Cultural Competence and Health

First Edition, 2006

California Childcare Health Program
Administered by the University of California, San Francisco School of Nursing,
Department of Family Health Care Nursing
(510) 839-1195 • (800) 333-3212 Healthline
www.ucsfchildcarehealth.org

Funded by First 5 California with additional support from the California Department of Education Child Development Division and Federal Maternal and Child Health Bureau.

This module is part of the California Training Institute's curriculum for Child Care Health Advocates.

Acknowledgements

The California Childcare Health Program is administered by the University of California, San Francisco School of Nursing, Department of Family Health Care Nursing.

We wish to credit the following people for their contributions of time and expertise to the development and review of this curriculum since 2000. The names are listed in alphabetical order:

Main Contributors

Abbey Alkon, RN, PhD
Jane Bernzweig, PhD
Lynda Boyer-Chu, RN, MPH
Judy Calder, RN, MS
Lyn Dailey, RN, PHN
Joanna Farrer, BA, MPP
Robert Frank, MS
Lauren Heim Goldstein, PhD
Gail D. Gonzalez, RN
Jan Gross, BSN, RN
Susan Jensen, RN, MSN, PNP
Judith Kunitz, MA
Mardi Lucich, MA
Cheryl Oku, BA
Tina Paul, MPH, CHES
Pamm Shaw, MS, EdD
Marsha Sherman, MA, MFCC
Kim To, MHS
Eileen Walsh, RN, MPH
Sharon Douglass Ware, RN, EdD
Mimi Wolff, MSW
Rahman Zamani, MD, MPH

Editor

Catherine Cao, MFA

CCHP Staff

Ellen Bepp, Robin Calo, Sara Evinger, Krishna Gopalan, Maleya Joseph, Cathy Miller, Dara Nelson, Bobbie Rose, Griselda Thomas

Graphic Designers

Edi Berton (2006)
Eva Guralnick (2001-2005)

California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

Portions of this curriculum were adapted from the training modules of the National Training Institute for Child Care Health Consultants, North Carolina Department of Maternal and Child Health, The University of North Carolina at Chapel Hill; 2004-2005.

Funded by First 5 California with additional support from the California Department of Education Child Development Division and Federal Maternal and Child Health Bureau.

LEARNING OBJECTIVES

To define cultural competence.

To describe why it is important for early care and education (ECE) professionals to be able to serve families with different values, beliefs, customs and behaviors in a culturally competent manner.

To identify three ways a Child Care Health Advocate (CCHA) can assist ECE programs in developing and maintaining cultural competence.

RATIONALE

ECE professionals are faced with the challenge of providing care and assistance to children and families from diverse backgrounds. Knowledge, skills and self-awareness are needed to provide quality care to children from different cultures and to challenge discrimination. ECE providers need to be aware of how cultural differences in parents' beliefs and practices may affect young children's ability to adjust to ECE programs. There are many different cultures and ethnic groups in California. Cultures vary in their beliefs about the cause, prevention and treatment of illness, and in their beliefs about childrearing. These beliefs influence peoples' practices to stay healthy or treat illnesses. Cultural beliefs may also delay or prevent people from getting access to health services. CCHAs working in ECE programs have an excellent opportunity to educate ECE providers, children and their families about issues related to health and culture. Providers need to understand the impact that different cultural, ethnic, social and environmental factors have on children from different backgrounds.

WHAT THE CCHA NEEDS TO KNOW

What Is Cultural Competence?

Cultural competence is a set of matching behaviors, attitudes, policies, structures and practices that come together in an organization to enable that organization to work effectively in cross-cultural situations (Hepburn, 2004; Cross, Bazron, Dennis & Isaacs, 1989). Hepburn (2004) defines the following four essential elements for a culturally competent system of care (i.e., a culturally competent ECE program):

- Value, accept and respect diversity.
- Have the capacity, commitment and systems in place for cultural self-assessment.
- Be aware of the dynamics that occur when cultures interact.
- Adapt to make room for diversity.

The Reality: California's Changing Population

Nearly 34 million people live in California, and the population is expected to increase by 16% by the year 2010. California's population increased by over 4 million from 1990 to 2000. According to the U.S. Census, California has become more ethnically and culturally diverse since the 1990s. The percentage of White people decreased from 57% to 47%, while the Hispanic population increased from 26% to 32%, and the Asian/Pacific Islander population increased from 9% to 12%. The percentage of Black and Native American people has stayed the same over the course of the decade, at 7% and 1%, respectively (U.S. Census, 2000). These numbers include both adults and children. See Table 1 for the percentages for the child population of California. Nearly half of all children (48%) in the state have at least one parent born outside the United States (Children Now, 2004). California's diversity can enrich the state as families share their cultures, languages and experiences with others.

TABLE 1: CHILD POPULATION (BIRTH – 17 YEARS) IN CALIFORNIA BY RACE/ ETHNICITY (2005)

Race/Ethnicity	Percent
Hispanic/Latino	47.4%
Caucasian/White	31.4%
Asian	9.4%
African American/Black	7.2%
Multiracial	3.4%
Native American	0.8%
Pacific Islander	0.4%

From Lucille Packard Foundation for Children's Health
http://www.kidsdata.org/topictables.jsp?t=24&i=7&ra=3_132

Biracial and Bicultural Influences

The statistics below show that the population is rapidly changing because of interracial marriage, and the numbers of biracial, biethnic and transracial children (adoptive parents are a different race than the child) (U.S. Census, 2000).

- In 2000, 7 million people, or 2.4% of the U.S. population, identified themselves as "more than one race." Of that group, 98% identified themselves as being of two races. In California, 4.7% identified themselves as more than one race.
- In 2000, 4 million married couple households stated that their spouses are of different races or origins.
- There are nearly 4 million multiracial children in the United States.
- Almost one third of the children adopted from the foster care system are placed with families of a different race, and 75% of children adopted from other countries by Americans are transracial.

English Language Learners

For the 2004-2005 academic year in California public schools, the student population enrolled in K-12 was very diverse: 47% of students were Hispanic or Latino; 31% were White; 8% were Asian; 8% were African American; 3% were Filipino; 1% were Amer-

ican Indian; and 1% were Pacific Islander (California Department of Education, 2004). Based on the 2000 U.S. Census, 26% of California school-age children were bilingual. Because of California's diverse population, a large percentage of children who enter the public school system are still learning English. These are students for whom English is not their first language. Table 2 shows the wide range of languages other than English that are spoken by children in California. Children also come into ECE programs speaking many different languages, and ECE providers need to be prepared to communicate with their families either through interpreters or other families who are bilingual.

