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THE ROLE OF STATE EARLY CHILDHOOD COMPREHENSIVE SYSTEMS IN PROMOTING CULTURAL COMPETENCE AND EFFECTIVE CROSS-CULTURAL COMMUNICATION

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This series of reports is designed to support the planning and implementation of the Maternal and Child Health Bureau (MCHB) State Early Childhood Comprehensive Services (SECCS) initiative. The reports are written by a team of experts to provide guidance on state policy development within this initiative. The policy reports on cross cutting themes include strategic planning, communications strategies, financing, results-based accountability, cultural competence, and data analysis and use. The policy reports on programmatic topics include medical home, early care and education, infant mental health, parenting education, and family support.

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Introduction

The MCHB State Early Childhood Comprehensive Systems (ECCS) Initiative provides an opportunity for states to develop more effective early childhood systems. An important goal of this system building enterprise is to optimize development for all children, so that they enter school healthy and ready to learn. The ECCS Initiative recognizes that families are central to and have the greatest influence on a young child's health and development. In addition, supportive services can be of value to children and families. Services and enhancement efforts within the ECCS Initiative are focused on the following five core areas:

- Access to comprehensive pediatric care and a medical home,
- Early care and education,
- Social and emotional development of children,
- Parenting education, and
- Family support services.

If a service system is to be effective, it must address the culturally diverse needs of *all* the children it is designed to serve. While service systems undoubtedly have common components and service delivery goals, their practices and policies cannot take a "one size fits all" approach. Understanding the preferences, needs, and experiences of diverse families is a pre-requisite for developing such a system. State leaders who design and operate service systems need to be well informed about the characteristics of the populations they are serving.

The United States is becoming increasingly diverse due to continuing immigration with 11.5% of current residents being foreign-born. The impact of these demographic changes is being felt more rapidly in the early childhood population than in any other group. Of all births in the US in 2000, 20% were to Hispanic women, and by 2050 half of all Americans will be non-white. Another factor contributing to increasing diversity in the US is a small but growing multi-racial population. For the first time in 2000 the US Census allowed people to mark more than one race, and 6.8 million Americans (2.4%) identified themselves as multi-racial--the most common bi-racial mix being White-American Indian/Alaskan Native followed by White/Asian and White/Black. More children (4%) than adults (2%) were identified as multi-racial. [1] These population trends present very real challenges to early childhood service providers in their quest to meet the needs of young children and respond to increasing diversity in the languages and cultural traditions of families in the United States.[1]

If early childhood systems are to be *effective* at the population level then they must be able to provide family-centered care to all the racial, ethnic and cultural groups that they serve. Despite major policy-driven and technological advances in healthcare, health disparities across different races and ethnicities persist. For example, the infant mortality rate of African-American babies remains at about twice that of White or Hispanic babies. Although multiple factors probably contribute to these disparities, there seems little doubt that providing health services which are culturally sensitive and effective across all races and ethnicities would decrease gaps in health and developmental outcomes.

The term "cultural competence" has been used to describe responsiveness to diversity at the system, organizational, and individual level. The focus on conceptualizing and addressing cultural competence as a quality of care issue has moved the discussions around culture and healthcare

delivery out of an abstract theoretical perspective into the mainstream of healthcare delivery systems. Increasingly, service systems are being judged not only on whether they provide care that is accessible, appropriate, capable, continuous, coordinated, acceptable and effective. [2] but also on whether those services, across all of the key parameters, are *culturally proficient*. The SECCS Initiative, in striving to create a high performing system of service delivery for young children and their families also provides the opportunity to shift expectations and goals from cultural competence to cultural proficiency.

A stronger research base is undoubtedly needed to determine which approaches are most effective in delivering this type of care. The National Center for Cultural Competence (NCCC), funded primarily through the Maternal and Child Health Bureau, has as its mission to "*increase the capacity of health and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems.*" The NCCC provides valuable tools and resources to assist service planners in designing programs which deliver culturally competent care.

The growing interest in the cultural competency of healthcare delivery systems has also led to a recent increase in scholarly works related to this topic. Organizations such as Zero to Three have published a number of articles related to cultural competence and cultural reciprocity – the efforts of staff to understand families' cultural beliefs and to use this understanding as a way to promote the healthy development of infants and toddlers (www.zerotothree.org).

This report explores what it means fro services to be culturally competent and how SECCS grantees can work toward enhanced levels of competence. In doing so, they will improve the quality of services not just for children who are members of ethnic minority groups, but for all of America's children.

What is culture?

Any discussion on the relevance of cultural competence to systems and services should be preceded by a basic understanding of *culture*. This section begins with a definition of culture followed by a brief overview of concepts related to culture (cultural paradigms and acculturation) that serve to increase understanding of the influence of culture on the values and behaviors of different groups.

Although there is no universally accepted definition, one helpful framework comes from cultural anthropology which defines culture as *"a system of shared beliefs, values, customs, behaviors and artifacts that members of society use to cope with their worlds and with one another, and that are transmitted from generation to generation through learning.*" [3] Culture is a broad concept. Individuals may belong to any of a wide array of different cultural groups. For instance, cultural groups can be based on gender, the geographic area of residence, religion, profession, sexual orientation, and income, etc.. Furthermore, individuals can subscribe to the values and beliefs of more than one culture at the same time. For example, a recently arrived immigrant may subscribe to a mix of beliefs from his or her country of origin, as well as some of the values of the country of residence (often referred to as mainstream culture).

In the past, consideration of culture in health services research has traditionally focused on race and ethnicity and the training of healthcare providers on culture has all too often been limited to lists of commonly held beliefs about the customs of different ethnic groups. More often than not, these

"commonly held" beliefs have been a compilation of beliefs across different ethnicities; for instance, Puerto Rican, Mexican, and Cuban beliefs may be categorized under a single "Latino" belief system. Such homogenization of different cultural beliefs and traditions can lead to oversimplification of complex and subtle differences and unrealistic expectations regarding expected behaviors. It can also result in stereotyping - assuming that individuals from the same ethnic group will all behave in a culturally predictable fashion. When providing health services, and designing health service systems, providers need to be aware of all of these aspects of culture, and the influence they may have on the provider-patient interaction and on the likely engagement of the family with the service system.

