



**Preschool Development Grant  
Birth through Five**

# **Qualitative Interviews of Underserved Populations in Wisconsin Early care and Education**

**Final Report**

**December 2020**

Prepared for the Wisconsin Department of Children and Families by the Center for Community and Nonprofit Studies, University of Wisconsin–Madison



**Wisconsin Department of  
Children and Families**



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A team of qualitative researchers interviewed 63 primary caregivers and early care and education (ECE) providers of five demographic populations currently underserved by the Wisconsin ECE system (Hmong, Latinx, Black or African American, Indigenous or Tribal, and rural white). To understand their experiences and needs in the ECE system, interviewees responded to questions about access, affordability, and quality of ECE; the ECE workforce; and the impacts of the COVID-19 pandemic. Their responses indicated the ways that factors of socioeconomic strata, race, culture, communication and language, and geography and transportation impact their experiences. The findings suggest an overall pattern: The current ECE system in Wisconsin is based on assumptions that fit a dominant model of socioeconomically-advantaged, white, monolingual English-speaking, suburban and urban families and the ECE centers they prefer and, as such, systematically underserves those who do not fit these assumptions. The report concludes with a set of recommendations for ways to improve the access, affordability, and quality of ECE, to support the ECE workforce, and to recover from the COVID-19 pandemic to better serve these underserved populations and others.

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The Preschool Development Grant Birth through Five (PDG) was a one-year federal grant that supported the state of Wisconsin in the completion of a needs assessment and a strategic plan to improve early care and education (ECE) in 2020. The needs assessment examined ECE accessibility, affordability, and quality, and workforce needs and challenges in a comprehensive, equity-focused manner for Wisconsin's most vulnerable, underserved, and rural populations.

The Wisconsin Department of Children and Families (DCF) contracted with the University of Wisconsin-Madison Center for Community and Nonprofit Studies (CommNS) to support one piece of the needs assessment. As requested, the CommNS led a team of researchers in a qualitative study to understand the experiences and perceptions of primary caregivers and child care providers from five demographic populations in Wisconsin: Hmong, Latinx, Black or African American, Indigenous or Tribal, and rural white. In individual interviews, caregivers and providers shared their thoughts on early care and education (ECE) in Wisconsin presently, including perceptions of access, affordability, and quality; workforce needs and priorities; and the influences of the COVID-19 pandemic on families and providers.

## The Research Team

The interview team included three faculty researchers (Drs. Maichou Lor and Stephen Quintana of UW-Madison and Dr. David Pate of UW-Milwaukee), a DCF researcher (Stephanie Lozano), and five UW-Madison graduate student researchers (Sandie Thao, Bakari Wallace, Kate MacCrimmon, Danya Soto Leyva, and Jessica Perez Chavez) all with racial, ethnic, and/or language backgrounds similar to one of the five interview populations. Dr. Amy Hilgendorf and Alexandra Wells of the CommNS provided overall coordination and support for the collaborative study, including the preparation of final deliverables.

Researchers recruited caregivers and providers from each of the demographic populations, interviewed participants, and collaborated on analysis. For clarity, we note that we are using the words caregiver to mean a child's parent, immediate family or primary guardian, and provider to mean a person or center providing child care for another's children, whether for another family member or as a staff person at a child care center or family (home-based) child care program.

## Research Questions

As the study team, we sought to address the following questions:

1. What are the most important needs for ECE in Wisconsin as identified by families, primary caregivers, and providers who are underserved by the current system (e.g., Black, Indigenous, or People of Color, with lower socioeconomic standing, and/or in rural areas)?
2. How do the day-to-day realities of people in these underserved groups impact their ECE needs and experiences?
3. What similarities and differences exist across underserved groups related to ECE experiences, needs, and challenges?

Additionally, with the onset of the COVID-19 pandemic in March 2020, we added a fourth research question:

4. What have been the implications of the COVID-19 pandemic for caregivers and providers related to ECE in these underserved groups?

## Recruitment and Interviews

Prior to conducting interviews, the team submitted the study protocol to the UW-Madison Education and Social Behavioral Science Institutional Review Board, who approved the project. The research team followed guidelines for protecting human subjects and researchers asked for oral consent from participants before each interview. Interviews were confidential and quotes for this report have been modified to avoid identifying information. We note that some

interviewees seemed hesitant to offer observations about some aspects of their child care or provider experiences, possibly because the interviews were being conducted for a state agency.

