

Doting On Kids:

Understanding Quality in Kith and Kin Child Care

December, 2003

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ACKNOWLEDGMENTS

We owe an enormous debt of gratitude to the grandparents, aunts, best friends and neighbors who openly shared with us what they do to support children in their care.

Many other people contributed to this study, and we are grateful to all of them. Marty Zaslow and Ivelisse Martinez-Beck provided helpful direction and insightful comments throughout the project from the design of the focus group guides to the review of the preliminary drafts. Caroline Zinsser and Kathy Modigliani participated in the initial interviews and then advised us on the focus group guide. Richard Sussman, Kerri Jones, and Caroline Jen helped organize the focus groups and recruit the participants. Rhonda Carlloss-Smith, Ann Collins, Barbara Goodson, Sarah Ocampo, Eva Marie Shivers, Gwen Stephens, and Bobbi Weber offered thoughtful interpretations of the focus groups findings.

We also want to thank Luba Lynch and Joelle-Jude Fontaine of the A.L.Mailman Foundation and Laurie Garduque of the John D. and Catherine T. MacArthur Foundation for their support of our work. In large measure, the acceptance of kith and kin care is a result of their commitment to meeting the needs of children and families.

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Executive Summary

Kith and kin child care--care provided by family, friends and neighbors who are legally exempt from regulation--is the most common form of child care for children under five whose parents are working. In the past several years, it has attracted increased attention as concerns about child care's role in preparing children for school have escalated. The quality of the care these caregivers offer to children has become a major issue for policy makers, practitioners and researchers.

What is good care in these settings where the caregivers are neither parents nor professional child care providers? What kinds of measures can be used to assess it? *Doting on Kids*, the Institute for a Child Care Continuum's study of kith and kin caregivers' perceptions of the quality of care they offer to children, explores these questions. It draws on findings from focus group discussions with caregivers across the country about their understanding of the children in their care; their interactions with them; their relationships with parents; and their views on health and safety.

The study points to some positive aspects of quality in kith and kin child care. According to caregivers' reports, the group size and adult-child ratios are low--typically one or two children in care. In addition, many caregivers described following accepted practices to keep children healthy and safe and that they use basic safety equipment. There were also indications of positive caregiver-child interactions--many reports of individual attention and physical affection, support for cognitive and language development, and opportunities for socialization. On the other hand, some findings, particularly those that related to caregivers' unrealistic expectations for children and views on discipline, raise some concerns about children's well-being in these settings.

The findings also indicate some fundamental differences between kith and kin child care and regulated child care provided in centers and family child care homes. Most of these differences are related to the special relationship that exists between the caregivers and the families for whom they provide child care. In kith and kin care, caring for children is only one aspect of a relationship that began before the child care arrangement started and will continue long after it ends. The roles of caregivers and parents are permeable and the boundaries between them fluid. As mothers, sister, friends and neighbors, these caregivers are more than child care providers, or teachers. The parents play different roles as well--sometimes as child care consumer, more often as daughter or close friend.

The study suggests several strategies for programs and practitioners to enhance positive aspects of care and to address areas of concern. In addition, it posits a new view of child care quality based on children's cumulative experience in multiple settings, and proposes measures for assessing kith and kin child care based on elements that are essential in every setting.

CHAPTER I: INTRODUCTION

Background

In the past several years, common perceptions of child care provided by family, friends and neighbors--kith and kin--have changed dramatically. Once largely overlooked by policy makers, researchers, and practitioners, kith and kin child care is now accepted as an integral part of the child care system. Several factors have contributed to this shift in attitudes. One is accumulating statistical data about reliance on family, friends and neighbors for child care arrangements. Another is increasing evidence that a significant proportion of publicly funded subsidies are expended on this type of care. The third is a rising concern about children's readiness for school, a trend that has created pressure on all types of child care to produce positive child outcomes.

The growing recognition of the role that kith and kin care plays in the child care system has stimulated wide interest in how to support these caregivers, especially how to improve the quality of care they offer to children. To address this concern, a large number of states have developed a variety of initiatives. Several new federal programs specifically identify kith and kin caregivers as a target population. The Child Care Development Fund, the federal child care program, now require states to incorporate training for kith and kin caregivers in their professional development plans.

Evaluating quality in kith and kin care presents a challenge, because these caregivers are grandmothers, aunts, close friends or neighbors of the children for whom they provide care. The parents who rely on them are their daughters, their sisters, their best friends, their next-door neighbors. Many kith and kin caregivers have little interest in child care as a career (Porter, 1998; Zinsser, 1991). Typically, they only intend to care for children who are special to them.

What is considered good child care in these settings, where the caregivers are neither parents nor professional child care providers? How does it compare to quality in child care centers or regulated family child care? What kind of measures can be used to assess it? The answers are important for policy makers, researchers and practitioners as well as the parents who entrust their children to these caregivers each day.

Definition of Kith and Kin Child Care

Kith and kin child care is care provided by family (kin), friends and neighbors (kith). It is also known as license-exempt child care or "informal child care" because providers offer child care outside the regulatory system.¹ In all 50 states, relatives who provide child care for related children in their own homes or in the caregiver's home are exempt from regulations that apply to family child care providers--child care operated as a business in the caregiver's home--or child care centers (National Child Care Information Center, 2001). Nannies or babysitters who care for children in the child's home are legally exempt as well.

¹ Kith and kin child care is not "kinship" care where the caregiver has full-time custody of the child.

Many states also exempt non-relatives who provide child care in their own homes if they comply with specific conditions. In general, these conditions are related to the number of children in care or the numbers of families whose children are in care. The regulations vary from state to state (National Child Care Information Center, 2001). In New York, for example, non-relatives who care for children in their own homes for more than 3 hours are exempt from regulation if they care for only 1 or 2 children. If they provide care for 3 or more non-related children, they must comply with regulations for family child care. California permits non-relatives to operate as license-exempt if they provide child care to children who are from the same family, irrespective of the number. If caregivers provide care to children from more than one family, they are subject to regulation as family child care providers.

When kith and kin caregivers accept publicly funded reimbursement to provide child care, additional conditions apply. The federal Child Care and Development Fund (CCDF), the largest source of public child care subsidies, requires states to set basic health and safety requirements for providers who receive state child care payments (Personal Responsibility and Work Opportunity Reconciliation Act, 1998). States must ensure that infectious diseases are prevented and controlled; that the physical premises and building are safe; that children are appropriately immunized; and that providers receive some health and safety training (Personal Responsibility and Work Opportunity Reconciliation Act, 1998).

Kith and kin caregivers who receive public subsidies may be subject to other regulations as well, if states choose to impose them. These regulations are most commonly designed to protect children from harm by the caregiver. A significant number of states require criminal background checks for both relatives (19) and non-relatives (22) (Gruber, 2003). Many require child abuse checks as well.

Review of the Literature

Research on kith and kin child care has accelerated since the passage of federal welfare reform legislation in 1996. Recent studies have examined questions that range from the use of kith and kin care and the nature of these child care arrangements to the quality of care that caregivers offer to children. These new findings, combined with the results of earlier studies, paint an increasingly detailed picture of kith and kin child care. Many questions, however, remain unanswered.

Use of Kith and Kin Child Care

Care provided by relatives and non-relatives in their own homes is the most common type of child care for children under five in the United States (Brown-Lyons, Robertson, & Layzer, 2001). It accounts for one in two child care arrangements for children in this age group. Statistics show that the proportion of children in care with relatives varies. It ranges from less than 20% in Minnesota and Florida to close to 30% in Alabama, Mississippi, and Michigan (Capizzano, Adams, & Sonenstein, 2000).

Families of all income levels rely on kith and kin child care, but it is more commonly used by poor families--those with incomes at, or below, 200% of the federal poverty level (Casper, 1997). Almost five in ten poor families rely on relatives compared to only a quarter of those

with higher incomes (Casper, 1997). Relative care is also a more common arrangement for African-American and Latino families. Approximately 46% use relatives for child care (Casper, 1997). By contrast, only 29% of European-American families turn to family members for care.

Kith and kin care also represents a significant proportion of care for many families who receive child care subsidies. In some states, it accounts for the majority of subsidized child care arrangements. For example, Connecticut reports that nearly 70% of children in subsidized child care are cared for by family, friends or neighbors (Porter & Habeeb, 2002).

Parents' Choice of Kith and Kin Care

A number of studies have examined parents' reasons for using kith and kin care. They have found that parents rely on kith and kin care for a variety of reasons. Some turn to family, friends and neighbors, because they want someone they know and trust to care for their very young children (Larner, 1994; Porter, 1991, 1998; Zinsser, 1991). Others use kith and kin care because it is flexible and fits their evening, night, weekend and shift work schedules (Anderson, Ramsburg, & Rothman, 2003; Brandon, Maher, Joesch, Battelle, & Doyle, 2002; Porter, 1998).² Still others want caregivers who share their culture and their values (Emlen, Koren, & Schultze, 1999). Cost and convenience factor in these choices as well (Emlen et al., 1999; Larner, 1994; Porter, 1991, 1998; Zinsser, 1991).

Nature of Child Care Arrangements

Several studies have looked at the nature of these child care arrangements, specifically the number and ages of children in care. The findings indicate that, on average, kith and kin caregivers provide child care for one or two children. For example, the Neighborhood Substudy of the National Study of Child Care for Low-Income Families found that kith and kin caregivers provided care for an average of two children, when all the children in care are under three (Layzer & Goodson, 2003). Studies in Illinois and Washington found that the majority of the caregivers care for only one or two children (Anderson et al., 2003; Brandon et al., 2002), while preliminary data from another study in North Carolina found a slightly higher average of three children in care (Maxwell & Kraus, 2002).

These studies indicate that most of the children in kith and kin care are under the age of two. In the Low-Income Child Care Substudy, 80% of the caregivers provided care for infants. Children under three also represented a significant proportion in Illinois and Washington. Approximately two thirds of the infants in the Illinois study spent some time in these settings; almost half of all the children in kith and kin care in Washington were infants (Anderson et al., 2003; Brandon et al., 2002). The proportion of toddlers in care was almost the same in both states--55% in Illinois and 58% in Washington state (Anderson et al., 2003; Brandon et al., 2002).

