Examining the tensions between cultural models of care in family childcare and quality rating improvement systems

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ABSTRACT

Although family child care (FCC) programs have been increasingly targeted by quality improvement efforts such as Quality Improvement Rating Systems, research suggests that these efforts often fail to align QRIS supports with the unique needs and interests of this population. The aim of this study was to examine the aspirations, strengths, challenges, and professional development needs of FCC providers who identify as immigrants or refugees living in a low-income, multi-ethnic urban community in California in order to design a professional development program that meets the criteria of our county's QRIS while at the same time honoring the community context. Results from focus groups indicate that providers described their work in terms that reflected cultural models of care that were often incongruent with definitions of quality embodied by our county's QRIS. Data provides empirical support for the continued examination of cultural models of care as a way to define quality in FCC settings and findings are presented via a multi-level theoretical frame that draws attention to the macrosystemic contexts of racism, poverty, the immigrant and refugee experience, and the universal standards of quality embodied by QRIS.

1. Introduction

Family Child Care (FCC) is defined as non-parental, paid child care that is regulated by the state and takes place in a provider's home to a mixed age group of children ranging from infants to school-age children (Morrissey & Banghart, 2007). FCC it is often the most convenient form of regulated child care for many low- and middle-income families (U.S. Administration for Children and Families, 2007), and families often prefer FCC over more formal center-based child care because of FCC providers' perceived informality, more intimate and individualized care (Browne, 2009), and lower cost (Fiene & Isler, 2007; Gerstenblatt, Faulkner, Lee, Doan & Travis, 2014; Lanigan, 2011). Shivers, Sanders, Wishard Guerra and Howes (2007) have noted that parental choice in child care arrangements is an important way in which families can support the development of their children's competencies that are prioritized and valued by the family and community. Importantly, because providers interact with parents and oftentimes live in the same neighborhood, they often understand the meso- and macrosystemic challenges facing the families they serve (Fernandez, Mootoo, Romero & Rasmussen, 2018).

Ensuring that young children participate in high quality early

childhood education (ECE) programs, including FCC, is an urgent national priority (Institute of Medicine & National Research Council, 2015). High-quality ECE programs have been found to have particularly large benefits for children growing up in low-income communities (Shonkoff & Phillips, 2000), and quality early education experiences may serve as a powerful protective factor against the toxic stressors associated with Adverse Childhood Experiences (ACES), many of which are experienced by children living in poverty (Metzler, Merrick, Klevens, Ports, & Ford, 2017). Although much of the quality improvement efforts in the U.S. have focused on center based care, improving quality in FCC has been targeted by recent federal and state policy initiatives (Bromer, McCabe, & Porter, 2013a; Porter et al., 2010). One example of these initiatives is the Quality Rating and Improvement System (QRIS). Developed and administered by individual states, QRIS is intended to support ECE programs to engage in continuous quality improvement and meet levelled standards demonstrating program quality. Data indicate that FCC participation in QRIS is much lower than in center-based programs in states in which participation in QRIS is voluntary (Hallam et al., 2017; Tout et al., 2011; The Build Initiative & Child Trends, 2015) and that programs that do participate in QRIS are likely to be rated at lower quality levels and are less likely to access the supports offered

([Smith, Schneider, & Kreader, 2010; Tout, Starr, Soli, Moodie, Kirby, & Boller, 2010](#)).

Recently, our county has begun to explore ways in which to include FCC providers in QRIS, and the purpose of this study is to describe how we, along with a local philanthropic organization and five ethnically-based community organizations (EBCOs), conducted focus groups with immigrant and refugee FCC providers living in a low-income, multi-ethnic, urban community. The aim of these focus groups was to learn more about provider's aspirations, strengths, challenges and professional development needs in order to inform our efforts to develop a professional development program that would support the quality indicators of our county's QRIS while being responsive to the community context. In the following sections, we first provide a brief overview of FCC, followed by a description of the immigrant and refugee experience in the United States. We then discuss the construct of quality in ECE and describe what QRIS looks like in our state and county. Next, we review the literature on FCC provider participation in QRIS and a conclude with a presentation of our theoretical orientation and description of the research context.

1.1. Family child care as part of the early childhood landscape

FCC is part of what [Kagan et al. (2007)](#) have referred to as the "non-system" of ECE in the United States that lacks the overarching governance, funding, and accountability mechanisms present in the K-12 environment. The ECE workforce is one of the most underpaid and undervalued sectors in the country and is comprised almost exclusively of women, 40 percent of whom are individuals of color ([Austin, Edwards, Chávez & Whitebook, 2019](#)). Early educators are among the lowest-paid workers in every state ([Whitebook, McLean, Austin, & Edwards, 2018](#)) and these low wages mean that 53 percent live in families that utilize public income supports ([Austin et al., 2019](#)). In California, where the current study took place, economic and food insecurity is common among child care workers, and they are twice as likely as other California workers and six times as likely as K–12 teachers to live in poverty ([Gould, Whitebook, Mokhiber, & Austin, 2019](#)). [Austin et al. (2019)](#) state that wage gaps are due to multiple factors that are inextricably linked, including the age of children served, funding source (e.g. parent fees, Head Start, subsidies), and the race/ethnicity of educators, with African American and Hispanic educators experiencing wage gaps when compared to their white peers. These gaps have historical and socio-political roots that stem from systems of domination that relegated the less desirable domestic and child care work needed by white families to women of color ([Hill Collins, 2009; Hondagneu-Sotelo, 1994](#)).

FCC providers typically have lower educational attainment than providers working in center-based settings and have limited access to ongoing professional development efforts, especially those specifically targeting FCC programs ([Whitebook, McLean, & Austin, 2016](#)). Running a FCC home is complicated, as providers are responsible for running a small business, caring for and educating young children while working long hours, while experiencing the social isolation that often results from working at home ([Build Initiative, 2019](#)). FCC programs have historically been conceptualized by images of mothering rather than teaching ([Freeman & Vakil, 2007; Tuominen, 2003](#)), and providers are often thought of as "the lady next door who watches everyone's kids" ([Freeman & Vakil, 2007, p. 122](#)). Indeed, one of the reasons that many women are drawn to FCC is that it allows them to care for their own children while earning income ([Tuominen, 2003](#)), and leaders of the EBCO's who participated in this study stated that FCC is a viable self-employment opportunity for immigrants and refugees residing in our county for several reasons. Operating a FCC home has relatively low start-up costs, and because it is operated from the home, it eliminates transportation barriers and makes it a practical option for immigrant and refugee women who may already be at home caring for children and need additional income to offset the area's high cost of living. In

addition, the operating environment for FCC businesses is very favorable, as state regulations do not require zoning approvals for homes in which family child care businesses are operated, have minimal space requirements, and require minimal structural modifications and landlord approvals. According to the EBCOs, these low barriers to entry provide the immigrant and refugee populations they serve with the potential to start a FCC business regardless of the structural nature of their home, their educational background, and/or their rental agreement.

1.2. Immigrant and refugee experiences in the United States

Immigrants and refugees represent distinct populations due to their migration process and their reasons for coming to the United States. Immigrants typically leave their home country and migrate to the United States in order to seek better financial and educational opportunities. As a result, immigrants often have more control over their migration process, having the ability to choose where and when to immigrate. The immigrant population has been increasing in our country, with immigrants and their U.S.-born children making up 27% of the overall U.S. population ([Pew Research Center, 2018](#)). Immigrant children are the fastest growing child population in the U.S., and specifically in California, where our study took place, almost half of all children (48%) are members of immigrant families with at least one foreign-born parent ([Migration PolicyInstitute, 2019](#)).

There seem to be some differences between immigrant families and native-born families in terms of the ways that families select child care for their children ([Karoly & Gonzalez, 2011](#)). It is not uncommon for parents in immigrant families to select more informal child care for their child(ren), often opting for a family member or a relative to provide that care ([Buriel & Hurtado-Ortiz, 2000](#)). In general, immigrant parents often prefer child care settings that incorporate or reflect values and behaviors from the family's culture ([Chaudry, et al., 2011; Forry, Tout, Rothenberg, Sandstrom, Vesely, 2013; Obeng, 2007](#)).

