CULTURAL COMPETENCE IMPROVEMENT TOOL

Decreasing Childhood Obesity by Increasing Cultural Competence

NBCDI
National Black Child Development Institute

Walmart

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Part 1:
Childhood Obesity & Culture – Background Information

What Is Childhood Obesity?

- Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. The terms also identify ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems (CDC, 2012).
- Childhood obesity is caused by an energy imbalance: when children consume more energy (calories) than they expend through normal growth, physical activity, and daily living.
- Childhood obesity is a complex condition resulting from the interaction of individual, family, community, and policy level factors.

Why Are We Concerned About Childhood Obesity?

- Childhood obesity is a significant health concern in the United States. About 31% of children and adolescents (ages 2-19) are classified as overweight and approximately 17% are obese.
- Between 1988-1994 and 2007-2008 the prevalence of childhood obesity increased at all family income and education levels.
- Obesity epidemic is at its worst for African American, Latino, and Native American children.
- In 2010, 24% of non-Hispanic Black children and adolescents were obese compared to 14% of non-Hispanic white children. Among young African-American children, 11.4% of those ages 2 to 5 are already obese.

How Is Overweight And Obesity Measured?

- Body Mass Index (BMI) is a number calculated from a child's weight and height.
- BMI has been shown to be a reliable indicator of body fatness for most children and teens. Although BMI does not measure body fat directly, research has shown that BMI correlates to direct measures of body fat (CDC, 2012).
- Different from adults, overweight and obesity in children and adolescents is defined not as an absolute number, but in relation to a historical normal group.
- Percentiles (shown in Table 1 below), which are the most commonly used indicator of growth, demonstrate the relative position of the child's BMI number among children of the same sex and age.

- ***About 31% of children and adolescents in the U.S. are overweight and approximately 17% are obese.***
- ***Obesity epidemic is at its worst for African American, Latino, and Native American children.***
- ***Childhood obesity is a complex condition resulting from the interaction of individual, family, community, and policy level factors.***
- ***Parents and caregivers play a critical role in supporting children to achieve and maintain a healthy weight.***

Table 1. BMI-for-age weight status categories and the corresponding percentiles

Weight Status Category	Percentile Range
Underweight	Less than the 5th percentile
Healthy weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile

What Are The Consequences Of Childhood Obesity?

- Childhood obesity can have a harmful effect on the body in a variety of ways (CDC, 2012). Obese children are more likely to have:
    - High blood pressure and high cholesterol, which are risk factors for cardiovascular disease (CVD). In one study, 70% of obese children had at least one CVD risk factor, and 39% had two or more.
    - Increased risk of insulin resistance and Type 2 diabetes.
    - Breathing problems, such as sleep apnea, and asthma.
    - Joint problems and musculoskeletal discomfort.
    - Fatty liver disease, gallstones, and gastro-esophageal reflux (i.e., heartburn).
- Obese children and adolescents have a greater risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood.
- Obese children are more likely to become obese adults. Adult obesity is associated with serious health conditions including heart disease, diabetes, and some cancers.
- If children are overweight, obesity in adulthood is likely to be more severe.

What Are The Risk Factors For Childhood Obesity?

Experts say that many factors place children at higher risk for obesity. These factors begin at infancy, and in some cases, during pregnancy:

- **Eating and Child Feeding Behaviors**
    - Diets rich in fruits and vegetables and whole grains have been shown to help children maintain a healthy weight and reduce the risk of chronic conditions.
    - Poor eating behaviors such as eating too many high fat and high calorie foods, fast foods, sugar sweetened beverages and large portion sizes have been linked to an increased risk of childhood obesity.
    - Parents and caregivers play a pivotal role in the development of their child's food preferences and energy intake.
    - Certain child feeding styles such as exerting excessive control over what and how much children eat, pressuring children to eat, or rewarding children with food, may contribute to children becoming overweight.
    - A growing body of research also suggests that breastfeeding can have a significant impact on reducing the risk of childhood obesity (Hediger et al. 2001).

