

# Perspectives on Family, Friend and Neighbor Child Care: Research, Programs and Policy

**introduction**

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RESEARCH, PROGRAMS AND POLICY**

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—Rena Rice

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## INTRODUCTION

**rena rice**

I worked as an early childhood educator until the birth of my daughter, Zoë, in 1976. When Zoë turned two, I decided to resume my career. My mother offered to watch her two days a week, and my neighbor, Mary Riley, told me she would be interested in taking care of her for the other three. Although my new position was educational director of a Head Start center, I wasn't interested in center-based care for Zoë at that age, even if it had existed in my neighborhood. I wanted her to have the individual attention of caring adults whom I knew and trusted.

I was thrilled that my mother wanted to care for Zoë as the two of them already had an extremely close relationship. Mom's caregiving style was consistent with mine, and I knew she would provide my daughter with unconditional love. Mary's husband, John, owned the pub in the center of our Brooklyn neighborhood, and the family was known and respected by everyone. They had a 12-year-old daughter, Bridget, who became a surrogate older sister to Zoë. The Rileys called Zoë "princess" and treated her accordingly. I remember how hard it was to leave my toddler on the first day of work, but I felt secure that she was getting the best possible care.

Although I am a middle-class professional, my experience mirrors that of many of the low-income parents and caregivers described in this *Occasional Paper*. The naturalness of the arrangement, the parents' sense of trust, the special relationships between the caregiver and child, are reflected in these essays. Family, friend and neighbor care has frequently been characterized in the media, and even in the early care and education field, as "substandard, unregulated care," a "fall-back" position when parents can't find or afford a regulated setting. However, up until quite recently, there was virtually no research to support any claims about this type of care.

Family, friend and neighbor care (also known as kith and kin care, license-exempt care, and informal care) became a "hot" topic in the child care field with the passage of the 1996 welfare reform act. In many localities, a large portion of public child care subsidy money was expended on these arrangements, but little was known about the caregivers or the kind of care they provided. This led to research efforts, program development, and new policies. A unique aspect of work in this field is the collegiality of the individuals involved in these arenas: we have been sharing stories and strategies informally since 1997. Over the years, our numbers have grown, and we began meeting annually in 2002. Earlier in 2005, we formed the National Alliance for Family, Friend and Neighbor Child Care. This volume represents all three aspects of the work: research, programs, and policy.

Porter and Kearns review the existing research on kith and kin child care. Synthesizing the results of numerous studies, most of which have been conducted in the past five years, they present findings about the parents who use it, the caregivers who offer it, and the programs that aim to support it. They also offer suggestions about assessing its quality.

New research is represented by Bromer's and by Reschke and Walker's studies. Bromer presents findings from interviews with urban African American relative caregivers, most of whom are grandmothers. Reschke and Walker present the perspectives of predominantly white, rural parents who also use grandmother care. Findings from both studies point to the special bond between the caregiver and child, and the close relationships among the three generations. Childrearing advice, discussed in both papers, can be both a help to the parent and a source of conflict.

Ocampo-Schlesinger and McCarty, and Argo and Chan describe programs for kith and kin caregivers. Ocampo-Schlesinger and McCarty are involved in a project for a Mexican American community in Phoenix, Arizona, one of the earliest efforts to reach out to kith and kin caregivers. Their program has served as a model for similar initiatives across the country. Argo and Chan work with a multi-ethnic immigrant and refugee population in Seattle, Washington. They offer nine essential "lessons" for supporting and maintaining caregivers' cultural practices and values, while helping them navigate American schools and society. Their goal is "raising bicultural children."

Policy is represented by Drake, Greenspoon, and Neville-Morgan's essay on licensing family, friend and neighbor caregivers. The common view in the early care and education field is that quality can be achieved through regulation. The authors question the universality of that assumption when applied to these child care arrangements.

For some readers, these essays will serve as an introduction to family, friend and neighbor care. Other readers may already be involved in working with this population of caregivers. Our hope is that this *Occasional Paper* will encourage greater recognition of the role that kith and kin caregivers play in the child care continuum and that it will stimulate further efforts to address this issue (Porter & Rice, 2000). At one time or another, more than half of the young children in the U. S. spend some time in child care provided by relatives, friends, or neighbors. If we are concerned about quality child care for all children, it is our responsibility as stakeholders in the field to promote understanding of kith and kin child care and to support *all* caregivers in their vital work.

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**FAMILY, FRIEND, AND NEIGHBOR CARE:  
CRIB NOTES ON A COMPLEX ISSUE**

**toni porter & shannon kearns**

Ask working mothers with young children about the kind of child care they use, and it is likely that half of them will say, “My mother” or “My sister.” That informal poll reflects reality. Family members account for 45% of child care arrangements for children under five whose parents are working.<sup>1</sup> Add friends and neighbors to the mix, and the proportion jumps to 55%.<sup>2</sup> Together, these caregivers make up approximately 73% of the child care workforce.<sup>3</sup>

The child care field uses several terms to characterize this type of care, although caregivers and parents would probably not be familiar with them. Sometimes it is called “license-exempt care,” because the settings are legally exempt from regulations that apply to centers or family child care homes. Another common term is “kith and kin” child care, kin as in family, and kith as in close friends and neighbors who serve as surrogate family. Less frequently, it is referred to as “informal child care,” meaning care provided by nonprofessional caregivers.

In all 50 states, relatives are exempt from licensing requirements.<sup>4</sup> Individuals who provide child care for nonrelated children can operate without a license under one or more of three conditions, depending on the state: the number of children in care at one time; the number of families who rely on the caregivers; and the number of hours children spend in care.<sup>5</sup> All license-exempt caregivers, whether they are relatives or nonrelatives, must comply with specific state requirements if they provide care for children who receive public child care subsidies.<sup>6</sup>

Until the mid-1990s, family, friend and neighbor care was largely overlooked by the child care field. A few studies looked at utilization<sup>7</sup> and a handful of others focused on caregiver motivation and interests.<sup>8</sup> There was only one study of quality.<sup>9</sup> Its results—that care was poor, largely because the caregivers were not “intentional” about their work—contributed to a pervasive perception that kith and kin child care was not good for children.

Attitudes began to shift with the 1996 federal welfare reform, as data emerged about Temporary Assistance to Needy Families (TANF) child care spending patterns.\* They showed that many welfare families were using license-exempt care: in some states, like Connecticut, more than half of the TANF dollars were expended on these arrangements.<sup>10</sup> The accumulating evidence that thousands of families used public dollars for license-exempt child care attracted attention from policy makers, practitioners, and researchers; and it turned the spotlight onto kith and kin child

\* Proportions varied widely depending on the child care supply, economic conditions, and licensing and subsidy systems.

care in general. It also prompted concerns about how children fared in these unregulated settings with untrained caregivers. The result was a flurry of attention: research on parents' choices and caregivers' interests, development of kith and kin programs, and studies of quality.

We know much more about this type of care than we did a decade ago. There is wide acknowledgement that kith and kin caregivers have a special place on a continuum of child care that extends from parents and regulated family child care providers to early childhood teachers.<sup>11</sup> The acceptance of the role that family, friend and neighbor care plays in the child care system has not been without consequences. Today, the quality of care that these caregivers provide is subject to the same scrutiny as other types of care: they are being held to the same standards for producing good outcomes for children.

On average, kith and kin caregivers provide child care for two or three children.<sup>12</sup> Infants and toddlers represent the majority; school-age children rank second, followed by preschoolers. Often, there are mixed-age groups in care. Children spend a great deal of time in these settings, up to 50 hours a week.<sup>13</sup> A significant proportion of the care is provided in the evenings, at night, or on the weekend.<sup>14</sup> The duration of the care varies; some children remain with the same caregiver for as long as three years.<sup>15</sup>

Many caregivers do not receive payment if they do not participate in the subsidy system. In one unpublished study of relative caregivers, 28% reported that they were paid by parents to provide child care. In some cases, parents did chores, paid for necessities, or gave gifts instead.

### **The Parents Who Use Family, Friend and Neighbor Care**

Although all kinds of families rely on kith and kin care, those who use it most frequently share some common characteristics. Many are young, single Latina and African American mothers without much higher education.<sup>16</sup> They tend to work in jobs with nontraditional hours, and have low incomes. Most have more than one child.