While many immigrants migrate for educational or financial opportunities, refugees, the majority of whom are women and children (UNHCR, 2017), flee their home country due to violence and persecution, and the majority have experienced or witnessed trauma ([Ellis, Hulland, Miller, Barret-Bixby, Lopes-Cardoso, Betancourt, 2016](#)). Many refugees face unique challenges once they arrive in the United States, including poverty, language barriers, discrimination, difficulty finding work, limited healthcare, and uncertain immigration status ([Renaud et al., 2003; Gerritsen et al., 2006; Momartin et al., 2006; Rousseau et al., 2008; Toar et al., 2009](#)). Many also experience a loss of social networks and family members due to war and violence, the loss of sense of safety and a loss of social status ([Ward, Oldham LaChance, & Atkins, 2011](#)). How well refugees fare in the United States varies on a number of different factors, including pre-migration experiences and the migration process. For example, refugees from Somalia and Burma, two of the refugee groups represented in our study, have some of the lowest literacy rates and are more likely to live in poverty compared to refugees from some other regions of the world ([Capps & Fix, 2015](#)). One of the often-reported stressors that adult refugees experience upon resettlement is loss of status due to lack of recognition of skills and education by the host country. Even though they may have been professionals in their home country and have attained high level of education, refugees are often forced to take lower-skill and lower-paying jobs because the host country may not recognize their education or their past work experience. Loss of status has been shown to have significant effect on family stress, socioeconomic status, and parental mental health ([American Psychological Association, 2010; Baranik, Hurst, & Eby, 2018; Zwi, Rungan, Woolfenden, Woodland, Palasanthiran, & Williams, 2017](#)).

We could locate only one study that examined the experiences of immigrant and refugee FCC providers in the United States. [Fernandez, Mootoo, Romero, and Rasmussen (2018)](#) examined the experiences of FCC providers who identified as immigrants and ethnic minorities and

lived in a low income community in New York. The providers described stressors related to parental behavior that did not respect the work/home boundaries of FCC, as well as stress related to the various roles providers assume, which included teacher, caregiver, social worker and business owner. The authors concluded that more research is needed in communities with similar demographics and socioeconomic conditions, a gap we sought to fill with the current study.

1.3. Quality as a construct in ECE

The concept of quality originated in the business industry and was related to customer satisfaction and adherence to clearly defined standards or norms (Moss, 2005). Reflecting this model, assessing the quality of early childhood programs involves structural and process measures that include state licensing regulations, national accreditation standards, teacher education, staff to child ratios, group size, and features of the physical facility (Helburn, 1995; Cryer & Clifford, 2003). Additional aspects of quality are related to a common set of metrics that have been accepted into the United States mainstream and reflect beliefs and practices that are considered 'best' or 'recommended' by both the literature and major professional and advocacy groups (Apple & McMullen, 2007; Reinke, Peters, & Castner, 2019). For example, the construct of developmentally appropriate practice (DAP) has been widely accepted as the universal standard of quality care in the United States, as has program accreditation by the National Association for the Education of Young Children. QRIS is the latest iteration of standardized conceptualizations of quality, as it seeks to award quality ratings to programs that meet defined program standards. Although the focus and structure of QRIS vary from one state to another, most QRIS include 1) clearly defined quality standards and provisions for rating quality according to these standards; 2) systems for monitoring quality; 3) financial incentives for quality improvement, training, and technical assistance; and 4) delivering support and information to families, allowing them to compare centers through transparency of quality (Lahti et al., 2015; Mitchell, 2009; Paulsell, Tout, & Maxwell, 2013; Zellman & Perlman, 2008). Reflecting dominant ideologies about quality care in the U.S., the goals of QRIS focus on school readiness, DAP, and child-centered care (Reinke, Peters, & Castner, 2019), and these goals are assessed via standardized checklists, rating scales, and child assessment. In this way, QRIS embodies the definition of quality in ECE proposed by Moss and Dahlberg (2008), which asserts that quality is "an attribute of services for young children that ensures the efficient production of predefined, normative outcomes" (p. 3).

Although many in the field of ECE have attempted to construct a universal definition of quality, others have cautioned against the universality of child development and child rearing practices (Britto, Yoshikawa, & Boller, 2011; Lubeck, 1998; Rogoff, 2003). Reinke, Peters, and Castner (2019), for example, note that the concept of quality child care is based upon Western ideologies about children and families and notions of the whole child, child-centered practice, and ideas about what a child care provider should believe and look like. Others have cautioned that standards such as DAP reflect middle class understandings of caregiving (Lubeck, 1998; Uttal, 1996) which may not coincide with the cultural and historical contexts of the families and child care providers who live and work in various cultural communities. Souto-Manning and Rabadi-Raol (2018) expand on this notion and draw attention to the "acultural and colonialist normative aims" (p. 204) inherent in a definition of quality that relies on a narrow conceptualizations of best practice and perpetuates inequities by ascribing problematic identities to multiply minoritized children, families, and ECE professionals.

Mainstream definitions of quality are central to QRIS, and the Early Childhood Rating Scale-Revised (ECERS-R) (Harms, Clifford, & Cryer, 2014) and Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008) are two of the most widely used measures of program quality, with the Family Childcare Environmental Rating Scale (FDCERS-R; Harms, Cryer, & Clifford, 2007) being used in FCC settings.

Researchers have identified concerns about the cultural relevance of the ECERS-R, which is used with some modifications in many countries (Moss, 2005). Sheridan and Schuster (2001), for example, found that German and Swedish users of the ECERS had very different understandings of several of the tool's indicators and that activities and routines, as well as expectations for planning and language, were quite different across the two settings. Pan et al. (2010) reported that a modified version of the tool failed to measure quality levels in China and called into question the benefit of modifying existing quality measures in other countries, citing the need for localized research to identify contextual factors related to quality improvement efforts. Similarly, Bull, Yao, and Ng (2017) examined the validity of the ECERS-R in Singapore and concluded that its use may be problematic given the privatized nature of early childhood and diverse population with varied social and cultural expectations for what quality ECE looks like.

The appropriateness of the CLASS with children who are dual language learners has also been called into question (Campaign for Quality Early Education Coalition, 2013), and researchers using the CLASS in diverse contexts have identified evidence of cultural misalignment in the CLASS trainings, several of the CLASS behavioral markers, and with the instructional support domain (Barnes-Najor, Thompson, Cameron, et al., 2020). Moreover, given the CLASS focus on independent thought, critical questioning, and student autonomy, Garrity, Shapiro, Longstreth and Bailey (2019) have questioned the cultural relevance of this tool for teachers, children, and families who come from cultural communities that prioritize collectivist values such as group harmony and respect for authority. Concerns about the cultural validity of tools used to measure quality by QRIS reflect Reinke, Peters, and Castner's (2019) assertion that these standardized evaluations of quality result in a distal perspective that may exclude the interests and desires of children, families, and ECE professionals and eliminate diverse knowledge, perspectives, and multiple ways of knowing.

1.4. QRIS in California

In 2012, California received a Race to the Top–Early Learning Challenge (RTT–ELC) grant to develop a locally administered, state-supported QRIS. Quality Counts California (QCC) is a statewide effort to strengthen California's early learning and care system to support young children and their families and is a collaboration between First 5 California and the California Department of Education, Early Learning and Care Division. QQC encompasses three layers that contribute to the state's quality improvement system at the local, regional, and state level. At the local level, QRIS consortia operate in all 58 counties, with several multi-county consortia. At the state level, First Five funding supports capacity building through regional hubs, which allow consortia to benefit from investments at the state level. State-wide coordination is focused on systems development, and coordination efforts include uniform data collection procedures, efforts to provide coaching and trainer certifications, and alignment across funding and partners (e.g. licensing, Head Start).

Participation in QRIS is voluntary and is built upon a Quality Rating Matrix which assigns sites a quality rating of 1–5. A critical feature of QRIS systems is that they are based on a hierarchy that results in programs having higher scores being presented as being of higher quality. The Quality Rating Matrix includes three core areas 1) child development and school readiness, 2) teachers and teaching, and 3) program and environment. These areas include many of the indicators typically associated with quality care in the U.S., including teacher child ratios and group size, teacher and director education, the use of developmental screenings and assessments, and assessments of teacher child interactions and program environments. The core areas, how they are measured, and the criteria for earning a score of five, are presented in Table 1.