Risk Factors for Childhood Obesity, Cont.

- **Physical Activity**
  - Regular physical activity is very important for good health and helps children maintain a healthy weight.
  - Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.
  - Children with active parents and caregivers tend to be more active, and children who spend more time outdoors were more active than children who spent less time outdoors.

- **Screen Time**
  - On average, preschool children spend 32 hours a week with screen media (The Nielsen Company 2009).
  - Passive screen time is believed to contribute to obesity by displacing physical activity, reducing children's resting metabolism, and promoting food consumption while watching or through unhealthy food advertising.
  - The American Academy of Pediatrics (AAP) recommends that children under two years old should not be exposed to any screen time and that children over two years old should be limited to no more than two hours of media per day (AAP, 2010).
  - However, the average child in the U.S. regularly watches between 2-3 hours of television a day, and nearly 30 percent of infants and toddlers have a TV in their bedroom.

- **Family History**
  - Genetics play a key role in a child's obesity risk. Genes help determine body type and how your body stores and burns fat.
  - Some studies have found that a child with at least one obese parent has a 60 to 100% greater risk of being obese compared to a child born to parents with normal, healthy weights (Katzmarzyk et al.1999).

- **Sleeping Patterns**
  - A growing number of studies have found a link between lack of sleep and unhealthy body weight (CDC, 2012).
  - For example, although teens require 8.5-9 hours of sleep, only 31% of high school students report getting at least 8 hours of sleep on an average school night. U.S. preschoolers get approximately 10.4 hours, while it is recommended that children 3-5 years of age should average 11-13 hours.

Risk Factors for Childhood Obesity

- ✓ ***Eating and Child Feeding Behaviors***
- ✓ ***Physical Activity***
- ✓ ***Screen Time***
- ✓ ***Family History***
- ✓ ***Sleeping Patterns***
- ✓ ***Socioeconomic Status/Income***
- ✓ ***Neighborhood Environment***

Risk Factors for Childhood Obesity, Cont.

- **Socioeconomic Status (SES)**
  - Low income children and adolescents are more likely to be obese than their higher income counterparts, but the relationship between SES and obesity is not consistent across race and ethnic group.
  - Among Black and Hispanic children and adolescents, there is no significant trend in obesity prevalence by income level for either boys or girls.
  - Childhood obesity prevalence decreases as the education of the head of household increases.

- **Neighborhood Environment**
  - Limited neighborhood availability of healthy food options and opportunities for physical activity has been linked to an increased risk of childhood obesity.
  - Children and families need access to supermarkets, healthy corner stores, parks, farmers markets, and fitness facilities to support healthy lifestyles.

What Can We Do to Address These Risks?

- The goal of obesity prevention in children and adolescents is to create an environment that promotes healthy physical, psychological, socio-emotional, and cognitive development.
- The risk of obesity starts early in life. One in five children is already overweight or obese by age 6. Healthy eating and active play in early childhood can help to prevent obesity later in life.
- There are many national and local initiatives to address childhood obesity, some of which are focused on caregivers, providers, and teachers, who can play an important role in shaping practices of children and their families.
- Programs and policies implemented in early care and education settings, as well as after-school and school-based settings, can help support children in achieving and maintaining a healthy weight.
- As childhood obesity increases in the United States, specifically among children of color, it is important for health and nutrition curricula to engage children from ***culturally and linguistically diverse*** backgrounds.
- In order for a curriculum to be effective in engaging these communities it must be ***culturally relevant***.

- ***Programs and policies used in early care and education; school-based; and after-school settings help support children in achieving and maintaining a healthy weight.***
- ***Health education programs contribute to teaching children the skills they need to be successful learners and healthy and productive adults.***
- ***It is important for health and nutrition curricula to engage children from culturally and linguistically diverse backgrounds.***
- ***In order for a curriculum to be effective in engaging all children and families, it must be culturally relevant.***

What is Culture and Cultural Competence?