TABLE 2: TOP 10 LANGUAGES OF ENGLISH-LEARNER STUDENTS IN CALIFORNIA PUBLIC SCHOOLS 2004-2005

1.	Spanish	85.1%
2.	Vietnamese	2.2%
3.	Hmong	1.5%
4.	Cantonese	1.4%
5.	Filipino (Tagalog)	1.3%
6.	Korean	1.1%
7.	Other Non-English	0.9%
8.	Mandarin (Putonghua)	0.8%
9.	Armenian	0.7%
10.	Khmer (Cambodian)	0.7%

Diversity of the ECE Workforce

ECE staff are also very diverse. Many ECE staff are from the same cultures as the children in the ECE program, which can help the program provide culturally appropriate care. ECE providers' diversity includes immigrants, some with limited English, different religious beliefs, sexual orientation, socioeconomic status and childrearing beliefs. Although there may be cultural and ethnic differences among staff, they can be connected to the common goal of creating a harmonious workplace and nurturing environment for children.

ECE Programs: A Dynamic Intersection for Honoring Cultures

The multicultural changes across the United States, and especially in California, have a strong impact on ECE programs. In ECE programs, families and staff from different cultures and generations work together in one of life's most intimate areas—the care and raising of young children (see Okagaki & Diamond, 2000). The way that people raise and care for young children (e.g., feeding, sleeping and communication) can be very different in various cultures (Shonkoff & Phillips, 2000).

The ECE community has a long history of honoring and celebrating diversity. *Responding to Linguistic and Cultural Diversity: Recommendations for Effective Early Childhood Education* (1995) is a position statement from the National Association for the Education of Young Children (NAEYC). This position statement says that the nation's children all deserve an early childhood education that is responsive to their families; communities; and racial, ethnic and cultural backgrounds. Head Start has a statement of multicultural principles that must be honored in their programs (see *Handout: Head Start Multicultural Principles*). A program evaluation tool, *Desired Outcomes for Children and Families*, created by California state child care regulations (State of California, 2002) and the State Department of Education (CDE), supports programming developed with input from families. Many early childhood curricula and initiatives also cover diversity, as well as ECE programs that include all children, such as the following:

The Anti-Bias Curriculum: Tools for Empowering Young Children (NAEYC, 1988) is one of the first in-depth anti-bias guides. Its goals are the following: to increase awareness of attitudes about gender, race, ethnicity and different physical abilities; to help readers identify ways that institutional racism, sexism and handicapism affect programs; to better understand how young children develop their identity and attitudes; and to plan ways to introduce anti-bias curriculum into ECE programs. Also available is a companion brochure *Teaching Young Children to Resist Bias: What Parents Can Do*.

Ten Keys to Culturally Sensitive Child Care (Mangione, 1995) is a unit within the *Program for Infant/Toddler Caregivers* curriculum developed by WestEd and handed out by the California Department of Education. This in-depth interactive training program highlights the 10 keys to culturally sensitive ECE programs: provide cultural consistency, work towards having staff from different cultures, create small groups, use the home language, make cultural elements part of the environment, uncover cultural beliefs, be open to the perspectives of others, seek out cultural and family information, make values clear and work through cultural conflicts.

Serving Biracial and Multiethnic Children and Their Families: A Video and Early Childhood Educator's Guide (Childcare Health Program, 2003). The guide highlights the unique issues facing biracial and multiethnic children and shows how ECE staff can help them process their dual identities. The guide includes the following topics: ages and stages of identity development, identifying and responding to the unique needs of biracial/biethnic families, and making sure that ECE programs are sensitive to culture.

Differences in Health Status of Racial and Ethnic Groups

Research has shown that many racial and ethnic populations or groups have higher levels of diseases, disabilities and deaths than the White populations. African Americans, Hispanics/Latinos, Native Americans, Pacific Islanders and Asian Americans, as well as immigrant groups, rural residents and the poor, are more likely to suffer from poor health and illness. In addition, children in immigrant families are less likely to have health insurance and to attend preschool than children in native families (Children Now, 2004). To play an important role in supporting the healthy development of all children in ECE programs, CCHAs should understand the differences in health status and the underlying factors for poor health in children and families of racial and ethnic minorities.

What are the major areas of difference?

The following are some major areas of difference in the health status of racial and ethnic groups compared with the White population:

- Lifespan.
- Infant mortality rates.
- Sudden Infant Death Syndrome (SIDS).
- Cancer screening and management.
- Heart disease and stroke.
- Diabetes.
- Low birth weight.
- Oral health.
- Asthma.
- Sickle cell anemia.
- HIV infection/AIDS.
- Infectious disease.
- Breastfeeding practice.
- Immigrant children may have infectious diseases that U.S. pediatricians do not see very often. These include conditions such as malaria, amebiasis, schistosomiasis, intestinal parasites, congenital syphilis (for which immigrant children may not be screened at birth), hepatitis A, hepatitis B and tuberculosis (TB).
- Immunization rates.

What are the underlying factors that may cause these differences?

Some factors that may account for the differences include the following:

- socioeconomic status (e.g., low income and low education of parents)
- housing
- lack of access to quality health care (e.g., insurance coverage, preventive health services)
- access to healthy, nutritious foods
- behavioral and lifestyle risk factors (e.g., smoking, drug abuse, alcohol use, nutrition, physical inactivity)
- unsafe environments

- environmental risks in home and neighborhood (e.g., lead exposure, asbestos)
- parenting skills (e.g., children with single parent, children in foster home)
- medical problems and chronic illnesses
- genetic factors (e.g., hereditary disease that passes on from generation to generation)
- discrimination and racism leading to increased poverty, unemployment, poor housing, etc.

Issues That Arise in ECE Programs

CCHAs may be asked to help work through cultural differences that occur between parents and ECE staff, or between ECE staff members. CCHAs need to explore the belief systems of those involved to see if compromise is needed. CCHAs may want to learn more about the following issues, knowing there are big differences among cultures, between people in each culture and between generations.

Causes of physical illness

Cultures often vary in their explanations and beliefs about why children get sick, including being exposed to cold or rain, an unhealthy diet, too many emotions, the system being out of balance (e.g., having too much or too little wind), a curse or an evil eye, "God's will," and the germ theory. Since illness often occurs in group care, conflicts about its cause and about what to blame often happens.