In order to support programs to attain the quality indicators needed to increase their quality rating, our county has implemented a large-

Table 1
Quality Counts California Rating Matrix Requirements for a Rating of 5.

Core 1: Child Development and School Readiness		
Element	*Measurement Tool*	*Criteria for Rating of 5*
1. Child Observation	Desired Results Developmental Profile (DRDP)*	Program uses DRDP twice a year and uploads into DRDP Online and results used to inform curriculum planning
2. Developmental and Health Screening	Health Screening Form (Community Care Licensing form LIC 701or equivalent)	Children have annual health screening or vision and hearing screening
	Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social Emotional (ASQ-SE)	Screening of all children using the ASQ & ASQ-SE; results used to make referrals and implement intervention strategies and adaptations as appropriate
Core II: Teachers and Teaching		
Element	*Measurement Tool*	*Criteria for Rating of 5*
3. Minimum Qualifications Lead Teacher/Family Childcare Home	N/A	Bachelor's degree in ECE/CD (or closely related field) OR BA/BS in any field plus/with 24 units of ECE/CD (or master's degree in ECE/CD) OR Program Director Permit AND 21 h PD annually
4. Effective Teacher Child Interactions	Classroom Assessment Scoring System	Independent assessment with CLASS with minimum scores: *Pre-K* Emotional Support – 5.5 Instructional Support – 3.5 Classroom Organization – 5.5 *Toddler* Emotional/Behavioral Support – 5.5 Engaged Support for Learning – 4 *Infant* Responsive Caregiving – 5.5
Core III: Program and Environment: Administration and Leadership		
Element	*Measurement Tool*	*Criteria for Rating of 5*
5. Ratios and Group Size	Licensing regulations	
6. Program Environment	Environmental Rating Scale for appropriate setting: ECERS-R, ITERS-R, FCCERS-R)	Independent ERS assessment. All subscales completed and averaged to meet overall score level of 5.5 OR Current National Accreditation approved by the California Department of Education
7. Director Qualifications	NA for FCC	

* Child assessment tool developed by the California Department of Education.

scale, quality improvement system that provides customized support to professionals working with children from birth to age five in high-needs settings via a variety of services including coaching, workshops, and family engagement support. When originally implemented, however, QRIS in our county was available only to center-based programs serving children 3–5 years of age whose families received child care subsidies. For this reason, FCC programs were almost completely left out of this quality improvement system until recently, when additional funds were made available to support FCC provider participation in QRIS. In the

community in which our study took place, only 14 of the 300 eligible FCC providers have received a quality rating through the QRIS, with all 14 receiving a rating of two.

1.5. Review of the literature on QRIS and FCC

Evidence suggests that efforts to include FCC providers in quality improvement efforts and QRIS often fail to meet the unique needs of this population (Bradburn & Dunkenberger, 2011; Bromer & Porter, 2017; Hallam et al., 2017; Public Health Law Center, 2017; Tonyan, Nuttall, Torres, & Bridgewater, 2017). Barriers to participation include the need to navigate multiple systems, such as state licensing requirements and the Child and Adult Care Food Program (CACFP) (Hallam, Hooper, Bargreen, Buell, & Han, 2017) and standards and expectations that are tailored more for center-based programs (Hallam, Hooper, Bargreen, Buell, & Han, 2017; Tonyan et al., 2017). Research also indicates that the perspectives and unique contextual factors related to FCC are often not taken into consideration during QRIS system design and implementation and that QRIS supports must be aligned with the needs and interests of FCC providers in terms of both content and modes of delivery (Hallam, Hooper, Bargreen, Buell, & Han, 2017; Tonyan et al., 2017). Evidence for the efficacy of this approach comes from Hallam, Hooper, Buell, Ziegler, & Han, 2019, who found that providers who participated in QRIS coupled with additional quality improvement supports, including community of practice meetings, on-site technical assistance that included an individualized quality improvement plan, coordinated professional development, and grants to purchase materials and equipment were more likely to achieve higher quality ratings than providers who participated in QRIS only.

As part of their study of 30 FCC providers in Los Angeles, the majority of whom participated in QRIS or another quality improvement initiative, Tonyan et al. (2013), (2015), (2017) conducted interviews with providers to learn more about their daily routines, decision-making, and the rewards and challenges of their work. Their study is grounded in Ecocultural Theory (ECT; Gallimore et al., 1993; Gallimore & Lopez, 2002; Weisner, 1997; 2002), which is based on the recognition that humans have culturally based ideas about how things should be that are situated within a particular ecology (Weisner, 2002). Results indicated that providers described two cultural models that reflect their values and goals for children. The first cultural model, Love and Affection, embodies the belief system of providers who valued and prioritized love and affection as critical aspects of their work, while the second model, School Readiness, describes priorities related to ensuring that children are prepared for school. Reflecting the construct of cultural communities, these cultural models provide insight into community held beliefs and values about what the education of young children should look like, and were enacted via everyday routines and activities.

More recently, Paredes, Hernandez, Herrera, and Tonyan (2019) conducted interviews with 54 providers, the majority of whom were Latinx (46%) or African American/Black (29%) to learn more about their decision-making, daily routines, and the rewards and challenges of their work, to learn more about how culturally valued beliefs about familismo and compadrazgo, both socially valued behaviors often found in Latinx families, were related to the Love and Affection cultural model identified by Tonyan (2015). Familismo refers to a strong identification with and loyalty to the family, both nuclear and extended, and embodies a sense of respect and cooperation among family members in which individuals prioritize the needs of their family over their own, which often includes non-family members who help raise children (Guilamo-Ramos et al., 2007). Compadrazgo, translated as co-parenting, can be formal as in a god-parenting relationship or can be a less formal bond between friends (Tatum, 2013), or compadres, who support parents as they help socialize children to adopt norms and behaviors consistent with the parents' values, traditions, and norms (Cauce & Domenech-Rodriguez, 2002). Results indicated that two thirds of providers described their work in ways that reflected the values of familismo and

compadrazgo and were congruent with the Love and Affection cultural model and the authors suggest that it may be beneficial to extend evaluations of best practices to include this model of care.

Our review of the extant literature on FCC provider participation in QRIS and on cultural ideals of care demonstrated by providers participating in quality improvement efforts highlights the importance of learning more about the aspiration, strengths, challenges and professional development needs of FCC providers from diverse cultural communities such as those who participated in our study. Given that we were interested in developing a professional development program for immigrant and refugee FCC providers, our research was guided by contextual approaches to development that take into consideration the beliefs, values, and practices of diverse cultural communities (Rogoff, 2003). We also considered Apple and McMullen's (2007) contention that the field must consider who makes decisions about professional development system requirements, who is affected by these decisions, and the "underlying power dynamics, competing elements, and moral contentions" inherent in professional development systems (p. 256). Our theoretical approach is described below.

1.6. Theoretical orientation

Bronfenbrenner & Morris (1998) have proposed that in order to explore the complexity of early childhood settings, researchers must adopt a contextual view of development that takes into consideration the various contexts (home, school, community) in which teaching and learning occur. Reflecting the contextual paradigm, Rogoff (2003) contends that participation in cultural communities leads to the development of practices, which are routines or ways of doing things that reflect the goals and ideologies of the community. These repertoires of practice are adaptive and make sense for the community based on its values and beliefs, which have been developed via common experiences. As described earlier, Tonyan (2013, 2015, 2017) has used cultural theories of development (Rogoff, 2003; Weisner, 2002; 2005) and the concept of cultural models (Quinn & Holland, 1987) to examine quality in FCC and proposes that quality can be defined "as the alignment of children's opportunities for learning and development with locally relevant ideals or cultural models" (Tonyan, 2017, p. 728). In this way, cultural models reflect cognitive schemas about what is valued in a particular cultural community and, importantly, individuals act based on these cultural models (Quinn & Holland, 1987). Given its focus on complex and culturally organized ideals of care, ECT reflects Rogoff's (2003) assertion that there is no "one best way" for children to develop and provides a framework for examining the cultural activities of a particular ecological niche. Because we sought to understand the aspirations, strengths, challenges and professional development needs of immigrant and refugee FCC providers, we drew upon contextual and culturally based theories of development to understand our findings.

