CHILD CARE CHOICES OF LOW-INCOME WORKING FAMILIES

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CONTENTS

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GLOSSARY OF TERMS

Center-based care: Child care arrangements that are not provided within a home setting, including private child care centers, Head Start centers, and publicly funded prekindergarten programs. A further distinction is sometimes made in the field between center-based and school-based programs, but given the small incidence of school-based programs in this study, all non-home-based programs are categorized and referred to as center-based programs.

Child care subsidy: Financial assistance provided through government funds to eligible low-income families, whereby the cost of child care is fully or partially paid by the subsidy source. The dollar amount of the subsidy payment varies depending on a family's circumstances. Research has shown that access to subsidies influences the type of child care that a family will use. The most common source of funding is the Child Care and Development Fund (CCDF), but some states also use Temporary Assistance to Needy Families (TANF) and other program dollars for eligible families.

Child Care and Development Fund (CCDF): A program established by the U.S. Congress in 1990 to support parental work and family economic self-sufficiency, and to make high-quality child care available to low-income working families. State-administered CCDF programs use program funds to reduce the cost of child care, improve the quality of child care, and promote coordination among early childhood development and afterschool programs.

Child care resource and referral agency (CCR&R): A local organization that connects parents with child care providers in their area, provides training opportunities for child care providers, and analyzes the supply and demand of child care services within a community. The local CCR&R in Providence is a nonprofit organization called Options for Working Families (OWF); it is funded by the State Department of Human Services, which also runs the child care subsidy program. In Seattle, Child Care Resources (CCR) is the local CCR&R.

English language learner (ELL): An individual who speaks English as a second language and lacks English fluency. In this report, we define respondents as ELL if they were currently or recently enrolled in English as a second or other language classes or if they responded that they lacked basic English language skills.

Family child care: A type of child care provided by a nonrelative within a home setting to multiple children. Depending in the state, family child care homes are required to be registered or licensed and meet specific child care regulations. In this report, however, because the legal status of providers is not always clear, we use family child care to mean any care setting (licensed or unlicensed) in which providers offer child care in their homes, serve multiple children from different families, and provide these services as an intended ongoing business.

Family, friend, and neighbor (FFN) care: A type of child care in which children are cared for by a family member, friend, or neighbor in an informal home setting. FFN care is also known as kith and kin care. In this report, we refer to informal relative care and informal nonrelative care separately. Nonrelative care arrangements provided by friends and neighbors who served multiple unrelated children were categorized as family child care, regardless of licensing standards.

Foreign-born or immigrant: A person born outside the 50 United States and territories, including Puerto Rico. In this study, a number of

Puerto Rican families spoke Spanish and were English language learners, but they were not identified as foreign-born.

Head Start/Early Head Start: Federally subsidized early childhood programs which aim to provide comprehensive child development services to economically disadvantaged children and families. Head Start funding supports two programs: Head Start, which serves children age 3 through 5 years and their families, and Early Head Start (EHS), which serves children birth through age 3, pregnant women, and their families. The programs promote school readiness by enhancing the social and cognitive development of children through the provision of early care and education, health, nutrition, parent involvement, and family support services to enrolled children and families. Head Start program schedules and hours of child care vary by grantee, with some providing half-day (morning or afternoon) care and others full-day care. EHS offers center-based, home-based, and combination services. Both Head Start and EHS grantees must adhere to federal program performance standards. Eligible children include those from families with incomes below the poverty level, children from families receiving public assistance (TANF or SSI) regardless of family income, and foster children regardless of their foster family's income. Programs may also enroll up to 10 percent of their children from families that do not meet the above requirements but who demonstrate a need for services.

Informal nonrelative care: A type of child care in which caregivers are friends, neighbors, or babysitters who are not related to the focal children and care for them in either their own homes or the child's home with no other nonrelated children present.

Informal relative care: A type of child care in which care is provided by a family member in the child's home or the relative's home.

Making Connections: A community-based initiative of the Annie E. Casey Foundation located in 10 low-income urban communities across the country. It aims to combat poverty and create opportunities for families by promoting economic success for parents, and ensuring school readiness and healthy development among children. The Making Connections initiative informed site selection for the current study because the neighborhoods in which Making Connections operates are home to a high concentration of low-income households and immigrant populations.

Personal social networks: The familial, neighborhood, or community-based support networks on which families rely for information, assistance, and other resources.

State prekindergarten: Center- or school-based early education programs funded by state or local governments that provide eligible children with the early learning skills they need to succeed in school. Thirty-eight states across the nation currently provide publicly funded prekindergarten programs. Some serve only 4-year-old children while others include 3- and 4-year-olds. Eligibility also varies by state, with most programs serving only low-income or at-risk children. Some programs, however, are universal; in these programs, all resident children are eligible for participation and are either automatically accepted for enrollment or selected based on a lottery system. The terms prekindergarten, or pre-k, and preschool are often used interchangeably, and states use differing terms to identify their programs.

The public prekindergarten programs described in this report include the Ready to Learn Providence pilot prekindergarten program (a lottery-based program for 4-year-olds), the Washington State Early Childhood Education and Assistance Program (ECEAP, for low-income 3- and 4-year-olds who do not qualify for Head Start), and the Seattle Steps Ahead preschool program (for 4-year-olds from families with moderately low incomes).

Special-needs children: Children who are identified as having a health, behavioral, or developmental need that requires care or medical

attention. Health needs include chronic and acute conditions that require medical care, including asthma. Behavior needs include diagnosed issues that require therapy and/or medication. Developmental issues include speech and language delays as well as conditions that affect children's physical or intellectual development since birth. While a narrow definition of special-needs children is often adopted in the field, in this report, we broadly categorize children as special needs if their parents report that they have any disabilities, special health needs, or developmental delays that have challenged them or have factored significantly into their child care decisions.

CHAPTER 1: INTRODUCTION

There is widespread and growing interest in how parents make decisions about their children's care. Most working families with children in the United States face this issue regularly, given that nearly 89 percent of the estimated 9.8 million children younger than age 5 with working mothers are in some type of regular child care arrangement (Overturf Johnson 2005). Early care arrangements are critical employment supports for working parents and important contexts for young children's development. Considerable public policy resources are directed at assisting families, especially low-income families, with their child care needs so parents can work and stay employed. There is also a growing public commitment to ensure that children enter school ready and able to learn, and a growing awareness that early learning opportunities present a unique avenue to achieve that goal.

Despite the widespread experience of early nonparental care and its importance to families, employers, educators, and the public good, the early childhood care arrangements families use for their young children vary considerably by type of care, setting, provider, and content and quality of care. In fact, much of this care is of mediocre or poor quality for children's development (Helburn 1995; NICHD Early Child Care Research Network 2000). Children also vary widely by when during early childhood they begin their first nonparental care arrangement, how much nonparental care they receive, how frequently their care changes, and how old they are when they first enter center-based early care

and education settings (Currie 2001; Heckman and Masterov 2007). This variation in turn affects later student performance and adult outcomes (Currie 2001). Policymakers should understand what explains this variation in child care arrangements if they want policy to align with the needs of children and working parents.

Most parents need to balance decisions about location, cost, and availability of early care with multiple work and family factors, such as employment schedules, and the choices available to families do not always match children's or parents' needs. However, the challenge is particularly acute for low-income working families for several reasons. These families' choices are constrained by limited resources. In addition, the fluctuating work schedules, nontraditional hours, and inflexible work policies many low-income working parents experience can further limit their options (Henly and Lambert 2005). Finding good care is particularly challenging in some low-income communities where the supply of quality care is more limited. Further, some low-income families may not have access to good sources of child care information, and they often must arrange child care hastily to meet work requirements.

Recently, some significant state and federal investments in the public infrastructure have supported access to early care and educational opportunities. The primary goals of the federal Child Care and Development Fund (CCDF) are to support parental work and family economic self-

sufficiency, and to make high-quality child care available to low-income working families (CCDF 2007). State-administered CCDF programs increase parents' options by reducing the cost of child care across settings. Similarly, programs primarily focused on promoting early learning and development, such as Head Start and state-funded prekindergarten, are increasingly trying to respond better to working parents' needs by providing such options as before and after care and transportation.

Yet despite these efforts to help low-income working families access affordable early care and education opportunities, many factors continue to constrain parents' care decisions. Such barriers make it more difficult for these programs to achieve their objectives. A clearer understanding of these barriers and how low-income families negotiate this complex terrain will help policymakers develop more effective and targeted strategies to provide low-income working families in underserved communities with the high-quality early child care options they need.

Conceptual Framework and Research Questions

Our research study examines the factors involved in the child care choices of low-income working families in two urban communities. Applying qualitative research methods, we explore how low-income parents' decisions are shaped, facilitated, or constrained by *family characteristics* as well as *contextual community factors,* such as employment, child care supply, information about available child care and subsidies, and social networks. In addition to examining low-income families in low-resourced neighborhoods as a whole, we focus specifically on the factors that shape the decisions of families who, according to literature, likely face particular constraints in

their child care choices. These families include *immigrant families*, where at least one parent is foreign born; *English language learner (ELL) families*, where at least one parent speaks English as a second language and lacks English fluency; and *families with children with health, development, or other special needs.*

This study focuses primarily on the process of parents' child care decisionmaking and builds on a growing body of research that has identified a range of personal and contextual factors that influence the type of child care that low-income families use. The study supports and adds to the extant research by going beyond the patterns of association between family characteristics and child care arrangements to describe the complexity of child care decisionmaking; the interplay between parental opportunities, preferences, and constraints; and the ultimate reasons parents select the type of care they do.

The conceptual framework below (figure 1.1) captures the key factors that shape families' child care decisions as identified by experts in the field. The Child Care Policy Research Consortium (CCPRC) has collectively developed this framework with the leadership of Roberta Weber (Weber 2011). Our research study fits into this framework and, ultimately, may offer some evidence of its usefulness and how it can support a better understanding of the interactions among variables that contribute to parental child care decisionmaking.

This study focuses most intentionally on the left side of the conceptual framework. Specifically, we examine the contents of the three boxes that serve as the context of parents' child care decisions—that is, family, community, and preferences—and how those lead to the child care arrangements that parents use based, in part, on the opportunities, constraints, and barriers presented during decisionmaking as well as any financial assistance used.

Figure 1.1   Parental Child Care Decisionmaking
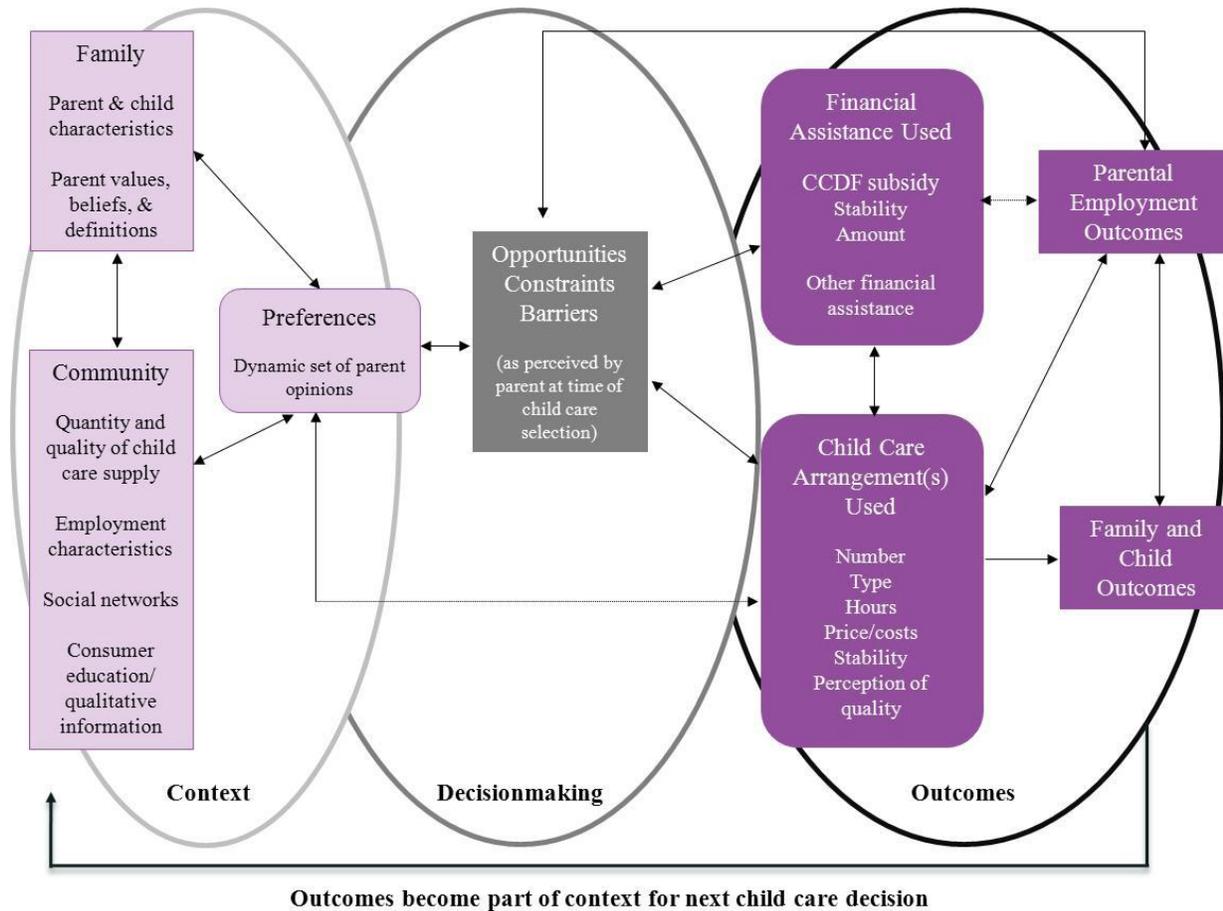
Source: Weber (2011).

With this conceptual framework to guide the inquiry, the study addresses the following research questions:

1. What are parents' preferences for child care? What about child care is important to parents?
2. What factors ultimately influence choice of care among low-income working families in the two study communities?
3. How does choosing child care—for parents overall and for these particular subgroups—interact with two key contextual community factors that can influence parents' child care decisions?

   - Employment contexts

   - Early care and education supply, information, and related program policies in targeted communities

4. How do particular family characteristics influence child care decisions, and do the choices of key subgroups of low-income families differ in important ways from low-income families generally?

   - Immigrant and ELL families
   - Families whose children have health or other special needs

5. What family characteristics or contextual factors seem to particularly facilitate or constrain the child care choices of low-income families and specific family subgroups? Which of these seem

amenable to policy strategies to support choices for low-income working families, and what should these strategies be?

Review of the Literature on Child Care Decisionmaking

In developing this study, we were fortunate to be able to build upon a relatively strong research base. Much of this research has focused on the outcomes of parental child care decisionmaking, revealing important associations between certain family characteristics and child care use patterns. Relatively less has attempted to unravel the decisionmaking process or examine the *how* and *why* parents make the decisions they do. Martha Zaslow and her colleagues have observed that "little is known about parents' decisionmaking process concerning what type of child care to use" (2006, xii).

In this section, we broadly sketch the pertinent research literature to help frame the overall study with the scholarship on parental decisionmaking as well as more specific literature on some subjects that are covered in more detail in subsequent chapters. We start by describing key parent and child characteristics, and how they influence the child care arrangements that families use, with particular attention to what is known about the child care decisions of particular subpopulations that are the focus of the current investigation. This is followed by a review of the role of some key community contexts in parental child care decisionmaking.

Parental and Child Characteristics and Families' Child Care Choices

A significant body of research studies has demonstrated that several child and family factors explain some observed variations in parents' child care choices (Chaudry 2004;

Meyers and Jordan 2006; Weber and Grobe 2010). This research has often been used to describe or explain the many strong associations between family characteristics and the care that families use for their children; however, much remains to be learned about the reasons.

Family and household composition has been shown to have some strong associations with child care use in much the way one might expect. For example, two-parent families are more likely to use parental care when another parent is working, and single-parent families are more likely to use relatives for child care (Boushey 2003). Families that have more children are more likely to use home-based child care arrangements, such as family child care (FCC) homes and family, friends, and neighbor (FFN) care than families with fewer children (Burstein and Layzer 2007; Chaudry 2004). The *age of a child* is very strongly associated with the type of child care parents use, with informal and home-based care arrangements used more often for infants and toddlers, and formal center-based care used more often during the preschool years starting around age 3 (Burstein and Layzer 2007; Kim and Fram 2009; Rose and Elicker 2008).

Key indicators of *family's socioeconomic status and resources,* such as parents' level of education and family income, have also been associated with the type of child care arrangements that families use. A higher level of parental education (and particularly mothers' level of educational attainment) is associated with greater use of center-based care (Kim and Fram 2009; Wolfe and Scrivner 2004). Higher-income families are observed to use more expensive types of care, such as formal center-based care (Blau 2001; Kimmel 2006). As family income rises, families make greater use of center-based care (Michalopoulos and Robins 2002).

In addition, significant research has focused on the variation in type of care by *race*

and ethnicity. In this area, some research shows that relative and home-based care may be influenced by cultural practices and beliefs among particular ethnic groups (Caldera and Hart 2004). Other research has questioned this association, suggesting instead that observed differences may result from community and institutional factors more than race and ethnicity itself (Huston, Change, and Gennetian 2002; Liang, Fuller, and Singer 2000).

There has been less research on how immigrant status may affect parents' child care preferences, options, and decisions. Some recent research has begun to examine the type of child care arrangements used by immigrant families, many of whom are also English language learners. For example, Matthews and Jang (2007) find that immigrant families, particularly those from large Latino populations, often struggle to find child care, and that these families, as well as the community-based organizations that serve them, are often unaware of child care options in their community, particularly more formal early care and education programs. Other studies have found similar difficulties for other immigrant families, including African and South Asian immigrants (Adams and McDaniel 2009; Obeng 2007).

The substantial challenges that many immigrant families face when seeking child care services in low-income urban communities have also been found for other types of social services. Rawlings, Turner, and Popkin (2007) suggest that legal, linguistic, and cultural barriers often contribute to these challenges. Possibly as a result of these challenges coupled with a lack of sufficient information, children of immigrants, compared with children of U.S.-born parents, are more likely to be in their parents' care at the earliest ages and less likely to attend formal preschool at ages 3 and 4 (Brandon 2004; Fortuny, Hernandez, and Chaudry 2010; Matthews and Jang 2007).

The effects of immigrant status on child care use may be difficult to separate from other family characteristics. Immigrant families with children are more likely to be low income (associated with lower rates of center-based care), to have lower levels of parental education (also associated with lower rates of center-based care), to be two-parent families (associated with greater use of parental care), and to have more children (associated with greater use of home-based care arrangements).

A family's native language and culture, particularly the presence of *English language learners* in the family, also play a role in child care decisionmaking. Although linguistic isolation (i.e., households where no one over age 13 speaks English exclusively or very well) and limited English proficiency often overlap with immigrant status, some families experience language and cultural barriers rather than legal barriers. An increasing number of people in the United States speak a home language other than English (Shin and Kominski 2010), including not only immigrants but native-born U.S. citizens and Puerto Rican-born U.S. citizens who migrate to the mainland.

Non-English speakers are more likely to use informal care arrangements than formal arrangements, such as center-based programs, for their children (Fram and Kim 2008; Hirschberg et al. 2005; Ishizawa 2006). Although some parents may prefer informal care arrangements for the sake of convenience or cost, or may value relative care for personal or cultural reasons, parents who do desire more formal care arrangements but have limited English proficiency may experience difficulties when navigating the child care search process. A fundamental obstacle for many ELL parents may be filling out necessary paperwork and communicating

with program staff about available services and the enrollment process, especially when services and resources are available in English only.

Addressing the language barrier requires creating language access plans that acknowledge the need to translate documents, use interpreters, and integrate cultural mediators (Matthews and Jang 2007). Moreover, some ELL parents may not have the opportunity to choose formal child care arrangements because they have limited knowledge of or experience with them.

In some cases, families may choose a child care provider based on their native language to facilitate ease of communication and cultural understanding as well as to provide consistency of language for the child. According to the 2001 National Household Education Survey, when a child has at least one parent who speaks a non-English language, the odds of having a non-English-speaking care provider are more than four times that of a child who does not have non-English-speaking parents (Ishizawa 2006).

However, some research indicates that parents of ELL children seek early care and education opportunities for their children specifically to help them learn English from native speakers to prepare for school (Obeng 2007). Liang, Fuller, and Singer (2000) find that parents exhibit a lower selection rate of center-based care when Spanish is spoken at home, but that Latino parents who demonstrate a more intense interest in having their children learn cooperative skills, like sharing, are more likely to select center care as a means to acculturate.

One focus in this study is how *child health and special needs* factor into parents' child care decisionmaking. This study defines special needs broadly to include physical, developmental, and behavioral needs, with particular emphasis on those needs that

parents identify as factoring into how they consider the child care they use for their child.

Some research has focused on the unique child care needs of children with special needs and health problems and their experiences in care. Parents of children with special needs face additional constraints and may require particularly complex caregiving arrangements (Parish and Cloud 2006; Zigler and Lang 1991). They consistently report having a more difficult time finding child care providers with the specific training, qualifications, and capabilities necessary to care for children with special needs or specific health concerns (DeVore and Bowers 2006; Rosenzweig et al. 2008). The limited availability of developmentally appropriate, affordable care in families' communities further restricts their choices.

Perhaps due to these difficulties, parents of children with special needs are more likely to seek informal care arrangements, such as relative care, than center-based care or other formal arrangements (DeVore and Bowers 2006). Booth-LaForce and Kelly (2004) find that children with special needs and other developmental risk factors enter center-based child care at later ages and spend less time in care, on average, than children without special needs or developmental delays. Families cite finding good-quality care and integration with other services as problems they face when trying to find care for a child with special needs (Booth-LaForce and Kelly 2004; Chaudry 2004).

Community Contexts and Families' Child Care Choices

Child care decisions are also being made within the broader context of parental employment and the local child care market, which may further facilitate or constrain parents' choices. Below we describe some of the research regarding the key contextual

areas of parental employment contexts and child care market contexts (including local child care supply, information, and policies), which form the focus of this study.

Families make child care decisions within various *employment contexts*. Families' child care needs and, subsequently, their decisions are shaped by whether and when they work. Low-income working parents face several challenges related to work schedules, including a greater likelihood to have part-time work, nontraditional hours, and fluctuating schedules (e.g., temporary, contingent, or irregular employment). Single mothers and low wage-earning mothers are more likely to work nontraditional hours and to have frequently shifting schedules (Heymann 2000; Hofferth 1995; Kisker et al. 1991; Presser 2003). More than a third of low-income mothers work nights and/or weekends. Mothers from very low income families are twice as likely to work seasonal jobs, to experience frequent job changes, and to work jobs with changing shifts (Presser 1995, 2003). Finding care can be especially problematic for low-income working families and families in which one or both parents work nonstandard hours (Henly and Lambert 2005; Presser 2003; Shlay et al. 2005; Snyder and Adelman 2004). All these employment realities can affect families' ability to use child care, as certain options may not match their scheduling needs.

The instability of many low-wage jobs is another important factor influencing low-income working parents' child care choices. Turnover rates are very high among populations that tend to work in low-wage jobs, such as lesser educated workers, younger and lower-skilled workers who are parents with young children, single mothers, and current or former public assistance recipients (Acs and Loprest 2001, 2007; Ahituv and Lerman 2004; Chaudry and Hawkins forthcoming; Holzer and LaLonde 1999). In

addition, job instability is high in the occupations that dominate many low-wage sectors (Holzer and LaLonde 1999; Lambert 2008; Newman 1999).

These complex employment choices for low-income families translate into limitations on child care choices (Henly and Lambert 2005). Parents must factor into their decisionmaking the relative alignment and sensitivity of their community's child care options to their employment constraints . Relatively few child care centers offer care during nights and weekends, so mothers working these hours are most likely to rely exclusively on fathers, relatives, or informal home-based care providers, or to use these options in addition to center-based care (Emlen 1997; Hofferth 1999; Smith 2002). Further, most Head Start programs and state prekindergarten initiatives are part-day and part-year, which may limit their use by working families.

However, some programs are trying to be more responsive to the needs of working parents. These efforts have taken several forms—for example, developing service models that provide care for the full workday, funding extended-day or "wraparound" care services, or collaborating with community-based child care programs that provide full workday services (Schumacher et al. 2005). These efforts have mostly focused on providing child care options for parents with full-time working schedules. Much less attention has been given to the needs of parents working nonstandard hours or those who experience significant employment instability (Henly and Lambert 2005; Presser 2003).

We are unable to examine low-income working families' decisions about child care without accounting for the *early childhood care and education context* within communities. This includes the *supply of child care options* within their communities. Low-income communities

tend to have fewer regulated child care providers than higher-income communities (Collins, Layzer, and Kreader 2004; Lee et al. 2004). Among families in the National Study of Child Care for Low-Income Families that opted to use in-home family child care, nearly a third indicated that they did not have any other alternative (Layzer and Goodson 2006).

Supply factors can thus shape child care preferences and use (Matthews and Jang 2007; Meyers and Jordan 2006). For example, Matthews and Jang (2007) suggest that immigrants' underenrollment in center-based care is likely partially attributable to an insufficient supply of affordable, high-quality child care in immigrant communities and not a preference for relative care alone. Similarly, a limited supply of providers trained to care for children with health or special needs makes finding appropriate child care challenging for these families.

The amount of *information about available child care options* that low-income working families have can also shape their child care decisionmaking. Lack of awareness and knowledge of local child care supply and how to navigate the child care subsidy system is common among low-income families (Layzer and Goodson 2006; Meyers, Heintze, and Wolf 1999; Shlay et al. 2002; Snyder, Bernstein, and Koralek 2006). Further, there is very little overall coordinated information available for families to learn about child care options. As a result, most families rely on neighbors, relatives, and coworkers as their primary source of information about potential child care arrangements (Hofferth et al. 1998; Layzer and Goodson 2006).

The high cost of many child care options puts some care out of the reach of some working families. However, *publicly funded early care and education resources* can help defray the costs of child care or provide free care. The federal Child Care and Development Fund subsidy program, the Head Start program, and state prekindergarten programs all expand access to care and widen the array of available care for families that would not be able to afford the actual cost of that care. However, even when taken together, these programs are not yet funded to meet all or much of the potential demand for these services.

In its most recent report to Congress, the Administration for Children and Families (ACF) estimates that 12 million children receive out-of-home care each year, and 1.6 million of those children received CCDF subsidies in 2008. Clearly, CCDF benefits a great number of American children and families, but those 1.6 million children represent a small fraction of those eligible to receive a subsidy. ACF estimates that only 12 percent of children eligible under federal law (i.e., families with incomes below 85 percent of the state median income) received child care assistance in 1999 (the last year for which data are available) (Greenberg 2007). The number of families receiving subsidized care could rise because of increased funding through the American Recovery and Reinvestment Act (ARRA) of 2009. However, states have been using those funds to improve the quality of care and to offer additional services to parents, and it is unclear at this time how much of that funding, if any, is being used to provide additional subsidies to low-income families (CCDF 2007).

In addition, significant variation in state funding, eligibility requirements, and the organization and administration of subsidies produce differing policies and practices throughout the country (Roach et al. 2002). As a result, families in some states have more options and greater purchasing power than do families in other states (Adams, Snyder, and Sandfort 2002; Piecyk, Collins, and Kreader 1999).

Access to subsidies influences the type of care that families use. In particular, access to

subsidies is correlated with higher use of center-based care (Anderson et al. 2003; Coley, Chase-Lansdale, and Li-Grining 2001; Raikes, Raikes, and Wilcox 2005; Shlay et al. 2002). Studies have offered different explanations for this result, and the directionality and causality of the relationship has been debated. There may be greater financial incentives to seek subsidies for center care. In addition, families already using center care may be more likely to apply for subsidies to assist with the high costs, and center staff may play a role in educating families on their options and encouraging families to apply for assistance (Burstein and Layzer 2007; Layzer and Burstein 2005). A family's co-payment depends on its household income and family size, and not the type of care it uses; therefore, since families pay the same regardless of the setting, they may select center-based care that is typically more expensive.

The design of state prekindergarten and Head Start programs also influences how many families enroll their children in these programs. In particular, eligibility criteria (e.g., child age, income level) and program hours affect families' choices (Johansen, Leibowitz, and Waite 1996). Half-day programs often do not meet the needs of full-time working families (Adams and McDaniel 2009). Even when families meet eligibility criteria, they often face waiting lists or a lack of available slots given limited program funding.

Research Gaps Addressed by This Study

The child care decisionmaking process is complex, involving multiple factors with varying influence on parents. The process is also dynamic and subject to frequent reconsideration and renegotiation as parents adapt their preferences to changing opportunities and constraints. Parents' child care decisions are made amid a complex interplay of many family factors and within intricate contexts that parents confront when managing the multiple demands of paid work and caregiving over time.

Although we are learning more about these issues, child care researchers and policymakers continue to struggle with understanding the process that parents go through when making care choices. We currently do not know enough about the options that parents believe they have access to, the constraints they perceive in their choices, the factors that facilitate or support their decisions, and how they then select their care arrangements. Relatively little research has examined the interactions between the broad array of child, parental, household, and community factors that families combine in their thinking when making child care choices, or how these interactions affect the choices of different groups of low-income families. Moreover, it is unclear what strategies may be implemented to support families in making the care arrangements they need. This study will begin to address these research gaps.

Research Methods

Site Selection

Given this study's emphasis on low-income working families, we selected sites with socioeconomic and demographic profiles that would allow us to examine the child care choices of low-income families and immigrants. When making our site selection, we looked to the Annie E. Casey Foundation's Making Connections initiative, a community improvement program located in 10 low-income urban communities across the country. Among the 10 Making Connections communities, those in Providence, Rhode

Island, and Seattle-White Center, Washington, were among the best suited for our study as both sites are home to a high concentration of low-income households and immigrant populations. As part of the Making Connections initiative, approximately 800 respondents were surveyed in each site using random-digit dial interviews. The survey yielded information on a wide range of questions. In 2006, before we conducted our study, 85 percent of the Making Connections respondents in Providence reported incomes at or below 200 percent of the federal poverty level (FPL), while 63 percent of Making Connections respondents in Seattle-White Center reported the same. In addition, in 2006, more than half of all Making Connections respondents in both sites were not U.S. citizens (i.e., were legal permanent residents, refugees, or other noncitizens): 59 percent in Providence and 54 percent in Seattle.

In Providence, our study centered around three Making Connections neighborhoods in the city: Elmwood, South Providence, and West End. These areas have been home to a diverse range of families and local businesses, and they have been immigrant-receiving neighborhoods for decades. While Dominicans—both U.S.-born and foreign-born—are among the more recent arrivals to these neighborhoods, the city has been home to immigrants from Latin America and Asia as well. The strength of the local economy relies heavily on manufacturing and warehousing, and these neighborhoods were particularly affected by the recession during the last two years. We also interviewed a small number of respondents who lived in other Providence neighborhoods or near Providence, such as the city of Cranston.

In Seattle, we focused on White Center, an unincorporated community in King County. It is south of downtown Seattle and home to families from many different backgrounds, including immigrants and refugees from

around the world (Asia, Latin America, Africa, and Eastern Europe). Local businesses abound, and dozens of languages can be heard in the neighborhood. Community members work in the area as well as other parts of King County. We also interviewed a small number of respondents who lived in nearby neighborhoods, including the cities of Seattle and Burien. Further information about the two study communities is included in appendix A of this report.

Sample

We began recruiting participants for our study from the pool of respondents from the Making Connections survey with the assistance of the National Opinion Research Center (NORC), which administers and maintains the survey. To qualify for participation, families needed to have a household income of no more than 250 percent of FPL, work at least 20 hours a week, and have a non–school-age child (under age 5) in nonparental child care at the time of recruitment. NORC identified 19 families from the Making Connections survey sample that met our study criteria, that NORC could locate, and that expressed interest in being part of the study.

In addition, we collaborated with the local Making Connections partner organizations as well as other key community-based organizations, all of which interact regularly with the range of families we were hoping to interview, and sought their assistance to recruit families. We also employed snowball sampling whereby we supplied a recruitment flyer with a toll-free phone number to local programs and participating families that they could provide to eligible families interested in participating in the study. This approach led us to 26 additional families. The final sample included 86 families: 43 in Providence and 43 in Seattle.

Study Components

The study included two primary research components, a *family study* and a *community study*, with the greater emphasis of our research efforts and the results reported here on the former. The family study included two rounds of in-depth qualitative interviews with selected parents in the two study communities in order to understand their child care choices. The first round of interviews was completed in the fall and winter of 2008–09, and the second round was conducted approximately one year later at the end of 2009.

A team of Urban Institute researchers conducted the interviews, which were approximately 90 minutes in length and conducted in English, Spanish, or in English with a translator when parents spoke a language other than English or Spanish. The data collection team consisted of eight field researchers who were trained by the principal investigator over several weeks on qualitative interviewing and conducted pilot interviews using the draft interview instrument before data collection in the study sites. Three of the four lead interviewers were bilingual English and Spanish speakers and conducted all the Spanish-language family study interviews. In all but 11 cases, interviews (most often with two members of the data collection team present, but sometimes with one) were conducted in families' homes; the other interviews were held in community centers, public libraries, and other neighborhood locations that parents preferred for their interviews.

Respondents were informed about the purpose of the study, the confidentiality of the interviews, the data security plan in place to ensure their anonymity, and the potential benefits and limited risks of participating in the study. Researchers asked for permission to tape the interviews using an audio recorder, and researchers also took notes during the interviews. Researchers used their notes and audio recordings to complete targeted transcriptions, which included key data points as well as qualitative narrative fields. Parents received $50 per interview as an incentive payment.

The in-depth semistructured qualitative interviews with parents, built on methods from a previous qualitative study of child care choices (Chaudry 2004), gathered information on families' child care arrangements and employment (the protocols used for interviews with families are included in appendix C of this report). We asked families to describe the child care decisions they made for a particular focal child in the family. For most families, the focal child was the youngest in the family; in 20 families, this was also the only child in the family. In three cases, the second-youngest child in the family was chosen as the focal child because the youngest child was a very young infant who had not been in child care.

The first interview focused more specifically on family characteristics, employment situations, and child care arrangements and preferences. The second interview was informed by the results of the first round of family interview data and findings from the community study (discussed in the next section). It focused additional attention on the child care decisionmaking factors and how parents weighed different factors, their perspectives on the supply of child care options in their community, their satisfaction with their current provider, their social networks within their neighborhood, and their participation in public programs. Researchers asked additional questions during interviews with immigrant families, ELL families, and families with children with health or other special needs.

In addition to the family study, the research team gathered data as part of the

community study to explore the local contexts in which families lived and worked. This component consisted of nearly 40 interviews with experts and stakeholders in early childhood care and education in the communities, including subsidy administrators, local early childhood and child care experts, employers and experts on local employment, child care providers, public agency case workers, and other local informants. We interviewed these key informants regarding several discussion topics, including local employment dynamics, child care supply, child care information sources, child care and public benefit program policies, neighborhood characteristics, and how these factors affect families' child care decisions. The interviews explored many contextual factors that parents identified during the family interviews, with a particular focus on understanding how these factors affect the choices of particular subgroups in the family study sample.

Data collection for the community study occurred between the two rounds of the family study in summer and early fall 2009. It built on the initial data collected during the first round of the family study and informed the protocol for the second round.

Analytic Approach and Descriptive Characteristics

We analyzed the family characteristics and decisionmaking process separately for each study site and then across sites for the total sample. Table 1.1 provides some descriptive characteristics of our family study participants. The sample includes children fairly well distributed across the age range of birth to age four, with more infants and toddlers in Washington (median = 24.5 months) and more older children in Rhode Island (median = 34 months).

Table 1.1 Characteristics of the Family Study Sample at Initial Interview

Respondent or focal child characteristic	Providence (*n* = 43)		Seattle (*n* = 43)		Total (N = 86)	
	n	%	*n*	%	*n*	%
Focal child age (in years)						
< 1	5	12	9	21	14	16
1	9	21	17	40	26	30
2	11	26	7	16	18	21
3	12	28	6	14	18	21
4	6	14	4	9	10	23
Single-parent household	25	58	16	37	41	48
Extended household	11	26	12	28	23	27
Foreign-born	26	60	26	60	52	60
English language learner	20	47	20	47	40	47
Latino	36	84	13	30	49	57
Special-needs child	15	35	8	19	23	26
Parent worked nonstandard hours[a]	24	56	28	65	52	60
Subsidy user	14	33	19	44	33	38

a. Nonstandard hours are defined as beyond Monday through Friday 8:00 a.m. to 6:00 p.m.

Participating families in both communities included two-parent and single-parent households. Single- and two-parent households were distributed relatively equally for the total sample; however, Providence had a larger share of single-parent households than Seattle. Three families were coded as single-parent households even though the parents were married, as the father resided in another country and was not a consistent part of the household. Approximately a quarter of families (23 of 86) in the sample lived in an extended household (i.e., at least one extended relative, such as a grandparent or cousin, lived with focal family in the same apartment or home at the time of the interview).

In most cases (73), the respondent was the mother, which included 41 single mothers and 32 mothers in two-parent households. In two cases, the father was interviewed in two-parent households; in 11 cases, the focal child's mother and father in two-parent families were interviewed together. None of the respondents were single fathers, noncustodial parents, or grandparents.

Respondents' race-ethnicity, in some respects, reflected the profile of the two sites. In Providence, Latinos made up 36 of the 43 families in the sample; Dominicans accounted for roughly half the Latino families, with the remainder from Central America or South America. In addition, many Latinos were nonimmigrants, including seven from Puerto Rico in the Providence sample. In Seattle, Latinos, primarily Mexicans, were also the largest ethnic group, representing 13 of the 43 families. There were also seven Asian and seven African respondents. Among all parents interviewed, three in five were born outside the United States and almost half were ELLs. About a quarter had a child with a health or special need, and more than a third received a child care subsidy.

Child Care Characteristics

Families in both Providence and Seattle used various child care arrangements for their young children. We defined a child care arrangement as nonparental care provided for a child within either the child's home, the caregiver's home, or another care setting. First, we examined all current nonparental care arrangements regardless of the frequency or duration (e.g., full-day, full-week center-based care; morning care provided for several hours a week by a babysitter; weekend care provided by an older sibling), and categorized arrangements as primary, secondary, or intermittent. *Primary care arrangements* were regular arrangements during parents' work hours characterized by relatively consistent schedules. *Secondary arrangements* were additional regular arrangements used to "wrap around" a primary care arrangement when the primary arrangements' hours did not match the parent's work schedule. Conversely, *intermittent care arrangements* were more irregular (i.e., "once in a while" or "as needed") and often used as periodic backup care when parents' needed additional assistance. Besides being needed to support parental work, nonparental child care was also used for socialization (e.g., children spending one evening a week with grandparents) and caregiving relief (e.g., parents needing a break from caretaking to run errands). However, the findings presented in this chapter relate to the regular child care arrangements that parents used when they were working or in school.

After identifying families' regular care arrangements, we examined the descriptive characteristics of the care arrangements, including the amount of total time spent in care each week, the number of arrangements used, and the type of care provider. The key characteristics we found include these four:

- Individual families varied greatly in their use of child care. Across the two sites,

children spent an average of 36.5 hours a week (standard deviation [*SD*] = 13.1) in nonparental care, ranging from 3 hours a week in a multi-age transitional preschool program to 62 hours a week in a family child care program plus evening relative care. Two out of five focal children were in child care more than 45 hours a week.

- Twenty-four (or 28 percent of) families across the two sites used more than one child care arrangement. In Providence, 65 percent of families relied regularly on a single child care arrangement, and 35 percent used two regular child care arrangements. In Seattle, 79 percent relied regularly on a single child care arrangement, 19 percent relied on two regular child care arrangements, and one family reported using four regular arrangements (specifically, relatives and a family friend who would take turns providing care each week).

- Children who had more than one regular arrangement were on average older than children who had only one regular arrangement (36 months versus 24.5 months). Consequently, while children spent approximately the same total number of hours in child care regardless of age, preschool-age children generally spent fewer hours in each care arrangement, thus experiencing more transitions between caregivers each day.

- Across the two sites, children had spent a median of 9 months (mean [*M*] = 12; *SD* = 11) in their current primary arrangement. Focal children in Rhode Island had spent longer in their current primary arrangement at the time of the first interview than had the children in Washington (median = 12 and 6 months, respectively).

Families used a range of child care arrangements and caregivers. We categorized these arrangements into four categories:

- *Informal relative care* included care arrangements provided by a family member in the child's home or the relative's home. These caregivers were primarily children's grandmothers and aunts who, in some cases, lived in the same household.

- *Informal nonrelative care* included arrangements where caregivers were family friends, neighbors, or babysitters who were not related to the focal children and watched them in either their own homes or the child's home with no other nonrelated children present.

- *Family child care* arrangements, for our purposes, included both licensed and unlicensed providers who offered child care in their homes; these providers differed from informal nonrelative care in that they served multiple children from different families and provided these services as an intended ongoing business. Because it was not always clear from the parent interviews which care arrangements were licensed family child care providers and which were unlicensed neighbors who provided care for children in their homes, all home-based group care settings were combined.

- *Center-based care* included all child care arrangements that were not provided within a home setting. These included private child care centers, Head Start centers, and publicly funded prekindergarten programs.

Tables 1.2 and 1.3 show the number of total arrangements used by families in each study site categorized by arrangement type. Since 24 families used more than one arrangement (23 had two arrangements and 1 had four), the table reflects the total number of arrangements, not families. However, the following bullets describe both the number of each type of arrangement and the number of families that used it.

Table 1.2 Regular Child Care Arrangements Used in Providence, by Child's Age

Focal child age (years)	Informal relative care	Informal nonrelative care	Family child care	Center-based care	Total
< 1	3	0	2	1	6
1	4	1	4	2	11
2	6	1	6	0	13
3	7	0	5	7	19
4	1	0	2	6	9
Total	21	2	19	16	58

Table 1.3 Regular Child Care Arrangements Used in Seattle, by Child's Age

Focal child age (years)	Informal relative care	Informal nonrelative care	Family child care	Center-based care	Total
< 1	7	1	1	0	9
1	9	2	4	6	21
2	5	0	2	2	9
3	1	2	4	2	9
4	2	0	1	3	6
Total	24	5	12	13	54

- Informal relative care was the most frequently used type of child care arrangement, accounting for 45 of the 112 (or 40 percent of) total arrangements across the two sites. Forty-two (49 percent) of the 86 families in the study used relative care; 64 percent of those 42 families used only relative care, while the other 36 percent used relative care in addition to another arrangement.
- Family child care was the second most commonly used type of arrangement, accounting for 31 (28 percent of) total arrangements, with a greater number of family child care arrangements in Providence than in Seattle. Thirty families across the two sites used family child care, with one family using two family child care providers.
- Center-based care accounted for 29 (26 percent of) total arrangements; 13 families used Head Start, 15 families used private center-based child care, and 1 family used a public prekindergarten program. Two of

these families used both Head Start and center-based child care.
- Informal nonrelative care was used the least by study families, accounting for seven arrangements (6 percent of total arrangements) for seven families.
- More than three in five families that had a second arrangement used informal relative care for the secondary arrangement (the rest used combinations of Head Start and other center-based care or family child care) as Head Start programs were only half-day and did not cover the hours of care needed by full-time working parents. Relatives often provided early morning, evening, and weekend care as well as transportation to and from other care arrangements, such as family child care or center-based programs.
- Although fewer children were age 3 and older in Washington than in Rhode Island, preschool-age children in both sites were more often enrolled in family care child or center-based care, with informal relative

care as a secondary arrangement. Infants and toddlers, on the other hand, were more often in informal relative care or family child care as their only arrangement.

The overall pattern of findings initially suggests either a parental preference for relative care and family child care or a greater availability and affordability of these types of arrangements versus center-based care. The variation in arrangements by child age also suggests constraints on parents' use of center-based care for young infants based on a lack of availability or affordability, and/or a difference in parental preference by child age. Infants, who typically require more hands-on caregiving, are more often in home-based settings, while preschool-age children, who are learning and developing school-readiness skills, are more often in center-based care. These patterns of child care use are similar to national statistics that show higher use of informal relative care than center-based care for children under age 5 but increasing use of center-based options as children age (Overturf Johnson 2005). We explore these factors and others that influence parents' choice of care arrangement in subsequent chapters.

Strengths and Limitations of Research Approach

The research team collected qualitative data and captured key characteristics by respondent and household. Qualitative data are well suited to examine how and why families make child care decisions for several important reasons. First, speaking directly with families yields valuable insights into the context in which they select child care. Second, in-depth interviews have the flexibility to capture details that might otherwise be lost in a large survey. Such details provide an opportunity to closely

understand and conceptualize a range of decisions, from a parent who carefully weighs competing options to another parent making difficult decisions with very limited time and information. Finally, rather than collect and analyze quantitative data that might help explain some families' decisions, qualitative interviews explicitly elicit individual families' views about child care and allow respondents to describe how child care fits into their day-to-day lives.

Qualitative data also provide valuable insight into otherwise identical outcomes. For example, two families that share many similar characteristics may arrive at the same child care decision for markedly different reasons. Likewise, two families that appear to share little in common may select divergent arrangements because of unique constraints or opportunities rather than differences in their preferences or family background. In sum, interview data afford an opportunity to understand how families view their options and the process deciding about child care.

Qualitative data collected for the family study also have limitations. First, while the research team relied on a range of sources and interviewed families that varied by type of job, child care arrangements, previous child care search experience, household composition, and other characteristics, we only interviewed 86 respondents across two cities, and our sample is not representative of either site.

Second, although families are the best source of information about their day-to-day routines and how they balance work and child care, parents do not necessarily have complete and accurate information about the range of child care options. Respondents did not relay a uniform familiarity with their neighborhood or nearby resources. When analyzing interview data, the research team balanced the value and limitations of parents' own perceptions—which varied in accuracy—

with the findings of the community study regarding the actual supply of care options. Therefore, while there were limitations to parents' responses, we used them to our benefit to identify a mismatch between parent perceptions of what is available and the actual supply.

Finally, families are understandably hesitant to criticize their own child care decisions, especially regarding their current care arrangements. A parent's decision regarding where to send his or her young child for child care is entwined with beliefs about parenting. It would not be surprising if parents reported a degree of contentment with a current arrangement that exceeds their actual satisfaction. However, although some respondents may have concealed their true feelings, many respondents were candid about what they did not like about their child's current care arrangement. Some parents even relayed how they learned from previous experiences and described—in great detail during some interviews—what they would do differently if circumstances changed.

Organization of the Report

As previously stated, the central purpose of this study is to examine the child care arrangements that low-income working families use and the factors that facilitate or constrain parents' decisions regarding child care. In the chapters to follow, we present the findings from our investigation of these issues in our two study sites. In chapter 2, we discuss the themes we identified regarding parental care preferences, or what parents view as important to them for their children's care, and the factors that influenced their care decisions. In chapters 3 and 4, respectively, we discuss the influence of the employment context and early care and education context in each site on families' child care decisions. Subsequently, chapters 5, 6, and 7 break down the findings for the three particular subgroups of interest in this study: parents who are immigrants, parents who are English language learners, and parents of children with special needs.

CHAPTER 2: PARENTAL PREFERENCES FOR CHILD CARE AND THE FACTORS THAT INFLUENCE THEIR CHOICES

Working parents with young children use various child care arrangements to meet their needs. As shown in chapter 1, home-based arrangements such as informal relative care and family child care were the most commonly used among our study participants, while approximately one in three parents used center-based care. Central to our research study was the question: Why do families use the type(s) of child care that they do? According to the conceptual framework for parental child care decisionmaking (Weber 2011), a mix of factors including parent and child characteristics, parental preferences for particular care characteristics, parents' employment context, care opportunities or the available supply of child care in the community, and barriers and constraints (e.g., cost, transportation) play a role in parents' decisions regarding child care. One of our goals was to closely examine the factors that influence parental child care decisionmaking among a diverse group of low-income parents to better understand how parental preferences for care interact with particular constraints within the context of parental employment and the available supply of child care. In this chapter, we discuss our findings regarding parents' stated preferences for particular child care characteristics and the factors that ultimately influenced their child care choices.

Methods

During the first parent interview, respondents were asked about their reasons for selecting their current child care arrangement(s). Interviewers probed as needed to fully capture the details of parents' preferences, options, constraints, and decisions. The questions included these six:

1. What do you look for when choosing a child care arrangement? What is most important to you?
2. If you could choose any kind of child care arrangement for your child, what would it be?
3. What do you consider to be the good things about your child's current primary care arrangement? Are there things you do not like about your child's current primary care arrangement?
4. How did your current child care arrangement come about? Why did you end up making this care arrangement? How did you learn about this provider?
5. Did you consider any other options at the time you made this decision? What were they? Why did you choose this one (and not the other options)?
6. Were you satisfied about the options you had? Is there something else you wanted that you were not able to find/arrange?

Using the open-ended responses to these items, we first conducted a qualitative data analysis using NVivo 8 software to code

similar themes that appeared across our interviews. When coding, we looked for the key characteristics that respondents said they looked for or valued, or that they liked about their current care arrangement. In some cases, respondents' discussions of their prior care arrangements also led to a conclusion about what is important to them. Seventeen parental preferences were identified through this qualitative analysis (table 2.1). We looked at the overall patterns of preferences for the whole sample and then for differences between the two study sites. The 17 preferences can be grouped in four categories: characteristics of care setting, caregiver characteristics, availability and accessibility of provider, and affordability of care.

Table 2.1 Parental Preferences for Child Care by Site and for Total Sample

Parental preferences	Providence (*n* = 43)		Seattle (*n* = 43)		Total sample (*N* = 86)	
	n	*%*	*n*	*%*	*n*	*%*
Characteristics of care setting: environment, activities, and services						
Activities and learning opportunities	30	70	23	48	53	61
Nutritious meals/ethnic foods	19	44	8	18	27	31
Health and cleanliness	12	28	13	30	25	29
Socialization with peers	11	26	6	14	17	20
Small group size and individualized attention	10	23	6	14	16	19
Separation of age groups	3	7	3	7	6	7
Serving multiple age groups	2	5	3	7	5	6
Support services for children and families	3	7	2	5	5	6
Caregiver characteristics: relationships and qualifications						
Sensitive caregiving and positive relationships	21	49	24	56	45	52
Safe and trustworthy provider	21	49	21	49	42	49
Bilingual or native speaker	23	53	14	33	37	43
Relatives as caregivers	15	35	13	30	28	33
Experienced/educated caregiver	10	23	4	9	14	16
Licensed provider	3	7	2	5	5	6
Availability and accessibility of provider						
Convenient or flexible schedule	8	19	15	35	23	27
Proximity or transportation provided	6	14	10	23	16	19
Affordability of care						
Affordability of care	7	16	6	14	13	15

We then conducted a second content analysis of parents' responses (primarily interview questions 4–6 above) to create a list of decision factors that appeared most prominent among families. Each family was then coded for these factors that contributed to their current care arrangement(s). Responses from additional questions were referenced as needed to understand each respondent's unique situation and what influenced her to choose the care arrangement that she did. This process involved significant discussion among project team members to pinpoint the underlying and determining factors that played a role in parents' ultimate decisions. As a result of the content analysis, we identified 16 common factors across the participating families (table 2.2). These 16 factors aligned quite closely with parents' stated preferences for care with each falling into one of the four categories. Additionally, three factors emerged that related to previous experience with child care for the focal child, a sibling child, or the respondent.

Table 2.2 Factors That Influence Families' Child Care Decisions by Site and for Total Sample

Decision factors	Providence (n = 43)		Seattle (n = 43)		Total sample (N = 86)	
	n	%	n	%	n	%
Characteristics of care setting: environment, activities, and services						
Physical environment	8	19	6	14	14	16
Activities and learning opportunities	8	19	4	9	12	14
Language used in care setting	3	7	3	7	6	7
Socialization with peers	2	5	3	7	5	6
Nutritious meals/ethnic foods	5	12	0	0	5	6
Caregiver characteristics: relationships and social networks						
Relatives as caregivers	15	35	13	30	28	33
Positive relationship with caregiver	10	23	15	35	25	29
Safe and trustworthy provider	7	16	10	23	17	20
Availability and accessibility of provider						
Convenience of location, transportation	15	35	20	47	35	41
Hours of care availability	6	14	16	37	22	26
Parents' work schedule flexibility	5	12	11	26	16	19
Affordability of care						
Cost of care	13	30	17	40	30	35
Child care subsidies	10	23	5	12	15	17
Previous experience with child care						
Previous experience of sibling	14	33	8	19	22	26
Previous experience of focal child	8	19	2	5	10	12
Previous experience of parent as a child	2	5	4	9	6	7

Not surprisingly, parental preferences often played a leading role in parents' child care choices. Many parents described the care characteristics they liked about their current arrangement as reasons for selecting it. For example, several parents selected a provider because, among other things, they spoke the same language.

However, in many cases, the ultimate decision factor(s) did not align with parents' stated preferences. In other words, some parents selected an arrangement for reasons other than a particular preference for that type of care. In some cases, particular barriers or constraints prevented families from accessing the care they desired or preferred. For instance, several families described liking the learning opportunities offered in center-based care but could not afford the cost. As a result, they selected a care arrangement such as relative care or family child care because those providers were more affordable (with cost of care the driving decision factor). In addition, some parents described their preferences in terms of a solution to a current barrier. For example, parents stated that the schedule or availability of the provider was important to their decision because they had difficulties finding child care that met their work hours. The interactions between these various factors illustrate some of the complexity of child care decisionmaking and form the foundation for our discussion of findings in the proceeding chapters.