Many families use kith and kin care by choice: 70% of the mothers in an Illinois survey, for example, said that they did not consider any other type of child care.<sup>17</sup> They say they want caregivers they know and trust, because they do not want their very young children in the care of strangers.<sup>18</sup> Some parents, especially newcomers to the United States, want someone who shares their culture—who speaks the same language, espouses the same values, and follows the same practices.<sup>19</sup> A third factor is flexibility: parents want care that fits their evening, weekend, or shift work schedules, and family members can provide it.<sup>20</sup>

Other families would not use family, friend and neighbor care if they could find some other setting. They turn to kith and kin because convenient care in regulated settings is not available.<sup>21</sup> If convenience is not a problem, cost often is, even with child care subsidies.<sup>22</sup>

## The Family, Friends, and Neighbors Who Provide Child Care

Our portrait of kith and kin caregivers is based on state-level studies since no national data are available. The findings provide some insights into caregivers' motivations, characteristics, and interests.

Many caregivers provide care for the same reasons. Most say that they want to help out the parent<sup>23</sup> and that they want their grandchildren or their nieces in care within the family.<sup>24</sup> They also say that they enjoy spending time with, and caring for, children.<sup>25</sup> Somewhat lower on caregivers' lists of reasons are helping children learn<sup>26</sup> and teaching children.<sup>27</sup> Many caregivers are not interested in a professional child care career; they only want to care for one or two children who are special to them.<sup>28</sup> Only a small proportion, generally nonrelatives, say that they provide care for the income it generates.<sup>29</sup> They are likely to consider child care as a business.<sup>30</sup>

Most often, the ethnicity of caregivers mirrors that of the parents who use them.<sup>31</sup> Many are people of color—Latinos, African Americans, and Asian Americans.<sup>32</sup> European Americans account for approximately 35% of the caregiver population.<sup>33</sup> On average, caregivers are in their mid- to late-forties, although their ages range from late teens to 70's and 80's.<sup>34</sup> Relatives tend to be older than other caregivers, with average ages ranging between 41 and 52.<sup>35</sup> Many are still in their prime working years, and have a job outside the home.\*

Most studies collect data on caregivers' education, child care training, and experience, because research has linked these characteristics with quality. They show that caregivers' educational backgrounds vary widely, ranging from less than high school to four-year college degrees.<sup>36</sup> There is also some evidence that caregivers have specialized child care training.<sup>37</sup> Caregivers have a wide range of experience caring for other people's children—four years, on average, although some studies report higher average years of experience.<sup>38</sup> This makes sense, given the wide age range of the caregivers.

Research on caregivers' interests underscores the place they hold in the child care continuum.<sup>39</sup> Like many parents, they want information about how children develop, activities that will keep them engaged, and how to help them succeed in school.<sup>40</sup> Another common request is information about how to set limits for children—"discipline"—a perennial favorite in parenting education programs.<sup>41</sup> At the same time, caregivers want information about health, safety, and nutrition, topics that are often on child care training agendas for regulated family child care providers.<sup>42</sup> They are also interested in learning how to communicate with parents; for them, however, the issues are different, because they are providing care to family or close friends. A small percentage of caregivers, typically those who are not caring for related children, are interested in information about becoming regulated providers.

\* *Approximately 20% of the caregivers in one study had a second job (Todd, Robinson, & McGraw, 2005).*

## Quality in Family, Friend and Neighbor Care

Because child care quality is such an important issue, several studies have examined kith and kin care for subsidized or low-income children.<sup>43</sup> The findings indicate that most of this care, like that in regulated settings, is rated low on standardized global observation instruments. This means that the variety of activities to stimulate cognitive development is limited, there are few books or other materials, and health practices are not optimal. There is also a lot of television. On the other hand, there is some evidence that caregivers are warm and nurturing with the children, that there is a lot of one-on-one talk, and that the caregivers engage children in routines.

As a result of concerns about quality in kith and kin care, many states have developed initiatives to support these caregivers. In 2004, 20 states were funding specific initiatives for this population.<sup>44</sup> The private sector has also become engaged in this issue, providing support to a variety of programs. The federal government has weighed in as well, by including family, friends and neighbors in the Early Learning Opportunities grants, professional development plans for child care providers, and Early Head Start. Most state-funded programs limit participation to caregivers who serve subsidized children, but the others are open to all kith and kin caregivers.

Programs use a variety of recruitment strategies. Initiatives that serve subsidized caregivers typically rely on mailings to the subsidy list, which are sometimes followed up by phone calls.<sup>45</sup> Others distribute or post flyers at libraries, faith-based organizations, or grocery stores, and make presentations at Head Start programs or schools. Some programs offer incentives such as First Aid kits, books, and cash payments.

Training is the most common strategy for enhancing kith and kin child care quality. It accounts for more than half of the state-funded efforts as well as many that are privately funded. Most programs, like Alabama's *Kids and Kin Program* and Crystal Stairs' *License Exempt Assistance Project* in Los Angeles, offer workshops; a few, like New Mexico's *Conversations Project* and New York City's *HRA/CUNY Informal Family Child Care Training Project*, use facilitated discussions or support groups.

Other strategies for improving quality in these settings include distribution of materials such as health and safety kits, or home visiting. Hawaii's *Learning to Grow*, for example, mails monthly kits to caregivers, while *SPARK Georgia Neighborhood Van Program* delivers materials to caregivers' homes. Missouri's *Project REACH* makes monthly home visits to rural caregivers; Action for Children's *License-Exempt Initiative* in Chicago uses a single home visit to provide caregivers with information about its services.

Whatever the funding source or strategy, program content typically focuses on similar child care topics: health, safety, child development, and, to a lesser extent, literacy. There is less attention to family support issues that have particular relevance for kith and kin caregivers, such as negotiating relationships with family members.

## Discussion

These early stages of work on family, friend and neighbor care have enriched our knowledge enormously. Some of it confirms what we know intuitively: that kith and kin care is the most common form of care for young children in the United States; that parents want their babies with family; and that grannies and aunts want to care for those babies. Other findings are more surprising: that there are blurred policy distinctions among states about caregivers who are regulated and those who are exempt from licensing; that caregivers want to know about the same issues as others who care for children; and that many programs for kith and kin caregivers fail to include the issues that are important to them.

This work also suggests the next generation of research questions. Some relate to services, others to quality. We need to learn more about the differences between family and friends as well as neighbors, and the individual approaches that have the potential to support them. We also need to know which approaches work, and how, so that we can effectively enhance the quality of care that kith and kin caregivers provide.

Quality is always the elephant in the room. The child care field now agrees that existing instruments for assessing child care quality may not be appropriate for kith and kin care, because they were designed to evaluate care in regulated settings. Evidence about quality based on instruments specifically designed for family, friend and neighbor care may yield other results than those in previous studies. We may also want to consider the issue of quality from other perspectives, such as what parents want and expect from this care, or the cumulative experience of children in the multiple child care settings in which they spend their time during the week.

Whatever approach we use, it is likely that we will discover some kith and kin care, just like care in other settings, will be poor. We can address this issue by providing resources to family, friend and neighbor caregivers, just as we do for regulated family child care providers and center-based teachers. Because parents will always use kith and kin care, our challenge is to strike a balance between honoring their choice of these settings, and responding to public concerns about the outcomes for children in these arrangements.

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## WAYS OF CARING:

### HOW RELATIVE CAREGIVERS SUPPORT CHILDREN AND PARENTS

**juliet bromer**

*I give Jamillah a lot of love. I just enjoy being with her. I enjoy our little time we spend. I like to play music and watch her dance.... I think if she learns anything from me, it's how to cuddle and how to love someone.*

– Mavis, a grandmother

*He knows that I'm the other half of the tree.... It's like he wakes up in the morning, he get to reaching for me. And we got a good relationship, I feel. You know? He's the type of baby, he knows that I'm caring for him."*

– Tanya, an aunt

The above statements are from relative caregivers who participated in a qualitative study that explored the support roles of African American child care providers in poor Chicago neighborhoods.\* This essay is based on in-depth interviews with ten relative caregivers—nine grandmothers and one aunt. In it, I discuss five themes: caregivers' adult-focused and child-focused motivations for caring, daily work with children, childrearing advice to parents, and caregiver-parent conflict. Caregivers' motivations to provide child care and the meanings they ascribe to this daily work suggest new ways of defining a child-focused approach to caregiving.

The support role of grandmothers and other close kin in African American families has been widely documented (Burton & Bengtson, 1985; Hill, 1993; Hunter, 1997; Hunter & Taylor, 1998; Jayakody, Chatters, & Taylor, 1993; Stack, 1970). The involved role of African American grandmothers, especially in realms of child care and parenting support, has been described as a source of strength and resilience for African American families, especially those living in poverty. Most studies focus on grandparents who co-reside with their grandchildren and take on surrogate parenting roles. Fewer studies have looked exclusively at the noncustodial child care roles of grandmothers and other close kin. And few have examined the meaning of child care work to African American caregivers.