All people are cultural beings. Culture is learned, shared, and transmitted from one generation to the next, and it can be seen in a group's values, norms, practices, systems of meaning, ways of life, and other social regularities (Kreuter et al., 2003). Familial roles, communication patterns, beliefs relating to personal control, individualism, collectivism, spirituality and other individual, behavioral, and social characteristics may help define culture for a given group if they have special meaning (Kreuter et al., 2003).

Cultural competence is defined in many different ways: some think of it as cultural sensitivity while others speak of anti-bias and still others consider it a cross-system, comprehensive approach which embeds culture into care. Most descriptions contain common threads, including the ideas that developing cultural competence is a process; culture is learned; and self-awareness is critical. For the context of this tool, we have included some definitions below:

Cultural Competence – *The ability to meet the needs of students from different cultures in a way that all students feel valued. It is an understanding and appreciation of the values, norms, and traditions within different cultures.*

Cultural Relevance *– The extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs.*

Culturally Diverse – *Having a variety of different cultures included among a group of people.*

Linguistically Diverse – *Having a variety of languages spoken among a group of people.*

Cultural Tailoring *– The process of creating culturally relevant interventions, often involving the adaptation of existing materials and programs for racial/ethnic subpopulations (Pasick et al., 1996).*

To develop culturally relevant health interventions, researchers and health professionals commonly consider two aspects of culture: surface structure and deep structure (Resnicow et al.,1999):

- ✓ **Surface structure (SS):** involves matching intervention materials and messages to observable characteristics of a target population. This may involve using people, places, language, product brands, music, food, locations, and clothing familiar to, and preferred by, the target audience. Surface structure refers to how well interventions fit within a specific culture.

- ✓ **Deep structure (DS):** involves incorporating the cultural, social, historical, environmental, and psychological forces that influence the target health behavior in the proposed target population.

Why is it important to have a health and nutrition curriculum that is culturally relevant?
To date, programs and policies designed to combat childhood obesity have been primarily met with limited success, in part because they fail to take cultural and racial perceptions of obesity and anti-obesity messages into account. Research indicates that "generic public health messages about overweight and obesity do not appear to resonate with [African-American and Latino communities]…Messages and interventions aimed at reducing childhood obesity should integrate culturally relevant suggestions and must be sensitive to families with limited resources." (HSC Foundation, 2007)

Culture is critical to each person's understanding of food, nutrition, and physical activity; indeed, every person has a cultural history that shapes who we are, how we learn, our points of view, what we think, family traditions, and the foods we eat. Likewise, the customs shared within individual families can be different within cultural groups.

Implementing a health and nutrition curriculum that is culturally relevant and having program facilitators that are culturally competent will help to ensure that the information provided to children and families is appropriate for improving the health of future generations in a strengths-based way that respects and values each learner, family, community, heritage and culture.

It is important to highlight that cultural competence is a process that is adaptable and evolves over time. For each individual, the process of becoming culturally competent requires a flexible mind, an open heart, and a willingness to accept alternate perspectives (Lynch & Hanson, 2004). A culturally competent teacher recognizes that one's own norms and values may unwittingly be transmitted to children without intention and this may impact their interactions. Teachers must therefore view their community as one that is constantly changing in its richness and diversity, as each family brings their own strengths and challenges to the communities in which they live.

Culturally competent programs and culturally relevant materials and curricula: (adapted from Cross, Bazron, Dennis, and Isaacs, 1989 and OPB, 2010).

1) **Value diversity** by accepting and respecting different cultural backgrounds and ways of life;
2) **Encourage cultural self-awareness** in facilitators and teachers;
3) **Are aware of the "dynamics" of cultural interactions** with the understanding that many factors affect cross-cultural exchanges;
4) **Apply and institutionalize cultural knowledge**; and
5) **Adapt to the diversity and cultural contexts** of the community being served.