Parent Preferences and Decision Factors: What Parents Consider When Selecting Child Care

In this section, we further detail each care characteristic that parents communicated as important to them and how strongly each preference guided, informed, or shaped parents' decisions when selecting child care. We use the four categories of themes (characteristics of care setting, caregiver characteristics, provider availability and accessibility, and affordability of care) to help organize our discussion. Within each category, we present the themes in descending order of frequency with which they were described by participants.

Characteristics of Care Setting: Environment, Activities, and Services

Parents valued the quality of the child care setting as demonstrated by their desire for a variety of specific care characteristics. Parents in our study discussed aspects of the physical care environment (such as health and cleanliness), the activities and services provided (including the provision of nutritious or cultural-specific meals), and the group structure (such as small group sizes and separation of age groups). These various components were described by parents as ideal elements of the child care experience. Eight consistent themes fall under this category of characteristics of the care setting.

Activities and learning opportunities

- Most parents (61 percent) stressed the importance of opportunities for learning in child care and often stated that they wanted child care to have an educational component in order to prepare their children for school. In addition, ELL families stressed the importance of learning English in child care. However, only 12 families (14 percent) stated that they selected their current care arrangement because it provided learning activities, including opportunities to learn English.

Parents across both sites reported that one of the most important things to them in the ideal child care setting was that their children would learn. Parents viewed child care as an

opportunity for learning and a place where children would be exposed to new things that parents at home could not teach them or did not have time to teach them. Several parents who discussed education mentioned their desire for their children to be engaged in a structured activity (e.g., reading, coloring, playing outside) and not placed in front of a television all day. Gloria, the mother of a 3-year-old girl in center-based care in Providence, described how her work schedule did not allow her the time to teach her child important skills, and that she desired a child care program that could compensate for this:

> *I'd rather send her somewhere close that's in a community type of day care … And, you know, what they teach the kids day to day. She learns a lot. She knows her ABCs. She can count to about 20. And this is all at 2 years old. She just turned 3 so it's good … She knows a lot. She really does, and I think it is because of the day care. I mean I could've saved money, kept her home. But I want her to learn now, you know. So, that's why she's there. I mean, it costs money, but—but I think it's better for her.*

This theme was expressed more frequently by parents of toddlers and preschoolers than by parents of infants. However, some parents of younger children also described the importance of enrolling children in a more structured academic program once they were of a particular age and needed language and social stimulation. For example, Zola said:

> *Eighteen months is good to put 'em into a center. Where they can start playing with other kids out of the home, they can get out of a house … and learn how to be in an environment with other kids, go outside, you know. They're exploring at that age, you know what I mean? They wanna learn, and it's good at that age when you can teach them there. They read to them, you know,*

> *they see all those toys—you know what I mean, they pick up a lot at that age. I think at that age, it's good for them to go for a center.*

Although many ELL families stressed the importance of protecting their children's native language skills (as described later in the Bilingual or Native Speaker section), approximately one in three ELL parents mentioned wanting their children to learn English in child care in order to prepare them for school. This was true for children of all ages; even parents of infants and toddlers described the importance of their children (eventually) learning English. As Vanesa, a Latina mother of an 18-month-old, described, "We all speak English, but when we're together we speak Spanish .… Once you go to a day care, I feel, you could learn English, because you're gonna go over English in school."

Provision of nutritious meals and ethnic foods

- Thirty-one percent of parents described the type and quality of foods served within the child care setting as important preferences. Yet, only five families (6 percent) discussed the provision of food as a factor in their decision and, specifically, their desire for the provider to feed their children food of a particular culture or ethnicity, or a certain level of quality.

Many parents we interviewed considered the provision of nutritious meals or particular ethnic foods from their culture as very important in the ideal child care setting. Having providers serve breakfast and lunch relieved some stress on parents whose busy morning schedules did not allow them the time to prepare meals for their children. Some parents mentioned Head Start in the context of wanting their children to be exposed to more nutritious foods than they usually got at home and to learn about making healthy food choices. Several parents offered stories of past child care experiences where their children

were not fed properly, which undoubtedly contributed to their concern about nutrition.

For example, Faye said one time she went into her 4-year-old son's child care center during breakfast and became very upset because the bagel her son was given was stale and hard.

> *I picked it up and I could have thrown it through the window and broke it. How would they feed their children—would they feed themselves this? My thing is—it may not be but that's how I'm feeling—they're inner-city children so just give it to them. I mean that's how I feel, and it's kind of insulting. Or they're just kids—they don't know. And I brought it to administrator and said "Here you go. This is the food you're feeding the children." So I guess they stopped giving bagels.*

Parents also expressed particular views regarding what their children should eat based on cultural backgrounds and preferences. For example, Vanesa, a U.S.-born mother of Dominican descent, decided to use her sister for child care after experiencing a series of unsatisfying providers, stating:

> *When I was looking for the babysitter, I was looking for somebody Spanish, I was. But more because of the culture. If I want to take her to an American one, they probably would have given her mashed potatoes or macaroni and cheese. While if I take her to a Spanish place, I know she was gonna eat rice and beans and, you know, chicken chopped up.*

Gladys, a mother from Trinidad who used family child care for her toddler, offered a contrasting viewpoint:

> *Do they provide snacks, do they provide meals, what are you offering them? Is this a Spanish day care, where it's just rice and a piece of chicken every day? You know, what exactly are you offering the children?*

Health and cleanliness of care environment

- Nearly 30 percent of parents described their ideal child care setting as a healthy and clean space. Fourteen families (16 percent) mentioned that the physical environment of the setting factored significantly in their decision, including health, cleanliness, and the licensing regulations of the setting.

Many parents expressed the importance of the physical environment of the child care setting, in particular the cleanliness of the space to promote healthy development. This was particularly important to parents with younger children who are "always putting things in their mouths." Parents expressed concern over the fact that child care settings are often not cleaned properly to stop the spread of germs, causing children to get sick more often and resulting in parents having to take time off work. Erika, an African American mother who used center-based care, said, "You take them to school and they're coming home with the flu and pink eye and all kind of rashes coming out of nowhere. Some schools have problems with lice."

Ola, a white mother from Seattle, expressed some distrust of the cleanliness of child care settings in relation to caring for children: "I saw these videos of places where right before the parents showed up they would hurry up and change all the diapers. They'd be having dirty diapers lying around and dirty bathrooms."

Diana described issues related to safety regulations, including cleanliness. She wanted "somebody that didn't have too many kids, somebody that I can like rely on and like I can go in and see that it's decent in here, it's clean, make sure she has like places they can take naps at."

Besides wanting a clean and healthy environment, Zola, a Puerto Rican mother in Providence, desired a setting that would instill healthy habits in her child: "teach them

values that they learn at home, like hand-washing."

Socialization with peers

- One in five parents described how they valued the opportunity for social interactions with peers in child care, as it was viewed as important for their development and school readiness. Six percent of families explicitly described choosing their current arrangement because it provided opportunities for children to socialize with peers.

Parents described the ideal child care setting as a place where children would have the opportunity to socialize with peers, learn to play with other children, and make friends. As Rosaline said, "The ideal thing would be a safe place, you know, some place that they could learn, that they could grow, that, you know, that they're loved and they have friends." Families recognized the importance of their children being in settings with other children and the development of social skills and positive behavior as pertinent for school readiness. Yosef, a father who expressed satisfaction in his daughter's Head Start program, stated, "I wanted her to learn discipline … and teach her how to interact with other people." In contrast, Suchin used relative care and described her child's need for peer socialization:

> Yeah, it is nice, but he doesn't get around a lot of other kids… He didn't know how to play with other kids for a while. All he wanted to do was hug and kiss everyone, and the other kids would push him away. He didn't know because that's what he would do with us .... He didn't know for the longest time.

Small group size and individualized attention

- One in five parents described their preference for a care setting with a small group size where their children would receive more individualized attention. No parent explicitly discussed selecting their current care arrangement for this reason; instead, parents

identified instances where this was a problem with their current child care.

Parents in both sites specifically mentioned their concerns over group size or adult-to-child ratio. In particular, parents expressed their preference for programs with fewer children where their children would receive more one-on-one attention. Duong, a Vietnamese father, explained, "I think if they're taking care [of] more kids, they have more people… one person taking care [of] a lot of kids, I don't think they can do a good job for every single one." Tonya, a mother of a young toddler in family child care, described her ideal arrangement as a center-based environment but with few children, because in large child care centers "there are too many children so they don't give sufficient attention to all."

Several of these parents thought most child care programs were too crowded with children and that teachers did not really know the children because there were so many of them. The majority (14 of 16) who commented on group size or ratio had children who were under age 3, indicating the stated importance of small groups and more individualized attention for infants and toddlers. For example, Uma, a mother of a 1-year-old in center-based care, described the importance of ratio to her: "The ratio was like 7:1 [in this one center], and that was a bit much for this age …. And where she's at it's a 4:1, so I know they're actually able to take care of them all and not get overwhelmed and frustrated."

Separation of age groups

- A small number of parents (7 percent) preferred a child care setting where their children were separated by age groups; however, this factor did not play a significantly stated role in any parent's decision.

In addition to wanting small group sizes for their children, parents described wanting a child care arrangement in which all children

were the same age or in which children were separated by age group. This was discussed primarily with families using family child care who commented on preferring the division of classroom space in center-based programs where infants, toddlers, preschoolers, and school-age children are generally separated. Tonya, whose young toddler was in family child care, noted, "It pains me with her, because there are bigger kids. It would have to be a place where they only accept kids of the same age, so that they don't share everything." Similarly, Vera, who had a bad previous experience with a family child care program, discussed her future plans to enroll her child in a center-based program where the children were separated into groups with peers their own age.

They have a lot of people for different sections, depending on their ages. And they dedicate time to all the children … because of that I don't want to bring them to a home care, because they are all together there.

Serving of multiple age groups

- Several parents expressed their preference for a child care program or provider who served children of different ages; however, this factor did not play a significant role in any parent's decision.

Parents with more than one child described the difficulty of finding arrangements all their children could attend, regardless of age (i.e., infants through school-age children). This preference was not exactly the opposite of the previously mentioned preference for separation of age groups, since center-based programs that divide children into different age groups may also be able to serve multiple age groups within the larger program. For example, Ola, a mother of five children ranging from 2 through 12 years old, preferred family child care where all her children could attend, including her school-age children after school. She explained,

Another big problem that I've seen is that there are a lot of day cares in the White Center area, but they only service little kids like up to 2, but I'm not going to go to three different day cares for all my kids. That's silly.

Support services for children and families

- Six percent of parents preferred child care settings that offered early intervention or support services. Parents with children with special needs often selected their arrangement to meet their children's needs.

Early intervention services within the child care setting were viewed as important for parents, particularly those with children with special needs (as described in more detail in chapter 7). Paloma, a recent Mexican immigrant whose child was receiving speech therapy through Head Start, appreciated the program and hoped that her child would be able to stay in it the following year. She wanted her daughter to go to Head Start "so that she may surround herself with other children and they can teach her to speak more." Two other mothers also discussed Head Start services for their special-needs children and thought a setting like that, where teachers were understanding and patient and provided therapy services, would be beneficial. One mother also described wanted a setting with specialized equipment for children with disabilities.

Sonja, a Latina mother from Providence, appreciated the parent training workshops offered at her daughter's transitional preschool program, which brought in lawyers, nutritionists, family planning experts, domestic violence workers, and others to talk with parents. She also said she liked having a social worker come to her home for visits and to work with her child to promote positive development.

Caregiver Characteristics: Relationships and Qualifications

Most of parents' comments about what was important to them related to the caregiver's characteristics. The personality and trustworthiness of caregivers, and their ability to care for children properly, were mentioned more often than providers' qualifications, such as education, years of experience, licensing, and background clearance.

Sensitive caregiving and positive relationships

- Almost half of parents expressed a preference for a caregiver who was sensitive to their child's needs and had a good relationship with them and their child. Twenty-nine percent of respondents specifically chose their care arrangement because of the positive relationship they or the focal children had with the caregivers, who were generally their friends or neighbors who had family child care programs.

Parents across the two sites stressed the importance of having a warm, caring, and nurturing caregiver who treated their children well and loved their children. They viewed positive relationships with their caregiver as essential. Inez, a mother from the Dominican Republic, stated that one of the most important things for her was "the way they are treated, because children, well, they go on absorbing this in their development… if they receive love, well this is also going to protect and shape their character." Qualities such as patience and attentiveness were frequently mentioned.

Several parents expressed the idea of having a caregiver who was not "in it for the money" but who saw her child care services as a profession and was dedicated to the care of young children. Inez used family child care, was satisfied with her providers, and described the arrangement this way:

> For us as parents, it is important to know that the person has a vocation for this. The lady that takes care of Ibrahim, we know

> that she likes this, that she likes to work with children, so for that reason, it is very important. There are some people who are only interested in the money.

Several parents (approximately one in ten) also mentioned that direct and open communication with the providers was very important to them. While the provider's relationship with the child was very important, parents also wanted a good relationship with the provider, in which they felt the provider would come to them to communicate issues about their children and update them on their well-being. Kate, a white mother who used family child care for her infant, specifically stated that she liked getting an update on her child when she picked her up at the end of the day and an occasional e-mail to inform her about what was going on. She explained that the way a provider spoke and talked to parents reflected "how she is going to deal with the kids." Lupe, a mother of a special-needs child, also stated that it was important to her that caregivers took her directions without getting mad. "When someone gives instructions, it bothers them. I would like them to take into account what I say and how I would like them to attend to my baby."

Safe and trustworthy provider

- One in two parents described their preference for a caregiver they could trust with the safety of their children. One in five respondents specifically selected their current arrangement because they trusted the caregiver.

The safety of the care environment was an important theme across respondents. Surprisingly, few parents who discussed the safety of the environment mentioned specific safety precautions, such as locking cabinets containing poisonous items, covering electrical outlets, and blocking stairwells. Instead, most parents discussing this preference described wanting a setting where

their children would be supervised properly and be safe from abuse and neglect.

Parents who discussed safety issues also often mentioned the issue of trust. These parents described how they wanted someone with whom they felt comfortable leaving their children, knowing that they would be well cared for, safe, and "in good hands." While some families specifically referred to family members being more trustworthy, almost half of parents in both sites expressed a general need to be able to trust their children's caregivers regardless of setting. Several parents described being able to tell if a provider was good and trustworthy by how their children responded to the provider. The idea of trust was explained in different ways, but ultimately represented parents' feeling of comfort—that they liked the provider, had a trusting relationship with her, and did not worry about their children being in her care.

Hazel discussed how she searched for a licensed family child care provider after taking on a second job and needing additional care. Trust was very important in her decision:

I check out every provider first. I check out their scene if I like it. I give them a chance. I ask my kids. My oldest kids tell me everything. And I see what they do. I build a relationship with them to know what kind of people they are and who lives in the family. And eventually you know when something wrong is happening and when something good is happening.

Several parents referred to a program they had seen on television about children being abused in child care. Kim stated, "I've seen them on TV. They let these people come in to the day care, without checking IDs. They had these people who were criminals working in the day care, so you have to cautious." A few parents even stated their fear of their children being molested, particularly in family child care settings where unknown adults may be left to supervise children. Querida, an immigrant mother, said she would rather stay home and not work than put her son in a care arrangement with someone who seemed unsafe, because of seeing abuse cases on television. "You see many cases on television about children who are left with other people and are abused and hit. And, in reality, for my children, I don't want any of this. For that, I prefer not to leave them with people I don't know." Another mother even mentioned wanting security cameras to monitor children's safety.

Udele's childhood experience with abuse shaped what she looked for in a child care provider.

It's important to me to find somewhere my children are not going to be abused, to be hit, to be treated right. And I know kids can be difficult, but you know what—you have to hold yourself back. Just because I've been through so much I don't want them [to go through] …. Nothing would hurt me more than I leave them somewhere and then something happens with abuse, be it physical, emotional, or sexual.

Bilingual or native speaker

- Forty-three percent of parents said they preferred a caregiver who was bilingual or who spoke their native non-English language. Just six ELL respondents (7 percent of all families) described choosing their current arrangement because the provider spoke their native language or had the same cultural background.

A common theme for many families across both sites was the language of the child care provider or the language used in the child care program. This was particularly important to families whose primary language was not English (see chapter 6 for a more detailed discussion of ELL families). Several parents who were not comfortable with their own English skills preferred having a provider who could speak their language so they could communicate more easily. Other parents

expressed a strong desire for their children to learn their native language, to preserve the language skills they already had and not lose them as they learned English. For example, Oliveira, a native of Puerto Rico, stated, "My family speaks English and Spanish, I wouldn't want a day care that was only one." Some parents expressed concerns about children losing their cultural identities if they did not speak their families' native language, and thus, preferred a provider who could reinforce their language and culture. Several parents also mentioned planning to return to their home country and wanting their children to know the language.

Two families in Providence specifically mentioned the idea of having a provider with a similar cultural background. Raisa, an immigrant mother from Guatemala, described her preference for a provider with her cultural background instead of the local providers she found, who were all Dominican: "There is a day care right close to here, but they are Dominican, so the accent we have is different, and food and accent are important to me."

Additionally, a few native English speakers also expressed an interest in their children learning a foreign language. Kim, who learned Spanish for her job in a health clinic, expressed the need for her child to learn another language for future employment. "Most of the jobs nowadays is Spanish. All the positions now they have to be Spanish, or bilingual. And it's hard because they're not really offering any English positions."

Relatives as caregivers

- One in three parents preferred having a relative provide child care for their children; the same proportion ultimately selected their current arrangement because of their desire to have a relative as a caregiver.

The importance of relative care was a consistent theme across families. Many parents described their preference to have a relative—most often the child's grandmother or aunt—care for their child. This preference and choice seemed to go beyond affordability, convenience, language, and culture (which are captured by other factors), and genuinely related to parents' value of family, causing them to think primarily or only in those terms when making a care decision. One parent stated:

> *Family members are probably the best option …. I don't believe that it's a good environment to have a kid in a place where somebody doesn't have a personal interest in them. I, I just think it messes up our whole society, the fact that we do child care. I think it should all be in the family's hands 'cause otherwise the kid could be with people that really don't love 'em.*

Family members were seen as the most trustworthy, sharing the same cultural beliefs about childrearing, and being able to love and care for the child better than a "stranger." The value of having family as caregivers was most evident among parents with infants and toddlers; about 80 percent of parents who expressed this idea had children younger than 3 years old.

Experienced and educated caregiver

- Approximately one in six parents described the ideal caregiver as having previous experience working with children and/or being educated or trained in teaching young children; however, the experience and education of the caregiver did not factor significantly into parents' decisions.

The experience and education of the caregiver were considered important characteristics of a child care arrangement. This theme was more often discussed by parents of preschool-age children than by parents of infants or toddlers (two-thirds had children over 3 years old). Parents believed that children started to learn more at that age to prepare for school and should have more qualified providers. Accordingly, more families in the Providence

site described the qualifications of the provider than in the Seattle site, since children in that sample were on average older than the total sample across sites.

One of the few fathers in the sample listed the qualities of child care that were important to him, including "trained staff, trained in something other than just watching your kids, you know, so some specialized training or advanced degrees." Faye, a U.S.-born mother who selected center-based care for her 4-year-old, stated that her ideal care arrangement "would have teachers with experience that know what they're doing and plan and get the most out of their day." Hazel, whose aunt cared for her children, complained that her aunt did not do enough educational activities with her children and said that she preferred a caregiver with more training.

> *She's my aunt, and because of family relation sometimes she doesn't do the proper things, I guess .… [she was treating them] as if they were relatives and I wasn't agreeing with that. I thought that if she was getting paid for something that she should do more. And just because they're her nephews or whatever she didn't feel like she had the obligation any more to show them ABCs or do something curriculum with them.*

Licensed provider

- Five parents preferred child care providers who were licensed and, as a result, selected licensed providers.

In addition to the broader interest mentioned for providers who had particular educational credentials or experience, a handful of parents mentioned wanting a licensed program for their children. For example, Oliveira stated, "I wouldn't leave them with someone unlicensed, would you leave your kids in unlicensed care? You don't know who's there .… License is security." Hazel had noticed that the licensing system had improved the quality of care by encouraging

providers to include educational programming or lose their license.

Some parents said that licensing meant that programs would be up to safety standards and regulations. Erika described feeling more comfortable using center-base care over family child care for her 2-year-old daughter since the center did background checks on their staff. She said this about family child care: "There are a lot of them that are not as clean, and they have a lot of family members, like, bouncing around, family members who help out who aren't really certified to take care of kids." She also felt that"[unlicensed child care workers] may not have that patience and knowledge that a person that is certified does" and that having family members just casually fill in opens the door to molestation and other problems.

Licensing seemed most important to families who used or discussed using family child care, where the possibility of children coming into contact with unknown visitors was seen as greater. This theme also relates to the parental preference for safe and trustworthy caregivers.

Provider Availability and Accessibility

Besides discussing the actual qualities of the program and the provider, many parents described the logistics involved in arranging child care, such as the hours of availability and access to the location, as essential details in their child care decisions.

Convenient or flexible schedule

- Twenty-six percent of families explicitly described selecting a particular arrangement because of the provider's convenient and flexible hours or operation or availability; 19 percent of families selected providers who were flexible in accommodating parents' work schedules.

Many parents described experiences in which providers would only care for their children

for a limited number of hours each day. In general, these parents needed child care for longer hours and at more flexible times of the day. Most of these parents worked shifts that ended later in the evening or that varied week to week, and they had previously found it difficult to find child care available during those hours. In general, the days and hours providers were available or open for business determined many families' child care options (as described in greater detail in chapter 3).

As one parent explained, "I don't like their hours. Nobody has a typical 9–5 job. Nobody raising two kids anyways isn't gonna just do 9 to 5." Honor, who used family child care for her 2-year-old daughter Ivy, described her struggles with the provider's schedule: "I think they should be a little flexible sometime. Not everybody can make it for 5:30, and not every parent has somebody who can go pick up their kids." Several other parents discussed not being able to use formal care arrangements because they would not be able to make the pickup times and did not have anyone to pick up their children.

Several parents mentioned that, ideally, more child care programs should be open 24 hours a day, 7 days a week. Oliveira, a home medical aid who worked night and weekend shifts, used family child care for her 19-month-old and other four children. She described the challenges she had faced in finding flexible care arrangements and that this was critical to her employment situation:

There's no day cares that are open those hours. They're like, "Well that's not our concern. It's being able to work." You're supposed to be able to work any hours they offer you for your job. Well, there needs to be more day cares that have longer hours.

At least one parent in each site considered the half-day afternoon session of their child's Head Start program too short and recommended that it be at least 9:00 a.m. to 3:00 p.m.—more like school hours—so the children could learn more. Yosef described, "In my dream world, I'd want [my child] to be in Head Start, but it would be all day," while Paloma said, "I would like it if it were more hours, if it were normal like the kids that go to school." Instead, these parents had to rely on informal care to help with child care in the morning while they worked.

Bill had an arrangement with a flexible schedule and described it this way:

It's convenient because sometimes I have to go into work earlier or I have to stay later and I don't have to worry about her telling me "Well, I'm closing" or charging more. We don't have to worry about that.

Proximity or transportation provided

- About one in five parents described their preference for a child care arrangement that was located near their home or workplace, accessible via public transportation, or provided transportation. More than twice as many parents (40 percent across both sites) mentioned that they chose their current care arrangement for one of these reasons or because the location was convenient in another manner, such as resident grandparents in multigenerational households caring for children while parents worked.

The proximity of the child care provider was a strong preference for low-income working parents and a key factor in their child care choices. Some parents said they preferred that the provider be close to their home, and others said they wanted child care near their place of employment. Radhwa, a Somali mother who worked full time for the City of Seattle as a case manager for public housing residents, stated that her ideal child care would be located in the same building as her office, where she could have lunch with her children. However, this was not an option; instead, her child was enrolled in a half-day Head Start program in the afternoon, and her aunt provided child care in the morning before Head Start.

Parents also mentioned transportation and scheduling pickup as an issue, or that they wanted either public transportation available nearby or transportation provided by the provider, such as Head Start buses or family child care providers who would pick up and drop off children. Ana, a Dominican mother whose son participated in a morning Head Start program, and her husband worried a lot about their schedule and picking up their two young children from child care. She said ideally there would be some type of transportation service where someone would be in charge of dropping children off at their homes "so that parents have one less thing to worry about." Some parents who had more than one arrangement, such as half-day Head Start followed by half-day family child care, expressed a desire for a provider who could pick up their children from school.

Affordability of Care

- Fifteen percent of families stated that their ideal child care arrangement would be affordable or have "good rates." Although many parents expressed in some way the high costs associated with child care, 35 percent explicitly chose their current arrangement because it was more affordable than their alternative options.

The high cost of child care was a common theme among families. Many described not being able to afford their ideal arrangement, such as center-based care, and not qualifying for child care subsidies or Head Start (see chapter 4 for more details). The majority (10 of 13) of families who specifically stated the importance of affordable care options had children under age 3. A few pointed out that child care was more expensive for younger children, which made the situation even more difficult. Hernanda, a Mexican immigrant mother with a 14-month-old child, who relied on her mother-in-law for child care, stated she would like early childhood programs such as Head Start to be offered for younger children

and for child care centers to not charge so much. "I wanted to let them go much younger [to a center] if they didn't charge so much … the younger children cost more." This mother was unaware of child care subsidies. By the second round of interviews for this project, this child had entered Head Start after being placed on the waiting list.

Bill also liked the idea of Head Start. But, he explained, his family made too much to qualify for such public programs, yet they still could not afford private child care for their almost-2-year-old:

> *A lot of the programs around here—you know it's only for real low income kids …. Most of the time we fall into the category where we don't qualify for any of the services but we don't really make enough money where we can have extra money to pay for something.*

Consequently, they relied on the child's grandparents for child care.

Suchin, who wanted but could not afford center-based care for her child, expressed enthusiasm about the free state-funded prekindergarten program in her area for which her 3-year-old would soon be eligible. "It would actually be wonderful because nothing is coming out of pocket whether it is through the school system or state funded or whatever." Although no respondents explicitly stated the age at which they believed programs should be publicly funded, a general theme among respondents was that care for more children should be affordable, and that child care subsidies and "school" programs for children (e.g., Head Start, prekindergarten) should be more available to families in terms of additional enrollment slots and higher income limits.

Previous Care Experiences

In addition to themes previously summarized that related to various care characteristics,

parents' previous experiences with child care played a large role in their decisionmaking. Thirty-eight respondents, including more than half of the Providence respondents and about a third of the Seattle respondents, described their previous child care experiences as a factor in their choice of care for the focal child. Twenty-two parents discussed their experiences with child care for the focal child's sibling(s) as a factor, and 10 mentioned the focal child's own prior care arrangements. Further, a handful of parents discussed their own care experiences as children as a salient factor in their choices.

For example, one respondent who chose her own mother to care for her child stated:

I guess that it's familiar. It's my mom, somebody I love and I trust. I like the idea that my daughter gets a little bit of the same experience that I got. There's a sharing of that experience so when she's older she might remember, "Oh, when Gran would do this …" and I'd be able to relate because I could remember when Gran did that with me or just different things being a kid.

Previous experiences with child care were both negative and positive. Some parents described previous cases of abuse or a poor provider that influenced them to select their current arrangement. For example, Milagros, a Salvadorian mother whose child had been abused by a babysitter, had decided to enroll in Head Start and use her sister-in-law for child care. She viewed those two arrangements were safer for her child.

Because many things happened with my children. Before, they didn't treat them well, and my children always have suffered. Because when I used to work during the day, a babysitter cared for them for me and only when they were little, they were really little. My son was just starting to talk and he told me, "She is not treating me well, Mommy. The babysitter was hitting me yesterday."

Other parents said they had positive experiences with a care provider or type of care for another child that influenced them to use the same arrangement for the focal child. Parents whose own care experiences influenced their decision often selected their parents (most often the focal child's grandmother) as caregivers for their children based on their positive childhood experiences being cared for within the home. Immigrant families also reflected on their childhood experiences growing up in the another country and on how these experiences influenced the type of care they received, which is described in more detail in chapter 5.

Alignment of Preferences and Decisionmaking Factors: What Are the Barriers for Families?

Through our analyses, we found significant overlap but also some differences between the themes that parents raised regarding their preferences for child care and the factors that actually influenced their child care choices. Characteristics of the care setting and of the caregiver, as well as the availability, accessibility, and affordability of the provider, were described as important to parents, and parents often made decisions based on these issues. However, whether certain preferences informed their decisions, or were characteristics of their current arrangement, also varied as often as they aligned. Although our coding of families' responses may not have captured precisely whether a preference was a decision factor for the same respondent, and the themes for preferences were not perfectly aligned with the themes for factors, the patterns across the sample nevertheless indicate some strong general variations

between what is important to parents and what led them to make their decisions.

In general, logistical considerations—such as the convenience of the location of the care setting and transportation, the cost of care, and the availability and hours of care—were driving factors for many families' decisions because of constraints that parents faced, not because they were associated with what parents wanted for their children's care. Characteristics of the care setting and the caregiver were most often described as important to parents but were generally less important factors in their decisions—or did not play a significant role at all.

The most significant example was that of parents' preference for activities and learning opportunities within their child care setting. This theme was the most evident in many parents' stated preferences, but a considerably smaller number of parents described opportunities for learning as a significant reason for selecting their current arrangement. While important to parents, learning opportunities often became secondary to finding an available arrangement that met their work schedules and that they could afford.

As Grace, a white mother from Seattle who chose family child care for her infant daughter, captured it,

> *The main thing is to find somebody with the hours that you need, the days that you need, a place that you can call in an emergency, that you can afford, and it's sad that you've gotta choose your day care by a place that you can afford, but that's kinda what we went through, what hours are going to work, who's going to be close.*

While convenient and flexible schedules were generally described together as a preference, the availability and flexibility of providers appeared as two separate themes in parents' decisions. Both served as important decision factors for many families. Parents described how they searched for and selected providers who were open for business or were available (in the case of informal providers) when they needed child care. As described in greater detail in chapter 3, other parents selected their providers because they offered flexibility in relation to the parents' job schedules. This was most evident among parents working nonstandard or shifting hours. Relatedly, some parents also discussed difficulties accessing the type of care that they desired because of age restrictions, waiting lists, or toilet training requirements they could not meet. They often settled for alternative arrangements because of the lack of availability of child care or other barriers to access. Chapter 4 addresses availability and access within the context of the early childhood programs available in the study communities.

Affordability of care was another prominent theme across families. Parents preferred affordable care options, and about half of both the Providence and the Seattle families discussed affordability as a significant factor in their care decision, particularly for infants. Many of these respondents described the high costs of private child care and being unable to afford this option. Affordability was a factor for nearly two-thirds of respondents with children under 2 years old in the sample as a whole, but only for about a quarter of the respondents with children age 3 and older.

Center-based care for infants was described as more difficult to find, and those programs were often described as too expensive for families. Head Start and publicly funded prekindergarten programs were described as attractive options for parents but were generally limited to preschoolers. Families that either did not know about public programs, such as Head Start and child care subsidies, or did not qualify for these programs often chose their

current arrangement because they could not afford something else.

For example, Suchin described how the high costs of center-based care influenced her decision to select informal relative care for her toddler and young infant. Although she preferred center care, she decided she could not use it given the difference in price:

No, [I don't use center-based care] just because I work part time and the other thing is too that it's so expensive. And if I put him in day care it would kind of just take away my checks. So what's the point in working? It just didn't work, and with my mom working second shift we really didn't have to. Our hands weren't tied like he has to go to day care. So at least we have help between my mother and my mother-in-law. We decided that financially it wasn't worth it and we didn't have to.

In both sites, parents were more likely to discuss child care costs as a factor in their decisions (35 percent overall) than they were to cite the availability (or lack thereof) of a child care subsidy (17 percent overall). Subsidy use is discussed in greater detail in chapter 4 on the early childhood context, but about 34 percent of respondents were using a child care subsidy at their first interview. Families who mentioned the availability of subsidies as a factor included current subsidy users as well as former users who had difficulties with obtaining or retaining their subsidies. Specifically, some families mentioned that they wanted to avoid repeating past experiences in which problems during recertification or a change in employment or education status had caused them to lose their subsidies, forcing them to change from one child care arrangement to another.

Udele, a mother in Providence who used a family child care provider, described how a subsidy had allowed her to use her current arrangement, which she otherwise could not afford. However, the situation left her concerned about the insecurity that came with needing something for her child's care that might easily be lost, especially given talks of cutbacks in the state's child care program and eligibility rules:

If they do cut it, if you think about it, if I was to pay for my kids to be in day care full time, they charge about a hundred and something each. So that would be my whole paycheck just to pay the day care. Makes no sense. Might as well not work and get on welfare, which is not an option for me, but if there wasn't a subsidy I wouldn't have any options, I mean, what would I do? I can't pay three hundred and something dollars a week for day care.

Lastly, the theme of relatives as caregivers was expressed by about a third of the sample and was a decision factor for the same number of families. Most parents who preferred relative care also used it. As noted in chapter 1, informal relative care was the most frequently used type of child care arrangement, with nearly half of families in the study using relatives for at least one care arrangement. More families used relative care than those who explicitly described it as a preference, which suggests that in some cases relatives were selected for other reasons, such as being more convenient, affordable, and flexible.

Parental Preferences and High-Quality Child Care

The characteristics of child care that parents most often discussed align in many ways with what is generally accepted as high-quality child care in the early childhood field. More than half of parents described the importance of a sensitive caregiver who had a good relationship with their children and cared well for their children. However, relatively fewer parents mentioned the importance of

having a licensed provider or a provider educated or trained to work with young children—two components considered critical for high-quality care. Many families said they wanted to have a bilingual caregiver or a caregiver who spoke their child's native language, in the case of immigrant families or families with a non-English home language. This characteristic was often the result of foreign-born parents' lack of English proficiency and their need to communicate to the provider in their native language. Yet it also reflected parents' desire for their children to learn their native language before (or as) they learn English. Interestingly, a few native English-speaking parents also expressed their interest in their children learning a foreign language in addition to English. Sensitive caregiving and addressing children's culture and home language within child care are two priority areas for research and practice (Bromer et al. 2010; Office of Head Start 2010).

Although more than half of parents mentioned opportunities for learning, few parents described specific learning experiences or activities. Most descriptions were brief and direct (such as "I want a place where my child can learn") or focused on school-readiness skills, such as learning the alphabet, colors, and numbers. Although a few parents mentioned the importance of scheduled activities, such as reading and art, none mentioned the importance of having a curriculum or activities that promote the development of different skills (e.g., language, literacy, numeracy). Moreover, only a few discussed the physical learning environment beyond cleanliness, safety, and presence of toys, going into such factors as the division of space (e.g., space for infants to crawl and climb) and the types of materials (e.g., books, games, puzzles, dolls, etc.). Some of this lack of detail may reflect the length and limitations of the parent interviews. Yet while these findings indicate that a number of parents

understand what "high-quality" child care means, they also suggest that some parents may not be aware of the importance of key factors that early childhood program standards consider important, such as provider qualifications and experience, socialization with peers, and the exposure to a safe and healthy learning environment (see National Association for the Education of Young Children 2005; National Association for Family Child Care and the National Family Child Care Accreditation Project 2005).

Summary and Conclusions

Our goal in this chapter was to examine what factors most directly influence parents' decisions regarding the child care they select for their children. Looking at the current care arrangements of 86 families, and exploring with them how and why they made these care arrangements, this chapter identifies what parents' preferences for child care were and what key factors most influenced their care decisions. It was possible to explore and describe with qualitative detail the parents' decisionmaking process for their child care choices, as well as what parents thought about their care choices, and the constraints they face in making care arrangements.

The findings reveal some of the complexities that low-income working families face when arranging care for their young children that meets both their needs and their preferences. Parents generally viewed child care as an opportunity for children to learn and socialize with peers, and they considered the best providers those who were caring and trustworthy and who spoke their language. Over a third of parents preferred having a family member provide child care—often because they did not trust anyone outside the family with their children or thought a relative could provide better care than a stranger. In other cases, families

discussed the importance of having convenient and affordable care, with an ideal arrangement being close to work or home and either free or subsidized. In addition to language, the theme of culture was quite evident, such that families desired a caregiver who shared their culture and who provided cultural-specific food for their children. Some parents also preferred small group sizes with children separated by ages as well as providers who served children of multiple ages.

In this chapter, we integrate analysis of what factors most influenced parents' decisions when arranging their current care with what parents stated as their preferences for child care choices. This integration offers important new insights and depth to the existing understanding of child care decisionmaking. Many families selected arrangements that aligned with their preferences, but others faced barriers in the affordability of care, accessibility to transportation, availability of care hours, and flexibility in relation to their work schedules. Parents' stated preferences for child care were not always apparent in their choices for care, and the care characteristics described as most important were not always strong factors in parents' decisions. Most significant, opportunities for learning were very important to parents, yet the presence of learning activities was a secondary factor in their actual care decisions, typically considered after the cost, schedule, and flexibility of the provider.

This discrepancy highlights the complexity of understanding the child care choices of low-income working families, which are often ultimately shaped by a narrow set of factors applied to an often narrower set of available options because of the contexts in which they make their care decisions. The contexts for child care decisions will be discussed in further detail in the subsequent two chapters. We will then discuss these factors in relation to the decisionmaking process for specific subpopulations of interest, such as immigrant families, English language learners, and families with children with special needs.

CHAPTER 3: LOW-INCOME WORKING FAMILIES' EMPLOYMENT CONTEXTS

Child care decisions and parents' choices about work are closely tied as "paired decisions." The general nature and exacting particulars of low-income parents' jobs (including low wage levels, limited benefits, irregular schedules, job instability, and limited flexibility) often tightly constrain the already-limited child care options available to them. For this reason, it is important to closely examine the employment contexts of low-income working families to help frame and understand their child care choices and decisionmaking.

In this chapter, we explain how parents' employment contexts shape, constrain, and (in some cases) facilitate how they choose child care and the characteristics of the care they use. First, we describe the employment contexts of parents in the study sample. Next, we discuss the most frequently reported challenges that these employment contexts pose for child care decisions. Finally, we analyze patterns across the sample to explore how these employment challenges affect parents' child care choices.

Employment Contexts for Families in the Study Sites

Across the study sites, the most prominent jobs and sectors in which parents worked reflected the jobs found in the low-wage labor markets in general, and within these two local economies in particular. The most frequent job grouping in the study sample was administrative and paraprofessional service

positions in education, health, and social services. Thirty-four of the 86 respondents worked in this broad category, including nursing assistants at health centers, medical assistants in doctor's offices, teacher's aides in schools, and family workers in Head Start centers, among others. Another 16 respondents worked in services; the most common jobs were cleaning services for homes or offices, but this group also included three hairdressers, a landscaper, and spa worker.

The other major job categories included factory work, office or sales work for large businesses or corporations, retail work, and small businesses/self-employment, with at least 10 percent of the sample working in each area. Some jobs were more common among respondents in one site than the other. For example, just about half of Seattle parents worked in health, education, and social services, while manufacturing work was more common in Providence.

Wage Levels and Incomes

Families in the two sites were remarkably similar in both wage levels and family incomes (table 3.1). Parents' median wage level was $10.50 an hour in Providence and $10.25 an hour in Seattle (the average hourly wage of the parents we interviewed was approximately $11.50 across the two sites).[1] In both sites, most parents worked full time, though nearly a third in Seattle worked part-time hours while just over a tenth of parents in Providence did. Very few, it turned out,

were working multiple jobs at the same time—only one parent in Providence and five in Seattle. The average work schedule was 35 hours a week in Providence, 31 hours a week in Seattle, and 33 hours a week overall. Thus, the average working parent across the two sites was working just under a full-time, 40-hour work week and making a little less than $400 a week. If a parent were to do this year round, his or her annual income would be approximately $20,000.[2]

Table 3.1 Employment Characteristics of the Study Sample (at time of initial interview)

	Providence (*n* = 43)	Seattle (*n* = 43)	Total (*N* = 86)
Median hourly wage	$10.50	$10.25	$10.50
Average hourly wage	$11.38	$11.55	$11.47
Worked multiple jobs	1 (2%)	5 (12%)	6 (7%)
Average total weekly work hours	35	31	33
Worked part time (less than 30 hours a week)	6 (14%)	14 (33%)	20 (23%)
Worked standard hours (within M–F 8 a.m.–6 p.m.)	19 (44%)	15 (35%)	34 (40%)
Worked nonstandard hours	24 (56%)	28 (65%)	52 (60%)
Worked evenings/nights regularly	10 (23%)	10 (23%)	20 (23%)
Worked weekends regularly	5 (12%)	11 (26%)	16 (19%)
Worked variable/changing shifts	12 (28%)	11 (26%)	23 (27%)
Any paid time off (vacation and/or sick leave)	24 (56%)	13 (30%)	37 (43%)
Any employment benefits (health insurance, 401(K), etc.)	16 (37%)	8 (19%)	24 (28%)

Employer Benefits

Most parents were in jobs that allowed them no paid time off, vacation time, or sick leave. Only 37 of the 86 were in jobs that had some paid time off in the form of sick leave and/or vacation time, which varied from three paid days off annually to three full weeks that could be used flexibly for vacation, illness, or caring for a sick child. The parents in Providence were nearly twice as likely to be in jobs that came with some paid time off as those in Seattle.

Forty-nine of the 86 working parents received no vacation time or sick leave from their jobs. These parents had the least flexibility to manage their child care and family needs with their work demands. Some of these parents said that in an emergency they could take unpaid time off to deal with a sick child or other family need. Others said that they could not and had to either rely on family members (their spouse or a child's grandparent or aunt) to help care for the child when he or she was ill, or use child care that would be more likely to accommodate a sick child's care (again, more likely a relative care arrangement). In several cases, parents said they would need to leave their job if they had a sick child or if they were sick because they would risk losing their job if they took time off.

Only 24 of the 86 parents (28 percent) received any other type of employer benefit (besides paid time off). In most cases, this was health care coverage; in a few cases, it

included some retirement benefit like a 401(K) plan, life insurance coverage, or some other employment benefit. Most parents who were covered under an employer's plan received coverage only for themselves (their children were often covered through state child health insurance programs), while a few received family coverage. Interestingly, in about a dozen cases, parents said their employers offered health care coverage but the employee share of the cost of the coverage was so high (sometimes as much as 40 percent of their take-home pay) that they ultimately declined receipt of this benefit as it seemed impractical.

Work Schedules with Nonstandard and Shifting Hours

Thirty-four of 86 (or 40 percent of) working parents we interviewed worked exclusively within the broad domain of a standard work week, which we defined as having their work hours fall on weekdays between 8 a.m. and 6 p.m. Fifty-two working parents (or 60 percent) worked at least some nonstandard work hours regularly, including 20 (or 23 percent) who worked evenings or nights regularly, 16 (19 percent) who worked weekends regularly, and 23 (27 percent) who worked variable and changing shifts that regularly included weekend or evening/night hours.[3] The implications of these complex, nonstandard, and irregular work hours significantly affected the types of care arrangements parents used for their children and how they considered their child care choices.

Limited Workplace Flexibility

Parents reported that many of their jobs were very inflexible in terms of scheduling and time off. Often, this difficulty was compounded by nonstandard schedules and regularly shifting schedules, making it very difficult for parents to find child care options

that aligned with these schedules. Some parents stated that the kind of work they did was inherently limiting, such as hairdressing or working in a fish factory, where client demand or the way the work was traditionally organized did not provide for much flexibility. Others said that, as often as not, employers limited their choices. As they described it, the work itself could have allowed for at least some flexibility (for example, office responsibilities that might be made up at a different time or an employment site with many similarly trained staff who could switch hours), but the employer maintained a hard line.

Employment Challenges and Constraints

The low-income families we interviewed in this study identified multiple challenges to working in low-wage labor markets in their communities, the broadest of which included finding and keeping jobs. Most of the employment constraints they faced had implications for their child care options and choices. While coordinating child care can create a barrier to employment, in this discussion we describe the general challenges stemming from parents' employment contexts that shaped and constrained child care decisions. We then discuss the implications some of these employment constraints pose for families' child care choices.

Limited Employment Opportunities

Many respondents discussed employment opportunities in both the Providence and Seattle communities as a primary challenge. Parents often held low-paying jobs that lacked benefits and had nonstandard and shifting schedules; in some cases, these jobs were temporary or contingent. Also, during our

interviews with families in the fall and winter of 2008 and again in the fall and winter of 2009, jobs had grown scarcer in their communities. Parents who found employment worked in jobs with these unfavorable characteristics because they had no other options to support their families. Parents were often acutely aware of their lack of alternatives and considered it good fortune to be employed.

In both study sites, especially during this time, employment scarcity forced many to enter and remain in less desirable jobs. Natalie, a Dominican mother in Providence who worked in customer service for a bank, mentioned that "people complain about their jobs, but they don't leave because they know they go out there they don't find nothing." Edith, a mechanical assembler in Providence, put it quite succinctly: "There are not many jobs in Rhode Island, so what I have is good."

Many respondents described the difficulties they and other friends and family had when trying to find work, and how they often considered themselves lucky to even have a job. This often made parents particularly focused on doing what they could to keep their current employment and more willing to make other aspects of their lives, like child care, fit around their work needs. Boupha, a Cambodian parent in Seattle who worked for a temp agency cleaning offices, was one of several parents who admitted she would like to change jobs but there were no available job opportunities: "Right now, I have no choice, so I have to stick in my job."

Instability of Work and Income

Many respondents who successfully found and secured jobs still faced employment instability. For example, some parents were only paid according to how much work was available, and the amount of work varied and worsened in the period we were talking with

them, especially with the downturn in the economy. Maricela worked as a hairstylist, but she was looking to work part time in the evenings at a fast-food hamburger chain. The work at the hair salon was variable, and she was only paid if there were customers, so she wanted a job where she could count on steady earnings: "I need a job that, although it pays me little, it will be dependable." Serafina, a Mexican mother, worked at a fish processing factory, and when there was no demand in the off-season, she often went without work and pay: "Last week I picked up a check of $98 because there was nothing. Those two weeks I worked no more than two days."

Ana, a married mother with four children, struggled with unstable employment. She is Dominican and moved to the United States from Puerto Rico, where she had worked as a security guard and in restaurants. She said she was surprised when she moved to the U.S. mainland how hard it was to find steady work. She worked temporary factory jobs in Providence for several months at a time, but said she also faced several periods of unemployment during which she would take English classes and continue her search for steady work. She explained how people always talked about the opportunities in the United States, but that she had had a difficult time holding on to a job in Providence because of frequent layoffs. She spoke about the unpredictability of temporary work, which was the only employment she had found so far:

Well, many people say that here in the U.S. there are many ways to live better, to excel, the jobs. However, I got here and it was different because it is difficult to work here … they fire you … it is much more difficult than in Puerto Rico because I worked there full time and never had any problem. In all of the jobs, the work lasted a long time, while here I had to leave work to look for another job because there is no

work, at that company … sometimes they close the [temporary employment] agency.

Inflexible Schedules and Lack of Benefits

In addition to the difficulty finding stable work, respondents discussed how aspects of their jobs contributed to their lack of employment security and job satisfaction. Such job constraints made balancing work and family life, particularly child care, more difficult. The inflexibility of some jobs did not allow parent to take time off for family emergencies if one of their children was sick. For example, Asuncion said she had limited flexibility at her prior job, which had an informal "last hired, first fired" policy. She struggled with no paid time off, no paid sick days, and no health insurance; she said she worked very hard but felt exploited.

> *They used to pay me 10 [dollars] per hour, but it was something awful—you felt like those 10 dollars an hour, it was nothing compared to everything you had to do at the workplace. I had 12 patients, and you felt like they were, like, exploiting you at work. Because in other places [of work], one … one person takes care of the laundry, another is in charge of distributing food in the cafeterias, and the CNAs were in charge of the patients. But, in this place, you did everything. The CNA had to do the laundry, distribute the food, and take care of the 12 patients, but—but I felt that at least I*

gained experience, like for another place [of work].

Like Asuncion, many parents across the two sites said they knew that at some point they would not be able to continue their previous jobs because of the strict schedules and high expectations. María, a Dominican single mother living in Providence, was working for a temporary staffing agency, receiving hourly pay and few benefits. One factory where María was placed was very inflexible: the bosses would take her "off the floor" for two weeks as punishment if she missed a shift because her son Martín was sick, and they would limit her work hours to a day or two when they called her back: "You pray to God that your kids don't get sick, that you don't get sick, so that you don't have to miss work." There was no flexibility for leaving work early for an emergency either, and employees could not take breaks during shifts without harassment.

> *There was no flexibility even to go to the bathroom. You can't go to the bathroom more than twice a day. And they yell at you, "Where were you?!" "Move it!"—it's incredible. And they watch you when you go to the bathroom and they follow you to the bathroom. [They say] "Move it! Move it! Are you tired? You can't be tired here!"*

If she arrived late, she faced strict consequences: "They deduct my pay and eat me alive."

Box 3.1 Natalie's Family Struggles to Maintain Work and Child Care

Natalie and Nelson live in Providence with their three children. Their youngest child, Norberto, was 6 months old when we met the family and had serious speech complications along with developmental delays. At the time of our first interview, Natalie was working as a customer service representative at the nearby branch of a large commercial bank, which she referred to as her ladder ("fui como mi escalera"). She earned over $12 an hour. Natalie worked 40 hours a week, including work on Saturdays; while she said her schedule did not allow her to spend much time with her children, she was glad to have a good work opportunity. She used to have more unstable, often temporary work in a cosmetics factory and a hotel for less money and with no health or retirement benefits. She liked her job at the bank because it was easy to get along with her coworkers, there was a professional work atmosphere, and the bank offered good benefits, which included a 401(K) plan and Blue Cross/Blue Shield medical insurance for her and her children. She also received paid time off and paid sick days, which she used to meet Norberto's special health needs. After using all her paid time off, Natalie had to use unplanned medical leave and did not get paid for the time.

When we interviewed the family again a year later, Natalie was no longer working at the bank and had been looking for a job for several months. She said that she had had to stop working six months earlier because "my little one is sick." Because of Norberto's many doctor appointments and visits, she had to miss an average of 12 hours a week of work. At first, her pay went down because she was not paid for the hours she had to miss. She finally left her job because of the "pressure" of the situation with her boss. She was trying to keep her job while still going to the doctor visits and other appointments, and her boss would regularly threaten to fire her for missing work. She said it was a "very stressful" time. The stress gave her severe migraines, which she attributed to multiple sources, including concerns about her child's health, her employment issues, the family's economic situation and not being able to pay bills, and "needing to depend on my husband's earnings [only] and I don't like it."

Because of her husband Nelson's work, it was even harder for him to help better coordinate work, child care, and their child's health needs. He worked the night shift 45 minutes away in Massachusetts, and his job had fewer benefits and no flexibility. He usually slept during the day and could not pick up the children.

In the end, with Natalie's income reduced, the cost of the family child care provider they were using was so great relative to what she was earning that she quit her job. She had applied for a child care subsidy, but their application was denied because their combined income was above the state cutoff. It was the best decision for them at that time for Natalie to stop working and stay home rather than work limited hours and pay for child care.

The family had faced this kind of situation before in a few different ways, which made it even harder for them. About six years earlier, Nelson had been fired from his job because their oldest child, Amanda, had had chronic bronchitis and he was consistently taking time off to care for her. Similarly, when Natalie returned from maternity leave after Norberto was born, her employer reduced her hours and refused to give her back 40 hours of full-time work: "I had to have them write me a letter because when I took my maternity leave they did not return me my regular hours, because the last two weeks of my pregnancy I had to go down to 30 hours per week, and they were saying that I wasn't reliable. But after the lawyer wrote the letter they haven't given me any problems."

This time, she found a lawyer through a phonebook, looking under "employment and discrimination," and called the Human Rights Commission and the State Department of Labor. Her doctor told her about the lawyers: "She said they're supposed to give you family medical leave." Previously, Natalie had had an operation to get her gall bladder removed, and the doctor wanted her to be out from work for two to three months, but she said she knew she could not do this so she went back to work after three days. She explained, "I had no problems at work for taking the three days off."

Limited Education or Training, and Combining Work with Education and Training

A key barrier to employment opportunities and job stability expressed by many parents was their relatively limited education or training. Several respondents cited education as vital to increasing their job options, particularly for better jobs with higher earnings potential, benefits, flexibility, and job security. Ossie, a single mother with a 10-month-old child, who worked at a large grocery chain, had some college education and said that she wanted to go back to school for nursing because of better job opportunities that she saw in this growth sector. She had some skills from when she went to trade school, but she explained, "There are folks who have 20 times more skills than me, and right now it's a competitive market."

At least one in five respondents we interviewed (18 of 86) were actively furthering their education or training while working. Although this could help reduce some of the employment barriers and constraints parents might face in the long run, it also created a more complex schedule; the combination of work and training further constrained and complicated their child care decisions in the short term.

Tahzib, a mother of two who had immigrated to Seattle from Somalia, was working part time for a home care provider agency while she attended school part time, in an attempt to further her education and potentially acquire better job opportunities. She had previously worked as a cashier and a nursing home caregiver and had never earned more than $9 an hour. She said she had not always been able to get full-time employment even though she preferred it, and she tried to make do with part-time work. She was planning to quit her job if it did not fit her school schedule. She had just finished exams for an adult basic education course, which lasted two months and met Mondays through Thursdays from 9 a.m. to 12 p.m., and she was waiting for financial aid for a full-time (8 hours a day) 12-month vocational training program in medical assistance located in another part of Seattle.