2. Research context

Cliffmor[1] is a multi-ethnic community located in a large, urban city along the U.S./Mexico border, and a significant majority of residents are below the self-sufficiency income level needed to afford basic living expenses without accessing public assistance. It is known for its large immigrant and resettled refugee population from Central and South America, Asia, and East Africa, and the languages spoken by licensed FCC providers in Cliffmor reflect the diversity of the community: 31% of providers speak Somali, 25% speak Spanish; 25% speak English; 6% Arabic and Swahili, and the remainder speak Vietnamese (2%); Farsi (2%) and Tagalog, Korean and Chaldean (less than 1% each).[2]

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[1] Pseudonym
[2] Information provided by our county's child care resource and referral agency

Home-based child care providers in California must obtain a license if they care for the children of more than one family in addition to their own children. A provider can obtain a license to care for up to seven children in a small FCC home or up to 14 children in a large FCC home. The only training requirements are 15 h of training on preventive health practices (California Community Care Licensing Division, 2020). There are 3501 licensed FCC homes in our county (California Resource and Referral Network, 2019) and Cliffmor has a relatively high concentration of FCC businesses compared to the general region.

3. Method

3.1. Research design

The examination of the experiences of others is a central aim of qualitative research, as it seeks to increase understanding of how individuals experience, feel, and interpret certain phenomena in their everyday lives (Davies & Davies, 2007; Van Manen, 2004). As such, focus groups were the appropriate methodological tool to address the aim of our study and reflect our interest in learning more about the aspirations, strengths and challenges of FCC providers living in diverse cultural communities. In addition, because of the number of languages spoken by participants, our collaboration with staff from the EBCOs was critical and enabled focus groups to be held in the providers' preferred language. This would have been challenging had we selected to do interviews with individual providers.

3.2. Focus group participants

Focus group participants were recruited with the help of a local philanthropic agency and five EBCOs located in Cliffmor. All five of the EBCOs identify as non-profit agencies serving predominantly refugee and/or immigrant communities, and have a history of working with FCC providers, both formally through grant funding and informally via their long-standing presence in the community.

Prior to the recruitment of providers, the researchers, representatives of the philanthropic organization, and directors of the EBCOs met to determine the best way to recruit participants and fully engage them in the research process. Based on this discussion, and upon approval from the university's Institutional Review Board, the researchers sent an email to the directors of the EBCOs outlining the timeframe and logistics for the focus groups that had been determined by the group. The directors then notified providers about the focus group opportunity through word of mouth, email, and telephone. Providers were informed that the focus groups were designed to learn more about their needs, goals, and current practices. Table 2 provides a brief description of each EBCO that hosted a focus group, and the number of providers who attended. Several of the EBCOs received funding to support FCC providers. The EBCO serving immigrant providers was a CACFP provider for the county, and providers received nutrition related services via this program. Another of the EBCOs had a grant to support providers through the licensing process and another had a similar grant in the past which had expired.

All 60 of the providers identified as members of immigrant or refugee populations; with the majority coming from three countries: Somalia (n = 17, 28.3%), Mexico (n = 15, 25%), and Afghanistan (n = 7, 11.7%). All but one of the providers were female (N = 59, 98.3%). Providers varied in terms of their English proficiency, with approximately one-third identifying as *Beginning* (n = 19, 31.7%), one-third as *Intermediate* (n = 22, 36.7%), and one-third as *Advanced* (n = 17, 28.3%). On average, providers had approximately 6 years of experience as a licensed FCC provider. Our demographic questionnaire asked providers to select the highest level of education they had earned, ranging from a GED to bachelor's degree. Approximately 8 percent (8.2%, n = 5) of providers had a GED, 37.7% (n = 23) had a high school diploma, and 8.2% (n = 5) had some units in child development. Close to seven percent 6.6%

Table 2
Profiles of ethically based community organizations.

Community Based Organization	Purpose	Primary Population Served	Number of Participants
La Paloma	Invests in underserved communities through programs that promote self-sufficiency.	Immigrants	16
Metro Refugee League	Provides opportunities for refugees, asylees, victims of human trafficking and survivors of torture to thrive in America.	Refugee	16
Karen Community Action Agency	Meets the needs of Karen and other ethnic minority groups from Burma.	Refugee	4
East African Organization of San Diego	Represents and advocates for African refugees and immigrants, with a particular emphasis on refugees from Somalia.	Refugee	16
Newcomer and Migrant Alliance*	Aids newcomers and migrants beyond the initial allocation period.	Refugee	8

* pseudonyms have been used for all EBCO's.

(n = 4) had an associate degree, and 6.6% (n = 4) had a bachelor's degree. Of those that had an associate or bachelor's degree, one was in child development, one was in education, and the others were in unrelated fields such as art, chemistry, civil engineering, and agriculture. Close to a third of participants (27.9%, $n = 17$) selected the category of "other" when asked to indicate their education level, which may indicate that providers had a limited opportunity to attend school in their home country. Providers served children of multiple-ages (infants to school age) and a small number of providers (n = 2, 3.3%) reported serving children with a diagnosed disability. All providers participated in child care subsidy programs offered by the state to support low-income families whose members are working and/or in school.

3.3. Procedures

Prior to the start of each focus group, and in accordance with IRB regulations, representatives from each EBCO reviewed the informed consent document with providers in their home language and described procedures that were in place to ensure confidentiality. Providers then completed a short questionnaire intended to collect information on provider demographics and characteristics of their FCC home. A semi-structured focus group protocol was used to guide the focus groups, and questions included why the providers entered the field, what they felt they did well, challenges they faced, their approach to teaching and learning, and their professional development needs. Because we were interested in how we could support provider's ability to work with local agencies serving the FCC community, we also asked them to share information about the agencies they worked with, what frustrated them, and what they wish they could change. Participants received a $25 Target gift card as an incentive for their time, and focus groups lasted between 1 and 2 h.

A significant challenge we faced as researchers was how to accommodate the number of languages spoken by focus group participants. In total, there were twelve languages represented, the most common being Somali (n = 16, 26.2%), Spanish (n = 16, 26.2%), and Arabic (n = 7, 11.5%). We relied heavily on the expertise of the EBCOs, and each focus group looked very different depending on the population served by the EBCO and its organizational capacity. For example, the focus group held at the EBCO serving immigrant providers was facilitated by a staff

person and was held primarily in Spanish, with providers switching to English as needed. The focus groups at two of the EBCOs serving refugee providers were facilitated by a member of the research team and the executive director, with participants and facilitators speaking in both English (researcher and executive director) and Somali (executive director). At another EBCO serving refugee providers, tables were set up to accommodate four languages: English, Farsi, Arabic, and Somali, and staff from the EBCO translated what was said to English for the researchers. Finally, at a small EBCO serving refugees from Burma, a staff member conducted the focus group and alternated between Karen and Burmese, translating to English for the researchers. Focus groups exemplified the process of translanguaging, which occurs when bilingual individuals access different linguistic features of the languages they speak in order to take advantage of their full linguistic repertoire and communicate effectively (García, 2009). Translanguaging is viewed as a discourse practice that is not centered on languages but on the natural, observable communicative practices of bilinguals (García, 2009), and participants and focus group facilitators used translanguaging to increase their ability to share their thoughts and ideas. All focus groups were audio taped, and researchers and members of the philanthropic organization took detailed notes during the focus groups. These notes included phrases that addressed the research questions, as well as contextual notes related to impressions or insights. For example, notes from a focus group with Somali providers included a description of laughter that occurred as providers passed an infant from one to another; notes from another refugee group described the middle school children who were in attendance and that several of the providers were related. Another contextual note was that several members of the Somali group included young women who were currently attending community college and assisting their mother in the family's FCC home. Following each focus group, researchers checked in with the focus group facilitator from the EBCO regarding any questions that arose or to get clarification about possible misunderstandings. Researchers also debriefed following each focus group in order to compare impressions and make additional notes.

Following the conclusion of each focus group, audiotapes were sent to the EBCOs, and staff who spoke the providers' languages listened to the tapes and wrote down key statements related to the focus group questions (e.g. a list of challenges and professional development needs as described by providers). The university researchers also reviewed written notes from each focus group to identify statements related to our research goals. When this step was complete, a meeting was held with the university researchers, representatives from the philanthropic organization, and staff from the EBCOs to discuss initial findings. This process allowed for EBCO staff who spoke the providers' languages and were familiar with the providers' cultural community to provide input and participate in preliminary data analysis. This step was critical as it helped to address the wide variety of languages spoken during focus groups and also reflected the collaborative and bi-directional nature of our relationship with the EBCOs.