Cultural Paradigms

Knowledge of the characteristics of different cultural paradigms serves to increase an understanding of the influence of culture on the values and behaviors of individuals within different cultural groups. For example, some cultures are more *collectivist* in orientation while others are more *individualist*. Collectivist cultural paradigms are more common to African, Asian, Latin American and Native American cultures and focus on relationships, human interactions, and connectivity between individuals. Individualist cultures are more common to western countries such as Europe, Australia, Canada and North America and emphasize self-determination and independence.[4]

The collectivist worldview place more emphasis on social relationships, and interprets events and actions in relational context. The individualist worldview places more emphasis on scientific thinking, and on teaching children even from a very early age to understand and manipulate objects. For example, when a child is learning to walk, an adult from an individualist culture may show excitement about this developing skill and growing independence, while an adult from a collectivist culture may interpret this as signifying a child's desire in relation to a person, saying "Look, he's walking towards you." These very early interpretations of developmental events expose the child to what is considered important in that culture, and so the child's own cultural orientation begins to form. [4] These different cultural pathways can be seen running through all aspects of human development, with one simple interpretation being that one path (collectivist) leads to "interdependence" while the other (individualist) leads to independence.[5]

In practice, of course, many cultures have elements of both individualism and collectivism, and even essentially individualist cultures have clear distinctions and different value systems. While much further research is needed on the full implications of this theory for healthcare practice, some understanding of these differences can be of real assistance in determining how best to meet the needs of parents in their task of optimizing the health and development of their children, while respecting their cultural identity. Demystifying issues of cultural differences is also important so that relevant culturally based knowledge and practices can be valued and brought to bear in program design and strategic planning.[6]

Acculturation

Another concept relevant to this discussion is acculturation. The acculturation process refers to changes or adaptations in cultural beliefs, values, and traditions resulting from contact with other cultures over time. Contact may result in the borrowing of certain traits by one culture from another, or the relative fusion of separate cultures (www.encyclopedia.com). Acculturation differs from assimilation, in which different ethnic groups combine to form a new culture.

Acculturation is an important concept for healthcare systems to embrace, as clients will tend to interact with systems in ways which are influenced by their degree of acculturation. Some cultural groups have a strong sense of wishing to preserve their own cultural identity, and therefore may interact less than other cultural groups with health and education systems that differ from or are in conflict with their cultural beliefs.

While acculturation is an important concept for service systems to understand the populations that they serve, the studies about the process of "acculturation" into US society itself show both positive and negative results. These studies have examined intermediate measures of acculturation and found them associated with both positive and negative health outcomes:

- A study on mortality rates due to preventable causes among urban Mexican-American infants revealed that rates for infants of US-born mothers were twice as high as those for infants of Mexico-born mothers.[7]
- Hispanic women born in the US tend to eat more convenience foods than their foreign-born counterparts, while a preference for speaking English at home among Latino women has been associated with lower vegetable consumption.[8]
- Foreign-born mothers who do not speak English (i.e., less acculturated) appear to be at higher risk of maternal depression and anxiety.[9]
- In the Canadian Longitudinal Survey of Children and Youth mothers who had symptoms of depression and mothers who were immigrants had increased risk of having a child with poor developmental attainment.[10]

These studies suggest that the process of acculturation is important for systems of services and providers both because of the challenges to effective communication, and the potential for positive and negative outcomes. Furthermore, the ability of these intermediate variables to reflect acculturation is complicated. For instance, a preference for speaking English at home among Latinos may reflect a choice to remain rooted in some aspects of a culture while permitting acculturation in others.

Providing care to families who have emigrated from different countries and depict varying degrees of acculturation to US culture is a challenge for American health care providers. However, it is just as difficult for these families as they face new cultural customs, unfamiliar health care systems, and medical management plans. In fact, both parties face acculturation challenges in the health transaction.[11] The measurement of acculturation is particularly challenging as current indicators such as country of birth, length of residence in the US, knowledge and use of English are often proxy measures of an underlying set of attitudes, beliefs, and behaviors that are more difficult to measure reliably.

What are cultural competence and proficiency?

A culturally competent professional has been defined as "*one who is able to facilitate mutually rewarding interactions and meaningful relationships in the delivery of effective services for children and families whose cultural heritage differs from his or her own.*"[12] Cultural competence extends far beyond addressing language barriers and providing translation services, and even beyond the hiring of a racially diverse group of providers. It requires providers to exhibit a high degree of self-awareness in regard to their own cultural beliefs and values. It also requires that providers develop the communication skills necessary to elicit information about other people's cultural beliefs and understand how these might impact the person's health, and how they understand and accept the

provider's message. Healthcare providers must develop the skills to communicate their message in a way that will best facilitate the desired outcome.

Cultural competence is an important concept at the level of the individual provider-patient interaction, and at program, organization and system level. The NCCC has defined competence within service systems as an *ongoing process* that involves *valuing diversity, conducting self-assessments (including organizational assessments), managing the dynamics of differences, acquiring and institutionalizing cultural knowledge, and adapting to the diversity and cultural contexts of the individuals and communities served.*[13] The themes of continuous self-reflection, awareness of cultural differences, education about the importance of culture in healthcare settings and adaptation to the cultural needs of the population are just as relevant at the system level as they are in the practitioner's office.

Cultural competence also encompasses the concept of *family-centered care* for parents and young children. Family-centered care offers a new way of thinking about the relationships between families and health care providers (www.familycenteredcare.org). Family-centered care providers consistently seek out the skills, knowledge and tools to communicate effectively and appropriately with all families, including those of different racial/ethnic and other subgroups. They seek to bridge differences, even when they are rooted in culture. These cross-cultural communication skills are a very necessary part of today's effective early childhood systems.

A central tenet of family-centered care is that the family is the constant in the child's life, while service systems and professionals come and go. In a family-centered care model, complete and unbiased information is shared with parents about their child's condition in an appropriate and supportive manner. Family strengths and individuality are recognized and different methods of coping are respected. Parent-to-parent support is encouraged and facilitated, and parent/professional collaboration is encouraged at all levels of healthcare - care of the individual child, program development, implementation, evaluation, and policy formation.

Family-centered health care delivery systems are designed to be flexible, accessible and responsive where the developmental needs of children and families are understood and incorporated into service delivery and all people are treated with dignity and respect (www.communitygateway.org). The principles underlying family centered care are entirely consistent with those underlying culturally competent care, and are also consistent with the medical home model - an approach to providing an entire range of high quality cost-effective health care to families by a child health care provider whom they know and trust.

The link between "family-centered care" and "family engagement" can be seen in the field of early care and education. Family engagement means involving the family in aspects of the early care and education setting, such as hiring and budget decisions and curriculum development. Family engagement has been identified as a particularly important factor for children who speak a language other than English at home or who are not proficient in English.[14]

The term *cultural proficiency* is relatively new, and implies some mastery of these cultural concepts across all levels of service delivery. It is this "next step up" from cultural competency to which early childhood systems should aspire. The abilities of providers to navigate cross-cultural communication reflect a range of skill: at the lowest level are cultural destructiveness and incapacity, and at the

highest level are cultural competence and proficiency.[15, 16] Culturally proficient services are provided in a manner that respects and is responsive to different philosophies, childrearing approaches, and practices. Services acknowledge that these different beliefs are rooted in different cultures and are an integral manifestation of their diversity. A culturally proficient early childhood system could be defined as *one which facilitates and encourages the optimal delivery of culturally sensitive services that parents of different cultures and ethnicities judge to be of good quality*. *"Culturally proficient agencies are expansive, advocating for cultural proficiency throughout the health care system and for improved relations between cultures throughout society. They are role models at both an institutional and patient-provider level and can offer the health care provider useful examples of how to close cultural gaps and improve your service delivery, even if you don't speak the same language as your patient."*[16]

This report focuses on the self-assessment and communications skills necessary to build the ability of systems, services, and providers to work effectively with diverse families. Striving for cultural proficiency is an important next step that will continue to grow the competence of systems, providers, and individuals.