In addition to the relatively large number of parents in the sample who were working in care-related services like nursing, many respondents like Tahzib and Ossie were either already in the field or seeking to enter it and went back to school to get certified in medical assistance, nursing, public health, and elderly care. Gladys was a full-time nutritionist who enrolled in an online program to earn a higher degree in public health. She said about her decision, "It's hard, but that's one thing they can't take away from you, is your education." Gladys recalled how it had been particularly hard when her computer was stolen because she needed it to complete her final requirements for her degree. She tried to log in as many hours as she could online, though it was not easy, and she had trouble concentrating on her "third job" of going to school: "By the time I get home, I get into my 'second job' mode. Taking care of the kids is a full-time job. Do what you gotta do, cook, bathe them, feed them…. that's my downfall: if I don't see [the classwork], I don't do it." While she and other parents persevered doing all three—work, family, and education—they struggled to keep it up, and it added to the already complex balance of maintaining work and child care arrangements, a balance that can easily get tipped by an uncontrollable event like a stolen computer.

Transportation and Logistics

Another common challenge for families balancing employment and child care decisions was transportation. As mentioned in chapter 2, 34 families considered transportation a factor in determining child care arrangements; for many, it was not just the distance of care arrangements from their home but the logistics of getting to and from work and child care. Some respondents discussed the particular challenges they faced with transportation and their employment. Chesa said that being a single parent without access to a car proved challenging: "It's so hard to be a single mom. Picking her up is hard with no car and not driving." Many respondents who did not have a car said they paid either a friend, coworker, or family member to drive them to work. Oliveira worked at a large discount clothing store, which was a 20- to 25-minute drive away, and her mom drove her to work: "She's not offering—she's doing me the biggest favor." For Hazel, part of the reason she was not making as much as she wished was that she no longer had use of a car: "Right now, I'm having car issues so can't work as good as I want to." Her new boss was helping her get back and forth to work by picking her up on the way.

Grace, a Seattle mother who was working at a food bank, explained how she was expected to call into work if she was going to be late for any reason, including transportation issues. But this, too, was difficult for her:

> First of all, we don't have a cell phone. That's just not something we can afford right now, so if I think the buses are running late, I'll try to call in from the airport [near the bus stop] and say, "You guys, I'm running ten minutes late. Please work with me." Thank God I have an understanding boss. If I can call and get

through, nothing happens. There was one time when the bus broke down and I was twenty minutes late and I got written up …. maybe once or twice a month something really bad will come up with the bus.

Family Characteristics

In addition, some subset of these low-income families faced several more specific barriers. Single-parent families struggled to balance work and child care without a second income or adult for support. Employment and child care challenges were further complicated for some immigrant families, families where parents are English language learners, and families where children have health, developmental, or other special needs. This study sample was in part selected to investigate the child care decisionmaking of these very families. These issues are discussed in more detail in subsequent chapters that focus on these groups.

Single parents

Forty-one of the 86 families (48 percent) in the study were single-parent families, including more than half of the Providence families. All were single-mother families. For many single mothers, the constraints posed by work and balancing work and child care proved challenging because financial resources were limited, no other parent could help provide or coordinate care, and employment contexts were sometimes more challenging. Nydia was in a job-search program in White Center where she took English classes for three months. The program also offered computer classes twice a week to help participants learn how to look for and apply for jobs. She liked these classes and wished that she could have continued: "I would very much like that [to take classes], but I cannot because I am alone." She expressed how being a single mother made going to classes even harder. If

the father of her children was around, he could help, which would have freed her up to take more classes.

Immigrant families

Nearly 60 percent of the study sample was immigrant families. Among their particular employment challenges, some immigrants discussed a lack of recognition for the education and training they had obtained in their home countries. Radhwa's husband, Robles, was a geologist in Somalia, but his degree "doesn't work over here." Some respondents earned higher degrees and held highly skilled jobs in their native countries but had difficulty finding and maintaining employment in low-skill jobs in the United States. Lourdes and her husband, Lionel, who had worked for a bank in the Dominican Republic (with a good pension and potential for promotion), had a difficult transition to the United States:

> I was coming from a bank with a good pension and with sights to progress, she also came from an office …. To work in a factory here, is, was a big difference, and at first it was not easy to adapt …. There in Santo Domingo, we were more comfortable, or for that matter, in terms of work.

The lack of recognition for skills or education received in a foreign country led many respondents to simultaneously pursue work and continued education, which added to the challenges they faced as both immigrants and low-income parents in an already-complex employment context. For example, Iago was a professional "ejecutivo," or executive, in the Dominican Republic with a college degree in computers. Since coming to the United States, he had not been able to work in that field and had held jobs at grocery stores, all of which eventually closed. When he was recently unemployed for five months, he studied English using temporary unemployment insurance benefits; "It is good

to study without work, and receive money for that. It is not easy when you have to study and work, is very difficult."

English language learners

Forty-five percent of the respondents in the sample were English language learners (ELL), nearly all of whom were also immigrants. As discussed in chapter 6, some ELL families said that barriers to employment and promotion were partly based on their language capabilities. Some further suggested that their limited English speaking and writing skills could lead to discrimination in the job market.

Many ELL families take English or ESL classes while unemployed or when seeking a better job. Asuncion, a single mother from El Salvador living in Providence, said she had had some difficult work experiences because the people she worked with had resented her thick accent; eventually, this led Asuncion to be laid off from her last job. As a result, during our second interview, she said she had been unemployed for six months and was receiving unemployment benefits and child care subsidies. Asuncion was using the time to take English classes at a local immigrant-serving community-based organization while she looked to secure a better job.

> I started studying last year for a CNA [certified nursing assistant] course, and then, thank God, I finished in July and passed my two exams at [a local community college], and now, last month I got a job at a health center, but it went badly for me because I found really racist people that always, apparently, didn't like my heavy accent, that I don't speak [English] fluently or understand English well, and each time I would tell them that if they could repeat something for me—maybe a question when I didn't understand them—she, the nurse, well, got so annoyed that she got me, she got me on the owner's bad side and they gave me a layoff. They told me that I had been

fired … I know that it's because of my English.

Parents of children with health, developmental, or other special needs

Low-income parents of children with heath, developmental, or other special needs (referred to as "special needs" in the rest of this chapter) have additional child care requirements that may constrain their employment options. The unique child care arrangements necessary for children with special needs are not always compatible with parents' employment situations and job schedules. Approximately one in four parents stated that at least one of their children had a physical, developmental, or behavioral need that required some special attention, which they needed to consider in family decisions like employment and child care arrangements.

Milagros in Providence said she had quit her previous full-time job because she was unable to manage the schedule with her son's special needs. She then took a job as a part-time cleaning woman, which provided no benefits or paid time off for sick days but gave her flexibility in her hours since she managed her own schedule. Wendy said she was looking for a job in administrative or youth/sports work, but she did not want a job that was "too serious" because of her son Will's heart defect, which required some regular attention. She, too, said that ideally she would like to work part time so she could spend more time with her children. She said she had stopped working at her previous job because she needed to be home with her daughter and Will.

The Role of Employment Constraints in Shaping Child Care Decisions

Many of the broadly experienced employment contexts shaped and constrained the child care choices of low-income families. When employment needs and potential child care arrangements conflicted, most parents faced difficult decisions about what arrangement to use; sometimes, parents needed to remake decisions quickly. Often the delicate balance between these paired decisions broke down either because of changes in one area or something else in parents' family life that affected them.

Among the common conflicts and complexities that arose between child care and work contexts were the hours of child care and work schedules, the relative flexibility of care providers and employers, having to rearrange care arrangements to fit changing work contexts, and having to leave jobs or lose jobs (and then often the child care arrangement as well) because parents could not make the two contexts work compatibly. At times, some parents simply could not find work that fit with their child care options, or vice versa, or they could not do so consistently over an extended period.

Nearly all families said employment shaped their decisions about child care. The hours of child care that were commonly offered by different types of care and by particular providers, and the flexibility within their operating schedule, were central factors for many families. Most families sought child care arrangements and work schedules that they could fit together as best as possible. Udele, a single mother from Providence, posed the dilemma these families face: "I need my job, and I need child care, what do I do?" Her question speaks to parents' absolute need to find and keep a job and the absolute need this implies for finding child care. Across the

study sample, when we talked to parents about their decisions, child care decisions sometimes preceded and sometimes followed employment decisions.

Most often, parents started with what they needed for the work and fit their child care decisions around these needs. Honor succinctly stated the case: "Most of the time, you have to choose your child care to fit your work, 'cause if not … [then] I don't think you would have a job." Some families compromised substantially on their choice of care to balance their work hours. The work schedule for Frances, a single mother from Seattle, had recently changed permanently from a standard daytime schedule to a 12 p.m. to 8 p.m. shift because her boss's child care arrangement had changed. The company gave Frances a week's notice of the change, and Frances had to take her daughter Fiona out of her child care center and find a new arrangement because the center was not open that late. Frances explained that the center's hours were not realistic for people struggling to make a living; "I don't like their hours. Nobody has a typical 9-to-5 job .… Centers should be open until 8 p.m." Although she preferred continuing in center care, Frances said that it was impossible to find a center that would accommodate her new work schedule, and so she ended up moving Fiona to her sister's care.

Fern and Fred from Seattle struggled to patch together child care for their daughter Fannie around their work commitments. They were both in job training programs and needed to be at school at 7 a.m., which posed a dilemma: "The good child care around here that I want to put her in, they start at 8 a.m., and I have to be at school at 7. So we don't have very many options." The only child care that they found during early hours was a family child care provider about a half-hour in the opposite direction of their school. Fern said, "It's hard because we're both trying to go to school, we're in a rush, and there are not a lot of options out there for us." Fred explained that the hours that most child care providers offered were not sufficient for people in the trades like themselves; "A lot of construction workers work a lot of overtime, too. It kind of screws people, and I don't know what it's intended for, who these child care centers are set up for." They chose to use the family child care arrangement they could coordinate with their schedule. But the new provider was inconveniently located and not Fern and Fred's preferred caregiver, just the only one they could find to fit their work constraints.

While most parents made child care decisions that fit with their work schedules, some said they arranged their work around their child care or faced limitations on how much they could accommodate work requirements without appropriate child care. Jacinta, a single Puerto Rican mother, was participating in a Seattle WorkFirst job training program and English classes for the six months before her interview. She had not been able to accept the jobs she had been offered because of the hours; they had been for night shifts, and the family child care provider that she had chosen could not look after her son Juan past 5 p.m. Jacinta said she had turned down about eight job offers in the past six months. Gail, another respondent participating in WorkFirst, said it was difficult finding work that would fit with her child care arrangements. A single mother of four, Gail said she had been looking for a job through WorkFirst but had only been offered positions with schedules that did not work with her preference for center-based child care, and so had yet to accept any. Gail explained, "It would be nice if they [the center] were open a little later, because it's really hard to find a day job within that time frame."

Camila, a single mother of 8-month-old Cristina in Providence, relied on her aunt and mother for child care while she worked and continued her education. When her daughter was sick, Camila or her mother had to take time off from work. Likewise, when Camila had a final exam, her mother would stay home and watch Cristina. When asked about whether work and child care affect each other, Camila said:

> My job has to work around whatever .... If anything, my daughter comes first, so they're gonna have to wait .… If [my aunt] can't take care of the baby and I don't have anybody to stay with her, then I can't go to work. I'm not gonna leave her.

Hours of Care and Nonstandard Work Schedules

Working parents with nonstandard or varying shift schedules, who were most of the families in the study, faced especially challenging circumstances when trying to arrange child care. One theme that emerged was the emphasis these families placed on finding providers that would work with parents' work schedules Many parents who worked during nonstandard hours—for example, those who worked at least part of their shifts during the early morning, evening, night, and weekend—said they were able to do so because they had some flexibility in the care available to them (such as relative care) or because they did their best to work around their schedule constraints. Sonia and her husband, who live in Providence, said they took pains to arrange their work shifts so they could take care of their daughter Salina between the two of them; they used center care for the hours it was available, although it did not correspond directly with Sonia's work hours or her husband's.

The variability of work hours constrained and complicated child care arrangements for many low-income working parents. Suchin in Providence had an unpredictable schedule as a registered nurse. Because of her variable schedule, her parents had become her child care providers. If Suchin's parents were no longer available to take care of her children, no other child care options would be able to cover her employment schedule:

> Not having a fixed schedule, especially for the past couple of months, it's definitely hard because I don't know what I'm doing. If my manager hasn't drawn up my schedule yet, I don't know what I'm doing. If I had a child care service, I'd be calling them up every day saying, you know, this is my different schedule, and next week it'll be this different time.

Many families who worked nonstandard hours faced ongoing challenges finding child care to correspond with their work constraints. For example, Gloria worked a shift that stretched into evening hours at a bank, after her daughter Greta's child care center closed. Gloria lamented:

> I wish I had a little bit more flexibility with the hours, because with day care, I can't find anything open late. So, that's the only thing. I don't get out 'til seven. Day care closes at five. It's the one thing I wish they can do: extend day care hours.

Fortunately, Greta's father was able to pick her up and care for her until Gloria's shift ended, allowing Gloria to balance both her provider's and her employer's schedules.

Some respondents who had jobs with nonstandard or varying hours reported that they eventually decided they wanted to either change their shifts or find new employment so their work schedule might be more amenable to their current or preferred child care arrangements. Diana, a single mother in Providence who worked at a community health center, wanted to renegotiate her work hours after coming back from maternity leave

48

to avoid evening shifts because the family child care provider who took care of her infant son, Dominic, did not want to provide evening care. Diana's mother, who had a more flexible schedule than the family child care provider and did not mind working evenings, had previously watched Diana's older child, but she could not look after both of Diana's children at once. Diana explained, "What I'm trying to do is, when I go back, try to talk to my boss to see if I do part time [to avoid] Tuesdays and Thursdays coming home at 8."

Diana did not know if her boss would allow her to change her schedule and understood she would lose hours and pay: "I don't have no problem working Tuesdays and Thursday but can I just work 'til 5 o'clock? I know that my hours will be short, but I'm fine with that." When we returned a year later for our second interview, we learned that Diana had asked her boss if she could change her schedule temporarily until she could find a new care arrangement but her boss did not let her do so. As a result, Diana had quit that job.

Dolores is a married mother of three children, including 3-year-old twins; one of her twins has serious medical needs, and Dolores has been unable to find a sustainable arrangement. Her mother provided full-day care while Dolores worked from noon to 10 p.m. three days a week as a medical assistant at a local hospital. She wanted to change her work schedule so she could avoid needing child care altogether; "I prefer going on night shift because it is more easier where I don't really have to deal with child care …. I could be here in the mornings, and he could be here at night." However, this arrangement would only be possible because her husband was at home to help with the caregiving.

Limited Work Flexibility

As described earlier, many parents in this study worked in jobs with inflexible scheduling and no time off for illness or to provide care to sick children. Parents were often unable to miss or leave work in the middle of their shifts without losing pay or even their employment. These jobs tended to have strict shift starting times, and even tardiness could have serious consequences.

Many parents who did get paid time off mentioned that even when they did have paid sick leave, it was often tightly controlled or discouraged. In some cases, sick leave was permitted only when the parent was ill, not a child. Several parents mentioned that they were required to bring a doctor's note stating they were sick and that their illness prevented them from being able to work for a specified period. Many parents discussed what they saw as a lack of understanding or compassion for their situation by their employers. Similarly, some parents who received vacation time also said it was tightly controlled and came with some employer reluctance. In many cases, employers required that vacation time requests be made well in advance (often two months ahead) and that vacations not be taken during peak periods or when other staff were taking time off.

Families discussed the role of relatively inflexible workplace policies in shaping their child care needs. Limited work flexibility created a very significant constraint for a great many families and severely limited the types and particular care arrangements parents could consider. The limitations that inflexible employment situations placed on families in their child care decisionmaking extended well beyond even the large group whose limited flexibility was related to the complexity of their hours.

We asked all the working parents to rate their perceived job flexibility in three different situations: if they were late, if needed to be

absent, or if they needed to leave in the middle of the workday for a family reason. We coded the families' responses as inflexible, somewhat flexible, or flexible.[4] Overall, about two of five respondents could be characterized as having at least some flexibility in these situations, while two of five had no flexibility in any of these situations, and the other one of five had some flexibility depending on the situation.

The examples below highlight some of the flexibility-related challenges families faced. These included employers who were altogether insensitive to workers' child care and other family demands, and other employers who begrudged employees flexibility or time off requests despite formal work flexibility and leave policies. Beyond creating increased stress for parents trying to cope with limited workplace flexibility by choosing care that might accommodate that limitation, these situations also led to greater anxiety about employment stability, and some parents lost their jobs or quit because of the pressures of continued work inflexibility.

Amparo, a single mother living in Seattle, worked for a national retail chain. She said that if she was running late or if she had to take time off because her children were sick, it affected her job: "They always get mad at me if I call in. I can't help it … How can they not understand?" She explained how her employer handled policies on working while ill and leaving work in the middle of a shift, which she explained as her biggest complaint:

> Well, sometimes they want you to come in even though you're really sick … and [leaving work early is] a big problem with them …. I'm like, if you need to go, you need to go, right? They're like, "Oh, you have to wait until somebody else gets here." I'm like, "My son can't wait. What if he dies right now and then you guys are gonna be responsible for it? You want that to happen to you guys?" They don't care.

In addition to the hostility Amparo sensed from her employer, she felt that there were repercussions for taking time off, such as when she had to call in because her child was ill and they cut her hours. She said she thought it was a combination of the economy and her taking time off to care for her sick son. Whether the employer was looking for a reason to justify cutting her hours, or just trying to keep her on her toes, the impact was substantial. Parents like Amparo rarely feel secure in their jobs or feel that it is "okay" for them to address their child's care needs or have an unavoidable family emergency without jeopardizing their employment and making matters worse for their families.

Another Seattle family, Fern and Fred, who were working and both enrolled in a commercial vocational job training program, described the training program as "not sensitive at all" to their responsibilities as parents. The classes began very early, before most child care arrangements were open. When their family child care provider changed her operating hours and could no longer accommodate their early-morning care needs, the program administrators were unsympathetic, according to Fern, and just said, "Oh well—guess you're not going to school." Fred explained, "It's a for-profit school and they don't give a — ." Fern and Fred decided they needed to change care arrangements once more to work around their employment and training needs.

Similarly, Asuncion worked for a jeweler in Providence for two years before losing her job. Although her boss would sometimes allow her flexibility, he did so grudgingly: "It's not like they like doing it." Asuncion said she would lose pay if she worked fewer hours, and she reported that she would likely lose her job if she could not work because of a family emergency.

As previously mentioned, Dolores has 3-year old twins who were born premature. Her

daughter Dionne had serious medical conditions that prevented her from attending regular child care with her twin sister and required frequent doctor visits. Dolores was working as a medical assistant in a hospital, but rather than understanding the complexity that such health conditions present, her employer threatened to penalize her if Dolores could not make her shifts. She explained, "You get fired. I mean it all depends; if you're past probation, you get a warning. You get a warning, and then you get a verbal, and then you're terminated. There's three steps to it." There was high turnover among supervisors in her department, meaning that the relative flexibility of Dolores's job was always in flux:

> Well, I don't know, you never know when you come in. It's not stable. I might get somebody who's really nice, bubbly, I might get somebody who is strictly business. Then I might get somebody who's just [on] a power trip. So I don't know from day to day.

Dolores's mother had often been able to care for Dionne during emergencies, but the grandmother was also employed and could not be her regular care provider nor be expected to always help out with the unexpected. Dolores was having great difficulty finding alternative child care arrangements. She said she always considered her own employment at risk if she could not manage her responsibilities.

Before losing her job, Gail, a single mother of four from Seattle, experienced several work-family conflicts. Occasionally, she would arrive late to her shift because of child care conflicts, and "They frowned on it, but they didn't say nothing …. They had an attitude, but they dealt with it because it was out of my control." Gail was not frequently tardy, but she reported that the company management would schedule her for fewer hours after she had been late, no matter the

reason—docking her from 30 to 18 hours a week. On one occasion, one of Gail's children had an accident at school, and Gail had to leave work in the middle of the shift. Her employer received the call directly and made Gail ask if she could leave. Gail argued, "That should have been automatic. I mean, it's an emergency, you know, go take care of your [kid]." The week after the call, she was again scheduled for fewer hours. If Gail had to miss a shift, even for child care reasons, she also would be docked time and pay. After missing a shift because one of her daughters was hospitalized with a respiratory virus, Gail's manager told her directly that they were going to cut back her hours, even after seeing proof of hospitalization. As Gail said, "They're hard. They're sticklers."

Flexibility in Care Arrangements

Inflexible work situations often led parents to place a premium on care arrangements that offered some flexibility. This was especially the case for the many families working nonstandard or changing work schedules, many of whom faced greater work inflexibility that also limited the child care options they could consider.

Hazel, a single mother of five in Providence, began working as an insurance agent about four months before our first interview, after previously piecing together multiple part-time jobs to earn enough to support her family. Hazel's schedule—as well as her income—varied regularly, and having a child care provider who understood the complexity of her work schedule was central to Hazel's decisionmaking:

> I like her understanding. I like that she understands my schedule. And that's the problem—it's hard to find a good child care provider that understands the situation. Like me, I don't have a legitimate 9 to 5. My schedule can change any time. Having child

care providers or day care centers that only open in the daytime whereas for the people that work at night or like a job like mine that my hours vary [does not work well]. I have to find someone that's gonna be flexible, that's gonna understand my schedule, that's gonna work with me.

Flexibility in child care dropoff and pickup times can be a deciding factor for some families, allowing them to make their child care decisions around their work needs. Honor, who clearly stated that employment had to be her first priority, said, "In my case, I'm fortunate, I have [my family child care provider] and she's always been pretty good for me. She's always been really there for me." She said she was not always able to predict her schedule, so having a flexible provider was how she managed her child care. Her mother also provided additional support, helping to pick up or drop off kids when she needed it, to make this arrangement work.

Udele also appreciated that her sons' family child care provider was flexible when she was running late to pick up the boys after work—and that the provider did not charge her late fees even though the subsidy contract said she was supposed to. Vega's children were cared for by a family child care provider who was also a family member, because "If you have relatives, they give you a little bit of hours if you have some hard time, or if you don't have a car or something like that, they might wait for you." Vega contrasted this arrangement with other child care providers who either charged more when the parent was late or required the parent to bring the child in earlier.

While providers' flexibility—found most often among relatives and family child care—helped parents work around less flexible job schedules and work environments, inflexible child care arrangements often made maintaining care more difficult. Irene ended an arrangement with a prior family care

provider who opened her home for care at 7 a.m. but required her to drop her daughter Isabella off between 7 and 8 a.m. or 9 and 10 a.m. because the provider would leave to drop off her own kids at elementary school. Irene tried to make this arrangement work, but over time it strained her schedule because "[when] I happened to miss them, I can't wait around for them to come back, because I have to be at work."

Fragile Fit between Care and Work

In many cases, the limited flexibility in work or care arrangements, and the changing dynamics in each domain, ultimately led some parents to choose between losing their job or attending to their children's needs. Some parents chose to quit their job rather than deal with continued inflexibility. For example, Nina had quit a previous restaurant job because she could not be available whenever her boss wanted her to work. "If I did not have a child, I could be here 100 percent of the time that you want, but I have a child and I have a family." She then went to work at a restaurant where she continued to struggle with the limited flexibility and no benefits. A few weeks before we first interviewed her, Nina had scheduled a doctor's appointment for her son Nesto at 1 p.m. and was expected to start work at 3 p.m. She was delayed at the doctor's office, then had to bring Nesto back to the child care center; by the time she returned to work, her boss was angry. Fortunately, Nina was able to set up a system with her boss and coworkers so they can more easily pick up each other's shifts. Most of the women she worked with also had children and had been through similar situations.

Others were not as fortunate. Udele decided to quit a previous job after her older son became ill and was in the hospital:

I was out without pay, because they don't give sick time and things like that, and I didn't have any help, and they were calling me at the hospital to come into work, "Leave your son there, come into work, we need you." So I just said, "It's not working out …" I took a temporary job …. I said, you know what? Leave it in God's hands, but I can't stay in a place where they're not going to understand that I have a child that's sick.

It was a risky decision at the time for Udele: she was pregnant, and the job she accepted was temporary. However, it was important to her that her employer understood her parental responsibilities.

Summary and Conclusions

The parents in these two study sites were for the most part working regularly and frequently in their children's earliest years. Most were in the low-wage labor markets in the jobs available in their respective communities. Most were working full-time hours for relatively low pay, and few received benefits from their employers like paid time off or health insurance. Probably most significantly for their child care choices, 60 percent of parents worked schedules that were nonstandard and, in some cases, shifting, and therefore did not align well with many of the child care options they might have wanted to use. But even when workers made care arrangements to correspond to these work hours, parents had to factor in the relative flexibility of the jobs and their employers, which were generally inflexible.

The low-income families we interviewed faced significant child care constraints that stemmed from their employment contexts.

General challenges included the lack of employment opportunities, which often made parents accept whatever work they could find, hesitate to push for more flexibility, and consider their work constraints fixed; most often, parents sought to make child care decisions and arrange and alter child care arrangements around their work constraints. Limited incomes and instability of work also meant some could not afford or consistently maintain through their earnings alone the types of child care they might have wanted for their children. Parents often sought to increase their human capital and earnings potential in better or more secure employment sectors by trying to work and improve their education and qualifications at the same time; this only added another dimension to their difficult balancing act between work and care decisions.

Parents' employment contexts and particularly the constraints they imposed on families' child care choices significantly influenced child care decisionmaking. Parents that worked nonstandard hours faced tremendous challenges arranging child care, since they had the most constrained choices, and many needed a significant amount of provider flexibility to accommodate irregular and shifting hours of care. Relatively few families with such schedule and flexibility constraints were able to use center-based care, while some were able to use family child care providers who offered longer care hours and flexibility. The fewer options available to low-income working families in general, and those with sharp employment constraints in work hours and job inflexibility in particular, likely contribute to greater fragility in the fit between work and child care, and to care instability over time.

CHAPTER 4: EARLY CARE AND EDUCATION CONTEXTS

Parents' child care decisions are influenced by many competing factors, such as their preferences for child care and their work schedules and flexibility. Regardless of what parents would like for child care—and need to cover their work hours—their decisions are also directly tied to the options they have. The early care and education context plays a large role in parents' decisions. Many parents' decisions about child care, it can be argued, are in reality not a choice, as particular barriers and a lack of reasonable options can constrain parents into a decision that may not be what they really want. For others, access to publicly funded early care and education programs like Head Start and prekindergarten, or to child care subsidies supported through the federal Child Care and Development Fund, can open doors to additional opportunities that would otherwise not be possible. Consequently, families are affected by the available supply of child care within their community, their awareness of such options, and their access to these programs.

These three themes form the foundation for our discussion of the early care and education context in our study. We set out to answer the following questions: What programs are available to families in these communities, do they know about them, and can they access them? In this chapter, we describe how the low-income working parents in our two sites viewed the supply of child care options in their communities in relation to the programs available. We discuss how parents learned about their options and the barriers to access that they faced. First, we provide an overview of the themes that guided our investigation of these issues.

Overview of Themes

Available Supply

The supply of child care refers to the programs and providers available to families within a given area. Although many families rely on relative care for various reasons (see chapter 2), for these purposes we focused on the supply of formal child care providers in the community such as center-based and family child care programs.

A general lack of supply may discourage some families from considering certain care operations, while causing others to be waitlisted or rejected by these programs. Supply may be particularly constrained for certain age groups, such as infants and toddlers, relative to the supply for preschoolers and school-age children. In addition, some families may be constrained from using certain options owing to a lack of child care that meets their scheduling needs (e.g., evenings and weekends). In other words, there may be a sufficient supply of child care options for families with standard work hours but not for those with nonstandard hours. Moreover, families may face a limited supply of high-quality care options, where children receive care from experienced and qualified professionals within a structured care environment that fosters warm relationships and positive child development. Some families may face additional constraints: parents without

English proficiency may be unable to find a bilingual provider, while those whose children have special health needs or developmental disabilities may be unable to find providers who can handle their specific needs.

Awareness

Parental awareness refers to how much parents know about child care options, and the sources of information they use to learn about these options. Common informal information sources include family, friends, neighbors, and coworkers, while formal sources of information may include child care resource and referral agencies (CCR&Rs) and local human service agencies. Advertisements in community locations, newspapers, and phone books are also possible sources. In addition, child care providers are good sources of information about other arrangements.

Parents may be unaware of child care options for several reasons. Some parents may forgo a detailed child care search because they are satisfied with a particular child care option available to them, such as having a grandmother available to provide care. Lack of interest in seeking child care outside the sphere of immediate relatives may result in parents never knowing about early care and education options in their community. In other cases, parents may not have personal contacts with broad experience or knowledge of child care options. Some parents may be unfamiliar with the local agencies that can refer them to child care providers in their area, or they may mistrust government agencies and not seek their assistance. Other parents may face additional barriers to accessing information, such as language and literacy, time pressures, or family obligations.

Access

Families may still face obstacles in accessing child care options even when there is a fairly adequate supply of child care in their area. The location of the provider and convenient transportation to and from the location affect a family's ability to access the program. Access can also be limited by the steps involved in applying to the program, being accepted and enrolled, and staying enrolled. Some people face challenges applying for child care because of complications filling out paperwork, demanding work schedules, and language and literacy issues. Additionally, enrolling and staying enrolled in a particular care arrangement depends on whether a family can afford it. Receipt of child care assistance (i.e., a subsidy through the state CCDF program) may facilitate initial access to child care, but stability of enrollment depends on retaining the subsidy. When a family loses its subsidy (because of changes in income or employment status, difficulty in meeting other requirements, or otherwise failing to successfully recertify), the family may not be able to afford to stay enrolled. Inflexible employment situations and other individual family factors can also contribute to difficulties accessing or retaining child care.

These three themes of available supply, awareness, and access shape families' opportunities for child care and ultimately influence the type of care they use.

Supply of Child Care Options in the Study Communities

Many families in our study expressed a preference for relatives as caregivers. This was particularly characteristic across families with infants and young toddlers, and for certain immigrant families. Most families reported being satisfied with their current child care arrangements, but, as their stories unfolded, a

good number described an ideal arrangement that was something other than what they actually used. Some relied on relatives, friends, and neighbors for child care because of the convenience, availability, and affordability but, if given the option, actually preferred a more formal arrangement. As noted in chapter 2, certain barriers kept families from accessing their preferred arrangement. Many of these barriers reflected conditions of the supply of child care in their community: the type of arrangements available, the cost, the eligibility requirements, and the number of available enrollment slots.

We asked several questions about parents' perceptions of their options: Did you feel that you had enough good options to choose from? Did you wish you had more options? Is there something else you wanted that you were not able to find or arrange? We compared their report of their options to a map of actual providers in their area based on a scan of the communities (see appendix B for a detailed description of study sites and early care and education programs).

Center–Based Care: Limited, Restrictive, Too Expensive, and Unable to Meet Parents' Scheduling Needs

Most parents perceived that there were not enough good options for child care in their area, and said they wanted providers that were more affordable and more available during the hours that they needed care. However, there were exceptions. Among those who did say there were adequate child care options in their area, or who did not express a strong opinion, most had been able to enroll in the program that they wanted to or were only interested in relative care at that time.

Ola, a mother of a 2-year-old who worked nonstandard shifts as a home nursing aide, stated that there should be more options for child care in her area. Several providers were unable to meet her needs given her schedule and her child's age. She reported that of the three center-based programs nearby, one served only infants and toddlers and another offered only after-school programs for school-age children. One child care center was open late, but it had a waiting list. As Ola explained, "They have a second shift, and I thought that was really cool, because that helps a lot of people .… There needs to be more than just the traditional hours." She was not satisfied with the local family child care providers either. Her current family child care provider was the only one Ola found that was available 24 hours a day and 7 days a week. Most child care providers she found were only available on weekdays, and sometimes she needed to work holidays and weekends. She also found that many family child care providers did not speak English well.

If you call up Child Care Resources, they give you so many people, but pretty much all of them don't speak English well, especially for people like me .… I think that before they get licensed, they should be able to speak English .… how can you communicate about the day if you can't really talk to them?

Head Start and Other Early Education Programs: Viewed Positively, but Difficult for Many Families to Access

Parents of preschoolers often expressed a preference for Head Start as well as other prekindergarten and center-based care programs, but they often encountered limited enrollment and waiting lists for these programs. Fern said she found child care providers from a list kept by the City of

Seattle. Her husband Fred called every provider on the list, but later admitted that he should have used an online search engine to locate child care providers in the area since the City's list was long and it was hard to pick out the ones closest to home. They had a difficult time locating high-quality child care in close proximity that had availability and fit their schedule. Head Start programs and center-based care options were filled to capacity; they could only find family child care providers with spaces available.

> *The waiting lists are just horrible around here. And another thing is that the good child care around here that I want to put her in, they start at 7 a.m. or 8 a.m. and I have to be at school at 7, so we don't have very many options.*

Iago and Inez, recent immigrants from the Dominican Republic living in Providence, described feeling that they did not have sufficient good options when they were looking for a program for their 3-year-old son. At the time of their first interview, they had recently applied for the Head Start program in South Providence but were placed on the waiting list. They had previously tried to enroll his older sister into the Head Start program, too, but they had not found space for her. A family friend was able to get his child into Head Start, but only because the child had a speech delay and was given priority for admission. Iago and Inez explained that they learned about Head Start even before arriving in the United States from a friend who was living in the States at the time. After being denied enrollment to Head Start, they arranged for an unlicensed neighbor they had met through nearby friends to care for their children.

Iago was not familiar with any other child care options, and we found no child care centers close to his home. He also did not know about Ready to Learn Providence, a free, pilot prekindergarten program that had recently become available in his neighborhood. The program did not have income restrictions but was universal and determined enrollment strictly by lottery. By their second interview, Iago and Inez had entered their son in the lottery for the Ready to Learn Providence program and were accepted. They had always thought Ibrahim would go to Head Start, but there were still no spaces available. So, once this new opportunity arose the following school year, they took advantage of it.

Parental Awareness of Local Child Care Options

As part of our interview protocol, we showed parents a street-level map of their neighborhood and asked them to mark the locations of all the child care providers they knew of in their area. Afterward, we showed parents another map on which all licensed or registered providers were identified (per the results of a search through the local CCR&R) and asked parents to point out the ones they recognized. Using this methodology, we were able gather information on the degree to which parents were aware of the options in their community. This approach helped us to understand parents' general awareness of the providers in their area, their opinions toward those programs or providers, and whether parents accepted these providers as viable child care options. In other words, we were interested not only in the supply of child care providers, but also in the way that parents' ability to access these options was limited by their knowledge of the supply.

Most Parents Aware of Some Available Programs but Poorly Informed about Many

In general, we found that parents could identify several child care providers in their

area—either by previous experience, word of mouth, or having seen them in their neighborhood. However, parents generally knew little about the programs or providers they identified that they had not previously used. Some recognized the name but did not realize it was a child care center (if it was located in a multipurpose building). Others knew of a program but never considered it a viable option because of various restrictions such as requiring a child to be potty trained or not accepting children of their child's age. In a few cases, a parent recalled a center that no longer existed or a center labeled on the map we provided was described as no longer open. Few parents were well informed about the child care providers and early education programs in their area.

Immigrant and ELL Families More Aware of Family Child Care Than Center–Based Options; ELL Families and Families with Special–Needs Children Often Aware of Head Start

The findings varied somewhat by family characteristics. In our Providence sample, foreign-born parents were more aware of family child care options, but less aware of Head Start and child care centers, than were native-born parents. This difference could be a result of the strong social networks seen in immigrant communities, in which families often relied on family child care providers of the same culture to care for their children (as discussed in chapter 5). English language learners were more aware of both family child care and Head Start programs than non-ELLs but less knowledgeable about prekindergarten and child care centers. They often spoke highly of Head Start as a program where their children could learn English and get the socialization and developmental support that they needed. In Seattle, both

foreign-born and ELL parents were better informed about the supply of Head Start programs than native/non-ELL respondents, but they were less aware of their other options. Thus, across both sites, Head Start appeared to stand out to ELL families in particular; not only was Head Start widely known among ELL parents, but they liked the program and what it offered.

Similarly, families with children with special needs in Seattle were more aware of the supply of Head Start and child care center options but less aware of family child care and prekindergarten options than other families. In Providence, however, families with special-needs children were more aware of all licensed child care options, including family child care. Since these families often sought child care settings that offered specialized intervention services (i.e., Head Start) or an environment where children could be cared for individually (i.e., family child care), they appeared to be more knowledgeable about formal, licensed care settings.

In Seattle, knowledge about child care centers tended to increase with child age, with parents of older children aware of more center-based options. However, there were no clear patterns by child age in Providence; parents of children of all ages knew about the same amount of information.

Information Sources: How Do Families Find Out about Their Child Care Options?

In addition to examining the supply of child care in the two study sites and the options available to families, we were interested in the sources that families used to find information on child care. In particular, we wanted to know whether families relied on formal or informal sources, whether they were aware of formal sources such as child care resource and

referral agencies, and how they preferred to receive information about child care options.

Previous literature suggests that parents need increased availability as well as information about quality care and child development to make informed decisions in the child care market (Coley et al. 2001). This especially applies to populations facing barriers to diverse information sources. For example, immigrant families and immigrant-serving organizations are often unaware of child care and early education programs and services (e.g., licensed child care, public prekindergarten and Head Start programs, and child care subsidies), and awareness differs within immigrant groups. Information, outreach, and dissemination about child care and early education is often not accessible, targeted, translated, and/or communicated in a culturally sensitive manner (Matthews and Jang 2007).

During the parent interview, we asked respondents how they found out about the child care arrangements they used. About two-thirds of families used one primary source of information, while the other third used multiple sources to learn about their options and inform their decisions. The ways that families found out about child care were very similar in Providence and Seattle (table 4.1).

Generally, families more often used informal sources of information (i.e., friends, family, personal experience) than formal sources (i.e., government office, CCR&R, provider advertising) to find child care. Across both sites, most families—a total of 62 (72 percent)—used family and friends in their child care search. Twenty-two families (26 percent) were informed by personal experience, often from using a particular arrangement for another child or their own discovery of a provider during outings in the neighborhood.

More formal sources were used less often. Sixteen families (19 percent) reported using a child care resource or referral agency, seven families (1 percent) found out about their child care from a government office, and another seven families (1 percent) were informed by the provider herself.

Table 4.1 Sources of Information on Child Care

Type of informant	Providence	Seattle	Total
Family/friend	35	27	62
Personal experience	12	10	22
CCR&R	6	10	16
Government office	4	4	8
Provider	3	4	7
Other	4	6	10

Most families who received child care information from formal sources were using child care subsidies or had received them in the past. For some of these families, connections to government offices helped them expand their child care searches beyond their network of friends and family. However, there were some exceptions. Lourdes, who received a subsidy to pay her family child care provider, had never heard of Options for Working Parents, the CCR&R in Providence, and had received all her information about child care from friends.

The next sections provide examples of each type of information source.

Personal experience

Many respondents said that they relied on personal experience when they began looking for care. For example, Janice was the sole person who made decisions regarding her 1-year-old son's care. She had relied on her own knowledge to make her child care decisions. She first thought about sending her son to a family day care provider, but the provider she knew was at capacity. Instead, without much thought, she quickly settled on a child care center she found near both her home and her job, mostly because of the convenience. But she was not completely satisfied.

> I don't really dislike it, but it's not my choice of day care—not my first choice …. It's there, I've known it was there, and, you know, I went in and checked it out, the teachers are okay, you know.

Family and friends

By far most families focused on information they gained from their immediate network of friends and family when searching for child care options. For some families, this stemmed from a lack of awareness of where to find formal information sources, but for most respondents, family members and friends were the most trusted sources for information.

Advice from friends, family, and coworkers was often central to a parent's child care decision across both study sites.

Some parents relied on friends and family to learn about formal care arrangements that they would not otherwise have known about. For example, Carmen learned about child care options from her coworkers at the factory and from classmates in her English class—two of whom worked in child care. Chesa, a 45-year-old mother of two from the Philippines, found her initial care arrangement when a friend referred her to a Somali family child care provider two streets away. She made sure that the day care was registered, and together she and the provider went to the Department of Social and Health Services (DSHS) to submit the paperwork for the provider to receive a subsidy. Iago, a father from the Dominican Republic, explained that his family mostly learned about child care options through friends and members of their church. He sometimes saw family child care providers in supermarkets giving out information about their business. However, he felt it was better if it was a personal referral from someone he knew.

Diana described her current arrangement for 2-year-old Dominic as the first time she had used a formal provider. She had known the woman who provided care for about two to three years as a casual acquaintance before she began watching Dominic.

> This is now a change for me, the day care. This is the first time with one of my kids going to day care …. So at first I was a little iffy about it, but since I knew the lady and I did my own research, saw how many kids she watched, talked to the other kids' parents—and they seemed to like her—so I said I can give it a try …. My second-oldest daughter is friends with her daughter, that's how I found out about her …. I knew her because our daughters talk, and you know,

my daughter will go by there or she'll come over here to pick up her daughter. She'll come in for a quick conversation.

Grace heard about a child care provider from a coworker whose children had gone there five years ago.

In the end, it was the fact that I had the referral from the girl and she spoke highly of it, and she had her children there quite a few years. And it was somebody I trusted, and I don't think she would have referred me if it hadn't worked out so well. I kinda knew in my heart. It's really hard finding somebody that you trust with your kids, but I haven't had any problems with her so far, thank God. I did a back ground check on her with her being an in-home day care …. She passed that. She had no criminal background. I talked to other parents. I probably called twenty parents before. I asked her, "Can I have the name and numbers of people who come here?" She gave them to me.

Providers

Some families found out about child care options through advertising by the provider. Hazel, a Mexican American mother of five, explained that she knew of Carita de Angel, a local home day care, because some woman gave her a card advertising it at a supermarket. When asked how he might find out about child care options, Duong, a father from Vietnam, said "usually we'd just drive by the street and see the signs."

Zola, a mother of six who was born in Puerto Rico, found out about her family child care provider when she noticed a flier advertising the care. As the woman's first client, she interviewed the provider to make sure that she was comfortable sending her children there. Zola also mentioned looking through the phone book to find resources regarding child care. When asked about the type of care she was looking for, she

responded that she initially did not know that much about her options:

I was looking for day care, period. I guess I was looking for a home day care. I really didn't know much about the centers. I knew people watched kids in their home.

Grace, a mother from Seattle, searched the newspaper, the phone book under "day care," and the Nickel-Nik (a free classifieds magazine) to find the places she considered. However, her search produced mostly teenage babysitters who were only available evenings and weekends, so she learned of her current family child care provider through a coworker.

Government offices

Maricela, a mother of two from Mexico, learned about her current day care provider when she went to the DSHS office. The caseworker gave her a list of providers that included the name, language, and hours of the providers. Maricela was looking for a provider that was open Tuesday through Saturday and that provided care in the evening. She stated that if she was going to give child care advice, she would send the person to DSHS, which she said had helped her a lot. "If they ask me for advice, I would send them to the Department."

Ola found her current child care provider when she called DSHS at 211. She said that finding child care was not hard, but finding quality child care was. She was pleased with resources for child care but believed the lists should be more accurate.

They have a really good resource for finding child care. It's just finding good child care that's hard. Because there are a lot of people that do day care and they're not good home day cares, and from the list that they have, some of the people weren't licensed anymore. It needs to be more updated …. I just did my homework, so out of the 15 people they gave me, four of them were not

day cares any more, some of them would only take up to 2 years old, and a couple of them would only take 5 and older, and I have kids of all ages, and I don't want to be running around. There are probably not enough places to provide for the needs of people.

Child care resource and referral agencies

About 19 percent of parents mentioned using a child care resource and referral agency for their child care search. Many of these families, however, were not satisfied with this resource for information and ended up turning to a second source. Kate, a 43-year-old mother of five, said it had been challenging to learn about all the options. She used Child Care Resources in Seattle, but explained, "They charge $45. If you couldn't afford that, what would you do? Look on Craigslist? There are advertisements for child care, but many of the good child care providers do not advertise." Ultimately, she did not use any of the providers that she found through the agency. Instead, Kate chose a family child care provider that she learned of through word of mouth; her eldest daughter, who was 21, worked there.

Eleanor had called Child Care Resources in Seattle in the past for information, but she found the search process too time consuming:

Sometimes when I'm working I don't have time to do all that .... I'd rather just ask the grandma .... Even if we're fighting and I don't want to talk to [my child's father], it's more convenient than for me to go out and have to try to look through all those different child cares to find one that I'd feel comfortable leaving my kids there. But I mean there are some times that I'm just like, you know, I should just do it that way.

Edith had recently used a CCR&R in Providence when she found herself in a difficult position, but she did not find it convenient.

How can I put it? It's hard. It is, you know what I mean? If you're not working, then you can go down [to the CCR&R], if you need to talk to somebody. That's fine. But once I get out of work, they're usually closed. I can't talk to anybody .... Even if they could point me in the right direction on where to go or who to talk to, or just say, "Well, I'm not sure, but I could find out for you." That would even be great.

Other sources

Some families mentioned sources that did not fall into any of the other categories. Some parents did not consider options other than care by a family member and did not engage in a search at all. Others found success with less common sources of information, such as referrals from medical professionals for children with special needs.

Juliana, a first-time mother, did not know about any child care options outside the family. The options that she eventually explored were all too expensive, and she learned that she and her husband made too much money to qualify for child care subsidies. When their son Julio was evaluated by the neurologist at Hasbro Hospital, she was referred to the parent help desk there, and they sent her all kinds of information on child care. Juliana enrolled him in Head Start, and at the time of the second interview, she was looking into whether he might be able to attend the pilot prekindergarten program in the area, even though he was not yet 4 years old.

They're being very helpful. They sent me a list. I have every letter they've sent me. They helped me look for cheaper day care.

Access to Child Care

Families in our study described a range of constraints, including waiting lists for child care or a limited number of child care options

for their child's age. Even when child care options were available and families knew about them, many still faced difficulties accessing specific types of care. The cost of child care was a significant issue for families who did not qualify for child care subsidies or government-funded programs like Head Start and prekindergarten. This section first highlights some of the challenges families experienced accessing child care. It then describes families' experiences using child care subsidies in more detail.

Difficulties accessing child care took on many forms. Hazel explained her difficulty finding care for all five of her children, three of whom were under 5 years old. According to Hazel, when you have only one or two children, you have more options and can enroll them anywhere. When you have more than that, "it gets more complicated," as most providers cannot accept all of them at the same time.

Ana described how she was happy to get accepted into Head Start, but said that it was difficult to balance her full-time job working in a factory with the half-day Head Start schedule. The dilemma forced her to leave her job, a decision she did not make lightly. However, the switch allowed her to spend more time with her children in the afternoon and to enroll in English classes in the morning. She recommended Head Start for families who do not work because of the 8a.m.–12p.m. schedule: "For a person who doesn't work, Head Start is really great. I like the way they work with the children, the education, all of that."

Edith had been looking for a child care center for her son Elijah since he was born. She described it as a "constant search." Initially, she tried to enroll him in a center in her neighborhood, but her income was too high to qualify for a subsidy, and she could not afford the care on her own. Center care would cost at least half her weekly take-home

pay, not leaving enough for other necessary expenses. The family child care programs she looked at either were at full capacity, had long waiting lists, or did not serve infants. She expressed frustration with the situation: "It gets to the point where you feel you're hitting your head up against the wall, you know what I mean, and nobody's up there to help you." As a result, she turned to a friend and family for child care.

Similarly, Grace had difficulty affording any of the arrangements she found. In her search for child care, Grace visited six child care centers in Seattle.

> There were two places I actually liked, one was an in-home, licensed place and the other was a bigger facility, but I just couldn't afford them. I would've had to take another job and that would've done no good. There's just no way I could've afforded them.

Child Care Subsidies and Payments

Data on child care payments are available for only 52 of the 86 families in the sample (with missing data resulting from refusal to respond or lack of knowledge). About half the families in our study reported that they did not pay for child care, including many families in relative care, all the families enrolled in Head Start or public prekindergarten (at least for that care arrangement if they used more than one), and six families who received full child care subsidies through CCDF (who had no co-payment). Nineteen families in the sample (about a third of those reporting payment information) received a partial subsidy that required a co-payment of $12 to $60 a week toward the total cost of care, which equaled about $125 to $150 a week for these families.

The remaining families who paid out of pocket for child care without a subsidy varied in how much they spent on child care, with some paying hourly, some daily, and others

weekly. Their child care expenditures ranged between $40 and $290 a week. Some families using relative care paid irregular in-kind payments, such as help with paying bills or buying groceries. Of those who were not using a subsidy, most respondents said that they knew about child care subsidies or had heard of them, with varying amounts of familiarity. Some had previously received a subsidy, a few had applied and were denied, and others knew of them and were interested but either thought they did not qualify or had not looked into what was required to apply.

Table 4.2 highlights the characteristics of CCDF subsidy users in our sample at their first interview. Most notable is the variation in subsidy use by child age and type of care. Families with children between 1 and 4 years old were roughly equally likely to receive child care subsidies, while several 3- and 4-year-olds were also benefiting from Head Start and state prekindergarten programs. Only one child younger than 1 year old received a subsidy. Young infants were primarily in the care of relatives, and, for various reasons, these families did not use a subsidy to pay them.

Only 9 percent of families using an informal care arrangement received a subsidy, and those four subsidy users all used relative care and had nonstandard work hours. Subsidy rates were higher for formal care arrangements; 60 percent of families using family child care and 52 percent of families using center-based care received a subsidy. Slightly fewer 4-year-olds than 2- and 3-year-olds received a subsidy. Since 4-year-olds were eligible for and often enrolled in Head Start, most of these families did not have to pay for services, and only in a few cases did they apply for a subsidy for before or after care.

Seven (30 percent) of the 23 children who had a special need received a subsidy. Roughly a third of foreign-born respondents and English language learners used subsidies.

Interestingly, we found no difference in subsidy use by parental work schedules; 20 of the 52 (38 percent) who worked nonstandard work schedules had subsidies, while 13 of the 34 (38 percent) who worked standard schedules also received subsidies. However, those with subsidies who had nonstandard work schedules more often used family child care and relative care than center-based care.

Table 4.2 Subsidy Users at First Interview by Age of Focal Child,
Respondent Characteristics, and Type of Care

	Providence	Seattle	Total sample	% of respective subsample
Subsidy users	14	19	33	100
Child age				
< 1 year	0	1	1	7
1 year	4	7	11	42
2 years	2	6	8	44
3 years	5	4	9	50
4 years	3	1	4	40
Characteristics				
Special–needs child	3	4	7	30
Foreign-born respondent	7	9	16	31
ELL respondent	8	7	15	38
Respondent works nonstandard hours	8	12	20	38
Type of care				
Informal child care	0	4	4	9
Family child care	11	7	18	60
Center-based care	3	8	11	52

Parents were eligible for child care subsidies if their household income was less than 180 percent of FPL in Rhode Island or 200 percent of FPL in Washington State, and if they were employed or enrolled in an approved education or training program. Qualified providers included a licensed child care center or after-school program, a certified family child care home, care by an approved relative of the child in the relative's home, or care by an approved provider selected by the family in the child's home. In neither state were unregulated, nonrelative caregivers who provided care in their own homes, such as neighbors or friends without registered family child care programs, eligible for subsidy payments. However, relatives qualified as eligible caregivers.

In Washington State, children also had to meet citizenship requirements, and all providers were required to fill out an application, pass a criminal background check, and submit a copy of a Social Security card and photo identification. This requirement may have discouraged undocumented parents and caregivers from using the subsidy system.

The City of Seattle also had its own child care subsidy system designed to reach families who did not meet income requirements for the state program. To be eligible for the program, families had to be low or moderate income, reside within the city limits, meet requirements for working or enrollment in job training, use the subsidy for a child from 1 month to 13 years old, and not be eligible for any other subsidy program. Unlike the state subsidy program, which allowed families to use both licensed and unlicensed providers, the city's program was restricted for use with 145 specific providers approved by the city. However, because many of our participants resided in White Center outside the city lines, they did not qualify for the program. Those who received a subsidy generally did not know or report on the type of subsidy they received.

Subsidies and Access to Child Care

The subsidy users in our sample often stressed that they would not have been able to afford their child care arrangements without a subsidy. Tahzib received a partial subsidy to pay her sister for child care and paid a $50 monthly co-payment for her two children. As she illustrated:

> If I couldn't get subsidies it would be hard. I couldn't pay for child care and I'd take care of them myself. I don't know what I'd do, but it would be very, very hard. It's very helpful [to have subsidies].

Although a few families reported difficulties applying for and retaining subsidies, a greater theme involved families being rejected because they did not meet income requirements. Natalie, a 26-year-old Dominican mother in Providence, said she had previously received a subsidy and paid only $100 a month for child care for all three of her children. Then, when she tried to apply, she was rejected. "They always deny me," she commented. Her income was $1,000 too high to qualify for a subsidy. Having a child with special needs added to the challenge. She said that if she had received a subsidy, "I wouldn't be struggling, because I have a sick baby. Working taking care of him was hostile back then."

Several respondents pointed out that families with able-bodied, married parents cannot qualify for a subsidy because two minimum-wage earners will exceed the income eligibility threshold if they work full time. Some discussed how they did not bother applying for a subsidy because they knew they would not qualify, even though they still could not afford child care.