3.4. Data analysis

Following the meeting with the EBCOs, we utilized the constant comparative method first proposed by Glaser and Strauss (1967) to analyze our data. This approach has been used widely to generate findings in qualitative research (Charmaz, 2014) and is used to develop concepts from the data by coding and analyzing at the same time (Taylor & Bogdan, 1998). We employed three levels of analysis as described by Corbin and Strauss (2008): 1) open coding, 2) axial coding, and 3) selective coding. The first and second author independently engaged in the open coding process by coding transcripts and field notes and labeling each incident/event described by the data with 'as many categories of analysis as possible' (Glaser & Strauss, 1967, p. 105). While open coding, we re-listened to audio recordings, and re-read field notes to gain a thorough understanding of the data. We also recorded significant

statements (Miller & Salkind, 2002) that reflected properties and dimensions of each code and engaged in memoing as we considered how these codes related to our county's QRIS standards. Following open coding, the first and second authors met to reconcile any differences in coding and merge open codes into similar categories via the process of axial coding. The inductive and deductive analysis of relating subcategories to a category is the goal of axial coding (Corbin & Strauss, 2008) and allowed us to identify connections between the categories identified during open coding, as well as consider how codes were informed by our theoretical orientation. Because the open coding stage of data analysis suggested differences in the experiences of immigrant and refugee providers, we were careful to note whether statements associated with each code were made by refugee or immigrant providers. This step resulted in 10 axial codes that reflected terms, experiences, and/or perceptions identified throughout the data. After further consultation with members of the research team, the first author divided the list of axial codes into two types: 1) actor codes that reflected the people who were the subjects of participants' comments, and 2) content codes that indicated the content of participants' comments (see Table 3 for a list of axial codes). The first author then re-examined the data and applied these axial codes to all data sources. During the third stage of analysis, axial codes were further reduced by considering how the coded statements were embedded within one another or overlapped. After conferring with the second author, the selective codes of Love and affection, Family, Community, Cultural Continuity, Teaching as Care, and Regulatory Bodies and Systems were identified.

4. Results

4.1. Love and affection

Providers from all focus groups spoke about their love for the children in their care and stated that this was a key reason why they entered the field. For example, a refugee provider stated, "I can take care of my own kids, I love kids, and want to work with kids" and "I love the hugs, sometimes they don't want to leave at the end of the day."

A provider represented the views of others when she explained why she attended the focus group, "I am here to listen, to have a voice, and to express what I feel. I love the children above everything." Providers also spoke about the importance of "treating the children with love" and having empathy for them, "To understand the kids, I need to put myself in their shoes to understand. There are times where adults forget this." The importance of providing a safe, warm, and loving environment was

Table 3
Axial codes.

Axial Code	Type	Definition
Children	Actor	Providers' description of children who are cared for in the provider's home
Families	Actor	Providers' description of families of the children who receive care
FCC as a business	Content	Providers' perceptions of FCC as a viable business
Feelings about FCC as a profession	Content	Provider's feelings about their chosen profession
Cultural practices	Content	Description of events or feelings related to cultural practices
Communication/ Information Flow	Content	Description of events or feelings related to communication or how/if information was shared
Challenges	Content	Description of events or feelings related to the challenges of operating a FCC home
Community	Content	Description of events or feelings related to their community
Conflict	Content	Description of events or feelings related to conflict
Support/Resources Needed	Content	Description of supports/resources needed to support their role as providers

important to all providers in our study, and was described as a valued aspect of their work.

4.2. Family

Data also indicated that both immigrant and refugee providers valued the closeness and family-like atmosphere of FCC and enjoyed their role as a second mother to the children in their care. For example, when asked why she entered the profession, one of the immigrant providers stated, "I like to see kids thrive and to help them socially, emotionally – I become part of the family." When asked to describe what they did well, providers discussed "patience and relationships" and several mentioned that they "feel like the second family to the children", with one stating "it is like having two mamas, and I love them all."

Although providers clearly valued the family centered nature of FCC, they also described challenges working with families. Providers from all focus groups stated that parents often picked up their children late and that children remained in care for more hours than scheduled. For example, a refugee provider stated, "One of the hardest things about the job is when parents don't pick up their kids when they are supposed to, and we have other kids to take care of." This also led to providers "working for free". Participants also shared that parents often expect them to do things outside of their scope of work such as taking their child (ren) to doctor's appointments or would bring sick children to care. Providers often felt disrespected by parents, and one provider stated, "It may be past 11am in the morning, and the child wears a dirty diaper, sometimes arriving without being changed." Providers from the immigrant group described challenges with child custody issues and what they perceived to be poor parenting, as exemplified by the following quotes: "lots of families are divorced and there are many conflicts, there are conflicts over custody. Parents need to put the children first" and "I have to raise the child and teach things that should be taught at home. Children are always on tablets at home, I am raising the child." Recalling the love and affection theme, one provider stated, "one of the challenges today is that many parents are divorced and they have many conflicts. I don't want this to affect the children" and seeing the children suffer "broke my heart."

Importantly, however, data also indicated that despite these conflicts and challenges, providers valued their ability to have a positive impact on families and to support families who they knew were struggling. As one provider stated, "sometimes they [the parents] are really young." When asked to describe their strengths, providers often referred to providing stability to children in their role as an extended family member. For example, an immigrant provider stated, "I like to be part of the family, to be a confidant to the family, they talk to me, I help the families. We give them [the children] the love that sometimes parents don't have the time to give." Providers stated that they often "felt like the family's therapist" and one noted that she is "working with the mother and the child." Data indicated that providers from all focus groups emphasized that an important and valued aspect of their profession was caring for the child within the family system.

4.3. Community

Also important to providers, and closely related to the themes of love and affection and family, was their role in serving their community. Data indicated that providers viewed community in a variety of ways and that service to and strengthening their community was something that is important to them. Providers from the refugee group spoke about their FCC home in terms of both family and community and stressed the importance of community members helping one another. For example, a provider from Somalia described that she and her friends had children who needed to be cared for and "my friends trust me to care for their children because I am part of the community - or we are family members." Another provider described that she opened her FCC home because she "likes kids, I can do it at home, we are family so we help

each other." Others stated, "the kids are happy because they have us, and so they have their community" and "it helps me financially, and I help other families in my community. It's easy and comfortable for me."

Providers from the immigrant groups spoke about challenges that were specific to the community of Cliffmor. For example, one provider spoke about working to improve the community, and stated, "I do it here in my community. To go out with a bag and pick up trash. To show the parents and neighbors how things should be." The providers from this group also engaged in a discussion about the local parks and the problems they encountered:

> There is a nice park by my house that I take my children to, but the problem is older kids come smelling of marijuana and those kinds of things but then I leave and take my kids away from there. I have run off many 14 or 15 year old kids telling them look, these things are not meant for 5 year olds. But I can't do it all. Who can solve these problems? Who can make the streets safer for kids so that we can walk happily to the parks?

Another provider discussed the need to have bathrooms at the local park and stated, "there aren't any bathrooms, and the kids can't hold it, and after a little bit we go running back to the house so the kids can go to the bathroom." This focus on both families and the community of Cliffmor was further exemplified when providers described why they attended the focus group, "I am here to listen and come to an agreement about how to better the community" and "I am here because I was told this was to support the community. What are the needs in the community? There are lots of needs, for the parents and even more for our children. They need lots of support."

The theme of community was also reflected in how providers from immigrant and refugee groups described the community of FCC providers living in Cliffmor, as demonstrated by the following quotes: "Our colleagues deserve respect, and we are here to expose our problems. What needs are there?" and "I am here to listen to the opinions of other providers, to see if we have the same issues, to hear different opinions and see if we can solve the programs in the day care because we have a lot." Providers expressed their gratitude that the focus groups provided them with a forum to come together as a FCC community, and when asked if they participated in a FCC support group, providers stated that no such groups exist. One provider stated, "We never really get together, this is it." Providers felt a support group could help them advocate for their profession on a variety of issues ranging from the health and safety issues described earlier to making changes to the subsidized care system. According to one younger Somali provider who was enrolled in community college, support groups offer an important space for sharing self-care strategies that have been effective for providers facing similar stressors, and yet they aren't available in her ethnic community. She stated, "Doing this job, it can be very stressful. One question is, how do you provide the providers a way to take care of themselves? You get more support in the Spanish-speaking communities, but for Somali's, I don't feel like we talk about self-care."