Causes of disability

Having a child with a disability is often linked to guilt and anger, the degree of which varies greatly among cultures. In some cultures, a disability is stigmatized, and in others it is accepted as "God's will." Linking the disability to events that happened during pregnancy is common, such as feeling a fright or another powerful emotion, eating certain foods, having a curse or being exposed to environmental teratogens (substances that cause physical defects in the developing embryo). Early intervention may seem foreign to some families, and that discomfort may lead to a lack of compliance or a misunderstanding of the parents' concern for their child.

Causes of behavioral problems

In some cultures, behavioral problems and mental illness are believed to be caused by evil spirits, curses or imbalances. Other cultures see behavioral problems and mental illness as a personal failing; some believe the cause to be organic, such as a chemical imbalance. It is important to support and not judge or blame families for their child's behavior.

Treatment of illness and specific symptoms

How illnesses are treated often matches people's beliefs about their causes. There are many different kinds of treatments. Some families deeply believe in, and only use, certain cures. Some families are very agreeable to using complementary treatments from different cultures as long as they are not asked to give up their own beliefs. Some treatments may be confused with signs of child abuse, and families may need to know of your concern when you see marks from coining or cupping. ECE providers may be asked to give treatments, such as herbal medicine not prescribed by a licensed professional—this is not allowed by the child care regulations (State of California, 2002) and should not be done.

Beliefs about immunizations

Parents may not have their children immunized because of fears of needles or side effects, cultural or religious beliefs, or a misunderstanding of the importance of immunization. While immunization regulations allow a waiver for personal or religious beliefs, CCHAs should do everything they can to identify and respond to parents' reasons not to immunize.

Childrearing practices

Cultural differences in diapering, toilet training, comforting, eating/feeding/nutrition, sleeping and discipline are the practices most likely to come to your attention. Parents and ECE providers often have very strong views, based on their cultural upbringing, about how to care for children. See *Handout: When Parents and Staff Disagree Over Caregiving Routines* for information about how to clear up conflicts between parents and ECE staff. Toileting practices vary and often depend on cultural expectations as to what age a child should learn to use the toilet. In some cultures, children as early as 6 months are put on the potty chair,

and caregivers are trained to watch for the child's "potty" signs. Current toilet training, or more appropriately *toilet learning*, practices in this country are guided by a child's "readiness" signs, which can begin as early as 18 months or as late as 3 1/2 years of age. Individual toilet learning plans developed by the parent and ECE provider are encouraged by child care regulations (State of California, 2002). Feeding and nutrition practices may cause a lot of conflict unless ECE providers and parents are willing to problem solve together with the help of the Child Care Health Consultant (CCHC). If a family's view of discipline and punishment conflicts with child abuse reporting laws, the CCHA must handle this issue with respect and sensitivity, while still informing the family about the child care reporting requirements.

Children's understanding of race and ethnicity

Children under 3 years of age do not accurately identify their own or other people's skin color and do not understand what it means to be from a different racial or ethnic background (see *Handout: Ages and Stages of Racial/Ethnic Identity Development*). ECE providers need to understand how children develop their ethnic and racial identity and how they can help children be accepting of all people.

WHAT A CCHA NEEDS TO DO

Develop Cultural Competence

There are three ways a CCHA can assist ECE programs in developing and maintaining cultural competence without sacrificing health and safety standards.

1. Learn about yourself, your culture and your own health beliefs.
2. Learn about other cultures, especially their childrearing practices, styles of family interactions and health beliefs.
3. Model and use creative problem solving to work through cultural differences that may get in the way of health and safety.

Learn about Yourself

> *Each of us tends to think we see things as they are, that we are objective. But this is not the case. We see the world, not as it is, but as we are—or, as we are conditioned to see it. When we open our mouths to describe what we see, we in effect describe ourselves, our perceptions, our paradigms* (Covey, 1989, p. 28).

To fully appreciate the diversity of people at work or in the community, you must first understand your own culture. Only after you evaluate your own attitudes and values toward diversity can you promote understanding, tolerance and appreciation of the diversity in us all. Based on work by Lynch and Hanson (1992), the two steps to understanding your own culture are as follows:

1. Define your own unique cultural heritage by answering questions about your family, such as place of origin; when and why the family immigrated; where they first settled; foreign languages that were and still may be spoken; political beliefs; jobs; education; social status; and any economic, social or job-related changes made in previous generations.
2. Examine the values, behaviors, beliefs and customs of your cultural heritage.

Learn about Others

There are many ways to learn about other cultures, such as through reading, observing, listening and asking questions. One of the best ways to learn is by personally talking to people from other cultures. Ideally, a "cultural guide" would be a friend, colleague or neighbor with whom you share trust and respect. Many sources try to describe the characteristics of different cultural groups. While these references can be very helpful in understanding the characteristics of groups, the information may add to generalized assumptions and stereotyping that may not apply to specific individuals.

In addition to seeking general information, it is useful to develop a series of questions to explore individual differences such as the following:

- What do you think caused you/your child's illness/condition?

- What do you think keeps you and your child healthy?
- How do you usually treat this illness/condition?
- Who do you usually see for treatment?

Achieving cultural competence requires that we lower our defenses, take risks and practice behaviors that may feel unfamiliar and uncomfortable. It may mean setting aside some beliefs that are cherished to make room for others whose value is unknown. It may also mean changing what we think, what we say and how we behave (Lynch & Hanson, 1992).

Negotiate Cultural Differences

One of the most important tasks of CCHAs is to make collaboration easier among culturally diverse CCHCs, ECE providers, families and community resource organizations. To do this, CCHAs must be aware of what others are saying, thinking and feeling; communicate ideas effectively; and creatively address problems that come up.

One useful tool in working through differences is *dialoguing* (Gonzelez-Mena & Tobiassen, 1999). Dialoguing aims to reach agreement and solve problems. The goal is not to win, but to gather information and understand the other's perspective, then find the best solution for all concerned. In contrast, the object of an argument is to win. Other differences between dialoguing and arguing include the following:

- The arguer tells; the dialoguer asks.
- The arguer tries to persuade and convince; the dialoguer seeks to learn.
- The arguer considers her point of view the best one; the dialoguer is willing to understand many viewpoints.
- The arguer tries to prove the other person wrong; the dialoguer considers that she has a gap in her knowledge.