² Approximately 42% of the families who rely on kith and kin care worked non-traditional hours—evenings, nights, weekends, and shift work (Capizzano, Adams, & Sonenstein, 2000).

Characteristics of Kith and Kin Caregivers

Caregiver characteristics have also been a focus of research. Studies have examined the caregiver's age, education, ethnicity and relationship to the child. The findings indicate that relatives represent the majority of caregivers (Brown-Lyons et al., 2001). In Connecticut, eight in ten kith and kin caregivers who provided subsidized care were relatives (Porter & Habeeb, 2002). Relatives accounted for 68% of the caregivers in North Carolina and 61% of those in Illinois (Anderson et al., 2003; Maxwell & Kraus, 2002). Grandparents represent a significant proportion of relative caregivers--more than a third in Connecticut and in Washington (Brandon et al., 2002; Porter & Habeeb, 2002).

Research indicates that caregivers' ages vary widely, ranging from late teens to seventies. The Study of Family and Relative Care found an average age of 53 for relatives (Kontos, Howes, Shinn, & Galinsky (1994). Preliminary data from North Carolina are similar: on average, caregivers were 51 (Maxwell & Kraus, 2002). Caregivers in the Growing Up in Poverty (GUP) Project, a study of welfare families in three states, were younger--47, on average--as were those in Illinois--42.7 (Anderson et al., 2003; Fuller & Kagan, 2000).

Educational backgrounds of kith and kin caregivers also vary, ranging from less than a high school education to graduate degrees. The Low-Income Child Care Substudy found that only 5% of relative caregivers had an undergraduate degree, although more than a third of the caregivers had some college education (Lazyer & Goodson, 2003). In Connecticut, 4% of the European-American caregivers had an associates degree (AA), while 8% of Spanish speaking caregivers had an AA and another 8% had a bachelors degree (BA) (Porter & Habeeb, 2001). In North Carolina, 13% of caregivers had a BA and 10%, an AA (Maxwell & Kraus, 2002). Close to a third of the caregivers in Washington state had a high school degree or some college, and 15% of the caregivers had college degrees.

Several studies have found that caregiver ethnicity corresponds to that of the parents who use them for child care (Brown-Lyons et al., 2001; Porter, 1998). More than half of the caregivers in the Low-Income Child Care Substudy, for example, were African American (Lazyer & Goodson, 2003) as were 61% of caregivers in North Carolina (Maxwell & Kraus, 2002). In Connecticut, the majority of the caregivers were Latino (Porter & Habeeb, 2002).

Caregiver interests and needs have represented another research focus. The findings indicate that caregivers are interested in learning more about providing child care. The majority of caregivers in a Los Angeles survey--71%--reported that they wanted information about caring for children (Malaske-Samu, 1996) as did 87% of those in a Rhode Island study (Butler, Brigham, & Schultheiss, 1991). Several studies show that caregivers want similar kinds of information. Commonly requested topics include health and safety, nutrition, child development, discipline, the subsidy system and other services (Anderson et al., 2003; Brandon et al., 2002; Porter, 1998). Some programs in California found that caregivers want to learn about domestic violence and child abuse as well (Wills, 2002).

Caregivers' preferences about how the information is provided vary. The Rhode Island caregivers wanted support groups or other kinds of informal gatherings as did those in Illinois (Anderson et al., 2003; Butler, Brigham, & Schultheiss, 1993). Caregivers in Connecticut indicated they were most interested in receiving written materials, videos or

audiotapes and in attending workshops (Porter & Habeeb, 2002), while those in Washington wanted newsletters, a hot line and meetings with other caregivers (Brandon et al., 2002).

There is also some evidence that caregivers are interested in obtaining materials and equipment. In Connecticut, caregivers expressed interest in receiving health and safety materials, books and toys (Porter & Habeeb, 2002). Those in Washington wanted safety kits and play kits as well (Brandon et al., 2002).

Quality in Kith and Kin Child Care

A handful of studies have examined the quality of care that kith and kin caregivers offer to children. Most of them use the Family Day Care Rating Scale (FDCRS), a global measure of quality, and the Arnett Scale of Provider Sensitivity as measures. The findings show that quality in kith and kin child care, like care in other settings, ranges from poor to good.

One study--the Growing Up in Poverty (GUP) Project--found that both kith and kin care and family child care scored low on the FDCRS: 7 in 10 homes rated as poor (Fuller & Kagan, 2000). On some measures, however, kith and kin care rated higher than center or family child care. Kith and kin caregivers were more attentive to children's talk than center-based or family child care providers, and they compared equally on the Arnett measures of social interaction (Fuller & Kagan, 2000).

The Three-City Study, a study of welfare families, had similar findings. Most of the kith and kin care was rated as poor: approximately 44% scored as minimal and another 44% as inadequate (Coley, Chase-Lansdale, & Li Grining, 2001). Only 12% were rated as good. In contrast to the GUP findings, kith and kin caregivers scored slightly lower on scales of provider sensitivity than other providers (Coley, et al., 2001).

Several studies have examined discrete aspects of care in addition to global measures. For example, the Low-Income Child Care Substudy found that relative caregivers offered fewer learning activities to the children in care than family child care providers and they used more television (Layzer & Goodson, 2003) while the Family and Relative Child Care Study found that relatives were less likely to seek out training and to participate in meetings for child care professionals than regulated family child care providers (Kontos, Howes, Shinn, & Galinsky, 1995).

These studies provide valuable information about the nature of kith and kin child care arrangements as well as characteristics of the caregivers. They also provide some insights into the quality of care that kith and kin caregivers offer to children. Because the research on kith and kin care is relatively sparse compared to that on center or family child care, there are many questions that have not been explored in depth. How, if at all, do relative caregivers differ from non-relative caregivers? How does the stability of these child care arrangements compare to that in family child care or center care? What effect do subsidies have on the supply of kith and kin child care?

One of the most important questions for policy makers and researchers relates to the effectiveness of efforts to improve quality in kith and kin care. To answer these questions,

the child care field needs measures that correspond to the kind of care that is provided by grandmothers, aunts, close friends and neighbors who are legally exempt from regulation.

This study explores the issue of what quality means in these settings. The next chapter describes the purpose of the research and the methodology. The findings follow in the third chapter. The final chapter discusses implications for practice and programs. It also presents preliminary measures for an instrument to assess quality in relative care.

CHAPTER II: PURPOSE AND METHODOLOGY

Phase I: Understanding Kith and Kin Caregivers' Perceptions of Quality

This study is grounded in the Institute for a Child Care Continuum's work on kith and kin child care. The impetus for its interest was the 1996 federal welfare reform legislation. Several studies of welfare families' use of child care in the late 1980s and early 1990s had indicated that many relied on family, friends and neighbors (Brayfield, Deich, & Hofferth, 1993; Gilbert, Duerr, & Meyers, 1991; Siegal & Loman, 1991; Sonenstein & Wolfe, 1991). There was a strong likelihood that this pattern would be repeated after the new welfare legislation was implemented.

Little was known about this type of care. Information about the nature of the child care arrangements and the characteristics of the caregivers was limited.³ Nor was there much data on strategies for supporting kith and kin caregivers or those that might improve the quality of the care they offered to children.

The Institute sought to provide answers to some of these questions. Its first study, *Neighborhood Child Care: Family, Friends and Neighbors Talk about Caring for Other People's Children*, provided some insights into the challenges that kith and kin caregivers face and the kinds of support they wanted. A second study, *Lessons Learned: Strategies for Working with Kith and Kin Caregivers*, discussed the experiences of 13 local programs that used different approaches to meet caregivers' needs.

As a result of its research, the Institute began to serve as a resource for kith and kin programs that were emerging across the country. Initially, it worked with collaborations of organizations to develop efforts to support kith and kin child care in New York and California. To help them prepare staff to work with this population of providers, the Institute developed a curriculum and a 30-hour course, which it subsequently offered to organizations from many states. It also provided advice to states that sought to address issues in kith and kin care.

By 2001, the number of efforts to serve this population of caregivers had burgeoned. More than 20 states now fund initiatives for kith and kin caregivers. The strategies vary from providing materials and equipment to ensure children's health and safety to offering training through home visits, workshops and support groups to enhance caregivers' knowledge and skills. Several states have also begun to integrate kith and kin caregivers in systemic child care quality improvement efforts such as career lattices. Efforts to link caregivers to other parts of the child care system such as Head Start are also underway.

Purpose

There is a growing consensus in the child care field that existing instruments for measuring child care quality may not be appropriate for family, friend and neighbor care, because these

³ A handful of studies had examined these issues (Butler et al., 1991; Malaske-Samu, 1996; Smith, 1991).

caregivers do not regard themselves as professionals (Collins, 2000; Rice & Mabon, 2001). Global quality rating scales, such as the FDCRS, use measures that reflect standards for regulated child care settings. In some areas such as “language and reasoning” and “learning activities” scores are based on the quantity of materials that are present in the home. Other instruments, like the Arnett, that measure sensitivity and responsiveness are designed for settings in which the child care is provided through a contractual agreement with the parent. This is not the case in kith and kin child care, where the distinguishing feature is the relationship between the caregiver and the child and the caregiver and the child’s parents.

The need for a specific instrument to assess quality in kith and kin care has escalated in the past several years, largely as a result of the growing public policy emphasis on school readiness. Pressure is rising for policy makers and program operators to demonstrate that child care programs can improve children’s readiness for school, especially in terms of their language and cognitive development. At the same time, there is an increasing interest in accountability. Policy makers and program administrators are being pressed to evaluate the effectiveness of efforts to improve child care quality and their impact on children. This means that they need to evaluate quality in kith and kin care along with care in other settings.

This study, the first phase of a multi-year project on quality in kith and kin child care, focuses on kith and kin caregivers’ perceptions of quality. It is intended to provide some insight into their views of what is important about the care they offer to children. In the second phase of the project, the Institute plans to use the research findings to develop an instrument to assess kith and kin child care quality. The final phase will consist of evaluations of several publicly-funded initiatives to improve quality in kith and kin child care.