Providers were also interested in working together to improve access to benefits such as health care. A Somali provider described, "When you reach 60-something, nothing. It's hard when you work all your life and you don't have benefits, insurance, or retirement, and you have to pay taxes", and another stated, "We'd be willing to pay union dues but it has to be beneficial." Providers also described concerns about potential burnout as a result of the excessive stress and constant demands of operating a FCC business in a new country. As stated by one refugee provider, "These are hardworking women but they don't give themselves credit. If you are doing this job, and you aren't taking care of yourself, you can get burned out, so I think we should have a training for this. We are human, too."

4.4. Cultural continuity

Data indicated that ensuring cultural continuity between the FCC home, the family, and the community was valued by the providers. Refugee providers in particular described a strength of their programs was their ability to provide culturally relevant practices that reflected the goals and values of their cultural community. For example, when asked what they did particularly well or were proud of, providers often described their ability to serve traditional food, and one provider stated, "I give them food, I cook African dishes and make sure it is healthy." Another provider from the Congo described how prayer was an important part of her daily schedule, and the importance of religion was also evident in the Farsi group. A provider from this group explained that religion in her community is very conservative and parents look for providers to teach children the principles of Islam, especially during the early years of life. During the debrief, a member of the EBCO serving the Farsi community explained that parents from their community often seek out providers who have knowledge of their culture and religion and that this is more important to them than a provider's ability to prepare children for school. A provider in the Farsi group also stated that it is often culturally valued for a wife and mother to stay home and care for one or more children in addition to her own, which is something FCC allowed them to do. Although immigrant providers did not explicitly describe the importance of transmitting cultural values and practices to the children in their care, the themes love and affection, family, and community reflect values common to the Latinx culture and a collectivist orientation to child rearing.

4.5. Teaching as care

When asked to explain their approach to teaching and caring for young children, providers described the caregiving aspects of their work, and many described the importance of serving healthy meals and having a routine. For example, a provider from one of the refugee groups stated, "Snack and food are one after the other. We have a routine." Two other providers from the immigrant group described their approach by stating,

> After eating and all that, I put educational videos on. We sing in Spanish, we watch videos about learning numbers and colors. On Fridays, we watch movies. It is 'social Friday' and they choose what they want to eat.
> We have a curriculum and routine but nothing else. The kids arrive and do whatever they want, but no real structure. For example in my case, at 8 in the morning it's breakfast, then the kids clean everything. By this time the sun is strong, and I take advantage of it and take the kids to the patio. Then we return less than 45 min later for reading and then I do music. After reading, the kids draw whatever they want and they describe it to me. After that, it's free time.

Providers from all focus groups discussed the social emotional aspects of teaching young children and the importance of play, and the Teaching as Care theme was closely related to the Love and Affection theme. For example, a provider from one of the refugee groups stated, "I love working with children, singing to them, playing with them." Another Somali provider described, "I want the kids to be safe, clean, happy, and no hitting". A provider from the immigrant group shared that "we are helping them emotionally and teaching them how to develop - how to speak, how to ask for something. That is what I enjoy" and another stated, "When I am playing with children, when I am teaching them, I enjoy very, very much seeing how they develop". When asked what she did well, a refugee provider stated "feed them right, play, go to the park, go on trips, make sure they are happy." Providers from the Farsi group described their approach as "not watching TV, providing educational toys, and teaching the alphabet." Providers also described the importance of "keeping children safe and healthy",

ensuring they "eat nutritious meals" and making sure "they don't fight." Providers also shared challenges caring for children from multiple age groups. They did not mention their role in preparing children to be successful in school.

4.6. Regulatory bodies and systems

When examining the intersection of the code 'Challenges' with other codes, we found that providers described struggles related to the regulatory bodies that govern FCC, including licensing, the subsidized care system, and the federal Child and Adult Food Care Program (CACFP) program. Refugee providers also described difficulties understanding the regulations, systems, and processes governing business in the United States, as well as conflicts between their cultural practices and many of the regulations governing FCC.

4.6.1. Licensing

Providers from both groups discussed challenges with licensing regulations. For example, providers in the immigrant focus group discussed difficulties managing adult to child ratios given the different ages groups enrolled in their home and the need to count their own children in ratios. Refugee providers described barriers related to obtaining, maintaining, and renewing their FCC license. For example, a provider from the Karen refugee community described that she had recently lost her license because of confusion over the paperwork that needs to be completed. Providers shared that it would be helpful to have a simple list of the things needed to get a license, a space set up like an FCC home that could serve as a model, and start-up money to assist with the costs of getting licensed. As one provider stated, "I want to know where to buy the smoke detector." Ongoing support related to renewing the child care license and increasing the licensed capacity of the home was also a stated need, and during several of the focus groups the first author was asked if she could provide information or assistance on issues related to licensing. One provider summarized the comments made by others when she stated, "The community helps us when we start our business, but there is no continuous support. Licensing doesn't mail out information letting us know what is required, then we get cited and lose our license. So, it's sad. So we need training in licensing information as well, because it's an ongoing process and it's changing."

Providers from the refugee groups reported challenges negotiating their cultural beliefs and practices with licensing regulations. For example, one provider explained that in her cultural community children typically sleep on mats on the floor and that "they [state licensing agency] want us to have cribs, but our kids sleep on the floor and the parents are fine with that." Not only is sleeping in cribs culturally incongruent with caregiving practices of families and providers, but purchasing cribs is an additional cost that providers cannot afford.

4.6.2. Subsidized care system

Providers from all focus groups described significant challenges related to our state's subsidized care system and discussed many difficulties associated with filling out the paperwork required to enroll children and receive payment for their care. One provider stated, "You keep having to go back" to re-do incorrect paperwork. Providers described difficulties with completing time sheets, and incorrect subsidy paperwork often resulted in providers not getting paid on time. A provider described the difficulty with being paid once a month, "We might turn in sheets on the first of the month, but we don't get paid 'til the following month. We are already late for the rent for the month. Who can do that? And that's not fair, who can do that? Everyone else gets paid for the first of the month, or every two weeks. It's always so late." During a debrief, one of the staff members from a EBCO serving the refugee population shared that math literacy was a challenge for many providers.

Providers also stated that it would be beneficial to have subsidized care programs offer support for parents who need assistance in completing their own paperwork and following the regulations governing subsidized care. Importantly, because of economic instability and language barriers, refugee providers had less power and ability to hold parents accountable than did immigrant providers. Providers from the Farsi group, for example, stated that parents will often threaten to disenroll their children if the provider tried to hold them accountable, and this often resulted in them working for free. Another refugee provider described that "the parents want to leave them for longer, but I don't know what the rules are." Importantly, while both groups felt stress related to ensuring parents followed the guidelines of subsidized care, immigrant providers had more systems in place to address these issues. Several providers in this group stated that they charged families when they were late to pick up their children and had contracts with parents that were helpful in setting and maintaining boundaries, although one provider stated that problems occur even though "they are given the contract and everything is specified."

It is important to note that while providers from both groups described challenges with the subsidized care system, these challenges were especially acute for refugee providers because of their limited English skills and because no one at the agency responsible for child care subsidies spoke their language. According to one provider, "most of us don't have the language, and this makes it difficult." Another provider stated "there is no consistency or convenience for the providers, they make you go back and forth. They don't speak the language. You have to deal with people who work there who don't understand what you are trying to say, even when you are speaking English." These providers indicated needing technical support in completing paperwork and having access to paperwork in their native language. One Somali provider stated "I feel we need more training in the documents that parents need to fill out, and documents for each child. There are at least 8 documents for each child. Imagine if I didn't know how to read. We need those documents in our language, like they have in Spanish." Recalling their frustrations with licensing, providers felt very strongly that they would not only benefit from having training in their own language, but that it was also important for agencies that provide child care subsidies to have staff that speak their language, as evidenced by the following statement from a Somali provider, "A lot of the trainings are in Spanish, but the training is not in our language. Certain programs need to focus on not only speaking Spanish but other languages as well, such as Somali. Providers and parents will feel so comfortable knowing that they have someone there who looks like them and speaks the same language. Refugee providers also struggled to understand the government's role in subsidized care, and a provider from the Burmese community described the fear she experienced due to the fact that the children in her care "are the government's children." During a debrief, the Executive Director from another EBCO serving refugee providers shared that parents sometimes tell providers that because providers are getting paid by the government to care for their child, the provider needs to pay the parent a portion of the money.