When culturally relevant programs and policies are instituted, learners will:

- feel valued and comfortable,
- have the confidence to share their thoughts,
- have the necessary knowledge to make decisions about their health that will help themselves, their families, and the communities where they live.

Part 2:
Introduction to the Cultural Competence Improvement Tool

- ***The Cultural Competence Improvement Tool (CCIT) lists characteristics of a curriculum that are culturally sensitive.***
- ***Educators using this tool can compare these features to what is present in an existing health and nutrition curriculum they are using with their learners.***
- ***Based on this comparison, they can evaluate if the curriculum is culturally sensitive and appropriate for their learners, and determine what needs to be***

Childhood obesity is a major health epidemic affecting our nation. While educating children on the benefits of a healthy lifestyle that includes eating healthy and being physically active are crucial to bring about change, the information must be relevant to their individual cultures and experiences.

What is the Cultural Competence Improvement Tool?

The CCIT can help schools, after school providers, and child care providers conduct a review of cultural competence in existing health and nutrition education curricula. This tool can be used in the following ways:

1) It can help providers select a health and nutrition curriculum that meets the particular needs of their learners (i.e., children and family members).

2) It can help providers improve the cultural relevance of an existing health and nutrition curriculum being used in their program.

3) It can be used to compare multiple health and nutrition curricula in order to choose a curriculum that best fits your program needs.

Please Note: *This tool will help you to implement a curriculum that enables you share important health and nutrition information with families from diverse backgrounds. It will not help you understand whether the curriculum includes all the best and most up – to – date information about health and nutrition practices generally. You should use a different assessment to help you do that.*

Overview: Instructions for Using the CCIT

Step 1: Assess the behaviors, practices and beliefs of your learners.
Step 2: Review existing curricula and complete the *Questions to Consider Before Using the CCIT.*
Step 3. Complete the *Cultural Competency Improvement Tool,* including the scoring summary forms (we recommend that at least two staff members complete the CCIT for each curriculum, if possible).
Step 4. Select a curriculum and create a plan for improvement

Part 3:
Steps 1 and 2 – Assess and Prepare

Step 1: Assess the behaviors, practices and beliefs of your learners.

To ensure that a curriculum is culturally sensitive and providers are culturally competent in providing information to children and families, it is essential that staff understand their behaviors, practices, and beliefs related to obesity and obesity prevention. Providers should assess parents and children's perceptions about different factors that have been associated with the risk of childhood obesity. This could be accomplished in a variety of ways including dedicating a staff and/or parent meeting to discuss these issues, conducting interviews or surveys with parents, or talking with and/or observing the behaviors of children. Providers can use the questions below to guide discussions and better understand the factors that contribute to obesity risk among the children and families they serve:

- **Obesity and Weight Status.** What do parents think about overweight and obesity? How do they judge if someone is overweight? What are cultural norms related to weight status? How important is obesity prevention? What do they believe are other important aspects of children's growth and development?

- **Eating and Child Feeding Behaviors**. What foods do parents and children normally eat? What foods do parents and children prefer? What factors (e.g. time, preferences, availability, etc) determine what families decide what they will eat? What are the cultural traditions, beliefs, and norms that influence parents' and children's' food practices? How do parents decide what to feed their children? How do new parents decide if they will breastfeed their infants?

- **Physical Activity.** Do children engage in physical activity? What types of activities do children and parents prefer? Do they believe physical activity is important? Why or why not? Do factors such as community violence prevention children from playing outside?

- **Screen Time**. How many hours of television are parents and children watching? What role do television, computer time, mobile phones, and video games play in the family? Are they on all the time? Are they distractions? Are there televisions in bedrooms? What do parents know about the recommendations for limiting screen time, and what are the challenges in meeting those recommendations? Who has had success in limiting screen time for their children, and how?