Throughout the project, the Institute has worked with several groups of child care stakeholders. One is an informal advisory committee of child care researchers, with whom it has convened meetings about the project to discuss evaluation of kith and kin child care, the study methodology, and reactions to the findings. Another is practitioners who have attended the Institute’s presentations at the National Association for the Education of Young Children (NAEYC) Annual Conferences. For the past three years, the Institute has engaged the conferees in study-related activities. The third group is an informal network of kith and kin programs, which have provided advice on the research issues and interpretation of the findings.

Methodology

Designing The Focus Group Guide

We used focus group discussions to gather our data, because this kind of quasi-ethnographic research reveals themes for further analysis. Initial questions for the discussion guide were proposed by child care researchers at a meeting in October, 2001. Later that fall, we asked participants at our NAEYC conference presentation to engage in the same task. We integrated both sets of questions into an interview protocol, which we tested with nine respondents that December.

Based on the interview results, we converted the questions into a focus group guide that we shared with several child care experts. In February 2002, we pre-tested the guide with 14 kith

and kin caregivers in a discussion in Yonkers, New York. The results pointed to the need to eliminate some questions and to modify the wording in others.

The Formal Focus Group Discussions

During April 2002, we conducted ten formal focus groups: four in Hartford, Connecticut and six in southern California (three in Bakersfield and three in Los Angeles). Several criteria were used to screen participants: the caregiver must have been providing care that was exempt from licensing; she must have been providing care for a minimum of 15 hours a week; and she had to be a relative, friend or neighbor of the child's parents.

Four of the focus group discussions were conducted with Latino caregivers (two with monolingual Spanish speakers and two with bilingual Spanish speakers), three with African Americans, and one each respectively with European Americans, Cantonese-speaking Chinese caregivers, and Armenian-speaking caregivers. Three of the groups included only relative caregivers.

Four organizations--Rambuh House and La Casa de Puerto Rico in Hartford, Community Connections in Bakersfield, and Child and Family Services in Los Angeles--hosted the discussions. Each provided child care as well as meals for the adults and the children. Participants were asked for permission to audiotape the discussion after they were assured that the information they provided would be confidential. They also received a \$25 cash honorarium.

Analysis of the Data

During July and August the English and bilingual audiotapes were transcribed as were the two monolingual Spanish tapes and the Cantonese tape, which were translated into English. The tape from the Armenian group was neither translated nor transcribed because there were only three participants. The transcripts were supplemented by observers' notes of the discussions. Three reviewers coded the transcripts independently to identify themes.

Characteristics of the Participants

A total of 67 caregivers participated in the focus groups.⁴ Data are available for 64 of them. Nearly three quarters were relatives of the children in care. Of the relatives, half were grandmothers. The others were aunts (36%) or other relatives such as cousins, grandfathers and great aunts. Most of the remaining caregivers indicated that they were friends of the parents. Two caregivers identified themselves as neighbors.

Of the 64 caregivers, 45 reported information about the composition of their household. One-third were married, one-third were the single head of the household, and the remaining third lived with another adult, including parents, siblings and live-in partners. Sixty-two

⁴ The Armenians were not counted in the sample because there were only three caregivers in the group. Two other caregivers, a bus driver and a grandfather, had not cared for children in more than two years. They were also excluded from the sample.

percent of the focus group participants had children of their own who lived with them. The average number was two, ranging in age from infants to 18 years old.

We did not ask the participants about their educational levels or their child care training and experience, but some revealed this information in the discussions. Several caregivers, particularly those in the bilingual Spanish focus groups, had completed some college. One young woman was enrolled in an early childhood program at a local community college. Some women talked about their experience volunteering with children in school; others mentioned that they had explored the possibility of becoming regulated family child care providers.

The focus groups were conducted in low-income neighborhoods, because many of the families who rely on these arrangements are poor or working class. Some caregivers told us that they had worked at low-wage jobs before they started to take care of their grandchildren or their nieces and nephews. Most did not have a second job, although one caregiver reported that she was working the night shift. A significant number depended on payments from the subsidies that their children, their siblings or their friends received for child care.

Nature of the Child Care Arrangements

Together, the participants in the focus groups provided child care for a combined total of 140 children, an average of two children in care. Children under five were the largest age group: they accounted for a little over half of the total. Two thirds of the children in this age group were under two. School-age children, those five and older, represented 46% of the sample. The smallest age group was preschoolers, those between the ages of three and five.

Nine children were living with their caregiver. Eight children shared the caregiver's household with their parents in "doubled up" situations. The exception was a child who was in her grandmother's custody. The caregivers reported that seven children had special needs, most of which were Attention Deficit Hyperactivity Disorder (ADHD) or asthma. Based on other comments, however, it is likely that there were more children with disabilities.

Of the 64 caregivers, 49 provided clear information about the child care schedules. Three in four cared for children during odd hours--before 8 a.m. or after 5 p.m. Five provided child care on the weekends, primarily for one day. Fewer than half of the caregivers--25 of the 64--reported that they were paid to provide child care. Nearly two thirds of them were paid through the parents' child care subsidies. The remainder received payment from parents.

CHAPTER III: FINDINGS

We did not ask specific questions about child care quality in the focus group discussion guide, because we were concerned that caregivers might provide socially acceptable answers about what was important for any child's development. Instead, the focus group questions were intended to elicit responses about caregivers' understanding of the children in their care and their interactions with them. The guide also included questions about caregivers' relationships with parents. In addition, there were questions about health and safety, because these areas are a major concern for policy makers, practitioners and researchers. (Please see Appendix: Focus Group Discussion Guide.)

A variety of themes emerged from the discussions. Initially we aggregated them into eight categories: caregiver characteristics; caregiver-child relationships and interactions; activities; caregiver-parent relationships and interactions; environment; safety; health; and children with special needs. When we reviewed the data, we collapsed several categories to sharpen the focus on interactions between the child and the caregiver. This process enabled us to focus on caregiver practice rather than environmental features like materials or health and safety equipment. The resulting categories are: caregiver knowledge and dispositions; caregiver-child interactions; caregiver-parent interactions; interactions between children in care; and health and safety.

Caregiver Knowledge and Dispositions

We began the focus group discussions with questions about how the child care arrangements started, although kith and kin caregivers' motivation for providing care has been well documented (Anderson et al., 2003; Porter, 1998; Zinsser, 1991). Most of the caregivers' responses parallel findings from other studies. For some caregivers, relatives as well as friends, the child care arrangements began casually as occasional babysitting and grew into something more permanent.⁵

[My sister] pretty much started out by asking if I can kind of substitute and do what she can't do, would be there to help even when she is there. And it kind of turned into, "Annie, I need to go here and I need to go here, and you stay with Casey." So, that's how it happened. And then, it just turned into an every day, all-day thing when she got a job. (An aunt caring for an infant)

Grandparents often offered to take care of their grandchildren. Sometimes they started to provide child care when the children were only a few weeks old. Some grandparents said that they didn't want their grandbabies with anyone else; others said that their daughters or sons did not want anyone but family to care for their children.

I had an opportunity to work at Wells Fargo, but I chose my grandbaby . . . I don't want a stranger raising my grandbaby, because nobody is going to love that baby like me. (A grandmother caring for an infant)

⁵ We have changed the names of the caregivers and the children to protect their confidentiality.

My daughter says that it's better if your own people care for the children. (A grandfather caring for a preschooler)

Most of the caregivers did not talk about payment as the reason they provided child care. For some, however, the availability of public child care subsidies meant that they could take care of these children. Otherwise, they would have had to earn money somewhere else. For others, the child care payment allowed them to stay home with their own children.

Well, I've been watching her ever since she has been born up until her mom was on the waiting list of Community Connections. I watched her on my own. So she was already signed up for the [day care voucher], so she said, well, she would just sign me up. (A grandmother caring for her 2½-year-old granddaughter)

If it wasn't for [the child care payment program], I wouldn't be able to do that for my daughter, because I have to work. [She] had her children in day care, not really scare stories, but there were some issues. And if the children were sick or had a temperature of so much, she had to take off work. And when she said, "Mom, you could do this and get paid," Mom thought it was a big drop in pay, but in the end, we figured out that we were able to do it, and it's worth it. (A grandmother caring for a 6-month-old)

I wanted to stay home with my daughter, so it was good because I was getting paid and I was taking care of my daughter, too. (An aunt caring for a 5-year-old)

Attitudes Toward Child Care

Many caregivers talked about how much they enjoyed being with the children for whom they provided child care. For grandmothers, caring for a grandbaby was something special. As one grandmother said,

We dote on these babies. My whole point is that we adore them Now I'm a grandmother. I sit down and enjoy it It's just different, it's calmer. I don't love [my granddaughter] more than [my daughter], it's a different love, it's freer. When you're a mother, you're so worried that you're going to do something wrong and you have to watch it, you have to be disciplined. But when you're a grandma, it's just freer. Good mothers graduate to blessed grandmothers. You know, it's like our reward.

The caregivers' faces lit up and their voices became animated when they described how they laughed when the children did something that was funny; how excited they felt when the children did something new; how much fun it was to play together. These kinds of responses cut across relatives and non-relatives.

And I am, like, so excited to do whatever I can with her. And I think I was more happy the first day she smiled and sat up and stood in the middle of the room by herself, you know, and I would, just, [it's] crazy. (An aunt caring for an infant)

She is real funny. If she hears me, she dances and she twists her little stuff around. She just do girl things, you know, to make you laugh, and it's real funny. (A grandmother caring for a 2-year-old)

They were watching the movie, then her and my daughter, they both started dancing, and then they were fighting because they both want to be Barbie. So, I just have to laugh. I have fun with that. [It was] fun for me, and fun for them. (From an aunt caring for a 5-year-old)

Some caregivers, family as well as friends, simply talked about how they liked being with children. A small minority did not express these kinds of sentiments. They did not seem to like caring for children, or even to like children very much.