CCHAs can improve their abilities to work through cultural differences by doing the following (Lynch & Hanson, 1992):

- Respect people from other cultures.
- Make continued and sincere attempts to understand the world from other persons' points of view.
- Be open to new learning.
- Be flexible.
- Have a sense of humor.
- Be comfortable with ambiguity.
- Approach others with a desire to learn.

Implications for Children and Families

Families will appreciate the effort made by a CCHA to understand their cultural background. Families can be invited to share their cultural heritage with the ECE program by bringing in items such as recipes, books and clothing from their culture to educate the ECE program, staff and children. Families can also join ECE staff in teaching a lesson, celebrating a holiday or teaching a language lesson.

Implications for ECE Providers

The CCHA can support ECE providers in learning about the cultural and ethnic backgrounds of the families served in the program. The CCHA can encourage the ECE provider to develop cultural competency and model behavior that is culturally sensitive. CCHAs can make sure that there are appropriate parent educational materials available in many languages. CCHAs can also provide developmentally appropriate books and toys on the topic of culture for the ECE program to have available for children and families. If there is a parent advisory group associated with the ECE program, the CCHA can encourage broad representation.

ACTIVITY 1: FAMILY PRACTICES AND ATTITUDES (THEN AND NOW)

In the spaces provided below, comment on the practices and attitudes in the household in which you grew up compared with your current household.

1. The person who was the authority figure:

   Then:

   Now:

2. Behavior towards elders:

   Then:

   Now:

3. Children's right to be heard:

   Then:

   Now:

4. Talking openly about feelings:

   Then:

   Now:

5. Disagreements and confrontations:

   Then:

   Now:

6. How affection was expressed:

   Then:

   Now:

7. How anger was expressed:

   Then:

   Now:

8. Differences in treatment between boys and girls:

   Then:

   Now:

9. How children were disciplined:

   Then:

   Now:

10. Value of education:

    Then:

    Now:

11. Eating habits:

    Then:

    Now:

12. Daily routines and schedules:

    Then:

    Now:

13. Being on time:

    Then:

    Now:

14. Feelings and attitudes about people from other cultures/ethnic groups:

    Then:

    Now:

15. Feelings and attitudes about people with special needs:

    Then:

    Now:

In what areas have the greatest changes taken place?

(Adapted from The Program for Infant/Toddler Caregivers Handout #20, CISS Conference)

ACTIVITY 2: SELF-ASSESSMENT CHECKLIST

Complete the *Handout: Self-Assessment Checklist for Personnel Providing Services and Support to Children and Their Families*. In which items did you score a C ("Things I do rarely or never")? The trainer will lead a discussion on the items that score a C. Why are these items important to you? Why is it difficult to put these actions into practice? How can this be overcome?

ACTIVITY 3: CULTURAL NEGOTIATIONS SCENARIOS

Berlin and Fowkes (1983) in *A Teaching Framework for Cross-Cultural Health Care* recommend a mnemonic tool (a method for helping you to remember) for cross-cultural communication and negotiation called "LEARN."

- **L** **Listen** with sympathy and understanding to the person's perception of the problem.
- **E** **Explain** your perceptions of the problem.
- **A** **Acknowledge** and discuss the differences and similarities.
- **R** **Recommend** a solution.
- **N** **Negotiate** an agreement.

Divide into small groups. Discuss and apply the LEARN guidelines to the scenarios below. Report back to the large group.

1. An Asian parent new to the ECE program brings her 18-month-old to the center and asks the teacher to keep her child indoors today because she has a cold. The ECE provider asks the CCHA to talk to the parent who seems upset that the provider cannot do what she asked for.

2. An ECE staff member who is an immigrant from Mexico comes to you crying because she just had an argument with the food service clerk. A parent (also from Mexico) of a child in the ECE staff's class asked that no milk be given to her child today because the child has a cold and the milk will only make more mucus. The staff member agrees with the parent. The food service clerk comes in very upset because the Federal Food Program rules say they have to offer children milk every day. The program is expecting a federal food program review, and she was told by the director to "follow the rules." The angry clerk says, "Milk has nothing to do with making more mucus, and I'm not getting in trouble by breaking the rules."

3. A staff member comes to you because she has noticed red lines on the back of a 3-year-old in her class. She thinks the marks are due to child abuse, is angry and wants to report the family. You observe the child, whose family recently came from China, and your assessment of the marks is that they are the result of coining.

4. A limited English speaking Latina parent with whom you are speaking starts to cry and repeatedly says to you through the interpreter, "It is all my fault, it is all my fault." Her child is 2 years old and has Down syndrome.

5. A parent who recently came from Laos is referred to you by the ECE program director because she does not want her baby immunized. During the conversation the mother tells you that she does not want germs put in her baby's body and would rather take a chance on the baby getting sick.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

1.011, 2.006, 2.007.

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

Title 22. None.

RESOURCES

Organizations and Resources

Organization and Contact Information	Description of Resources
African American Health Network www.aahn.com	The African American Health Network provides information on a variety of cultural and health-related issues for African Americans.
Association of American Indian Physicians (AAIP) www.aaip.com	AAIP is dedicated to pursuing excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing practices and restoring the balance of mind, body and spirit.
Association for Library Service to Children www.ala.org/ala/alsc/alscresources/booklists/booklists.htm	Develops and supports the profession of children's librarianship by enabling and encouraging its practitioners to provide the best library service to our nation's children. Web site lists books on diversity and multiculturalism for children.
California Tomorrow 1904 Franklin St Suite 300 Oakland, CA 94612 (510) 496-0220 www.californiatomorrow.org	California Tomorrow has built a strong body of research and a national reputation for facilitating institutional change processes and the challenging dialogue such change demands about intergroup relations, institutional oppression, equity and access. California Tomorrow works with schools, family-serving institutions, early childhood programs and communities to respond positively and equitably to diverse populations. California Tomorrow identifies and designs new models of practice for a diverse society.
Cross-Cultural Health Care Program www.xculture.org	Mission is to serve as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. Training and educational materials available.
Diversity Rx www.diversityrx.org	Diversity Rx promotes language and cultural competence to improve the quality of health care for minority, immigrant and ethnically diverse communities. It is funded by National Conference of State Legislatures, Resources for Cross Cultural Health Care and Henry J. Kaiser Family Foundation of Menlo Park, CA.
Indian Health Service (IHS) www.ihs.gov	IHS, an agency within the U.S. Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. IHS's mission is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.
Intercultural Communication Institute www.intercultural.org	A nonprofit foundation designed to foster an awareness and appreciation of cultural difference in both the international and domestic arenas. Resources for training and education.