The ten caregivers in this study offered child care on a full-time basis to at least one relative child. Four caregivers also offered care to additional children who were not related to them. Children in care ranged from young infants to school-age. The schedules included nonstandard hours (nights, weekends) as well as daytime hours to accommodate parents' jobs. Three caregivers were paid by family members

\*This chapter reports on a subset of findings from the author's dissertation, which is part of the broader Study of Work-Child Care Fit, directed by Julia R. Henly, University of Chicago. The dissertation includes data from both parents and a cross-section of child care providers.

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The caregivers ranged in age from 26 to 74 although most were in their mid-40's. Only one caregiver held a college degree and none had formal training in child care. Six of the caregivers were married and seven lived with the families of the children in care. Most notable was the economic marginality and level of personal hardship that these caregivers faced. Nine reported economic hardship, two had serious health problems, and four held full-time jobs. They all lived in urban neighborhoods with high family poverty rates (Census Bureau, 2000).

### **Adult-focused Motivations**

Caregivers viewed their care of kin as an extension of a natural role they had always played in their families: as one woman put it, "Quite naturally, I would be the one to watch them." They also emphasized an obligation to help family members and often framed their motivations to provide child care in ethical terms. Mrs. May, a great grandmother caring for her grandson and great grandson, commented:

*And that's what families are supposed to do. That's what they are about. I'm not saying we're a family and you go your way and I go mine. That's not a family. A family sticks together! A family helps each other.*

Feelings and arrangements about payment further illustrated caregivers' ethical commitments to help family members survive economically. Caregivers wanted to help family members who demonstrated an effort to help themselves. They alluded to this ethic of self-sufficiency when they explained why they did not charge relatives for child care. As Martha, a young grandmother, put it: "I know she's down there trying—that was good enough.... I kept her for a long time before I got anything... 'cause I know she's down there trying to do something with herself." Other caregivers spoke about the unpredictable paychecks of parents and empathized with working parents' economic struggles.

Caregivers' feelings about payment also focused on ideas about reciprocity. Mrs. Tanner, a grandmother who cared for her grandchildren as well as neighbors' children, expressed discomfort with the idea of being paid and how that might change her relationships with friends and family. She mentioned hard times in the past where she relied on her family to get by and did not want to jeopardize familial relationships by charging for child care " 'cause I'll never know if I ever need the few favors returned, the favor turned around, you know. I don't usually charge. I don't

like to charge people.” Indeed, the few caregivers who were paid by their relatives said it was usually the parent who insisted.

### **Child-focused Motivations**

Caregivers also emphasized the health and well-being of relative children as a primary motivator for providing child care, citing their close relationships with children and their fear of abuse in organized child care settings. Most caregivers initiated the child care arrangement with their relatives. As one grandmother explained: “It was just a volunteer thing for me to keep her.... Because it’s my first grandbaby and I loved her.” For relative caregivers, love of an individual child rather than a general interest in children motivated them to offer care. As another grandmother put it, “I’m not really a kid person.” Aunt Tanya’s quote at the beginning of this essay suggested that caregivers often took on second mother roles with children, especially relatives who co-resided with kin. Similarly, Martha described how living in the same building as her granddaughter facilitated the relationship: “This is like home for her too. She just walk on in.... She’s my grandchild—just like she’s mine.... She’s my baby. I’m grandma.”

In some cases, caregivers’ child-focused motivations to care for relatives were differentiated from their adult-focused motivations to care for children unrelated to them. Karla explained how monetary need motivated her to care for her neighbor’s child: “I told her, yeah, I could use the little few dollars...around the house, you know, get me some cigarettes and whatever.... That’s how I started taking care of her baby.” While Karla also accepted monetary payment from her daughter, grandmotherly love and protective feelings motivated her to take on the full-time care of her 18-month-old grandson: “I don’t want him in preschool.... ’cause he can’t talk and if somebody up there do something to him he can’t tell you who did or what.”

### **“Doing Daily Things”: Taking Care of Kids**

The caregivers I interviewed talked about their informal efforts to address children’s cognitive, social, and emotional needs. Several read books and introduced the alphabet to children. Mrs. Smith, a college-educated grandmother, viewed herself as a teacher to her grandchildren and regularly planned cultural and educational activities, hoping to expose them to a world beyond what she called “the hood”:

*You know I have my little school stuff, my ABC’s.... Instead of looking at the TV all the time, I have the music on.... I say it’s opera and I tell them different names.... I have to plan for them.*

The elderly Mrs. May found ways to make her limited one-floor, three-room apartment into a learning space: she converted an old sofa into a climbing apparatus and made up writing and drawing games with her grandsons.

Caregivers’ narratives about what they wanted for children further revealed a

kind of emotional care. Grandmothers in particular emphasized teaching their grandchildren the importance of forming close relationships. They talked about passing on the security and reliability of grandmotherly love:

*I mean I just want them to know when they think of their grandmother, they think of “my grandmama love me.” That’s all I want.*

*If anything goes wrong as far as they are concerned, whatever is in their little life, they talk to grandma and tell grandma.*

Caregivers also emphasized the importance of teaching children how to care about and for others as a moral value. Mavis taught her 17-month-old granddaughter “how to cuddle and how to love someone.” Mrs. May used her own disabilities to teach her grandsons the value of caring for others:

*They see me struggling trying to do something. As small as they are, they will really help! They gonna git up. And they get behind me and push me ‘cause I let them do that so they will learn how to, you know, to help people? So they’re learning how to give help to older people, sick people. They’re learning how to do that, to help.*

Other caregivers talked more broadly about social and moral development, as Mrs. Smith explained: “Morals, a lot of morals.... I teach them to respect each other, because, see, they get to fighting. I say you don’t fight your cousin, your brother....” Aunt Tanya, who cared for her ten-month-old nephew, talked about the importance of character training: “I do want him to be a sharing person. I want him to be, ah, not selfish.”

In addition to cognitive and social-emotional development, caregivers’ focus on daily routines with children further revealed an intentional approach to caregiving. Much of their time with children was spent in family routines and what one caregiver called “daily living”: getting up in the morning, preparing for school, eating, bathing, and going to bed. Caregivers sometimes described these activities as ones only a grandmother could do and took pride in the intimate care they offered children. Mrs. Tanner describes her attention to children’s individual needs:

*I’ll probably get them up about a quarter to eight. So they can stretch and wake up before they go to school. I don’t like a kid to just wake up and get dressed and go to school because then they have a bad day.*

She also explained how she re-read books to the children each morning to “refresh” their memories before they went to school.

## **Mothering Mothers: Childrearing Advice to Parents**

Caregivers in this study confirmed the well-documented finding that African American grandmothers provide substantial support and guidance around parenting issues especially to young, first-time mothers (Hunter & Taylor, 1998). All ten caregivers gave personal advice to mothers about child-related concerns. For some, this support to parents was an indirect way of helping children.

Advice about routine baby and child care included the importance of home-cooked meals, feeding schedules, and potty training. Many caregivers acted like coaches to mothers, giving out daily tips and assessments of mothers' parenting skills. Mrs. Smith called her grandson's mother every morning at six a.m. to remind her of the day's schedule, which included getting the child to preschool on time. She acknowledged that this constant pressure was difficult on the young parent but explained how her approach was successful:

*I say, "Wanda, you can get mad at me but I'm gone keep pushing." You know 'cause she's young and she figures "You acting just like my mother." I say, "Well, Wanda, I'm trying to help you that's all.".... She'll sit there and look at me and listen. But then she'll catch on and then the next day, "Okay I'm do so and so."*

In addition to giving specific childrearing advice, caregivers encouraged mothers to spend quality time with children. They acknowledged that multiple stressors and distractions in parents' work lives often made it hard for mothers to find time for their families. As one caregiver told her sister-in-law, "You gotta make time. You gotta make time for the kid." Caregivers also challenged mothers to focus on individual emotional and cognitive needs of children:

*Read to her, teach her to do certain things.... Give her the quality time so she'll learn something.... I always tell her to spend a lot of time with her because now she basically needs that.*

*Let him get on the floor and play.... She read to him. I tell her that's good 'cause its gonna help him in the long run.... I tell her that was good to do.*

Caregivers' advice to mothers about discipline further illustrated their child-centered approach. Six caregivers encouraged mothers to take the child's perspective when disciplining. Mrs. May chided her daughter for using physical punishment and encouraged her to talk to her child instead: "You git 'em up to you, you look in his eyes, and you talk to him, and he's a thinking child already, so you show him some points where he shouldn't do these things. He's gonna hear you! He may not hear you right now, but he will hear you!" Mrs. Smith encouraged her grandson's mother to take a developmental perspective: "She was saying that he's bad, but he's

not being bad, he's angry. I say he go through that little stage." Sally, who cared for her infant grandsons, imparted her own vision of child development and urged the parents to take an empathic approach:

*Well, as far as bottles go, I tell them not to take the babies off the bottles so quick, 'cause it's a pacifier.... They need to be a baby as long as possible, especially if you're a working parent, they really need to be a baby as long as possible 'cause they miss their mommy and their daddy.*

### **Challenges to Child-focused Caregiving**

Findings from large-scale studies of African American grandmothers point to the role conflicts and burdens of grandmother care in many families where early timing of motherhood and grandmotherhood occur (Burton & Bengtson, 1985). Other studies point to relationship conflict between mothers and grandmothers over childrearing values that may compromise the child care arrangement. Hunter's (1997) study of young African American parents' reliance on grandmothers for parenting support found that levels of support were related to "feelings of family closeness" (p. 262). Jayakody, Chatters, & Taylor's (1993) study of family support provisions to African American mothers suggested that child care assistance from grandmothers was often accompanied by conflict and parental dissatisfaction.