They like to be at my house. I don't know why. I can't explain it to you. I play with the kids . . . I'm like a big old kid, you know, so they like to be at my house. (An aunt caring for her 2-year-old nephew)

Question: What's the most enjoyable part of taking care of other people's children?
Answer: They go home early. They don't mess up too much. (An aunt caring for 14-month-old twins)

That's another thing I don't like about [her]. When she's eating something, and she don't like it, I tell her, "Go put it in the [garbage can], not on the floor." . . . She does it because I don't like it. I go, "Who teach you that?" Oh, my God, she is the worst. (A grandmother caring for her 2-year-old granddaughter)

Understanding of Child Development

As the caregivers talked about their care for these children, they often revealed their understanding of child development. Some caregivers had appropriate expectations for the children. They were aware of the child's developmental stage and how to respond to it.

When you put a routine in there, they know what to expect and it makes happy babies . . . Children have got to have that stability. (A grandmother caring for an infant)

I sit on the floor. I play their ABC's with them, play with the bar rolling. Their thing right now is they like to tumble. (An aunt caring for 14-month-old twins)

They learn by rhythm, a rhythm to the music and all that. (An aunt caring for a 2-year-old)

He scribbles and he doesn't talk, doesn't say a lot of words, but he understands everything you are saying. He went to the drawer and he got some little scissors out. My daughter said, "Mom, he's got the scissors!" And she is like freaking out. I said, "I know. Those are his." She said, "You let him cut?" I said, "Well, he is learning. And he colors and he paints and he does everything. That's how he learns." (A grandmother caring for a preschooler)

One grandmother was caring for her 6-year-old grandson, who had been diagnosed with ADHD. She seemed to understand his problems.

He is a hyper kid. A hyper kid moves all the time and he can't be still. That's how come he don't sit and look at TV. You might see him here now, and if you turn your head and close your eyes, he might be way over yonder, turning the water on. Hoot and holler, that is helping him none. That's harming *your* body [emphasis by caregiver]. So you can't do nothing about it.

Other caregivers reported what the children were doing without any apparent awareness of how their activities related to their development. They did not seem to know what could be expected at different stages. This lack of understanding applied primarily to socio-emotional development for infants and toddlers, but there was an example about a preschooler as well.

He calls me whenever she [her daughter, the baby's mother] don't get up in time to make that bottle. And I ask her what happened to him, and he looked at her, like you know, . . . sniffing like she beat the stink out of him. And he would get in my arms and he get to laughing at her, just teasing at her, so I could just fuss at her. He is doing it for attention, just attention to get his momma in trouble. (A grandmother caring for an 8-month-old)

Like you take a toy and wind it up, and it [the crying] just keeps going So what I do is, I walk away, and I say, "Okay. You're not hungry. You're not wet. Give me this little toy if you don't want it." You got to walk away and let him cry. (A friend caring for a 10-month-old)

So, most of the time, the only way I get to entertain her and teach her things is by putting Barney on or whatever. But those videos don't last long enough She's a one-year-old, all she wants to do is eat the box. (An aunt caring for an 11-month-old)

My granddaughter is uncontrollable And I have had one heck of a time straightening that out She still lies, and she's wetting her pants four and five times a day, and she's three. But now, it's yes ma'am, no ma'am. (A grandmother caring for a 3-year-old)

Awareness of Child's Emotional State

Some of the caregivers talked about how they responded to children who were unhappy, withdrawn or angry. These situations were often related to what was happening at home--a pending divorce or a visitation from a parent. When the caregivers talked about these times, they often described their own confusion about how to respond.

[Sometimes] he didn't want his momma touching him, he didn't want nobody touching him. So he has moods. (A grandmother caring for an 8-month-old)

Because [her father] is gone now, and . . . that hurt her a lot . . . For me, when she talks about her father, she misses him. I don't even know what to say because, for me, I don't think he's coming back, he's out of the U.S., he went to Puerto Rico and it's very tough. (An aunt caring for a 5-year-old)

His parents are going through a divorce. He wants to live with his dad, he wants to be with his dad . . . "I know what you feel: you can talk to me." So he started to talk to me . . . he said he didn't think that anybody loved him. (A grandmother caring for her 6-year-old grandson)

Sunday, they came back from seeing their father, because he got out of prison two weeks ago and he has restricted visitations. The youngest one, his father has been in and out of prison for the last four years of his life. And he doesn't take it very well. When he comes back, he is worse than when he left. He feels that he can do whatever he wants when he goes to visitations. So he comes back too upset and then he upsets me and then I get angry and so, I don't mean to take it out on him, because I don't understand, but sometimes I snap. I take it out on him, and then a bit later I feel guilty so I go apologize and try to explain, but trying to explain something to him is very difficult, because he thinks what he says, he's right, there is no other answer. (An aunt caring for her 5½-year-old nephew)

Caregiver-Child Interactions

Love, Special Relationship, Physical Nurturing

Many caregivers, especially grandmothers and aunts, talked about their love for the children in their care and the special relationship they share. Most expressed deep feelings of love and attachment to the children. The caregivers also talked about how much the children seemed to enjoy being with them. This reciprocity was especially strong between grandmothers and their grandchildren as well as aunts and their nieces and nephews.

She is the only niece in town. She gets love and attention from me as if she were my own child. (An aunt caring for her 11-month-old niece)

He just loves me, just loves being in my house. He sees me, his eyes light up and he runs and just jumps in my arms. (A grandmother caring for her 2½-year-old grandson)

In my house, she is like another kid. For my husband, she is like another daughter . . . She finds a family love in my house. (An aunt caring for her 5-year-old niece)

Even friends and neighbors expressed very strong attachments to the children and their parents.

She knows that we love her so she likes to be with us. The parents know about the attachment, so they are assured when we take care of the children. (A friend caring for a 3-year-old)

Interviewer: The treatment. Which is what?

Caregiver: A lot of love.

Interviewer: Mucho amore, is that what I heard you say, mucho amore. . . .

Caregiver: Muchos besos (many kisses). (A neighbor caring for a 3-year-old)

There were many reports of physical nurturing such as holding, rocking, kissing and hugging, especially with infants and toddlers. Some caregivers simply described these interactions, but others talked about their own enjoyment in the children's responses to them.

She has so much fun with me, and she gets rocked, you know. I've got grandma's old-fashioned rocking chair at my house, and I *get* [emphasis added] to rock her. (An aunt caring for an infant)

Kiss him. Cuddle him. Because as soon as he gets in there, the first thing he does is run to [me]. (A friend caring for an infant)

He will dance and I tickle his knee because he looks so cute. I just want to hug him and give him a kiss and a squeeze. And he is hugging you and smiling, you know he is happy, too. (A friend caring for a 21-month-old)

Supporting Language and Literacy Development

Singing with children and talking to them was a common theme in the focus groups. Caregivers said that they sang and cooed to infants and had conversations with toddlers, answering their questions and repeating words to model correct pronunciation.

He will start to play patty-cake and he will sing, we sing songs together. (A grandmother caring for an 8-month-old)

I'll sit him in his car seat thing in the kitchen while I'm cooking dinner and talk to him. (A grandmother caring for an infant)

She likes it when aunt tells her stories. (An aunt caring for a toddler)

I teach him, he goes "twuck, twuck," and I say "truck." (A grandmother caring for a toddler)

I draw the house, and I make her a door, and I say, "Here is the window," and I will make a chimney for the smoke to come out. And I will say, "Here is the tree." She says, "I don't want no tree." (An aunt caring for a preschooler)

Reading to and with children seems to play a large part in daily caregiver-child interactions. Across all groups and ages of children, caregivers reported having books in the home and reading as a regular activity.

The last three shelves are full of her books. [Before her nap] I always pick a good book that is more than just pictures and hold it in front of her and she can look at the pictures while I read the words. (An aunt caring for an infant)

I read to them. I said, “Yes, a doggie, and this is what the doggie do.” (A friend caring for a toddler)

[He says] “The boy went to the store. The boy seen the man.” He is making believe that he is reading it, he is putting his own stuff in it. Boy, they have some good imagination. (A grandmother describing her school-age grandson reading a Bible story)

Besides reading, many caregivers mentioned writing activities.

They are learning how to write their name right now. And the ABCs. (A friend caring for twin preschoolers)

Sometimes I teach her how to write Chinese characters, and she seems to really like it. (A grandmother caring for a school-age child)

Homework

Some of the caregivers spoke about supporting the children’s school work. African American and Latina caregivers, in particular, talked about helping preschoolers and school-age children with their homework, and making sure the assignments were completed. A typical example came from a friend who is caring for a 7-year-old:

I help him with his homework and then after he is done I check it and I tell him what he did wrong, I explain it to him, and he understands it. It is important for them to improve in the school, to make better in the school. I think that is the most important thing.

Other Activities

Besides reading, writing, and doing homework, caregivers describe a variety of other learning experiences that support cognitive and socio-emotional development. Some caregivers talked about the role they play as teachers in these activities, especially for children under five.

The descriptions of these interactions provide some insight into the kinds of materials the caregivers have at home for children. Most of the caregivers simply talked about “toys,” but there are mentions of busy boxes, rattles and mirrors for infants; crayons, finger puppets, toy cars and trucks, legos, pull toys and pretend toys for toddlers; dress-up clothes, paints and computers for preschoolers. In the discussions, no one talked about blocks or materials that could be used to make music. Nor was there much discussion about outdoor toys other than bikes or scooters.