Rosaline, a married Haitian mother with two sons in center-based care, described how she was not eligible for a subsidy:

> I don't get any help. My husband and I have to pay from our pockets for both of them, which is not great. When you ask for help, they say we make too much money. When a person asks for help, they ought to get help because whatever we are making doesn't apply for what we want. So we have to pay from our pockets every Friday .... My main thing I wish they could bring the bracket for a family of four or five higher to help us. That's my main thing .... Like I said, if you have money, why would you go and ask help for your children? It's because the money you're making is not enough so you go to apply for what you don't have. It's just that you don't get it.

Rosaline's past experiences trying to get assistance had made her ambivalent about asking again.

> I'm always scared to go. Not scared, but I'm like, why go? I know they are going to say "You make too much," but, me, I tell the truth. I give you the truth. If you want to help me, you'll help me. If you don't want to help me, I'll find a way .... Because we do what we're supposed to be doing, we're not sitting and doing nothing. We go to work. Whatever we're doing, it's not enough. We ask to have a little bit more to add on to what we have, and they don't give it to you. Some people, they lying. They cheat to get everything they need.

Suchin, a Laotian mother from Providence, decided to use relative care for her infant son Sam instead of a formal day care program that cost more than she could afford. She explained why she did not seek subsidies:

> People will work to have their child in day care, and to me it's like, why work if you're going to spend more than half of your money on day care? You just stay home .... And a lot of times a state-assisted program isn't going to help because of your income.

They look at your income and they're not going to help you …. Oh, I never bothered to. Even from the time that I was little and they said my parents made too much money, which is nowhere near true, but they would say the same thing about us. They don't look at everything else, like my student loans that I'm paying back. They just look at your gross income without any bills at all. That's sad, but that's usually how it is …. Usually if you're a single mom they get all the help, but with two adults with kids they usually don't help you because they say you make too much.

Summary and Conclusions

Child care decisions are greatly influenced by the supply of child care available within the neighborhood as well as how easily families can access those care options. In this chapter, we examined how families viewed their options for child care within the context of what was available and affordable to them. Among the findings that emerged from this evaluation were the lack of enrollment slots available to some families—with waiting lists often mentioned for Head Start and child care centers—and the scarcity of affordable care options, particularly for younger children. We also found significant limits in the supply of high-quality child care options for low-income working families that fit their nonstandard and shifting work schedules, as also detailed in chapter 3. These findings suggest a strong need for an increased supply of affordable, high-quality child care options, particularly subsidized early childhood programs like Head Start, Early Head Start, and public prekindergarten. Even in our small

sample, families made a strong case for Head Start that has implications for program policy and implementation. In particular, they shed light on the lack of available enrollment slots, rigid income requirements, and the challenges of half-day program schedules.

Families used various resources to find child care and generally preferred to receive information by word of mouth. Most relied to some degree on friends, relatives, and coworkers for information and recommendations, but some had used more formal resources. Families expressed mixed feelings about their experiences using CCR&Rs and local human services agencies for their child care search. A few preferred it and found the resources valuable, while others found the information outdated, unreliable, or too time consuming to manage. Parents' lack of knowledge about how to search was also highlighted.

Over a third of families in our study received a child care subsidy at some point during the study and emphasized how critical the subsidy had been to their family's stability. Families who did not qualify for subsidies struggled to earn enough to pay for the child care arrangements they wanted, and some said they found the system unfair. In particular, several married, two-parent working families expressed their equal need for subsidies but did not qualify for assistance with two incomes. A few even surmised that if they worked part time or quit their jobs, they would have qualified for assistance. These stories provide strong evidence of the high costs of quality child care and the need for child care assistance even for those families earning moderate incomes.

CHAPTER 5: IMMIGRANT FAMILIES

This chapter addresses the child care choices of low-income immigrant families. Very little qualitative research has been done about how and why low-income immigrant parents make child care choices, though immigrant families are an important and growing population. Previous studies have explored the policy context within which immigrants use early care and education arrangements (Matthews and Ewen 2010) and have examined those arrangements using quantitative methods (Brandon 2004; Caldera, Lindsey, and Tacon 2001; Capps and Fortuny 2006; Capps et al. 2005; Crosnoe 2007; Liang, Fuller, and Singer 2000; Matthews and Ewen 2006) or a mix of quantitative-qualitative methods (Anderson, Ramsburg, and Rothbaum 2003; Flaming, Kwon, and Burns 2002; Howes, Wishard Guerra, and Zucker 2007). Some primarily qualitative research has been done using interviews of community respondents (Matthews and Jang 2007) and highly educated immigrant families (Obeng 2007). One recent study based on focus groups with Nigerian and Pakistani immigrant parents explored how language and cultural barriers affect parents' perceptions and use of prekindergarten programs (Adams and McDaniel 2009).

To contribute to these discussions, this chapter addresses the following key research questions:

1. What are the child care choices of low-income immigrant families, and how do those differ from low-income families overall?

2. How do immigrant parents' experiences growing up in other countries and their U.S. experiences of being an immigrant shape any distinct views they may have regarding child care?

3. What role do immigrant social networks play in providing information or supplying child care?

Foreign-born and U.S.-born parents generally identified many of the same factors when discussing their child care options and eventual decisions. Immigrant families also described a number of influences that intensely or uniquely affected their child care decisionmaking: a very strong motivation for a trusting relationship with the caregiver, preferences regarding language spoken at child care, nutrition and ethnic food as an important consideration when weighing various child care options, and immigrants' experiences growing up and being cared for by parents and relatives. In addition, immigrants' age at arrival and neighborhood networks further shaped and affected their child care options and decisions.

Immigrant Families in the Study Sample

Table 5.1 provides background on the 52 immigrant parents we interviewed. Seventeen and 12 came from the Dominican Republic and Mexico, respectively. Another five came from Central America, and one came from South America. All together, 35 of the 52 (or two-thirds) were from Latin American countries. The remainder were eight immigrant families from Asia (Cambodia, Vietnam, Philippines, and Thailand), seven from Africa (mostly Somalia), and two from the Caribbean countries of Haiti and Trinidad.

Table 5.1 Immigrant Parents' Regions or Countries of Origin

Country or region	Number
Dominican Republic	17
Mexico	12
Asia (Cambodia, Vietnam, Philippines, Thailand)	8
Africa (Somalia)	7
Central America (Guatemala, El Salvador)	5
Peru	1
Haiti	1
Trinidad	1

Note: Sample size is 52.

The foreign-born study sample was diverse in other characteristics as well: the parents' age at arrival in the United States, length of time in the United States, English language proficiency, household structure, and migration history. In table 5.2, we group respondents in the sample according to their age when they arrived in the United States.

The immigrant respondents arrived in the United States at different points in their lives, which ranged from childhood to their early forties. The median age at arrival was 19 (the average age was 18), and on average respondents had been in the United States 13 years by the time we interviewed them. Six had been in the country for less than 5 years; 18 had been here between 5 and 10 years; and 28 first settled in the United States more than 10 years before our interviews.

Nearly half (24) first settled in another part of the country before moving to the Providence or Seattle area. In most cases, these immigrants first settled in established gateway cities on their current coast—Los Angeles on the west coast, and New York or Boston on the east. In addition, some Dominican respondents immigrated to Puerto Rico first before moving to Providence. All the refugees from Somalia living in White Center were settled immediately in King County

Table 5.2   Immigrant Parents' Characteristics by Age at Arrival in United States

Characteristic	Youth immigrants (arrived younger than 18)	Young adult immigrants (arrived age 18–24)	Adult immigrants (arrived age 25–41)
Number in sample	19	17	11
Average age at arrival to U.S. (years)	10	21	30
Average length of time in the U.S. at first interview (years)	20	10	7
English language learners	9	14	10
Moved directly to the Providence, RI, or Seattle, WA, area	10	9	9
Single parent[a]	9	3	6
Parent before moving to U.S.	0	1	7

Notes: These groups exclude five respondents with missing age data, all of whom arrived in the United States at least 10 years ago. Groups are based on the respondents' age upon emigrating, not their age at the time of interview.
a. Single parents include three mothers (one in each group) who were married but whose husbands were not in the country and thus had little involvement in child care decisions and household responsibilities.

upon arriving in the United States in a refugee settlement community, and they had remained in the area since their arrival.

Immigrants in the study sample did not differ in many ways from the U.S.-born respondents in the sample in their job characteristics (as described in chapter 3). Most respondents in both groups were working mothers, and respondents in both groups tended to have jobs that paid relatively low hourly wage levels and work schedules that averaged 33–34 hours a week. Immigrants did not have significantly distinctive work schedules, with a quarter working on weekends and fewer than half (46 percent) working only during the standard 8a.m.-6p.m. work day, in line with the overall distributions presented for the sample in chapter 3. Low-income workers generally have little or no work flexibility and few benefits, and immigrants in the sample were no different: most immigrants had jobs that provided no paid time off for vacation or sick leave (60 percent), no employer benefits such

as health insurance (70 percent), and little or no work flexibility to meet family needs.

Types of Child Care Used by Immigrant Families

Immigrant parents, who made up most of the study's overall sample, used all types of child care: informal care by family members, informal care by friends and neighbors, family child care (i.e., home-based group settings), and center-based care (e.g., child care centers, Head Start programs, and prekindergarten). Immigrant respondents reported using each type of care in very similar proportions to U.S.-born parents. Table 5.3 presents the total number of care arrangements for U.S.-born and immigrant parents. The distribution of types of care used—for primary as well as all regular care arrangements—among immigrants closely resembles U.S.-born parents, with only slight differences.

Table 5.3   Child Care Arrangements of U.S.-Born and Immigrant Parents

All regular arrangements	Informal relative care		Informal nonrelative care		Family child care		Center-based care		Total arrangements
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	
U.S.-born parents	16	41	2	5	10	26	11	28	39
Immigrant parents	26	39	5	8	20	30	15	23	66
All parents	42	40	7	7	30	29	26	25	105

Notes: Regular care arrangements include primary and secondary arrangements that support parents' work, education, and training but exclude intermittent care such as unpredictable last-minute babysitting or irregular monthly arrangements that may or may not support work, education, and training. Sample sizes are 34 for U.S.-born parent and 52 for immigrant parents.

Child Care Decisionmaking Factors for Immigrant Families

Overall, while immigrants in the sample had similar child care to U.S.-born parents, they did express some differences in their opinions and preferences about child care. Immigrant parents were influenced by many of the same factors as U.S.-born parents in making child care arrangements, as well as by additional factors related to growing up in their country of origin, settling in the United States, and the very heavy reliance on social networks for information and access to child care resources.

Table 5.4 below indicates the degree to which immigrant families mentioned different factors that influenced their child care decisions.

Table 5.4 Key Factors in Immigrant and U.S.-Born Parents' Decisions Regarding Child Care

Decision factors	Immigrant parents (*n* = 52)		U.S.-born parents (*n* = 34)		Total sample (*N* = 86)	
	n	%	n	%	n	%
Characteristics of care setting: environment, activities, and services						
Physical environment	6	12	8	24	14	16
Activities and learning opportunities	9	17	3	9	12	14
Language used in care setting	6	12	0	0	6	7
Socialization with peers	2	4	3	9	5	6
Nutritious meals/ethnic foods	5	10	0	0	5	6
Caregiver characteristics: relationships and social networks						
Relatives as caregivers	17	33	11	32	28	33
Positive relationship with caregiver	16	31	9	26	25	29
Safe and trustworthy provider	9	17	8	24	17	20
Availability and accessibility of provider						
Convenience of location, transportation	18	35	17	50	35	41
Hours of care availability	14	27	8	24	22	26
Parents' work schedule flexibility	9	17	7	21	16	19
Affordability of care						
Cost of care	18	35	12	35	30	35
Child care subsidies	6	12	9	26	15	17
Previous experience with child care						
Previous experience of sibling	14	27	8	24	22	26
Previous experience of focal child	8	15	2	6	10	12
Previous experience of parent as a child	4	8	2	6	6	7

The most common factors immigrant families described were identical to those given by the entire sample. The three most frequent decisionmaking factors were transportation, cost, and the value of having family members as caregivers. Not only were the actual factors determining the child care arrangement similar for immigrant and U.S.-born parents, so too were the ways in which immigrant families described these factors. Immigrant families explained the factor of *location and transportation* as both a limit and as an advantage. Nydia, a Mexican mother in Seattle, chose to send her two daughters to a particular child care center because the other options she considered were too far away and, having recently acquired her driver's license, she was afraid of driving on the highway. Quina, another Mexican mother in Seattle, chose to send her young son to her sister's house, which was less than 10 minutes away by car, because it was convenient to both her home and work and limited the driving that would be required.

The cost of child care was another factor important to both immigrant families and sample families as a whole. Suchin figured from the outset that the money she could earn working would be siphoned off to pay for any care arrangement she could find: "If I put him in day care, it would kind of just take away my checks. So what's the point in working?" Other families realized, after searching for more formal care options, that none were affordable. Camila, a Dominican mother in Providence, found that all the child care centers she called for her daughter were too expensive, and decided on a combination of friends and family that she relied upon for care.

Many immigrant respondents indicated the importance of having a family member as a caregiver. For many who used relatives for child care, this was an absolute preference, while for others it was a matter of availability,

a preference for using relatives while their children were young, affordability, or compatibility with work schedules. Juliana, another immigrant from the Dominican Republic living in Providence, said she visited some child care centers, which were all too expensive, and ultimately gave up the search, deciding, "Well, family is family. They're going to know what to do." Similarly, Brianna, whose sister takes care of her daughter, assumed that her sister would be available purely on account of their relationship. When asked how they came to an agreement where her sister would watch her daughter, Brianna said, "We don't agree. I just drop her off."

Immigrant families' most important child care considerations

When asked to describe their ideal care arrangement, once again immigrant families had some similar responses to U.S.-born parents. Like many working parents in the whole sample, many immigrant respondents expressed how nonparental child care itself was an unsatisfactory option, since in an ideal world they would stay home with their children. Maricela expressed frustration at not being able to see her children grow up: "I'd like to spend more time with my children, to see them develop, because you know that kids grow up pretty fast, and when you turn around, you say 'Oh, why didn't I enjoy them more.'"

Some immigrant respondents reasoned that in this country they needed to work, and took a practical perspective that if they worked they were going to make sure their care provider was the next-best thing to them. Querida said the only option she knew of or would consider for child care was her sister. Querida never even looked into day care and did not know how much one pays or even how to pay, and if her sister were to cease being a viable option, she believed she would have to quit her job and stay home with her

son. Staying home as an ideal care arrangement was by no means pervasive across all immigrant families, however. Zalika recounted how she and her husband used to take turns watching their children when they were infants, in shifts, but said she still preferred formal child care:

> I don't like child care in the home .... When they stay with us they don't want to learn. At the child care [center] it's more like class. I like that better.

In a few cases, too, families mentioned that ideally they would have wanted their children to be raised in their country of origin, or at least have more contact with it, and a few considered sending their children for spells to their parents' country of origin for child care. Juliana was dissatisfied with the choices available to her in Providence and found it difficult to manage her work and her son's special needs. In an attempt to reduce her stress, she sent her son, Julio, back to live with her grandmother in the Dominican Republic for a few years, before later settling on her mother-in-law in Providence as a child care provider.

Home-country preferences and immigration experiences influenced in other ways how some immigrant parents considered child care arrangements. Some parents pointed out that the discipline and behaviors that their children would be taught in their native country would be ideal, and this was something they looked for in a child care arrangement in the United States. In a few cases, families were separated across countries and mothers lived alone with their children. One mother feared that her son, whose father lived in the Dominican Republic, lacked a strong male role model in his life. In response, she valued discipline during her search for child care.

Other differences and distinct decisionmaking factors among immigrant families

Some immigrants cited various factors that affected their views on child care and their decisions, to a somewhat greater degree than for the rest of the study sample. For example, trust, which was a very significant decisionmaking factor across the whole study sample, played a distinctly important role in immigrant families' decisionmaking. Many immigrant parents said they only considered options where they knew they could trust the person watching their children. An intense lack of trust of strangers watching their children was more commonly expressed among parents in the immigrant sample, and did not come up quite as intensely with parents born in the United States.

Querida, a Mexican mother, said she chose her sister for child care because she did not trust anyone else to take care of her son: "I know that I will leave him with her and she will take care of him well …. To leave him with other people, I don't have enough confidence." Similarly, Yolanda, who moved to the United States from Mexico nine years earlier, associated her need for trust in a provider directly with her immigrant status: "We are alone here in this town. The only house that we trust is with those two women [the Mexican caregivers who lived nearby]." Phoung, a Cambodian immigrant, was one of many mothers in the sample who chose a close female relative because she only trusted family members with her children: "I'm very paranoid who takes care of my kids, so, it's just hard. Besides family, I don't trust them." On the other hand, a few respondents stated the opposite preference. Tale, a Somali immigrant, found that she trusted a good-quality child care center more than a home-based child care program or her family because of the large number of people able to watch over her children at the same time.

Immigrants were also much more likely to consider language as a factor in their child care choices. Six immigrant families counted the language used by the provider as an important aspect of their decision to enroll their child with that or another provider while, not surprisingly, none of the non-immigrant families mentioned language. Zalika, a native of Somalia, would not consider any child care provider who was not Somali and who did not speak Somali. In contrast, while Maricela, a Mexican immigrant, found it problematic when caregivers did not speak Spanish, it was not a decisive factor for her. Another Mexican immigrant in Seattle, Nydia, feared not being able to communicate about her son's progress with his caregivers: "For some questions [I have], she wouldn't understand if I asked how my kids were." Nydia imagined that enrolling her son in the center meant having to bring a friend or relative who could translate.

Another important decisionmaking factor, described in more detail later, relates directly to the experiences of immigrants as they settle into the country and the receiving community to which they have moved. Many immigrant parents felt alone and without access to quality information about available options, so they relied on trusted friends, family, and other contacts to refer them to quality child care. One mother decided to send her son and her other children to Head Start after a community member told her about it and talked about the quality of the care. Another mother asked people she trusted, like one of her coworkers, whether they had heard of different providers and how they rated them, ultimately applying to a child care center that a friend recommended.

Some Latino immigrants cited ethnic food and nutrition as an important factor. Some Latino parents worried their children were going hungry while at child care, either because they did not get enough food or because the provider served unfamiliar food that their children did not like. A few parents said that they specifically preferred that their children be cared for in an environment where their native culture could be taught, especially through food. Raisa, whose son was still only a few months old, wanted him to be in a setting that would, when he was old enough to eat solid food, offer Guatemalan options: "[Someone] like his aunt, who makes sure to prepare his compotas and atoles. It's very important for us."

Immigrant Parents' Experiences and How These Contributed to Their Child Care Preferences

Growing Up Outside the United States

One essential factor that could lead to different opinions and choices surrounding child care for immigrants is how parents' memories of growing up outside the United States affect their decisions after emigrating. Except for those who had left their native country at a young age, immigrant parents recalled clearly how they or their siblings were cared for as children. Some had experience raising their children in their country of origin and were able to compare their child care experiences as parents in both places.

All but four immigrant respondents who spent all their childhood and experienced regular nonparental child care when growing up in another country had been watched by family members. They said that the most common and preferable nonparental care arrangement in their home countries was being taken care of in a home setting, exclusively with family.

Further, most of these parents were cared for as children by their mother who did not work, and had never experienced nonparental care. Having a child's mother as the primary care provider was the cultural norm in nearly all their native countries. Vega explained that in Somalia, mothers tend to stay home: "Mothers don't usually work, they have a lot of children, mothers do laundry, cooking, and fathers work to make the money." While mothers are the first option for child care, sometimes other close female relatives filled the role, and sometimes from necessity. For example, Idel's mother died when she was very young, so her grandmother was her primary caregiver growing up in Somalia.

Immigrant parents recounted how, growing up, the mothers who worked during the day or could not stay home took advantage of their large social networks to find a care provider. Contrary to the experience of families in the United States, one of the first options many parents turned to in this situation was care by siblings or cousins. Silvia, when she was a child in Mexico, was cared for by her older siblings because both her parents worked during the day. Because her aunts and uncles lived in the same neighborhood, they would look out for Silvia and her siblings, though they were not the primary providers.

For the most part, immigrant parents who grew up outside the United States reflected fondly on the early childhood contexts in their countries of origin. They recalled many reliable people (whether family or neighbors) who could provide care in their home countries, including many extended family members and neighbors. Silvia said it was different in Mexico because people did not have strangers take care of their children— they could send them to their mother's, or an aunt's, or any relative's home since the whole family was nearby.

Another crucial aspect of early childhood according to many immigrant families, and absent among U.S.-born parents' responses, was letting children wander without worrying about their safety. Numerous families recounted how, with so many family members and trustworthy neighbors, young children could be left alone for long periods without the intense supervision of a babysitter or teacher. Gladys, who had moved from Trinidad when she was very young, contrasted what she perceived it was like being a mother in a rural setting with being in Providence:

> This isn't the mountains, where you leave them and they come back to you. If you leave them, somebody takes them. This is America, where you have to be aware of your surroundings.

Other families echoed parts of this sentiment, some stressing the assurance that, when left alone, the child would return. Idel focused on the goodwill of neighbors and friends to be responsible for the child:

> In Somalia, before the war, you don't get scared if your child goes outside. If he don't know his house, someone will bring him back. Here, I worry if something happens. I have to take him to the park and sit there. It's different here than in Somalia.

Other respondents mentioned that not only would friends and relatives in their native countries take it upon themselves to care for a child or bring the child back home, living in the United States added a dimension of fear that someone might hurt a child who is left alone. Vega, another Somalia immigrant, noted, "At two years, they can go outside [in Somalia] and they'll come home, but here you worry about a lot of things. They might take them, they might hurt them."

Immigrant parents explained that in addition to a preference and norm for parental care or care by extended family,

formal care arrangements were beyond the reach of most parents in their home countries. Idel noted that only people with money could even afford to hire a babysitter in Somalia, so parents there preferred to rely on ad-hoc and free alternatives: "If you went shopping, a neighbor watches them, and you never worry about anything." Chesa acknowledged that the emphasis of the child care in the Philippines was primarily convenience rather than educational: "The priority [in Seattle] is the welfare and education of the children, whereas in the Philippines a parent would ask anyone they trusted to take care of their child." Paloma reflected that opportunities such as Head Start would be prohibitively expensive in Mexico and not something the government would have provided:[5] "In your home country, if you want your child to go to that kind of program, you have to pay for it. It's a luxury." In the Dominican Republic, Lourdes found that there were fewer legal standards for safety or quality care, which made her wary of sending her children to a center. "They're more careful [here]. There, not so much. There isn't any oversight over there, and you get a little scared."

Only a few parents in the sample expressed an outright preference for the types of child care available in the United States. One of these was Ana, one of only four parents in the sample who had been in formal care arrangements when they were children. She said of the Dominican Republic: "In general, people over there take care of their kids at home … but good thing here is that they have day care." She couched her preference for child care as one of the many reasons she would rather live in Providence than the Dominican Republic: "If they let me choose, I'd prefer to stay here than there—in terms of the quality of life, for the kids, child care, work, and those things."

Most immigrant families did not explicitly connect the child care they had used or had

been put in while living in their home countries with the care options they considered in the Providence and Seattle areas. Those who did gave reasons that ranged from general to specific experiences from childhood. For instance, Raisa, whose 2-month-old son Ramón spends the day at his aunt's family child care home, recognized that she could not stay home instead of working. She mentioned that because in Guatemala mothers will take care of the children, she always wanted someone who would provide child care in their home.

Settling in the United States

Immigrant respondents were different ages when they arrived in the United States; some emigrated as children, others as young adults, and the rest as adults in their late twenties and thirties, with some having had children in their countries of origin before emigrating. Their settlement experiences shaped their immediate integration and access to work and personal networks, which in turn influenced their child care options and decisions. In the following section, we highlight how settlement experiences differ by age of emigration and how these experiences affect families' integration into their local neighborhood, including access to child care information and options.

Youth immigrants

Youth immigrants typically followed family (usually their parents), and their initial years in the United States were directly affected by the relative strength or weakness of their family's network in the receiving community. The sample included 19 young immigrants, who on average had arrived in the United States at age 10, had spent two-thirds of their lives in the United States, and were 30 years old at the time we interviewed them. Half the people in this group were ELLs.

The two highlighted cases of Milagros and Honor describe how youth immigrants' integration and child care options relate to their parents' networks in receiving communities (boxes 5.1 and 5.2). Their experiences relay how varying sources and levels of support can bolster or dampen child care options while coming of age in a new country. Milagros's account captures instability and stressful life events, while Honor's reflects a smoother transition to the United States.

Box 5.1 Milagros's Difficult Transition to Providence

Milagros fled El Salvador in 1986 when she was 16 years old, escaping terrible violence and instability at home during the civil war. Milagros said the turmoil in El Salvador, her emigration, and adjustments in the United States took a toll on her; over time, her relationship with family members in the area became strained and unreliable. After years of successive unsettling experiences, she was a single mother of four children with few options for support. As a result, her child care experiences remained unstable for many years.

Milagros's three oldest children had had a string of negative experience with child care providers, and she recalled how she thought her children had suffered under the care of past caregivers, including physical abuse and neglect. She said she had always been anxious about finding a child care provider who she could trust to meet her youngest child, Mario's, needs. When Mario was born, she dreaded the challenges associated with balancing work and child care. Milagros turned to her sister-in-law, who had helped her find and provide child care in the past. Milagros had come to rely on her as a stabilizing presence and source of support. Her sister-in-law recommended Head Start and spoke highly of the program, reassuring that it was a place she could trust: "Because my sister-in-law said to me 'Look! There's a Head Start nearby. Go apply… it's good… for sure.'" Milagros's sister-in-law continued to watch Mario in the evenings when Milagros worked. Milagros was especially relieved that her sister-in-law and the Head Start staff were both able to tend to Mario's medical needs and asthma attacks, which she said provided her with a relatively rare source of comfort and peace of mind. Absent her sister-in-law, Milagros believed she might have been confined to multiple unstable child care arrangements.

Box 5.2 Honor Transitioned from Reliance on Family for Child Care to Broader Options

Honor, a single mother with five children, was 12 years old when she moved from the Dominican Republic to Providence. Her own immigration experience mirrored that of her mother, who had migrated to New York City and then to Providence as a child. By 2008, Honor was in her early 30s and had benefited from relatively stable settlement and coming-of-age experiences in Providence. She also demonstrated full command of her household, especially when her extended family became less involved as child care providers. Honor remarked, "My mom, she is my biggest help right now, but she has a job now that doesn't allow her to come out as often as she used to. So I can't count on her as I used to. And my sisters, they help me out as much as they can."

Honor explained how she had slowly grown to rely on a family child care provider. She described her in endearing terms: "We talk about everything, even personal stuff. She's like a mother. She's an older person so if I have a problem or an issue with one of my kids, like oh, they're not listening, they're not behaving, she'll just tell me or I'll ask her, 'Can you just guide me or tell me what to do?' She will help me out with that." Honor relied on family child care for her two youngest children. She liked that arrangement for her youngest children before they enrolled in any early education program as her oldest child had done. When we interviewed Honor a year later, she had enrolled her youngest child in an afternoon Early Head Start program. She also continued to rely on her family child care provider for the bulk of care hours she needed for the two youngest children.

Young adult immigrants

Seventeen respondents emigrated as young adults between ages 18 and 24 and were less reliant on their parents' networks for finding jobs, securing assistance, and finding child care. Their child care experiences were often facilitated by a broad range or resources that included extended family, government programs, and friends. Similar to the youth immigrants, most had been in the United States for more than 10 years; unlike youth immigrants, however, almost all the young adult immigrants (14 of the 17) were ELLs.

The examples below illustrate how settlement experiences can affect the child care options and decisions of immigrant parents who arrive during their early adulthood. Akara emigrated to Seattle for marriage and encountered a relatively smooth path for child care as her mother-in-law bridged the complexities of her and her husband's work schedules (box 5.3). Ana emigrated seeking job prospects and experienced difficulties securing stable work and child care in Providence (box 5.4).

Box 5.3 Akara Leaves Cambodia and Joins Her New Husband's Extended Family in the United States

Akara emigrated from Cambodia at the age of 21 after meeting her husband, Atith, there. Akara left her family in Cambodia and effectively joined her husband's extended family. When asked about child care, she said she had deferred to her husband's judgment and expressed gratitude that her mother-in-law provided care for their infant son, Arun, while she worked. Akara beamed and said, "[My auntie] is good because she loves my son." Akara said she worried about leaving Arun with anyone else because she would have no way of knowing if they could take care of him: "I worry about somebody who—with my son—is good or no good." Since Akara and Atith worked different shifts, she said that they rarely saw each other during the week. Arun's grandmother served as a caregiving bridge between his mother's and father's care to ensure continual care for him during the parents' long workdays.

Box 5.4 Ana Starts All Over Twice with Mixed Success before Securing Stable Child Care

Ana, originally from the Dominican Republic, embarked on a difficult journey before settling in Providence. She left for the United States at the age of 23 with her husband and their two youngest children after 13 years of working in different industries in Puerto Rico. They originally settled in New York before joining one of Ana's sisters in Providence. The move proved a difficult transition. The family spent its first week in a homeless shelter and had difficulty keeping jobs long enough to earn two wages at the same time. Ana said she turned to public assistance to make ends meet, including TANF, food stamps, and child care subsidies. During these adjustments, Ana relied on informal and family child care arrangements, but several arrangements turned out to be unstable, and she said she stopped working at one point because she was worried the children were becoming rebellious in her absence and with the changes in child care. She also left work because she could not earn enough to pay for stable center-based child care.

A month before our first interview, Ana had just enrolled her son Antonio in Head Start after her friend had recommended the option. She remarked:

I like the way they work with the kids...although I'm a mother, I learn something every day because they are professionals, teachers, and have studied [child care]. And I learn things from them, too. They set a good example, and that helps me interact well with kids, too, especially with the small ones. Because that age is a really important stage, between four and six years old...My little one has been tough. I've had to interact differently with them... I started to have to change my way of being with him, of correcting him. When I used to correct him gently, he used to take advantage of me ... But now, he doesn't. They are calmer; they obey me.

Adult immigrants

Adult immigrants generally had some greater challenges adjusting after emigrating, and some had fewer network supports to help in their integration. Those who sought and secured publicly funded programs and services (including child care resources) enjoyed more stability than other adult immigrants. Among these parents, finding child care for their youngest children either offered an opportunity to integrate or presented challenges alongside other difficulties, such as finding stable work.

Unlike other immigrants, the 11 adult immigrants who arrived between ages 25 and 41 had thus far spent the majority of their lives in their home country and become more accustomed to their life back home, especially those who had already started a family in their home country or were further along in their career. They on average had arrived to the United States at age 30 and had been in the United States seven years when we spoke with them. All but one of the 11 adult immigrants had limited English proficiency. Their child care experiences were colored by hesitation to start over and frustration with obstacles in their new lives (boxes 5.5 and 5.6). Unlike those who had emigrated before age 25, of which only one family had a child in their country of origin, half the adult immigrants had at least one child before coming to the United States.

Box 5.5 Paloma, a Reluctant Immigrant, Becomes Integrated through Care Options in the United States

Paloma was hesitant to move permanently to the United States—or, as she put it, "I was never drawn to it." She grew up on the border and her oldest daughter was born in Texas, but Paloma considered Mexico her home until she moved at age 27 when her husband got a job in Seattle, where her sister was also living. For about a year after moving to the United States, Paloma said she wanted to go back to Mexico but did not. Her younger daughter Pilar was born two years after she arrived in Seattle. With the new addition, Paloma continued to rely on her extended family for child care and said she did not want to investigate other options. Her outlook soon changed. When Pilar was 2½ years old, Paloma noticed something was wrong. Family members remarked, "She talks like a younger child would."

Paloma visited the local Women, Infants, and Children (WIC) clinic where she had received services and referrals before. They told her about an in-home speech therapy program. The speech therapist brought a Head Start application over to Paloma's home and asked if she wanted to enroll Pilar in "school." Paloma then went to a local early education program that helped her fill out the application. When we interviewed her a year later, Pilar was still enrolled in Head Start and Paloma said that she had made great strides in her speech development. Six years after moving to Seattle, Paloma said her only complaint was that her parents did not also live in the area. A once-reluctant immigrant who considered Mexico her home came to deeply appreciate the early childhood resources she was able to access for her daughter in the United States and in her new community.

María left the Dominican Republic at 27, leaving behind an abusive ex-husband and a well-paying office job. She first arrived in New York; after giving birth to her son Martín, she moved to Providence. She had trouble finding stable work or work that fit her skills, and the transition to temporary factory work was particularly difficult:

Over there I have my career. I have a good income there, more or less, and I'd be with my two kids. I wouldn't have to ask for my daughter [to come to the U.S.]. Here I don't earn a good income, I work standing up, under pressure… Just imagine that I was used to working in an office, in front of a computer, wearing nice high heels, wearing makeup in an air-conditioned office,… and then I came here where I have to be subjected to this and under the direction of people who you know are less educated than you are.

To find work, María knew she needed to find child care. A friend introduced her to a family child care provider in her neighborhood, who became her first option for care. "A friend of mine introduced me to her… told me she had a home day care…. She had a flier that said [she had a] home day care, and it was close to where I lived." Soon thereafter, the provider began taking care of Martín; she has since become a surrogate family member since she is the other primary figure in Martín's life. "We're a team," said María. "She was my first option and my only option." A month before the interview, María began receiving child care subsidies. "It's been a month that I haven't been paying her because I asked for help from the government for child care and the government is paying her…. Thank God, because you can imagine."

The relief proved temporary; María soon lost her job and would not regain stability at work or with child care for another nine months. Eventually, she successfully enrolled Martín in an afternoon Head Start program after she advocated for him by visiting multiple providers and organizations in the community. By then, she had also enrolled Martín in a subsidized center-based care in the morning, which took care of his transportation between the center and the Head Start program. María said this latest mix of arrangements provided much-needed stability for the family. Plus, it covered her working hours, which ranged between 35 and 39 hours a week.

Immigrants' Social Networks

During the second round of the family study, we asked 43 immigrant parents to identify their local neighborhood, or the boundaries of their local area that included the places they visited the most. We then asked our respondents about their family members and friends in their local neighborhood networks, including how many friends and family lived in their area. The data reflect each family's place-based social network. For analytic purposes, we categorized respondents into one of three groups based on the relative size of their neighborhood network:

- 15 had large networks of at least 10 family members, friends, or other people who served as resources in their community
- 16 had medium networks of 5 to 10 people

- 12 had small networks of fewer than 5 people (6 of these had networks of only 1 or 2 people)

We examined how immigrant families with various network sizes chose child care. First, we noted important differences in their use of different types of child care by network size. We then analyzed parents' responses to questions regarding their awareness of local child care options, sources of child care information, and reliance on people in their network for help and advice. The qualitative data, coupled with network data points, revealed how the number of people in one's network (as well as the nature of their connections) could affect child care options and decisions.

Table 5.5 indicates child care use for the types of arrangements of the 43 immigrants based on the network size of the immigrant. Not surprisingly, those with small or medium networks knew fewer people to consult regarding child care. The immigrant families with small networks relied on a single type of care (family child care) for half their arrangements and used relatives for child care less than those with somewhat larger networks. Immigrants with medium networks used relatives for nearly half their care arrangements. Immigrants with relatively large networks—including parents with

relatives and/or family members living in their neighborhood—were distributed more evenly across family child care, center-based care, and informal relative care. In general, immigrant families with larger networks ended up choosing a more diverse set of arrangements, which may reflect a broader source of information and options.

The detailed qualitative discussion that follows explores how immigrant networks affected or shaped parents' receipt of information and awareness of options in the community, availability of child care options, and child care arrangement decisions.

Table 5.5 Immigrant Parents' Child Care Arrangements by Network Size

Network size	Informal relative care	Informal nonrelative care	Family child care	Center-based care	Total[a]
Small	3	1	6	2	12
Medium	9	1	5	4	19
Large	7	2	4	6	19
All networks	19	4	15	12	50

Note: Sample size is 43.

a Totals include primary and regular care arrangements used while parents worked or took classes.

Immigrants with Large Networks

Immigrant parents with larger social networks typically described more child care options, and some had more backup and secondary child care options and varied sources of information and referrals. Large networks therefore helped overcome some constraints, such as information about available care alternatives, though they could not help parents overcome other constraints, such as cost.

Nydia had access to multiple arrangements and benefited from the opportunity to consider a wide array of options before choosing one that best reflected her preferences. A single mother with about 30 family members living within her

neighborhood area, she relied on a network she had built since arriving in the United States more than 15 years earlier from Mexico. She visited several child care providers and obtained recommendations from family and from staff at a local human services office, who also offered transportation and translation. Nydia recognized several care settings in the neighborhood and said she had sufficient options at her disposal. She preferred her own mother when weighing her options but said, "My mother, she's a little sick, and can't commit to that much care."

Nydia visited three child care centers. She said she prized cleanliness above everything when conducting her search, and marveled: "[They were] really clean. The truth is I would see the places and I would say, 'Well, I don't

even know which of the three [to choose]!'" She was also pleased that at one center the staff included teachers who spoke Spanish. She qualified for a child care subsidy and kept her son Nicolás in the same arrangement throughout the year between the first and second interviews of the family study.

Nydia's experience in many respects was made easier because her network was not only large but very knowledgeable about resources for raising children in the area, and because of her own resourcefulness. Although not every respondent with a similar network size had her good fortune, many were able to consider a similar array of options. Iago, for example, arrived in Providence from the Dominican Republic and moved near his extended family. Subsequently, his immediate family arrived with a built-in community that included an active local church. Iago and Inez initially placed their children, preschool and toddler age, in a family child care, but Iago was not pleased with the initial choice: "We noticed that the babysitter was more interested in the money than caring for the kids." Iago turned to his network because he wanted a more structured child care setting like a center: "We had other options, like my mother for example, but we didn't use them."

Eventually, Iago and Inez settled on a family child care provider, qualified for a $75 subsidized co-pay for the care, and put their son, Ibrahim, on a Head Start waiting list as a backup:

> We have a person now who's in the babysitting business but … we already had this person; we were already linked to her, and I'd feel bad separating the kids, on the one hand because they are already used to her and her schedule, and also because taking the kids away from her; you know, it would be giving her less business. I mean, that would really weigh heavily on me.

A year later, they enrolled Ibrahim in the Providence's pilot public prekindergarten program after entering and winning a lottery for a slot. When Ibrahim was not attending this program, Inez stayed home to care for him after leaving work for reasons unrelated to child care.

Nicolás' and Ibrahim's parents eventually chose center-based care and, like other parents with large networks, considered multiple types of care options before choosing an arrangement. When Rita, a Mexican mother in Seattle, sought child care, she turned to key family members, her many friends, and a local service provider to learn about options in the area. She said she did not experience a shortage of options, including some among her personal network who could provide child care; "Of all the friends that I know, I have many to choose from, but they weren't as convenient as [the friend I used]."

During her search, Rita heard about Head Start but said she was initially unaware of other center-based options. When she learned about and considered a non-Head Start center arrangement that she could only afford with a child care subsidy, she decided, "I wouldn't be able to do it because I'd have to report what I earn, and I get paid in cash." She had also formed other reservations about center care for her 3-year old daughter Rosita:

> There are more kids [at a center], and perhaps they're better equipped to care for them, but no. I know a few people who have their kids [in a center], and even there they don't pay attention to them …. Nobody can give them love like you can, but they don't pay attention to them [at a center].

When we first spoke with Rita, her mother was taking care of Rosita for $15 a day. During our follow-up interview, a neighbor was taking care of Rosita, and Rita said she had other options within her large network she could turn to as well. Rita had no complaints about either choice and succinctly summarized her priorities for child care, which concisely reflected many other parents'

sentiments: "Confianza, respeto, limpieza [Confidence, respect, cleanliness]."

All families with large networks said they had multiple options and were pleased with their care choices at the time of our last interview. In some instances, however, a large network coupled with multiple options did not translate into favorable outcomes. Lupe said she had tried many arrangements for her infant son Leandro, in large part using referrals from her extensive neighborhood network. Leandro had had several short-term arrangements (sometimes multiple arrangements at the same time) as an infant: family members, a neighbor who lived nearby, a number of friends, and a family child care provider she learned about through friends. When we asked whether she had enough good options, Lupe replied,

No, what options? … There was a time when … I used to take him every day with [a friend, plus] two days with another woman who lives really far away, and one day with my sister. And my husband would say, "You should really try to take him to just one person."

Lupe said she could not find reliable, consistent providers. At one point, she could no longer find anyone to take care of Leandro consistently at night or on the weekends, so she stopped working on Saturdays and Sundays. When asked about other child care options in the area, Lupe said she was aware of some but was hesitant. She explained, "Yes, there are a number of places, and they all charge a lot of money, and the American ones [are] really expensive."

Between our first and second interview, Leandro had begun a new family child care arrangement with a neighbor. But Lupe said she was mostly unsatisfied with the arrangement because she found the provider inattentive. She said that she considered placing Leandro back in one of his previous arrangements but presumed it would be

equally disappointing. Lupe said she had applied for child care subsidies but did not qualify because she and her husband's combined incomes exceeded the eligibility threshold. Although she said she had plenty of backup options and could try fitting together several different arrangements, she did not have consistent, reliable care she could afford for Leandro.

Immigrants with Medium Networks

Unlike immigrant parents with large networks who used their connections to help them navigate the child care options in their communities, often finding multiple care options that met their needs and preferences, parents with smaller networks frequently said that there were few or no child care locations in their neighborhood. However, the number of center and family child care providers in the area was usually somewhat broader (at least on paper) than what these parents perceived. This disconnect is not surprising. When seeking child care, these immigrant parents turned to relatives more frequently than other immigrant parents. In fact, about half of parents with medium networks relied on closely knit family members as their main (and many times their only) option.

Camila, a young Dominican woman in Providence, was a relatively new mother with an 8-month-old daughter, Cristina. After her relationship with Cristina's father disintegrated, Camila relied on her mother—who lived in the same building—and aunt to help raise Cristina and to be her primary care providers. Camila was working full time as a cashier at a casino, taking classes, and completing an acupuncture internship. She said she had little time to look for child care, and that she had done Internet searches rather than getting personal referrals. Camila said she had visited a couple of centers where she

had wanted to enroll Cristina but said, "It's too expensive. I can't afford it."

The decision to rely on relative care was common among immigrant parents with a medium-sized, close-knit network. Tahzib, a Somali immigrant living in Seattle, also relied on her mother—who lived with the family—to care for 9-month-old daughter Tahira based on her preferences as well as her network. Reflecting on the decision, Tahzib cited logistics and other reasons. She said, "It takes more time to drop them off [at a center]." She continued, "I don't think it's safe, like home day care, I've heard a lot of people complain. This way is safe. I don't have to worry about them." Tahzib noted that she had also considered a family child care program for her infant daughter, but "decided it wasn't the right thing for me" and did not pursue it.

When asked to identify child care options in her area, Tahzib mentioned that she noticed a Head Start program one day, stopped by to learn about it, and signed up Tahira's 3-year-old sister on a waiting list. In addition, she had heard a local center was an excellent option but then quickly interjected, "I don't know what I know about it, so I'm not going to use it, so I'm not interested in it." Tahzib said she had not learned much about any other options because she knew few people in the area. Her friends echoed her own preferences for family, and Tahzib looked no further. Absent good information about multiple alternatives, she decided it was safer to entrust Tahira to her mother and sister, who provided primary and secondary care, respectively.

Some families with small or medium-sized networks did not have a close, available, capable, and trusted parent or friend to care for their young child. Maricela, a Mexican immigrant and single parent who lived in Seattle, made her child care decisions under a number of constraints, including a relatively limited network. She had no friends in the

area and relied on a few family members as her network. While she was looking for a consistent child care arrangement, her sister-in-law—her only family in the area—offered to take care of her 2-year-old son, Manuel. This was not the arrangement Maricela preferred, and she had a tense relationship with her sister-in-law, so she looked for other alternatives.

Maricela visited two child care options that she noticed while walking through her neighborhood. She said she walked away from the first center because they spoke only English and had no interpreters. She also stopped by a family child care provider and liked that the caregiver spoke Spanish and was available on Saturdays. "She was the only person I talked to." However, she could not afford the cost of family child care and indicated that she was waiting to hear about an application to receive a child care subsidy in order to help pay for it. Meanwhile, she relied on her sister-in-law to take care of Manuel but continued to hope she could find something better and make a change. She was unhappy with the arrangement and could not always pay her sister-in-law. "When it didn't go well, I'd tell her that I'm going to pay her less because things aren't going that well." A year later, Manuel was attending family child care with the provider Maricela had found the year before, with the help of an approved subsidy.

In addition to providing child care, relatives in these medium-sized, but relatively close-knit, networks often provided information about other child care options to transition children to nonrelative care as children got older. Honor, a Dominican single mother of five in Providence, had worked two jobs when her older children were younger, and her mother had secured a child care license and took care of them. "It was too much for me. My mom took care of my kids at night, and she was certified through the

state." After a few years, her mother could not care for Honor's children because of work obligations, and Honor had no other friends or family in the area who could take care of her children. As a result, she conducted a broader child care search.

Honor said that she knew and recognized a number of centers in the area, mostly because her older children had attended a number of after-school programs or centers, and that she really liked one center that her sister used, but it was not an option. "Their waiting list was long, so I had to choose a home care." Honor's aunt then referred her to a family child care provider for her youngest son Hector. Honor explained how she made the most of her tight-knit network:

> My grandmother had worked with [the provider's] husband, and her husband had said to my grandmother—because my aunt was working part time and then at that moment [my mom] started working full time and [my aunt] needed somebody to watch her daughter, so her husband had talked to her about her, and she just had finished getting her license also.

The provider then became a trusted friend and part of her network and had been taking care of Hector for two and a half years during our first interview while the boy was on a Head Start waiting list. When we returned a year later, Hector still attended the family child care program, never having received the coveted placement in Head Start that Honor had sought for him.

Immigrants with Small Networks

Immigrant parents with small and very small networks had very few sources for child care information and child care options, and were more likely to experience child care instability. Several families with small networks said they learned about child care options by trial and error, describing a series of short-term arrangements. For some immigrant parents with small networks, local public resources became pivotal sources of child care information.

Teresa, a Dominican single mother of two children, had a very limited social world. Her weekly routine consisted of work and taking care of her children after getting home from work. She said she rarely left her block, except to work or walk down the streets for groceries. Teresa did not see anyone in her neighborhood regularly: "In this country, there is no time to see or talk with neighbors. Everyone is doing something. You get in the car and go to work." Every morning, Teresa picked up her mother and drove her back to the family apartment to take care of Tomas, her 2-year old son. This was the only care arrangement she had ever used for him, and Teresa said she had no alternate arrangements as a backup. When asked who else might be able to take care of her children, she said she could try to look for someone else but that she did not have any ideas. At the time we spoke, she had no complaints about her current arrangement but also had no other options.

Most immigrants with a very small network did not have a single, stable arrangement, such a consistent close relative to provide care, and some seemed to routinely balance several short-term arrangements. Over the years, Boupha, a Cambodian immigrant in Seattle, had tried a number of care arrangements by trial and error. Boupha had no friends in the area and relied on a few family members for support. When asked what advice she would give someone seeking child care, Boupha would recommend that they "look in the computer, maybe in a newspaper … Ask them if they have parent [in-law]. If not, go walking and looking for home day care, child care." Within her isolated network, she remained mostly unaware of the various options in her neighborhood.

Eight years after arriving in the United States, Boupha began working at a child care center. She learned about subsidies, applied, and qualified by the time it had come to enroll her third child, Boran, in center care as an infant. When asked about subsidies, she said, "If you low income, they will help you, but if you [both]work and have high income [together], it's no." She later lost her subsidy when her household income rose beyond the eligibility threshold, and she turned again to her mother-in-law for child care. Boupha remarked, "She takes care of them good, and especially now I have no choice. I don't have anyone else to watch them. And if I put them in the day cares, it's more, you know, 'cause there are three kids, altogether it would be all my income to pay for their day cares." A year later, Boupha had yet to find a stable arrangement or to get her children back into center-based care.

Nina also experienced a series of short-term arrangements and found and used care over time through trial and error. She was a first-time parent, largely unfamiliar with local family child care and center-based options for her 2-year-old son. Since she knew none of her neighbors and had only a few family members in the area, she turned to coworkers for advice and tried various child care providers. She liked her first provider and said, "I never had complaints." However, the provider moved away, and Nina knew she did not want to quit her job to stay home: "The truth is I always liked working … And I used to say that I also want to work, I don't want to depend on what [my husband] gives me."

Nina then tried a series of different providers she met through her coworkers. Her son Nesto's arrangements sometimes changed every few days, and none lasted more than two months. The changes resulted in a constant state of child care instability. "I had about 10 babysitters, after the [first] lady who had him for about 10 months." Finally, a coworker recommended a nearby family child care arrangement and helped her apply for a subsidy she would need to afford the arrangement. She qualified for subsidy assistance, and she started the care arrangement. Reflecting on her experiences, Nina said that having more family around would make child care easier because she would feel comfortable leaving Nesto with them: "You can always trust family."

Some parents with very small networks turned to other sources for support. When we first spoke with Silvia, a friend was taking care of her son Santiago three days a week while she and her husband worked. When asked what she would do as a backup option, she said, "My first option would be to look for day care, and my second option would be to try to change my hours." During our follow-up interview, Silvia's work schedule was no longer stable and predictable. She decided to look for a full-time, stable, and affordable child care arrangement. Given her isolated network, she decided to visit a WIC clinic to ask about child care. "They always give you good information over at the WIC [clinic] about food stamps, food banks, child care, and English classes." The staff described different options to her and then helped her enroll Santiago in a local center-based program and a Head Start program, which between the two have full-time care hours. Without the staff at the local clinic, Silvia might not have learned about other options or received the assistance that she needed to apply.

Vega came to the United States in 1997 as a refugee from Somalia and had no family or close friends in her neighborhood. She relied on the local offices (including government and nonprofits) for information about public assistance programs, child care subsidies, and child care options. Vega applied and received a subsidy for relative care, and made co-

payments to a relative who took care of Khalid, her son. She also knew about Somali child care providers who advertised their services at the welfare office or the YWCA: "We have Somali child care. They are licensed and to put your kids in you have to know the person, how they treat them, how they're doing." Her ability to access community resources made the difference between having reliable child care and possibly trying to piece together unstable child care arrangements.

Summary and Conclusions

Not surprisingly, foreign-born and U.S.-born parents alike identified many similar factors when discussing their child care options and eventual decisions. This chapter briefly discussed some of these similarities in decisionmaking factors and child care use by immigrant families, and focused on some important distinctions in child care decision making that emerged when speaking with immigrant parents.

Immigrant families cited several influences that affected their child care decision making, which highlights how their experiences as immigrants could have implications for their child care decisions.

- First, when asked to describe what was most important to them in a child care arrangement or what their ideal arrangement might be, many immigrant parents recalled their own experiences growing up and being cared for primarily by parents and relatives. Some discussed how nonparental care itself was not ideal to them, but many reasoned that they wanted to or needed to work, and sought care that best approximated their own experiences and care preferences. For a good many, this meant that if they were not going to be caring for their child, they wanted an available relative, especially when children were very young.

- Second, immigrants expressed a strong preference for a trusting relationship with the caregiver. The possibly more intense emphasis on trust may be related to immigrants needing to rely on the few people in the community who are familiar to them within a new culture with different childrearing practices. Language barriers that made communication with some potential providers more difficult could have also contributed to this added emphasis.

- Third, unlike nearly all U.S.-born parents, immigrant parents routinely discussed their preferences regarding the language spoken in child care settings. This factor is discussed much further in the next chapter.

Immigrants' age at arrival also helped shape their later child care experiences. Immigrants who arrived in the United States as youth thrived or suffered depending on their parents' networks in receiving communities. Immigrants who moved to the United States during their transition to adulthood (age 18 to 24) turned to a range of other people as a resource for child care options. Immigrants who settled in the United States at age 25 or older had typically spent most of their lives in another country. Their child care experiences were marked by hesitation to start over and frustration with the challenges of adjusting in their new lives.

Immigrants' neighborhood networks of family and friends strongly affected their child care options and decisions.

- Immigrant parents with larger networks typically were aware of or had access to multiple options, including many different types of child care. Often, their different options resulted in broader and more productive child care searches, plans for backup arrangements, and more varied sources of information and referrals. Large networks alone, however,

could not always overcome all these parents' constraints, such as cost or limited supply of some types of care.

- Parents with medium networks described a narrow range of options and often said they knew of few or no child care locations in their neighborhood. These parents relied on relatives for child care more often than other immigrant parents.

- Immigrant parents with small networks were especially isolated and even less aware of sources for child care information or care options. Many of these parents experienced child care instability and child care searches that were marked by trial and error. In a few cases, local community and government resources helped them seek and secure child care.

CHAPTER 6: ENGLISH LANGUAGE LEARNER PARENTS

Child care decisionmaking can be very complex for multiple reasons. As highlighted in the previous chapters, this process is even more challenging for low-income families that face transportation difficulties, limited financial resources, and shifting work schedules. Lacking English language proficiency can add a further layer of complexity for many low-income working families as they navigate the child care system.

This chapter addresses questions about the child care decisions for English language learner (ELL) families, specifically the following: How does language affect, inform, or constrain their child care options and decisions? Do the child care decisionmaking factors—and the types of care used—differ for ELL and non-ELL families?