Alongside the loving relationships with kin, caregivers also mentioned conflict and burden when describing child care arrangements. They spoke about the hard work of caring for children on a round-the-clock basis while dealing with full-time jobs, economic hardship, age and health problems, and raising a large family. Seven caregivers described disagreements with their daughters that sometimes posed a challenge to the child care arrangements. Although grandmothers saw themselves as second mothers to their grandchildren, they did not want to be perceived by family members as surrogate parents. Discipline, for example, was viewed by most caregivers as a parental responsibility. As Martha explained to her daughter, "I'm the grandmother. Grandmothers are to hug and kiss. You discipline your child."

The burden and physical exhaustion of child care posed another challenge to caregivers. They talked about the hard work of filling in for mothers whose jobs demanded long work hours. Mavis felt her daughter took advantage of her availability to be on call 24 hours a day:

*There are times when I resent... where I feel like I'm the person that's always running back and forth, back and forth, and then when she gets here, she still wants to do the fun stuff.... I have to go to work, I still have to take care of my house and you want to go out and party.... Yeah, I'm feeling like I'm more Rachel's mom than Rachel's mom is.*

Despite these barriers, caregivers held remarkably strong commitments to their fam-

ilies and reported few disruptions in child care arrangements.

## Discussion

Relative caregivers' descriptions of their motivations and daily practices suggest new ways of defining what it means to offer child-focused care. They may have implications for how the early childhood profession measures the quality of care in relative care settings. Caregivers' motivations to help out mothers and children were driven by both ethical obligations to family as well as deep attachments to individual children. Caregivers emphasized the importance of cognitive as well as emotional and moral development. Daily routines and rituals also demonstrated intentional and attentive care to children.

Conflict reported by caregivers, however, suggests that in some cases the tensions involved in such close relationships pose barriers to supportive child care for all parties involved—child, parent, and caregiver. Relationship conflicts may increase the burden for caregivers, who are often struggling with other personal obligations. Collaboration with and support from other arenas such as child care centers, family support programs, and social service agencies may help to offset the stress caused by the caregivers' multiple roles. In turn, this may mitigate opportunities for conflict and burden in these intimate relative care settings.

Similar to past examinations of African American networks of intergenerational support, this qualitative analysis of ten African American caregivers shows that, in addition to child care, caregivers offered significant parenting support and advice to mothers. They provided daily, hands-on coaching to parents about the details of childrearing. Support and encouragement to parents suggest indirect ways that caregivers focused on the well-being of children in their care. Indeed, the strength of the caregiver-parent relationships and the passing on of childrearing wisdom in these relative care settings may be hidden dimensions of child care quality.

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## THE ARIZONA KITH AND KIN PROJECT

### sarah ocampo-schlesinger & vicki mccarty

In early 1999, the Association for Supportive Child Care (ASCC), a leader in the early childhood field in Arizona, was approached by the City of Phoenix to offer services in the low-income South Phoenix community. Federal welfare reform had been recently enacted. People transitioning off welfare and looking for work were at the center of the City's agenda. The City of Phoenix formed a job development committee to help them move from welfare to work and, in keeping with a larger federal focus, to revive the inner city.

In considering job development for the residents of any community, the focus quickly shifts to child care needs: Is good child care available? Will the child care resources be enough? The City of Phoenix commissioned the Morrison Institute of Arizona State University to conduct a study of the area's child care needs. They asked the following questions: "What is the problem?" "How big is the problem?" and "Where are the gaps in child care?" The City thought that the study would show where additional child care programs were needed. Instead, it revealed that there were available slots in the area, but people were not using them. They were using, and more importantly, had chosen to use, "kith and kin" (family, friend and neighbor) care instead.

Our colleague, Susan Wilkins, ASCC's Executive Director, had been part of the job development committee during this process, and took the lead in the development of one of the first kith and kin projects in the United States. Founded in 1976, ASCC is a nonprofit organization dedicated to "enhancing the quality of care for children" in the State of Arizona. It has always worked with the early care and education community to assist child care programs—both family child care and center-based care—in their efforts to meet state certification and licensing requirements or accreditation standards. For many years, ASCC felt confident in its belief that the first step to quality was through regulation. After learning about the large population of kith and kin caregivers, the staff of ASCC realized that these caregivers had to be included on our "radar" if we truly wanted to affect the quality of care for all children. The Phoenix pilot of the Arizona Kith and Kin Project began in March 1999.\* We sought to work with at least 25 caregivers in weekly training-support groups at three different sites in South Phoenix: two Head Start programs and an independent child development center.

ASCC has shifted from its original belief that quality in child care settings can improve only through regulation. We are now firmly committed to reaching out to the underserved population of kith and kin caregivers in our communities to provide

\* A grant from the Arizona Community Foundation helped launch the project. Shortly after its inception, the Seabury Foundation provided additional funding.

training and support. Through these efforts, ASCC is tapping into an audience of caregivers who, through their willingness to help out friends or family members by caring for their children, have unintentionally entered a field unknown to them as a profession—the field of early care and education. Participating in the project contributes not only to their personal growth and empowerment, but helps them to have a greater understanding and respect for the important work they do.

We recruit participants through Head Start programs, libraries, schools, faith-based organizations, community centers, and outreach to parents, teachers, and social workers. Approximately 99% of the program participants identify themselves as Hispanic and primarily Spanish-speaking. Currently, the program works with approximately 350 kith and kin caregivers annually. Very often, these caregivers live in some of the most economically distressed neighborhoods in the area, with a typical income of between \$10,000 and \$19,000. Most of the time, the child care arrangements enable a family member to hold a job. Participants care for between one to seven children, with an average of four. The children's ages range from one month to 12 years; the typical age group is birth to four.

### **Ana's Story**

Ana, a Mexican American mother of three who had recently moved into an apartment after a period of homelessness, noticed a flyer in the library advertising the Kith and Kin Project. From the address, she saw that it was housed in the same community center where she was taking English as a Second Language classes. Ana had been begun caring for a neighbor's child in her housing complex, and she decided to join the 14-week group. Initially, the snack served at the support group was often her only meal of the day. She soon became a regular member, gaining emotional sustenance and support from the other members. She learned about early brain development, support for language and literacy, health and safety, nutrition, positive discipline techniques, parent-caregiver communication, and more.

Soon, she began caring for other neighbors' children, which increased her income. She found her attitudes and behavior changing: "I used to be real impatient with kids. I didn't realize why you shouldn't do things like hit or scream at the children. My first semester was quite a surprise." At the end of her second 14-week semester, Ana participated in the annual health and safety training day, where she learned CPR, first aid, and home safety tips; she received as gifts a smoke detector, fire extinguisher, first aid kit, and outlet covers for her home, as well as a voucher for a car safety seat.

When the local United Way asked for a caregiver to speak before a group of program managers, we asked Ana to talk about her experience. She told them how she regularly phoned her relatives in Mexico, who were caring for two of her own children, telling them what she had learned in the sessions. "I know they can be impatient and yell at children, too, so I wanted them to treat my children differently." Ana has come full circle and now assists with the Kith and Kin groups by pro-

viding child care on-site for the children of participants while their groups are in session.

### **Program Assessment**

So far, ASCC has conducted three reviews of the Arizona Kith and Kin Project. Independent evaluators collected data through observations of training-support groups, participant questionnaires, focus group discussions with participants and staff, telephone and in-person interviews, journals kept by the program facilitator, and written or recorded journals kept by participants. The last assessment, in 2002, *The Staying Power of Kith and Kin*, reflected the lessons learned across all three evaluations.