With infants:

I was teaching him words—eyes and nose and hands and feet, things like that to let him get real knowledge. (A grandmother caring for an 8-month-old)

We do the little square things. We have got the snail that has the shapes and we are teaching her “open, close” and we are teaching her peek-a-boo. (A grandmother caring for a 9-month-old)

I take him outside so he can see the trees. (A grandmother caring for an infant)

With toddlers:

I teach her the alphabet, numbers and rhymes. I play with her. (A friend caring for a 2-year-old)

I take her out and we go for a little walk on the porch and we feed the birds. (A great-aunt caring for a 19-month-old)

With preschoolers:

Sometimes, I teach them things, like social rules. (A friend caring for a preschooler)

We have got two puppies and fish and all kinds of animals, and twice a week we go to a parent center at my kids’ school where we sit and we have story time and activity time and art time. (An aunt caring for a preschooler)

They help cook, they sort clothes. They actually help make the beds, clean. (A grandmother caring for a 2½-year-old and a 6-year-old)

With school-age children:

[She] realized that the bell pepper had seeds, so we dried them out, and we took them out and [planted them] and we are watching and hoping and praying. (A grandmother caring for a 6-year-old)

I stand there at the door and watch them walk in and pay [the cable TV bill], get the change and the receipt, and they walk back. (An aunt caring for a 7-year-old, a 5-year-old, and a 3-year-old)

Television

Television and video games were a presence in the homes of many caregivers.

Grandmothers, aunts, friends and neighbors all talked about children watching educational programs, cartoons and videos as well as about older children playing video games. In most cases the children were preschoolers, although there were occasional references to infants and toddlers and TV. Most of the caregivers who were watching school-age children did not allow them to watch television until they had finished their homework.

She watches Dora the Explorer. She has a backpack, she has lots of toys, and every time she goes and grabs her backpack and puts a lot of things inside and she says she has the same things as Dora. And we play a lot. (A grandmother caring for a toddler)

They were watching the movie, *The Nutcracker*, and then her and my daughter, they both started dancing. (An aunt caring for a 5-year-old)

The kids are not allowed to play Nintendo at home all the time at their house because their parents say they will waste electricity. I let them play as much as they want. (A friend caring for a school-age child)

Discipline

Caregivers described a wide range of disciplinary styles and practices from permissive, to authoritative and proactive, to harsh and punitive. The permissive caregivers seemed to lack strategies for behavior management (Baumrind, 1966), as the following example illustrates:

I have to give it to her [when the child screams for something]. And they [the parents] tell me, “No, no, you are not supposed to give her whatever she wants.” (A grandmother caring for a 2-year-old)

I pick up after they go home. I let them make the biggest mess . . . I let them just tear things apart. So then they go to sleep and I pack it all up. (An aunt caring for a 2-year-old)

Caregivers who exhibited a learned or intuitive understanding of child development were able to set reasonable and appropriate limits and to use proactive strategies to prevent behavioral problems.

I train them from an early age . . . you put all these toys there, there is times to “clean it up.” [Caregiver sings a “clean up song” that the child learned in preschool.] (A friend caring for a 2-year-old and an 18-month-old)

I just keep him close to me; I have to. I had to rearrange everything. So I put the couches in front of all the plugs and things that he can’t get to. (An aunt caring for a toddler)

If they hit or something I say, “No, no, don’t do that.” I talk to him . . . If they go out and do something that I know is wrong, “Come in here.” Or, “Go in that bedroom and lay down.” You know, don’t hit them, just make them stop doing things. (A grandmother caring for a school-age child)

Still other caregivers were very forthright in reporting their uses of authoritarian, harsh discipline, including physical punishment.

I am not going to stand here and tell them 50 times to do what I told them to do, and they are not going to mind me. So, they do five to six trips to time-out every day. (A grandmother caring for a 3-year-old and a 4-month-old)

Well, you see, I’m the grandma that would beat the kids so I don’t have any problems with the kids . . . When they go to other people’s houses . . . they know they’d better not touch that. Because they touch that, the next thing they might be on the wall a little bit. (A grandmother caring for a 2-year-old)

See, I punish him. I'm not afraid of using the paddle. (An aunt caring for a 5½-year-old)

Child-Child Relationships and Interactions

Children of Provider and Other Children in the Provider's Household

Most of the interactions between the child in care and children in the caregiver's household were with the caregiver's own child or children. These children were generally older. One caregiver was caring for a friend's 4-year-old twins. She said,

One is 16 and one is 12 and they act like they are 5 years old . . . They like to play with them . . . since the 16-year-old is like a movie fanatic, they will sit with her sometimes . . . You know, everything that is going on in the house they want to be a part of, whether it's my older brother that is there . . . they are really like, I don't know how to say, they interact with everyone in the house. (A friend caring for 4-year-old twins)

Another caregiver described her 14-year-old son's relationship with the 12-year-old boy, the son of a friend, for whom she cares:

My son is 14 years old. He likes to play with him outside. My son likes to play skateboard. And Joseph has learned how to play skateboard . . . But he loves to play with my son . . . And my son tries to help him. And they are good, good friends. And Joseph says he is my big brother.

Caregivers reported that their children or other children in the household often played an older sibling role to the children in care. One talked about the surrogate caregiver role played by her older children:

My 14-year-old and my 15-year-old will be there all the time, she will go walking with him or something like that. And my 17-year-old, you know, they will take him and just go walking with him up and down the street and he likes that. (An aunt caring for her 14-month-old niece and 10-year-old nephew)

Several caregivers described relationships between their own children of a similar age and the child for whom they were caring.

She likes it because she is always with my daughter so they are very, very close and they go to places with my daughter and they watch Disney movies . . . They go play and sometimes they are so tired they take a nap and then I give her a shower. They like to take a shower together. They play in the bathroom . . . She is an only child, too, and my daughter is the only kid in the household. When they get together, they are more like sisters than cousins. (An aunt caring for her 5-year-old niece)

Neighborhood Children

A few caregivers described interactions between the children in their care and neighborhood children.

He's making friends where, you know, the neighborhood that I'm in is a cul-de-sac and so we have got all kinds of kids. And they get to go out, they get to play. (An aunt caring for her nieces and nephews)

So, usually the other neighborhood kids would be there and they are always holding him, he is going from arm to arm and, you know, they will put him in the stroller and go push him around the corner and go walk with him. (An aunt caring for her 14-month-old nephew)

Caregiver-Parent Interactions

The category of caregiver-parent interactions is not usually found in assessments of child care quality. We include it because the relationship between the parent (or legal guardian of the child) and the caregiver is what distinguishes kith and kin care from all other types of child care. Because of the preexisting and often close personal relationships between mothers and their daughters, sisters and their siblings, close friends and neighbors, issues arise not only around child care, but also around the interpersonal relationships of the adults.

In the focus groups, “kin” took many forms. There were mothers and mothers-in-law, sisters and sisters-in-law, great-aunts and cousins. Among “kith,” some friends had known each other since childhood; others had taken care of the children’s parents when they themselves were young. Still others had met the parents through their school or work and had become friends. Neighbors often lived on the same street or several minutes away.

Frequency of Communication

Most of the caregivers reported that they have frequent communication with the parents. They share information about the child’s day at drop-off and pick-up time, and also via phone calls during the day and in the evenings after the child has gone home. Frequency of contacts ranged from “she calls me like twenty times a day,” to “she is calling me two or three times a day,” to “every day” (at pick-up and drop off) to “almost every day.” Only one neighbor said, “She just picked up the kids and she was gone and that was it.”

Content of Communication

Caregivers and parents share information about the child’s daily activities and behavior. These conversations are often casual and informal.

She’s my sister-in-law, so we don’t have no problems at all. We talk all the time. We get along pretty good. (An aunt caring for a 5-year-old)

She asks everything. She say, “How is Carmen? She is crying?” And we talk about that. (A great-aunt caring for a toddler)

For neighbors, there is some wariness, a concern about making sure that parents know what has occurred during the day. One neighbor talked about recording the child's activities to protect herself from misunderstandings.

Now when I start to take care of any kids, I write everything, every day If something happen [sic], when the mother comes to my house, she needs to sign. (A neighbor caring for a 6-year-old)

Another neighbor who was caring for an infant described an exchange of important information:

She gave me emergency numbers, a whole bunch of them. She is a good mother, very responsible. She brought her with fever sometimes. She told me how to give the medicine, how much. (A neighbor caring for an infant)

Many caregivers advised the parents about child rearing. In most cases, this advice came from grandmothers, who were caring for their daughter's children.

That's one thing I'm trying to teach my daughter. When she had the baby at three weeks I was trying to tell her that you have to have a routine with the baby. (A grandmother caring for a 9-month-old)

I keep my grandbaby healthy by teaching my daughter. Like with the baby food, if you look on the back of the plums at what's in it, it's absolutely nothing. But on this other one you have got 45% Vitamin C. (A grandmother caring for a toddler and an infant)

He [her son] will holler at them, and I'll say, "Matthew, don't you holler at them kids. You just go outside." (A grandmother caring for a 2-year-old)

Relationships

One of our questions was how the child care arrangement affected relationships between the caregiver and the parent. Many mothers or sisters said that nothing had changed in their relationship. They had always been close, and they still were. Other relatives--mostly sisters who were caring for their brothers' children--said that they had never gotten along. Even though the situation hadn't changed, they said that it did not affect their relationship with the child.

Things don't change. You don't get no closer, you are already close. (A grandmother caring for a 6-year-old)

It hasn't changed, it's almost the same, because we kind of grew up together. (A cousin caring for a school-age child)

I love him, I respect him, that's my brother . . . I mean he loves his kids, takes care of his kids, but it's just like him as an individual, we just never got along. [But] around the kids, we are fine. (An aunt caring for 14-month-old twins)

Some caregivers, relatives and friends alike, reported that they have become closer to the parent since the arrangement started.

[Our relationship] got closer . . . I guess because she is trusting me with her kids, you know, them are her babies. (A sister caring for her 14-month-old nephew)

My relationship has grown. It's becoming like family almost, and I know that she trusts leaving her kids with me and she can depend on me and she knows that I will try to be there when she needs me. So, we have become really, really close . . . Her sisters and we are getting to know each other's families more . . . So they're part of my family now. (A friend caring for twin preschoolers)

Conflicts

Some caregivers reported occasional conflicts with parents. The most common cause was discipline. Mothers disagreed with their daughters or sons; sisters had different attitudes than their sisters or brothers. Most of the time the caregivers said that they are stricter with children than the parents are.