Organization and Contact Information	Description of Resources
Inter-Face International 3821 East State St., Suite 197 Rockford, IL 61108 Tel: (815) 282-2433 Fax: (815) 282-5417 www.inter-faceinter.com	Inter-Face International helps health care organizations reach out to patients and staff of other cultures.
Jamarda Resources Inc. www.jamardaresources.com	Jamarda Resources, Inc. works to increase health care workers' understanding of cultures, ethnic groups and religions through consulting, diversity training, workshops and continuing education products.
Minority Health Network (MHNet) www.pitt.edu/~ejb4/min	MHNet is a Web-based information source for those interested in the health of minority groups.
Multicultural Paths: EdChange Multicultural Pavilion http://curry.edschool.Virginia.EDU/go/multicultural/sites1.html	Multicultural Paths provides resources for educators, students and activists to explore and discuss multicultural education; facilitates opportunities for educators to work toward self-awareness and development; and provides forums for educators to interact and collaborate toward multicultural education.
National Association for the Education of Young Children (NAEYC) 1509 16th Street, NW Washington, DC 20036-1426 Tel: 202/232-8777; 800/424-2460 Fax: 202/328-1846 www.naeyc.org	NAEYC is dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for all children from birth through age 8. NAEYC is committed to becoming an increasingly high performing and inclusive organization.
National Alliance for Hispanic Health www.hispanichealth.org	The nation's oldest and largest network of Hispanic health and human services providers. Health fact sheets available on a wide array of health topics in English and Spanish. Lists helplines and hotlines with services available in Spanish.
National Center for Cultural Competence (NCCC) http://gucchd.georgetown.edu/nccc/index.html	The mission is to increase the capacity of health and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. Web site contains a searchable resource database.
Office of Minority Health www.omhrc.gov	The mission of the Office of Minority Health is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs to eliminate health disparities. They publish a newsletter called "Closing the Gap" that lists links to Web sites for rural minority health. Closing the Gap: Newsletter of the Office of Minority Health (OMH) www.omhrc.gov/ctg/rh-17.htm

Organization and Contact Information	Description of Resources
Transcultural Nursing Society www.tcns.org	Transcultural nursing is "a formal area of study and practice focused on comparative human-care (caring) differences and similarities of the beliefs, values, and patterned lifeways of cultures to provide culturally congruent, meaningful, and beneficial health care to people." The Transcultural Nursing Society is an international nursing forum for scholarly discussion of global culture care needs.

Publications

Andrews, M.M., & Boyle, J.S. (1999). *Transcultural concepts in nursing care.* Lippincott Williams and Wilkins, Philadelphia, PA.

Aronson, S. (2002). *Model Child Care Health Policies.* 4th edition. Healthy Child Care Pennsylvania.

Carlson, V.J., & Hardwood, R.L. (2000). Understanding and negotiating cultural differences, concerning early developmental competence: The six raisin solution. *Zero to Three, 20(3)*, 19-24.

Copple, C. (ed.). (2003). *A world of difference: Readings on teaching young children in a diverse society.* Washington, DC: NAEYC.

Derman-Sparks, L., Gutierrez, M. & Day, C.B. (1989). Teaching young children to resist bias: What parents can do (brochure). Washington, DC: NAEYC.

Gonzalez-Mena, J. (1993). *Multicultural Issues in Child Care.* Mountain View, CA: Mayfield Publishing Company.

Gonzalez-Mena, J. (1997). *When Parents and Staff Disagree Over Caregiving Routines.* Program for Infant/Toddler Caregivers (PITC), Training Module IV, "Dealing with Differences." Retrieved May 9, 2005, from http://www.pitc.org/cs/pitclib/download/pitc_res/549/03%20Dealing%20with%20differences.pdf?x-r=pcfile_d

Igoa, C. (1995). *The Inner World of the Immigrant Child.* Mahwah, New Jersey: Lawrence Erlbaum Associates.

Lipson, J.G, Dibble, S.L., & Minarik, P.A. (1996). *Culture and nursing care: A pocket guide.* San Francisco, CA: UCSF Nursing Press.

McKenna, J.J. (2000). Cultural influences on infant and childhood sleep biology, and the science that studies it: Toward a more inclusive paradigm. *Zero to Three, 20(3)*, 9-18.

National Association for the Education of Young Children. (1996). NAEYC position statement: Responding to linguistic and cultural diversity recommendations for effective early childhood education. *Young Children, 52(2)*, 4-12.

Wright, M. (1998). *I'm Chocolate, You're Vanilla.* San Francisco: Jossey-Bass Inc.

Audio/Visual

Lally, J.R., Mangione P.L., Signer, Butterfield, & Gilford, S. (1993). *Essential connections: Ten keys to culturally sensitive child care* [Videotape]. United States: The Program for Infant/Toddler Caregivers (Developed collaboratively by the California Department of Education and WestEd).

REFERENCES

Berlin, E.A., & Fowkes, W.C. (1983). A teaching framework for cross-cultural health care. *Western Journal of Medicine, 139(6)*, 934-938.

California Department of Education, Child Development Division. (2000). *Desired Results for Children and Families.* Retrieved Jan 27, 2005, from http://www.cde.ca.gov/sp/cd/ci/desiredresults.asp.

Childcare Health Program. (2003). *Serving biracial and multiethnic children and their families: A video and early educator's guide* [Motion picture]. Available from Childcare Health Program, 2625 Alcatraz Avenue, Suite 369, Berkeley, CA 94705.

Children Now (2004). *California Report Card: Focus on children in immigrant families.* Oakland, CA: Author.

Covey, S.R. (1989). *The 7 habits of highly effective people: Powerful lessons in personal change.* New York, NY: Simon and Schuster.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely disturbed, Volume 1.* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Derman-Sparks, L., & the A.B.C. Task Force. (1989). Anti-Bias Curriculum: Tools for Empowering Young Children. *National Association for the Education of Young Children (Series), #242*, Washington, D.C.: National Association for the Education of Young Children.

Gonzelez-Mena, J., & Tobiassen, D. P. (1999). *A place to begin: Working with parents on issues of diversity.* Oakland, CA: California Tomorrow.