The findings show that transportation, on-site child care, scheduling, and follow-up made participation easy for the caregivers. Nearly all expressed satisfaction with the program. They enjoyed learning from others and appreciated being asked for their opinions. Sharing conversations and activities with other caregivers gave them a greater sense of worth. They noted that their care had improved because they had learned to be more patient with and attentive to children. The results indicated that participants most often changed what they had done in their activities with children. Because they now understood how children behaved at different ages and developmental stages, they could discipline them more effectively, communicate with them better, and were able to implement what they had learned about child safety and nutrition.

While the evaluations all reflect program strengths, they are based on self-reported data. Although home visits are not part of the program, fortunately we had the opportunity to observe some of the participants during the field test of the Child Care Assessment Tool for Relatives (CCAT-R), a new assessment instrument for relative caregivers. Sarah, who was one of the observers, could quickly see the impact of the program in some homes—finding homemade toys that the caregivers had learned to make in our groups, seeing behavior management guidelines for the children posted on the wall, finding children’s materials placed at their eye level, and observing caregivers on the floor with kids. At other homes, she felt the need to “step in” or create a teachable moment. She experienced first hand what another staff member had stated: “It is a challenge to know that a caregiver needs guidance and that they are just not quite ready to receive it. I have learned to walk away and let them come to me or encourage other caregivers to share their experiences. They usually come around.” Like her colleague, Sarah found herself hoping that this caregiver would bring it up at the next Kith and Kin meeting.

### **Challenges and Joys**

The staff must manage feelings stirred up by heartbreaking stories. One group facilitator said, “I heard a caregiver talk about her 18-year-old son who is in jail and will be sentenced to 10-30 years. Another participant shared that she cannot

feel half of her body because of an epidural she was given during labor.” The close relationships, however, are also what bring joy and pride to the work.

Funding for the program is an ongoing challenge. As one staff member stated, “The high cost of this program, the little money that we have, and having to eliminate some of the sites, is one of the most challenging tasks.” Inevitably, the staff develops close relationships with the participants. This makes it difficult to let go of the groups when funding is no longer available. Even for a program with positive evaluation results, our Kith and Kin training-support groups are always in jeopardy. In some areas, the Kith and Kin Project is the only source of training and support for this group of child care providers. The elimination of our groups would leave these areas without services. Besides our own grant-seeking activities, we are also collaborating with Head Start centers, housing departments, and other community-based organizations in exploring opportunities to continue and expand the program.

Program assessment is another challenge. We are hoping to use the CCAT-R in the near future to assess changes in behaviors through direct observations rather than through self-report alone. Our findings will enable us to determine what areas of the program need to be revised or enhanced. We are also working on expanding the program to other populations of caregivers. For example, we are participating in a program for incarcerated teen parents who rely on grandparents or other relatives to care for their children while they are in prison. We are developing a program to meet the needs of these caregivers.

The Kith and Kin Project continues to be a model that can be replicated, an experienced source that provides assistance with the challenges faced by this population of caregivers, and a location to visit and see first hand how the training-support groups function.

## LICENSING FAMILY, FRIEND AND NEIGHBOR CAREGIVERS: PARADOXES AND POSSIBILITIES

**pamela jakwerth drake, bayla greenspoon & sarah neville-morgan**

Many family, friend and neighbor caregivers are “hidden” and receive little support and limited monitoring. Some aspects of their care—such as small group size, extended relationships with the children, and similar cultural backgrounds—are associated with higher quality. But these caregivers typically have little or no formal training in child development or child safety, and little knowledge of resources that can help them improve the quality of their care.

One potential solution to this problem is to help caregivers navigate the procedures to become licensed family child care providers. This would ensure a minimum amount of training, and would put them on the “radar” for additional education as well as monitoring. This paper identifies issues related to licensing family, friend and neighbor caregivers and explores the relationship between licensing and child care quality.

Statistics about the number of family, friend and neighbor caregivers who may be interested in seeking licensure vary widely. In its study, the First 5 California Family, Friend and Neighbor Child Caregiver Support Project (Drake, Unti, Greenspoon, & Fawcett, 2004) found that fewer than half (about 40%) of the caregivers were interested in becoming licensed, 30% were unsure about it, and 33% did not want a license. There were some differences among those who responded. For example, slightly more than half (53%) of the nonrelative caregivers were interested in becoming licensed compared to one-third (33%) of the grandparents. There also was stronger interest among Hispanic and European American caregivers than those who were African American or Asian American: half compared to less than a quarter.

Expressing an interest in becoming licensed is only the first step of a time-consuming and sometimes complex and stressful process. In one state study, only 34% of family, friend and neighbor caregivers said they were willing to complete all of the licensing requirements; 63% said they were not willing to complete any of them (Brown-Lyons, Robertson, & Layzer, 2001). In addition, some caregivers who start preliminary steps may not be able to comply with other requirements because of their immigration status; their own criminal history, or the criminal history of family members (including the child’s own parent); or their housing (Morgan, Elliott, Beaudette, & Azer, 2001). A licensed provider needs a minimum level of liability insurance, which is especially important for renters, but can take a significant portion of her income (Drake et al., 2004).

### **Licensing Requirements and Quality Child Care**

Licensing requirements are minimum standards for a basic level of care

(NCEDL, 2002). Definitions and requirements vary by state (Lemoine, Morgan, & Azer, 2003; Morgan et al., 2001; Porter & Kearns, 2005). They typically define the “threshold” of the number of children allowed in care without a license (ranging from 0 to 12 across states), as well as any exemptions. These are based on relationship (e.g., close family member), number of families for whom a caregiver provides care, or number of hours in care. The requirements also specify the content and number of hours of preservice and inservice training. Preservice requirements are generally low, fewer than 12 hours. Typically, this training only includes health, safety, and CPR; few states require child development information for family child care licensing.

Providing basic health and safety training and materials to caregivers may make the child care safer, but there is no evidence that it will improve the overall quality of care. Studies show that the quality of much child care (including all forms of licensed care) is generally low. On the other hand, some stakeholders believe that even the minimum level of training required for licensing could have an effect on family, friend and neighbor care because studies indicate that it ranks lower in quality than regulated family child care or center-based care (Brown-Lyons et al., 2001; Fuller et al., 2000).

One consideration in developing a policy for family, friend and neighbor child care is the issue of regulation versus quality improvement. If the focus is the latter, then options that offer various types of support might be more appropriate and effective. What is most important is that policy makers thoroughly weigh all options and potential consequences and develop their policies “intentionally rather than inadvertently” (Morgan et al., 2001, p. 11).

The most stringent policy would be to require licensing of any individual who provides regular child care, whether related or not. It is unlikely that any state would ever consider licensing relative caregivers, although many impose requirements for those who receive child care subsidies. Other options may be more realistic and easier to implement:

- Requiring licensing (or training/inspection) for all nonrelative caregivers. However, this option would be costly and difficult to monitor, particularly for those caregivers who do not care for subsidized children.
- Requiring licensing (or training/inspection) for any nonrelative caregiver of children in families that receive a child care subsidy. Families who need the subsidy, however, may not apply for it if they do not want or cannot find a licensed caregiver.
- Creating a tiered-reimbursement system that ties higher rates of government subsidy or other financial support to licensing levels or training requirements (National Child Care Information Center [NCCIC], 2002). This may be the most realistic option, but it would only apply to caregivers who receive subsidies and who consider the increase in reimbursement high enough to warrant the additional expense of licensing.

- Requiring a fingerprint and background check, like California's TrustLine, for all caregivers who receive subsidies even if they are related to the children they care for.

### **Support Options**

Licensing may not be the best first step for family, friend and neighbor caregivers. Some studies suggest that efforts to recruit caregivers to become regulated fail, in large part, because the caregivers are afraid of government intrusion and are committed to informal care (Bromer & Henley, 2002). When programs change their objectives from licensing to providing support, they can be more effective at recruiting caregivers (Collins & Carlson, 1998). Many of the child care experts who participated in various aspects of the First 5 California Family, Friend and Neighbor Child Caregiver Support Project stated that it would be more cost-effective and equally important to provide some of what the licensing process guarantees: health and safety training and smoke detectors, for example. They emphasized the importance of providing culturally appropriate and nonthreatening support, with a focus on helping caregivers prepare children for school.