- **Sleeping Patterns**. Are children and parents tired most days? Are there cultural norms related to sleeping behaviors or bedtime routines? Where do children sleep? What are children's bedtimes, and are they easy to stick to? What keeps children awake at night, and how does that impact their energy and activities during the day?

- **Socioeconomic Status (SES).** What role does income play in determining what families eat and the activities they choose? Are families shopping on a budget? Do some families participate in food assistance programs, such as the Supplemental Assistance Nutrition Program (SNAP, formally Food Stamps) or the Supplemental Nutrition Program for Women, Infants, and Children (also known as WIC)? Do families use pantries to supplement their food supply?

- **Neighborhood Environment.** What food and physical activity options are available in the communities where the families live or school or child care facility is located? Do families have access to fresh fruits and vegetables and whole grains? Does the neighborhood provide easy access to high fat foods, such as chips and snack cakes and sugar sweetened beverages, such as soda, fruit punch, and fruit drinks?

The answers to these questions provide the first step in ensuring that the curriculum you choose meets the needs of your target population.

Step 2: Review existing curricula and complete the *Questions to Consider Before Using the CCIT*.

The questions below provide general characteristics of a health and nutrition curriculum. Review your curriculum to see if it has the listed features below. If you answer *"No"* to three or more questions, you should consider adopting a new health and nutrition curriculum. If you answered *"Yes"* to three or more questions, you can use the CCIT to evaluate your curriculum for cultural relevance.

	Yes	No
1. Does your curriculum have health topics that apply to your learners? *For example, if obesity is a topic that affects your learners, it should be part of the curriculum.*	___	___
2. Does your curriculum discuss movement as a healthy activity? *For example, students discuss how playing outside each day helps their bodies grow strong.*	___	___
3. Does your curriculum include movement activities? *For example, there are activities where learners run, jump, skip, or play freely as part of the lessons.*	___	___
4. Does your curriculum include lessons on healthy food choices? *For example, there are lessons that describe the types of foods that are considered "healthy," such as fruits and vegetables.*	___	___
5. Does your curriculum help learners connect food choices to their health? *For example, students relate how different foods help their body to get stronger, play harder at recess, keep from getting sick, etc.*	___	___

Curriculum Description Analysis Items

The next set of questions collects general information that is needed to understand and review any health education curriculum and make a final curriculum selection. One person can complete the curriculum information and give the results to others. Although most of this information can be found in the curriculum materials, it might be necessary to contact the publisher, the developer, or a website for information. Skip any items that are not relevant.

1. Name of curriculum: _____

2. Year published or developed: _____ *If applicable, year revised:* _____

3. Publisher/Developer/Distributor:
_____

4. *Summarize the overall goals or focus of the curriculum (e.g., obesity prevention; healthy eating)*

_____

_____

5. Who is the intended audience? _____

_____

6. What topics does the curriculum address? (Check all that apply)	*7. What grade levels does the curriculum address? (Check all that apply)*
____Obesity and weight perception ____Healthy eating and nutrition ____Physical activity ____Screen time ____Community health and wellness ____Other: _____	___ Pre-Kindergarten ___ Kindergarten ___ Elementary School ___ Middle School ___ High School ___ Specific Grade Levels: _____

1. How many lessons/sessions are in the curriculum? _____

9. How are lessons are divided by grade level (i.e., 10 lessons in Grade 5, 5 lessons in Grade 6) and by health topic (i.e., 5 lessons on tobacco, 5 lessons on promoting physical activity)

By grade level: _____

By health topic: _____

Part 4:
Cultural Competence Improvement Tool

Reviewer's Name: _____ **Date:** _____

Description

The questions on the following pages will help you understand the level of cultural relevance within your health and nutrition curriculum. There is no answer key with correct answers. However, the summary score at the end of the scoring sheet will indicate how culturally relevant your existing curriculum is. Higher summary scores are associated with increased cultural relevancy. You can use the form marked Multiple Curriculum Comparison Scores (page 18) to consolidate and compare scores for more than one curriculum.