Goode, T., (2002). *Promoting cultural and linguistic competency: Self-assessment checklist for personnel providing primary health care services.* Georgetown University Child Development Center, UAP, (June 1989. Revised 1993, 1996, 1999, 2000 & 2002) Retrieved November 17, 2004, from http://gucchd.georgetown.edu/topics/cultural_linguistic_competence/index.html. Adapted from Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings.

Hepburn, K. S. (2004). *Building culturally and linguistically competent services to support young children, their families, and school readiness.* Baltimore, MD: The Annie E. Casey Foundation.

Lynch, E.W. & Hanson, M. J. (Eds.). (1992). *Developing cross-cultural competence: A guide for working with young children and their families* (2nd ed.). Baltimore, MA: Paul H. Brooks Publishing.

Mangione, P.L. (Ed.). (1995). *Infant/toddler caregiving: A guide to culturally sensitive care.* Sacramento, CA: California Department of Education.

National Association for the Education of Young Children. (1996). NAEYC position statement: Responding to linguistic and cultural diversity recommendations for effective early childhood education. *Young Children, 52(2)*, 4-12.

Okagaki, L. & Diamond, K.E. (2000). Responding to cultural and linguistic differences in the beliefs and practices of families with young children. *Young Children, 55(3)*, 74-80.

Shonkoff, J. P., & Phillips, D. A. (Eds.) (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, D.C.: National Academy Press. National Research Council and Institute of Medicine.

State of California, Health and Human Services, Department of Social Services. (2002). Manual of Policies and Procedures, Community Care Licensing Division, Child Care Center, Title 22, Division 12. Chapter 1. Chicago, IL: Barclays Law Publishers.

State of California, Department of Education (2004). *Top 10 Languages of English-Learner Students in California Public Schools 2003-2004.* Sacramento, CA: Education Demographics Unit. Retrieved August 1, 2004, from www.cde.ca.gov/ds.

U.S. Census (2000). Retrieved August 17, 2004, from www.quickfacts.census.gov/qfd/states/0600.html.

U.S. Department of Health and Human Services, Head Start Bureau. *Multicultural principles for Head Start programs.* (Catalog #77). Washington, D.C.: Head Start Information and Publication Center.

Wright, M. (1998). *I'm Chocolate, You're Vanilla.* San Francisco: Jossey-Bass Inc.

HANDOUTS FOR THE CULTURAL COMPETENCE AND HEALTH MODULE

Handouts from Other Sources

Page	Handout Title
21	*Ages and Stages of Racial/Ethnic Identity Development*
23	*Head Start Multicultural Principles*
25	*Self-Assessment Checklist for Personnel Providing Services and Support to Children and Their Families*
29	*When Parents and Staff Disagree over Caregiving Routines, by Janet Gonzalez-Mena, from PITC (Program for Infant/Toddler Caregivers), Training Module IV, "Dealing with Differences" (1997)*

AGES AND STAGES OF RACIAL/ETHNIC IDENTITY DEVELOPMENT

Stage	Racial Self-Identification	Racial Constancy	Origin of Racial Identity	Racial Classification	Racial Attitudes
I. Racial Innocence Age 3	Most children are unable to accurately identify their skin color, much less their race.	Children reside in a world where anything is possible, including changes in skin color and gender.	Children are unaware of the biological origin of their skin color.	Children are unable to correctly categorize people by race.	Preschoolers are developmentally inclined to see people as individuals rather than as members of racial groups.
II. Color Awareness Ages 3-5	When asked, "What color are you?" children are just as likely to describe the color of their clothes as their skin. Children can accurately identify their skin color using words like brown, white, tan, and black. Some children also use familiar words related to food like chocolate, peach and vanilla.	Children believe that if they desire, they can change their skin color by magical means like wishing and painting.	Preschoolers believe that God, their parents, or they themselves have used magical means to produce their color.	Children can accurately group people by skin color but not by race. Children describe others in their own terms like chocolate, vanilla, pink, and peach. Some children use other words like lemon girl (for an Asian girl) and cherry girl (for a red-haired white girl). All light-complexioned people, including Asians, whites and blacks, are seen as "white." Children describe people as "brown" who have medium-brown complexion; "black" is used only to describe dark-skinned people.	Children are predisposed to be friendly to anyone who acts positively toward them. Children at this stage continue to see people of their own and other races without skin color and racial prejudices. However, children who are routinely taught racial bigotry begin to form negative association with certain skin colors.

Stage	Racial Self-Identification	Racial Constancy	Origin of Racial Identity	Racial Classification	Racial Attitudes
III. Awakening to Social Color Ages 5-7	Children can accurately identify their skin color and begin to make relative skin-color distinctions, like light-skinned and dark-skinned. Most children are unable to reliably identify their race.	Children begin to perceive that their skin color is a permanent feature of their bodies and understand that the effect of the sun on the skin is only temporary.	They begin to grasp the connection between their color and their parents' and expect skin colors of family members to be similar. However, they do not yet fully comprehend the genetic basis of skin color.	Children begin to understand that skin color means something more than mere color, but they are inclined to categorize people by color, rather than race. They use conventional terms - brown, black, white - to describe people. Black is used to describe only brown and dark-skinned blacks and white to describe Asians and whites. When asked, children can identify Chinese people. Children begin to use ethnic labels, like Puerto Rican and Italian, sometimes inaccurately.	Although they do not yet fully understand them, children begin to adopt skin-color prejudices of their family and friends as well as those presented by the media. For example, children may begin to express a preference for light or dark skin and to see "white" or "black" people as negative stereotypes.
IV. Racial Awareness Ages 8-10	Children can accurately identify their race using terms like black and African American. Some biracial children say they are "part" black or African American and "part" another race, like white.	Children comprehend that racial identity is permanent.	Children understand the genetic basis of racial identity. Unlike younger children, they understand the reason members of the same family can have different skin tones.	Children rely not only on skin color but also other physical cues, such as hair color and textures, as well as facial features to determine a person's group - white, black or African American Chinese, and so forth. As they mature, children realize that physical cues can be unreliable in determining some people's race. Children begin to also rely on more subtle cues - including social and behavioral ones - when making racial identifications.	Unless they are sensitively taught not to prejudge people based on their race, children may adopt full-fledged racial stereotypes, common in the culture and their own racial group.

Adapted from "I'm Chocolate, You're Vanilla" by Marguerite Wright

HEAD START MULTICULTURAL PRINCIPLES

1. Every individual is rooted in culture.

2. The cultural groups represented in the communities and families of each Head Start program are the primary sources for culturally relevant programming.