Relevance of Culture to ECCS Initiative Planning

Culture is relevant to the ECCS initiative in a myriad of ways ranging from understanding parenting practices to eliminating persisting disparities in health outcomes. This section discusses the relevance of culture to the ECCS initiative and includes the following:

- Cultural differences in the goals of childrearing
- Cultural influences on parenting practices
- Cultural differences in developmental milestones
- Effect of early childhood experiences on the life-course
- Persistent racial/ethnic disparities in health and education

Cultural differences in the goals of childrearing

It is hard to imagine an area of health, education, or social service where culture plays a bigger role than in early childhood. Most early childhood experiences are shaped by parent cultural beliefs, practices and routines. Parents are the primary influence in a young child's development not only through what they choose to do in the home, but also through decisions they make about what services they are going to access on the child's behalf. Research has shown that even in basic care-giving activities such as soothing a baby there are characteristic differences in the strategies used by different racial and ethnic groups.[17] These nuances of care-giving performed at such an influential early period are likely to have far-reaching effects on how the child grows and develops and ultimately behaves as an adult.[12, 18] Infant and early childhood sleeping arrangements and approaches to common sleep problems are also strongly culturally determined. Bed-sharing is common among Asian families, while in mainstream US culture, with its more individualist orientation, babies generally sleep in their own cribs from an early age.

There is evidence that parents from different cultural groups have in mind different "goals" when raising children which may have profound influences on the patterns of everyday parent-child interactions. Martini studied four different cultural groups of families in Hawaii. When asked to list

the characteristics of "successful adults" in relation to how parents were raising their child, important differences were found:

- Filipino-American parents wanted their children to grow up to be obedient, good citizens who respect authority and conduct themselves well, displaying good manners.
- Japanese-American parents most wanted their children to achieve, to live a well-ordered life in contact with the family, and to master the demands in their lives.
- Caucasian-American parents most wanted their children to become self-reliant, happy, spontaneous and creative.
- Native Hawaiian parents most wanted their children to be socially connected, happy in their networks and self-reliant.[19]

Given these findings, it is not difficult to imagine that these groups of parents would respond differently to assertive behavior in a young child, would use differing styles of discipline ranging from permissive to authoritarian and would place different emphasis on activities which emphasized social skills and connectedness over mastery of skills.

Similar differences would be reflected in the services parents access on behalf of their children. For example, center-based preschool experience has been demonstrated to enhance children's school readiness skills and is used more by Caucasian parents than by Hispanic parents. Hispanic parents tend to favor family daycare or home-based care settings for their pre-school-aged children.[20-22] One possible interpretation of these tendencies is that Hispanic parents may value social relationships above more structured opportunities for early learning—a more collectivist outlook. Programs designed to increase the attendance of Hispanic children at center-based preschools may be more effective if they investigated the underlying, cultural rationale for choosing home-based care. A more culturally competent approach may be to respect parents' desires to have their children remain in home-based care and explore how these settings can be supported to enhance children's school readiness skills.

Parents from different cultures also differ in their beliefs about how much a child's learning capacity can be influenced by educational experiences. In a 2001 study on childcare in the state of California, more than half of Latino parents reported that they *strongly agreed* with the statement that their child's learning capacity was fixed at birth compared with 15% of White parents.[23] Parents that feel strongly that neurodevelopmental functions are essentially "set" at birth may be less likely to seek an early childcare environment with a strong learning component than parents who embrace a transactional, or more dynamic and experientially focused model of child development. In the transactional model[24], neurological, social and psychological development is viewed as a dynamic process that results from the complex interaction between the child and the care-giving environment. Proponents of the transactional model would be more likely to see potential benefits in stimulating early childhood development, and in seeking early intervention services for children with developmental challenges.

Cultural influences on parent attitudes and practices

Parenting practices are greatly influenced by culture – not just what parents do, but also the underlying beliefs and expectations which drive their behaviors. In an analysis of the 2000 National Survey of Early Childhood Health, Kuo et al (2004) noted significant differences in frequency of

reading to young children between Hispanic families and White and Asian families. However, culture is not the only influences on parental reading to young children. Some of these include the parents' literacy level (in English or their native language), financial and time constraints, comfort and familiarity in using government resources like libraries, etc. Suggestions by child health or child care providers to parents to increase their frequency of reading to their children or to start reading at a younger age may be of limited effectiveness if the parents do not accept, value, or prioritize the potential benefits for school readiness and future school success. Providers need to understand the parents' rationale for not reading to their children—be it due to a personal experience with regarding oneself as a successful adult and not having been read to, or the need to overcome significant barriers such as those mentioned above. Additionally, some cultures have a lower reliance on education through literacy than others. For example, many African-American families have strong oral (singing and storytelling) rather than reading traditions which may influence the rate of conventional literacy activities with their children.[25]

Parents who themselves were not educated in the US may be less knowledgeable about the US educational system and may be unaware of the likely educational demands placed on their children even in the early years of school instruction. Foreign-born parents may also lack knowledge of additional help which may be available to their children if they are experiencing developmental or learning difficulties. Parents from cultures with more paternalistic health and educational systems may wait for the doctor or teacher to raise a concern before mentioning any difficulties they may have noted. Such parents will be very unlikely to be vocal advocates for services for their child, who might "miss out" on potentially useful interventions. Worse still, the parents' attitudes might be misinterpreted as a lack of interest in their child's progress, or an unwillingness to address problems.

Providers who feel that the behavior of the parents in the home should change should begin by exploring the goal(s) of the changes they wish to recommend with the parents and their family. Parents can identify cultural practices and ways of interacting with their children that might be aligned with these goals. Providers and parents can then work together toward these common goals. However, parents may not always agree with and accept the goals proposed by providers.

Cultural differences in developmental milestones

Culture lies at the core of parenting practices and consequently play an important role in defining the developmental pathways that influence child health and development.[24, 26] Parents from different cultural backgrounds are likely to have different goals for child-rearing and different strategies for achieving them. Parents with one set of goals may or may not be aware of the other goals, strategies, and the knowledge base that supports them. Consequently, a particular behavior exhibited by a child may sound alarm bells for parents of one culture, prompting engagement with the healthcare system, investigation and management while in a family from another culture that same behavior might be regarded as within the range of normal. For example, in a study comparing Anglo, Puerto Rican and Filipino parents on ages at which key developmental milestones were expected, significant cultural differences in expectation were found.[27](**Table One**) If parents of an 18 month old child are asked "Can your child drink from a cup?", an answer of "no" from an Anglo family who introduced the cup at age one year and have tried consistently to encourage their child in its use may indicate an emerging developmental problem for that child. The same answer from a Filipino family may indicate that they have not yet tried to introduce a cup, so the child has yet to practice or demonstrate that skill.