Please Note: *This tool will help you to implement a curriculum that enables you share important health and nutrition information with families from diverse backgrounds. It will not help you understand whether the curriculum includes all the best and most up–to-date information about health and nutrition practices generally. You should use a different assessment to help you do that.*

Directions:

- For each question, check the answer that best fits your curriculum.
- If possible, provide supporting evidence or comments.
- Add up the total number to get a **summary score.**

Competency	Examples	Never	A little bit	Some of the time	A lot	Supporting Evidence / Comments
		0	1	2	3	
Appearance (SS)						
Competency 1. Do curriculum materials reflect the cultures, ethnic backgrounds, or target characteristics (e.g. disability) of your learners?	*Worksheets, posters, names, books, pictures and videos show children of various genders, races, ethnicities, ages, religions, and abilities in a range of roles*					
Language (SS)						
Competency 2. Does the curriculum include modifications and/or supplemental materials to accommodate the languages spoken by your learners?	*Key terms are shown in appropriate languages; worksheets are available in appropriate languages*					
Educational Content – General (SS,DS)						
Competency 3. Does the curriculum include activities, accommodations and modifications for students with diverse learning styles?	*Includes use of art, physical movement, singing, or other alternatives in addition to traditional instruction*					
Competency 4. Does the curriculum provide alternatives to written communication that make the information accessible to your learners and/or family members with limited literacy, developmental disabilities, and/or English proficiency?	*Includes the use of visual aids, symbols, gestures, physical prompts*					

Competency	Examples	Never	A little bit	Some of the time	A lot	Supporting Evidence / Comments
		0	1	2	3	
Educational Content – Health and Health Behaviors (SS,DS)						
Competency 6. Does the curriculum acknowledge that the meaning and/or value of terms such as *"health"* and *"healthy behaviors"* may vary among different cultures?	*Explicit acknowledgement; Discusses "health at every size;" or explores folk definitions of illness*					
Competency 7. Does the curriculum acknowledge that customs and beliefs about food and physical activity, its value, preparation, and use are different among cultures?	*Understanding beliefs about the balance between physical activity and rest; Value of food and family*					
Competency 8. Does the curriculum allow for flexibility with physical activities to promote movement in a culturally competent way?	*Uses traditional dances from different cultures, movement to traditional music, games from different countries and cultures, etc.*					
Competency 9. Does the curriculum allow for flexibility in food choice examples in order to accommodate learners from different backgrounds?	*Healthy fruits, vegetables, and whole grains that are traditional to diverse cultures (e.g. corn tortillas as a whole grain, collard greens and plantains as a vegetable)*					

Competency	Examples	Never	A little bit	Some of the time	A lot	Supporting Evidence / Comments
		0	1	2	3	
Neighborhood Environment, Social Context, and Family Resources (SS, DS)						
Competency 10. Does the curriculum offer modifications to movement activities for learners whose program, home and/or neighborhood environments may have limited access to recreation areas?	*In home activities vs. just outdoor activities; Activities using limited and inexpensive equipment*					
Competency 11. Does the curriculum acknowledge that accessibility to healthy food and socioeconomic status may limit food choices for learners and their families?	*Discussions about limited access to fresh fruits and vegetables at stores within learners' neighborhood*					
Competency 12. Does the curriculum consider alternatives for a lack of nutritious food and/or an overabundance of non-nutritious food that may occur among learners' homes?	*Suggest using frozen or canned vegetables, and ideas for how to make traditional food healthier (oven-baked instead of fried, etc.)*					
Competency 13. Does the curriculum acknowledge different types of family structures?	*Single-parent households, male-female roles, extended family members as primary caregivers, other non-traditional family units*					