The team recruited interview participants through a combination of methods, including: contacting community centers and child care providers, contacting Child Care Resource & Referral agencies and asking them to send information to families and providers, recruiting through personal or professional contacts (for example contacts in local government or community centers), posting information on social media, and asking participants to invite others. Participants were included in the study if they identified as belonging to one of the demographic groups and also fit one of the following categories: a) were a primary caregiver of one or more children, b) were a child care provider, c) worked in a field related to ECE (e.g. home visitation), or were a professional involved in local ECE policy decisions.

The interview team recruited participants through the months of July to October 2020, and conducted interviews from August to November 2020. Interviews primarily took place by telephone and were 45 minutes to 1 hour in length. A total of 63 interviews were conducted during the study with interviewees located across Wisconsin. 61 of the 63 interview participants were women. About two-thirds of the participants who provided income information made less than \$40,000 per year. Of those who made above \$40,000 per year, only three were providers and the rest were primary caregivers. Table 1 shows the number of participating caregivers and/or providers in each demographic, along with the Tribal affiliation or Wisconsin county where they resided.

**TABLE 1: Interview participant demographics.**

| Demographic Group | Caregivers | Providers | Dual (Caregiver & Provider) | Total Participants | Counties and Tribal Affiliations   |
|-------------------|------------|-----------|-----------------------------|--------------------|--|
| Black             | 14         | 3         | 2                           | 19                 | Dane, Milwaukee  |
| Hmong             | 9          | 4         | 1                           | 14                 | Dane, La Crosse, Outagamie, Marathon, Wood   |
| Latinx            | 7          | 2         | 0                           | 9                  | Dane   |
| Rural white       | 5          | 4         | 2                           | 11                 | Barron, Douglas, Pierce, Polk, Sawyer, St. Croix, Washburn, Lac Courte Oreilles Tribe        |
| Tribal            | 0          | 7         | 3                           | 10                 | Badriver, LCO, Red Cliff, Lac du Flambeau, Oneida, Menominee, St Croix, Potawatomi, Ho-Chunk |
| <b>Total</b>      | <b>35</b>  | <b>20</b> | <b>8</b>                    | <b>63</b>          |  |



The study team asked interview questions that were intentionally similar to those asked at the PDG Listening Sessions (see Appendix 1 for the interview questions). However, caregiver interview questions were revised for each demographic group to make their meaning more understandable and to avoid academic or professional jargon. For Tribal interviewees, the team added a question regarding whether the current structure of ECE was perceived to honor Tribal traditions and customs.

### **Collaborative Analysis**

After completing the interviews, the research team met multiple times over a period of four months to collaboratively analyze interview results. We began with deductive coding, examining the findings from the standpoint of the DCF Preschool Development Grant framework – Accessibility, Affordability, Quality, and Workforce – and the DCF Equity and Inclusion Framework (Appendix 2) to ensure a critical systems lens. We also examined the interviews for findings related to the ongoing COVID-19 pandemic, its impacts, and implications for recovery in ECE. We looked for common themes across demographic groups and for patterns within groups. Our analytic approach then shifted to incorporate inductive coding, or looking for additional themes suggested by patterns within the interviews themselves, and these yielded a final set of themes, presented in the findings below.

As with all qualitative research, we want to note two important considerations to keep in mind:

1. Qualitative research is conducted by people and each researcher brings their own ideas, experience, and subjectivity to research study. While the systematic practices of qualitative research and a thoughtfully-recruited and engaged research team with varied experiences enhance the validity of the study and its results, this report presents our best understanding, not objective “truth.”
2. Coding and the presentation of themes involves a portrayed simplification of lived experience. As such, it is important to recognize that interviewees are more complicated than what is presented here, with each individual’s experience different from each other’s, whether of the same demographic group or not, and that no individual’s experience can represent the entirety of experiences for others of a particular shared background. Additionally, it is important to remember that these themes intersect and interweave with each other (e.g., one’s socioeconomic experiences are further influenced by one’s racial experiences), rather than have a distinct influence in one’s life.

In examining the shared and distinct experiences and perspectives of caregivers and providers in these underserved groups, we identified various factors interviewees pointed to as influencing how well the current ECE system served their needs. Some of these factors and their consequences were common across all demographic groups, while some were more particular to certain groups.