3. Culturally relevant and diverse programming requires learning accurate information about the culture of different groups and discarding stereotypes.

4. Addressing cultural relevance in making curriculum choices is a necessary, developmentally appropriate practice.

5. Every individual has the right to maintain his or her own identity while acquiring the skills required to function in our diverse society.

6. Effective programs for children with limited English speaking ability require continued development of the primary language while the acquisition of English is facilitated.

7. Culturally relevant programming requires reflects the community and families served.

8. Multicultural programming for children enables children to develop an awareness of, respect for, and appreciation of individual cultural differences. It is beneficial to all children.

9. Culturally relevant and diverse programming examines and challenges institutional and personal biases.

10. Culturally relevant and diverse programming and practices are incorporated in all components and services.

SELF-ASSESSMENT CHECKLIST FOR PERSONNEL PROVIDING SERVICES AND SUPPORTS TO CHILDREN AND THEIR FAMILIES

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in early intervention and early childhood settings. It provides concrete examples of the kinds of values and practices which foster cultural and linguistic competence.

Directions: Select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

Physical Environment, Materials and Resources

_____ 1. I display pictures, posters and other materials which reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.

_____ 10. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

_____ their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ they may or may not be literate in their language of origin or English.

_____ 11. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

_____ 12. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

_____ 13. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 14. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.

_____ 16. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice.

_____ 17. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____ 18. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 19. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).

_____ 21. Even if my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 23. I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.

_____ 24. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.

_____ 25. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 26. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self help skills.

_____ 27. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 28. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 29. I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and families.

Adapted from Goode (2002) Promoting Cultural and Linguistic Competence and Cultural Diversity in Early Intervention and Early Childhood Settings.

WHEN PARENTS AND STAFF DISAGREE OVER CAREGIVING ROUTINES

By Janet Gonzalez-Mena

Parents and caregivers sometimes hold very strong views about how babies are supposed to be cared for.

These deep-seated ideas are embedded in each of us and remain mostly subconscious and nonverbal until challenged by someone with a conflicting view. We must find ways to manage and resolve conflicts, both cultural and individual, especially those conflicts relating to caregiving practices. For several years now I've been examining areas of disagreement around infant routines such as diapering, feeding, toilet training, holding, comforting and "educating" babies. My aim is to help people find ways to manage and resolve conflicts so they can make a better match. The more the adults in their lives work at settling disagreements, the fewer inconsistencies in approach the babies will experience. My theory is that with adults working hard to manage their conflicts the child will be exposed to fewer culturally assaultive experiences.

So what do you do when you're a caregiver and you and a parent disagree about what's good for babies? I see four outcomes to cultural and individual conflicts in infant/toddler caregiving situations.

1. Resolution through mutual understanding and negotiation. Both parties see the other's perspective, both-parties give a little or a lot.
2. Resolution through caregiver education. Caregiver sees parent's perspective. Caregiver changes.
3. Resolution through parent education. Parent sees caregiver's perspective. Parent changes.
4. No resolution.

*The worst "no resolution" scenario is that neither side see the other's perspective—neither changes. There is no respect and conflict continues uncontained or escalates. Sneaking around may occur, or underhanded fighting.

*The best "no resolution" scenario is that each has a view of the other's perspective, each is sensitive and respectful but unable, because of differing values and beliefs, to change their stance. Here conflict management skills come into play as both learn to cope with differences. The conflict stays above board—though perhaps not always in the open.

The fourth outcome is a fairly common outcome as people deal with diversity, while hanging on to their own cultures. Conflict management skills (as opposed to conflict resolution skills) are important for all of us to learn as we go through life bumping in to conflicts that can't be resolved. Handled sensitively and with respect, learning to mange these conflicts in healthy ways provide the challenges that make life interesting.

Here are examples of each of these outcomes.

1. Resolution Through Mutual Understanding And Negotiation.

These conflicts involve "win-win" negotiations with movement from both sides.

Here's the scene: We have on the one hand a parent who hates to see her child messy. On the other hand we have a caregiver who provides messy sensory activities. At first, these two expressed angry feelings to each other. But they were developing a relationship at the same time they clashed over this one issue. They talked about their feelings and their perspectives regularly. Gradually they began to understand each other.

The caregiver educated herself. She went to some trouble to find out why being clean was so important to this parent. It took lots of talking before she understood that clean meant "decent" to this family. She found out

that this family had an experience with Child Protective Services accusing a neighbor of neglect because her child looked dirty a lot. But it wasn't just a defensive stance this family took. They felt clothes show the quality of the family. They felt the were sending their child to "school" and when the child goes to school clean and well dressed it show the parents respect for education. So naturally it was upsetting to them when the child was picked up with clothes full of grass stains, food, or finger paint. They couldn't accept the suggestion of sending their child in old clothes. I didn't fit in with their image of decency or "school."

While the caregiver was getting educated, she was also educating the parents about the importance of sensory experiences that involve messes. Finally they came to an agreement that the caregiver would change the clothes of the child during messy play, or at least make sure she was covered up, so that when the parents returned they would find their child as they left her. The parents were not completely convinced that messy experiences were important but they said it would be okay as long as their daughter's clothes weren't involved. The teacher continued to feel they were overly concerned with appearances. Neither side completely gave up on reforming the other side, but both felt okay about the arrangement.

2. Resolution Through Caregiver Education. Caregiver sees parent's perspective. Caregiver changes.

Here's the situation: The caregiver believed that babies should sleep alone in a crib – tucked away in a darkened, quiet spot (the naproom). Licensing agreed. But along came a baby who couldn't sleep alone. He cried and got very upset when put in a crib by himself.

At first the caregiver thought he would get used to the center's approach, but he didn't. He became distraught and refused to sleep when he was put in to a crib in the naproom. So after talking to the parents, the caregiver discovered the he had never slept alone in his life and the parents didn't even have a crib. He came from a large family and was used to sleeping in the midst of activity. The caregiver had already discovered that he went to sleep easily in the play area on a mattress with other children snuggling or playing around him. She had no objection to letting him nap in the play area, but that approach to napping was against regulations, so going along with what the parents wanted presented a problem. Instead of trying to convince the parents (and the baby) to change she went to work to convince licensing. She was able to get a waiver once she convinced them that she was only able to fulfill the spirit of the regulation – that each child has a right to quiet undisturbed sleep – if she didn't isolate the child in a crib in the naproom. In this case the caregiver made the changes – accommodated the wished of the parent and the needs of the child. You might not agree that she should have done what she did, but she felt quite comfortable about what she considered a culturally sensitive decision.