The overlap between ELL and immigrant respondents was significant (table 6.1), but the two groups did not completely overlap, and it is important to distinguish how language status might guide aspects of care decisions differently from immigration status. Since the level of English language proficiency varied substantially across our sample, a family's language served as an important variable. Our analyses focused on two broad themes that emerged most prominently from the data we collected. The first, and complementary to the findings in chapter 5, was that ELLs also tapped into their personal networks to learn about child care options, including family, friends, and neighbors who spoke a language other than English. Second, when weighing different child care options, some ELL parents preferred arrangements that provided greater English exposure while others wanted arrangements where their families' native language would be spoken more within the care setting.

The English Language Proficiency of the Study Sample

Our study sample included a significant number of parents who lacked English language proficiency. Almost half the interview respondents self-identified as ELLs—those who were currently or recently enrolled in English as a second or other language (ESOL) classes or responded that they lacked basic English language skills. As would be expected, there was a large overlap between ELLs and the foreign born, with 37 of the 52 foreign-born respondents identified as ELL (see table 6.1). As described in chapter 5, the immigrant respondents arrived in the United States at different points in time, and many who arrived in their youth were English proficient. Also, some immigrants who arrived as adults had learned some English in their native countries. As a result, they varied in their English language proficiency.

Table 6.1 English Language Learner (ELL) Respondents by Nativity

	Foreign-born	U.S.-born	Total
ELL	37	3	40
Non-ELL	15	31	46
Total	52	34	86

Among the ELL respondents, the three who were U.S. born all spent much of their youth in Puerto Rico or the Dominican Republic. One was born in New York but soon after moved to the Dominican Republic and did not return to live in the United States until she was in her early twenties. Another was born in Puerto Rico, moved to the mainland at age 2, moved back to Puerto Rico at age 12, and had only recently returned to the U.S. mainland as an adult. The third was born in Puerto Rico and had lived in the United States for over 30 years since age 11. These three respondents spoke Spanish as their native language,[6] and it was not until their late childhood or early adulthood that they began to study English.

Interview Questions and Language Used

Parents' primary or preferred language was determined before the interviews when families were recruited, screened, and their interviews scheduled, so either a Spanish-speaking interviewer was assigned to the family or, for speakers of other languages, arrangements were made for a translator. Respondents who were not English proficient were asked about their language skills and the role of language in their child care decisionmaking process. Specific questions included the following:

1. Which languages does your child mostly speak (or which languages is your child learning) when at home? When in child care?

2. What is the language used by your child care provider? Does the child care provider speak your language? If not, how do you communicate with the provider?

3. What language or languages do you think it is important to have your child exposed to when in child care? Did the language used by the provider influence you to select this provider?

Of the 40 ELL respondents we interviewed, the majority (32) spoke Spanish as their native language.[7] Three interviews were conducted in Somali and two in Khmer using native translators who reported back to interviewers in English. The remaining three ELLs (one Cambodian and two Somali) had at least a basic level of English language proficiency and responded to the interview in English.

As part of the interview protocol, ELL respondents were asked to report on their level of English language verbal proficiency and English language comprehension on a five-point scale (1 = none, 2 = poor, 3 = basic, 4 = proficient, and 5 = fluent). About half the 40 ELL respondents reported having a basic level of English verbal and comprehension skills, with comprehension skills generally rated higher than verbal skills, while the remainder mostly reported poor skills. Only three parents reported having no English verbal skills, and no parent reported having no English comprehension skills, indicating that all respondents could understand at least some spoken English words but not at a basic or conversational level.

Children of ELL Parents and Language Exposure

Children of ELL parents varied in their exposure to languages both at home and at child care. The variation among families was associated with several factors, including parents' level of English proficiency, parental preference for speaking their native language versus English in the home, the presence of older school-age siblings, and the dominant language of the child care provider and other adults and children within the child care setting.

According to ELL respondents, their native language was the dominant language (i.e., preferred spoken language or primary language being acquired) for roughly two-thirds of the focal children in the sample while English was the dominant language for the remaining third. It was difficult to identify the dominant spoken language for the large number of infants in the study sample, but parents commonly reported speaking only their native language to their infants. As their children grew older, their exposure to English through external sources—television, peers, and school settings—became greater.

Most ELL parents voiced a preference for their children to speak their native language in the home. Some parents did not understand English well enough to communicate, others spoke their native language at home because close relatives (such as grandparents) did not know any English, or (in most cases) parents preferred the use of a native language as an effort to preserve the family's native language and culture. Regardless of English proficiency, parents who wanted to ensure their children spoke their native language made an effort to speak to their children only in their native language while at home.

Families whose focal child was older (i.e., age 3 or 4) or had school-age siblings showed a different language pattern from those with a single young child. Parents reported that focal children who were relatively older often had a strong command of both their parents' native language and English, which they learned outside the home in early care and education settings, from friends, or from television; younger children, who were still developing basic language skills, usually learned the family's native language first and occasionally spoke some English words or a blend of both languages. Children often learned English from older siblings, and some parents struggled to get their children to speak their native language in the home since their children preferred to speak English with each other.

Parents suggested that children's language skills were strongly associated with the languages that they were exposed to in child care. ELL parents often viewed child care as an opportunity to either reinforce their native language or learn a new language. The language used by the provider as well as the presence of learning activities in the care setting—particularly those focused on English—were key factors for ELL parents. Some ELLs described a preference for a bilingual environment where their children could both learn English and speak their native language, and where the parent could communicate with the provider, while others had a preference for a native-language-only environment that would preserve children's native language and culture (with the belief that they would learn English later in school). Still others wanted an English-only environment where children would be fully immersed in the English language to prepare them for school and their future success in the United States (with the belief that they would learn their native language at home but that their parents lacked the ability to teach them English). These preferences were roughly equal in frequency; however, we sometimes found blurred lines between parents' desire

for a program that would teach children English, but that had bilingual staff that could assist the parents, and their desire for a program that was truly English immersion or bilingual.

Preferences for particular language environments also varied by child age as well as prior experience with child care for sibling children. Many parents desired care arrangements for their infants and toddlers that were similar to the home environment, with the same language, culture, and food. For older preschool-age children, many ELL parents looked for settings where their children would be exposed to English and learn necessary cognitive and social skills to prepare for kindergarten. The latter finding is consistent with previous research that has found that, among immigrant families, one main reason for sending children to child care centers is to help them learn English from native speakers (Obeng 2007).

The examples in the next sections capture parents' views on their children's language acquisition, which usually entailed a preference for learning multiple languages in different settings, but retaining the child's native language.

ELL Parents Promoting Retention of a Non–English Language at Home

Yolanda, a Mexican immigrant, described how she and her husband wanted their three children to speak only Spanish at home. "Among themselves they speak English, but with us we make them speak in Spanish. We don't want them to lose their Spanish." When Yolanda spoke to them in Spanish, they responded in Spanish, but her 4-year-old sometimes mixed the languages when talking with his parents: "Me puedes servir juice?" Her husband was not worried about the children learning English: "We're not worried

about English. English they learn at school. Spanish, only here." Their children spoke English with their friends, too, including their Latino friends. Yolanda and her husband were, however, worried about their children losing their Spanish skills and wanted their children to go to a bilingual school to perfect their Spanish skills: "Right now they speak and write in English. They speak Spanish but don't write it."

Iago and Inez from the Dominican Republic also expressed concern over their children losing their Spanish skills.

> We are realizing they are losing [their Spanish], meanwhile English is gaining an edge. There are many times that you say something to them and they don't understand you .… But the influence of the television and also school can be more than the Spanish that they learn in the home.

The couple expressed how they wanted their children to know both languages, but the language programs at their school did not support bilingualism. "[The language program] is not sufficient for the kids. It's for kids that live in this country who speak Spanish. The interest of theirs is that they truly speak English … the objective is that they dominate English."

Having older school-age children also affected the use of language in Tonya's family. A single mother from Guatemala, she stated, "Sometimes the children speak in English, but I tell them, 'please speak Spanish,' because they have to learn … because as we are Hispanic, we speak Spanish." Tonya explained that her three children preferred to speak in English with each other, but her youngest (22 months) was learning both English and Spanish. She hoped he would speak both languages being with a Spanish-speaking family child care provider.

Additionally, some non-ELL respondents who were bilingual chose to speak their native language with their children. Camila,

who emigrated from the Dominican Republic in her youth, was fluent in English but spoke only Spanish with her infant daughter. The child's aunt and grandmother—her two child care providers—also spoke only Spanish with her. Camila explained,

> Why would I speak English to her if she's gonna learn it in school? I want her to know Spanish. 'Cause it's harder, like, if you talk to them in two languages at the same time, she's not gonna know anything. She's just gonna get confused and not talk anything at all.

Her sentiments echoed those of ELL parents who were worried their children would grow up not knowing their families' native language.

ELL Parents Exposing Their Young Children to Multiple Languages

Most ELL parents reported speaking only their native language in the home with their children; however, some described occasionally using English to introduce their children to new words or responding to their children in English when they spoke English. The importance of learning one's native language and culture while also acquiring English proficiency resonated among many families, particularly those with older children who were approaching school age.

Vega spoke primarily Somali in the home but understood and spoke English comfortably as well. Her children spoke English among themselves, while she and her husband spoke Somali to them: "I try to speak our language .… Sometimes I mix it, sometimes I talk my language and sometimes English." Tahzib, another Somali mother, explained that her toddler daughter had not had exposure to English but that she was introducing her to some words, as she would like her to speak both English and Somali "because she's in this country and that's what they speak, and I want her to learn." Similarly, Tahzib wanted her daughter to be able to speak English with her friends.

In several families, one parent spoke English fluently while the other preferred their native language, and their children varied their language depending on with whom they were speaking. Vera likened the language mix of her son to a "rice and chicken" combo: "He has an 'arroz con pollo'… the father in English and I in Spanish." She described how her 11- and 9-year-old children spoke and understood both languages, but her 5-year-old had not wanted to speak Spanish. Because her older children spoke English at school and with each other, and their aunt who provided child care for all the children preferred English, her youngest had developed a stronger preference for English as well. He would answer in English if spoken to in Spanish.

According to one Somali mother, she preferred speaking Somali in the home but anticipated that her children would learn to speak English in child care: "In general, kids like English. I don't know why ....You cannot tell them to speak your language because the other kids speak English, too. They have to speak English." Maricela also emphasized the importance of being bilingual to go further in life. "I feel that now it is very important to speak both languages. Those who speak both can advance further, because there are lots of programs in English and Spanish, too." According to Maricela, when she moved to her neighborhood, there were no programs for youth in Spanish, but many bilingual programs had been launched since. She wanted her son to speak both English and Spanish with his friends and in school for the same reasons.

Children Learning More than One Language across Home and Child Care Settings

As previously mentioned, ELL parents often considered the language of the provider when selecting child care—either preferring or purposefully selecting caregivers who spoke a particular language. Providers widely varied in their English language proficiency and use of English. Those who worked in Head Start or center-based programs generally spoke fluent English with some bilingual teachers or family support staff. In family child care homes, ELL families often selected providers who spoke their native language to maintain continuity between the home and child care environments, but some providers who served children from different backgrounds spoke primarily English, even when it was not their native language. Children who were cared for by older relatives such as grandmothers were generally exposed only to their native language. In some cases, however, such as Vera's, younger relatives used both languages or had a preference for English.

María from the Dominican Republic selected a Spanish-speaking family child care provider to reinforce her 3-year-old son's Spanish skills. He understood Spanish but primarily spoke English, and María wanted him to be truly bilingual. She described how her sisters who were raised in the United States were not comfortable with their Spanish and blamed it on the large child care centers where they went when they were little.

I want my son to speak both languages perfectly and write and read them. Because I have a few sisters that were born here who vaguely speak Spanish and don't know how to write in Spanish. They say they can read, but I doubt it. They understand you, but they respond to you in English. And my mom doesn't speak English …. they were always under the care of those big day cares.

Conversely, Lupe, an immigrant mother of a 4-month-old boy who received child care from a neighbor, said she preferred that someone who was not Latino take care of her son so he could learn both English and Spanish before starting school. "I prefer that it be someone who is not Latino, because here in the house, we speak only Spanish, and I want him to learn both languages from the time he's really little and he has to learn before he goes to school." She described seeing Latino children struggle because they did not speak English like their peers at school and did not want her child to be in this situation. "It's the case of many Latinos that when they go to school they have a hard time because … all their little classmates speak English and they don't."

Although bilingualism was generally viewed as an asset, several parents expressed a concern about their children learning more than one language simultaneously. They said that this experience might confuse their children and contribute to a language delay. Suchin, a non-ELL mother who emigrated from Thailand as a young child, explained, "I think the kids should know more than one language and it's the best time to teach them now, at a young age, because they're more receptive to that." However, she also thought her 3-year-old son's speech delay stemmed from the multiple languages he was learning, including English, Laotian (which his mother also spoke), and Portuguese Creole (which his father also spoke).

I noticed that he wasn't saying a lot, but I think that was more part of a denial thing [on my part, and I was] thinking that he'll be okay, [that] he'll say more …. He gets frustrated when he's trying to say something and we don't understand him, so hopefully it will really help him.

94

Her son had been receiving speech therapy since he was 2.

Similarly, Diana, a non-ELL of Puerto Rican and Dominican heritage, described that her 2-year-old son Dominic's change in child care arrangements—from being with his grandmother who spoke only Spanish to a family child care provider who spoke primarily English—might have confused her son in the beginning and delayed his speech. "I thought the reason he wasn't talking was because of the language … I was thinking it confuses him [and] that's why he was talking the way he talks, because he doesn't know whether to talk Spanish or to talk English." Chapter 7 in this report further explores the perceptions of parents whose children participated in speech-related interventions.

Types of Child Care Used by ELL Families

ELL respondents within the study sample used similar child care arrangements and at relatively the same rates as non-ELL study respondents. Also, an equal number of ELL and non-ELL respondents used a secondary care arrangement. These similarities mirror those between immigrant and U.S.-born parents in the sample with some minor differences found between ELLs and non-ELLs in the sample. ELL respondents used family child care and center-based child care slightly more than non-ELLs and informal

relative care less often (table 6.2). Additionally, while children of ELLs and non-ELLs were enrolled in center-based care at an equal rate, children of ELLs were enrolled specifically in Head Start at a rate twice that of non-ELLs (23 and 9 percent, respectively).

The ELL families in the sample may have met income eligibility criteria for Head Start more often than other families. Some Head Start programs also may have given priority to ELL children, as lack of English skills is often considered a risk factor in terms of school success. This finding supports results from the 2001 National Household Education Survey that showed that, among children age 2 to 5 in center-based care, language-minority children were more likely to be in Head Start than non-language-minority children (32 versus 12 percent, respectively) (Ishizawa 2006).

ELL respondents used informal care arrangements slightly less than non-ELL respondents in the study sample did. This finding varies from previous research showing that non-English speakers are more likely to use informal care arrangements than formal care settings, such as center-based care (Fram and Kim 2008; Hirshberg et al. 2005; Ishizawa 2006). However, because we categorized any nonrelative home-based group care settings as (licensed or unlicensed) family child care, the line between informal and formal care in our study differed from that in other research. Looking strictly at

Table 6.2   ELL and Non-ELL Parents' Primary Child Care Arrangement Types

	Informal relative care		Informal nonrelative care		Family child care		Center-based care		
	n	%	n	%	n	%	n	%	Total
ELL	17	33	3	6	16	31	16	31	52
Non-ELL	28	47	4	7	15	25	13	22	60

informal relative care in our sample, usage rates were slightly higher for non-ELLs, while the use of formal center-based care was the same for both groups. Also, the children of ELL respondents were slightly older on average than the children of non-ELL respondents (29.8 and 24.7 months, respectively), which might explain part of the small variability in care arrangements—since younger children in general were cared for most often by relatives and children must meet age criteria to enroll in Head Start.

Decisionmaking Factors for ELL Families

To examine the role of various factors in the child care decisions of ELL parents, we compared the decisionmaking factors that motivated ELL and non-ELL parents' child care choices. We found several large descriptive differences. First, only ELL families cited the language used in the child care setting as a reason for selecting a particular care arrangement; however, this was the case for only six respondents, or 15 percent of ELLs. For example, Raisa, a 28-year-old single mother who emigrated from Guatemala five years before her interview, stated that being Hispanic is important, but not as important as speaking Spanish, for choosing a child care provider: "Because sometimes you understand but you don't know how to respond to what someone is saying to you, so it's better for you to communicate and know what the children are doing and how they're being treated [by child care providers]." Similarly, Sonja, a Peruvian mother with a toddler in center-based care, explained that she liked that the staff was bilingual "because there are so many children that speak Spanish there, [the children] get used to it."

ELL families in our study were influenced by the nurturing or positive personality of the caregiver in her relationship with the target child. Also, ELL families selected their child care somewhat more often based on the type and quality of the food provided than did non-ELL families. They also tended to already know (or, in some cases, seek out) other female neighbors who spoke their language and shared the same culture and foods. As a result of these commonalities, they developed a relationship with their providers and identified them as good caregivers for their children. Additionally, a greater number of ELL respondents reported the learning opportunities within the care arrangement—particularly the acquisition of English language skills—as an important factor. Many of these families enrolled their children in Head Start or center-based care to provide them with an environment that would stimulate their learning and language development. Families who selected other types of care also valued learning opportunities but did not readily mention structured learning opportunities when discussing their primary decisionmaking factors.

When ELL parents' relatives lived nearby and were available, they were generally the first choice for care or provided secondary or intermittent care. However, as explained in chapter 5, some ELL families had smaller social networks as a result of immigrating to the United States later in adulthood without parents or relatives who could assist with providing care for their children. Compared with immigrant families as a whole, ELL respondents had moved to the United States in later childhood or early adulthood, earned somewhat less, and had more nonstandard work schedules and unstable unemployment. This group (immigrants who were also ELLs) specifically described a lack of transportation

or convenience, high child care expenses, and the lack of flexibility of child care arrangements around their work schedules as barriers. These constraints limited their use of center-based care or other formal care arrangements, much as it did for other families. As was common in the sample as a whole, ELLs often selected child care arrangements that were convenient, affordable, and flexible.

Compared with the non-ELL families in our sample, a larger percentage of ELL families had older children, and fewer were first time parents. ELL respondents more often described a previous child care experience of an older child as well as their own childhood experiences as influencing their decisions. This was particularly the case when maternal grandmothers were selected to provide child care, because mothers desired that their children have the same care experience that they had growing up and believed their mothers knew best.

Some differences also existed across the two study sites. Availability and expense were cited more often by respondents in the Seattle site, while care characteristics, such as the physical environment, learning activities, quality of meals, and socialization with peers, were cited more often by Providence respondents. However, some of these differences may stem from differences among the families interviewed, as the Seattle parents had more infants and toddlers, while more Providence families had preschool-age children.

Information Sources: How Do ELLs Find Out about Their Child Care Options?

The availability of information about child care options is a main component of the child care decisionmaking process. We were particularly interested in how ELL families came to learn about their current care arrangements given the language barriers that they faced, and the resources or individuals that informed their choices.

Compared with non-ELL respondents, ELLs reported using a narrower range of resources to seek information about child care options. Similar to the sample as a whole, they relied mostly on family and friends to provide advice or assistance. However, unlike the non-ELLs, ELL respondents relied much less on their personal experiences when making a child care decisions. This difference may result from ELL families having lived in the United States for a shorter time than non-ELLs, not having experienced the child care system before, and having fewer members in their networks (such as an older generation) who had raised children in the United States.

English language proficiency—or the lack thereof—appeared to be associated with families' use of formal sources for child care information. About 9 percent of all respondents reported getting help from a state agency to find child care—roughly the same rate for both ELLs and non-ELLs. However, no ELL respondents used a child care resource and referral agency, while seven (or 14 percent of) non-ELL respondents did. Families were not always clear on the differences among government agencies. When asked whether they knew about or used local CCR&Rs in their area, only one ELL respondent reported being aware of child care resources, which she learned about at her local Department of Social and Health Services office when she applied for public assistance and job training. These results suggest that some government agencies in our study sites were equipped with bilingual staff or translated resources and materials for ELL families, and that they may have assisted families with their child care search when they came to apply for child care subsidies or

other work support or public benefits. Yet, few ELL families were specifically aware of CCR&Rs in their communities and the resources that they provide.

The Role of Language in Child Care Decisionmaking

As previously described, ELL parents varied in their level of English proficiency and, as a result, their options for child care and their awareness of available providers. The following sections focus on how language played a role in parents' child care decisions. We selected two families from each study site with varying levels of English proficiency and different care arrangements in order to capture variation among families in each subgroup. These illustrative examples highlight the varied experiences of ELL families when arranging child care for their young children.

Very Limited English Proficiency

Maricela, a single mother of two who emigrated from Mexico in her early adulthood, was renting a basement apartment in her brother's home at the time of the first interview, where he and his wife and their three children also lived. Maricela relied on her sister-in-law for child care and paid her $30 a day to provide full-day care for her 2-year-old son, Manuel, and before- and after-school care for her 6-year-old daughter, Maria. Maricela worked as a hairdresser but recently faced a reduction in clientele due to the deteriorating economy, which greatly affected her pay. Tension arose around her sister-in-law's expectations for payment, which caused Maricela to look for a new child care arrangement. As she explained, "There just isn't enough clientele to have the extra expense of paying for my son."

Maricela applied for child care subsidies the day before her first study interview because she did not make enough money to pay her sister-in-law. By the second interview, she had received a child care subsidy and made a co-payment of $50 a month for care for both her children outside the home. Maricela had some trouble with the subsidy application process, particularly with the documentation required. Her salon paid her in cash, so she had difficulty getting proof of income for the application. She also paid her brother rent in cash, so she had to get another form of proof of housing expenses. The whole application process took about one month, and during that time she called or visited the state Department of Social and Health Services (DSHS) office four to five times.

According to Maricela, in order to keep her subsidy, she was required to recertify every six months. During her first recertification, she had some difficulties and was left without a subsidy for 15 days. Since she could not afford to pay the provider without the subsidy, she ultimately had to take her son out of child care until the paperwork was approved. When this happened, her sister took care of Manuel during the day and Maricela left work early to pick up her children before her sister left for work. Without the child care subsidy, she said she would not be able to afford child care for Manuel and would probably send him back to Mexico to live with family.

Once Maricela had her subsidy, DSHS helped her locate child care by giving her a list of providers in the area, which included their names, languages, and hours of operation. Maricela later explained that she had referred other parents to DSHS, which she says helped her a lot. However, given her nonstandard work schedule and desire to have a bilingual English-Spanish environment, Maricela's options were limited.

She visited one child care center that she really liked, but the center was open only until 5:00 p.m. and not on weekends, which did not fit with her evening and weekend work hours. She walked into another place that looked really nice from the outside, but they spoke only English and did not have interpreters. As she explained, "Sometimes there are places that I like but I can't [use them] because they speak only English." Only one provider—a Latina family child care provider—was available during the hours Maricela needed, including evenings and Saturdays, and also spoke Spanish. Although she preferred the activities available at a center, she also liked that the family child care provider was open 24 hours a day and 7 days a week and was located within walking distance from her house, so she contacted her and set up the arrangement.

In hindsight, Maricela saw her inability to speak English as a barrier to getting quality care for her son. In particular, she worried that her children were not happy with the home care situation. Her son cried a lot and her daughter told her stories of being locked in a bathroom during naptime when she was not quiet. However, finding a good alternative was a challenge.

Moreover, Maricela did not have good communication with the provider, who spoke very little with her. She generally looked for child care where the staff spoke Spanish so she could communicate with them and so the children would be exposed to both languages. As she described, "I prefer that there's a mix so that they don't forget Spanish and that they learn English." Yet her preference (or requirement) for language combined with her work schedule left her with few options.

Limited English Proficiency

Katia is a 35-year-old mother of a 10-year-old boy and a 4-year-old girl who emigrated from the Dominican Republic in 2006. At the time of the first interview, the father of her children lived in the Dominican Republic; she was trying to bring him into the United States by marriage but had not yet been successful. Her sister and extended relatives lived nearby in Providence; however, they did not have a good relationship and rarely saw each other. Katia remained socially isolated and relied on the generosity of a previous coworker—who she met while working at a box factory—to navigate the child care system.

Upon arriving in the United States as an adult, Katia did not know any English and felt completely lost. She first worked cleaning houses, then began working through a temporary agency until she secured a more permanent factory worker position. When searching for child care, it was very important to her that her children learn English, but she also preferred a place that had bilingual English- and Spanish-speaking teachers so she could communicate with them. Her top choice was to enroll her children at the YMCA child care center her sister's children attended because she liked the care the children were receiving there. However, her sister refused to help her get into the program, and Katia did not feel comfortable seeking the option on her own. Instead, Katia's sister referred her to two family child care providers who spoke Spanish. She tried one provider for just two weeks but did not like the setting. The provider was licensed, but Katia did not like the way her children were treated there. The provider did not feed them well or engage them in learning activities but instead left the children alone to watch television.

Katia did not know of any organizations that might help her locate child care. She went to the local welfare office, following her old coworker's advice. Because of the language barrier, however, she did not know how to ask for help, and they did not refer her to any providers. Her previous coworker stepped in

again and helped Katia search for child care. She did everything for Katia from looking at options and filling out applications to applying for a child care subsidy. With the help of her coworker, Katia was able to enroll her children in the YMCA she had wanted them to attend from the start.

The YMCA center had bilingual teachers who helped Katia overcome the language barrier, although, according to Katia, the language of the teachers did not matter as much to her as their motivation to teach. At the family child care, the children were fed only junk food, but at the center they ate sandwiches and more nutritious food. Like the majority (two-thirds) of study respondents, Katia preferred structured, educational activities for her children at child care. She liked that her children had books to read and activities to do together with other children, who were a mix of native Spanish and English speakers. Her children made friends and learned English from other children. And her son, who was in the after-school program at the YMCA, played sports at the center.

Katia later decided that she wanted to improve her caregiving skills and begin a career in child care. Her son's teacher told her about the AmeriCorps program, and she decided to apply for a position. She was accepted and began working as an assistant teacher in a child care center under a two-year contract with AmeriCorps; she has since learned basic English on the job. Katia described a strong preference for center-based care because of the experience that she had gained from working in a center. She believed that in centers (compared to family child care), the providers are more highly trained, there are more activities and rules in place, and there are more opportunities for peer interaction. Katia also believed that no matter what age, children should be in center-based care as it is better quality.

Basic English Proficiency

Botum is a 32-year-old Cambodian immigrant who lives with her two daughters age 4 (focal child) and 5. She moved to the United States almost seven years ago after being sponsored by her now-ex-husband who was raised in the United States and already living here. They settled and had their two children but later separated. At the time of the first interview, the children's father was still involved and saw the girls three days a week, and he sometimes watched them when Botum needed help with child care.

Botum had a high school education in Cambodia where she had studied English, and had recently taken ESL classes in Seattle. She spoke only Khmer at home but understood and spoke basic English. Her older daughter spoke more Khmer than English, whereas her younger daughter, Balin, spoke more English than Khmer. Botum preferred that her children speak both languages, but she acknowledged that they would ultimately speak whichever language they pleased.

Botum worked as a housekeeper at a nursing home and had a shifting schedule of four days on and two days off. Her hours were always 7:00 a.m. to 3:30 p.m., but the days varied each week. When searching for child care, her top priority was to find a provider who was flexible with her changing work schedule. She spoke with her Cambodian friends in the local neighborhood about options and soon discovered her friend's sister ran a family child care program. Botum never considered enrolling her children in a child care center, primarily because she did not know of any, but instead preferred this particular provider since she was a family friend. As a result of her tight social network with other Cambodian families in the neighborhood, her child care search was relatively simple.

Her child care provider was a Cambodian woman who did not speak any English. Botum did not choose the provider because of a specific language preference but because she was a close friend. According to Botum, she would consider a good child care provider who spoke English, but she also believed it was important for her and her family that their child care providers and school staff spoke Khmer. However, only one person at her 5-year-old daughter's school spoke Khmer, and that person was not fluent.

Balin had been with the same family child care provider for two years. However, Botum said that children should start formal schooling when they are 4 years old. Her older daughter was enrolled in Head Start the year before starting kindergarten. Botum applied for Balin to attend Head Start as well, but unfortunately the program was full and so she was placed on the waiting list. Botum hoped that Balin would be accepted to Head Start the next fall, since she would still be 4 years old when the school year started and it would be her last opportunity to attend.

Greater English Proficiency

Dinora was born in Puerto Rico and moved to Boston when she was 11 years old. Because there were so many Cubans and other people who spoke Spanish in her Boston neighborhood, she managed to get by without learning much English in her neighborhood or at school. However, when her family moved to Providence three years later, Dinora discovered that her high school was not bilingual like her old school in Boston had been. She was placed in ESL classes for three years before being enrolled in mainstream classes. Dinora later married an El Salvadorian who knew little English, so Spanish became the language spoken at home.

Dinora had five children: three grown children (age 21, 23, and 25) from a previous relationship and a 7-year-old as well as a 2-year-old (Daniel) with her current husband, Diego. Dinora worked as a medical assistant in the oncology department at a local hospital and often translated for doctors and medical staff who did not know Spanish. When Dinora and Diego's older son was born, her sister took care of him for about three months, but after Dinora's sister moved, it became difficult to maintain this care arrangement.

Dinora then heard from coworkers about a child care provider who had a family child care program. Dinora trusted this caregiver initially and sent her son there for three years. Later, she found out that the provider used incredibly foul language around her son and was hitting him because he did not want to sleep. When Dinora heard this, she took him out of the provider's care immediately. At this point, she remembered a former patient who took care of children. She called the woman and arranged for her to take care of her son. When Daniel was born several years later, the provider began to care for him as well. Dinora paid the provider $100 in cash each week and did not receive any child care subsidies. The provider's house was only about five minutes from their home. She said it was very important to choose a place near her home.

Dinora knew very little about formal child care. She had stayed home with her three children from her previous marriage but could no longer afford to do so with her two younger children. She originally looked for family child care because she felt that children got sick more often in center-based care and there were too many children present. The fact that family child care providers take care of children when they are sick was also an advantage for her. She had no requirement for the language of the provider but liked that the provider she selected spoke English and that she was a Christian woman who taught religion. Dinora spoke English fairly well and could communicate with her provider

without any problems, but Diego spoke what Dinora referred to as "broken English" and preferred to speak Spanish. They both believed it was important for their children to learn both languages at child care or at school. As she described, "I think it is really important that they teach both languages because if they teach only English, well, there is a barrier between us."

Her provider told her that once Daniel turned 3, Dinora should look for a school for him because he would be at the age when he needed to start learning more. There were two child care centers located nearby that she planned to visit to see which was better suited for her son. Dinora was generally reticent about child care centers but was comfortable with the two located nearby because she had coworkers who sent their children there. A coworker recommended one center in particular. The other center had both a program for normally developing children and one for children with special needs. Dinora thought this program would be a good opportunity for Daniel, but also felt that it was too expensive for her—$135 a week.

Summary and Conclusions

In this study, the immigrant and ELL subsamples were relatively large and did not completely overlap; thus, we tried to provide careful attention to how parents thought about child care decisions as English language learners separate from or in addition to being immigrants. We found some distinct concerns and challenges that were related to being an English language learner.

The findings presented in this chapter highlighted how language has played a role in child care decisionmaking for English language learners in our sample. Parents widely varied in their level of English proficiency, as did their children. They also varied in their preference for speaking their native language as well as their openness to practicing English in the home. Most ELL parents encouraged their children to learn their native language first—some stating that they would learn English later in school—while others saw the more immediate importance of learning English, with proficiency in their native language naturally developing over time (if the child wanted to learn). They also embraced the idea of bilingualism and saw the importance of learning English for school. Some parents preferred or had selected a child care provider based on their language—either the family's native language or English. Children's exposure to language from parents, siblings, friends, and caregivers contributed to their language acquisition.

Positive relationships with friends and relatives, especially within closely-knit local networks, were the most prominent factor in ELL parents' child care decisionmaking. As such, ELL families most often selected family child care providers and relatives who also shared the same language and culture, as well as Head Start programs where the teaching staff spoke their home language. The language of the child care provider (largely the same language as the family) as well as the opportunity for learning activities within the child care setting that supported the development of English language skills were also important factors for ELL parents. Some families, particularly those who were recent immigrants, lacked any English skills and had more limited social networks. These families struggled with the language barrier when navigating the child care system.

The most difficult challenge was locating affordable child care close to home that fit parents' work schedules, which were often nonstandard or shifting. Some providers were not open and available when parents needed child care, did not speak the native language of the family, or were too expensive for those

not receiving subsidies. Publicly funded programs like Head Start were highly praised by the small group of ELL families who used them, but a few described being unable to enroll because they did not meet income requirements or being placed on the waiting list for a program at maximum capacity. Lastly, among ELL families, affordable options for infants and toddlers were not as available as those for preschoolers.

A family's language contributed significantly to its child care preferences, options, and decisions. Finding a provider who spoke the parents' primary language, especially when children were young, or child care settings that might facilitate continual dual-language learning, was important to ELLs. Parents' language capacities also factored into the sources they used and trusted for child care information. Like the sample as a whole, ELLs relied on close social networks, but more specifically, individuals they knew who shared a common language, which may have limited their awareness of their options. Language often served as a helpful foundation for social networks within immigrant communities, but it also presented a barrier to families that lacked such networks and the English skills to find child care that met their needs.

CHAPTER 7: CHILDREN WITH SPECIAL NEEDS

Many families interviewed for this study reported that their children had health and developmental needs that affected parents' child care decisions. Of the 86 families we interviewed, 23 families had children with an identified special need, a broad categorization that, following previous research, we defined to include behavioral, nonbehavioral, and speech or language needs that affect parents' care child decisions, the care of the child, and/or other children cared for by the provider (Ward et al. 2006).[8] This chapter addresses the research question, which factors constrain or influence the child care decisions of low-income families with special-needs children? We introduce the subsample by the type of health and developmental needs of the children and discuss their particular needs and how these needs are reflected in parents' child care decisions.

Key themes emerged across different types of needs, some of which were also seen in prior research. First, parents discussed instances when they could not find a caregiver willing and able to care for a child with special needs. This is similar to the finding reported by Ward and colleagues that parents were "being turned down by child care providers because of the special needs of their child or concluding that there was no child care provider adequately equipped to care for their child" (2006, 10). Publicly funded programs such as Head Start provided stability for parents of children with special needs, especially children with asthma, speech, and behavior needs.

Second, parents had mixed success ensuring that child care providers administered medication when necessary.

Asthma medication posed the least difficulty for providers. Caregivers, however, hesitated to care for children with chronic physical health needs alongside other children. As found in other research, some parents of infants with special needs reported they deliberately kept children home rather than enroll them in child care (Booth and Kelly 2002; Booth-LaForce and Kelly 2004).

Third, the additional demands of caring for their children's needs (i.e., appointments with specialists and doctors) only complicated the challenges faced by all families to balance low-wage work with child care. Children with speech-related needs often received additional services from specialists that were provided at home or at child care. Parents of children with other needs had less success securing medical and child care services that could be well integrated with parents' work responsibilities. Parents were responsible for scheduling multiple ongoing doctor appointments at different locations, often despite having inflexible work schedules.

Fourth, some needs were diagnosed at birth (e.g., developmental disabilities) or at their first onset (e.g., asthma), while others evaded easy or early detection and were diagnosed later in development (e.g., behavior or speech problems) and often within a child care setting. Parents were often required to adjust in response to their children's emerging needs.

Fifth, some parents continued weighing their children's needs and child care options over time, whereas others found some relief as their children's needs decreased. For example, doctors and medication could help with some physical health needs such as

asthma, but chronic conditions required significant ongoing attention from parents. Parents whose children had needs that intensified or persisted made decisions within constraints that other parents of children with special needs did not face.

Sixth, parents of children with severe special needs faced the greatest challenges making child care decisions while managing their children's needs. Parents of children with chronic physical health needs had limited child care options, and the families in our sample whose children had multiple needs were among the most constrained when making child care decisions.

The Special Needs of Children in the Study Sample

We asked parents questions designed to capture a range of needs that affect child care choices or care contexts. We identified 23 focal children who had at least one health or developmental need. An additional five parents reported either a previous need that no longer affected their child or a potential speech, behavior, or other problem that remained undiagnosed. Ten children in the

sample had multiple needs. There may have been additional children with special needs in our sample, as our sample included some very young children and speech and behavior difficulties in particular are often detected later in life. Also, some parents may not have reported health conditions that their children had overcome or outgrown.

Table 7.1 shows the number of children within each group. We found fewer confirmed cases of special needs in the Seattle sample, but the Seattle sample included more children under age 2, so some cases of special needs may not yet have been identified.

We spoke with parents whose children had a range of conditions, with asthma the most prevalent. Speech problems were the second most common need identified in our study. Given the small number of children (4) with behavior problems, this study can provide only limited insight into the constraints that parents of children with behavior issues face. We only interviewed parents with a current child care arrangement, and we did not speak with parents of children with special needs who could find no child care arrangement.

Table 7.1 Focal Children with Special Needs

Health or developmental need	Number
Asthma	11
Speech and language	9
Physical health (chronic)	7
Physical health (acute)	3
Behavior	4
Multiple needs	10

Notes: Sample size is 23. The number of health and developmental needs does not add up to 23 because 10 children had multiple health needs.

As detailed below, parents of children with intensive medication regimens, ongoing treatment, and surgeries had more limited child care options than parents of children with more modest health or developmental needs. Except for asthma cases, parents whose children had physical health problems struggled to find providers who were willing and able to care for their ill children. The following sections examine child care choices among families whose children had a range of special needs.

Asthma

Prevalent in many urban areas, asthma was the most common health need from which children in the sample suffered. Eleven children in the sample had asthma. While children in urban areas, and especially children in low-income families, generally have high incidences of poorly managed asthma (Smith et al. 2008), all but two children in our sample had cases that were either controlled or mild enough that parents did not consider them disruptive. Parents whose children had asthma typically described noticing breathing problems when children were infants or young toddlers. Some parents said they had experience identifying asthma symptoms and caring for them because they also had older, asthmatic children.

Asthma alone presented fewer limitations than the other needs identified in this study. In general, child care providers agreed to care for asthmatic children, administered asthma medication, and (in many cases) witnessed improving asthma conditions over time. Even among asthmatic children with additional needs, asthma itself did not severely affect their parents' child care options or decisions. Indeed, it was common for parents of children with asthma in our sample to say that they felt

fortunate they had not dealt with a recent health emergency.

In general, parents said they made sure that child care providers knew how to address their children's asthma, such as by keeping inhalers and medication at child care. Milagros from Rhode Island had experience managing her child's asthma but had not faced an asthma emergency at the time of our interview. In years past, she had struggled with the asthma suffered by her older son, a rowdy ("tremendo") 10 year-old-boy who acted up as a young child at child care and had multiple special needs. Milagros's sister-in-law eventually stepped in to provide reliable child care for the older son. Several years later, when her youngest son Mario was also diagnosed with asthma and doctors prescribed a pump, Milagros worried that she would have to relive her past experiences with impatient caregivers who would not help her son manage his asthma. Fortunately, when she applied for Head Start, she learned that the staff was willing and able to administer the pump when necessary. She was relieved and kept an asthma pump at home, at Head Start, and—just in case she needed last-minute care—at her sister-in-law's home.

However, even when parents are able to properly handle their children's asthma, difficulties can persist that influence parents' child care decisionmaking. Properly managed asthma, in most cases, requires parents to responsibly administer regular preventive medication; be actively mindful of dust, cockroaches, smoking, and other irritants in the house; and look out for irritants in potential child care settings (Shahani et al. 1994). Jacinta, a single mother from Puerto Rico, actively managed her 4-year-old son Juan's asthma by taking him to a doctor every two weeks. Juan also had a sensitive skin condition. Jacinta was especially vigilant and

had high standards for child care settings. To mitigate asthma attacks, she sought a specific kind of setting: "Everything needs to be really clean, because any [amount of] dust gives him an attack." She also avoided places that would not administer asthma or skin medication and was especially cautious about any illnesses. She visited a large child care center and chose not to enroll Juan because she feared one sick child would make everyone else sick. Instead, she placed Juan in a smaller center with 12 other children to reduce the chances of him getting sick. She had a close relationship with the provider, who called her with questions about caring for Juan: "She asks me, 'Look, I gave him this, what can I do to make it go away, or anything so he stops crying.' "

Speech and Language Needs

Nine focal children in the study had an identified speech-related problem. The severity of children's speech delay or impediment varied considerably, but the children's conditions generally improved when they received effective services and treatment. Unlike some health needs, speech problems can be difficult to detect among younger children. Consistent with previous research (Ward et al. 2006), parents of children with speech and language needs were among the most satisfied with their child care arrangements. According to parents' reports, many children with diagnosed speech delays or impediments were able to receive effective services and interventions. These children were often referred to and enrolled in Head Start, and some received publicly funded services at home and/or at child care.

Paloma's daughter Pilar had always lagged behind other children in her speech: "She talks like someone who is younger." Paloma first noticed a possible delay when Pilar was 1 year old but assumed that she

would grow out of it. When Pilar was almost 3, relatives began to repeatedly mention that Pilar's speech had not developed. At her next appointment at the WIC clinic, Paloma mentioned Pilar's speech problem to a staff member. The WIC employee referred Paloma to a speech therapy program. Unfortunately, the program focused on children age 3 and under, and Pilar would soon age out of the program. A speech therapist provided services for a few months.

Pilar's speech impediment had improved by the time we reinterviewed Paloma a year later, largely because a private speech therapist was helping Pilar one on one every week: "It's someone who is helping her with speaking. The only thing is, they're helping her in English, and not in Spanish. She's learning a lot of words in English." During speech therapy, Pilar practiced words and used signs to communicate words that she could not pronounce. Paloma hoped Pilar could receive help in Spanish: "She's going to learn English whether she likes it or not, so I wanted her to speak Spanish, but there weren't any programs [in Spanish." Aside from the single criticism, Paloma indicated she thought the therapy had helped Pilar.

Chronic Physical Health Needs

Seven parents in our sample had children with chronic physical health issues other than asthma. The specific conditions varied widely, and they also ranged in severity. Chronic health conditions tended to directly affect, limit, and disrupt parents' child care decisions. In addition to a dearth of providers willing and able to care for chronically ill children, these families faced substantial child care and cost constraints, which often proved unsustainable in the context of low income, unemployment, and/or loss of health insurance. Ward and colleagues (2006) found that the severity of a special need was highly

predictive of whether a child care provider would accept and care for a child. Consistent with such findings, parents of children with the most serious chronic illnesses in our sample experienced greater care challenges and more constrained options. These families faced multiple child care challenges at once, such as making sure that providers administered needed medications, juggling doctor's appointments, and scheduling surgeries.

Rosaline's son Rene was diagnosed with Long QT Syndrome, a potentially dangerous heart condition which required him to take medication three times a day. Rosaline described the condition: "It's not something you can see. If I don't tell you, you won't know. He'll be acting normal. My doctor says that he can just not do sports so that's not going to be anything major for him." Rene attended a child care center and brought his medication to child care. Rosaline applied for assistance to help cover his medical expenses but was denied.

> So everything now we have to pay out of pocket, which we don't have. That is my main concern. Why didn't they give it to me? There were people who encouraged me to go because I pay for his medication every month and he has been diagnosed with it so I can prove everything but they still say that we make too much money and that they cannot help us. And, on top of it, they cannot help us with child care, they cannot help me with SSI, either. So really everything comes from our pockets.

At the time of the second interview one year later, Rene's father had lost his job. The family's diminished income and sustained medical costs prevented them from being able to continue Rene's enrollment at the child care center.

Another family with stable employment and health insurance was able to stabilize its child's care as he grew older. Will, who was 2 years old at the time of our first interview, was born with a congenital heart defect and had had eight heart surgeries since birth. Severely ill, he also visited the hospital for tests every four months and was due for further surgery. Will was very susceptible to getting sick, and the intensity of the situation put considerable stress on his mother Wendy and her husband. Fortunately Wendy's husband had health insurance from his employer that covered the entire family. Wendy said that insurance coverage had been essential since Will "is literally a million-dollar baby" because of his health problems. Will had another surgery and catheterizations scheduled in the near future.

Although Wendy said Will was not as "fragile" as before, his condition still affected the family's child care decisions. She said that he "can do everything right now as a normal, any other 2-year-old," but added that she would not leave Will "with [just] anybody" due to his condition. They "eased back" into relying on close friends or family for child care. However, only Wendy and her husband administered Will's medication. On a rare occasion, they measured the doses and gave Will's grandparents detailed instructions about how to give his medication. They were careful not to leave him with babysitters longer than four hours, and no one else gave him baths or put him to bed. Given the family's employment stability and health insurance, Will's parents were able to slowly manage his chronic health needs and began slowly exploring non–family child care options.

Acute Physical Health Needs

Our sample included three children with acute physical health needs. Some parents of children with acute health conditions were able to adjust by delaying their preferred child care arrangements until their children's

conditions improved and their health recovered. In one case, a child's acute health needs completely altered his parent's child care options.

Hunter, a 2-year-old boy in Seattle, was confined to his home. His mother Hannah had planned to enroll him in the child care center where she worked, which would have been her ideal arrangement. However, Hunter was born seven weeks early, resulting in several simultaneous health needs, and Hannah's arrangement fell through. Hunter did not have a fully developed immune system or lungs at birth. He also needed physical therapy to treat a weak neck. Doctors recommended that he avoid other children to minimize the risk of getting infant pneumonia, and that his parents keep him out of large child care centers until he was at least 9 months old.

Two different informal caregivers took care of Hunter until he was old enough to feed himself, at which point Hunter's great-grandmother began taking care of him. By this time, his health had dramatically improved, and Hannah could finally consider placing Hunter in center-based care. However, about the time they were ready to make the transition, her husband lost his job and they could no longer afford it.

Behavioral Needs

Behavioral challenges, like speech and language issues, can remain unnoticed or undiagnosed among young children. Unlike speech and language needs, however, behavior needs can pose ongoing and rigid constraints on parents' child care options. In our sample of children under 5 years old, only four parents described behavioral challenges that affected their child care choices. Although the cases of confirmed behavioral needs in our sample were few, taken together they offer some insight into the difficulties

parents face when providers turn away or stop caring for a child they say is excessively temperamental.

In all but one of the four cases of behavioral challenges in our study, a child received behavior services alongside speech therapy. In the remaining case, the parent had referred her child for psychological evaluation to address his behavioral problems. Aside from these four families, two other parents described challenges posed by temperamental children. While neither parent had considered seeking a formal assessment, the circumstances had still affected child care decisionmaking since caregivers repeatedly refused to care for their temperamental children.

The evidence from these few cases supports previous work by Ward and colleagues, who stated, "child care providers we surveyed said they found it more difficult to care for children with behavioral issues than to care for children with physical/medical special needs" (2006, 11). In addition, they found that "child care expulsions are a significant problem for parents of children with special needs" (2006, 14). Ward and colleagues also found that the parents of children with behavioral issues and special needs had more child care problems than did the parents of other children with multiple types of special needs.

Two examples from our study illustrate how behavior needs can result in child care instability in the absence of caring and well-trained caregivers. In both cases, caregivers proved unprepared to care for a temperamental child, and parents scrambled to find a replacement. Neither parent saw the need to seek the advice or assistance of a behavior specialist. Nina, a Seattle parent, relied on 10 different consecutive child care providers because her 4-month-old son Nesto was constantly and—according to providers—extraordinarily fussy. She

mentioned that providers would consistently make comments about his behavior, pointing out that he was more difficult to care for than other children his age. Nina was upset that providers always complained after taking care of Nesto, and she dismissed their criticism: "They tell you that your kid this, or your kid that. Well then, you tell yourself that you have to find someone else, because this lady complains about this, she complains about that." In her eyes, her infant son was a handful but not a problem child.

A toddler's mother had a similar experience. Lupe remarked that a previous caregiver appeared unmotivated to care for her 2-year-old son Leandro, who was very active, constantly demanded attention, and would not go to sleep easily. She believed the caregiver preferred to look after less troublesome children: "It was convenient for him to take care of that [other] girl, and she thought he was difficult because the girl would just be laying down … He'd put her to bed and she'd be asleep for four hours, but putting [Leandro] to sleep was a 'show' [a lot of trouble]." Similar to Nina, Lupe changed her child's care arrangement in favor of someone who did not think Leandro was too much to handle.

María was the only parent who sought an assessment and services for her child's behavior needs. Her 3-year-old son Martín was the only child in the sample with a confirmed, diagnosed behavior problem: attention-deficit hyperactivity disorder (ADHD). When María moved to the United States in 2005, she fled an abusive relationship and started over with no family or resources. She could only afford to pay rent for a small garage that had been converted into a tiny one-bedroom apartment with a kitchen and living room smaller than most master bedrooms in the area. Her job with a temporary employment agency ended without notice after our first interview, and

Martín began acting out more than ever before. María noticed that Martín was becoming increasingly hyperactive. When he started acting out and kicking other children, María sought professional help and requested a formal evaluation.

Martín was diagnosed with ADHD soon thereafter. The diagnosis came as little surprise to his mother, although she ascribed his issues to a cramped living environment and to his reaction to her stress and desperation following her job loss. María also said that Martín's limited options for playing and socializing with children his age was another cause of his aggression and hyperactivity. She even kept information from his behavioral specialist to avoid medicating him: "I haven't told the doctor what he's like because I don't want them to give him medication, but a lot of people tell me the kid is hyperactive, but I tell myself that I can keep him under control." María insisted that enrolling him in a Head Start program would quell Martín's outbursts. However, it would take over a year after Martín was diagnosed with ADHD before her idea could be put to the test. Thus began an ordeal that involved placement in a child care center for troubled children coupled with mounting challenges at home.

After María's recounting of her son's behavior problems, a friend recommended that she take Martín to a program that specializes in services for children with special needs. Martín spent a couple of months receiving counseling and one-on-one attention from a bilingual psychologist. The mental health professional befriended the family, visited the family home, and advised María to move to a larger living space.

She [the psychologist] said that, first of all, [Martín] doesn't have something to identify with here because she said that if you look around—she just said—it's ME. You can see that the mother [me] likes flowers, this

and that, but [Martín] doesn't have space, and it's true. This house only has one bedroom, and I don't like seeing toys everywhere. He has his toys in the corner, hidden away in the bathroom where, if he takes them out, he has to put them away, because the house is so small and I don't like seeing toys everywhere and, what she said was, he can't live like this.

María agreed that Martín needed space that he could consider his own, but she believed that she could not afford it. She held on to the hope that she could enroll him in Head Start, where he could learn to express himself and be around other children. Meanwhile, Martín began withdrawing further at home.

Despite her gratitude for receiving in-depth assistance and guidance from the psychologist, María recounted how she worried that in some ways the treatment might be making Martín's condition worse.

He would say, "Mommy, I'm sad." And I would say: "Why, baby, why are you sad?" "I'm mad, I'm upset, I'm sad." "Why?" "Because I don't want you to turn off the light." "Why not?"…I've never had a problem [with the light]. When I asked a psychotherapist, she tells me that there had been a girl there who had been raped at night with the lights off. So she's afraid. She never wants the light off. I said, "Wait a second, I need to take my son out of there, because he's picking up things from other kids." There are kids there with bigger problems than my son has. My son has never been touched; he's never been abused; none of that. On the contrary, I think [Martín] needs a little discipline, some spanking.

She stopped sending him to the program and instead decided to go to the Dominican Republic for a month. She was still unemployed at that time.

The trip benefited Martín. While abroad, he had more freedom to go outside, play with children his age, and be away from their small apartment. When they returned to Providence, María was determined to enroll Martin in Head Start. She advocated for him at the Providence Center and at Head Start programs. She eventually succeeded and enrolled him at a child care center in the morning and Head Start in the afternoon. A few months after he was enrolled in Head Start, she thought there were improvements in Martín's behavioral problems, and María felt vindicated in her initial belief that what Martín most needed was attention in an constructive setting with other children.

The experiences of the few special behavioral challenge cases in the sample suggest proceeding with caution by working with parents to identify sustained or increased behavior needs in a manner that does not (a) stigmatize children with severe mental health and behavior problems or (b) place sole burden on parents to ensure a child is not turned away from for behavior needs. María's experience in particular illustrates how parents may respond positively to advice about their children's behavior if a professional takes time to get to know the family. María also benefited from culturally sensitive, bilingual assistance.

Services for Children with Special Needs

Families whose children had special needs received many benefits from specialists and other child and family services providers. This was especially true for children who had speech problems, especially for those who received early speech intervention services through publicly funded programs like Head Start. In fact, most children in our sample who received behavior therapy and related

services were referred for evaluation and counseling by speech therapy specialists.

When Lourdes's daughter Luz was a toddler, her speech was delayed and the family had a difficult time understanding her speech. Lourdes applied to Head Start and, even before Luz started in Head Start, through the program for early intervention services. At age 3, Luz was diagnosed with speech and hearing problems and qualified to receive coordinated speech therapy services from the program. When asked how the speech delay affected her child care decision, Lourdes said,

> The only thing it changed was that she got into Head Start early. The Head Start, you apply and the application takes a year and then some. For my older daughter, we applied for her when she was 3 years old, and they called her when she was 4. But [Luz], since she had an "intervention" in the speech therapy program, when she got out of the program they wrote her a letter saying that she could get into Head Start as soon as possible. So we applied when she was 3 and the same year she got in right away, because of her language limitation …. In that sense, it was a good thing.