Below, we discuss these factors – by theme of socioeconomic strata, race, culture, communication and language, and geography and transportation – and detail their implications, as indicated by interviewees. Additionally, we share findings related to the impact of the COVID-19 pandemic and the vulnerabilities in the system that this pandemic has revealed. We note that while we have chosen particular quotes to illustrate different factors, the quotes often have relevance in multiple findings and point to the ways that the factors intertwine and influence one another.

### Socioeconomic Strata

The majority of participants noted the high expense of child care and described it as unaffordable to most families. Further, as participants were generally in low-income or poverty situations, they offered insights into the ways that the high cost of care impacted decisions for other aspects of their lives, such as how many children to put into care, what bills to pay at what time, and what jobs they could take:

“For me to go back to work full-time right now, my son would have to be in daycare Monday-through-Friday full-time. And since we don't qualify for child care assistance, because with our careers, we make too much money. But it's just enough money to pay for child care. I mean, we have a mortgage and other bills to worry about too, and another child.” – **Rural white caregiver**

“Es más alto la babysitting que lo que gana uno.” (“Babysitting costs more than what I earn.”) – **Latinx caregiver**

Providers noticed these challenges too:

“...And you see these single parents or families from low-income, where they're really struggling. They're really, really struggling to make these payments because they're trying to balance between, okay, if I make this payment, right, my children are going to starve tonight. So now I'm going to have to not make this payment so that I can pay for our electricity bill, so our, you know, electricity or water doesn't get shut off or our heat doesn't get shut off, or I can afford formula for my child or what not.” – **Hmong provider**

Given concerns about affordability, the cost of care was often presented as a key driver in caregivers' decisions around care. Some caregivers noted that rather than choosing child care

based on what they prioritized most highly for care, they asked family members to care for their children or accessed employer-sponsored or discounted care because these were the most affordable:

“I have my parents watch my kids. Sometimes my sister does too because we live together. I’m lucky if I can even compensate my parents. Oftentimes I can’t afford to pay them, and it’s like paying for household expenses is perceived as compensation. Many Hmong families live in intergenerational households – it’s like a survival means because that’s how you keep costs low, even though you have a lot of bills... We’ve just found certain ways to help ourselves to live within our means.” – **Hmong caregiver**

A number of caregivers noted that their jobs were not set to the standard weekday schedule that most child care centers accommodate, but had evening and weekend hours, as well as schedules that changed on short notice. Across all demographic groups, interviewees voiced needs for more accessible hours that matched caregivers’ work schedules. Caregivers spoke of needing earlier start times, extended hours after school and in the evening, among other offerings, to support their work schedules:

“We’re full time workers. I work 30 minutes away from our child care. When I’m getting off work, it’s rush hour also and it’s frustrating. It adds on more stress when they charge people the late fee. I wished there was more child care in workplace settings.” – **Hmong caregiver**

Despite being in poverty or low-income situations, several interviewed caregivers did not participate in child care subsidy programs, like Wisconsin Shares. Some caregivers did not access assistance due to lack of awareness of what was available to them. This was especially the case for some Hmong and Latinx caregivers and sometimes was a reason to defer to family for care.

Other caregivers noted the requirements for the child care subsidy programs as deterrents. Specifically, caregivers noted that Wisconsin Shares required sharing information that they may not want to give and, from their perspective, opened them to a heightened level of surveillance and associated consequences:

“So, I have a family who... is three years [removed from] domestic violence from her child’s father. But in order for her to get the child care subsidy to put her kids in child care, she has to figure out where he is. And she has to figure his information, and I’m like, that’s nuts! Like, that’s not something that she wants to do... So I’m kind of going back and forth with child support because I’m like, she’s in a domestic violence situation, why does she have to reach out to him? Can’t she just tell you guys she doesn’t know where he is and leave it alone?” – **Black caregiver**

Another caregiver noted that child support payments being paid by the other parent, even though seized by the state, were being counted as her income and made her ineligible for subsidies. Some Tribal caregivers noted concerns about how use of child care subsidies could negatively impact other benefits available to them, including benefits provided by Tribal nations.