One California strategy is to enlist caregivers in a "pre-entry" track of the Compensation and Retention Encourage Stability Initiative/Child Care Retention Incentive program (CARES/CRI).<sup>\*</sup> The goal of this program is to encourage center-based staff and family child care providers to participate in training as well as to remain in their current programs. Research links training and teacher stability with quality of care; staff and providers with more training tend to stimulate children's cognitive and language development (Kontos, Hsu, & Dunn, 1994). Since most family, friend and neighbor caregivers do not meet the requirements for entry into CARES, First 5 California instituted the CRI pre-entry level; this allows counties to reach out to caregivers, connect them to resources, and provide them with incentives to participate in training. These caregivers may then enroll in CARES steps or the Child Care Initiative Project (CCIP) program, which seeks to increase California's supply of licensed quality child care through recruitment and training activities.

Aware of the link between training and quality, First 5 California supports providing incentives and training to caregivers across the entire continuum of care. These efforts can be strengthened by targeting family, friend and neighbor caregivers and linking them with other programs such as CCIP and Family Child Care at Its Best. Whichever training strategies are utilized, it is important to consider caregivers' preferred methods of receiving information—through informal rather than traditionally structured classes (Drake, et al., 2004). This will challenge program developers to find creative ways to organize the delivery of information that addresses standards and competencies, while responding to caregivers' preferences.

<sup>\*</sup> CARES/CRI is funded through a partnership between First 5 California and the local county First 5 commissions.

Encouraging participation in the Child and Adult Care Food Program, which provides subsidies for meals and snacks, is another possible strategy for improving the quality of family, friend and neighbor care (Morgan, et al., 2001). Participants receive three annual monitoring visits from their sponsoring agency. Recruitment may be a major issue: in 2001, family, friend and neighbor caregivers accounted for less than one-half of one percent of the California participants (Grubb, 2002). In addition, some research suggests that caregivers may need technical assistance to navigate the program's requirements (Henchy, 2003).

Another approach to consider may be family support, which focuses on parents and children, and could include relative caregivers as part of the extended family. One aspect would be to help parents make better-informed decisions about choosing quality child care. Parents might also be provided with strategies for interacting with caregivers, including communicating their own interest in the caregiver's training—especially in such topics as health, safety, and CPR. These models would put the responsibility for monitoring training and quality in the hands of the parents, but they also would acknowledge the legitimacy of relying on the extended family for child care.

### **Unintended Consequences of Licensing**

Any policy initiative carries with it the risk of unintended consequences. Some of the potential *negative* effects of encouraging or requiring large numbers of family, friend and neighbor caregivers to become licensed follow below:

- If large numbers of caregivers were to seek licensure simultaneously, the strain on an already overburdened system would increase. For example, more personnel would be needed for application processing and monitoring.
- Once licensed, caregivers are no longer unregulated. They are now free to care for additional children and to charge higher fees. Thus, legally, they are no longer simply a grandmother caring for a grandchild. If having a license encourages the family, friend and neighbor caregiver to operate more like a licensed caregiver, the supply of family, friend and neighbor caregivers may shrink, and parents' child care options may be reduced (Annie E. Casey, 2004; Walker, 2004.)
- Likewise, if caregivers perceive that the goal of agencies is to license them, (and change them to operate more like a licensed caregiver), they may start pulling away and may shy away from any type of support. This would effectively increase their mistrust of "the system."

There are also potential (secondary) *positive* consequences:

- If providers become licensed and take more children, the supply of available regulated child care spaces will increase (Morgan et al., 2001).

In California, regulated care is only available for 25% of children under 14 with parents in the labor force (2003 California Child Care Portfolio, California Child Care Resource & Referral Network). An option might be to support licensing only if providers intend to care for additional children.

- Licensing could provide economic benefit to the provider.
- Caregivers might be taken more seriously and treated with more respect by parents if they were licensed (First 5 Focus Group Study).
- Licensing would provide some level of regulation and compliance with basic health and safety guidelines.

Many caregivers might need help completing the licensing process. Assistance could include financial support for application fees, safety equipment, or home improvement; transportation to training sessions; language assistance; and technical assistance completing the application or clearing criminal records. The specific type of support will vary based upon the knowledge, current status, and resources of the caregiver.

## **Conclusion**

There are many options for supporting family, friend and neighbor caregivers. Focusing programmatic and fiscal attention on licensing will benefit some caregivers, but will leave many others without assistance. Research is contradictory about the value of investing in licensing initiatives. For example, turnover among subsidized family, friend and neighbor caregivers in Alameda County, California was 70% in one year (Whitebook, Phillips, Yong, Crowell, & Gerber, 2003), while other California research with caregivers who did not all participate in the subsidy system indicates a lower attrition rate: children under six had been in care for 1.4 years, on average, and almost 90% of the caregivers had no plans to stop providing care in the next year (Drake et al., 2004). In addition, many caregivers who no longer receive subsidy payments remain involved in the child's life, and therefore still benefit from the training and support they received.

We suggest that a variety of strategies would best serve the goal of enhancing the quality of care provided by family, friends, and neighbors. These strategies should be selected based on the demographics of the individual caregiver, her relationship with the child, her reasons for providing care, and her long-term goals. In the meantime, the child care field has made a great leap in embracing kith and kin caregiving. The next steps in working with these caregivers can serve to make a life-long difference for many young children.

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## **GRANDMOTHERS AS CHILD CAREGIVERS: A UNIQUE CHILD CARE ARRANGEMENT**

**kathy l. reschke & susan k. walker**

In this paper, we draw attention to grandmothers who provide child care and the parents and children they serve, by sharing the results of our study of a group of employed mothers who used grandmother care on a regular basis. These mothers were particularly challenged in finding child care and in achieving family well-being because they were functioning on limited incomes and lived in rural communities where resources and services are scarce. Although their experiences cannot represent those of all mothers who use grandmother care, they are valuable in understanding the perspective of many women with few feasible options who depend on this type of care.

The women in our research were participants in *Rural Families Speak*, a large-scale study in which more than 400 mothers in 15 states were interviewed about many aspects of family life. The goal was to assess low-income families' well-being in a post-welfare reform era. The participants were recruited through the Women, Infants, and Children Feeding Program, as well as other programs that serve families with limited resources.

For our sample, we selected 42 working women who named their own mothers as their regular child care providers. All of them were poor, with average monthly incomes of approximately \$1,000. Two thirds (28) were non-Hispanic Whites; the remainder were African American (7), Hispanic (5), Asian (1) and multi-ethnic (1), a distribution that is similar to the national breakdown of families at or below 100% of the federal poverty line (U.S. Census Bureau, 2002). Participants' ages ranged from 18 to 43, with an average of 25. Approximately four in ten (18) lived with their mothers. Most of the women were single: only 12 were married or living with a partner. On average, they had slightly under two children; two-thirds of these children were under six. Forty-five percent of the mothers had a high school diploma or GED; 19% had less than a high school education. Of the 34 women who reported an average number of work hours per week, 44% worked part-time (less than 35 hours per week); fifteen women reported that their work hours varied from week to week, and seven were working two jobs.

### **“It’s Always Mom, No Matter What”: The Practical Benefits of Grandmother Care**

Of the practical aspects of grandmother care that mothers appreciated, the most striking was flexibility. Grandmothers often provided child care during nontraditional work hours, when mothers' work schedules were unpredictable, and when children were ill. Grandmothers provided help with transportation, meals, baths, and other physical necessities. Typically, these grandmothers were only caring for their own grandchildren, so they could accommodate families' variable schedules, includ-

ing providing care during school holidays and summer or when emergencies arose. Ellie\*, the mother of two young boys, summarized it well: “Whatever time we work, she watches them.”

The physical nearness of grandmothers to their daughters added to the flexibility. Kewona’s description of coping with a common emergency—a sick child—provided an example of the unique benefit of having a co-resident grandmother: “When she’s sick and I have to go to sleep, [my daughter] sleeps with my mother because my bedroom is downstairs and my mother’s is upstairs. So to make sure she’s all right, I tell my mother to let her sleep with her.” Several other women mentioned the convenience of having their mothers living next door, down the street, or in the same town. Their proximity may have increased the degree to which mothers relied on them for most, if not all, child care needs. The only times grandmothers weren’t available to provide care was when they were working outside the home and on occasions when they were ill or otherwise physically unavailable.

Another benefit of grandmother care was financial. The provision of child care within these families is likely one of many intergenerational transfers of goods and services that is common to families with limited resources (Rossi & Rossi, 1990; Silverstein & Bengtson, 1997; Sutor, Pillemer, Keeton, & Robison, 1996). Only five participants stated that they regularly paid their mothers for child care; three others mentioned giving whatever they could, whenever they could. Some mothers said that their mothers refused payment; exchanging services, however, was acceptable. As Ivy described it, “Me and my Mom, I do her yard work and I plant her flowers and I clean her car.... I just do little things for her.”