Once enrolled in Head Start, Luz began to overcome her speech delay. She also had access to a number of doctors (speech, ear and throat, and hearing specialists). Lourdes was able to make appointments with each doctor on different days, and her boss was understanding and flexible. Luz underwent an inner-ear operation and received assistance from speech specialists. Subsequently, Luz's parents noticed that Luz became more expressive: "In Head Start, she's started to loosen up … and ever since then she's really alert, smart, speaks well …. [Before, she was kind of] closed up. She's more social because she wasn't very social before." By the time of our second interview, Luz had overcome her most difficult speech-related challenges.

In addition to diagnosis and treatment of speech problems, some children received referrals to additional services as a result of speech-related therapy. Yara described her experience with her daughter Yelina, who had problems speaking: "I can understand her, but other people—I have to tell them what she says." Yara noticed right away when Yelena started talking: "I thought she just didn't know how to talk." Yelena made sounds and make up her own words. "All that time, I thought she was not developing, but she was trying to talk." Yara enrolled Yelena in early intervention services focused on speech development when she was 2 years old. One year later, Yelena continued receiving speech therapy at a school-based program.

The speech therapy program then referred Yara to additional resources (including behavior therapy) that she would not have known about otherwise. "I called a few of them, but none of them really had what I wanted until I called Providence Center." Soon thereafter, Yara signed up for a parenting class as well as family therapy with her boyfriend and two daughters. The class "helps parents learn to deal with their children and their behaviors." Yara worried about Yelena: "She's bad. She don't listen, she talks back, and she hits and she swears sometimes." Yelena underwent a brain scan when the neurologist said he believed that she might have ADHD. Yara said, "That could be one of the reasons she's running and acting like a fool." The speech therapy program also qualified Yelena for Head Start at age 3, a year earlier than her mother had planned to enroll her. Yara reflected, "I wanted her to learn discipline, and they teach that at any school … and teach her how to interact with other people." Head Start staff members also administered Yelena's asthma medication when necessary.

Hazel also sought speech therapy for one of her twins, both of whom were born

prematurely. When we last spoke with her, she said her son Harry's diagnosis remained elusive. Doctors evaluated Harry, but they remained unsure whether he had an identifiable developmental problem or simply a challenging personality. An early intervention worker began working with Harry's family child care provider to help him with speech therapy as well as other services such as physical therapy for his twisted legs and behavior therapy. Harry practiced speech through activities with his siblings, which made him less self-conscious.

> *It's so important when you're young ….*
> *People in school make fun of people like that.*
> *His speech is not bad, but his*
> *comprehension is delayed a bit for his age.*
> *He's behind, but he's catching up.*

However, after nine months, the child care provider found the services too time consuming and stopped cooperating. The lapse in services seemed to set back Harry's development. He did not receive intervention services until he enrolled in Head Start, but by that time he was more withdrawn than his twin brother and tended to break his toys. Hazel attributed his behavior to his speech and related needs.

Children with Multiple, Severe Special Needs

Ten focal children in the sample had more than one type of special need (table 7.2). Eight had multiple special needs including speech delay, while two of them had been born prematurely, which had significantly affected their health since birth. The majority of children with multiple needs did not have chronic or severe needs. In most cases, their parents were able to arrange for child care as well as additional services, treatment, or medication that met their children's needs.

However, three families of children with multiple and severe needs faced a range of constraints above and beyond the other families of special-needs children, and similar to those experienced by parents of children with chronic illnesses. Each child in these families had ongoing diagnosed health needs that started at birth. In these families, the parents resorted to sole reliance on very close relatives as child care providers, absent any other options at their disposal. Although each family struggled to make ends meet and care for a child's special needs, relatives and health insurance played a key role in shielding these families from unstable child care arrangements and financial hardship.

Table 7.2 Focal Children with Multiple Needs

Health or developmental need	Number
Asthma	3
Speech and language	8
Physical health (chronic)	4
Physical health (acute)	3
Behavior	3

Note: Sample size is 10.

The first time we visited Juliana in Rhode Island, she was living with her husband and her son Julio, who was almost 4 years old, in her aunt's house, where they rented a room. Juliana's husband worked full time at a drug store, and she had recently started working as a teacher's assistant. Juliana had dropped out of her second year of college when she became pregnant. She had had a very difficult pregnancy and found it hard to continue school. She had just restarted college a few months before our first visit and was taking college classes at night. Julio was born two and a half months premature with a number of physical health needs: one of his legs was shorter than the other, he had little arm movement on one side, and he had tonsil and hearing problems. When Julio was 6 months old, though, Juliana began to suspect that he had other developmental needs, and a visit to a doctor confirmed that he would need ear surgery. Juliana said she had tried to avoid surgery because of the cost, and Julio still had not had the surgery at the time of our first interview.

Juliana continued to notice problems with her son. Around the time Julio was 6 months old, she decided to take him to her mother's house for child care because she did not trust other providers to care for him. When Julio was 1 year old, she noticed that he did not reach for toys and had not started crawling, so Juliana brought him back to the doctors. At this point, doctors diagnosed Julio with conditions that contributed to physical and speech delays.

At around the same time that Julio was diagnosed with additional conditions, his grandmother, who had been taking care of him, moved back to the Dominican Republic. With her mother gone, Juliana found it extremely difficult to manage her work and deal with all of Julio's health problems and doctor's appointments. In addition, her husband made too much money to qualify for child care subsidies, and they did not know about any child care options outside of family. She was also scared about putting him in a day care center considering how much he cried and because he had special needs.

After exploring several other options, Juliana gave up her search and decided to send her son to the Dominican Republic. She reflected, "Well, family is family. They're going to know what to do. My mom took such good care of him that I didn't know if anyone would be able to do that." Julio would also be able to receive free special-needs treatment in the Dominican Republic. Indeed, Julio received good physical and speech therapy while he was there, and Juliana explained that the doctors in Dominican Republic were more helpful and more willing to prescribe him stronger medicine than the doctors she had met in the United States.

Juliana said she had believed that her son would stay in the Dominican Republic permanently. However, despite her preference for the cost and quality of ongoing health care that Julio was receiving there, she brought him back to the States a year and a half later. Doctors in the United States had indicated that Julio would need a series of surgeries for his tonsils and hearing, and Juliana felt more comfortable having these procedures done in the United States. In addition, the cost of the surgeries would be covered by Julio's public health insurance.

After Julio came back from the Dominican Republic, Juliana began searching for a child care center for him to attend, which she found difficult. In particular, she needed to find a center that would be able to provide for his multiple health needs while still being affordable. For the two months it took her to find a center, Juliana had Julio's paternal grandmother care for him, which she said was not ideal. The center that she ultimately found was able to work with Julio's needs, especially his speech delay.

When we spoke with Juliana a year later, much had changed. Most important, her husband had moved away after seven years of marriage:

> The thing is that I'm going to school right now and he wasn't very supportive of that and raising a child and the last three years the relationship hasn't been the same …. What's the point of being in the same household if we're fighting and arguing"

Her husband's absence had put a strain on Juliana's ability to care for her son: "Now, it's really hard because we were together for seven years, and now I have to do everything myself because he's not home." In addition, she had begun to look for prekindergarten options after a neurologist who evaluated Julio had connected her with additional information on child care. Health professionals attending to him suggested enrolling Julio in the public prekindergarten program, even though he was too young.

Natalie was another parent in Rhode Island who faced major difficulties balancing a child's medical needs with work and child care. Her son, Norberto, was diagnosed at birth with Beckwith-Wiedemann syndrome, resulting in problems with his heart, blood sugar, and tongue. Because of his condition, Norberto had to see a number of specialists, including a heart doctor, a genetic counselor, an oncologist, an eye doctor, a surgery specialist, and a preventative intervention specialist. His conditions required frequent visits to the doctor, and Natalie had to manage transportation to be able to take Norberto all over the city for his appointments. She was able to take care of her son's doctor's appointments while her partner worked. Apart from the preventative specialist, who visited the family at home, Norberto's doctors worked at three different locations, one of which was a 20-minute drive away. Norberto's weak health also made him susceptible to illness. Natalie estimated that

he would get a cold every month and, every time, she would have to stay at home with him, to "make sure he gets his medicine and doesn't turn purple." In addition to these regular and unscheduled appointments, Norberto's condition required operations. In fact, when we spoke with Natalie the first time, Norberto had recently had tongue surgery to help him avoid potential speech problems.

Natalie was generally able to navigate the maze of doctors and specialists in order to properly care for her son. But, not surprisingly, the intensity of Norberto's condition made it difficult for her to balance this with her own schedule. Natalie worked long hours doing customer service at a bank and required a child care arrangement that would be both flexible and responsive to her son's special needs. Natalie said she was not aware of any centers or informal providers who could meet these standards, so she was fortunate that her mother happened to be a licensed family child care provider and could provide care for Norberto in her home. Natalie paid her mother in cash because her annual income was $1,000 above the threshold for a subsidy.

As discussed in chapter 3, Natalie's work life suffered the most from the responsibilities of caring for Norberto's special needs. Apart from having to miss days and hours unpredictably from her job at the bank, Norberto's special needs also affected Natalie's performance at work. After missing days when Norberto was sick, Natalie said she would be "messed up" at meetings and not updated on new procedures. She would also miss meetings where her manager would tell her about new services. Natalie said she was "out so often, [she] lost track of what [she] was doing." Her boss pressured her to reduce her absenteeism and regularly threatened to fire her, despite an official policy that should have afforded Natalie more

flexibility to care for her special-needs child. In response, Natalie said she began having migraines, felt pressured to leave, and ultimately quit and lost her employer-sponsored health insurance that covered the family.

By the second time we visited Natalie, however, the stress from Norberto's condition had abated considerably. Natalie had qualified for Rhode Island's state health insurance program, and Norberto's medical emergencies had become less frequent. Still, he needed to see a nurse or doctor at least once a week. Since Natalie was not employed after she quit her job, she no longer had Norberto enrolled in her mother's family child care home. The grandmother still helped with care on occasion for free, but he was not in her care regularly because Natalie could still not qualify for a child care subsidy and could not afford the cost of one of the limited family child care slots. Natalie did seem to be under less stress when we met the second time, and she said she was hoping to begin work as a cashier at a local grocery store and was studying cosmetology.

Dolores's experience raising her daughter Dionne with multiple special needs was similar in many ways to the two cases described above. However, her experience had been especially difficult because her sick daughter had a relatively healthy twin sister, which allowed Dolores to witness two divergent developmental trajectories. The twins were born prematurely, and both initially had health issues. However, Dionne continued to have health problems while her sister grew stronger. Besides respiratory problems, Dionne had a bladder disorder and low motor skills. She also had problems with her social development, refusing to play with her sister and having trouble talking, though this had not been of immediate concern to Dolores: "We're not pushing any …. She's just gonna be a late bloomer."

Because of Dionne's many health needs, she had numerous specialists and received various medical treatments, such as a catheter, feeding tube, and intensive respiratory care at a hospital. All these treatments caused Dionne to be delicate and Dolores to be cautious: "You've got to always be gentle because there's tubes in her and stuff you know. So constantly just over watching her when she's here." Dolores also found a therapist to provide speech therapy, including sign language lessons, in a hospital setting.

Dolores said that she was pleased with all the medical attention Dionne received. In addition, most of this care was covered by Medicaid. However, this coverage did not include experimental or alternative treatments, and she had difficulty paying: "Everything was covered, but certain things if I'm going to go on out, you know like a research thing, or something that's coming new, I've had to get a loan out for something. Yeah, I did that one time, but I'm never gonna do that again."

Dionne's extreme medical needs made her development and care needs very different from her sister's, and it meant that Dolores had to devise two parallel care arrangements for her daughters. After waking her daughters in the morning, Dolores needed to make sure that Dionne's various machines were plugged in and her medicine was ready before making herself some coffee: "It's very chaotic. It's very hard to go into details because it's not a dull day and never the same day." Dolores's mother came to her house to take care of Dionne during the day, while Dionne's sister attended day care 45 minutes away. Halfway through the day, when Dolores's husband was done with his shift at work, he relieved his mother-in-law and stayed home with Dionne until Dolores and Dionne's sister returned home.

When we spoke with Dolores the first time, though, her mother was becoming less

available to take care of Dionne, and Dolores was looking for a new care arrangement with little success. In particular, the costs and distance of many specialized care programs and the reluctance of nonspecialized care providers to enroll special-needs children were barriers to finding a good option: "They're expensive, way out, very biased, you know because they're only for rich middle-class and rich kids." Ultimately, Dolores decided to entrust both children to a neighbor she knew from church who ran a family child care program in her home. This made the child care aspect of juggling both her children's schedules simpler, since the new provider was much closer to Dolores's home, and flexible.

Still, care for Dionne permeated Dolores's work life. When we spoke with her the first time, she had taken some time off for a hysterectomy but hoped to return to her job as a medical assistant in a local hospital. She planned to work the night shift so she would not have to deal with arranging child care, and because she had had trouble leaving early when Dionne was sick. However, by the time of her second interview, Dolores had begun taking classes for a degree in nursing and had stopped working altogether.

Parents' Views on Making Care Decisions for Children with Special Needs

In addition to exploring how they balanced child care and their children's health and developmental needs, parents were asked to share their advice for others in similar situations.

Need for Better and More Information

When asked what she would advise other parents whose children had a speech delay, Hazel said she would tell them about her son Harry's experience with speech therapy. She then recounted her own experience, which began with a Head Start program that referred her to special-needs services in the local school department when Harry started kindergarten. She recommended that parents speak with Head Start and school teachers and staff. Hazel said she knew of a broad network of special needs programs in Providence, including programs that provided services for special-needs children without other options. She elaborated, "Sometimes it's hard to get into. It can be hard to find a space, but once you're in, they're very helpful and will refer you to a whole network of places and resources for your child."

Dolores advised other parents to seek information about inclusive child care for special-needs children, like her daughter Dionne, but she emphasized that this information was not easy to find. She also wished she had better information about transportation to and from child care and doctors' appointments, and wondered whether it might be possible to avoid traveling long distances on public transportation. Dolores felt she had little information to ensure her Dionne had reliable child care options that could accommodate the girl's health needs. Dolores also recommended that parents seek information about their children's health conditions and how to best address it in child care contexts. When asked what she would advise others to do, Dolores said:

Just do a lot of praying and, you know, ask a lot of questions, and don't always jump. Don't always take one opinion from one

doctor; get a second opinion. Do a lot of research as far as what they have to offer as far as if it's here or something like that. So it's basically just, just always have a big hope in your mind and in your heart that things will get better. If it's not, then, you know, leave it to God.

Overcoming the Stigma Associated with the "Special Needs" Label

Parents also reflected on the label "special needs." They warned against a narrow definition of special needs that only includes, for example, physical or developmental disabilities. When Lourdes's daughter experienced speech and hearing problems, she resisted the temptation to think her daughter would easily outgrow the problems and instead sought an assessment from speech development specialists. During the process, she began to unlearn her assumption that children with health needs are not "normal." Reflecting on her daughter's experience, she said preferred child care arrangements that served children with various levels of health and developmental needs. She explained, "Everybody wins—the normal kids learn to not say 'That kid is different, I'm not going to talk to him,' and they complement each other." Her sentiments support previous research. Stoiber, Gettinger, and Goetz write, "Patterns evident throughout the data support the goal of increasing both parents' and practitioners' exposure to diverse learners and strategies for accommodation. It appears that propinquity or 'getting up close' to children with diverse disabilities and to inclusion has a powerful positive effect on our beliefs about inclusion" (1998, 122). Lourdes also warned parents not to become discouraged by apprehension that others might apply a label to their child.

Lourdes reflected on the term "special needs" as a result of her own experiences seeking care for her daughter Luz. She explained,

The little one, she was in speech therapy and was a special girl. But she overcame that stage … and she speaks like a parrot; [she speaks] clearly, everything. But she was in the program as a special girl because she had a small limitation …. Really, it's a good thing to look for help for them. [There are people] that don't like putting their kids in a programs so that they're not pigeonholed with the label.

Lourdes considered her child "special," similar to children with behavioral problems and developmentally challenged children. She resented the terms "abnormal" and "retarded."

While overcoming their own hesitation, Lourdes and her husband benefited from learning about their daughter's health needs alongside other parents. Lourdes recommended that parents attend informational or group sessions with parents of children with special needs. She remarked,

Sometimes, you feel like, my kid has a label. I went to a lot of talks for parents of special kids … because it's for my daughter's good …. If a child has been identified to be there it's because they need something, and I need to go to look for the help that she needs. It doesn't matter if you get the label of a special child if they are going to give you the help that your child needs.

Parents of children with speech problems typically emphasized early assessment and treatment. Lourdes's husband said he would have regretted avoiding an assessment and services for their daughter for fear of the "special needs" label. He advised,

It's for his own good, because if we hadn't done it, we'd be regretting it today … Don't think twice. I mean, if your child has a

problem, a deficiency … don't be ashamed to look for help because in the long run—if you don't do it—you're going to regret it … It could be worse, I mean, it's worth [doing] at once, I mean, while the child is still young—and also take advantage that those benefits are available.

Parents whose children had other types of health needs did not emphasize early detection, perhaps because other types of needs are more easily diagnosed or evident.

Summary and Conclusions

Many children in the families we interviewed in Providence and Seattle had particular health and developmental needs that parents needed to factor into their child care decisions. The most frequently diagnosed special needs included asthma, speech concerns, acute and chronic physical conditions, and behavioral problems. Many children with special needs received specialized services, and for some this was coordinated with their regular case. But for many parents, it was a struggle to make this happen and took time, patience, and perseverance.

Parents emphasized the need for better and more complete information about special-needs services as early as possible when a child's needs have been diagnosed. Their reflections suggest that parents of children with special needs might have a wider range of options if better and more information was made available to them. Their comments also suggest that recognizing the range of needs (e.g., chronic and acute, severe and non-severe) could help reduce the stigma that parents felt about the label "special needs." Doing so could, in turn, encourage parents to seek appropriate services, treatment, or accommodations with less hesitation or worry that their children might be singled out or excluded at child care settings.

Parents suggested improvements in services for children with special needs, including more training and education of center-based and family child care providers regarding serving children with acute and chronic physical health needs and those with behavioral challenges, in inclusive settings. Many parents with children who had asthma and speech delays said that they found their care settings were largely more supportive of helping address their children's special needs, and felt they could trust their provider to care for their child's needs. But finding trustworthy and supportive providers was a greater challenge for children with these other physical health and behavioral needs and those who had multiple needs.

CHAPTER 8: POLICY STRATEGIES TO IMPROVE CHILD CARE CHOICES

The findings presented in this report offer a detailed and layered picture of how low-income working families learn about and consider child care options, make child care decisions, and ultimately view their choices. In this concluding chapter, we summarize the key findings from the study and discuss the policy implications, suggesting how the early care and education system could more effectively support the child care needs of low-income working families like those described in this report. We conclude with several recommendations for possible policy strategies to improve the child care choices available to low-income families.

Overall Summary of Study Findings

The first major findings were drawn from an analysis of parents' general preferences for child care and the key factors that most influenced their actual child care decisions. The findings illustrate some of the complexities that low-income working families face when arranging child care that meets their preferences and accommodates their personal constraints, including what is available and what they can afford.

In some cases, parents reported they were using the type of care they preferred for their child. This was particularly true for more than a third of parents, who said they absolutely preferred having a family member provide care for their child; in most cases, these families were using informal relative care

when we interviewed them. These parents most often had infants and toddlers, and some of them preferred relative care because they did not trust anyone outside the family with their children. In many other cases (including some of those who used relative care), parents' stated preferences aligned poorly with the factors that they said influenced their ultimate care decisions; these parents preferred a different care arrangement than what they had. Affordability of care, accessibility to transportation, availability of care hours, and caregivers' ability to accommodate parents' varying work schedules often prevented parents from selecting the care they might have preferred.

A large number of parents said they viewed child care as an opportunity for children to engage in learning activities and socialize with peers. When it came to making care decisions, however, the educational and social environment was less often a determinative factor than whether the care was affordable, convenient in terms of the hours of care and location, and consistent with parents' work schedules. These logistical factors often left parents with little opportunity to consider some potentially preferred child care options.

The integrated analysis of parents' child care preferences with the factors that most influenced their actual care decisions offers new insights into child care decisionmaking. The care characteristics many parents described as most important were not always ultimately strong factors in their decisions.

The child care choices that many families described and the factors that most guided their decisions changed as their children aged and circumstances changed. Not surprisingly, parents of most infants and young toddlers strongly valued nurturing care provided by trusted individuals, particularly family members, in a smaller, home setting. Similarly, many parents of 3- and 4-year-olds preferred formal, center-based care for their children. Most notable was parents' awareness of and interest in Head Start. Yet, because of the limited supply of publicly funded programs like Head Start and other affordable center-based options that matched parents' work schedules, some parents could not find or access these arrangements in their communities.

The supply of formal, center-based care options varied between the two settings we studied, but overall these options were limited relative to the potential demand, as indicated by the number of families who stated preferences for center-based care for children as young as 2 or 3. Many respondents said they wanted to place children in center-based care earlier than they were often able (after spending some time on waiting lists or searching for available slots or the means to access them). In many instances, there were not enough nearby centers in their communities, and families could not access the free Head Start programs or child care subsidies required to afford center care.

Almost all parents in the sample relied primarily on their personal social networks for information about child care and available public resources, at least initially. The size of parents' networks and how helpful they were varied. Social networks played a particularly important role for immigrants and ELLs. Some families also learned about child care options from the providers themselves through different advertisements; current providers also served as a source of referral to

other care options. Few families in either Providence or White Center were aware of more formal information sources for child care, like CCR&Rs, and some among those few who had used them said they had not found these agencies helpful. Provider contact information was often outdated and unreliable, and lists often did not provide enough key details on the provider or were too lengthy to sort through. The power of the information exchanged through the parents' social network ties suggests that any information about child care options, programs, or policies might best be communicated by targeting the networks or sources that are trusted as much as the networks.

Several families in our sample had children who attended publicly funded Head Start and prekindergarten programs, and approximately a third of families indicated that they had received a child care subsidy at some point during the study period. However, many parents said they were unable to access public resources for early care and education because of limited slots, the particular hours of care parents could arrange through these programs, and the challenges of accessing benefits. Overall, we found (and the parents suggested) that public programs and resources were not sufficiently funded and available to meet the community's needs.

Almost all child care difficulties were intensified for the large proportion of parents in our study whose jobs involved nontraditional schedules or limited flexibility. Parents working nonstandard hours faced substantial challenges making child care arrangements and often had the most constrained choices. Many needed a significant amount of provider flexibility to accommodate irregular and shifting hours of care. Fewer parents with such schedule and flexibility constraints were able to use center-

based care options (compared with parents with traditional work hours), while some were able to use family child care providers who offered longer hours and more flexibility. The limited care options available to low-income working families in general, and those with sharp employment constraints in particular, likely contribute to the fragile fit between work and child care and to care instability over time.

The difficulties that families faced arranging child care and the complexities of their decisions were remarkably similar across the low-income families we interviewed, including those who were immigrants and/or English language learners. This suggests that their shared circumstances as low-income working parents affected their care choices more than their different national origins and language abilities. Immigrant families and ELL parents both had very similar preferences and faced similar challenges to other low-income parents, particularly when they lived in the same community, experienced nearly identical employment situations, and had access to the same resources.

There were, however, some differences in the intensity and nature of the challenges experienced by immigrant and ELL families. The immigrants in the study were very heterogeneous across the two sites in their country of origin, their age at emigration, their level of integration, and the social network resources in their communities. Variations in the number of social connections and sources of information shaped immigrants' child care choices. While immigrants are not the only parents who rely strongly on social networks, their status as newcomers to the community and local culture, as well as possibly different touchstones in their care expectations and experiences, likely increase the importance of networks. And, given how social networks influence care decisions, immigrants who

have very limited social networks, and who might be isolated from information and resources in their communities, may face even greater child care challenges.

For families where parents identified themselves as ELLs, language played an important role in their child care decisionmaking. They were often the only families that indicated that the language spoken by the provider and in care settings was a very significant factor. Some ELLs strongly preferred that their children develop capacities in the dominant home language while they were young, and they selected providers who spoke their language to reinforce those skills. They also expressed a need to be able to communicate with the provider easily. Other ELLs, particularly those with preschool-age children, described the importance of their children learning English and a preference for a bilingual or English-speaking child care setting or provider. Although the latter option was not always available, some ELL families described selecting a care arrangement (e.g., Head Start) because of the opportunity to expose their children to English.

Families in which children had particular health and developmental needs faced added challenges. Along with the struggles experienced by all low-income working, such as limited choices and the need to accommodate irregular work schedules, parents of special-needs children needed to find reliable and timely information about child care resources and specialized services. In many cases, these families also needed more help supporting flexible care arrangements, including those that accommodated children with special needs, than did other parents. Often, low-income families were unable to access these integrated information sources easily.

Parents in this study demonstrated the process through which they considered the

child care options that resulted from their particular family circumstances and work contexts combined with the information, supply, and resources available to them. In many cases, decisions allowed parents to meet their care and work needs simultaneously, even in difficult circumstances. Still, other parents clearly had to compromise on their children's care in order to satisfy both caregiving and work responsibilities. Additionally, maintaining the alignment between work and care over time was a constant source of tension. This stress added to the already difficult circumstances of parents' low-paying, inflexible jobs.

The relative mismatch for many low-income working families between what they would have preferred for child care and what they used—in addition to the sense that some wanted to access high-quality, center-based care (and at an earlier age) and could not—implies that more could be done to make additional higher quality, formal care available to families in low-income communities. The supply and affordability barriers families faced also indicate the need for additional assistance so low-income families can overcome work and income constraints in order to access higher-quality care.

Linking Parents' Child Care Decisionmaking to Program Policy

At this point, we reintroduce the conceptual framework for parental child care decisionmaking that informed this analysis to identify how the findings contribute to our understanding of this process. Some of these findings could inform policies to better support the child care choices of low-income families.

Figure 8.1   Parental Child Care Decisionmaking

Outcomes become part of context for next child care decision
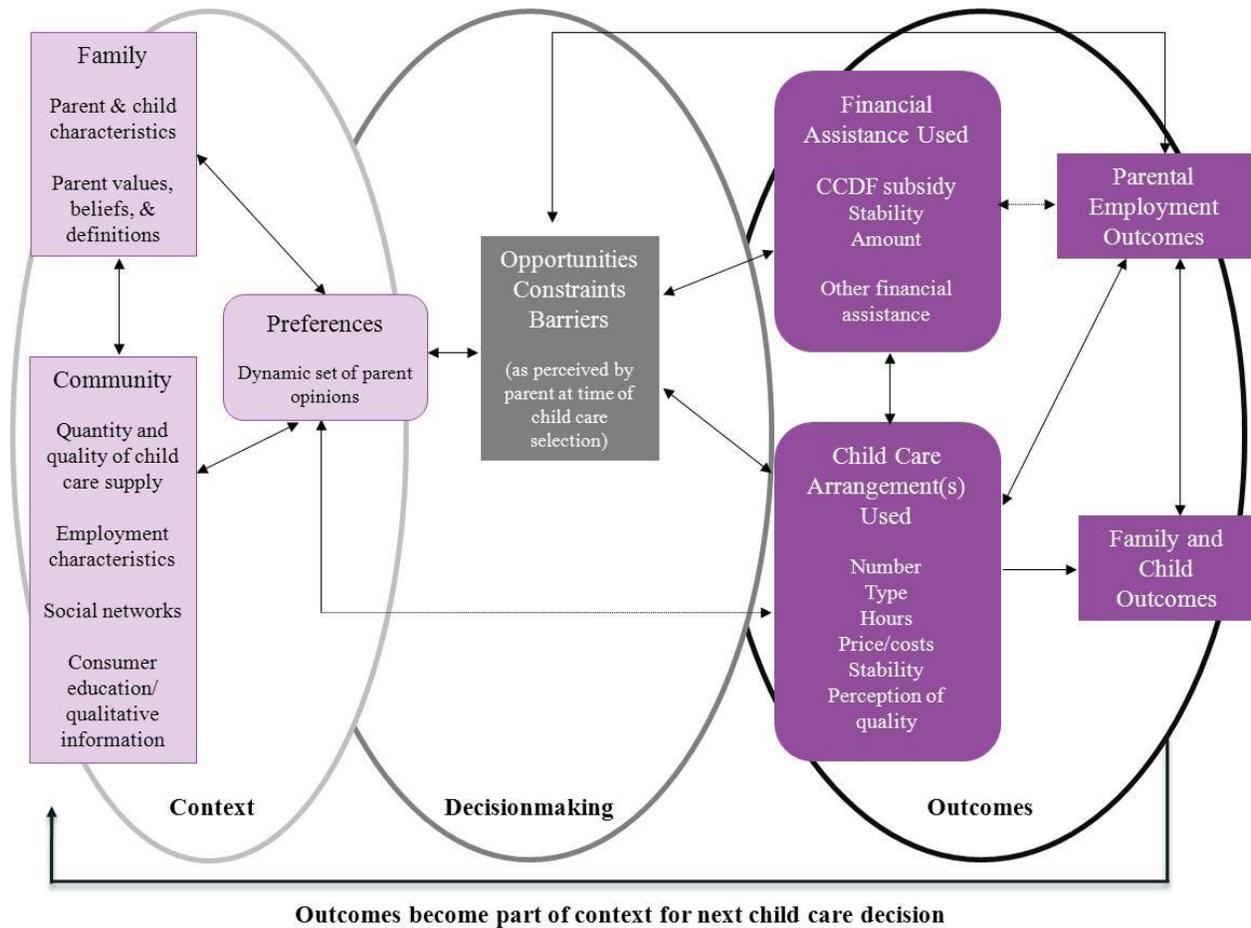
Many areas that we focus on for policy implications include elements listed in the community box in the lower left side of figure 8.1. These community elements strongly interacted with families' personal characteristics and preferences to inform care choices. The most relevant elements, and those for which this study has some clear policy implications, included the quantity and quality of child care supply, the employment characteristics, the role of families' social networks, and, to some extent, the qualitative information parents have about child care options.

Another part of this conceptual framework for which the study may have policy implications is the nature of the interactions between parental preferences and the opportunities, constraints, and barriers that families face when making child care decisions (i.e., the two-way arrow that goes between the preferences box and the opportunities box). Finally, this study highlights the importance of considering the level of financial assistance needed to help families make care arrangements that are consistent with their preferences and supportive of their children's development.

124

Policy Strategies to Address the Child Care Choices Available to Low-Income Working Families

This study's findings can be used to inform policy strategies that will improve the availability and the quality of center-based early childhood care and education programs in low-income communities, the sources of information about child care options and resources, and the interactions between child care and work.

Strategies to Increase Child Care Opportunities and the Supply of Center-Based Care in Low-Income Communities

Each low-income community has its own early care and education needs, and each may also like to see resources allocated differently to best respond to these needs. However, several themes common to the two communities in this study are also consistent with the findings from previous studies of similar populations (Chaudry 2004; Knox, London, and Scott 2003). What seems clear from these analyses is that child care options in these communities are very limited, especially options for high-quality, center-based care; the public resources devoted to helping address this shortage cannot meet community needs; the mix of public programs available to low-income families varies greatly by community; and the programs that exist are often splintered and hard for families to navigate.

These findings suggests that federal, state, local, and community leaders should evaluate and respond to early care and education needs by significantly increasing resources, strategically integrating these resources to provide a continuum of child care opportunities from birth to age 5 that meets families' needs and preferences, and targeting

these efforts where the supply and integration of services is most limited.

While the findings of one qualitative study with a relatively small study sample in two communities may not warrant such a broad recommendation, the findings confirm those of other studies of low-income communities (Chaudry 2004; Fuller and Liang 1996; Kisker and Love 1996; Queralt and Witte 1998; Scott, London, and Hurst 2005). And, the rationale for evaluating and responding to early care and education needs seems clear. First, high-quality early childhood development programs can be a crucial support for young children's learning and development. High-quality programs can lead to later academic success and behavioral outcomes (National Research Council and Institute of Medicine 2000).[9] The care that children receive as infants and toddlers factors into the presumed ability gap seen at the start of kindergarten (NICHD 2005) that proves very difficult to close later (Kilburn and Karoly 2008).

The families in this study discussed their preferences for child care options that provided stimulating activities and learning environments, and many discussed wanting to find center-based care starting at age 2 or 3. However, some could not find such options in their community, could not afford what they did find, or found that the available options did not accommodate their complex and inflexible work contexts. A great many parents with young children, like the ones in this study, need support to meet the dual demands of nurturing and providing economically for their children. In this study and prior research (Chaudry 2004), we have heard a great many parents' stories of making care arrangements based on limited options and information, leaving their children in settings they later discovered were poor quality.

Second, public resources for young children's development and care remain exceedingly scarce. In fact, per child spending for children in the early years is a small fraction of what is spent on children during school years. Public investment in children is lowest during the developmental period when there is a growing consensus that it matters the most:[10] before children enter publicly supported schooling at age 5. One analysis of federal and state government expenditures for children birth to age 3 found they averaged about $4,000 per child, less than half of the approximately $10,000 per child spent on children over age 3 (Macomber et al. 2009). Another analysis of state and local early care and education (ECE) spending on children in New York City found that approximately $1,300 was spent annually per child on all publicly subsidized ECE, compared with $11,900 per pupil expenditure for children in K–12 education (Chaudry, Tarrant, and Asher 2005). Children in low-income families are at a greater relative disadvantage than other children before they ever enter school. Since differences in early care and education contribute to the presence of an early achievement gap that potentially worsens later, the insufficient investments in young children in low-income families and the age inequities in public investments in children appear especially unjustifiable. More than anything else we discuss in this study, the very limited and tightly rationed public support for early care and education shapes the child care decisions and care used by low-income families.

Third, the health and development of children in low-income families is seriously compromised because their families lack the resources and opportunities to make the necessary investments, and the public weal does not do enough to help. As the practical experiences of these families making child care decisions with limited options under very tight constraints indicates, we should not ration such fundamental access to early care and education or leave families on their own to develop tentative, piecemeal, and uneven pathways for their children. We do not ration access to K–12 education; arguably, we should take a similar approach during the critical developmental years from birth through age 5.

When a child's life trajectory is beginning to take shape, we should make much more public investment so children in low-income families do not simply continue to fall behind. Efforts are needed to reduce the burden on parents who too often struggle heroically to make the most with very limited choices. Thus, an overarching recommendation is for a significant expansion of the developmental care and education resources for children from birth through age 5, and for efforts to increase the supply of high-quality care and educational programs in low-income communities (Aber and Chaudry 2010; Chaudry 2004).

Several complementary strategies can be used to increase the early care and education opportunities desired by low-income families, particularly the supply of high-quality center-based care options that are most limited. These strategies include increasing and shifting Head Start program slots, expanding child care subsidy funding to more fully meet the needs of low-income families with children from birth to age 5, and using more of existing and expanded ECE resources to support the supply of care in low-income communities. Each of these suggestions is discussed below, as well as some related ideas about improving child care quality and better integrating early care and education services.

Increase and shift Head Start and Early Head Start resources to very low income communities

Something that became clear in the Providence and White Center family

interviews is the high regard that parents had for Head Start and the difficulty several families had in accessing the program. The Head Start program was especially desirable for ELL and special-needs families. Those who had participated found the program very beneficial and a particularly good fit because of its comprehensive services to families (e.g., speech therapy for language-delayed children; English language learning for non-native speakers), better trained staff to address families' unique circumstances, and higher program standards. Head Start has implemented multicultural principles to address the home language and culture in its programs (Office of Head Start 2010), the success of which is reflected in the interest of ELL and immigrant participants. Several families discussed being directed to Head Start early on; some immigrant and ELL families had heard of the program through their social networks, while a few families with special-needs children were referred by professionals they consulted about their children's needs and child care situations.

A key potential strategy for increasing and shifting Head Start and Early Head Start resources would be to fully fund Head Start, particularly in communities with the highest concentrations of low-income families. Such a strategy should seek to expand and integrate Early Head Start programs with Head Start, so children and families with the greatest needs in these communities are offered comprehensive services earlier and more continuously in their lives. This strategy would help communities such as White Center better serve the neediest low-income working families, particularly dual-language learners and special-needs children who may benefit the most from its service-rich comprehensive model.

The American Recovery and Reinvestment Act (ARRA) increased funding for Head Start and Early Head Start for fiscal years 2009 and 2010 after several years in which funding for the programs was kept flat, meaning it declined in real terms after accounting for inflation.[11] This funding provided a good start toward continued Head Start and Early Head Start expansions that would represent an important investment in some of the most disadvantaged children from the earliest possible opportunity. Further, this expansion could include shifting or retargeting the still-limited reach of the Head Start and Early Head Start programs.

One important element of a strategy for retargeting these resources would be to shift the eligibility guidelines based on the percentage of children under age 5 living in low-income families within a given community and to give greater preference to communities with the highest percentages. For example, rather than basing eligibility on individual family income, a program expansion could target communities like Providence and White Center, where most families were low income (50 percent or more families with children with incomes below 200 percent of FPL) or where a relatively high concentration of children were poor (more than 25 percent of children in families living in poverty). This change would allow the program to provide services to all children in the most disadvantaged communities, regardless of family income. This change could simplify eligibility determination and reach more children in the highest risk communities with comprehensive services.

Targeting Head Start and Early Head Start expansion to the most disadvantaged communities could also limit some costs of further expanding the program and build an effective infrastructure for program delivery in communities with the least amount of ECE infrastructure and where private ECE investments rarely occur. Meanwhile, such policy changes would facilitate eligibility determination. Currently, eligibility for most

families is based on income, which can be difficult for some families to document and which can create rough and arbitrary cutoffs for critical developmental services needed for a broader spectrum of children—almost all of whom live with many of the disadvantaged circumstances associated with growing up in poverty conditions.

This type of bold expansion of Head Start and Early Head Start would help address the many needs of children who are living in low-income families, especially those who might otherwise be most socially isolated or most in need of comprehensive services. Early Head Start in particular can serve as a primary hub for services for children in their earliest years since the program provides regular services to children from birth (or even before birth with prenatal services) until age 3. The Early Head Start program model includes several complementary components meant to improve children's early development, including intensive early services to promote socioemotional and cognitive development for infants and toddlers, programs to help parents identify and support their children's needs over time, and referrals to developmental services to meet children's specific needs. The program is available in several service models that can also complement families' other preferred child care arrangements for their children when they are youngest, such as informal relative care.[12]

Guarantee child care assistance for low–income working families with young children

A more broadly based policy strategy would be to further expand funding for the federal and state Child Care and Development Fund (CCDF) to better support access to a broader array of child care options and to help families overcome the limitations of their own resources, which might not allow them to choose the most appropriate care at

developmentally important stages for their young children. An expanded CCDF could maintain and build upon initial funding increases in ARRA by moving aggressively over the next several years toward offering low-income families a guarantee of child care assistance. Such an expansion could go hand in hand with creating stronger incentives for states and providers to make significant supply-side efforts to increase center-based care options in low-income areas, and it could be coupled with incentives to foster quality improvements to programs and mandate greater integration efforts for early childhood programs.

The costs of meeting a primary family need like child care is often beyond the financial means of many low-income working families.[13] As many families in this study relayed, working in a low-wage job is not very economically beneficial in terms of the net take-home pay for some parents without subsidized child care. The market costs of many child care options can consume a large part of their incomes, particularly for single mothers who earn low wages (Chaudry 2004; Overturf Johnson 2005; Smith 2002).

Similarly, studies have suggested that the lack of subsidies and the structure of subsidies under a tightly rationed system can contribute to child care and job instabilities (Adams et al. 2002; Chaudry 2004; Lowe, Weisner, and Geis 2003; Scott et al. 2005). Also, as many families in this study related, the child care they can afford often falls short of what they would want for their children's care and development. High-quality child care should be viewed as an essential work support for parents. There is an ample case for more government support to help parents access affordable child care and to address the size and quality of the child care system.

The Obama administration has demonstrated efforts to enhance the families' access to affordable care options, but further

work is needed to extend supports to all low-income working families. ARRA provided $2 billion in supplemental discretionary CCDF funds, which provided approximately a 20 percent increase in federal program funding for FY 2009 and FY 2010 (the latter of which totaled $5 billion; see ACF 2010a). In President Obama's 2011 federal budget, he requested a total of $1.6 billion in additional CCDF funds, but the 2011 federal budget was never passed by Congress; government programs have operated through continuing resolutions for the first months of FY 2011. Previously, several years of flat-level funding eroded the real value of federal child care investments, and the number of children being served declined over time (Center for Law and Social Policy 2009; First Focus 2009).

These ARRA investments should be considered a first step toward full funding for a child care development fund that **guarantees child care assistance to all young children (between birth and age 5) in low-income families in which parents, regardless of marital status, are working.** This policy strategy has been advanced and discussed by one of this report's authors and others in greater detail elsewhere (Aber and Chaudry 2010; Chaudry 2004; Greenberg 2007).

As a starting point for this strategy, the federal government could guarantee child care assistance for all low-income working families with young children, in which each parent is working and the families earnings are below 250 percent of FPL. Given the concern raised by some families in the study that the way subsidy eligibility and access was structured made it more difficult for married, dual-income earners to qualify for child care assistance, one could consider experimenting with slightly different income cutoffs for the child care guarantees for single-parent and married-couple families, such as 225 percent of FPL for single-parent families and 275 percent of FPL for two-parent

families. It would seem appropriate for all parents receiving subsidies to contribute a reasonable share of their income toward the cost of child care (roughly the share of income that nonsubsidized families spend on care, or about 7 percent).[14] The co-payment could be adjusted for changes in income during an annual benefit recertification. Parents would be required to periodically recertify their continued employment and income through simplified means such as mail or web-based processes.

Broadened income eligibility and the guarantee of child care assistance for low-income families could be phased in to address the potentially large funding increase this could represent and the uncertainties about what percentage of eligible families would take up subsidies. The phase-in would also allow child care markets to adjust in order to provide greater access to families that may choose to use higher-quality care options that were previously unavailable.[15]

The effort to expand CCDF to offer low-income families a child care assistance guarantee should include some additional components: avenues to increase supply in low-income communities, quality improvements, and efforts to better integrate early childhood programs.

Support the development of child care supply in low–income areas

One concern about increasing child care subsidy resources in the current system is that, compared with the development of Head Start centers, child care subsidies do not often address the limited supply of quality care options in low-income areas. Across the country, much of the CCDF resources for child care subsidies go toward care provided to families through vouchers, while a few states and localities use subsidy funding to provide child care contracts so providers, particularly centers and family child care providers, will serve low-income and

underserved areas that may not draw private, for-profit centers. Applying subsidy resources toward contracted care presents a supply-side strategy for increasing child care options in low-income communities, rather than a demand-side strategy that might not increase the supply of high-quality care in these communities.

Previous research has suggested that contracted care can help maintain child care stability, and by extension, employment stability (Scott et al. 2005). The child care administrative agency that establishes the contract can mandate routine assessments as a condition of funding, helping to better assure continuous quality improvement and consumer satisfaction (Fuller et al 2002; Meyers 1990). The greater use of contracted care over a voucher system could be done in combination with the development or expansion of Head Start centers that also provide child care services to subsidy recipients. Families participating in Head Start could receive seamless services without the burden of obtaining a voucher and searching for an additional care provider.

Ensure quality care

A program to fund a larger child care subsidy system with guaranteed assistance should be implemented along with policies to promote higher quality care to better support child development.[16] The families we interviewed often discussed their preferences for child care arrangements that demonstrated some of the qualities associated with a high-quality environment: opportunities for learning activities, sensitive and qualified caregivers, nutritious meals, safe and clean environments, and small group sizes (Forry, Vick, and Halle 2009; NAEYC 2005; NAFCC 2005). We propose that in exchange for receiving the added federal resources that would support a child care guarantee, states should be required to develop strong, externally validated quality rating and

improvement systems (QRIS) for all forms of subsidized child care. That way, expanding child care options would not hinder the quality of services families receive.

Twenty-three states have implemented a statewide QRIS to improve the quality of early care and education programs, and more than 25 others are developing a QRIS or other quality improvement system.[17] Evaluations of QRIS in six states have shown positive impacts on child care quality. A further option would be to tie reimbursement levels to the quality of care, as some states have already moved toward doing (Tout et al. 2009). Eighteen of the 23 states with a QRIS pay a higher child care subsidy reimbursement rate to programs that meet the quality standards.[18]

To be effective, these ratings must be advertised and made readily available to all families receiving or applying for subsidies, so quality information can be more transparent and factor more into families' child care decisionmaking. Targeted media campaigns that can reach a low-income audience can increase parental awareness of the importance of quality child care and educate parents on how to access quality ratings from state systems.

Integrate early childhood programs

Finally, strategies that build upon the child care subsidy system should be implemented without exacerbating the current fragmentation in early care and education program services. Many local communities like those studied for this project have various early childhood programs, such as Head Start, public prekindergarten, private center-based care and preschools, faith-based nursery schools, and family child care programs— each with its own funding sources, administrative oversight, enrollment processes, eligibility criteria, and hours of operation. This disconnect among early childhood programs already makes it difficult for families to navigate services in many

communities and sometimes leads to inefficient, poorly targeted services.

Families in the two communities in this study confronted a very splintered, obfuscated set of potential options. This splintering tends to create confusion for families seeking services, deter some parents from learning how to access care or apply for services, cause mismatches in services to needs, and create discontinuities in care. Families needing full-day services with extended hours often must search for and patch together multiple arrangements, which can disrupt their employment situation and their children's well-being. For example, our study families indicated the half-day Head Start schedule was problematic because they were forced to find a second arrangement before or after the program to meet their need for full-day child care. An integrated service model with either blended funding to support a full day of child care services or the provision of on-site, wraparound child care for Head Start participants would provide continuity that benefits both parents' schedules and children's development and learning. Indeed, significant integration efforts for early childhood programs must be mandated as part of any major expansion in child care development funding to make these investments effective.

Child care subsidies offer parents and state programs some important flexibility to build around program services like Head Start and state prekindergarten programs that have limited service hours. In addition, Head Start and most prekindergarten programs have established program quality standards that can create an important basis for improving the quality standards of other CCDF-funded center-based programs and integrating common standards across programs. However, if administration of these programs is splintered, or if the resources offered by each are used simply to supplant

rather than truly supplement the efforts of the others, combining these resources may turn out to offer less than the sum of the parts. Unless programs are integrated and streamlined, new resources would move us no closer to a functioning ECE system that adequately serves the many children who need one.

Strategies to Improve Information and Access to Services

Families in the two study sites, even those who were able to access public support for early care and education, raised many concerns about accessing services. Access could be problematic for the full range of families we interviewed, but issues were in many cases most intense for certain families, including those whose options were most limited by work constraints, those who had children with special needs, and those who had the most limited social networks.

Low-income families face significant obstacles to finding appropriate and stable care arrangements for their children, and some families are unaware of the child care options or forms of assistance and subsidized programs that might be available. Low-income families then have difficulty accessing subsidized care options because of the confusing array of different programs that might exist in their community and the complex enrollment and eligibility procedures. Government program officials and child care providers need to develop stronger coordination strategies to ensure that learning about and applying for ECE services in local communities is made as easy as possible and is oriented to the real-life contexts of working families. Therefore, strategies to improve access need to provide simpler, clearer information to parents through multiple sources that are likely to reach them, as well as unified, simpler

enrollment processes for the range of available community care resources.

Parent information

While some families in the study knew a great deal about the different types of care and programs in their community, many more knew little about care options beyond what they were using or had used. The more complex their care needs were or the fewer social network resources they had, the less parents seemed to know about alternatives and the fewer avenues they had to find care to meet their needs. Early care and education administrators must develop more effective strategies for parental outreach to better inform parents about care options and how to access available public resources. Simply supporting CCR&Rs and expecting parents to find their ways to them does not seem to reach families. Rather, it is necessary to develop ways to inform social networks more broadly and to reach broad-based trusted sources such as pediatricians, health clinic staff, WIC staff, and community-based ECE programs and schools. Efforts also need to be made to ensure that CCR&Rs and other community-based sources have reliable contact information for child care providers that is consistently updated and reflects the characteristics of providers that parents look for during their search (e.g., native language, hours of care, transportation). A few parents in our study also indicated that the high fee associated with using CCR&R online databases deterred them, which suggests that such services should be freely available to the public.

Enrollment access

Some primary strategies for improving access to ECE services build on efforts that were taking place in the study communities—and in many communities to different degrees—as well as efforts to streamline access to other work supports (Adams, Snyder, and Banghart

2008; Chaudry et al. 2005). These strategies could include shifting toward more centralized enrollment points in underserved communities, so enrollment in early childhood development programs could have a common front door and over time could become primarily community based. Second, a universal application or common application processes for different early childhood development services in a community, city, or county could reduce the burden on families and allow families to learn about all the available programs and services for which they are eligible. Third, eligibility requirements across programs could be aligned to make accessing and retaining child care straightforward and more streamlined, with simple and clear eligibility forms, documentation requirements, and automated systems. Such integrated enrollment and eligibility determination would help parents enroll their children in the most appropriate early care and education arrangement available, including combinations of different services (such as prekindergarten and subsidized family child care) and would foster unbroken transitions for young children (for example, moving from a subsidized family child care arrangement to a Head Start center at age 3).

Strategies to Improve Work–Care Fit and Promote Greater Work–Related Flexibility

To improve care options for children in low-income working families, it is also critical to improve the fit between their care choices and work contexts. Foremost, it is important to develop and support strategies that provide much greater child care options for the large and growing proportion of families in which low-wage working parents have nontraditional schedules. In Providence and White Center, several parents with

nontraditional or shifting work schedules were using family child care providers that offered longer and more flexible care hours (including two who had 24-hours-a-day service models). This kind of expansion in service hours was much less common in center-based care programs, and strategies that promote models with broader service hours are much needed. Any significant investments in CCDF and/or Head Start and Early Head Start must incorporate extended hours in order to meet the actual needs of families in these communities for higher-quality early childhood care and education. According to national statistics, only half of children are enrolled in Head Start programs for a full day (generally six hours or more), while others attend Head Start only in the morning (38 percent) or afternoon (13 percent) (Aikens et al. 2010).

In the case of CCDF expansions, as discussed earlier, some significant amount of any new investments must be directed toward "supply-side" child care investments. Contracting with child care centers that offer a broader array of hours would be an important first step. The families in this study who wanted to use center-based care, but could not because of the limited or inflexible hours, indicated they would like to see centers that offered care that started earlier (beginning as early as 6 a.m.) or extended later (until roughly 8 p.m.). In most circumstances, expanding center-based care into nighttime hours is not feasible or what parents prefer for children.

Significantly improving the child care fit for many low-wage workers who work nontraditional hours and have inflexible work schedules may require changing employment standards and employer practices, neither of which is easy and both of which are beyond the scope of this analysis. In general, U.S. employment policies provide limited support for caregiving and family responsibilities

relative to many other advanced economies (Gornick and Meyers 2003). Some work-family policy strategies that other analysts have advanced that seem worth serious consideration include legislating a minimum number of paid sick days for employees, paid family leave, and right-to-request legislation (Boots, Macomber, and Danziger 2008; Boushey et al. 2008; Lambert and Henly 2009). A few state and local governments have adopted policies mandating that employers provide a minimum number of paid days off for illness for their employees, ranging from three to nine days annually, and federal legislation was introduced by Senator Edward M. Kennedy in 2008.[19]

Another strategy to consider that has been developed in a few states, including California, New Jersey, and Washington, is to establish employee-financed paid family leave programs to ensure that parents have some financial and employment security to address family needs, particularly those that arise around children's birth and infancy or to care for children with severe or long-term illnesses.[20]

Others have suggested that the U.S. adopt legislation similar to what the United Kingdom enacted in 2002 that established the right of workers, particularly those with children under age 6, to request flexible working arrangements.[21] Employers are required to consider and either accommodate workers' requests or document reasons for denying them. Initial results have shown most employees' flexibility requests have been granted (Department of Business, Enterprise, and Regulatory Reform 2009).[22]

Conclusion

This report provides an in depth study of the child care decisionmaking of low-income working parents, including a rigorous and detailed analysis of their care choices, and

discusses how to develop policy strategies that might better support these parents' care choices. In studying 86 low-income working families in two diverse urban communities, we witnessed them arranging child care in the context of clear preferences, personal resources and opportunities gained from sometimes strong personal networks, and significant constraints. While this sample is not large or nationally representative, the stories of these families highlight challenges that diverse low-income families face when arranging child care. The findings shed light on the complexity of managing work with the care of young children, and the added constraint of limited affordable care options on care choices.

This final chapter of the report provides some potential strategies for addressing the concerns raised in the study and improving the early care and education opportunities of children in low-income working families and disadvantaged communities. The limited yet splintered supply of public programs and child care subsidies contributes to the lack of child care options, including those that might best meet parents' preferences for care. The recommendations in this chapter can serve as an important starting point for developing policy changes needed to address critical issues raised in the study's findings. While more analysis and development of the strategies is needed, the potential public investment required will be significant.

The strategies discussed to increase, integrate, and improve the quality and accessibility of early care and education programs are indeed ambitious. Suggesting more universal access to preschool education, increased federal funding for child care assistance, and improved work supports for low-income working parents may sound like tone-deaf overtures, particularly when there are constant calls for reductions in federal outlays. Yet, there is a broad-based consensus on the desirability of high-quality early care and education as witnessed by the widespread use of such programs by families that can afford them and by the research evidence that supports their positive outcomes for children. In addition, the amount of federal and local public spending directed toward supporting the growth, development, and needs of young children from birth to age 5 is miniscule in the context of overall federal and state budgets (Isaacs 2009; Macomber et al. 2009).