For caregivers who engaged with assistance programs, their interviews provided insights into how these programs operated and functioned together, often in ways they found to be challenging and stressful. For example, caregivers who received subsidies spoke of struggling to meet school or work requirements that felt unrealistic with family and other responsibilities or of having to attend appointments that were scheduled at difficult times and places. Participation in the subsidy programs could still present difficult decisions and issues to navigate, such as how to prioritize their time or the educational and career opportunities to pursue:

**“They don’t consider the time I need to study; they just go off of my school schedule.”**  
– Hmong caregiver

Some caregivers spoke of feeling stuck in decisions around taking a raise or a better paying job or potentially losing their subsidies. Altogether, this dynamic challenged caregivers’ efforts to improve their employment situations and escape poverty:

**“I mean, if you don’t make a lot and you qualify for subsidies, that’s great, but what if you get a better job? And that’s some of the challenges, they look at it as if they take this position that they’re making more money but they’re losing their subsidies, they can’t work.”** – Tribal provider

**“One common thing that I have experienced from single parents, Black parents – all parents, honestly – and it’s not necessarily particular to child care, but it’s just the way that the system will support, is set up as well. You get support the less you do, you know what I mean? The less you do for yourself, you get support. And as soon as you start to try to empower yourself, your supports are taken away from you.”**  
– Black caregiver and provider

On the workforce side, interviewees readily noted the low wages that providers received and that many providers were themselves in positions of poverty. Providers felt strongly that pay increases and improved benefits were needed for child care staff and that current compensation was out of line with expectations for their work and their training. This felt unjust to providers and presented challenges to staffing:

**“They are raising children, and we’re paying them \$10 an hour. That’s not even livable. I can’t give people a hard time when they want to leave to go work at Wal-Mart for \$15 an hour, because I’d do the same thing. Even though it’s a very meaningful role, we still have survival here, and we definitely have seen good people leave, and that’s challenging for me.”** – Tribal provider

“It’s hard to say, ‘You know what? I want you to invest all this time and effort and do all this stuff’ for the same amount of money you could get to stand behind a cash register.” – Tribal provider

Caregivers who turned to family members for care urged compensation for these individuals as well. They felt that the state had a role to play in formalizing family care providers for their time, resources, and expertise:

“When I lived in Illinois, I was able to actually have my sister watch my child, someone I trusted. And they paid her to do that so she wasn’t just sitting, not making any money or, you know, struggling or just trying to help me. They were actually helping her. I get down here [Wisconsin], and the people that I trust my child to go with I have to pay out of pocket, which is just taking more from me and what I could have for my kids.” – Black caregiver

Providers who operated their own child care centers stated several challenges to keeping their centers financially afloat, noting instability in the funding model and challenges related to staffing within licensing requirements:

“As far as the income, it isn’t always stable. I mean, a parent can pull out – give you two weeks’ notice – and they’re gone. And that could be \$500 a month. So, there’s that instability of income. How to improve that, I don’t know.” – Rural white provider

“I only have two weeks of vacation, and we don’t have sick days. Those who have a contract like from a normal contractor or a company, those benefits we don’t have. I would have to pay someone to take my place... I couldn’t be away. I really couldn’t be absent. I have to be present because I am the one with the license and I have to attend to my business, and so we really don’t have any support because we are individual business owners... All the expenses in the house really depend on this business and when there isn’t a business income there isn’t a household income because we’re really dependent on the business.” – Latinx provider

“I think if folks are looking at this from a business model, it’s not sustainable. Those who get into it are in it for the kids.” – Rural white provider

Altogether, interviewed providers described highly stressful economic situations that could negatively impact not only their centers, but also their well-being, personal financial security, and their overall capacity to care:

“[T]he money part does get, again, I use that word over and over again, but that gets worrisome. It gets stressful. ...my daycare business is what keeps me in my house because that income is what pays my mortgage, pays all the bills, you know, this and that... But, so sometimes I just want to say, ‘Oh, I don’t want to do this anymore.’ I don’t want to have to think about the money, you know.” – Rural white provider

## Race

Several participants noted concerns related to race and racism in ECE. Caregivers and providers who identified as Black most often noted these concerns, but Hmong interviewees did as well, especially related to anti-Asian racism associated with the COVID-19 pandemic:

“Before COVID I would usually take my kids with me to go shopping but we’ve completely eliminated going shopping together, I go alone now. I also feel like with our president calling COVID-19 the China virus, it added more of that stereotype and that racism. He made it okay for others to believe it. We’re cautious of going out.”