Table One: Mean Age Expectations for Developmental Milestone Attainment

Developmental Milestone	Anglo	Puerto Rican	Filipino
	(Age in months)		
Eat Solid Food	8.2	10.1	6.7
Training Cup	12.0	17.1	21.9
Utensils	17.7	26.5	32.4
Finger Food	8.9	9.4	9.5
Wean	16.8	18.2	36.2
Sleep by Self	13.8	14.6	38.8
Sleep all Night	14.4	14.5	32.4
Choose Clothes	31.1	44.2	33.1
Dress Self	38.2	44.2	39.2
Play Alone	25.0	24.8	12.3
Toilet Trained (Day)	31.6	29.0	20.4
Toilet Trained (Night)	33.2	31.8	34.2

Cultural beliefs and practices differ and reflect different socialization goals. Self-assessment, reflection, and communication skills are critical to uncovering these differences. The ability to bridge cultures is relevant to anyone that works with children and families. Conversely, it is also important that providers refrain from making assumptions about childrearing practices and attribute differential milestone attainment to cultural factors when a fuller developmental assessment might be warranted.

These differences have additional implications for the provision of developmental assessments. Developmental assessments are complex processes magnified by different expectations and values of families and assessors.[28] Assessment procedures, materials, and instruments all need to be culturally appropriate if the assessment is to be valid. When the cultures of the families and the assessor coincide there is a high probability that valid information will be obtained and interpreted accurately. However, when they do not, there is a real possibility of misinterpretation of the findings.

Developmental assessments will only be culturally responsive when assessors acknowledge their own subjectivity and the potential for bias of their own personal and socio-cultural viewpoint. Diversity is present whenever there is a possibility that the assessor, in interaction with a child, will attribute a different meaning or value to behaviors or events than would the family.[28] The child must always be viewed within the context or background of the family's socio-cultural milieu. A competent developmental assessment might require the presence of a "mediator" – someone who is familiar with both the environment of the child and family and the assessment environment.[28] Mediators from early childhood services outside of the healthcare system, e.g. preschool teachers, childcare providers, may have much to offer to the developmental assessment process. Closer collaboration between staff from different early childhood sectors would benefit the developmental assessment process with the potential to improve outcomes for children and families.

Effect of early childhood experiences on the life-course

The young child's early development sets the stage for early and lifelong success.[29] Starting with physical, cognitive, social and emotional development, leading into school readiness and achievement and later the ability to live independently and productively as an adult, the effects of the early years are far reaching. Adults who are involved with the criminal justice system and who have an ongoing need for social services support can often trace the roots of these poorer outcomes to adverse events and influences in early childhood. Although challenges in early childhood can be difficult to

overcome, this period of life is also increasingly seen as a time of great potential. If developmental and behavioral difficulties can be identified early, and effective interventions commenced, there is growing evidence that the individual's life course trajectory can be positively influenced.[30] Early identification of neurodevelopmental problems with appropriate intervention is an important aim for state early childhood systems.

The detection of a potential developmental problem in a young child will have very different effects in families of different cultures. Some cultures may embrace the concept of the benefits of early detection where parents may be active advocates for their children, being pro-active about use of services and seeking legal help if they feel their children are not receiving appropriate or sufficiently intense interventions. In other cultures, however, the diagnosis of a developmental problem may be seen differently, and it is important that providers have the skills to learn about parents' cultural beliefs. Partnering with families and communities to identify how these cultural beliefs manifest at the family and community levels is critical. Interpretations of a diagnosis of developmental delay may interact with a host of cultural beliefs, including those about religion, genetic determination, social standing, racism and discrimination, etc.

Persistent racial and ethnic disparities in health and education

The Institute of Medicine's 2002 report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" concluded that bias, stereotyping and prejudice on the part of healthcare providers might be contributing to observed inequalities in health outcomes. Despite tremendous technological and pharmaceutical advances over the past few decades, health disparities among different racial and ethnic groups persist [2]and in some cases are remarkably resistant to improvement. There seems little doubt that variations in access to healthcare, and the way in which individuals of different ethnicities interact with the healthcare system in general and with individual providers in particular to some extent explain these disappointing trends. For example, the infant mortality rate for African-American babies remains at about twice the level for Caucasian babies. In contrast, the infant mortality rate for Hispanic babies is generally lower than that for Caucasians. Black babies are almost twice as likely as non-Hispanic white and Hispanic babies to be born at low birth-weight, and around three times as likely to be born at very low birth-weight. {Child Trends and AAP Center for Child Health Research, 2004} Breastfeeding rates also vary by ethnicity with 34% White non-Hispanic babies being breast-fed until 3 months or more while the rate is 28% for Hispanic babies and only 20% for African-American babies.[1]

Culture and School Readiness

With an increasing awareness of the growing cultural diversity of the early childhood population comes an increased appreciation of the challenges and opportunities this poses for the K-12 educational system. Despite efforts at educational reform, and improvements in some areas, racial and ethnic gaps in educational achievement persist. In the 2002 National Assessment of Educational progress, 16% Black and 22% Hispanic twelfth grade students displayed "solid academic performance" in reading vs. 42% of their White classmates. The No Child Left Behind Act of 2002 aims to close these achievement gaps, but the focus to date has been principally on school-aged children.[31] There is a growing realization that marked disparities already exist before children start kindergarten, and that some children have "already been left behind," and are potentially so far behind that they may never catch up.

School readiness refers to more than just academic readiness, with physical and mental health and social-emotional well-being increasingly recognized as important contributors to a child's ability to do well in school. Consequently, known racial and ethnic disparities in physical health, socio-economic background, environmental stress, parenting experiences, and early childhood education programs will all contribute to gaps in readiness at school entry.[31] While doubts continue to be raised about the reliability of school readiness testing and, in particular, about the cultural appropriateness of the test instruments, nonetheless significant gaps have been identified at school entry. For example, using the Peabody Picture Vocabulary Test-Revised (PPVT-R), the vocabulary of black children in first grade is about half that of white first-graders, although analysis of the Early Childhood Longitudinal Study – Kindergarten sample (ECLS-K) revealed a smaller but still significant gap.[32] Evidence is emerging about the importance of early family routines, which differ significantly across cultures, and their contribution to aspects of child development. Much further research is needed on the impact of these early learning experiences on later school readiness and school achievement.

