including research development, testing and evaluation, designed to contribute to generalizable knowledge".
- **Not Human Subjects Research as defined by 45 CFR 46.102(f):** As presented, the activities described above do not meet the definition of research involving human subjects as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention ***or*** interaction with the individual, or identifiable private information".

Note: Modifications to projects not requiring human subjects review that change the nature of the project should be submitted to the Human Subjects Protection Program (HSPP) for a new determination (e.g. addition of research with children, specimen collection, participant observation, prospective collection of data when the study was previously retrospective in nature, and broadening the scope or nature of the research question). Please contact the HSPP to consult on whether the proposed changes need further review.

APPENDIX G:

CONTRACTUAL AGREEMENT FOR USE OF IAPCC-R

Clinical, Administrative, Research & Educational Consultation
in Transcultural Health Care

J. Campinha-Bacote,
PhD, **MAR, PMHCNS-BC, CTN-A, FAAN**
Transcultural Healthcare Consultant

To: Solomon Joshua
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Solomon Joshua to use my tool, "Inventory for Assessing the Process of Cultural Competence Among Professionals-Revised (IAPCC-R)" to access the level of cultural competence of 5 healthcare providers. I have received $80 for 10 tools for this pre/posttest study design.

TIME FRAME: Permission to use the IAPCC-R is time limited to be used on November 20, 2017. **Upon November 21, 2017, all unused tools must be destroyed.**

ADMINISTRATION: This onsite permission only grants administration of the IAPCC-R via an onsite pencil and paper administration in which / Mr. Solomon Joshua hand-administers the tool to each participant and immediately collects these tools following its completion. Mr. Solomon Joshua that the IAPCC-R cannot be administered in an offsite format such as in on an online course, internal or external mailings, or via an Internet website offering without granted permission.

RESTRICTIONS OF COPYING: Mr. Solomon Joshua **agrees that** the IAPCC-**R nor any of its 25 items cannot be copied** or reproduced for any other reason. This includes, but not limited to, being copied in any formal or informal publications or presentations, a dissertation, a DNP project/paper, Capstone project, or thesis, in any academic papers, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic

formats. The IAPCC-R is only to be used for the above purpose of administering this tool in this above study to only 5 participants.

PUBLICATIONS: Mr. Solomon Joshua that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND **COSTS:** In any action to enforce any provision of this Agreement,

The prevailing party will be awarded reasonable attorney's fees and costs.

513-469-1664
513-469-1764
meddir@aol.com
www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

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