She will let him do anything, and that's why he do what he do at my house. (An aunt caring for a 2-year-old)

When [the child] comes back at the end of the day [from visitation at his father's house] he feels he can do what he wants because his dad lets him. And it upsets me that his probation officer should make him go by what my house rules are. But he just figures, "Well, my dad lets me do what I want, so you should let me do what I want." (An aunt caring for a 5½-year-old)

In many cases, these caregivers, especially if they are siblings, simply let disagreements over discipline go.

We both discipline him different. I think that's kind of sometimes our problems by me being the oldest, and I'll be telling her, you know, my kids is almost grown . . . So we do have a little problems about that. But we always get it straight, we never really have no conflict about it. (An aunt caring for a 14-month-old)

Others try to work things out. One caregiver, who is caring for her 11-month old niece, talked about her sister's reaction to the way she had tried to comfort the baby who was fussy after a trip to the pediatrician for her immunizations.

My sister and I had a horrible fight . . . I said, "Okay, fine, screw you, put her in day care, I'm not doing this." My sister is my best friend, and my best friend is more important to me than \$400 a month.

Then they developed a way of resolving their differences.

When we're sitting here doing family things or it's mom's birthday, we are not discussing baby-sitting issues. If you need to discuss baby-sitting issues with me, you come before you have to go to work or you stay a little later and talk to me. "When I have [the child] we're on the clock and you are not my sister, you are my business partner and she is not my niece, she is the child I care for. And when we're at a family gathering we're sisters, we're best friends." And it just worked incredibly well. We have learned to separate the lines real quick.

A neighbor confronted a conflict with the parent head-on:

It seemed like she thought I wasn't feeding [the infant], that I didn't want to feed her. So we sat down and we spoke and I said, "You make me feel bad because you are making me think that you don't believe that I'm trying to make her eat." (A neighbor caring for an infant)

Attitudes Toward Parents

Many caregivers expressed empathy with the parents' situations. A large number were parents themselves and they understood parents' desires for a safe and loving environment for their children. They also expressed compassion for the parents' situations of having to work in order to provide for their children.

Most of these statements came from friends or neighbors. One neighbor, who was caring for an infant said, "Shanika's mother used to pay me \$60 a week. I understand that, because she wasn't making enough." Relatives sometimes expressed these views as well. As one grandmother caring for a toddler said, "I treat them very good so the mother will feel better because I know, I used to go to work and leave my girl with day care. I used to go crying."

Several caregivers talked about the emotional benefits that their relationships with the parents provided for them. One neighbor said, "When I was going through a rough time, she . . . supported me good and always talked to me. She made me feel positive all the time. I needed that." Some relatives saw the child care as a way of receiving reciprocal treatment. As one grandfather said, "If I help them take care of their children, they will certainly treat me better."

A few caregivers expressed negative attitudes toward parents. In most cases, these statements came from relatives. Some were critical of the way the parents cared for the kids. In some cases, this criticism was implicit; in others, it was clearly stated.

I told the mother about [the baby's constipation] and the mother didn't do nothing. To me she really don't know how to handle that baby. (A great-aunt caring for a 1-month-old)

My sister is crazy. (An aunt caring for an infant)

Others were angry at the way they were treated. Mothers felt they weren't treated with respect or that their children took advantage of them. One mother complained that her daughter-in-law expected too much from her:

She wants her own freedom. Me and my son have to do everything for her children. Everything. Cook, clean, whatever. Don't even give me no respect, or she don't have no sympathy. (A grandmother caring for a 2-year-old)

Sisters complained that their siblings did not pick up their nieces and nephews when they said they would, for example:

She would drop him off and then she don't come back until the different times or whatever. Then she will call you up and [I] say, "No, no, you have business trying to run for somebody, you run over here and get your kids."

Health

Nutrition

When we asked caregivers about how they keep the child in their care healthy, most caregivers talked about nutrition. They stressed the importance of ensuring children ate healthy foods.

Cook meals. Because I don't give junk food . . . like Snapple, cheese . . . [I feed him] yogurt and stuff like that. I don't buy cookies with frosting and . . . graham crackers. I . . . buy Ritz with no salt on the top and stuff like that. I believe in good, you know, that kind of food. (A great-aunt caring for a 19-month-old)

They thought that McDonald's, Burger King and Taco Bell were part of the seven basic food groups. And they came to my house and they are eating broccoli and they went, "What's this?" I said, "It's broccoli." "What's that?" . . . "What is your favorite dinner?" "Macaroni and cheese." Well, that wasn't because it was their favorite, that's because that's all they ate. (An aunt caring for her nieces and nephews)

The Latina caregivers especially stressed the importance of nutrition. Several caregivers mentioned the importance of "good eating habits" and "giving [children] the right kind of food." They talked about the importance of ensuring children were well-fed.

I kind of insist that she eats . . . I say, "No, no, you don't even go outside. You have to eat a few mouthfuls of it." (A friend caring for a 4-year-old)

Health Practices

Many caregivers described similar practices for keeping children clean: they washed their hands; they changed diapers; they bathed them. They also taught children about how to keep themselves healthy--how to wash their hands and brush their teeth. Others talked about ensuring that the children were dressed appropriately for the weather or making sure that

they had enough sleep. A few caregivers talked about keeping their own homes clean to keep children healthy.

I make sure that everybody gets bathed and I clean their clothes afterwards but, yes, everything is kept sanitized and everything is kept clean. (An aunt caring for a 7-, 5-, and 3-year-old)

When it gets cold, I give them another layer of clothing. When it gets hot, I'll help them take some clothes off. (A grandmother caring for a 2½-year-old)

Having them in a clean environment. Could put him on the floor and I know that he is not going to pick up any kind of germs because I mop and I clean and knowing that he is not going to pick up a penny or something like that and put it in his mouth and choke him . . . keeping them in a clean, healthy, safe environment. (A great-aunt caring for a 19-month-old).

Shared Responsibility for Health Care

Some caregivers talked about playing a collaborative role with families in keeping children healthy. Several caregivers described taking the children in their care to the doctor's for check-ups.

Make sure they go to the doctor and get their shots and everything. (A grandmother caring for her 3- and 1½-year-old and 1- and 1/2-year-old grandchildren)
I'm also the one that takes them and gets them all their immunizations . . . everybody gets regular check ups and everybody goes in and gets all their fun stuff. (An aunt caring for a nephew and two nieces)

Safety

Several overarching themes about indoor and outdoor safety emerged from the discussions. Caregivers consistently talked about supervising children and the need to monitor them. Many mentioned different kinds of equipment--outlet covers, fire extinguishers and fences--that they use to keep children safe. Some also talked about the importance of ensuring that children played with safe toys that were appropriate to their age.

Close Supervision

Across the focus groups, caregivers talked about watching children and monitoring them closely. Caregivers regard this as a crucial strategy for keeping children of all ages safe, whether they are in the house or outside. They also talked about the importance of fences when the children were playing outside, being careful while crossing the street, and protecting children from strangers.

I just keep him close to me. (A grandmother caring for an infant)

We always follow them around to make sure that they don't fall. (A grandmother caring for a toddler)

Make sure that you always have them in your eyesight. (A neighbor caring for a preschooler)

I don't let the little guys go out in the front because there is no fence in the front.

When I take the kids for walks, when we are crossing the street, I always make sure I have them both in my hands. When we cross the street, I always tell them to look both ways and never to cross the street by themselves. (A friend caring for preschoolers)

I don't like grown folks to fool with him . . . don't touch him, don't play with him . . . It's not that I'm thinking everybody is bad. I don't think this. But I would rather for you to keep your hands off him. (A grandmother caring for a school-age child)

Some caregivers' supervision was more casual. One caregiver, whose grandson had previously broken his arm climbing said:

"Get down, Billy, before you break . . . Get down, Billy, before you do this."

Interviewer: So yesterday he went up on the roof?

Caregiver: Yes, but, see, he had broke his arm once before, climbing. (A grandmother caring for a school-age child)

Several caregivers mentioned the importance of setting limits for the children in their care and delineating what was allowed and not allowed.

He knows when he comes to my house, he can't run around and touch stuff . . . I have to put things up before they get there, you know what I'm saying, child proof or so. (An aunt caring for a 14-month-old)

Just don't let them climb onto tables and chairs. Beds are ok. (A grandmother caring for a 2- and 1/2-year-old)

There is no jumping on the beds. (A grandmother caring for a preschooler)

Safety Equipment

A significant number of caregivers across all the focus groups discussed the kind of safety equipment they use to protect children from hazards in the home. They talked about outlet covers, cabinet locks, first aid kits, and fire extinguishers. They used safety gates to protect children from falling down the stairs or doors to keep them out of the kitchen. A few caregivers mentioned helmets for children who rode bikes.

With kids, outlets are most dangerous to children, so it's important to cover up outlets with the plastic, especially since their fingers are so small. If it gets wet and they stick it in the outlets, it's very dangerous. (An aunt caring for twin toddlers)

I have a gate so I could block him from the kitchen, and the stairs, so they don't go down the stairs. (A friend caring for a 2-year-old)

When I'm working by the stove, there's a barrier around it so they cannot get in. When they were younger, we used to put them in a playpen so they cannot come out. (A friend caring for a preschooler)

Many caregivers put knives, poisons, and medicine out of reach or moved furniture to make sure that children did not hurt themselves. Some caregivers described health-related safety precautions they take to ensure children are safe while sleeping and being fed, while others discussed the need to make sure that children's toys were safe and age-appropriate. Some learned about how to keep children safe based on information from the news.

Now [that she is taking care of the baby at her house], I spent like a million dollars on everything I possibly could use. I have this little note pad . . . and be like refrigerator lock, oven lock . . . and started writing all this stuff down. Things like . . . covers for the stove where I thought, okay, she can't reach it yet . . . And everything is up high, and I still have boxes that say display case on it because they are all glass and they are not coming out forever. (An aunt caring for an infant)

I see in the news, it caught my eye real quick. Then I have to tie [the cords] up. (A friend caring for a toddler)

Put [infant] to sleep on her back. Feed her in an upright position. Or don't put her to sleep with a bottle in her mouth. (A friend caring for an 18-month-old)

Toys are spongy so they won't hurt him. (A grandmother caring for her two infant grandsons)

Discussion

The issue of how to define quality in kith and kin child care has represented a challenge for researchers and practitioners. What are the expectations for the kind of care that family, friends and neighbors provide? How do we define good child care when the caregiver is the grandmother, the aunt or the close friend?