For some children, when they enter the school system, there are significant cultural differences between their home and school environments, with different emphasis on different types of learning activities. In US schools, teachers focus on independent academic achievement whereas Hispanic parents, for example, are often more concerned about social behavior.[33] Two Native American concepts – that one learns by observing rather than by participating and that one learns for the benefit of the group rather than for the self--also lead to mismatches between Native American children and the schools.[5] Supporting families in their efforts to prepare their children for later success in school, and supporting children through the transition into school are important goals of early childhood programs, and must themselves be culturally competent.

Cultural awareness and early childhood systems

Early childhood health and educational systems are committed to optimizing development for all children and to reducing or eliminating the obvious disparities noted above. While services such as access to a medical home, good quality childcare, and family support can ameliorate some of the risks for poor outcomes in these racial groups, cultural mismatches between provider and family can limit access and reduce quality.

<u>Cultural awareness at the provider level</u>

At the provider level, the "success" of a program may be judged in part by parent satisfaction with services. In health care settings, poor provider-patient communication is associated with low patient satisfaction, poor adherence to recommendations and sub-optimal health outcomes. Effective communication can reverse these trends and result in improved outcomes.[34] Communication difficulties can arise from a lack of

- cultural knowledge or awareness,
- communication skills and expressed empathy on the part of the provider,
- appropriate and trained translators available to speak the client's language.

Exhibit One discusses some of the characteristics of culturally competent providers.

It has been estimated that over 80% of communication that takes place in human interactions is non-verbal, and the importance of gestures, facial expressions and awareness of personal space have not been emphasized in current training of providers in cross-cultural communication. For instance, there

is tremendous cultural variation in interpretation of "personal space." Americans and Northern Europeans tend to touch infrequently and have large spaces between them during business, while Arabs and Latinos may stand closer and touch frequently. An Arab provider who is unaware of these differences might consistently stand close to patients when giving advice, resulting in them feeling a sense of discomfort and invasion of their personal space. Even if the health content of the provider's advice is excellent, the patient's discomfort may result in a low satisfaction with the service, difficulty with applying medical advice to their lifestyle, and possibly rejection of the accompanying health message.

Problems with using translators in healthcare settings are well documented. Lack of availability of translators is a very real issue, and while there is near universal agreement that their provision is essential there is great debate over who should fund this service. The quality of translation also varies, and even when the translator speaks the same language as the patient they may come from different cultural sub-groups. The position of the translator as an intermediary in the communication between the provider and patient may add a third culture into the transaction, so issues of cultural awareness and sensitivity are just as important for translators as they are for providers. In many settings the patient's relatives or friends are used as translators. However, this practice may result in erroneous translation of medical terminology as well as introducing confidentiality issues and a likely reluctance to discuss personal or sensitive topics. In the early childhood field this issue is magnified further when older siblings are used as translators, and evidence is emerging that significant errors and misunderstandings arising from such translation arrangements are probably common.[35]

The Commonwealth Fund Health Care Quality Survey (2001) on parents' perceptions of pediatric care under Medicaid managed care reported that only half of those needing translation were offered one, and that translators used were either a family member or a staff member of the provider's practice. Only 37% Hispanics who spoke only Spanish reported that it was easy to understand instructions compared with 51% Hispanics who spoke English. Only 16% Non-English speaking Asian Americans reported it was easy to understand instructions compared with 47% those speaking English.[36]

Exhibit One: Characteristics of Culturally Competent Providers

Self reflection for recognizing cultural biases
Culturally competent providers take the time to become mindful of potential biases and prejudices and how they might be addressed in their practice.

Openness to learning about cultural complexities
Culturally competent providers exhibit humility about what they think they already know and are open to in-depth understanding of the nuances and complexities of inter- and intra-cultural influences and variations.

Experience in diverse communities
While providers may not necessarily be of the same cultural background as the communities they serve, cultural competence involves a broader world perspective, often gained from experience living or working with different cultural groups.

Comprehension of historical and institutional prejudices
This knowledge is critical for providing services that integrate how historical and current social systems,

institutions and societal norms contribute to disparities among different communities.

Rapport and trust with diverse communities
Culturally competent providers prioritize relationship building with diverse communities. Relationships are viewed as mutually beneficial.

Flexibility in practice
Rather than coming in with prescriptive service/practice strategies, culturally competent providers realize limitations to established approaches and are willing to adapt to honor different cultural values, practices, and contexts.

Acknowledgement of power differentials
Culturally competent providers acknowledge the various power differentials possible in an interaction between providers, individuals and the communities being served.

Translation and mediation across diverse groups
Culturally competent providers are skilled in communicating advice and recommendations in a manner appropriate for individuals and communities being served.

Adapted from Inouye et al 2005 and Barrera 2002.

Cultural competence at the program and system level

Cultural competence is just as important at program and systems levels, and can be examined with regard to system/program design and implementation, with regard to the system/program's acceptance of multiple cultural paradigms, as well as the system's ability to measure efforts in culturally competent ways (**Exhibit Two**).

Given the existing trend toward greater diversity in the nation's communities, it is increasingly important to ensure that systems design and implementation include input from those the system is designed to support. This includes problem identification, strategy development, workforce training, data collection and evaluation. Systems need to ensure that they are responsive to the cultures they serve, and employing staff of the same cultural group as the service population is one strategy for developing cultural awareness in a program or system. Another resource to improve the integration of multiple cultures into systems design are cultural guides. These may be community leaders who are representative of the community and knowledgeable of the culture and can serve as useful resources to understand parent needs. They play several roles including providing insights about cultural norms to providers as well as providing insights about services to families and acting as facilitators of more positive outcomes[37, 38]. Neither of these strategies completely replace the need to ensure that staff have the self-reflection skills, and communication skills to successfully investigate differences, and respond to them appropriately.

The ability of systems and programs to respond effectively to cultural differences depends on an acknowledgement of and respect for multiple world views Respecting difference means that the system understands that different practices are rooted in rational cultural contexts and ways of thinking. In effect, a member of one cultural can respect the practices of another while not adopting the other culture's ways of thinking. Systems also need to respect different types of knowledge: while "expert" or "academic" knowledge is vital, the communities being served constitute expert repositories of their cultures' childrearing beliefs, values and practices.

Finally, measuring the success of early childhood systems at the population level is both challenging and critical. Assessing the cultural competence of the system is similarly difficult. A program which appears very successful based on internal evaluation may seem less so when its impact is measured in relation to community need and to the cultural groups it is actually serving. For example, programs such as Reach Out and Read, where pediatric providers hand out free books and provide anticipatory guidance on the value of adults reading to young children have had positive effects on the reading patterns of families served by the programs. However, if the Reach Out and Read programs within a geographic area only operate from private pediatrician offices where translation services are either patchy or non-existent, and these offices are selectively avoided by families who speak only Spanish, then that group of the population who are most at-risk of not reading at all to their children will not have benefited from the intervention.