Efforts to address the nation's and states' fiscal balances can and should address the imbalances in priorities at the same time they address the challenges of the bottom line. Most important, the struggles of the families we interviewed to find and arrange the best care for their children in their current contexts are impossible to deny. Their experiences directly lead us to suggest policies to improve these contexts and produce better choices and outcomes for all children from low-income working families.

APPENDIX A: THE TWO MAKING CONNECTIONS STUDY COMMUNITIES FOR THE STUDY OF CHILD CARE CHOICES OF LOW-INCOME WORKING FAMILIES

When this project was initially developed, we sought to build on the foundation of existing research efforts being made as part of the Making Connections initiative, a multiyear community-building effort in 10 low-income communities across the United States. The study was able to build upon an extensive base of existing knowledge and contacts to enhance our recruitment, study planning, and understanding of the community contexts.

We selected the Making Connections communities in Providence, Rhode Island, and in White Center (an unincorporated area in King County, Washington, that borders the city of Seattle) because both were low-income communities, with high concentrations of low-income families, and both had relatively high immigrant populations among the Making Connections sites. Both are urban settings that have broadly similar demographic characteristics and socioeconomic profiles, but with some contrasts as well. King County, WA (population: 1.88 million), and Seattle (population: 582,000) have larger populations and have experienced much greater growth over the past half-century than Providence County (population: 626,000) and the city of Providence (population: 171,000). The racial and ethnic makeup of Seattle is nearly 75 percent white, 8 percent African American, 13 percent Asian, and 5 percent Latino. The racial-ethnic makeup of the city of Providence is 50 percent white, 13 percent African American, 6 percent Asian, and 39 percent

Hispanic (Latinos can also indicate they are white or African American).[23]

The immigrant share of the population is higher in the city of Providence (29 percent immigrants) than in the city of Seattle (16 percent immigrants). More than 80 percent of Providence's immigrant population is Hispanic, while the city of Seattle has fairly large Asian and Latino populations (who represent more than 60 and 30 percent, respectively, of the immigrant population). A majority of immigrant families with children in both cities are low income: 58 percent of Providence families with children and one or more immigrant parents have incomes below 200 percent of FPL, and 51 percent of such families in Seattle do.

The local economies in Providence and Seattle were both deeply affected by the economic downturn that started in 2007, around the time this research study began. Providence's economy was affected earlier and more deeply than Seattle's. Providence had a higher overall unemployment rate, greater increases in households whose incomes fell below the poverty level during this time, and much higher rates of families relying on public benefits (including Temporary Assistance to Needy Families, Supplemental Security Income, and the Supplemental Nutrition Assistance Program) between 2007 and 2010. Some differences in the degree of the economic downturn reflect the Providence economy's greater reliance on the service, construction, and transportation

sectors for more than half (54 percent) of its jobs, compared with less than a third (31 percent) in Seattle.

The two study sites within Providence and bordering Seattle are lower-income communities that have higher concentrations of immigrant families than the cities do. The Providence site measured worse on many demographic and socioeconomic characteristics, including family and poverty income, employment, and need for public benefit supports, than the White Center community. In the rest of this appendix, we first provide more focused site descriptions and key demographic data for each community to help readers better understand the findings of the study. We then provide additional information on the child care supply and programs in the two sites to contextualize the child care decisions of families discussed in the report.

Providence Study Site

In Providence, our study centered around the three Making Connections neighborhoods of Elmwood, South Providence, and West End, all of which are located within the city borders (map A.1). The population in the Providence study site is approximately 22,200 and has been declining recently, as it has for the city of Providence as a whole. Forty-eight percent of the households in Providence have children, and nearly half the community residents are children under 17.

The Providence study neighborhoods have been home to a diverse range of families and local businesses, and they have been immigrant-receiving neighborhoods for decades. Data from the most recent Making Connections survey in 2009 indicate the neighborhood's racial and ethnic composition: 6 percent of residents are white, 20 percent are black, 62 percent are Hispanic, 7 percent are Asian, and 5 percent are other.

Map A.1   Providence Study Site
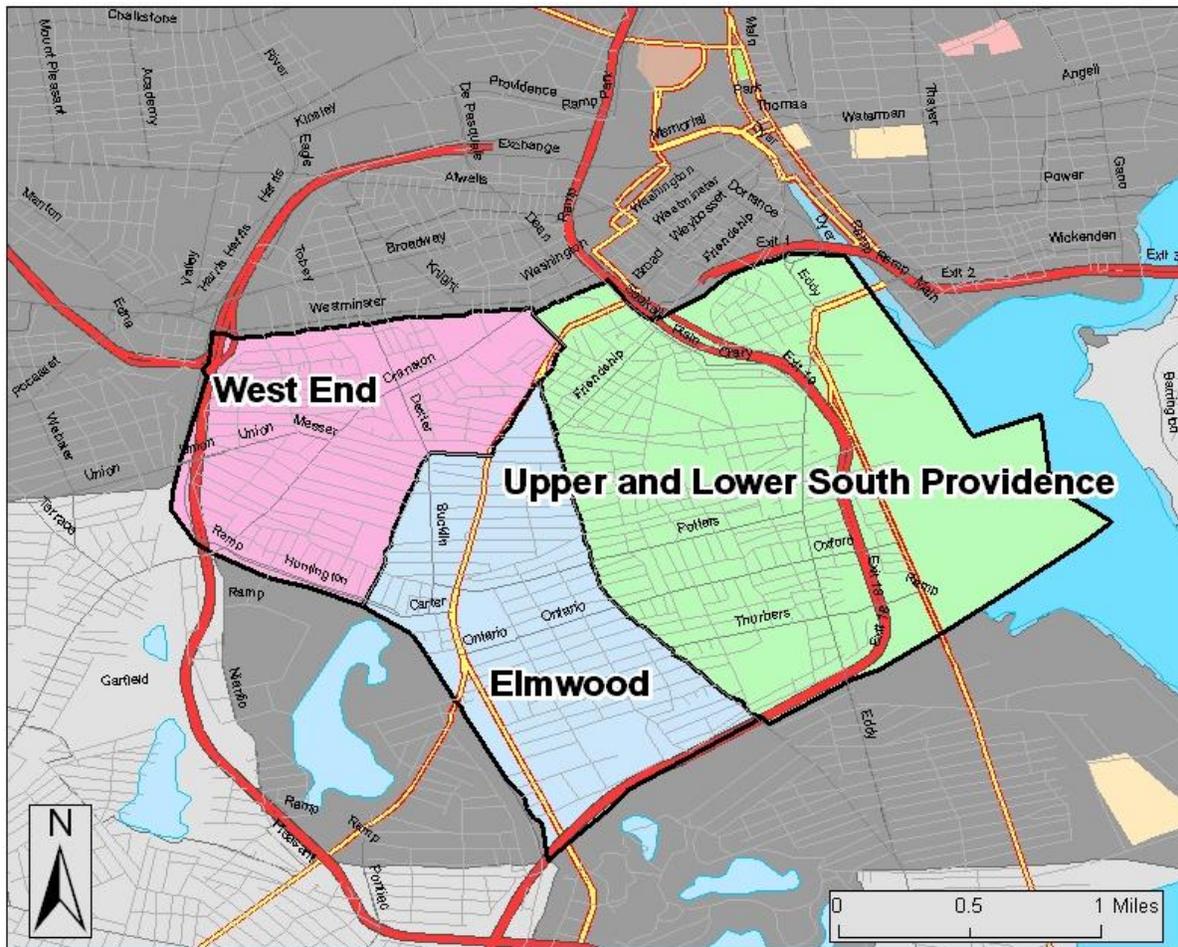
Two-thirds of the adult Providence survey respondents were foreign born. Dominicans are the newest arrivals to the Providence study neighborhoods, while the city as a whole has also become home to large immigrants populations from Latin America and Asia. While more than 70 percent of the foreign born in Providence originate in the Dominican Republic, 15 percent come from Mexico and Central America, and about 10 percent from Southeast Asia.

Approximately one-quarter of the Providence population could be considered English language learners. Based on whether respondents needed the survey translated, we estimate that 44 percent the population in the neighborhood were English language learners.

Low–Income and Poverty Levels among Families in Making Connections Study Site

Nearly 9 out of 10 families with children (88 percent) in the study community had household incomes below 200 percent of FPL, and nearly two-thirds (64 percent) had incomes below FPL(defined as poor). The poverty rate among families had increased from 56 to 64 percent between 2006 and 2009. The share of families with children with income from wages and employment

dropped dramatically because of the recession, from 85 percent in 2006 to only 73 percent by 2009. However, even among families with employed adults, 45 percent lived below the poverty level, and 80 percent lived below 200 percent of the poverty level (defined as low-income working families).

Local Economy and Employment

The strength of the local economy has for many years been its heavily reliance on manufacturing and warehousing. Thus, these neighborhoods and residents were particularly affected by the recession and its sharper impact on these industries during the recession.

The educational attainment of local residents in the Providence community is significantly lower than the average for the surrounding metropolitan area. Just two-thirds (66 percent) of community residents have a high school or equivalency degree, while 38 percent have any postsecondary education.

At an even greater rate than other large metropolitan areas, the Providence metropolitan area experienced very high job loss and unemployment very early in the recession and over the period of the research study. For a prolonged period, the Providence metropolitan area suffered with

unemployment rates consistently higher than the national average. The Bureau of Labor Statistics (BLS) reports the average monthly unemployment rate for the Providence-Fall River-Warwick RI-MA metropolitan area in November 2010 was 11.1 percent,[24] a very sharp increase from the 5.4 percent unemployment rate at the start of the study in 2006 (table A.1).

According to the analysis of the Making Connections survey data for the neighborhood, among families with children, employment decreased dramatically during the recession. In 2009, only 65 percent of the population had at least one adult employed, down from 80 percent in 2006.

Public Benefit Supports

Twenty-six percent of families with children received TANF in 2009, which was relatively unchanged from the survey results three years before. However, as has been the case nationally during the Great Recession, the share of families receiving food stamps (SNAP) increased sharply from 44 percent in 2006 to 60 percent in 2009. And, more than one in four (27 percent) of families with children received housing assistance. Seventy-three percent of children had public health insurance.

Table A.1 Average Monthly Unemployment Rate for Providence-Fall River-Warwick, RI-MA Metropolitan Area

Year	Rate
2007	5.4%
2008	7.6%
2009	11.4%
2010	11.2%

Sources: 2007, 2008, 2009 and 2010 Local Area Unemployment Statistics, Bureau of Labor Statistics (at http://www.bls.gov/lau/).

Seattle Study Site

The Seattle-White Center study site is located within King County. We mainly focused on White Center, an unincorporated community in King County southwest of downtown Seattle, and had some study respondents from the immediately surrounding community in the city of Seattle to the north and Burien to the south (map A.2).

The White Center community has a population of more than 20,000 and is home to families from many different backgrounds, including Asian, Latin American, African, and Eastern European immigrants and refugees. Data from the most recent Making Connections survey in 2009 indicate the neighborhood's racial and ethnic composition: 25 percent of residents are white, 11 percent are black, 34 percent are Hispanic, 19 percent

are Asian, and 11 percent are other. The proportion of neighborhood residents who are white has been declining in recent years, while the Hispanic population has been increasing and other racial and ethnic groups have remained stable.

Half the adult White Center survey respondents are foreign born, with nearly a third from Southeast Asia (Cambodia and Vietnam) and 42 percent of immigrants in the community originating from Mexico and Central America. Others come from Africa and the West Indies, South America, other regions of Asia, and Europe. The foreign-born population is significantly higher in White Center than the average for the rest of King County. Local small businesses abound, and dozens of languages can be heard in the neighborhood.

Map A.2   Seattle-White Center Study Site
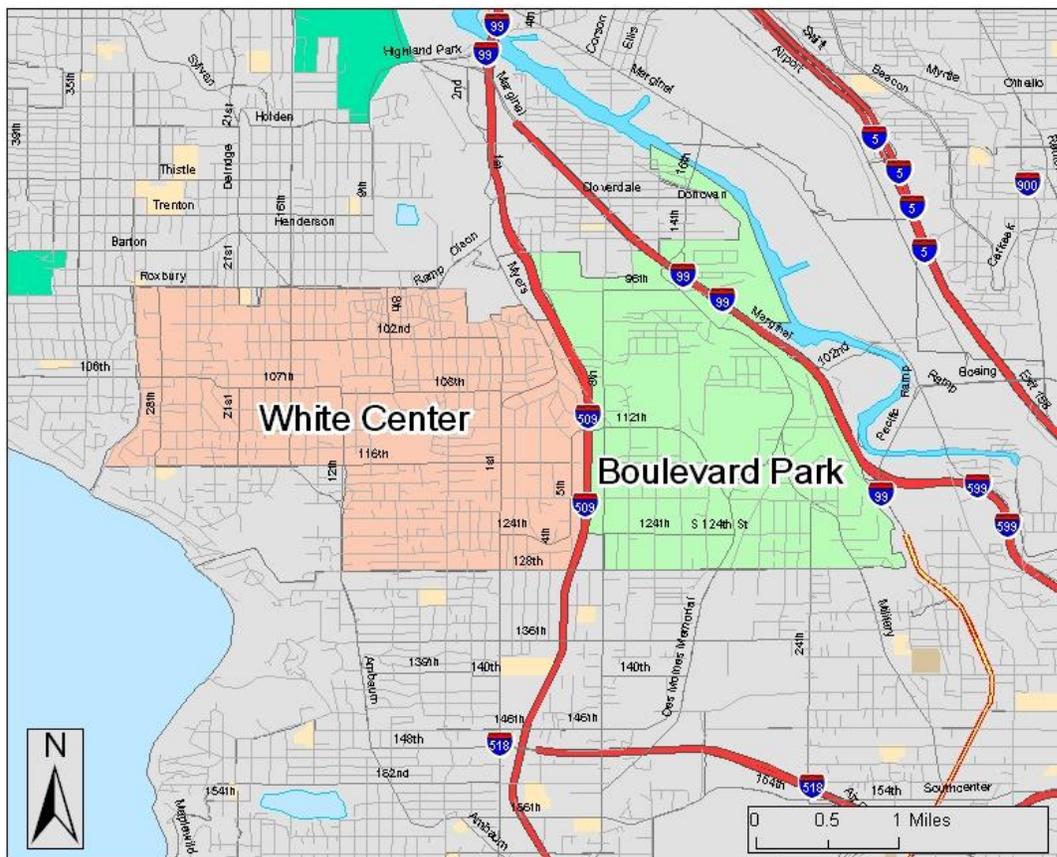
Low–Income and Poverty Levels among Families in Making Connections Study Site

Nearly 6 out of 10 families with children (59 percent) in the study community had household incomes that were below 200 percent of FPL, and one-third (34 percent) had incomes below the poverty level. This is despite the fact that 90 percent of households reported work earnings. The poverty rate among families increased by 5 percentage points between 2006 and 2009.

Local Economy and Employment

An industrial area in the first half of the twentieth century, today White Center's economy is dominated by small businesses. Many community members work in the immediate area as well as other parts of King County.

The educational attainment levels of local residents in White Center are lower than the average for the surrounding metropolitan area in King County. While nearly four-fifths (78 percent) of the community residents have a high school or equivalency degree, less than half (46 percent) have any postsecondary education.

Like most large metropolitan areas, Seattle experienced very high job loss and unemployment over the period of the research study, which coincided with the start of the Great Recession, its quick and severe

deepening, and very slow and uneven recovery.

The BLS reports the average monthly unemployment rate for the Seattle-Tacoma-Bellevue Metropolitan Area in November 2010 was 9.1 percent,[25] a very sharp increase from the 4.1 percent unemployment rate at the start of the study in 2006 (table A.2).

According to the analysis of data across the two most recent waves of the Making Connections survey data, employment in the White Center community decreased among households with children during the recession by approximately 7 percentage points. In 2009, 85 percent of the surveyed households had at least one adult employed, down from 92 percent before the recession in 2006. Most employed respondents worked full time, though this number decreased from 89 to 81 percent between 2006 and 2009.

Public Benefit Supports

Seventeen percent of families with children received TANF in 2009, which was relatively unchanged from the survey results three years before. However, as has been the case nationally during the Great Recession, the share of families received food stamps (SNAP) increased from 25 percent in 2006 to 30 percent in 2009. And, one in six (16 percent) families with children received housing assistance. Fifty-seven percent of children had public health insurance.

Table A.2 Average Monthly Unemployment Rate for the Seattle-Tacoma-Bellevue Metropolitan Area

Year	Rate
2007	4.1%
2008	4.9%
2009	8.7%
2010	9.1%

Sources: 2007, 2008, 2009 and 2010 Local Area Unemployment Statistics, Bureau of Labor Statistics (at http://www.bls.gov/lau/).

APPENDIX B: EARLY CARE AND EDUCATION CONTEXT IN STUDY SITES

This appendix provides a brief overview and context of the supply of early care and education (ECE) programs in the two study sites. For each community, we describe the ECE supply and programs during the time of the study, including the supply of licensed child care providers in the area according to information gathered from the local child care resource and referral agencies.

## Supply of Child Care and Program Contexts in Providence

The ECE supply in Providence includes both private and public programs. In addition to private center-based and family child care programs, there are two publicly funded programs for preschool-age children (funded through Head Start) and a state pilot prekindergarten program.

Child Care Providers

The local CCR&R in Providence is a nonprofit organization called Options for Working Families (OWF). OWF is funded by the state Department of Human Services (DHS), which also runs the child care subsidy program, and is based in the same building that houses the DHS in Cranston, just outside Providence. Families may visit the agency for information during its office hours or call its hotline number.[26]

Using the three main zip codes for our study community, the Options for Working Families web site identified 32 child care providers, including 18 centers and 14 family child care providers. The number of providers within the boundaries of the Making Connections site was even smaller (map B.1). The sites within the study community that offered the pilot prekindergarten program showed up in the search but were not identified as such.

Map B.1   Child Care Locations in Making Connections Providence Neighborhoods and
           Surrounding Area
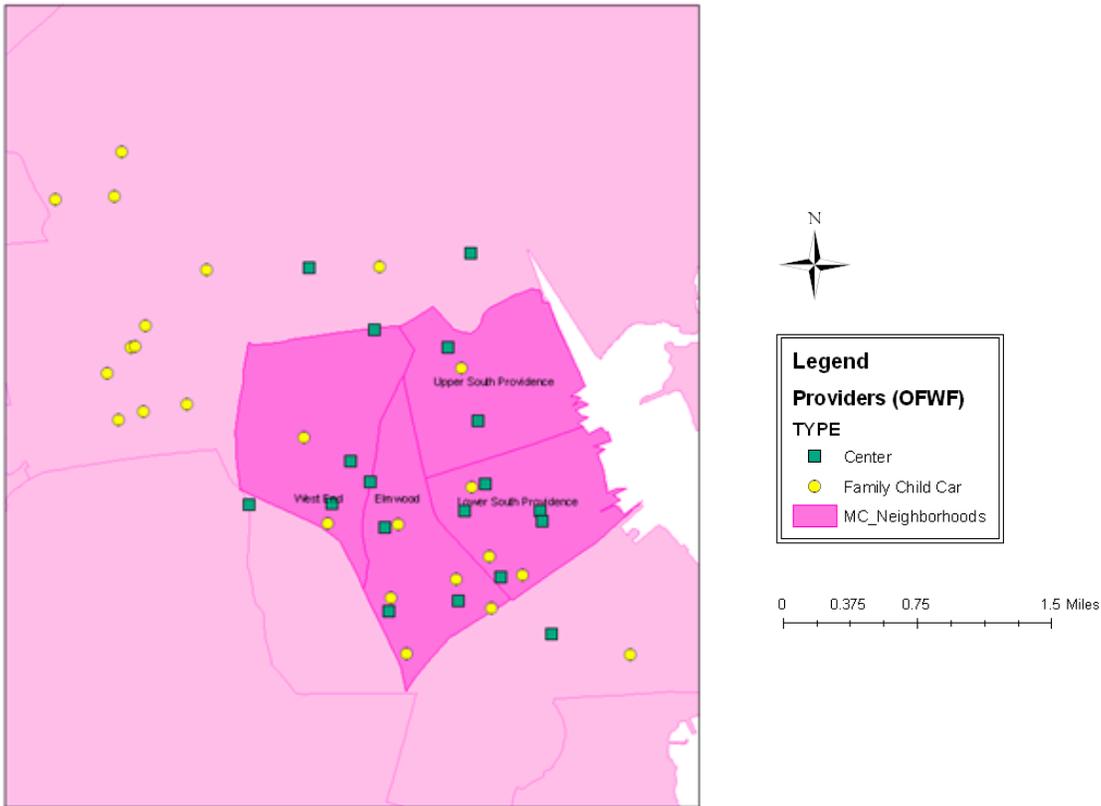
According to information provided by OWF, more local centers indicated they had capacity to serve families with children with special needs, and more had bilingual providers, than did family child care providers. None of the centers offered care on weekends, while some family child care providers indicated that they did. Just over a third of family child care providers indicated that they were open seven days a week, and several indicated that they were open only four days a week. All but two centers accepted subsidies.

When we started the study, some recent research had shown a recent decline in the supply and quality of licensed child care options in Providence, as well as Rhode Island as a whole. This decline resulted from a relatively sharp reduction in families

receiving subsidized child care following a decrease in the income eligibility level for child care subsidies (see section below on child care subsidies).[27]

To complicate matters, the foreclosure crisis has also affected the supply of family child care providers. In the city of Providence, foreclosures have led 6 percent (41) of family child care providers to lose their homes and their businesses, since state licenses are specific to a certain address (Ready to Learn Providence 2008).

Head Start sites

At the time of our community study in 2008–09, there were a limited number of Head Start programs in Rhode Island[28]—only eight in the entire state, none of which were located within our study area. However, three programs were within three miles of the

community where our families lived (map B.2).

Rhode Island's State Pilot Prekindergarten Program

In fall 2009, Rhode Island initiated a new pilot prekindergarten program for low-income families in four communities: Central Falls, Providence, Warwick, and Woonsocket. This venture was headed by the state Department of Education rather than DHS, which administers the Head Start and child care subsidy programs. The Department of Education received $700,000 from the state to launch the program and financed four of the seven demonstration classrooms. Two local school departments funded the other three classrooms for an additional $300,000.

During the first year, the prekindergarten program served 126 4-year-olds across the seven locations. Two locations were within our study area in Providence (see map B.2). While the program is still relatively small, it helped fill an important need, since there were no Head Start programs within the immediate geographic area. Some of our families reported sending their children to Head Start, but they had to be bussed or otherwise transported to programs outside the neighborhood. There was no income eligibility screening for the prekindergarten program, and applicants were selected by lottery. The four communities participating in the pilot phase were selected in order to serve a cross-section of moderate- and low-income families.

Map B.2   Public Preschool Programs in Making Connections Providence Neighborhoods and Surrounding Area

143
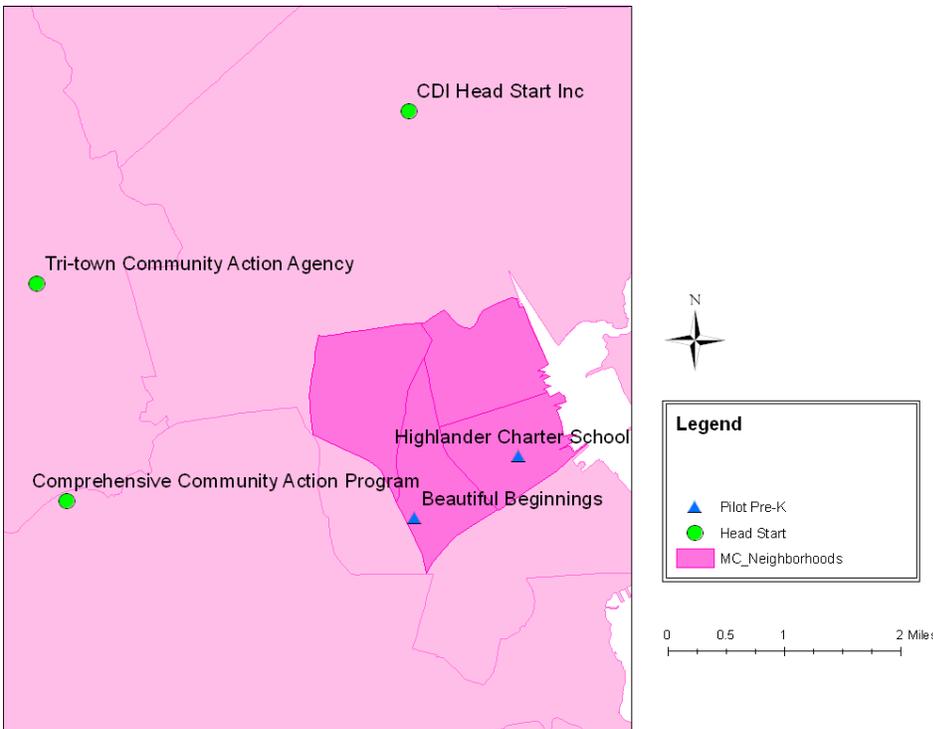
Rhode Island's Child Care Subsidy Program

The Child Care Assistance Program (CCAP) is Rhode Island's subsidy program funded by the federal Child Care Development Fund. Over the past five years, CCAP was significantly scaled back because of budget cuts. Most notably, income eligibility was reduced in September 2007 from 225 percent to 180 percent of FPL. In addition, the state increased child care co-payments, lowered reimbursement rates, and made other program cuts. The decline in the number of children receiving subsidies reflects these changes. Between 2002 and 2004, over 13,000 families received a subsidy. In 2007, this number had decreased to 9,000.

Child care assistance is guaranteed to all income-eligible working families who are residents of Rhode Island, and there are no waiting lists for subsidies and no time limits on assistance. Families do not have to be enrolled in the DHS Family Independence Program (their TANF program) or receive any other state aid to qualify for child care assistance. Families receiving cash assistance through the Family Independence Program (FIP) are eligible for a child care subsidy if they are working or if they are engaged in an approved training or education program.

Parents mainly find out about CCAP through DHS field staff, DHS offices, the DHS web site, community-based organizations, OWF, parent employment programs, or child care providers. Non-FIP families applying for CCAP can either mail or bring in their application and documentation to a centralized, statewide child care assistance unit in the DHS Family Resources Center in Providence. Eligibility is reviewed by the department. Families can recertify by mail and usually have to do so every 12 months. Both FIP and non-FIP applicants must document the citizenship of their children as well as the earned and unearned income sources and work schedules of all working parents in the household.

Parents who participate in CCAP have several options for providers. They can use (1) a licensed child care center or after-school program, (2) a certified family child care home, (3) care by an approved relative of the child in the relative's home, or (4) care by an approved provider selected by the family in the child's home. About 80 percent of those using CCAP choose options 1 and 2.

Supply of Child Care in White Center

There are three different publicly supported programs for preschool-age children in the White Center study site: federally funded Head Start program sites, Washington's state-funded Early Childhood Education and Assistance Program (ECEAP) prekindergarten program, and the City of Seattle's Step Ahead preschool program for 4-year-olds. All three programs are restricted to low-income families, all are free or low cost, and all help children prepare for kindergarten academically, socially, and physically. Seattle's Head Start programs are housed within public schools, while ECEAP is based in nonprofit community organizations and the Step Ahead sites are in both public schools and community organizations.

Child Care Providers

Families living in King County, Washington, may use Child Care Resources (CCR), the local child care resource and referral agency, to search for child care options.[29] According to a study of child care in the White Center community conducted in 2007, there were 17 licensed child care centers and more than 60 licensed family child care providers in the area (Paulsell et al. 2008). As part of our

community study, we conducted an online search of all the options available to families within their zip codes. These searches yielded a set of options that mapped out across the families' neighborhoods (map B.3). CCR referred us to 81 possible licensed child care settings (15 centers and 66 family child care homes) in our families' zip codes. Many of these were located outside the study area. The CCR database also provides useful information about the providers. Table B.1 summarizes the provider characteristics.

Map B.3   Child Care Resources Referrals for White Center Respondents' Zip Codes


145
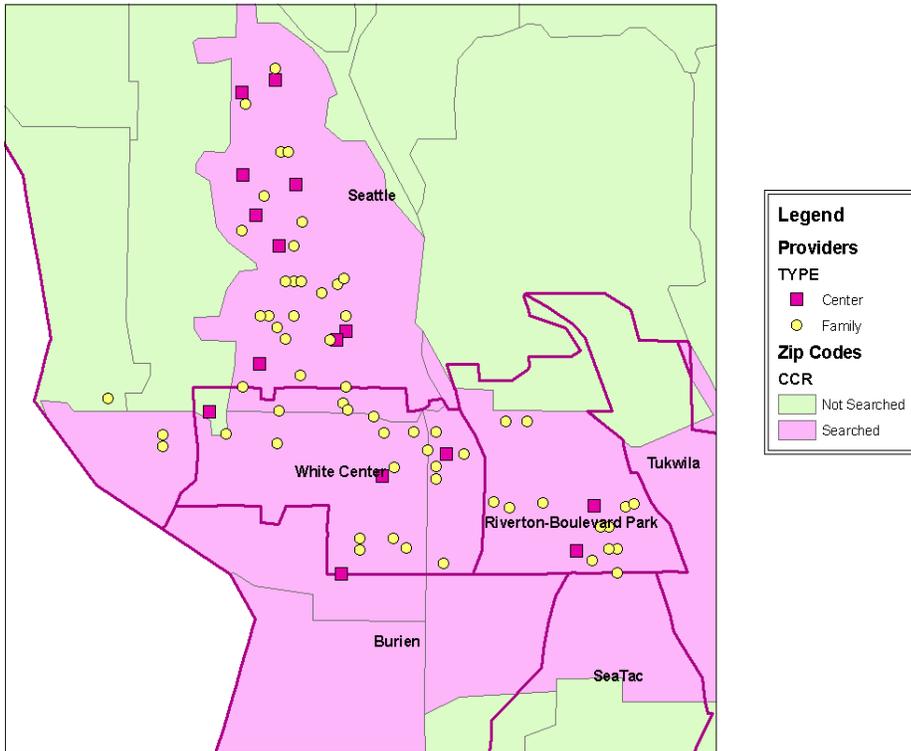
Table B.1   Supply of Licensed Child Care Providers in White Center Families' Zip Codes

	All Providers		Center-Based Care		Family Child Care	
	Number	Capacity	Number	Capacity	Number	Capacity
N	81	1,352	15	812	66	540
Child age						
<1	65		5		60	
1–2	75		9		66	
3–4	79		13		66	
5–6	81		15		66	
7+	67		11		56	
Hours						
Before 7 a.m.	60	840	8	411	52	429
After 7 p.m.	27	202	0	0	27	202
24 hours	10	92	0	0	10	92
Subsidies						
DSHS	75	1,195	14	703	61	492
Seattle	5	219	4	207	1	12
ECE programs						
Head Start	2	92	2	92	0	0
E-CEAP	0	0	0	0	0	0
Steps Ahead	1	39	1	39	0	0
Language capacity						
Spanish	18	498	7	393	11	105
Somali	22	273	3	140	19	133
Vietnamese	6	95	2	68	4	27
Other African	10	67	0	0	10	67
Other Asian	3	52	2	40	1	12

While there were more family child care homes than child care centers in these communities, the child care centers had a larger enrollment capacity, and therefore accounted for 60 percent of the licensed enrollment capacity. There were very few center-based options for children under the age of 1 year, while most family child care providers accepted young infants. Many more family child care homes than centers offered care hours before 7 a.m. or after 7 p.m., and 10 family child care providers indicated that they provided care 24 hours per day for a total capacity of 92 children. State subsidies were widely accepted by both child care centers and family child cares. Subsidies available through the city of Seattle were mainly restricted to child care centers, though one family child care was reported as an enrolled provider for this program.

Center-based programs were more likely to offer bilingual caregivers. The high number of Somali-speaking family child care providers was notable in the White Center study site, and care by a Somali home-based family child care provider was a very strongly held preference by the few Somali families we interviewed.

Head Start sites

The greater Seattle area had 14 Head Start center locations administered by five grantees that were spread throughout different neighborhoods of the city (map B.4). Three centers were located within the boundaries of White Center where most study participants lived. The Puget Sound Educational Service District (PSESD) oversaw all three of those Head Start programs,[30] two that it ran directly and one that it subcontracted out to a local child care center. Seattle Public Schools operated three other school-based Head Start centers adjacent to White Center across its northern border. There were no Head Start programs within Burien or Boulevard Park, two other adjacent communities where some study participants resided.

Map B.4   Head Start Locations Near White Center

147
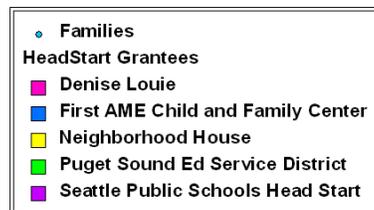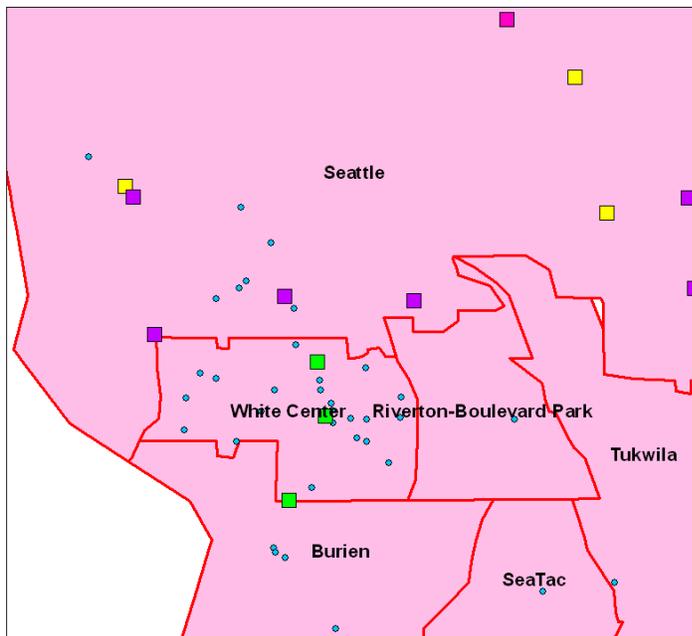
Washington State Early Childhood Education and Assistance Program (ECEAP)

Like Head Start, ECEAP programs are tuition-free programs targeted to low-income families with children. ECEAP was developed to serve areas where there are no Head Start programs.[31] Because several Head Start programs had already been established within the service area that overlapped with our families' neighborhoods, there were no ECEAP programs established near White Center. Only one ECEAP site was within close proximity to our study participants (map B.5).

Map B.5   ECEAP Locations Near White Center
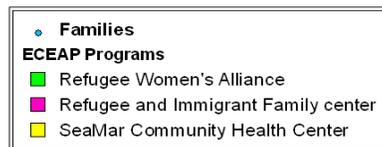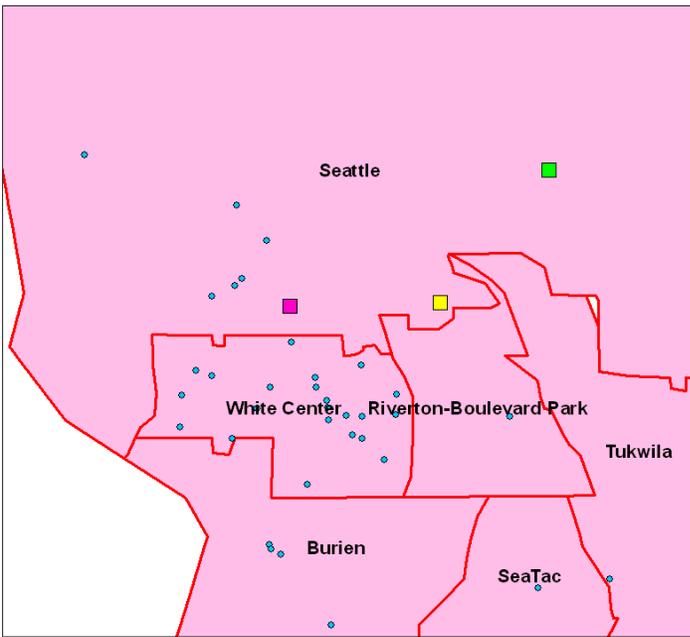
Seattle Steps Ahead Program

The Steps Ahead program, like ECEAP, is administered by the Department of Human Services' Early Education Division. Steps Ahead is meant to serve moderate-income families who do not meet the income requirements for Head Start or ECEAP, but who make less than three times the FPL.[32] Steps Ahead offers part-day and full-day programs during the school year. To be eligible for the Steps Ahead program, however, a family must reside within the boundaries of the city of Seattle; thus, most of our study participants were not eligible (map B.6). There was only one Steps Ahead program close to where our Seattle residents lived.

Map B.6   Steps Ahead Locations Near White Center

149

Washington State's Child Care Subsidy Program

The State of Washington program is called the Working Connections Child Care Program and is funded by federal and state funds and administered by the Washington State Department of Social and Health Services (DSHS). Families who earn up to 200 percent of FPL are eligible for child care subsidies. To qualify for a subsidy, parents must be working or enrolled in an approved work activity, meet income requirements, and have children who meet citizenship requirements. In 2008, child care subsidies served an average of 12,000 children each month in King County, where the study participants resided (Washington State CCR&R Network 2008).

All child care subsidies and public health insurance eligibility screening and processing are handled in virtual call centers as of November 1, 2009. Call center child care eligibility workers are still physically located in local community services offices (CSOs) but are managed and overseen by a central administration, rather than local staff. When parents call in to the virtual call center, they are first routed to their closest office. If no eligibility workers in that office are available at the time of their call, parents are automatically transferred to the next closest location, and so on, until someone is available to handle their case. Eligibility is preliminarily determined on the phone; most parents are granted subsidies on the same day and send in documentation for confirmation afterward.

According to the web site, parents could apply for Working Connections child care subsidies in a few ways. One was an online application. Another option was to call in and have an application mailed to them. A third option was to go in their local CSO. Applications could then be either mailed back in or brought in to the office for processing.

Qualified parents can use subsidies to pay for care provided by licensed child care centers or family care providers, relatives who provide care in their homes, or adults who provide care in the child's home. However, all providers must fill out an application, pass a criminal background check, and submit a copy of their Social Security cards and photo identifications. This requirement may discourage undocumented parents and caregivers from using the subsidy system.

Seattle's Child Care Subsidy Program

The city of Seattle also has its own child care subsidy system designed to reach families who do not qualify for the state child care subsidy program. In 2010, over $2 million was allocated to the Child Care Assistance Program payments. To be eligible for the program, families must be low- to moderate-income (up to 300 percent of FPL), reside within the city limits, meet requirements for working or job-training enrollment, use the subsidy for a child from 1 month to 13 years old, and not be eligible for any other subsidy program. Unlike the state subsidy program, which allows families to use both licensed and unlicensed providers, the city's program is restricted for use with 135 providers approved by the city. All families applying for child care subsidies from the city initially undergo a screening process over the phone. When they call in, the caseworker can also help them locate one of the qualifying programs and send them a complete listing, though many families actually apply for subsidies from the city after receiving a referral from a qualified provider. Once a family is determined eligible, the family must visit a central office in downtown Seattle to turn in documentation and complete the process.

APPENDIX C: INTERVIEW GUIDES USED IN THE FAMILY STUDY COMPONENT OF THE CHILD CARE CHOICES OF LOW-INCOME WORKING FAMILIES PROJECT

The primary data source for the study of Child Care Choices of Low-Income Working Families with Vulnerabilities was interviews with 86 low-income working families in the two study communities, most of whom were interviewed at two points in time—in the fall and winter of 2008/09 and in the fall and winter of 2009/10—approximately one year apart.

The family interviews involved in-depth interviews, most often in families' homes with a primary goal of understanding the child care decisionmaking of families, including their preferences for child care, the factors they consider when ultimately making care choices, and the degree of access and constraints they face in choosing care arrangements.

The protocol we developed and used in the first round of interviews included information on the family context, baseline data on household characteristics, and details about parents' current child care arrangements, their preferences and goals for child care, and their decisionmaking process for their care arrangements. We also explored with parents how they considered their particular characteristics and circumstances, such as their family composition, immigrant status, language status, or children's special needs, to the degree any of these were relevant in their care decisions. In addition, we discussed in some detail their current employment situations, as well as the array of child care options and resources in their community, and how those contexts factored into their care decisions. These question areas allowed us to explore how families

make these choices, and they provide insights into how families perceive key aspects of the community context as supporting or constraining their choices. As such, the first round of interviews laid the groundwork for some community contextual interviews we did between the two rounds of interviews with families as well as for the second round of family interviews.

The protocol for the second round of interviews provided opportunities to ask follow-up questions regarding each family's home, child care, and work situations, including questions from the first interviews that upon transcribing and coding had not been adequately covered, as well as changes in those domains since the first interviews. In the second interviews, we also explored more deeply parents' views on their community; knowledge of neighborhood child care options; sources of information; use of formal and informal sources for information and support; knowledge and use of child care subsidies; and their access to public programs, community services, and child care assistance as well as other social safety net programs.

Each interview was designed to last 90 minutes and to be with one respondent, a parent (most often the mother), though in a few cases both parents were present and participated. Interviews were done in the parent's preferred language. English and Spanish interviews were conducted by bilingual interviewers from the study team. Three interviews were conducted in Somali and two in Khmer using native translators who reported back to interviewers in English. The

semistructured, open-ended discussion guide was purposively designed to allow site visitors maximum flexibility in tailoring their discussions during specific interviews to the different perspectives, conversational styles, and contexts of respondents while still ensuring that all key topic areas of interest were addressed.

INTERVIEW PROTOCOL—FAMILY STUDY INTERVIEW ONE

Introduction and Explanation of Confidentiality and Obtaining Informed Consent

I.   Primary/Initial Interview Topic Areas

   A. Family and Child Background

   B. Current Child Care Arrangements

   C. Child Care Preferences and Goals

II.   Family and Child Characteristics Influence on Child Care Choices

   A. Immigration

   B. English Language Learners (ELLs)

   C. Children with Special Needs

   D. Family Composition

III.   External Contextual Factors

   A. Employment—Parents' Work Contexts

   B. Availability and Access to Community Assistance/Services and Public Benefits (Including Child Care Assistance and Early Childhood Programs)

Documents to Bring:
- **Informed Consent Form**
- **Data Collection Grids for Household, Employment and Child Care Information**

Interview One Goals

1. The broad and primary goal is to get families to relate their decisions regarding their current child care choices and the factors that went into their use of their current arrangement(s).

2. We will also in this first interview focus significantly on identifying and discussing specific child/family contexts of the child or family that may directly or indirectly influence their choices of child care, and how this interaction between these child and family characteristics and child care occur to influence child care decisions choices (e.g., the type(s) of care or settings for care, the specific provider(s), uses of multiple care arrangements, the hours of care or geographic area in which it is located, etc.). We will initially and specifically explore with families several child/family vulnerabilities family-specific choice contextual factors:

- Immigrants (foreign-born parents)/English language learning families (parents for whom English is not their first language and they are not nearly fluent);
- Children with special health needs including physical, learning, or other disabilities (that can significantly influence the care the child needs/receives (as identified by the parent);
- Families in which children are in kinship care; and [maybe change this to be about family composition/structure more generally and focus on how several family factors, such as single parent families, extended family members in household, kinship care, and presence of siblings, affects choices?]
- Any significant parent-identified child/family context raised in initial questioning around decisions/choice regarding current arrangement.

3. We will spend some time (though less time in the first interview) to develop initial baseline information regarding several important (external) contextual factors that also shape child care choices, relying initially on those parents identify as well as asking about specific contextual factors influencing child care arrangements, including:

- Employment—parents' work contexts (including type of work, work schedule, level of flexibility) (would we focus more on mothers' work contexts?)
- Availability and access to care choices in community—(the perceived) supply/availability of early childhood care and education as well as local policies/programs, and availability/access to subsidies
- Information available and/or used to inform child care choices
- Parents who receive TANF or possibly other forms of government (that may inform/constrain/guide care choices)

The major method used to get this information in the family study will be to conduct a semistructured interview with a parent in their home. These interviews, while informal in setting, will be as structured as possible to ensure common data across respondents and for different interviewers:

- There are a small series of topics that is important to explore in each interview, and for which we will collect data from each respondent in each area following a fixed set of questions.

- The actual flow of the interview depends on each respondent, and varies accordingly, but the interviews touch on the same key themes. Thus, though we'll start the interview with the same initial topic of

questions, the questions are not necessarily to be read or asked in the same order or in a precise manner, but rather may flow more naturalistically from the exchange between respondent and interviewer.

- Spend a little bit of time first hanging out with mother (or father) and child to ease into interview and build rapport. If possible, do this first in the visit, before recording. If two people are at the interview and a young child is home with the interviewee (the only adult present) suggest that one interviewer can play/hang out with child to make interview easier (assuming child and parent are comfortable with this). We would also bring some children's books or toys/things to play with to help.

INFORMED CONSENT AND CONFIDENTIALITY STATEMENT

Read this as written (same as what appears on consent form for parents to sign). Hand them a copy to sign and give each interviewee a copy of the form.

Thank you for being a part of this research study on the decisions families make regarding child care for their young children. This is a study we are doing at the Urban Institute, a research organization in Washington, D.C. As a participant in the project, you are being asked to participate in two in-depth interviews during visits to your home by members of the Urban Institute research team.

The goal of the study is to understand as much as possible about child care choices so that we can analyze policies related to child care and see how to improve child care programs. The best way to learn how to improve services is to talk with people who use and work with these services and therefore know them best. We want to know and tell what it is like for parents to be working and at the same time to make arrangements for the care of their children.

The interview will last about **1 to 1 ½ hours**, and, if it is okay with you, we would like to tape record so it is easier for us to write our notes from the interview. As a thank you, the Urban Institute is offering $50 for your time. We will want to return in one year and talk with you again in a second and final interview, and we will offer an additional $50 for the second interview. The study is being funded by the Administration for Children and Families in the U.S. government's Department of Health and Human Services and the Casey Foundation (a foundation in Baltimore, Maryland).

All of the information you provide will be kept confidential. When the interviews are all done, the Urban Institute will write a report. The report will not use your name or identify you in any way. The answers you provide during an interview will be combined with answers from many individuals and used to explain overall patterns.

If you participate, we promise you the following things:

1. Everyone who works on this study has signed a Pledge of Confidentiality requiring them not to tell anyone outside the research staff anything you tell us during an interview. The only exception is if you tell the interviewer about your intention to harm yourself or someone else it may have to be reported. Your responses will be kept confidential with the only exception: the researcher may be required by law to report a suspicion of harm to yourself, to children, or to others.
2. Your participation is voluntary. You only have to answer questions you're comfortable answering, and you can choose to stop the interview or not to be in the study at any time.
3. Whether or not you decide to participate in the study, it will not affect how your child care is handled or any services you receive.

If you have any questions about the study, you can call collect to the project's director, Ajay Chaudry, at 1-866-720-9624 or write to him at The Urban Institute, 2100 M Street, NW, Washington, DC 20037.

I. Primary/Initial Interview Topic Areas

A. Family and Child Background

Some of these may have been answered by now (in prior phone call/screening to set up interview), but these serve as a checklist to make sure these questions are covered to help set context about current child care arrangements, care choices, and contexts for care choices to follow.

1. **Tell me about your family and home.**

   How many children do you have, what are their names, and how old are they?
   Do they all live at home? Are they in school, in preschool, in child care?
   Who else lives [here] with you? How old are you?

   Ask the following two questions to decide who will be the focal child. If the parent answers no to both questions and there are no children (under 5) in the household with special needs or who are in kinship care, then the youngest child will be the focal child. If a parent answers yes to either question, then confirm the type(s) of special needs and kinship care arrangement by referring to the questions in section II.

   There are some circumstances that some families face that can affect their child care decisions, and we want to be sure to identify those so we can ask you the right questions:

   - **Do any of your children (younger than 5) have particular needs that other children her/his age do not have?**
   - **Are any of the children you care for (younger than 5) living without either of their parents in your home?**

   If household composition is unclear, you may need to confirm/clarify the number of adults and children in household (and also break down, if multiple-family household, the number of families and composition).

   [Use Household Information Grid to organize this data collection]

   Focal child/children for study will be youngest child between ages 6 months and under age 5 (won't start kindergarten before September 2009) OR a child under age 5 who has special needs or is in kinship care.

2. **I would like to know just some basic information about your work (and the work of your partner/spouse). I would like to start with you and the work you are doing now.**

   - **Do you have a job right now?**
   - **How many jobs do you have now?**
   - **How many hours did you work last week? Is this more than usual, less than usual, or about the same?**

   [Use Employment Information Grid to organize this data collection]

3. **I would like to ask you a little more about your work and each of the jobs you have. Starting with [**NAME JOB—job where she works most hours regularly**]…**

- **How long have you been doing this work (for each job)?**
- **Do you get paid hourly or by salary (for each job)?**
  - *If respondent is paid hourly, then ask: "How much do you get paid per hour, for each job?"*
- **Now, if could you please tell us about your work schedule for each job, do you work the same number of hours each week, or does your schedule vary week to week?**
  - **Do you work the same number of hours each day or does your schedule vary day to day?**
  - **If your hours vary, how many hours of work do you average a week for each job?**

- **Do any of your jobs include working any shifts or hours that include:**
  - **Weekends?**
  - **Evenings (after 6 PM)?**
  - **Early mornings (before 7 AM)?**
  - **During the night/overnight (graveyard)?**
- **Can you ask for a specific shift or hours for any of your jobs?**
- **Now consider all the jobs your currently hold, how many hours of work do you average a week?**
  - **Is this typical or not?**

4. **Where are your jobs located? Are any of them close to your home? Are they close to child care?**

   How do you get to your job(s)? How do you get to and from where you need to be when you're working?

5. *[If partner/spouse in household]* **Now, I would like to ask a little about your** *[partner's/spouse's]* **work, if that's okay with you.**

   - **Does he/she have a job right now?**
   - **How many jobs does he/she currently have?**
   - **How many hours would you estimate that he/she worked last week? Is this more than usual, less than usual, or about the same?**

   [Use Employment Information Grid to organize this data collection]

For our study on understanding children's care and family's decisions about which care to use we are focusing most on one child *(focal child)*. **Which is the youngest child in your family [***assuming they are between 6 months and 4 years old***]?**

6. **We will be focusing on [***name of focal child***]. When is** *his/her* **birthday?**

   Record child's age in years and months (e.g., 2 years, 4 months); note or ask (if not present or still not known) if the child is a boy or girl.

7. **Please describe for me what your child's day (a typical day) is like.**

   Who does your child spend his/her time with regularly? Where (for instance, yesterday if a weekday or work day for parent)?

Help along by asking detailed questions and follow-up:
With each parent? Care providers (multiple)? Siblings? Father? Family Relatives (relationship)? Friends (relationship)? Others?
Where child spends time, how gets from place to place? Is this typical of every work day when parent is working; whether it is different on other days.

And, now I'd like to get a sense of what his/her day is like on a day when you did not have to work. Could you describe how your child spent her time on a recent day and evening when you didn't go to work?

Help along by asking similar detailed questions (if needed).

B. **Current Child Care Arrangements**

I'd like to start now to ask you specifically about the child care arrangements your child is in right now, particularly the arrangements you use when you (and/or other parent) are working.

[If necessary: I am most interested in the care arrangements [CHILD] is in right now when you are working, and how and why you decided to use this care for your child, though I expect as we talk about that we'll also want to discuss some of the ones he or she has been in the past.]

1. **Please tell me who takes care of your child when you are at work?**

   - *If someone else regularly takes care of the child, clarify what is the relationship to the caregiver to the child, and note if the caregiver lives in the same household?*

   - *[Perhaps follow up with: "Are there other times (times other than when you are at work) when your child is being cared for by someone other than yourself? For example? Who takes care of her/him then?"]*

2. **Now, I'd like to get some more details about the child care you are using {***name specific arrangement***}.**

   Who provides the care?
   What hours of the day does it cover? How many hours per week, and does this vary from week to week?
   Where does *he or she* **receive this care (e.g., family's home, caregiver's home, elsewhere)?**
   How does *he or she* **get there? How far is it (***travel time***)?**
   How long has the child been in this arrangement?

   [Use Child Care Information Grid to organize this data collection]

   What are other (*secondary***) child care arrangements your child is in now?**

   - *If necessary probe further: Is there anyone else who cares for/watches after [child] in addition to [primary care arrangement]? Is there anyone else that [child] stays with/spends time with? [For example, a few hours, evenings, or weekends with father's family, grandmother, aunt, etc., could be relevant to when use other arrangements for employment or considering choices.]*

[Note anything that could be relevant for understanding when respondent uses other arrangements for employment or considering choices.]

- *Does anyone care for the child regularly on the weekend, overnight, or late in the evening (after 6 pm) or early in the morning (before 6 am)? [Note if this is because of parent's work schedule]*
- *If parents are not living together, probe about when child spends time with other parent (father) and if child does spend significant time with father, who the child is cared for during time with father, and whether he provides child care help (e.g., provides care when mother works, or arranges or pays for child care used for child).*
[Get similar detailed data on all current arrangements, including ongoing secondary care arrangements]

3. **Tell me what you think about the principal arrangement.**

   Get open-ended detailed narrative of the current arrangement(s), including:

   - *What were you [the parent/mother] looking for in the care, and how did you find or decide to use this caregiver?*
   - *How did you find or decide to use this caregiver?*
   - *What are the good and bad things (what do you like most and not like so much) about the care?*
   - *What is your relationship with the caregiver like, and what is communicated between mother and caregiver about the child?*

   Probe/follow up on anything else parent spontaneously mentions (e.g., timing of care relative to work hours and changes in jobs; the cost of the care, or use of subsidies) [we'll be returning to get detailed answers of some of these in follow-up questions, though if parent mentions them you can get some of this detail now.]