Competency	Examples	Never	A little bit	Some of the time	A lot	Supporting Evidence / Comments
		0	1	2	3	
Competency 14. Does the curriculum promote learning opportunities that engage families from different cultural backgrounds?	*Explicit inclusion of extended family members; opportunities to integrate nutrition and activity into cultural celebrations*					
Competency 15. Does the curriculum include specific activities for children to do with family members at home that match their cultural background and that are in line with the curriculum objectives?	*Take-home materials in multiple languages, clear instructions for activities such as grocery shopping for healthy foods together*					
Staff Training						
Competency 16. Does the curriculum encourage or include trainings for facilitators and other school or program staff that are focused on cultural competence, in addition to the curriculum content?	*Professional development explicitly addresses race and culture and encourages conversation about culturally-influenced topics such as health, nutrition and physical activity*					
Cultural Competence Summary Scores			_____	_____	_____	_____ **(TOTAL)**

Interpreting the TOTAL Summary Score:

40 – 48 = Exemplary Cultural Competence
30 – 39 = Good Cultural Competence
20 – 29 = Fair Cultural Competence
0 – 19 = Poor Cultural Competence

Summary

Directions: Use this form to summarize important comments from throughout your review or important information from discussions regarding the scores (examples are included below). Make a list of the information content provided in the curriculum and compare it to the characteristics of your population in the table below. Make additional copies if necessary, or do the exercise in a shared group with paper on the walls.

Concept	Characteristics of My Target Population	Curriculum Content
Healthy Eating and Food Preparation	*Families and children at our school/agency mostly eat out during the week (many at fast food restaurants) but prepare traditional "soul food" meals on weekends. Foods include collard greens, sweet potatoes, macaroni and cheese; preparation methods used include mostly stewing and frying.*	*The curriculum provides a discussion of how to prepare culturally appropriate vegetables and information about alternatives to fast food meals for families during the week. However, the curriculum does not suggest alternate cooking methods to frying such as baking chicken and fish. In addition, the curriculum does not any provide recipes.*
Physical Activity	*Families and children at our school/agency have limited access to equipment and fitness facilities.*	*The curriculum only includes activities that use expensive equipment or require a lot of space.*

Comparison of Scores & Selection of Curriculum

Reviewer's Name: _____ **Date:** _____

Directions: Use this form to compare scores for multiple curricula. List the individual Cultural Competence Summary Scores for all curricula or grade groups that were reviewed.

1	2	3
Curriculum Title: _____	Curriculum Title: _____	Curriculum Title: _____
Score	**Score**	**Score**
_____ /48	**_____ /48**	**_____ / 48**
Potential for Modifications (circle your answer)		
High / Medium / Low	High / Medium / Low	High / Medium / Low

Using the summary and the score comparison, engage in discussions with other staff members who have also completed the CCIT. **We recommend that at least two people review each curriculum, if possible.**

Working together, you can then select the curriculum you will use based both on the summary score, and what you collectively believe is its potential for modifications that can make it more culturally relevant, using the improvement plan below.

Part 5:
Curriculum Improvement Plan and Cultural Tailoring

Directions: Use this example form to set goals for improving the cultural relevancy of the curriculum you have reviewed using the information you collected in Step 1 and scores from the CCIT. Take the summary of comments above and add a column to include recommendations for specific adaptations that address the issues you identified. You can also work directly from the CCIT, moving through each competency that received a score of 0, 1 or 2, and adding recommendations for each competency area.

Then use the recommendations to set goals for your work adapting the curriculum, using the forms below to assign responsibilities, timeline and progress monitoring.