Importantly, because the agencies responsible for providing subsidies were not always convenient for refugee providers (no one to speak their language, difficult to access by bus), they often relied on the EBCOs for assistance with paperwork. This stretched the already limited resources of the EBCOs, and in some cases, although grant funding to support FCC providers had expired, providers still came to the EBCO for assistance. As explained by one provider, "I have worked with the [EBCO] a lot, including trainings, paperwork, asking questions, because it is the only place where I can come where they speak my language." Language was not a barrier for the immigrant providers, as many of the required forms and trainings are available in Spanish, and staff at the agencies providing subsidized care are often bilingual in English and Spanish.

Difficulties navigating the subsidized care system often made it difficult for refugee providers to maintain full enrollment, and providers described the economic instability that resulted from low and/or fluctuating enrollment as one of the biggest challenges they faced. For

example, a provider from the Somali group explained, "I will stay in the profession as long as I am able to enroll enough children to stay open" and "when you love your job so much, you keep working. And it's hard to find kids, to be honest." Fluctuating enrollment made calculating their income difficult, and providers stated that this impeded their ability to plan for the future and/or purchase additional learning materials and supplies. Several shared that they were interested in learning more about how to purchase a van to transport children to and from school or increase their licensed capacity, but that this was difficult because of unstable enrollment and income. This represented a challenge that typified a great deal of their work: providing transportation is a service that is valued by parents and helps providers attract clients, yet purchasing a van (or hiring additional staff in order to enroll more children) was challenging because of the economic uncertainty of the work. A provider described another enrollment issue described by others when she stated, "A recruitment issue is that the agency requires providers to take their classes, but the times are difficult if you are taking care of kids, so you might be enrolled in a referral program but not getting kids because you haven't taken the classes."

Refugee providers also described that an additional barrier to full enrollment was a lack of referrals from outside of their own cultural community. A provider from Somalia, for example, stated that while she often receive referrals from the local resource and referral agency, parents "See how we are dressed [hijab] and they don't come back" and another described "It's hard to fill the spots in a reasonable time because some of the neighbors might not trust us as a Muslim community. It's a challenge for them. So that's a big obstacle. Most of our children come from friends and family." Providers were eager to serve children from outside their own cultural community, with one stating that she although she currently served only Somali children, "I am interested in expanding to different cultures. I want a business card with different languages." Another provider stated,

> We do a lot of things that other providers in the community don't do. Usually in the beginning when they see us they don't trust us, especially the outside community, but once they get to know us, they always spread good word and say we are really good for the kids. Especially when I have the families for longer.

Maintaining full enrollment was not a concern for the immigrant providers, and several stated that they had waiting lists and established practices for marketing their program to families (e.g. fliers posted around the community, relationships with local elementary schools). These providers also relied on word of mouth and referrals from past clients to ensure that they were always at their licensed capacity.

4.6.3. Child and adult food care program

CACFP was another regulatory body that refugee providers had difficulty navigating. While all of the providers in the immigrant group were enrolled in this program, none of the refugee providers participated. Providers from the refugee group reported that they chose not to participate in the state's food reimbursement program because the paperwork was too difficult and the program had nutritional and food service preparation requirements that conflicted with their cultural practices (e.g., separating foods into food groups versus combining them into a single dish). One provider described that the program was too rigid and "requires that we only serve American style food. Our food doesn't fit the requirements even though it is healthy" and "we don't do mealtimes like American style, so unless you meet those food requirements, you aren't going to get reimbursed." This further contributed to the economic instability of refugee providers, as they were unable to access a resource designed to alleviate some of the costs associated with providing care to young children. Providers requested advice on how to negotiate these practices so that they honored their cultural beliefs (and often those of the parents) while maintaining regulatory standards that allowed for reimbursement.

4.6.4. Business practices

Another challenge described by refugee providers was their lack of knowledge about how to manage a small business, with one provider stating, "We need to know to run a business in the United States." Providers discussed challenges understanding accounting, calculating and saving for self-employment taxes, and lease/renter rights. Several providers described their difficulties with landlords who wanted to charge them more rent if they increased their licensed capacity, and discussed their fears of eviction if they needed to make a change to their apartment or home to comply with state regulations. Providers from the immigrant group, on the other hand, described training and support that was available to them on issues related to taxes and tenant/landlord rights from one of the agencies managing subsidized care that contracted with a Spanish-speaking attorney. They found these trainings very helpful and stated that they would like to attend more.

5. Discussion

Understanding the aspirations, strengths, challenges and professional development needs of immigrant and refugee FCC providers requires a multi-level theoretical frame that reflects theories of development within context as well as those that reflect cultural understandings of development. To this end, and to facilitate the discussion of our findings, we have organized our results, presented in Fig. 1, in a nested model that accounts for experiences and influences at both proximal and distal levels. At the center of this model are themes related to provider's lived experiences that represent the ways in which providers described their aspirations, strengths, challenges, and professional development needs. These themes include the Love and Affection cultural model of FCC first identified by Tonyan (2013, 2015, 2017), and four new themes that emerged from our data: Family, Community, Cultural Continuity, and Teaching as Care. These themes are embedded within the larger theme of Regulatory Bodies and Systems that govern FCC, which are enacted within the larger, macro-systemic contexts of poverty, racism, the immigrant and refugee experience, and mainstream conceptualizations of quality. In keeping with the tenets of ecological systems theory, each level of this model influences the others in complex and dynamic ways.

At the center of this model is Love and Affection, which reflects a cultural model of care in which providers prioritize love and affection as a valued aspect of their work (Tonyan, 2013, 2015, 2017; Paredes, Hernandez, Herrera, & Tonyan, 2019). Closely related to the Love and Affection theme are the themes of Family, Community, Cultural Continuity, and Teaching as Care. Taken together, they reflect a collectivist orientation to child rearing often found in many immigrant and refugee cultures that value interdependence, group success, extended family structures, and a focus on family well-being above individual achievement (Rothstein-Fisch, Greenfield, Trumbull, Keller, & Quiroz, 2010). The majority of providers in our study were from Somalia, where the definition of family includes many individuals, including aunts, uncles, and cousins (Heger Boyle & Ali, 2010), and refugee providers spoke frequently about their role in helping to care for children in their family and community and the importance of providing culturally responsive care. Although immigrant providers did not explicitly describe the importance of providing culturally responsive care, the five themes at the center of our model reflect values commonly associated with Latinx families, and our findings recall Paredes et al. (2019) identification of ideals of care that reflected the constructs of familismo and compadrazgo. Our findings extend this work to the FCC providers living in Cliffmor, as data indicated they valued their role in extended family networks that supported culturally valued practices and beliefs. Shivers et al. (2007) have noted that families often want a provider who shares their cultural values, language, and traditions, and because a primary goal of QRIS is to inform families about quality in ECE, it is thus critical to consider how quality rankings serve families, particularly those with children in FCC settings, by providing information that is of value to
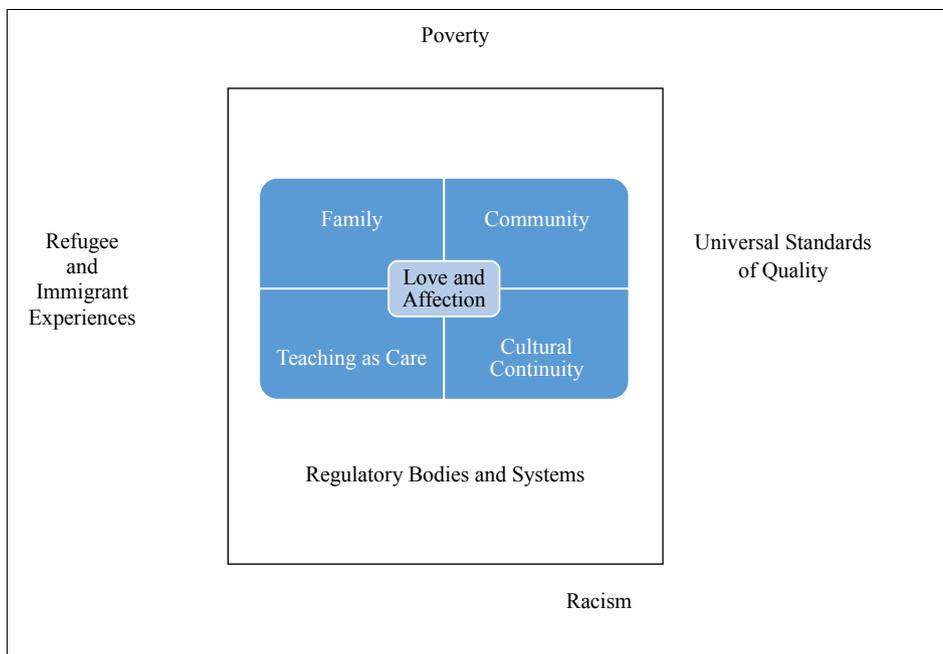
Conceptual Model

Fig. 1. Conceptual Model.

parents.