4. **Who was involved in deciding to use the current {*primary child care arrangement*} (or set of care arrangements)?**

5. **How did this arrangement come about/Why did you end up making this care arrangement? How did you learn about this provider?**

   Probe: What were the events surrounding the choice?
   [Questions will provide some sense of individual family/child contexts and vulnerabilities as well as how external contexts shape the choice that will be useful for later questions, including tailoring these.]

6. **Did you consider any other options at the time you made this decision? What were they? Why did you choose this one (and not the other options)?**

   Probe: How did you find out about what options were available to you (these and the one you used)?

   Probe: Were you satisfied about the options you had? Is there something else you wanted that you were not able to find/arrange?

7. **How do you pay for child care? [*ask for each arrangement*]? How much does the care cost you (daily, weekly, monthly)?**

8. **What assistance do you receive, either in money or help from the government, local agencies, or people you know?**

   Probe: if receiving assistance, what agency, what government program, what community provider is providing the assistance; or if an individual is helping pay for the care (father, grandmother) or providing free care, who it is and how it works.

9. **Did you have any different child care arrangements before your current child care arrangement for {*name of focal child*}?**

   If yes, probe: Let's go over the various arrangements from when you first used child care. When did you first start using child care? How old was your child at the time you started this arrangement? Further probe for each transition age of child at each transition and reason for the transitions.

C. Child Care Preferences and Goals

Many of these questions are likely to have been answered in the context of section B, but follow up and get more detail on responses if it seems necessary. If there is not much time, begin to probe and plan to return (noting this).

1. **What do you consider the good things about *your child's* current primary care arrangement? And, are there things you do not like about *your child's* current primary care arrangement? (***Or alternative way of asking: Is there anything about your care that has been or is a source of worry or concern to you?***)**

2. **How would you say that *the child* likes their care arrangement(s)? What does *he or she* say about their provider?**

3. **Tell me about the kinds of child care choices you have in your community.**

4. **When you were thinking about where to put {*focal child*} when you ended up choosing {*current arrangement*}, did you look at other options? If yes, please describe…**

   - **Did you feel that you had enough good options to choose between? Did you wish you had more options? Please discuss** (*e.g., what other options might you have wanted*)**. How would you like to have learned about possible options?**

   Probe: Is there any kind of care you would like to have in your community that you don't have?

5. **What do you look for when you are choosing a child care arrangement? What is most important to you?**

   Ask question as open-ended rather than priming respondents for answers they might think you are seeking.

   - **Tell me a little about how you decided that these things are important…** *[Did you learn this from your friends? From any books or magazines? From your family? From your instincts?]*

6. **When you chose {*current arrangement*}, how did you learn it was available or originally hear about it?**

7. **When you think about the child care decisions you have made for {*focal child*}, could you tell us how you found out about these options? For example, did a friend tell you? Did you know from seeing it in the community?**

8. **What are things that make finding the child care you want for *your child* difficult?**

9. **If you were going to choose a different arrangement for your child now, what would you be looking for? (***Alternate wording: If you could choose any kind of child care arrangement for your child, what would it be?***)**

   Probe: Is there any kind of care you would like to have in your community that you don't have?

II. Family and Child Characteristics Influence on Child Care Choices

Intro/Transition to Section:
Some parents find that their personal circumstances make it easier or harder for them to find the care they need. For example, immigrant families, parents who speak multiple languages or languages other than English, and parents who have children with special needs may face particular child care challenges. In this part of the interview, we'd like to know whether you have any particular circumstances that either help or get in the way of you finding the care you need for your child/ren.

A. Immigration

Respondent's immigration/migration experiences, education and language use experiences

[Note if respondent is mother or father, and ask if other parent is an immigrant and if from the same country of origin]

Respondent _____ Mother _____ Father

Respondent's Spouse/Partner Country of Origin (if not U.S.) _____

1. **Maybe we could start with you telling me about yourself.**

   [Give respondent chance to answer spontaneously with an open narrative; the level and detail of responses will vary.]

   Tell me about where you grew up.

2. *If born outside U.S.:* **When did you come to the U.S.? What was that like?**

   [NOTE: if hesitant about legal status, don't probe too deeply at this visit into details of the journey; ask later when rapport has built up further]

   - *Why did you/your family come to the U.S.? [probe reasons: jobs, economic, educational opportunities for children, experiences of relatives who came before]*
   - *How is it that you/they came to {location}? What did you/they hear about the city?*

3. *If immigrant:* **How is raising children different here vs. in {***country of origin***}? Do you do something different for child care here than what you might do in {***country of origin***}?**

   [Probe: differences in family life/routines, parental work, culture, child care options and how care decisions are made]

D. **English Language Learners (ELLs)**

[The following questions are included for parents for whom English is not their first language and they are not English proficient.]

Now I would like to ask you some questions about language.

1. **What languages do you speak?**

2. **Do you UNDERSTAND English? Do you SPEAK, READ, WRITE it?**

   Are there other members of your family or close relatives who speak English and who you rely on translate or explain information that is in English?

3. **Which languages does {***focal child***} mostly speak (or which languages is** *focal child* **learning) when at home? When in child care?**

4. **What is the language used by child care provider? Is the child care provider bilingual? If not, how does communication occur between you and the provider?**

   [Ask first for primary care provider, and then for other secondary care.]

5. **What language or languages do you think it is important to have your child exposed to when in child care?**

   Probes: arrangement that allows your child to learn English? English only? where child can communicate mostly in your native language with the provider? where you are able to talk with the provider in your native language? provider knows both English and native language?

   [Try to probe/determine relative importance of each, and why any of these may be particularly important to them.]

6. **Have you used information about child care written in English? Another language?**

7. **Have you spoken with friends or other contacts about child care arrangements? Do some of them mostly or only speak English? Do some of them speak other language(s)?**

8. **If you had to communicate with someone about your child's care in English, would you be able to communicate on your own?**

   Are there people who helped you figure out how to find child care? If so, who has helped? Did they communicate with you in your native language? Use an interpreter? Speak only in English?

E. Children with Special Needs

[Including physical, learning, or other special needs (that can significantly influence child care decision, the care the child needs/receives as identified by the parent).]

We are interested in learning more about families who care for children with particular needs, which means any child who might need extra help because of a medical, emotional, or learning challenge. These children might need medicine, therapy, or extra help in school—things that other children don't typically need or only need once in a while.

1. **Tell me about {***focal child***} and any particular needs he/she has had in his/her development/growth since he/she was born until now.**

2. **Does {***focal child***} have any other identified delays in their development that you or anyone else have noticed that (you think) are significant (e.g., motor skills, learning;** *use nontechnical language for these***)?**

   Comparing {*focal child***} to other children her/his age, do you worry about whether/how she/he**
   - **is learning to do things for her/himself in about the same time frame as other children,** *for example mobility (moving around, speaking, hearing, eating, toileting, etc.)*?

3. **What about any [***diagnosed***] disabilities or delays in their development?**

   [May need to provide an example, such as: some children may show signs of hearing troubles or delayed speech when they are babies or toddlers]

   [If disability condition or developmental delay exists, then probe with appropriate follow-up questions: whether they were actually diagnosed by a doctor or other professional, possibly mentioned to them by child care provider, etc.]

4. **Medical conditions—for example, do they have any medical conditions, particular problems in their development or physical challenges? If yes, please describe…**

5. **What about his/her behavior? When making decisions about child care, do you consider his/her behavior?**

   [Probe to determine if child's behavioral challenges—such as getting along with others—are significant compared to other children their age or if they are like most other children.]

   [Probe whether others (e.g., teachers, other parents, family members) have mentioned or noticed any challenges, such as attention difficulties; socially withdrawn; bullying, aggressive behavior; child rocks or does repetitive actions that can cut her/him off from others; child does not relate/respond to others.]

The following questions apply to families who respond that they care for children with special needs.

6. **Do any of {*focal child's*} particular situations we just discussed [name any specific developmental disabilities or delays, health conditions, or behavioral challenges mentioned by parent] affect the child care you use for {*child*} (and specifically their current care arrangement)? How so?**

[Probe: Ask about how having a child with special needs affects the family, other children in the home, other adults or family members in the home? In general, ask parent to describe how having a child with special needs has changed their life.]

7. **Have any programs turned you down because of {*focal child's*} special needs?**

8. **How many times have you had to change {*focal child's*} program and why?**

9. **Is the program you've chosen meeting {*focal child's*} needs?**

Ask parent to describe/explain if they mention that a caregiver or care arrangement…
   …doesn't administer medications
   …doesn't include {focal child} with other children in play/educational activities
   …calls more often than parent feels necessary regarding {focal child}
   …doesn't have special services on site
   …is not safe for {focal child}
   …is not accessible (e.g., handicap access on site and transportation)
   …is not supportive concerning {focal child's} special needs
   …has too many transitions for {focal child} during the day

10. **Does {*focal child*} see a medical specialist? How often?**

Probe: How did you obtain these services for {focal child}?

Probe: Where does your child receive these services (number of places)? Do your child's therapists or medical specialist ever talk to the person who cares for your child?

NOTE: Early intervention services may be offered in different locations.

Probe: How does the schedule or location of these services affect your child, your schedule, or your ability to work?

F. Family Composition

We are interested in learning more about family members (and close family friends) and how they help parents in taking care of children.

1. **Do you have any relatives or close friends that you rely on for child care?**

   If yes, probe:
   > *Who are the people you rely on? What is their relationship to you and to {*focal child*}?*
   [Probe if relative lives with family or close by; if used for primary/secondary care; and evolution of care arrangement]
   [Probe further if some relatives are mentioned and others are not, which relatives provide care and which do not and why?]

   If no, probe:
   > *Do you have relatives or friends who you would want to provide child care but are unable to or don't want to?*

   [If no relatives or friends could turn to: Do you wish you had relatives or friends you could use for child care and would you use this kind of care if it was available?]

2. **Do you pay {***your relative/friend***} for this care?**

   [Probes: how payment arrangement came about; how determined amount of payments, always a paid arrangement, etc.]

3. **Do you also provide child care to {***the same relative/friend***} or to any other relatives or friends? Why or why not?**

4. **Does {***focal child***} reside with an extended family? If so, are other relatives able to care for the child some or all of the time?**

   Probe: Do multiple families live together in the household?

5. **We are interested in learning more about how people's particular family situations affect the child care they use or are able to use for their children.**

   So for example, how do you think that {*being a single parent, being a two-parent family (where both parents work), living with extended family, having X number of children or the child having siblings (younger and/or older), etc.***} affects the child care you use for {***focal child***}? How so?**

   [Probes: In general, ask how current family composition impacts their life and decisionmaking, particularly around child care.]

Families in which children are in kinship care

We are interested in learning more about families where the child's parents are not living with them. We want to understand what kinds of services families use to help take care of a child.

Defining Kin Relationship and Agency Involvement

I want to ask you about what it's like raising {*focal child*}, and later I will ask you about any assistance or help you've had since you started raising {*focal child*}.

1. **What is your relationship to the child?** *(If respondent says "foster parent" probe further about relative relationship—i.e., is the child also your grandchild, niece, nephew, cousin, sibling?)*

2. **How did you arrange to become the primary caregiver of the child** *(Alternate wording: How did the child come into your care)?*

3. **How did you gain permission to care for the child?**

    [Probe to determine whether the family has interacted with the child welfare system without probing about circumstances that may have led to agency involvement.]

    [Probe to determine whether biological parents were involved in the decision to use kinship care.]

4. **If agency was involved, did you become a licensed foster parent for child? Are you currently a licensed foster parent for child?** *(If expired, find out when)*

    [This question will give us three classifications: No agency involvement; Agency involvement, but not a licensed foster parent or expired; Agency involvement, and is a licensed foster parent]

Child Care and Other Services

Now I'd like to ask you about any help you've had using child care since the time you started raising {*focal child*}. We are interested in learning about any government or community organizations that have been involved with your family, and any people who have offered to help you.

5. *(If agency involved)* **What services does** {*use agency name*} **provide to you?**

    [Probe: social services, health/medical services, counseling or mental health services, financial services, legal services, services for caregivers.]

    Probe if not mentioned: do they assist you with child care?

6. *(If agency involved and agency gives child care help)* **How do they help you with child care? Finding care, paying for care, transportation to care, other?**

7. *(If not agency involved)* **Have you received any services from public agencies or other agencies in the community to help you care for {***focal child***}?**

   Probe if child care is mentioned: What agency or service helps you with child care? How do they help you with child care? Finding care, paying for care, transportation to care, other?

8. *(Ask of all)* **Have you ever had any difficulties with your current child care arrangement? What were those difficulties?**

   [Probe regarding difficulties enrolling child in care, transportation to care, paying for care or arranging payments.]

9. **In addition to yourself, whom do you rely upon most to help with the care of {***focal child***}?**

10. **Is the child's father in contact with {***focal child***}? If so, how is he involved? Does he ever provide care for {***focal child***}?**

11. **Is the child's mother in contact with {***focal child***}? If so, how is she involved? Does she ever provide care for {***focal child***}?**

12. **Do you receive a regular payment from the government to help with the care of {***focal child***}? Do you know what type of payment?**

    Payment could be of several types, TANF child-only, foster care (only if licensed foster parent), Social Security, Supplemental Security Income, child support, or might not know

    NOTE: Important distinction—foster parents often get occasional stipends for various things for the child—clothes, school supplies, etc. These occasional stipends are different from a regular payment.

13. **What information on services is available to families providing kinship care? Is there specific information on child care?**

14. **If an organization (e.g., nonprofit, government) provided assistance for child care services for kinship care families while you worked, would you apply?**

[If not already probed, take time to ask about any issues that uniquely affected the family's decision(s).]

III.   External Contextual Factors

This section covers basic background on local area factors and is included to gain insights before discussing these in more depth following the Community Respondent Study interviews.

A.   Employment—Parents' Work Contexts

I asked you a little bit about your work earlier, and now I would like to know what you think about each job you have, and if the job is good for you in terms of meeting your family obligations and arranging child care for your children. [*Start with primary job***]**

1. **One of the things we are interested in are the nature of people's jobs and how much flexibility/support they offer for parents to meet their family needs and arrange child care to coincide with their work. I would like to ask you about what it's like working at (each of) your jobs.**

    - **Do you get paid time off for vacation days? For sick days? Do you have unpaid sick days?**
    - **What happens if you're late to work?** *[Probe: Does your boss give you warnings? Would you get fired?]*
    - **What happens if you have to leave during the middle of a shift to take care of your child or for an emergency?**
    - **What happens if cannot be at work because your child is sick or if a babysitter cancels and you can't work?** *[Probe: Can you call in and change your schedule?]*

2. **What happens if you are not able (or don't show up) to work for one day? More than one day? More than one day in a row?**

3. **In the last few {***3, 6, 12***} months, have you had to be absent from work or missed any work hours because you had to take care of your child? How often?**

4. **Do you think the job you currently have affects the kind of care that you use for {***focal child***}?** *[Probe: How so?]*

5. **Thinking about {***focal child's***} care, is there anything you would want to change about your work or is there another kind of job you would rather have?**

G.   Availability and Access to Community Assistance/Services and Public Benefits (Including Child Care Assistance and Early Childhood Programs)

One of the things we are interested in understanding better is community resources for child care and early education. We know it is very hard to raise a family and meet all of a family's needs from what parents might be able to make from working. So we want to know more about what other sources families may be able to use or turn to, and how these help, and especially what assistance or programs they are able to use for child care.

1. **What assistance or services do you know of or use to help make ends meet?**

[Probe for specific basic needs: How about programs that help families with food? Child care? Health care? Housing/rent? Paying bills/money needs? Information about legal assistance?]

2. **Do any of these programs (that you are using) help to make things easier?** *[Probe how?]*

3. **Now, I would like to ask you more about child care programs, and then will ask you about some others. Do you use public child care subsidies/assistance for** {focal child}**?**

   If yes:
   > *Were you using subsidies before you were in {current arrangement}, or did you seek them out in order to be able to use {this particular arrangement}?*

   > *Did you make a different decision because of the subsidy? What would you do for child care if you didn't have a subsidy?*

   If they don't use subsidies, ask them:
   > *Do you know about subsidies?*
   > *Do you think you could get them?*
   > *Do you want them… describe*
   > *What difference do you think subsidies would make?*

4. **Where do you go if you want information about child care in your community?**

5. **Do you know what the [***insert name of CCR&R***] is?**

   If yes, have you ever used them for information about child care? Please describe.

6. *For those with children who are 3 or 4 years old (or almost 3 is fine) who are not enrolled in Head Start***… Do you know about Head Start? [***insert local Head Start center name***]**

   If yes,
   > *Is your child eligible? Why or why not?*
   > *Are you interested? … if yes, why… if no, why not?*

   If no, would you be interested in enrolling your child in a program that… [insert a generic description of such a program]?

7. *For those with children who are 3 and 4 (or just 4 in some places) who are not enrolled in prekindergarten…* **Do you know about prekindergarten [***insert name of school- or community-based programs***]**

   If yes,
   > *Is your child eligible? Why or why not?*
   > *Are you interested? … if yes, why… if no, why not?*

   If no, would you be interested in enrolling your child in a program that… [insert in a generic description of such a program]?

Now I want to ask you about government services you are using.

1. **Over the time you have had {***focal child***}, have you ever received some form of public assistance (TANF) or welfare [***"where the government mails you a check every month"***]? If yes, are you currently receiving welfare?**

2. **Did you participate in {***insert name of state/local welfare-to-work program***}, or work while you were on TANF?**

   Probe: When? Ever used TANF? Ever used it while in current care arrangement?

   If have received welfare, probe: "Do the rules for the welfare program affect the child care you use or are able to use for your child? Please describe this for me."

3. **What did you do for child care for {***focal child***} while you were doing your work activity or work while you were on TANF {***insert local name if different***}?**

4. **Did you start this arrangement because of TANF requirements that you be in a work or training activity?**

5. **Did the TANF or {***subsidy voucher program name***} program help pay for any or all of the costs of the child care you used when you were in your work or training activity?**

   If yes, do you think you would have chosen this care anyway, or did the help paying for care allow you to make a different choice than you would have otherwise made? Please discuss.

   If no, do you know whether you can get help paying for child care? Please discuss.

6. **Could you describe how the process of finding care worked when you were on TANF? For example, how long did you have to find care before you started your work activity… was it long enough? Did you get any help in finding care from the TANF agency, or any other agency?**

7. **Are there other community services or government programs you know about or have been able to use to help meet your families' basic needs?**

   [If applicable, clarify whether the following programs were used or benefited focal child and/or other children in the family.]

   How about programs that help families with food?
   - **Food Stamps**
   - **WIC** *("food, formula, and nutrition help for pregnant women and babies")*
   - **Free or reduced school lunch**

   Health care?
   - **Health insurance** *(State Medicaid Program State Child Health Insurance Program, S-CHIP)*

   Housing/rent?

- **Public housing or section 8** *("where you get help with your rent")*

Paying bills or other money needs?
- **Disability** *("SSI," "monthly check when you or someone in your family is sick or can't work because of some health condition")*
- **Unemployment** *("unemployment insurance," "money to help you out if you've lost your job while you're looking for a new one")*
- **EITC or "tax check"** *("where you get money back at tax time," "EITC")*

Information about legal assistance?

8. **What do people you know** *[relatives, friends, neighbors]* **think about these programs/using these forms of help? Do you know people who use these programs/use these forms of help? What do they think about them? Do you know people who refuse to use these programs? Why do they refuse?**

   [Probe if the people they know turn elsewhere for assistance meet these needs in alternative ways.]

[If not already covered, take time to ask about other significant community-identified contexts with implications for child care choice]

I.   Household Members

II.   Language

III.   Employment

   A. Respondent Employment

   B. Partner/Spouse Employment

   C. Home & Neighborhood

IV.   Child Care and Early Education

   A. Current Arrangements

   B. Information

   C. Decisionmaking

   D. Cost of Care and Subsidies

   E. Supply of Child Care Options

   F. Early Education & School Readiness

V.   Access to Community Services, Public Programs, and Sources of Assistance

   A. Service/Program Application and Receipt

BLUE = INSTRUCTIONS FOR INTERVIEWER
BLACK = QUESTIONS *(and questions not fully covered in round one)*

Follow-Up on Family Background

Many of the items in this protocol were discussed during the first wave of the family study but serve as follow-up questions to assess the family's current home, work, and child care situations. Reasons for any change in household situation, employment, or child care arrangement should be documented. Additional questions are also asked on spouses/partners, child care, and service access. Rather than script what your introduction may be like, tailor your introduction depending on the families' circumstances (i.e., whether they moved, whether anything has changed in the home since the first interview) or the interviewer (i.e., if the same person(s) are conducting the interview or whether the interviewers did not meet the respondent in person). Spend some time at the beginning getting reacquainted/acquainted and easing into the interview.

Thank you for taking time out again to talk to me/us. Last time we visited you we asked a lot of questions about your family, your job, and any child care arrangements that you had. Today we'd like to talk about some of these things again to see if anything has changed. We'll also ask some new questions that will help us better understand your family's current situation and how you are able to provide child care for {*focal child*}. Like last time, it may seem like some of the questions may be a bit personal, but remember the information you provide will be kept confidential and not shared with anyone, and is meant for us to understand families' circumstances and how child care fits in. And, if you don't feel comfortable answering something, just let me know and we'll move on. Are you ready?

I. Household Members

First, I'd like to talk about your family and your home.

Have you moved at all since we last visited?
> What were the reasons for your move? Probe to determine whether downturn has (a) created negative pressure (potential to lose home; not keeping up with rent), (b) lowered their rent, or (c) created more abandoned homes on their street or in their neighborhood.

Who currently lives in the home with you, including all adults and children?
> Has anyone moved in or out of your household in the last year? If so, why?
> Do you have any children who are not currently living with you?
> If so, where is he/she living?

Use Household Information Grid to organize data collection; review existing grids and update missing or incomplete race-ethnicity data for all household members

For each person (including respondent):
How is {*name*} related to {*child*}?
How old is {*name*}?

For each child in household:
Is {*name child*} currently in school, preschool/pre-k, Head Start, or child care?

II. Language

I'd now like to talk about what language you speak and how much you use English.

Is English your first language? If yes, then skip to question on focal child's first language
    If not, what was your first language?

How well do you SPEAK [and UNDERSTAND] English, would you say:
    Ask twice, once for speaking and again for understanding.
    USE AN AID (SUCH AS CARDS OR PAPER) AND ASK RESPONDENT TO CHOOSE
- Fluently, without any problems
- Proficiently, is comfortable speaking English but occasionally says things incorrectly or forgets how to say something
- At a basic level, can communicate enough to get by in public places, like the grocery store or post office, but can't tell stories or explain things in detail
- Poorly, only knows simple words and phrases and struggles to explain him/herself in English
- Not at all

And what about {*focal child's primary caregiver(s) at care***}?**
    Ask twice, once for speaking and again for understanding.
    USE THE SAME AID REFERENCED IN THE PREVIOUS QUESTION

Is English {*focal child's***} PRIMARY/DOMINANT language?**
    If not, what was his or her first language?

What languages would you like {*focal child*} to speak at home? With friends? In child care? In preschool or school? For each, probe what it is about that combination of languages that respondent feels would be valuable for child.

III.   Employment

A. Respondent Employment

Last time we met, you were working at _____ insert job(s) **during _____** insert schedule (during the day; at night)

Are you still working there? Confirm last position in record.

IF STILL AT SAME JOB, SKIP TO GENERAL JOB QUESTIONS

IF NO, THEN CONTINUE

When did you leave the prior job? What were the main reasons for leaving?
Do you have a job right now?

If yes,
How long have you had the job? Was there a gap in between your current jobs and the one you worked since we last met? Make sure you get a picture of their employment since the first round

If no,
When was the last job you had? Confirm employment at Wave 1 in records.
How long have you been out of work?
What were the main reasons for you leaving this job?
Are you looking for another job?
What has it been like trying to find a new job?
SKIP GENERAL JOB QUESTIONS

Is that your only job? How many jobs do you have now?
Where else do you work? Have there been any other changes in your job situation (number of jobs, shifts, pay, etc.)

I would like to ask you a little more about your work and each of the jobs you have. Starting with {NAME JOB—job where he/she works most hours regularly}…

Use Employment Information Grid to organize this data collection—USE THIS OPPORTUNITY TO VERIFY OR UPDATE WAVE 1 GRID—GO THROUGH DATA COLLECTED IN ROUND ONE, DOCUMENT CHANGES. Note that the employment grids have a new field: EDUCATIONAL ATTAINMENT. If not already recorded, ask about highest grade or level of education attained. We will categorize families the following way:

Take a moment to make sure they have mentioned all employment activity in the past year. It's possible the respondent might not think about odd jobs or temporary work right away. Ask:

We would like to get some additional detail about your jobs, especially since it may affect how you arrange your child care:

Where are your jobs located?
How do you get to your job(s)?
Do you own a car? (Who owns car, if you drive?)
Are you close to public transportation?
How long does it take to get to work?

How far are your jobs from child care?
How long does it take to get from work to child care?
How do you get from your job to child care?

If household employment has changed, ask whether they think it is related to the recession:

Do you think the recession had affected you and your family? How?

Has the recession affected your employer (layoffs, reduced hours, etc.)?

Now we'd like to talk about any education/training you may have received since we last met.

ASK RESPONDENT TO CHOOSE
- less than high school
- high school or GED
- some college
- 2-year college degree
- more than 2 years in college

Since we last spoke with you, have you taken any **classes**? Describe. Even if respondent is not working, ask if they have taken classes.

Have you enrolled in any training programs to help find or get a job? Describe. Probe for the name of the program and sponsor agency, such as "RI Works" (formerly "Family Independence Program") or TANF in Rhode Island; or "WorkFirst" or TANF in Washington.

For each ADULT in household, other than respondent:
Is {*name adult*} currently going to school?
If so, what is he/she studying OR taking classes?

Is {*name adult*} currently working?
If so, what does he/she do?
Does he/she contribute financially to the household, such as pay for things like rent, utilities, food?

I have a few other questions about your home and family I didn't ask last time

Are you currently married or single? How would you describe your marital status: never been married, married, separated, divorced, or widowed?

For any of the following questions, build on the information you already have—i.e., last time I think you said CHILD's father lived nearby, and CHILD saw him, is that still the case or has anything changed in the past year, etc.

Tell me how {*focal child*} gets along with [spouse/partner].
How often, how long does {*focal child*} see [spouse/partner]? Get an idea about the amount of interaction.
What is your relationship with [spouse/partner] like?
Probe, if applicable, about involvement of other significant others in making decisions that affect the household (esp. child care).

H. Partner/Spouse Employment

This section was included in Wave 1 but you should probe for more complete data. If respondent does not have a partner/spouse SKIP to section on "Home and Neighborhood."

If partner/spouse in household:
I would like to ask a little about your (partner's/spouse's) work, if that's okay with you.

Last time we met, your (partner/spouse**) was working at _____** insert job(s) **during _____** insert schedule (during the day; at night)

Is (he/she**) still working there?** Confirm last position in record.

When did (he/she) leave this job? What were the main reasons for leaving?

Does (he/she) have a job right now?

If yes,
How long has (he/she) had the job? Was there a gap in between their current jobs and the one they worked since we last met? Make sure you get a picture of their employment since the first round—GO TO GENERAL JOB QUESTIONS

If no,
When was the last job (he/she) had? Confirm employment at Wave 1 in records.
How long has (he/she) been out of work?
What were the main reasons for them leaving this job?
Is (he/she) looking for another job?
What has it been like for (him/her) trying to find a new job?
SKIP GENERAL JOB QUESTIONS

GENERAL JOB QUESTIONS—PARTNER/SPOUSE

Is that (his/her) only job? How many jobs does (he/she) have now?
Where else does (he/she) work?
Have there been any other changes in their job situation (number of jobs, shifts, pay, etc.)

I would like to ask you a little more about (his/her) work and each of the jobs (he/she) has. Starting with {NAME JOB—job where he/she works most hours regularly}…

Use Employment Information Grid to organize this data collection—USE THIS OPPORTUNITY TO VERIFY OR UPDATE WAVE 1 GRID

We would like to get more detail about the following questions, especially since it may affect what you do to make sure your child gets to child care.

Where are (his/her) jobs located?
How did (he/she) get to your job(s)?

If not already discussed earlier and if relevant:
Does (he/she) own a car? (Who owns car, if [he/she] drives?)
Is (he/she) close to public transportation?
How do you get to work?
How long does it take to for (him/her) to get to work?

We have a few questions about how you and {*spouse/partner*} work together to make sure your child/children get to and from child care (and school).

Who drops off {*focal child*} at care?
Who picks up {*focal child*} from care?

Is this the regular arrangement for drop offs and pick-ups?

If there is a regular arrangement for drop offs and pick-ups
How/why did this come about? How/why was this decided?

Who generally takes time off from work if {*focal child*} is sick? Why?
If partner/spouse usually takes time off: Has (he/she) run into any problems at work because of this?
If respondent usually takes time off: Would (partner/spouse) take time off?

What happens if (he/she) has to pick up or drop off {*focal child*} on a day you can't?

I. Home & Neighborhood

Probe to determine whether respondent was affected by the recession. For example, if they moved or lost their home, ask "Do you think that happened because of the recession?" or tailor according to specific circumstances.

And, now about I want to know more about your home:
Do you rent or own your home?
How would you describe your home: Is it an apartment, single family home, condo, other? If obvious do not need to ask
How much do you pay in rent/mortgage each month?

I would also like to know about your neighborhood:

These questions can help us know how closely respondents are linked to their community (people and organizations) or whether a respondent is relatively isolated

What would you call this neighborhood [main neighborhood R lives in]? What are the borders? Show map; DRAW BORDERS AND LABEL WITH NAME How long have you lived here? Has it changed over that time? How?

Where are the places you go to the most? …organizations you visit most? Draw/label on map

How many relatives do you have in your area/neighborhood?

How well do you know the other people in this neighborhood? How well do you know others in your building? On the same block?

How often do you get help or support besides money, like babysitting, lending small appliances, and rides from people in your family who do not live with you?

Do these family members live in the neighborhood?

Please think about the neighborhood where you live. Do any of these family members live in that neighborhood?

How often do you give help or support besides money to people in your family that do not live with you?

How often do you get help or support besides money from friends?

Do these friends live in the neighborhood?

Please think about the neighborhood where you live. Do any of these friends live in that neighborhood?

How often do you give help or support besides money to your friends?

IV. Child Care and Early Education

Now I have some questions about your child care arrangements.

Is _____ {*insert primary care arrangement***} still watching your child [OR] is your child still going to _____ {***insert primary care arrangement***} for child care?**

A. Current Arrangements

Last time we met we talked a lot about the child care arrangements that you use for {*focal child*}. Confirm arrangements in record. You mentioned that… Describe arrangement: e.g., "CHILD is in Head Start in the mornings and your mother watches him in the afternoons."

For each arrangement: Are you still using this arrangement?
If yes, using same arrangement:
- What are the reasons you haven't made a change? Probe to get full description of what factors kept parents at that arrangement.
- Has anything about child care changed (hours, cost, etc.)?

If no, arrangement has changed:
- Why are you no longer using this arrangement? Probe main reasons. Get enough background details to see whether our "factors" played any role (e.g., expense, physical environment).
- What did you like about the last place? What did you not like?

Are you using any other child care arrangements?
If respondent does not mention additional arrangements, verify by asking:
So your child is always with {*caregiver*} when you're working/at class?
Have you had to do anything else to make sure someone is looking after him/her?
Does someone else (neighbor, family member, friend, etc.) ever take care of him?

If arrangement has changed: I'd like to get some more details about {name specific new arrangement}.

Use Child Care Information Grid to organize this data collection

Who provides the care?
Where does *{child}* receive this care (e.g., family's home, caregiver's home, elsewhere)?
How many hours per week do you use this arrangement? Does this vary from week to week?
How does *{child}* get there? How long does it take to get there?

How satisfied would you say you are with your current arrangement:

What is your relationship like with the caregiver like?
What do you like or not like about this arrangement?

J. Information

If care arrangement(s) changed: How did you learn about this provider? How did you find (or hear about) this care? Who did you talk to? How did you choose the care?

What are things that make finding the child care you want for your child difficult?

How would you like to learn about new options? Probe for how they would prefer to receive information.

If someone came to you asking for advice about child care, what would you tell them? Would you tell them about a specific person/program? Tell me about that.

If you needed help with a child care emergency (if you needed someone to take care of your child at the last minute), who would you call?

K. Decisionmaking

If care arrangement(s) changed: Why did you choose this particular care arrangement? What kinds of things affect where you take your child for child care?

Who else makes decisions about child care? How does that work? Does anyone help you choose child care or give you their input? Probe: partner/spouse, other people in household, family?

We are interested in learning more about how particular factors affect the child care you use.

Family structure

So, for example, how do you think that {being a single parent, being a two-parent family where both parents work, living with extended family, or multiple children} affects the child care you use for {*focal child*}? How so?

Probes: In general, ask how current family composition impacts their life and decisionmaking, particularly around child care

Child age

Some parents prefer different types of child care arrangements depending on their child's age. What do you think about that? Do you think your child's age has influenced your decisions?

What type of arrangements do you think are best for infants? Toddlers? Preschoolers? School-age children?

Employment

Did you choose your child care to fit your job or your job to fit your child care? (i.e., which came first?)

How does your child care affect the kinds of jobs that you (and your partner) have open to you?

How do(es) your job(s) affect the kinds of child care you have available to you?

Would you use the same care if your shift at work changed?
    If applicable: How about if your (partner/spouse's) shift changed?

If your child care changed [adapt depending on respondent's arrangement; for example, what if your neighbor/mother could no longer take care of focal child?], would that affect anything about your job, like your schedule?

Language

If respondent is not an ELL and no language other than English is spoken at home on a regular basis, skip: Does the language spoken by your care providers affect your child care decisions? How?
    Probe if necessary: For example, would you choose the same care if your caregiver was fluent in [respondent's first language, e.g., Spanish] or if English was your first language?

L. **Cost of Care and Subsidies**

Thinking about all the care arrangements you use, how much do you spend (out of pocket) on each care arrangement during the week? Probe for costs of intermittent care to gauge whether it's a regular or major expense.

What child care assistance do you receive, either in money or help from the government, local agencies, or people you know?

If respondent does not use subsidies, skip: Would you use the same care if you didn't have subsidies?

Probe: if receiving assistance, what agency, what government program, what community provider is providing the assistance; or if an individual is helping pay for the care (father, grandmother) or providing free care, who it is and how it works.

Do you use public child care subsidies/assistance for {*focal child*}?
RI CHILD CARE ASSISTANCE PROGRAM (Department of Human Services)
WA CHILD CARE PAYMENT ASSISTANCE PROGRAM (Human Services Department)

    If yes:
        Were you using subsidies before you were in {*current arrangement*}, or did you seek them out in order to be able to use {*this particular arrangement*}?

        Did you make a different decision because of the subsidy? What would you do for child care if you didn't have a subsidy?

    If they don't use subsidies, ask about:
        • Any prior use?

> • Any application?
> • Any knowledge?
> • Any interest? Describe
>
> Do you think you could get them?
> What difference do you think subsidies would make?

Does anyone help you pay for child care? Probe: family, child support, other friends/family?

Do you pay out of pocket for any other child care expenses? …. food or supplies? … for an occasional babysitter while you're at work or taking classes? Do you help a friend or neighbor in some way in exchange for their help watching your child/children while you're at work or taking classes?

If you could change your situation and have any kind of care arrangement, regardless of the cost, would you prefer a different child care arrangement, or are you satisfied with your current?

M. Supply of Child Care Options

Do you feel that you have enough good options to choose from when looking for child care?

Ask respondent to identify and list child care programs in the area. Keep this open-ended.
What child care options are there in the area? Where are they? Do they go by a certain name?

What other options would you like to have? Is there any kind of care you would like to have?

After asking them about what is available, use a map that has child care programs in the area.
Do you recognize any of these programs? What do you know about it? What have you heard? Is it a care setting you considered (would consider) for {*focal child*}?

N. Early Education & School Readiness

Thank you. Now I want to ask about programs for young children.

How important do you think it is for children under 5 to be in formal education (to be in a structured school setting)? When do you think they should start (school; formal education; structured school setting)?

For those with children who are 3 or 4 years old (or almost 3 is fine) who are not enrolled in Head Start… Do you know about Head Start? How did you find out about it?

Please code responses to the next set of questions using this framework (USE AID SUCH AS CARDS):
- Any prior use?
- Any application?
- Any knowledge?
- Any interest? Describe

If no, would you be interested in enrolling your child in a program that… [insert a generic description of such a program]

In Washington, there's the Early Childhood Education and Assistance Program (ECEAP) and Steps Ahead. In Providence, RI, there's a pilot pre-K program as well as a pre-K program in the School Department.

For those with children who are 3 and 4 (or just 4 in some places) who are not enrolled in prekindergarten… Do you know about prekindergarten [insert name of school- or community-based programs]

If yes,
Is your child eligible? Why or why not?
Are you interested? … if yes, why… if no, why not?

If no, would you be interested in enrolling your child in a program that… [insert a generic description of such a program]

If focal child does not attend formal center-based care, including Head Start, then SKIP to kindergarten questions below.

If you did not need child care any more, would you still send {*focal child*} to {*name of center*}?

I want to ask you about what kind of school options you want for your child.

If focal child is not currently enrolled in kindergarten, skip the following questions.
How did you learn about the school for your {*focal child's*} kindergarten?

If child attended pre-K or educational program before kindergarten
Did most children from the old school/program move with your child to the new one?
Did you use any other child care in between schools/programs?
Do you think {focal child's} was prepared for kindergarten when [he/she] started?

V. Access to Community Services, Public Programs, and Sources of Assistance

-
-
-
-

For most people, it's hard to make ends meet. What do people in your neighborhood do? Have you ever tried to do something like that?

> Provide examples if necessary: Some people do work on the side at home to make extra money when they can, like bartending, cleaning, babysitting, lawn mowing.

We talk to a lot of families and know how hard it can be to make sure your family has everything you need, and we want to know how you do it. We ask about these things because every family is different, and we want to know how different aspects of your life affect each other.

Please code responses to the next set of questions using this framework:
(1) Current use	(4) Any knowledge
(2) Any past use	(5) Any interest
(3) Any application	

I'd like to ask you about specific programs and services that you may use **IN THE PAST YEAR** to help make sure your family has everything they need. Are your currently using [name of program from list below; describe the program if respondent not familiar with program/service name]?

- Food Stamps ("govt program that provides families who need it with a (EBT) card or coupons they can use to pay for food at the grocery store")
- WIC ("food, formula, and nutrition help for pregnant women and babies; coupons for formula, milk or peanut butter")
- Free or reduced school lunch
- Health insurance for children and for adults in the family(State Medicaid Program, State Child Health Insurance Program, S-CHIP; in Rhode Island, "Rite Care" and "Neighborhood Health Plan" are Medicaid programs)
- Help with utilities or rent (e.g. "any program where you get help to pay the rent or a bill when you need it")

- Unemployment any time in the last year ("unemployment insurance", "money to help you out if you've lost your job while you're looking for a new one")

Employment supports (e.g. "help from the govt. with transportation to/from work or other things to help with your job")

Are there other community services or government programs you know about or have been able to use to help meet your families' basic needs?

What do people you know [relatives, friends, neighbors] think about these programs/ using these forms of help? Do you know people who use these programs/ use these forms of help? What do they think about them? Do you know people who would qualify for these programs but don't want to use them? Why do you think they feel that way?

[Probe if the people they know turn elsewhere for assistance meet these needs in other ways]

A. **Service/Program Application and Receipt**

Now that you asked whether they use a specific program, get a sense of how respondent "flows through" applications and service receipt:

For the following ask only about one major program, preferably one is that not very common so that we get some variety. Later, you will ask about child care services and subsidies, so make sure to cover some other program or service in this section. This is a list of priorities you can use to determine on which program you should focus:
1. Health insurance for children (even if R also uses food stamps or WIC)

2. Food Stamps (even if R also uses WIC, but not if the children have health insurance)

3. WIC (only if R does not use food stamps and children have no health insurance)

If none of the above apply, then:
4. Housing or utilities assistance

5. Unemployment or employment supports such as transportation

6. If none, any services for which they applied

7. If none, any services they know enough about to answer the questions below

To know about interruptions, ask…
About how long have you been receiving XXX? Was this the first time you applied for XXX? Did you apply for and receive XXX before but then stopped for some reason and later applied and starting receiving XXX again? If yes, when and for how long?

Did you stop receiving XXX because you changed jobs or because another change at home?

Let's talk a little about what you knew about XXX before you applied. First, tell me how (and from whom) you heard about XXX and why you decided to apply. (Probe: TANF caseworker, other service provider, neighbor/friend/family member.)

Did friends, family members, or anyone from a community group tell you anything beforehand that helped you? If so, what was it? (Probe: Written information, agency outreach efforts.)

To know about the application process, ask…
What, if anything, had you heard about the application process for XXX? Did this have any impact on your decision to apply? If yes, in what way?

Where do you start if you want to apply for XXX? Where do you go from there? How do you get from Point A to Point B—what did you have to do? Where/how many places did you have to go?
Probe…
- o How many different workers did you meet with?
- o Where/how many places/offices did you have to go? Were you able to conduct any business by phone or were all meetings conducted in person?
- o What documentation and paperwork were you required to produce?

Are any parts of the application process confusing? Is anything difficult or time-consuming to complete? Did you have any other problems/issues? (Probe for access issues: inconvenient office hours; excessive waiting times; embarrassing situations (e.g., filling out paperwork in stores, etc.); transportation; child care issues; extensive or confusing paperwork)

Were you referred to other service providers or services provided by the same agency/organization? Did you have to fill out referral forms? Did the agency or worker follow up on their referrals?

Overall, was the experience as you expected? If no, what was different than you thought it would be?

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NOTES

[1] All but four respondents across both sites worked for hourly wages ranging from $5 to $35. The respondent who earned $35 an hour worked part time and was an outlier in the stability and consistency of her hours. Lower wage earners were generally in factory and service positions, and higher wage earners were generally in retail/small business or administrative and paraprofessional staff in health, education, and social services positions.

[2] Only 5 of the 86 respondents worked 40 hours a week or more with benefits and flexibility. The median hourly wage for this group was $13.50 (thus, their earnings would be about $27,000 annually). Four of these five were administrative and paraprofessional staff in health, education, and social services, and three of these worked in health care services.

[3] Seven respondents worked both regular weekend and regular evening/night hours, which is why the numbers total more than 52.

[4] Examples of inflexibility included strict guidelines on lateness or absenteeism, being pressured to use sick days for unexcused absences, official "three strikes" policies that tallied workers' unexcused absences, or retribution from employers for missed shifts.

[5] The situation in Mexico may be very different now than it was when Paloma left the country. Mexico has made preschool education a national priority. Since passage of the obligatoriedad law in 2001, the preschool enrollment rate for 4-year-olds in Mexico is over 80 percent, higher than in the United States. See Yoshikawa et al. (2007).

[6] Throughout this chapter, native language is used to refer to non-English languages spoken by parents.

[7] Additionally, five bilingual respondents preferred Spanish for the interview but were not coded as ELL. Thus, a total of 37 interviews were conducted in

Spanish by a bilingual interviewer using a translated instrument.

[8] Ward and colleagues (2006) surveyed 441 parents of children with special needs and conducted focus groups with 41 of these families. Their children's conditions included attention-deficit hyperactivity disorder (ADHD), Down syndrome, autism, asthma, mental retardation, speech and language difficulties, epilepsy, seizure disorders and developmental delays, post-traumatic stress disorder, pervasive developmental disorder/not otherwise specified, fetal alcohol syndrome, muscular dystrophy, oppositional defiant disorder, visual and hearing impairments, paralysis, cleft lip and palate, spina bifida, cerebral palsy, and Prader-Willi syndrome. More than half of families in the sample included children who required regular medication.

[9] A large national study brought together the nation's experts in child development to examine the relationship between care quality and cognitive development across child care types and among children from different family backgrounds. It conclusively found that children enrolled in higher-quality care scored higher on cognitive and language tests and assessments at several points in their early development, and that this finding held across families varying by ethnicity, income, and home contexts (National Research Council and Institute of Medicine 2000).

[10] Several studies looking at investments in ECE programs have proved they are cost effective. Longitudinal studies showed that children who participated in enriched center-based developmental care had higher levels of academic success: higher achievement test scores and grades, less need for special education, less grade retention, higher high school completion rates, and higher four-year college attendance. Later in life, those who had participated in high-quality center-based care had higher earnings,

were less likely to be engaged in criminal activity, and were less likely to receive welfare supports (Reynolds et al. 2001; Schweinhart, Barnes, and Weikart 1993).

[11] ARRA provided $2.1 billion over two years for the Head Start and Early Head Start programs to expand enrollment by 64,000 children starting in fiscal year (FY) 2009. In FY 2010, Head Start appropriations totaled over $7.2 billion. In FY 2009, the program served nearly 1 million children, with more than 66,000 children under the age of 3 in Early Head Start programs, across all 50 states, the District of Columbia, and Puerto Rico (ACF, "Head Start Program Fact Sheet: Fiscal Year 2010," http://www.acf.hhs.gov/programs/ohs/about/fy2010.html).

[12] Early Head Start programs can provide one of a few alternative service delivery models to meet the needs of the children and families they serve (ACF 2009). The center-based option provides full- or half-day child care and enrichment experiences to children in an early care and education setting. Families receive home visits from staff members at least twice a year. The home-based option brings Early Head Start staff into family homes every week to support child development, and twice a month it offers opportunities for parents and children to come together for learning, discussion, and social activity. The combination option combines center-based and home-based services. Some Early Head Start programs also provide home visits to family child care providers to help them learn developmentally appropriate caregiving strategies. Since the program serves pregnant women in addition to families with children up to age 3, expectant mothers may enroll in Early Head Start to receive home-based services.

[13] The cost of child care varies widely by region of the country, type of care, and quality of care. Average annual estimates from the National Association of Child Care Resource and Referral Agencies (2010) range from $4,560 to $18,773 for full-time center-based care for an infant and $4,460 to $13,158 for full-time center care for a 4-year-old child. Family child care costs are slightly lower on average but still more expensive for infants than for preschoolers.

[14] One possibility would be to expect low-income parents to pay between 6 and 10 percent of their earned income for child care, which some studies suggest is the average family expenditure for child care (Giannarelli and Barsimantov 2000; Overturf Johnson 2005; Smith 2002).

[15] Some combination of the graduated implementation and phase-in of costs could be employed, though this would add complexity. The move to a guarantee could be implemented gradually by increasing the minimum income eligibility cutoff in phases. For example, the cutoff could move to 200 percent of FPL the first year, then 225 percent of FPL the next year, and 250 percent of FPL the following year. The changes could also be implemented by rolling out the guarantee for an age cohort, then increasing the guarantee for more children as they age. For instance, if the guarantee for care assistance were enacted in 2011 or 2012, and if the first group of eligible families was those who had eligible children born on or after January 1, 2009, the expansion would likely cover children younger than age 3. Then, the limit could expand over the next few years to cover all children under age 5. Starting with infants and toddlers expands funding more gradually and ensures that the children who could most benefit from new care opportunities and greater stability receive them sooner.

[16] Federal statute requires that a minimum of 4 percent of CCDF expenditures each year be spent on activities to improve the quality of child care and other additional services to parents, such as resource and referral counseling regarding the selection of child care providers. Many CCDF lead agencies are using funding to develop quality rating and improvement systems and provide professional development activities to child care providers. In FY 2009, states spent $988 million or 11 percent of total federal and state expenditures on quality activities (ACF, "Child Care and Development Fund Fiscal Year 2009: State Spending from All Appropriation Years," http://www.acf.hhs.gov/programs/ccb/data/expenditures/09acf696/overview.htm). The FY 2010 CCDF appropriation included $271 million for quality expansion activities, of which $99.5 million was to improve the quality of care for infants and toddlers, and $19 million to improve school-age care and CCR&R services, including $1 million for the Child Care Aware hotline (ACF 2010).

[17] National Child Care Information and Technical Assistance Center, "QRIS Quick Facts," http://nccic.acf.hhs.gov/poptopics/quickfact_QRIS.html.

[18] National Child Care Information and Technical Assistance Center, "QRIS Quick Facts."

[19] The Healthy Families Act, introduced by Sen. Kennedy, would have covered employers with 15 or

more employees and provided a minimum of seven sick days a year for all workers who worked 30 hours or more a week and a prorated amount for those who worked 20–30 hours a week (Boots et al. 2008). The bill was introduced but never went up for a vote. San Francisco, Washington D.C., and Milwaukee have passed paid sick day laws; San Francisco's was the first, passed in November 2006 and implemented in 2007.

[20] California's Paid Family Leave program was the first such program, implemented in July 2004, and has been the closest studied. The California program uses funds raised from payroll taxes on employees to provide partial wage replacement up to a wage ceiling by supplementing the duration of funding that women receive following pregnancy from the state's Temporary Disability Insurance program.

[21] In 2009, the law was amended to extend this privilege to parents with children age 16 and under (Department for Business, Enterprise and Regulatory Reform 2009).

[22] A U.S. variation on the U.K.'s right-to-request flexible work law was introduced in Congress in 2007. The Working Families Flexibility Act would have allowed any employee working for an employer with 15 or more employees to request a change of hours, schedule, or work location, and required that the employer and employee try to negotiate a solution that could meet the worker's needs without disrupting the business (Boots et al. 2008).

[23] 2008 American Community Survey 1-Year Estimates, Data Profile, U.S. Census Bureau.

[24] Bureau of Labor Statistics, "Monthly Rankings for Unemployment Rates for Metropolitan Areas," http://www.bls.gov/web/metro/laulrgma.htm, November 2010.

[25] BLS, "Monthly Rankings for Unemployment Rates for Metropolitan Areas, WA Metropolitan Statistical Area," http://www.bls.gov/web/metro/laulrgma.htm, November 2010.

[26] OWF also has an online database that families may use to search for licensed child care providers in their area. The search mechanism is available in both English and Spanish. There is no charge for the service, but registered users are only allowed a total of four searches. Upon registering online, parents enter information on their address, employer name, age of up to four children, language preference, and the type of care for which they are looking. The types

of care available to choose from include child care center, preschool program, family child care, school-age program, nursery school, in-home care, and camp programs. Parents can also select from search criteria related to special needs, including developmental disabilities, physical disabilities, medical technology, autism spectrum disorder, behavioral health, works with early intervention, and works with child outreach. The search engine then produces a list of providers with their contact information. Once a provider is selected in the database, additional information is displayed, including training of the provider, the days on which care is provided, part-time versus full-time options, whether the provider accepts child care subsidies, and the setting for family child care providers. The system does not, however, provide information on languages spoken (only indicating whether the provider is bilingual), the hours of care offered, the ages that the program accepts, cost of care, or enrollment capacity.

[27] See Priest et al. (2009). According to this study, 53 percent of child care centers and 37 percent of family child care providers surveyed in Rhode Island in the months following the subsidy cuts reported experiencing "major" impacts from the cuts. To stay in business after the loss of families that could no longer afford to have their children in child care after the complete or partial loss of their subsidy, many providers had laid off staff, reduced staff hours, imposed new fees for families, or closed or consolidated their programs.

[28] Rhode Island's Head Start program is administered by the DHS in Cranston. To be eligible for Head Start, families must have incomes at or below the federal poverty level. Foster children and families that receive Social Security or Supplemental Security Income benefits or any cash assistance through TANF are automatically income eligible. About 10 percent of Head Start slots are available for children who are not income eligible but have a special need for services, such as children with special needs. Children must also be age eligible. For Early Head Start, children must be between the ages of birth and 3 years. For regular Head Start, the child must be between 3 and 5 years old and not eligible for kindergarten.

[29] CCR offers an online database of licensed child care programs in King County along with resource specialists available by phone to assist families in their search. According to CCR, 6,570 families received referrals to child care providers in 2006.

More than half these families were low income. About a quarter of these requests were for providers offering care for nonstandard work hours. To use the CCR online database, families must sign up online and pay a $40 fee with a credit card. The subscription lasts six months. Families with low or moderate incomes may subscribe to the online database for free by calling a resource specialist for login information. The CCR site provides portals in other languages (e.g., Vietnamese, Spanish, Amharic, Somali, and Russian) but these include only pages with informational overviews and phone numbers for families to call. No online searches are available in languages other than English.

[30] To participate in the Head Start program in Seattle, children must be at least 3 years old by the local school district's cutoff. Though both 3- and 4-year-olds are accepted, Head Start prioritizes the admission of 4-year-olds. Children must come from families at or below 130 percent of FPL ($21,200 for a family of four in 2008). Up to 10 percent of Head Start children can be from families who are above the income limits. They are accepted into the program because of developmental factors, such as developmental delay, disability, or other special needs; and/or environmental factors, such as family violence, chemical dependency, child protective services involvement, or incarcerated parents. Parents can apply for Head Start through the sites or through the grantee agencies that oversee the sites.

[31] To participate in ECEAP, children must be at least 3 years old by August 31 of the participating year, but the program prioritizes admission to 4-year-olds. The income limit for eligibility—110 percent of FPL—is slightly lower than for Head Start. Like Head Start, up to 10 percent of ECEAP children can be from families who are above the income limits but who present a developmental or environmental risk factor.

[32] To be eligible for Steps Ahead, children must be 4 years old by August 31 of the participating year.