3. Resolution Through Parent Education. Parent sees caregiver's perspective. Parent changes.

Here's the story. The caregiver kept putting babies on the floor to move around and explore toys. She found out that most of the parents in the program wanted their babies to be held all the time. Although they complained to the caregiver, instead of stopping the practice, she started a series of discussions – both individual and group. She educated the parents about the value of freedom of movement. She knew that safety issues were a big concern, as well as dirt, germs, drafts. She knew that in their own home the floor wasn't a safe place for babies. She discussed the subject more than once. She didn't resolve the conflict with all the parents, but she continued to work at it. Once she helped them clarify their goals for their children they realized that freedom to move was vital to their children's development! Because she had a philosophy that babies should not be confined either by being held all the time or by being in infant swings, high chairs, infant seats, she didn't compromise. She showed the parents how their children would be safe on the floor by having the immobile ones fenced off from the mobile ones. She practiced in the open what she felt was so important, and after she convinced a few parents they began to convince the others. This caregiver was of the same culture as the parents, so she wasn't an outsider coming in telling them what to do without understanding their culture. She was an insider who had a different perspective and was able to help them

see that their goals and their practices were in conflict with each other. You may not agree with what she did, but she felt very strongly that she was right in changing the parents – in educating them to another view.

4. Conflict Management When There Is No Resolution.

The caregiver in this example was uncomfortable when a new parent told her that her one year old was toilet trained. She didn't believe it and felt that parent was trained, not the baby. She and the parent started a series of conversations about this subject. Even though the caregiver didn't change her approach to toilet training, through the discussions the caregiver was able to quit feeling critical of this parent as she was eventually to see where she was coming from.

The caregiver came to understand that toilet training means different things to different people. To the caregiver it meant teaching the child to go to the toilet by herself, wipe, wash hands, etc. The child must be old enough to walk, talk, hold on to urine and feces, let go after getting clothes off, and wash hands. In other cultures, where interdependence is important, adult and child are partners and the adult reads the child's signals and as well as trains the child to let go at a certain time, or to a certain signal, even though the child is only a year old, or perhaps even younger. This approach works best without diapers or complicated clothing like overalls. Although this caregiver did not change her own approach to toilet training she was respectful of someone who does something different from what she did. She was accepting of the difference and quit feeling angry or superior to the parent.

The parent came to understand the caregiver's perspective, too, though she still wanted her to give it a try. The very few times the caregiver did try, it didn't work because she didn't have the time, or the relationship, or the techniques, or an understanding of the interdependence point of view.

This conflict was unresolved but was managed by both parties. The mother continued to "catch" her child at home, and put diapers on when she was in day care. Neither parent nor caregiver felt entirely satisfied, but both parties managed to cope and weather it through until the child was old enough to become independent about her toileting.

Responding to conflict in sensitive, respectful ways.

It's much easier to do parent education (if that is appropriate) if you are of the same culture as the parents. You can see their perspective better. You can work from the inside. Working from the inside of the culture is very important.

Is it ever okay to go along with something you don't feel good about? I can't tell you if it's okay or not. It depends on your bottom line and how flexible you are above that. It's not okay from my point of view to go along with sexism, oppression, or abuse, even if you are told that it is cultural.

Below are some tips about allowing cultural conflicts to rise and responding in sensitive, respecting ways.

Know what each parent in your program wants for his or her child.

Find out their goals. What are their caregiving practices? What concerns do they have about their child in your program? Encourage them to talk about all this. Encourage them to ask questions. Encourage the conflicts to come to the surface—to come out in the open.

Become clear about your own values and goals.

Know what you believe in. Have a bottom line, but leave space above it to be flexible. When you are clear you are less likely to present a strong defensive stance in the face of conflict. It is when we are ambiguous that we come on the strongest.

Become sensitive to your own discomfort.

Tune in on those times when something bothers you, instead of just ignoring it and hoping it will go away. Work to identify what specific behaviors of others make you uncomfortable. Try to discover what exactly in yourself creates this discomfort. A conflict may be brewing.

Build relationships

You'll enhance your chances for conflict management or resolution if a relationship exists. Be patient. Building relationships takes time but they enhance communications and understandings. You'll communicate better if you have a relationship. And, you'll have a relationship if you learn to communicate.

Become an effective cross cultural communicator.

It is possible to learn these communication skills. Learn about communications styles that are different from yours. Teach your own communications styles. What you think a person means may not be what he or she really means. Do not make assumptions. Listen carefully. Ask for clarification. Find ways to test for understanding. This is a complex subject but it has to do with reading body language, along with verbal content. It has to do with how feelings are expressed. It even has to do with such basic things as your sense of timing, and perception of space, including how close you stand. Even tone of voice can be grossly misinterpreted. All of these are to some extent culturally determined and influence the messages we send and receive. If you are in a conflict, try to determine whether the conflict is a difference in communication styles or process or if it is about content or motives.

Learn how to create dialogues – how to open up communication instead of shutting it down.

Often if you accept and acknowledge the other person's feelings you may encourage him or her to open up. Learn ways to let others know that you are aware of and sensitive to their feelings. Notice when your own expression of feelings gets in the way of continuing the dialogue – or perhaps it's a judgmental attitude that's keeping you from listening to the other person in a conflict situation. Keep at it. Use gently firm persistence. Don't give up. Keep trying to see their point of view and make your own known. It helps if you listen at least as much as you talk.

Use a problem solving approach to conflicts rather that a power approach.

Be flexible when you can. Negotiate when possible. Look at your willingness to share power. Is it a control issue you are dealing with?

Commit yourself to education – both your own and that of the parents.

Sometimes lack of information or understanding each other's perspective is what is keeping the conflict going.

I am concerned that each infant find the kind of consistency between his or her care at home and that in child care that will allow him or her to become a solid member of his or her own culture. Culture is learned unconsciously and carried on most unconsciously for the rest of one's life. Those with too varied an input in the early years may wind up to be cultural chameleons—which may be a good thing—but they may also end up being marginal people who never feel that they fit anywhere. Babies who encounter constant cultural assault may develop low self-esteem. I believe we need a lot more studies and thought about exposing infants to cultural assaults in the early years.

© Janet Gonzalez-Mena This document may be reproduced for educational purposes.