Because primary aim of our study was to use the results to inform our professional development efforts to support provider participation in QRIS, it is critical to juxtapose these five themes with the three core areas addressed our state's QRIS matrix. In order to receive a five on the core area of child development and school readiness, providers must conduct observations of children, use observations for screening and assessment purposes, enter results into the state's data collection platform, and plan curriculum based on this data. These expectations for child development and school readiness are in stark contrast to how the FCC providers in Cliffmor described their work, with none of them mentioning school readiness as valued outcome of their profession. Rather, the providers in our study valued the caregiving aspects of their work and aspired to make sure children were happy, had opportunities to play, and were served healthy, culturally appropriate meals.

It is also important to note that in order to receive the highest quality rating on the core areas of both teachers and teaching and program environment, providers must achieve a predetermined score on the CLASS (Pianta, La Paro, & Hamre, 2008) and FCCERS-R (Harms, Cryer, & Clifford, 2007), which could be problematic given concerns that these tools fail to account for the complexities within and across cultures and languages. As noted earlier, these measures are framed by Eurocentric standards of care and support dominant discourses that may be at odds with the goals and values of providers and families from diverse cultural communities. Given the well-documented and unfortunate history of deficit thinking that has plagued education both in the United States and internationally (Gee, 1996), it is important for the field of ECE to consider the effects of asking providers from diverse backgrounds to change their practices to reflect the dominant perspective (Garrity & Guerra, 2015).

An additional measurement of quality required our state's matrix is that providers earn a bachelor's degree in order for their program to receive a score of five. Achieving this benchmark may be especially difficult for the providers residing in Cliffmor, as low-income providers and those with limited English may experience difficulty accessing higher education (Public Health Law Center, 2017), and may be unable to afford costs related to the training and education required by QRIS, even when subsidized (Sugarman & Park, 2017). In addition, guides and

trainings designed to support provider success in QRIS and often only available in English, with assessors or evaluators who also only speak English (Public Health Law Center, 2017). Somali refugees, who comprised the majority of providers in our study, often have low literacy rates and struggle with English fluency because of interrupted education (Johnson et al., 2009), and providers in our study described language barriers as a significant challenge. Reinke, Peters, and Castner (2019) contend that QRIS privileges certain types of education, credentials, and training and excludes diverse ways of knowing in favor of the dominant discourse. The themes at center of our model provide further empirical support for the use of cultural models when examining quality in FCC settings and call into question the one size fits all approach of QRIS.

Similar to the findings of others, providers in our study experienced difficulties engaging with regulatory bodies and systems and described challenges related to paperwork, communication, and provider payment practices (Barnes & Henly, 2018; Sandstrom, Coffey, Henly, Bromer, Spalding, Thomas, Geenberg, & Derrick-Mills, 2018; Shivers, Tonyan, & Weber, 2019). QRIS represents another system that providers must navigate, and Hallam et al. (2017) have identified that a barrier to FCC provider participation in QRIS is the difficulties they experience navigating multiple systems. In their framework designed to bridge policy and practice in FCC, Vieira and Hill (2019) describe the need to address many of the challenges identified in our study, and caution that, without careful implementation, QRIS can inadvertently perpetuate inequitable systems by giving the highest-resourced programs additional resources while further marginalizing under-resourced programs, which often serve low-income, at risk children.

As described by our model, these regulatory bodies and systems are embedded within the more distal contexts of poverty, racism, the immigrant and refugee experience, and mainstream definitions of quality embodied by QRIS. It is critical to note that the challenges documented during focus groups were especially acute for refugee providers who described a level of economic instability and stress not experienced by providers in the immigrant focus group. Unlike immigrants, who can choose where and when to enter a new country, refugees have much less control over their migration experience, and language barriers, lack of understanding of business practices in the United States, and difficulty enrolling children from outside of their own

cultural community created stressors unique to this group. These stressors occurred within the context of the refugee experience, which includes trauma, loss of family members and wider social networks, and potential loss of social status. Additionally, the refugee FCC providers in our study were primarily Black, and reported experiencing discrimination from landlords and/or other community members, foregrounding an additional stressor that minoritized, especially Black, refugee FCC providers may encounter. Our findings suggest that refugee providers may face stress associated with discrimination and stigma once they arrive to the United States, in addition to experiencing stress and trauma prior to migration.

5.1. Limitations

The results from this study are not generalizable because we did not have a representative sample, and additional research is needed to examine whether our findings can be corroborated in other cultural communities. Another limitation of this study is that we did not collect demographic information on the children and families enrolled in the FCC homes, which limited our understanding of provider experiences. Finally, although our study was grounded in cultural approaches to development, we did not ask specific questions about culture or cultural practice related to caregiving in the providers' countries of origin. More research is needed to explore these complex issues.

5.2. Implications for practice and next steps

Reinke, Peters, and Castner (2019) contend that a blatant omission in mainstream conceptualizations of quality is the perspective of those outside the expert or governmental realms, including families, practitioners, and children, and results from our study gave voice to those actually doing the work of caring for young children and informed our approach to professional development in several ways. Reflecting the extant literature on provider participation in QRIS, providers residing in Cliffmor wanted professional development that was responsive to the FCC setting (Hallam, Hooper, Bargreen, Buell, & Han, 2017; Hallam et al., 2019; Tonyan, Nuttall, Torres & Bridgewater, 2017) and was provided at the EBCO in their home language. In response to the data indicating that providers, especially those from refugee backgrounds, struggled financially, we partnered with three of the EBCO's to provide a 12 week, comprehensive training series designed to increase FCC providers' skills and knowledge related to business practices, including marketing, contracts and compliance, and bookkeeping. A key feature of this effort was the use of cultural navigators who reflected the cultural communities of Cliffmor. Cultural navigators provided assistance with obtaining and maintaining the FCC license, served as a resource in the areas of enrollment and parent relations, acted as a liaison between providers and agencies responsible for subsidized care, and helped providers negotiate conflicts between their cultural beliefs and practices and expectations for quality child care in the United States. Importantly, while the EBCOs had the capacity to provide trainings in Spanish, they were unable to provide training in Somali. To address this issue, the cultural navigator representing this population attended the trainings conducted in English and helped translate/interpret the content into the providers' home language during one-on-one coaching sessions.

We have shared our findings with our local Quality Counts California Consortium, the team responsible for implementing QRIS in our county, and are engaging in ongoing conversations about how to honor the values, strengths and challenges faced by providers when considering their participation in QRIS. Finally, given the potential mismatch between expectations for teaching and learning found in the cultural communities in Cliffmor and expectations of our state's QRIS, the next phase of our research includes using photo-elicited interview techniques proposed by Tonyan (2017) to learn more about providers' daily lives in order to provide a further window into the beliefs and practices that guide their work with children and families. Our hope is that our work

furthers the discourse in the field as to how we can create a sustainable FCC workforce that is both high-quality and uniquely responsive to the community context.

CRediT authorship contribution statement

Sarah M. Garrity: Conceptualization, Data curation, Methodology, Investigation, Formal analysis, Writing - original draft, Writing - review & editing. **Sascha L. Longstreth:** Data curation, Investigation, Formal analysis, Writing - review & editing. **Vanja Lazarevic:** Investigation, Writing - review & editing. **Felicia Black:** Writing - review & editing.

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