Concept	Characteristics of My Target Population	Curriculum Content	Recommendation for Adaptations
Healthy Eating and Food Preparation	*Families and children at our school/agency mostly eat out during the week (many at fast food restaurants) but prepare traditional "soul food" meals on weekends. Foods include collard greens, sweet potatoes, macaroni and cheese; preparation methods used include mostly stewing and frying.*	*The curriculum provides a discussion of how to prepare culturally appropriate vegetables and information about alternatives to fast food meals for families during the week. However, the curriculum does not suggest alternate cooking methods to frying such as baking chicken and fish. In addition, the curriculum does not any provide recipes.*	*Add culturally appropriate recipes. Provide tip sheets with preparation methods that can be alternatives to frying*
Physical Activity	*Families and children at our school/agency have limited access to equipment and fitness facilities.*	*The curriculum only includes activities that use expensive equipment or require a lot of space.*	*Find alternate activities that can be done with inexpensive equipment (ex. Jump ropes, hula hoops) and can be done in small spaces (e.g. sock toss)*

Overview

Progress monitoring (check circle and enter month as date):

- **Self – assessment date: _____**
- **Observation/Reflection date(s): _____**
- **Staff meeting check-in: _____**
- **Other: _____**

Goal 1:

CCIT Competency #: _____

Staff responsible: _____ Check-in date: _____

Goal 2:

CCIT Competency #: _____

Staff responsible: _____ Check-in date: _____

Goal 3:

CCIT Competency #: _____

Staff responsible: _____ Check-in date: _____

Improvement Plan

This sheet can be copied to plan for as many goals as you have identified in the process of increasing the cultural relevance of the curriculum you have identified.

Goal:

Corresponding CCIT Item(s):_____

Staff responsible: _____ Progress Check-in Date: _____

Steps toward reaching goal: _____

_____

When and how will you discuss and/or evaluate progress toward meeting this goal?

_____

_____

How will you know you are making progress towards meeting this goal?

_____

_____

What support do you need in order to meet this goal?

_____

_____

This section for use by curriculum quality advisors.

Date of Progress Check: _____

Progress made:_____

Support Given (date and type):_____

Part 6:
Additional Resources

Listed below are additional resources that can be used to improve the cultural competence of your health and nutrition curriculum.

Additional Definitions for Cultural Competence

National Center for Cultural Competence: http://www.nccccurricula.info/culturalcompetence.html

National Education Association: http://www.nea.org/tools/30402.htm

Oregon Department of Education Resources on Cultural Competency:
http://www.ode.state.or.us/search/page/?id=656

US Department of Health and Human Services:
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

Online Resources for Implementing Culturally Competent Practices

- ✓ Hepburn, Kathy Seitzinger. Building Culturally and Linguistically Competent Services to Support Young Children, Their Families, and School Readiness. 2004.
  http://www.aecf.org/upload/publicationfiles/hs3622h325.pdf
  - *This toolkit was developed by the Annie E. Casey Foundation; Georgetown University Child and Human Development and provides guidance, tools, and resources that will assist communities in building culturally and linguistically competent services and practices related to young children and families.*
- ✓ National Association for the Education of Young Children (NAEYC). 2009. Quality Benchmark for Cultural Competence Project. Washington DC. Online.
  http://www.naeyc.org/files/naeyc/file/policy/state/QBCC_Tool.pdf
  - *This tool is a guide for evaluating, identifying, and adding culturally competent practices into an existing early childhood program. A matrix is provided that lists concepts, ideas, and guidance for implementing culturally competent practices in a program. Finally, this resource includes additional references that can be used for further education in cultural competence.*

- ✓ Center for Law and Social Policy (CLASP); Information on improving cultural and linguistic competence in child care policy and practice. http://www.clasp.org/babiesinchildcare/recommendations_print?id=0005&type=online_resources

    - *This website has a listing of several resources that provide trainings in cultural competence for early childhood programs including the Program for Infant/Toddler Care (PITC), New Voices/Nuevas Voces, and the CLASS Early Childhood Research Institute.*

- ✓ National Center for Cultural Competence; Georgetown University Center for Child and Human Development. http://nccc.georgetown.edu/

    - *This website has a great deal of information on cultural competence in health care and family programs. The site includes listings of publications addressing cultural competence that can be downloaded.*

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Part 7:
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Part 8:
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