### **“She’s My Mom and I Trust Her”: The Relational Benefits**

The psychosocial aspects of grandmother care seemed to be at least as significant to mothers as the practical characteristics. The salience of the mother-grandmother relationship emerged in several ways, but it was no more evident than when mothers talked about trust. Time and again, participants answered questions about why they liked their mothers as caregivers with global statements such as “because she is my mom and I trust her.” A few women elaborated by mentioning specific situations, such as a child’s illness, in which they could trust their mother’s judgment.

Other mothers mentioned children’s physical safety in grandmother care, especially in contrast to “strangers” or nonfamily members. Solana noted, “I don’t really trust him with anybody, so... I know that he’s always safe with her.” Hearsay influenced some mothers’ negative opinions of nonfamily child care arrangements, but a few had based their mistrust on personal experience. Chevonne explained how her son came back from a child care provider with “a footprint in the middle of his back.” When asked how she reacted, she replied, “I just never sent him back. I wanted to kill [the provider].” Chevonne asserted that “I have this really bad prob-

\*Pseudonyms are used throughout to protect participants’ confidentiality.

lem about trusting people with my kids after that. I do. I admit it. I'm just protective...." As a result, she depended on "good old Mom."

The concept of grandmothering seemed to add to the participants' satisfaction with their mothers as caregivers. Grandmothers, by definition, were expected to give extra love and support to children as well as to provide an effective substitute for working mothers. As Emiliana said, "I don't have to worry about them being unwanted there, 'cause they're always wanted there 'cause, of course, it's their grandma!" By virtue of grandmothers' positions within the family constellation and expectations for their nurturance, mothers often indicated that grandmothers were the best choice as child care providers. They also highlighted how much their trust in their mothers affected their emotional well-being as they worked outside of the home. Tansy commented, "To put it bluntly, I wouldn't be working if I didn't have her 'cause I trust nobody. If one of my kids is sick, I can go to work and feel comfortable that they're being taken care of and I couldn't do that with anybody else."

For some participants, the trust in and dependence upon their mothers for the care of their children extended to the point where mothers saw grandmothers as co-parents. Bryanne described the degree to which she relied on her mother: "I would have to say that she is my other half when it comes to parenting." Liliana explained that she had no help from her partner regarding parenting. "I do it all by myself... well, with my Mom."

Mothers also talked about the positive influence of the caregiving arrangement on intergenerational relationships. They described how the child care experience strengthened a relationship that was weak or problematic in the past, or enhanced a relationship that was already good. Almost every mother pointed to her own mother as the most important person to her and to her family. It was clear that grandmothers' instrumental support, including child care, contributed to these positive feelings. Mothers were described as having "always been there," as well as "very helpful," "dependable," and "supportive."

Participants also said that the child care strengthened ties between grandmothers and grandchildren. For instance, Ivy said of her children, "They adore my mother because she does everything I don't do for them. She gives them ice cream... she lets them get filthy.... They love her and I appreciate that she does it for me." The close relationship between grandmother and grandchild was also an important source of trust. As Summer said, "I know my kid's going to be okay because her and my Mom are best friends."

### **"There's Nothing Wrong With It But...": The Challenges of Grandmother Care**

The interviews also pointed to challenges. Some mothers struggled with parenting boundaries. Lysette provided an example:

*Well, I'm tense with my mom. I love my mom. But we just have very different opinions on things... like one day [my daughter] had to take some med-*

*icine. She's got a throat infection. I was trying to give her medicine. She hates the taste of it. I understand that. But she still had to take it. Mom's like, "She won't want it. Just don't give it to her. You're being mean to my baby." I say, "Don't do that to her when I'm trying to make her mind." It's like that just completely annihilates any authority that I have with her.*

Lysette's comments reflect her frustration with her mother's interference in her own role as parent. Yet, after she relayed this incident, Lysette reassured the interviewer about her feelings for her mother: "I love her. We don't get along all the time, but she's a big support to me." Although at times parents also experience conflict with nonrelative caregivers about caregiving practices, the mother-grandmother relationship may make such conflicts far more emotion-laden, complex, and difficult to resolve.

Large-scale studies indicate that adult daughters tend to underestimate the health limitations of their mothers, and that grandmothers continue to provide care despite these limitations (Guzman, 2003). While this was not a prominent theme among the women in our study, a few talked about significant issues relating to their mothers' health. They did not, however, voice concern about their mother's ability to care for children. For example, Liliana reported that her mother had diabetes, heart problems, high blood pressure, arthritis, and emphysema. Yet, she also reported that her mother had been the sole child care provider for her four children, all of whom were under age seven at the time of the interview. We suggest that it is the strength of the mother-daughter tie that provides the impetus for grandmothers' determination to provide child care in spite of health limitations and risks, particularly in rural low-income families with few other feasible child care options.

Another negative aspect of the relational context of grandmother care may be its effect on mothers' assessment of the caregiving. Studies of communication between mothers and their child care providers indicate that raising concerns about caregiving practices is difficult for mothers even when there is no familial relationship (Uttal, 1996). Nearly all of the women in our study made only positive, usually general, comments about their mothers as child care providers. Although it is possible that all of the grandmothers were providing excellent care, it is more likely that the mother-grandmother relationship constrained mothers from expressing any criticism or concern. Criticism in such a caregiving situation might appear ungrateful, add stress to the mother-grandmother relationship, and put the caregiving arrangement, as well as other types of support, at risk.

### **Implications for Education and Support**

Taken together, the voices of the 42 rural, low-income women in our study reflect how very important the caregiving arrangement with their mothers was to them. Mothers valued the emotional benefits of the arrangement to themselves and their children. They depended upon the practical benefits of the flexible and afford-

able child care as well. The relationship was so important that it may have prevented them from recognizing or raising concerns about the care.

Programs that offer support to families using grandmother child care need to reflect an understanding of the immense impact that the mother-grandmother relationship has on the arrangement. They should build on the strengths of the grandmothers' long-term emotional commitment to the well-being of their grandchildren by providing information about children's learning and development in this context. They should also acknowledge the depth of grandmothers' determination to provide care by providing advice about health issues and other stressors. To address some of the challenges for parents, support should focus on strategies for setting role boundaries, conflict resolution, and communication—all of which would ultimately benefit the child as well.

Opportunities should be provided for low-income families to connect to community resources and social programs that can enhance the well-being of the child and the whole family. These might include making the mother aware that relatives may be eligible for child care subsidies; introducing the mother and grandmother to free early literacy programs provided by the local library or other agencies; and facilitating the inclusion of grandmother child care providers in low-cost training and support—such as first aid and CPR classes or preparing child-friendly meals and snacks—that is offered to professional child care providers.

Millions of children in the United States are being cared for regularly by their grandmothers while their mothers are working, looking for work, or attending school. Grandmother care is particularly common among low-income rural families, such as those in our study. It is our hope that more effort will be placed on understanding, valuing, and supporting grandmother care in order to enhance the experience for children, mothers, and grandmothers, especially those under the stress of poverty.

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## LESSONS FROM THE FIELD: CULTURALLY COMPETENT SUPPORT FOR FAMILY, FRIEND AND NEIGHBOR CAREGIVERS IN SEATTLE

### **mergitu argo & hueiling chan with christina malecka**

Refugee Women's Alliance (ReWA)<sup>1</sup> has worked in the area of family, friend and neighbor care since 2004, and is already serving over 70 caregivers through workshops focused on raising children to become bicultural, CPR and safety issues, nutrition, child development, school readiness, and discipline and guidance. ReWA has twenty years of experience working with Seattle/King County's East African, West African, Southeast Asian, Chinese, Latino, Russian, and Bosnian immigrant and refugee communities. In addition to workshops for caregivers, ReWA is training a group of twelve trusted advocates from immigrant/refugee groups to be peer educators on the topic of family, friend and neighbor care. Chinese Information and Service Center (CISC)<sup>2</sup> has more than thirty years experience working with Seattle/King County's Chinese and Taiwanese immigrant community. Its program to support family, friend and neighbor caregivers started in 2001, and currently serves more than 200 caregivers and children through workshops, play groups, and multilingual tools and guidebooks. Programs are offered in Mandarin, Cantonese, Taiwanese, and Toisanese dialects, as well as in the English language.

ReWA and CISC are participating in a four-year-old initiative to support family, friend and neighbor caregivers and promote the value of kith and kin care. This Family, Friend and Neighbor Resource Network @ King County is a project of the SOAR Opportunity Fund<sup>3</sup>, a public-private partnership among local governments and corporate, private, and public foundations that supports programs that benefit King County's children and youth.