Other cultural groups may be excluded from services due to factors other than race. For example, a high socioeconomic status family with a child who is deaf or hard of hearing may choose not to access an intervention program which is located in a geographic area which they consider unsafe, even if the intervention itself when measured at the provider-client level is of excellent quality and would be the one best suited to that child's pattern of disability.

Culturally competent measurement can be facilitated by maintaining respect—for differences between cultural groups and among individuals within a culture, as well as differences in power. Culturally competent systems utilize measures that are developed in collaboration with the service population, that accommodate different cultural contexts and may require alternative means of data collection, and which have been validated for multiple cultural groups.

Exhibit Two: Guiding Principles for Culturally Competent Systems Building

Inclusion in design and implementation

- Culturally competent systems are not imposed on diverse communities; communities understand and support the rationale for why and how culturally competent services are structured.
- Diverse beneficiary stakeholders are actively involved in all phases of system planning, including problem identification, development of strategies, training, data collection, and evaluation.
- Culturally competent systems ensure that they are responsive to the communities they serve in part by representing their diversity in multicultural staffing and expertise as much as possible.
- To the extent possible, culturally competent systems empower diverse providers and staff to evaluate their own culture, those of others, and build respectful, responsive, and reciprocal relationships.

Acknowledgement/infusion of multiple world views

- Culturally competent systems acknowledge the uniqueness of different cultures, and the varying manifestations of culture within different individuals and sub-groups
- Culturally competent systems show genuine respect for different cultures by understanding that different practices are rooted in rational cultural contexts and paradigms of thinking.
- Culturally competent systems exhibit reciprocity where "expert" knowledge does not exclusively reside with the providers. The communities being served are assumed to best know their childrearing beliefs, values, and practices.

Appropriate measures of success

- Culturally competent systems employ measures of success that are discussed or collaboratively developed with those being served.

- Culturally competent systems employ measures that accommodate different cultural contexts and consider alternative or nontraditional ways of collecting data.
- Culturally competent systems test measures for multicultural validity across diverse communities, and modify their measures as appropriate.

Adapted from Inouye et al 2005 and Barrera 2002.

Implications of Cultural Competence for Early Childhood Policy

Developing policies that support cultural competence has the potential to improve and enforce cultural competence across all services. An example of such a policy would be to include cultural competence requirements in the provision of licensure and certification examinations for programs and providers. In addition to providing higher quality care, such a measure would support continuing education and promote research on culturally appropriate practices. It would encourage the development of the communication, self-assessment, and self-reflection skills needed to uncover cultural differences and effectively communicate when differences exist. It would encourage the use of assessment tools and instruments that contribute toward improving child health and are culturally competent. Setting up policy incentives for the recruitment of multilingual and multicultural staff would also support cultural competence. For example, requiring cultural competence in requests for proposals and contracts would encourage local level programs to seek resources, and recruit culturally competent staff to deliver services that are paid for by state-level programs. This section presents the implications of cultural competence for early childhood policy and is organized into three broad areas:

- Educating and training providers
- Involving parents in the planning process
- Evaluating providers and services

Educating and training providers

The American Academy of Pediatrics has issued a policy statement on "Ensuring Culturally Effective Pediatric Care: Implication for Education and Health Policy".[39] This statement acknowledges the importance of cultural competence for training in medical school, residency and continuing medical education. The AAP is committed to incorporating the principles of cultural competence into all aspects of pediatric training, education and practice. AAP also acknowledges that these educational efforts must be supported through health policy and advocacy activities that promote the delivery of culturally effective care. Strategies to achieve this aim include enhancing the racial and ethnic diversity of the pediatric workforce.[40]

In December 2000, the Office of Minority Health published the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Wider dissemination of the 14 standards together with their incorporation into all aspects of provider training and the practices of healthcare organizations should provide a framework for building cultural and linguistic competence.[41] The Association of Medical Pediatric Department Chairs has recognized that provision of culturally competent pediatric care will involve the integration of pediatricians, institutions, families and communities into the process.[42] This approach resonates strongly with the goals of the ECCS initiative.

Further research is needed to establish the most effective ways to provide training on the principles of culturally competent care to trainees. Communication remains a cornerstone of effective provider-patient interaction, and is often challenging in the cross-cultural setting. One study showed that pediatric residents tended to regard culture as residing in the patients (not in themselves), reflecting their assumption that western medicine is acultural. These findings indicate a lack of awareness of prejudice in the clinical environment, and the need for practitioners to spend more time reflecting on their own professional culture and beliefs.[43]

Involvement in service-learning community projects provides an opportunity for trainees to visit the homes of families of ethnic and socio-economic backgrounds different from theirs and to develop enhanced cultural sensitivity. Language immersion courses for pediatric faculty have shown promise, with one such course resulting in improved physician language skills, communication and trust between non-Latino doctor and Latino patient.[44] Cultural competence and anti-racism training has been neglected in the child health services, but there is substantial evidence that it is well received by professionals, can be a positive experience for trainees, and when delivered in an appropriate and non-threatening manner, can change attitudes, beliefs and practices.[45]

ECCS grantees could integrate cultural competence standards into their strategic plans and encourage training and education related to the communications skills necessary to identify one's own cultural bias, the beliefs and practices of a member of another culture, and how to communicate health and development related messages effectively and appropriately. The National Center for Cultural Competence (www.georgetown.edu/research/gucdc/nccc/index.html) is an excellent resource for tools and information. Examples of organizations that cater to the needs of specific cultural groups include the Association of Asian-Pacific Community Health Organizations www.aapcho.org, the National Coalition of Hispanic Health and Human Services Organizations www.cosmho.org; and the Hmong Resource Center www.hmongcenter.org etc.

Involving parents in the planning process

If early childhood systems are to achieve cultural competence, then all systems that are part of children's lives and support their health and development should be involved in the process. Consideration should be given to forming a strategic plan for achieving culturally and linguistically competent services at both community and organizational levels.[46] This strategic planning process should include community resource assessment, support-building, and facilitation of leadership, including representation from families and communities. The involvement of families in the design, development and adaptation of programs to meet community needs embraces the concept of *inclusive governance* "as a means to include families and community members in the policy making of the organization, assuring a best fit approach to services."[47] Consideration should be given to mandating such parent and family involvement for agencies receiving government funding.

Just as new migrants must go through a period of acculturation to their new country, so must service providers acculturate to the needs and characteristics of the families they serve. Although most trainees and providers are in daily contact with patients and clients from a wide variety of ethnic and socio-economic groups, and have many opportunities to use these interactions to enhance the cultural competence of the workforce, these opportunities are often lost.

Parents from a variety of racial and ethnic backgrounds should be invited to sit on advisory boards for clinics, healthcare agencies, coordinating councils, and other early childhood service organizations. Programs such as the Hope Street Family Center in Los Angeles, CA have had significant success with this approach. Parents should be encouraged to provide feedback on how service systems can better serve the needs of their ethnic groups. Parents may also be willing to take part in training sessions on cultural sensitivity. Advisory boards should also require that translated consumer materials undergo pilot testing and peer review by parents.