This study sought to answer these questions. The findings are based on responses from a small number of caregivers who chose to participate in focus group discussions in Connecticut and California. They do not represent a scientific sample, although there was an effort to recruit caregivers who reflected the ethnic distribution of the families that use kith and kin child care.

Structural Features

Research on child care quality typically looks at two aspects of care: structural features and process features (Vandell & Wolfe, 2000). Structural features include the number of children, group size, caregiver qualifications, and health and safety. The number of children in care, group size and adult-child ratios are important elements in child care quality because they

affect the attention that providers can give to individual children as well as the total number of children for whom they can provide good care (NICHD, 1996, 1999). These three features are typically dictated by state regulations.

There has long been a concern that license-exempt caregivers care for large groups of children. This does not appear to be the case for the caregivers in the study. The caregivers in the focus groups, like those in several other studies, only care for one or two children. This means that the group size and the adult-child ratio are low. In addition, the largest proportion of children are infants and toddlers, for whom low adult-child ratios are especially important (NICHD, 1996).

Caregiver qualifications--education and special training in child care--are also linked to quality (Arnett, 1989; Berk, 1985; Burchinal, Roberts, Nabors, & Bryant, 1996; Howes, 1983). Some research indicates that caregivers with higher levels of education and training in child development provide better care for children, although special training may play a more important role than educational levels (Arnett, 1989; Burchinal, Roberts, Nabors, & Bryant, 1996; Helburn, 1995; Peisner-Feinberg & Burchinal, 1997; Tout, Berry, & Zaslow, 2003). Many of the caregivers in the focus groups had not completed much education beyond high school. Most did not have any formal child care training.

Health and safety, other structural features, are also factors in child care quality (Vandell & Wolfe, 2000). Because kith and kin caregivers are exempt from many of the requirements that are imposed on regulated child care, there is a concern that these settings may not be safe for children. Most of the caregivers in the focus groups seem to be aware of common safety practices for young children. Their knowledge reflects information that is available to the public--the Back to Sleep campaign, for example--or television news. The majority used basic safety equipment such as outlet plugs and gates. They also used common sense approaches such as close supervision and putting poisons out of reach to keep children safe.

The caregivers also seem to be aware of basic health practices and good nutrition for children. They recognized the importance of hand washing for both themselves and the children (Niffenegger, 1997), and they understood the need for children to brush their teeth. Many of the caregivers, particularly those in the Spanish focus groups, were concerned about ensuring that children had enough to eat.

Process Features

These measures examine interactions between caregivers and children that support cognitive, language, and physical development. They are related to the influence of adult-child relationships on children's social and emotional development (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969). The findings from the focus groups point to some positive caregiver-child interactions in kith and kin care. There are many reports of physical affection, the kind of kissing and hugging that could be expected from caregivers who are close to the children in their care.

Caregivers also reported that they pay a great deal of attention to the children. Although the care takes place at home, household activities did not appear to interfere with caregiving

activities. Most caregivers reported that they set aside household chores like cleaning or cooking for times when the child was sleeping or was not present.

Many caregivers evidenced knowledge of what children need, although it was unclear whether this knowledge was intuitive, based on their own experience raising their children, or learned from other sources. A significant number reported engaging children in activities that support cognitive and language development. They described talking to, singing with, and reading to children as well as writing and dramatic play. There were also reports of activities that support children's fine and gross motor skills.

The data indicate that there were opportunities for children's socialization as well. Other children, particularly the caregivers' children, were often present. They interacted with the children in care as playmates or surrogate siblings. Neighborhood children played this role as well.

On the other hand, some findings--those that are related to caregivers' lack of understanding of child development--have serious implications for kith and kin child care quality. In some cases, their expectations for children are unrealistic, and, as a result, their responses are inappropriate. In others--their views on discipline in particular--their practices raise some genuine concerns about children's well-being.

There are also some clear indications of differences between kith and kin child care, especially relative care, and regulated family child care or center care. The hugging and kissing that was common in caregiver reports is discouraged in regulated child care because it is regarded as inappropriate contact. Caregivers' activities with children are less structured than those that occur in a family child care home or center where the providers have been trained to use curricula and work with larger groups of children. The child care takes place within the family at home: there may be fewer materials and little equipment like child-sized bookshelves or water tables.

The findings point to some even more fundamental differences as well. Most appear to be related to the special relationship that exists between the caregivers and the families for whom they provide child care. Research shows the benefits of parent-teacher partnerships for children's school success (Barrera & Corso, 2003; Bowman, 1994; Epstein, 1995; Harner & Davis, 1990; National Parent Teacher Association Standards, 2003; Rockwell, Andre, & Hawley, 1996; Shonkoff & Phillips, 2000; Swap, 1993; Vandell & Wolfe, 2000), but little attention has been paid to caregiver-parent relationships as an aspect of child care quality that contributes to children's learning. Family child care providers and teachers may develop attachments to the children in their programs, but the nature of the attachment is different from the hard-to-codify love frequently reported by kith and kin caregivers. When the child leaves the child care program, these relationships almost always end. In kith and kin care, caring for children is only one aspect of a relationship that began before the child care arrangement started and will continue long after it ends.

The relationships between caregiver and parent in kith and kin child care create permeable roles with fluid boundaries. As mothers, sisters, friends and neighbors, these caregivers are more than child care providers, advisors and teachers. They view their advice as a normal prerogative of their relationship to the parent, and see responsibilities such as taking the

children to the doctor for check-ups as a natural extension of the care they provide. The parents play different roles as well--sometimes as child care consumer, more often as daughter or close friend.

The nature of these relationships can have both positive and negative effects. Children can benefit from the care that is provided within the family and the continuity of relationships outside of the child care arrangement and over time. At the same time, they can be affected by unresolved conflicts between the caregiver and the parent. The caregiver may unwittingly project some of her feelings on the child or the children may pick up cues from the adults. Because many of the caregivers reported that they continued with the child care arrangement despite the conflict, these issues warrant attention to protect the well-being of the child.

CHAPTER V: CONCLUSION

The results of the focus groups have implications for both practice and research. They point to directions for initiatives that aim to improve child care quality as well as for staff who work with kith and kin caregivers. The findings also provide the basis for an instrument to assess quality in kith and kin care.

Implications for Programs and Practice

Kith and kin caregivers often do not realize the significant role that they play in supporting child development and the family system. Programs can help caregivers recognize and validate what they are already doing well for children by increasing their knowledge of normative child development. They can help caregivers understand that the love and nurturing they provide is vital to children's development in all domains, that social and emotional development is an important underpinning of cognitive development and school readiness, and that the special attention they provide to children contributes to their ego strength and ability to learn (Burchinal, Peisner-Feinberg, Pianta, & Howes, 2002; Bus & van IJzendoorn, 1995; Shonkoff & Phillips, 2000).

With a "strengths" approach, programs can address the areas that emerged as problematic, particularly those related to discipline, working with parents, and television viewing. Workshops on reasonable and appropriate disciplinary strategies can offer caregivers positive alternatives to physical or other harsh punishment. Support group sessions on working with parents can help caregivers reflect on their own feelings about conflict and understand parents' and children's perspectives as a way to resolve difficult situations. Workshops can provide information about the effects of TV on children, how to choose appropriate programs, and how to encourage conversations with children about TV content.

Initiatives for kith and kin caregivers require staff who understand the special place they occupy in the child care system. Training for staff must include information about the unique aspects of this kind of care and the factors that distinguish it from care that is offered by professional providers. Much of the training content--child development, health, safety, nutrition, and discipline, for example--for practitioners who work with kith and kin caregivers may be the same as that for practitioners who work with other providers, but it must be tailored to meet the needs of caregivers who do not intend to have a career in child care. At the same time, practitioners must be prepared to address issues that arise from family relationships, which represent a distinctive feature of kith and kin child care.

Providing additional materials and equipment represents another strategy for meeting caregivers' needs. Many caregivers report that they have materials, but the variety and appropriateness seem to vary. Distributing books, toys, puzzles, and materials for arts and crafts as well as music--and the information about how to use them--can address this issue.

Implications for Measuring Quality

Our early research led us to view child care as a continuum that extends from parents to center-based early childhood teachers, with kith and kin caregivers between parents and regulated family child care providers (Porter & Rice, 2000). The child care continuum assumes that children need a healthy and safe environment wherever they are--at home, in grandma's house, with friends or neighbors, in regulated family child care or in a center. It also assumes that anyone who provides child care for children--a parent, grandmother, aunt, friend, neighbor, regulated family child care provider or early childhood teacher--should have the knowledge and skills to support children's development.

The findings from the focus group discussions have now led us to a new view of child care quality. It is based on the assumption that children experience child care in a variety of settings during the week or even within a single day. They may begin the day with their parents, spend the morning at a center and the afternoon with grandma, and then return to their parents at night. It also assumes that children do not have to have the same experiences in all of these settings. They may not sing songs at home, but they may sing with adults and children at church, in school or in a center. What is important is that children's total experience in child care supports all the developmental domains.

In this context, quality can be viewed as a cumulative measure of what children experience across all settings rather than an individual measure of what children experience in a single setting. Clearly, some elements must be present in every setting. The question is which aspects of quality are essential--must be present everywhere--and which need only be present in some settings. We believe that the essential features include nurturing and attachment; sensitivity and responsiveness; language stimulation; opportunities for exploration and stimulation; opportunities for gross and fine motor development; adequate supervision; appropriate discipline; and a safe and healthy physical environment.

Measuring Quality in Kith and Kin Child Care

This view of quality has influenced the next phase of the project--the development of an instrument designed to measure quality in kith and kin care. The new instrument assesses essential features of child care quality in the context of kith and kin care. It consists of measures for nurturing, sensitivity and responsiveness; support for cognitive, language and physical development; supervision/discipline; and relationships with parents. It also includes checklists for materials as well as health and safety practices and equipment. Some of the measures are loosely based on existing instruments. Others, particularly those that are intended to assess qualities of nurturing and intensity of relationships, are new.