Over the past four years, we have learned valuable lessons about culturally respectful, empowering, and meaningful support and communication with caregivers. We've experienced our share of struggles: there is never enough money or staff time, and working in a multilingual context can be challenging and frustrating. Staff at both ReWA and CISC learned to be patient with low attendance in our workshops during their initial phases, and experienced some disconnect between what we wanted to teach and what caregivers wanted to learn. Yet, rather than getting bogged down by our struggles, we prefer to learn from them and persevere. It is our hope that the lessons learned through trial and error can help other programs across the country. In this paper, we highlight the nine most important factors we've found for creating a culturally inclusive support program for family, friend and neighbor caregivers.

### **Understand that Family, Friend and Neighbor Care is the Preferred Form of Care in Most of the World**

Traditionally, Chinese, Southeast Asian, African, and Latino families have

<sup>1</sup> [www.rewa.org](http://www.rewa.org) <sup>2</sup> [www.cisc-seattle.org](http://www.cisc-seattle.org) <sup>3</sup> [www.philanthropyw.org/opportunityfund](http://www.philanthropyw.org/opportunityfund)

relied on informal networks of friends and family to help with child rearing. Within immigrant communities in the U.S., nothing seems more natural or right than relying on family, friends and neighbors for many types of support, including child care. In Chinese families, grandmothers and aunts are the preferred caregivers: why send your child to be cared for by a stranger when they can spend time with a loving grandma? East Africans define family well beyond blood relationships, and it is common for them to refer to each other as “cousin,” “brother,” or even “Ma,” based on feelings of kinship rather than formal ties. Additionally, licensed child care is expensive, and the subsidy system is confusing and difficult to access. Many refugee and immigrant parents work several jobs; often their hours include nights and weekends, times rarely offered by licensed care. Most importantly, immigrant parents are deeply concerned that their children retain their home language and culture while also learning English and American traditions.

### **Start with Questions, Not Answers**

When ReWA started our family, friend and neighbor child care program, we intended to focus on development and school readiness. Yet, when we asked participants what they wanted to learn, it became clear that they desired basic information about safety and nutrition. We adjusted our curriculum to meet participants’ needs first, and as a result, we were able to lay the groundwork for later discussions about child development and school readiness.

### **View Mistakes as Learning Opportunities**

When CISC first started its program, we decided it would be best to conduct home visits with known caregivers in the Chinese immigrant community. This turned out to be a total failure! Caregivers viewed home visitors with their clipboards and checklists as “inspectors.” Some feared they would be turned in to authorities for providing child care without a license. In hindsight, we realize that not only was this culturally inappropriate within our own community, but also that just about anybody would be turned off by someone coming into their home with a checklist and an agenda for “teaching” them how to care for children. Through this debacle, we re-learned the importance of establishing relationships before doing any type of home visit.

### **Programs for Culturally Specific Communities Are Most Effective When Delivered By Members of Those Communities**

Imagine yourself an immigrant in a new country, with limited resources and no knowledge of the language or culture. Where would you turn? Most likely you would look for an organization that serves immigrants from your country or has staff who speak your language. The same goes for the communities with which ReWA and CISC work. The strength of our programs is that they are run by organizations and leaders that are embedded in the communities we serve. We know and respect the populations with which we work, because we are part of those populations.

## **Relationship-Building and Support Networks Are Key to Success**

Both ReWA and CISC have a goal to make every workshop or play group an opportunity to build community, and something that participants look forward to. We include food, fun, and informal time in our events whenever possible. One of the biggest successes for both of our programs has been the support participants have created for each other. For example, Seattle/King County's Chinese population is geographically scattered, and we were delighted to notice participants in CISC's play groups and workshops becoming resources for each other.

Because many recent immigrants are illiterate in their own language, or simply prefer verbal over written communication, translated flyers and brochures have limited usefulness. Instead, ReWA has built programs through one-on-one communication and relationships. Mergitu, for example, is a recognized leader in Seattle's East African community, and does not draw a strict boundary between her role as a ReWA employee and her role as a community leader. Because she is willing to be a visible community leader at the grocery store and at New Year's celebrations as well as in her office, she builds trust and interest in the programs ReWA has to offer.

## **Language Need Not Be a Barrier**

Neither CISC nor ReWA allows spoken language to be a barrier to empowering caregivers: there is always a way to communicate with someone, even if it is initially only through a smile, nod, or touch on the shoulder. At CISC, we offer our programs in English as well as three distinct Chinese dialects. In any given ReWA caregiver workshop, we may provide simultaneous interpretation from English to Oromo, Amharic, Cambodian, Vietnamese, Spanish, and Mandarin—and back to English again. Yes, this is chaotic, and sometimes nuances and exact wording are not precise. But learning still takes place, and relationships are formed. What is missed verbally is more than made up for in nonverbal communication that is rarely present in a group where everyone speaks the same language. Because participants must carefully observe each others' facial expressions and patiently await interpretation, powerful ties are formed across cultural and language barriers. This more than makes up for any difficulty with verbal communication.

## **Translate *Culture*, Not Just Words**

We always attempt to “translate” western ideas about how to connect with and teach children in ways that are culturally appropriate. At CISC, we've devoted hours to creating materials that present child development and school readiness concepts with respect to Chinese culture and tradition. For example, we changed the game “Simon Says” to “Grandma Says” in recognition of vertical authority structures in Chinese family relationships and the important role of grandparents in Chinese children's lives. By introducing everything we do as an opportunity to prepare children for school, we have introduced concepts of play and child development that were unfamiliar to Chinese grandparents. At first, grandparents were reluctant to get on

the floor to play with children, or to allow kids to get messy, or be sloppy. By modeling play behavior, and explaining the connection of creativity and fine motor skill development to school success, we were able to help grandparents understand the value of play.

At ReWA, we know that in Cambodia and Vietnam, it is not appropriate for parents to sit on the same level with children in play. So, we teach caregivers that children learn and get ready for school by helping with tasks like counting socks while folding laundry or identifying fruit at the grocery store. For East Africans, a more appropriate form of adult-child interaction is the transmission of oral history, so we adapt western ideas of “play to learn” as story-telling activities.

At the same time, both CISC and ReWA work to demystify western culture for caregivers, and to explain why it is that Americans do what they do. We teach the value of western concepts of play, emotional coaching, and a more demonstrative emotional and relational style, with the understanding that, like American parents, the caregivers and parents in the communities where we work love their children fiercely and want what’s best for them. This is not about replacing a traditional set of skills or values with a new set. It’s about using the best of both worlds and increasing everybody’s tools and options.

### **A Shared Goal: Bicultural Children**

We are aware of how frightening some aspects of Western culture look to immigrant parents and caregivers. Over the years, we have learned to work with caregivers’ fears and values and to help them make decisions about what will work best for the kids in their care. We recognize that immigrant parents are faced with a balancing act every day in deciding what they want their children to retain from their home culture and to acquire from this new one.

Most three- to five-year-olds who come to CISC’s play groups do not yet speak English, and playgroups are conducted in Chinese and English. We might read the same story in English and Chinese to help kids connect words, concepts, and pictures; or we might teach “Twinkle, Twinkle, Little Star” in English and Chinese. Caregivers enjoy these English lessons as well, and they increase their own confidence by encouraging kids to be bilingual.

At ReWA, we have focused on demystifying the American school system for caregivers and parents to bridge the gap between immigrant families and public schools. In many cultures, it is not appropriate for parents to play an active role in their children’s school or academic life, so immigrant families are unfamiliar with the value or purpose of the PTA or homework assistance. We share the local indicators of school readiness, like knowing the ABC’s and numbers, as well as obtaining immunizations by contextualizing them with more familiar examples.

At CISC, we share with caregivers that, while in many Asian cultures it is inappropriate for children to make direct eye-contact with adults, American teachers may perceive lack of eye contact as a sign of autism or lack of assertiveness that

could create a barrier for kids. In one ReWA workshop, when participants were reluctant to let children use scissors, a caregiver shared a story about a child being placed in special education because she could not use scissors!

### **Don't Compartmentalize Services**

People will be less receptive to child development information if their basic needs aren't met, and at ReWA, we make a point to notice when people seem upset because they are faced with barriers to survival or well-being. It is not enough to simply refer someone to a food bank. Sometimes it is important to help caregivers navigate a foreign social service system for the first time, to introduce them to families in their community who share their culture and language, or to simply lend an ear to fear or isolation.

At ReWA and CISC, we never cease to be awed by the wisdom and commitment of the caregivers with whom we work. They have taught us more in the past four years than we could ever hope to teach them.

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