Family Resource Centers (FRCs) are often associated with central points of healthcare delivery such as Regional Centers for children with developmental challenges. These centers are committed to helping parents and families traverse the healthcare and education systems and are often well-versed with the cultural needs of local communities. In addition, they also have extensive knowledge of local and community resources available for families with young children. FRC staff can play the role of cultural guides, working within their ethnic group of origin to gain trust and to educate families about how to interact with local and statewide systems and become effective advocates for their children. ECCS initiative grantees may consider ways to link FRCs with existing healthcare, education and childcare resources.

Evaluating providers and services

As the concept of cultural competence is embraced by early childhood systems, better ways to assess whether services are truly culturally competent and effective need to be developed. Measures of cultural competence and family-centered care could be included in parent satisfaction surveys. More work is needed on learning about parent views of "culturally competent care." Practitioners should also be surveyed both on their educational needs and on whether they themselves view the interactions they have with patients as culturally effective. Although improved cultural competence may ultimately improve clinical indicators, an initial focus on process measures is appropriate. [48]

One measure which may prove useful in the short-term is that of "family-centered care." This measure includes items about how often providers took the time to understand the specific needs of the child, whether the parent was respected as the expert on their child; whether providers asked parents how they were feeling and whether providers understood how the parent preferred to raise the child. This measure has been used in state and national surveys[49, 50] and could be modified to include additional items more specific to cultural competence.

To date there has been very little formal evaluation of any of the methods attempted to improve cultural competency. Development of valid and reliable indicators of competence is needed if early childhood systems are to be accountable for this important aspect of performance. The regular reporting of such indicators to primary care providers, especially in the form of "league tables" of cultural effectiveness will be most likely to effect practice patterns and result in positive system change.

Opportunities for improvement

Fortunately, there are numerous opportunities to improve cultural competence at all levels of early childhood systems. State MCH leaders are in a good position to take a broad view of services as they

operate in the early childhood field and to advocate for increased cultural awareness across all programs and providers within those systems. The NCCC has developed a checklist to assist State Title V programs in incorporating cultural and linguistic competence into all aspects of programs serving children and youth with special healthcare needs and their families[51] Many of the recommendations are equally relevant for the broader Maternal and Child Health service base. While limited resources will remain an important issue, many of these suggested improvements require little fiscal outlay, and focus more on a change in behavior on the part of providers and a re-ordering of priorities on the part of institutions and programs. This section offers the following suggestions to improve cultural competence:

- Train early childhood providers in cultural competence by
    - Improving cultural awareness,
    - Improving communication skills,
    - Learning the appropriate use of translators,

- Program/Practice
    - Know the populations served,
    - Find out what parents want,
    - Consider culture when staffing services,
    - Consider culture when framing important health messages.

Training

Train early childhood providers in cultural competence

Training of healthcare and education providers begins at the undergraduate level. State MCH leaders can play a useful advocacy role here in encouraging institutions responsible for training the early childhood workforce of the future to include cultural competence in their curricula, and to develop measures of competence against which the performance of graduating students can be assessed. Trainees across all service sectors – childcare, education and health - need training on basic knowledge and beliefs of cultural groups but the training must not end there. Equally important is training that will make their care and advice more effective. This includes training in:

Improving cultural awareness: Evidence is emerging that when socio-cultural differences between patient and provider are not explored and communicated, patient dissatisfaction results. [48] If these differences are to be recognized and explored in a meaningful way, then it is essential that the provider has the self-awareness and training necessary to recognize when a potential "clash of cultures" can occur. For example, a provider may discover that a mother did not follow his medical advice to administer daily anticonvulsants to her child. If the provider was trained in a culture in which there is a strong expectation that the patient will comply with the doctor's advice, then he may see her actions as a questioning of his judgment. However, if the provider has a greater degree of cultural awareness and has developed enhanced cross-cultural communication skills he may be able to sensitively explore the reasons for the mother's actions. The provider may discover that consistent with the beliefs of her cultural group, the mother feels that taking daily medication will "weaken" its effect and will ultimately result in her child having to take stronger and stronger medications. She may even believe that the medicine should be withheld so that it will be "more effective" when her son does have a seizure. In cases such as this, open discussion would provide an opportunity for

reeducation and negotiation about the medication.[48] If the patient is to "reject" the belief of her own culture, and "take on" the belief of the healthcare provider then she will at the very least have to have a trusting relationship with that provider.

Improving communication skills: These are the cornerstone of effective provider-patient interactions. Training in *reflective listening* and in *empathetic response* should provide basic skills which will help bridge cultural communication gaps. Key steps in *building trust* also need to be conveyed including acknowledging patient concerns, orienting them to the provider's decision-making process (noting that many patients/clients are mistrustful of the health or early childhood systems) and offering reassurance.[48] Many of these skills are best taught using structured clinical case scenarios and vignettes drawn from real-life experiences. In clinical training providers should be encouraged to probe beyond the "presenting problem" to gain an understanding of the patient's underlying values and beliefs. Another approach to building communications skills is to examine cultural competency as related to "skilled dialogue." Skilled dialogue argues that respectful, responsive, and reciprocal relationships empower communication to overcome the barriers to understanding different cultures. This understanding allows the creation of new options for action that work in each cultural paradigm.[52] While not discussed at length in this report, this approach informed the discussion of **Exhibits One**, **Two** and **Three.**

Learning the appropriate use of translators: One issue in need of more attention is that many providers complete their training without ever having been coached in the best way to use a translation service or having been observed communicating with a patient through a translator. Many providers enter private practice settings where access to translators is limited. In such cases, use of telephone translators will need to be considered, adding another layer of complexity and potential for clinical miscommunication when the translator is not included in the non-verbal communication exchanges.

Providers need to be aware of their options for translation services, either in-person or by telephone. Use of bilingual clinical administrative staff for translation could be effective as long as they are trained. Also, state MCH leaders could play a leadership role in making this resource information available, possibly at relatively low cost using existing state web-sites, with a page dedicated to cultural competence. Providers should be encouraged to use professional dedicated translators wherever possible, using family members only in emergency situations where other options are not practical.

Where exchange of information is taking place via a translator, it is more important than ever to reinforce this information with written instructions. Pre-printed information on common early childhood medical, developmental, behavioral and educational issues should be made available in a wide range of languages. Traditional problems with storage and distribution of these resources can be largely overcome with use of web-based systems with parent handouts which can be downloaded and printed.