Understanding of Child Development

For professional teachers and family child care providers, knowledge of child development almost always refers to the stages of normative development, that is, "ages and stages." Children also develop as individuals--given their inborn personality or temperament, and in a social context--given the environment and culture in which they are reared. We posit that kith and kin caregivers, like parents, are "expert" in the individual and social-contextual development of the children in their care, although they may lack formal training or education in normative child development.

It could be argued that all the constructs in the new instrument pertain to the developing child in the broadest sense. To assess support for specific domains it focuses on several discrete areas. It acknowledges the primacy of language development, a precursor to literacy development, in measures of caregiver-child and child-caregiver communication. There are also measures to capture pre-verbal communication of infants and toddlers, a precursor to verbal communication. Pre-literacy activities such as story-telling, nursery rhymes, and songs, are measured as well.

“Scaffolding”--how the caregiver prompts, guides, and encourages the child to reach higher levels of understanding and skill--plays an important role in all aspects of cognitive development. To measure more focused instances of “scaffolding,” the instrument includes items that measure caregiver activities such as encouraging experimentation with objects; encouraging independence or autonomy; explaining or demonstrating how to do or use something; and using routines as learning opportunities.

Nurturing

Nurturing is essential for children because it promotes strong emotional and social foundations that are important for cognitive and language development. The instrument includes measures for holding and patting as well as the kissing and hugging that were reported by the caregivers.

It also includes measures for the nature and intensity of the relationship between the caregiver and the child. Based on the data from the focus groups, these take the form of interview questions about the caregivers’ attitudes towards the child care she provides. They focus on the caregiver’s interest in spending time with the child and being a part of her or his life over time as well as the satisfaction she derives from the care she provides.

Sensitivity and Responsiveness

Many observation instruments include measures of caregiver sensitivity and responsiveness because these two aspects of caregiver-child interactions contribute to children’s emotional and social development. The instrument incorporates a number of measures from existing instruments that have been modified to fit reports from the focus groups. Items that measure positive behaviors and interactions include comforting children and responding to children’s distress as well as reciprocating children’s positive physical gestures, while those that measure negative aspects of these constructs include restraining the child for reasons other than safety and imposing activities on children without regard to their interest, as well as ignoring them.

Other measures of sensitivity and responsiveness in the instrument are related to understanding child development. They include observations of interactions that indicate an understanding of the child’s cues as well as interview questions about the caregiver’s awareness of the child’s emotional state and how to respond to it.

Support for Language Development

Support for language and literacy development is an essential feature of child care quality, and the instrument includes a significant number of measures to assess this aspect of caregiver-child interactions. Many of them are based on existing measures of language

interaction such as singing, story telling and reading that correspond to the focus group findings. The instrument also includes measures of the type and frequency of caregiver communication that were not identified in the focus groups, such as questioning or naming or labeling objects.

Support for Cognitive Development

In general, caregivers did not report that they engaged in the kinds of didactic activities that are common to classroom-based settings or even family child care. Instead, they talked about activities that provide opportunities for supporting exploration and stimulating development such as playing patty-cake, using shape or sorting toys, feeding birds, taking children for walks, or cooking with them. Some also talked explicitly about teaching children numbers, colors, or letters. The instrument includes measures for these constructs of cognitive development that are based on existing instruments.

Support for Physical Development

Constructs for physical development include support for both fine motor and gross motor development. Caregivers reported activities that promote fine motor development such as coloring and drawing as well as those that support gross motor development such as helping children to walk or providing opportunities for climbing and running. The instrument measures these constructs through observations of the child's behavior and the availability of materials.

Discipline

Discipline, often conceptualized as child socialization, is an important part of an assessment of quality, as both permissive and punitive approaches have a detrimental effect on development, while reasonable and appropriate discipline helps children internalize controls and become self-actualizing citizens and responsible members of society. The instrument includes several accepted measures of the type and frequency of disciplinary practices that are consistent with the focus group data. Minimizing frustrations through redirection, explaining consequences of behavior are designed to assess positive practices, while using physical punishment and inappropriate use of time-outs is a measure of negative practices.

Relationships with Parents

The focus group findings indicate that the relationship between parents and caregivers in kith and kin child care is different from the relationship between parents and teachers or family child care providers. The roles that caregivers and parents play in the relationship affect the nature of their interactions and communication.

Existing measures for parent-caregiver communication are not designed to assess these special aspects of the relationship. Nor can these aspects of the relationship be easily observed, because this type of interaction often occurs outside of the child care setting. The instrument uses an interview to measure these aspects of quality. Questions focus on aspects of the relationship such as the congruence of views on child-rearing practices, shared understanding of the role that child care plays in each other's lives, and mutual interest in each other's well-being. In addition, it measures the extent of the caregiver's involvement in the life of the child and the parent outside of child care.

Conclusion

This is an important time for kith and kin child care. It meets the needs of many parents who work non-traditional hours, those who have infants and toddlers under three, and those whose preschoolers are enrolled in part-day early childhood programs.

Many entry-level and low wage jobs, the kind in which most welfare parents find employment, require evening, night, or weekend work. Regulated family child care and centers do not usually offer child care outside of conventional hours--before 8 a.m. or after 6 p.m.--or on Saturday and Sunday. There are a relatively small number of spaces for infants and toddlers in regulated out-of-home care. Center-based care for infants is expensive, because it requires low adult-child ratios. These costs are often passed on to consumers in the form of tuition, which many parents cannot afford, even with a child care subsidy. Family child care providers are sometimes reluctant to provide care for infants and toddlers, because regulations limit the number of children under three for whom they can provide care. The number of pre-kindergarten programs for 3- and 4-year-old children is growing, but most of these programs are part-day or school-day (until 3 p.m.). Working parents must make arrangements to care for their children for the remainder of the day.

Although there may be changes in the supply of regulated child care, there is a strong likelihood that kith and kin child care will continue to fill these gaps for many years to come. For this reason, understanding quality in these child care arrangements is important not only to ensure positive outcomes for children but also to reassure the parents who rely on it. Assessments of the quality of care that family, friends and neighbors offer will reveal its strengths as well as its weaknesses. The results will support strategies to sustain and enhance the care when it is good and to improve it when it is poor.

If our notion about quality is valid, the new instrument can be used in any child care setting. The goal would be to follow the child through each type of care. We propose to start with kith and kin child care because that is the kind of care on which so many parents depend. With the rising concern about the relationship between child care and school readiness, parents, practitioners, policy makers and researchers need to know whether kith and kin child care supports children's development.

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APPENDIX:

Focus Group Discussion Guide

Opening:

We are talking to a lot of people about taking care of other people's children. We're having some of these discussions here in the Northeast and some more in California. There are no right or wrong answers to the questions we are going to ask. You are the experts: we want to learn from you.

Our discussion will take about two hours. If you would like to use the ladies' room, please do so now. Also, please take your drinks now so that we can all talk together.

This discussion is confidential. You will not be identified in any way. We ask you to introduce yourself by your first name only, so that we can follow what you say. We would like to audiotape the discussion. Do I have your permission to turn on the tape recorder?

Thank you.

Is everyone comfortable? Let's begin.

Introductions

Let's start by talking about ourselves a little. Please tell me your name, the names and ages of your own children, whether there are any other adults in your household and how long you've lived in this neighborhood.

Now let's talk about the children you watch. How many children do you care for? What are their first names and ages? Their relationship to you? Do any of these children have special needs (disabled in some way)?

Okay. Let's try to figure out the days and times you care for these children. We'll start with the days of the week, and then the times each child is dropped out and picked up.

Think about the youngest child you watch. When did you start to take care of him (her)?

How did the child care arrangement start?

Other folks? Same? Different?

What did the parent say to you about taking care of the kid? What did you ask her?

Probe: Schedules? Duration? Payment/barter? Decision making process?

Other reactions? Same? Different? Why?

What did the parents think they were getting from you as a caregiver? Probe: Nearby?

Convenient schedule? Cost? Trust? Safety? Family/ friend? Culture: language, traditions, religions, values?

Other responses? Same? Different?

Let's talk about you and _____ (the youngest child). What does _____ like about coming to your house? Other reasons? Please tell me some examples. Other people? Same? Different?

What do you think is different or special for _____ in being with you than his parents? Probe: Individual attention? Different relationship? Different children? Different place? Different things to do? Food? Please explain. Others?

What do you think is different or special for _____ in being with you than being in other child care like preschool or day care? Probe: Individual attention? Different relationship? Different children? Different things to do? Food? Please explain.

What was the most enjoyable part about caring of _____ yesterday? Please tell me more about what happened. Why was it satisfying to you? How do you think _____ felt? What about other people?

Now let's talk about the most upsetting or least enjoyable thing that happened when you were caring for her/him yesterday. Please tell me more about what happened. Why was it upsetting or unpleasant for you? How do you think _____ felt? When was the last time something upsetting happened? What was it? How about other people? Same? Different?

What do you think is the most important thing you do for _____ when you take care of him/her? Why? Please explain. The next most important thing? Why? Other people? Agree? Disagree? Why do you say that?

How do you keep _____ healthy? Please explain. Other people?

How do you keep _____ safe indoors? Please explain. Probe: What do you mean by childproofing? Outdoors? Please explain. Other people? Same? Different?

Let's talk a little about what it's like for you when you care for other people's children. How do you take care of the things you need to do for your family and yourself when the kids are there? Please give me some examples. Probe: Housekeeping? Laundry? Cooking? Food shopping? Appointments? Phone calls? What do the kids do when you are doing those chores or having those appointments? Please tell me more. Other people? Same? Different?

Now let's talk about your relationship with her/his parents when you're caring for _____. How has your relationship changed since you have been taking care of _____? How much time do you spend with _____ parent? Other people? Agree? Disagree?

When you talk to the parent about _____ what do you talk about? Probe: behavior? Health? Getting along with other kids? Getting along with me? Please give me some examples. Other people?

Thank you very much.