Program/Practice

Know the populations served: Whether a sole practitioner operating within a narrowly defined geographic area, or the director of a statewide early childhood program, it is important that service providers are knowledgeable about the cultural values, beliefs, practices, and childrearing approaches

of the populations they are trying to serve. Just as a new business starting up in a community would want to perform some "market research" to find out the likely tastes, likes and dislikes of local residents, so too would healthcare providers be well advised to study their surrounding population and to tailor services and programs to fit local needs. Examination of the diverse cultural groups to be served forms a very important component of this community needs assessment. It is important to demystify issues of cultural differences so that relevant, culturally based knowledge, practices, and approaches can be considered and included as part of a responsive community needs assessment.[6]

While resources for specially commissioned studies are scarce, a surprisingly large amount of publicly available data exists to help inform service providers about the cultures of their clients. Many datasets are now accessible on the Internet or from government departments. State MCH leaders can increase awareness of existing datasets and reports among local providers.

While a basic knowledge of the principal racial and ethnic groups in each area is essential, it is important that racial minority groups which have been traditionally "hard to reach" are also well documented. For instance, the Hmong people have belief systems that may run counter to traditional Western medicine. Knowledge of locations of Hmong and other such communities and their beliefs can assist in service planning.

Find out what parents want: Service providers benefit from working with parents in the local community. This provides them with multiple opportunities to determine among other things, diversity in the child population, information about cultural beliefs concerning child development, behavior and learning, cultural practices including daily routines, language preferences, and unmet service needs. A more formal canvassing of parent information, opinion, and need could take the form of a short survey administered to parents by different service providers, a suggestion box prominently displayed in waiting areas, or a focus group held with parent representatives. Focus groups with a number of parents representing different groups may be very revealing about how services are viewed and accessed. Many early childhood services have advisory boards and planning groups. The presence of parents from different racial groups and cultures served by the early childhood programs may yield valuable information to guide service development and delivery and improve effectiveness.

As discussed earlier, another resource to understand parent expectations and needs are cultural guides. These are usually community leaders who are representative of the community and knowledgeable of the culture and can serve as useful resources to understand parent needs. They play several roles including providing insights about cultural norms to providers as well as providing insights about services to families and acting as facilitators of more positive outcomes.[37, 38]

It is very unlikely that a single method of service delivery will work equally well for all cultural groups. For example, use of the provider office as the principal "platform" for the delivery of healthcare advice and even educational guidance may work well for some families but not all. Conversely, use of the childcare worker as a trusted source of advice for the parent may be very appropriate for some families who minimize their contacts with traditional medical providers but may not work as well for a high SES family who prefers to access advice from their pediatrician. Greater knowledge about different cultural preferences for accessing medical guidance and assistance could help with building a comprehensive early childhood system with greater flexibility about platforms

leading into the system, and greater variation in the pathways taken through the system by different cultural groups.

Consider culture when staffing services: It is generally accepted that there is a shortage of healthcare providers of certain racial groups in the US. While it is not necessarily desirable to have the ethnic mix of providers in a healthcare setting mirror the ethnic mix in the population, it is apparent that, for example using an all Anglo English speaking staff in a neighborhood which is predominantly serving a Spanish-speaking Latino clientele would present some challenges. Some of these challenges could be addressed with the use of translators, enhanced provider training in cultural competence, as well as continued staff development. Staff development efforts would promote a self-assessment of cultural knowledge, bias, stereotyping, culturally-specific health beliefs and practices, use of complimentary and alternative medicine practices versus the western biomedical model and its regimens, and awareness of the concern and needs of the community. Equally important, staff development would focus on building the communication skills necessary to investigate difference and create culturally grounded options as appropriate. Where ethnic minority staff is hired, it is important to ensure that they are appropriately qualified, trained and mentored. Ethnic minority students need to be recruited to the healthcare professions, and these recruitment efforts need to start early. Programs which offer a mentored student experience in a healthcare setting to young people from ethnic minorities could have a significant impact on later recruiting efforts to a career in health services.

Consider culture when framing important health messages: The routes by which important health messages are delivered to the population will likely need to vary for different cultures. Professionals may respond best to articles published in peer-reviewed journals, and indeed these can have far-reaching influence on clinical practice. State MCH leaders could interact with editors to make them aware of important issues in the early childhood field, and of topics that would be of particular interest to and usefulness for practitioners.

Healthcare providers have traditionally been slow to embrace use of the media for health messaging. However, television, radio, the Internet and newspapers all represent very powerful routes to deliver important public health information. Many culturally distinct forms of media exist, e.g. Spanish language TV stations and newspapers, Asian newspapers published in the US, local and neighborhood newsletters, and radio programs targeting religious or political groups. Increased awareness and culturally competent use of these potential educational routes could dramatically increase the effectiveness of health messaging across the population and take advantage of existing cultural networks.

Exhibit Three: Key Points for Reviewing Your Culturally Competent Strategic Plan

- To what extent does the plan reflect knowledge about the cultural and historical context of the community being served?
- To what extent does the plan encourage the self-reflection and communications skills needed to communicate across cultures and with individuals?
- Through what means has the planning and implementation process been informed by both "expert" and community knowledge, values and experience?

- In measuring and monitoring systems development efforts, how are dimensions of cultural competence and community responsiveness considered as measurement criteria? For instance, are there measures of staff knowledge and abilities? Are outcome measures stratified by cultural group? Are there measures of how well staff reflect the service population?

Adapted from Inouye 2005 and Barrera 2002.

Conclusions

Cultural diversity is growing in American society. Culture is increasingly understood as a broad concept, related in part to race and ethnicity but also encompassing socio-economic status, religious affinity and geographic place of residence among other factors. With an increasingly diverse population, now being reflected in a growing diversity of service providers, there is the potential for cultural misunderstandings and cross-cultural communication difficulties in almost every clinical and service-based encounter. As such, issues of cultural competence are now regarded as integral to the provision of good quality care not just for members of racial minority groups, but for all Americans.

Parental childrearing styles and goals are strongly influenced by cultural factors, and service delivery systems that are culturally dissonant, or which fail to reach out to a diverse population are unlikely to be successful. Early childhood systems need a high level of cultural sensitivity and awareness if they are to be effective, and the State Early Childhood Comprehensive Service Systems initiative provides an opportunity for State MCH leaders and early childhood service providers to reflect on their current level of cultural competence and to examine ways in which this aspect of quality can be measured and improved. **Exhibit Three** offers some key reminders as ECCS grantees pursue their strategic planning and during implementation.

Fortunately, there are excellent opportunities to improve the cultural competence of our early childhood systems. The American Academy of Pediatrics and the Institute of Medicine have both highlighted this area as a priority if persistent racial and ethnic health disparities are to be eliminated. The publication of national standards for culturally and linguistically appropriate care, and the focus of the American Academy of Pediatrics on the medical home model and on family centered care have all placed the issue of cultural competence on the national healthcare agenda. The diversity of our population should be viewed as an opportunity to learn more about a range of cultural groups, to involve members of different cultures in service planning and evaluation, and to develop truly comprehensive, coordinated, and culturally competent early childhood services. In doing so, America has the potential to optimize the development of all its future generations.

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