– Hmong caregiver

Most frequently, participants of color noted that the racial backgrounds of providers were generally not representative of their children or of their community, as the majority of providers they engaged with were white. For caregivers of color, this reality presented concerns about the quality of care and safety of their children, as they felt that white providers struggled to affirm children’s racial identities and their parenting. Caregivers also wanted curricula and materials (e.g., children’s books) to affirm their children’s racial identities. One interviewee spoke to the benefits of having staff that reflected the racial identity of children:

“So I just believe that our children need to see us being there, being the one to, in a different light, if that makes sense... I believe that the care and concern of the children seeing us and seeing someone that looks like us. I’ve had several experiences where I’ve been actually working, and a little girl, a little African American girl, she was looking at me and just kind of like, she said, are you Black? You know, and I said, I am. And I know it was because all she saw was white teachers.” – Black caregiver and provider

Black caregivers in particular noted challenges when communicating with non-Black providers, as they recounted feelings of not being listened to and expressed hesitancy in sharing information with providers for fear of being judged or inappropriately reported on. Some caregivers of color also indicated that they felt they were treated poorly in comparison to white parents or that provider decisions and policies were made to please or attract white parents:

“I think when Black women speak, we’re not taken seriously... So it’s like when you say something, they kind of make little of it. I’m saying my child can’t do this, and they’re like, well, probably not really. Like, ‘She doesn’t really know what she’s talking about. I know better.’ It’s like you think that you know better because you’re white. But you don’t know what’s best for my child.” – Black caregiver

Concerns for the racial safety of their children influenced caregivers’ decision-making around care. For some, these concerns influenced decisions to turn to family or friends for care, knowing that these providers would reflect the racial identities of their children, affirm their racial identities in interactions and through the curricula, and could be trusted.

Some caregivers of color felt they had to choose between a “high quality” center with newer facilities, more well-credentialed staff, and other positive features, but which lacked racial diversity among the staff and the other children, or another care option that would offer the safety and quality of racial affirmation:

“It might just be... the Black mom in me, but I’d rather my kids be safe than be inclusive... There are people with ill intentions, especially when it comes to Black kids... And I don’t want to raise my kids in a society or a community – because a school is a community – I don’t want my kids to be in a community where they ever have to feel attacked. It’s okay to feel uncomfortable sometimes – but it’s not okay to feel attacked, to feel afraid in school, to feel, you know, any type of way like that, any type of bad way.” – **Black caregiver**

Providers of color, especially Black providers, also spoke of racialized experiences and experiences of racism. These included experiences of providers being paid less than their white co-workers, heightened monitoring by supervisors or state licensers, and receiving more complaints from white parents. A Hmong provider spoke of racist experiences, including difficulties in finding practicum placements as a student, increased scrutiny by licensers, and receiving lower pay than white co-workers. Despite talk of efforts to address racism, providers saw such problems persist:

“[I]t was just certain things that I see that they make available for them that they don’t make available for Black child care providers. It just, it doesn’t make sense to me. If you are saying you want to help this problem that we see and have more teachers and everything of color, then why aren’t you doing more than what you’re doing to make that happen? I don’t understand that at all. That doesn’t make sense.” – **Black provider**

“I just want to say like as far as Black women, I feel like, especially in [my city], a lot of African-American women have lost their licensing and certifications and stuff like that due to miscellaneous stuff, and... it’s like, I just feel like I’m getting attacked as a Black businesswoman that’s trying to run her in-home child care, because I don’t know, people like, don’t want to see us to be great or something... You know, as a Black business owner and child provider too, you know, got to be cautious.” – **Black provider**

## Culture

Interviewees highlighted culturally-relevant care models, curricula, and materials as important aspects of “quality” that were not often included in official definitions. For instance:

“We are applying quality care because we are following the licensure guidelines and we’re trying to stay updated. We are also providing good education because we offer a bilingual education and so we have to attend to the needs of each child in terms of their culture, their language, their health, and their safety. All these things have to be included in the care; you understand. Without forgetting that you have to include

love to all these practices because if you don't have love for the kids you can't work in this field.” – **Latinx provider**

For caregivers, having culturally-relevant care from a provider with a shared background was valued and sought after, but often hard to find:

“It was really hard to find [a provider]. I remember talking to one of my friends trying to find a Hmong caregiver. It was important for me to find a Hmong caregiver for my daughter because not only are we away from family and will she spend most of her education in a white-dominant culture, it was important for me to show her who she was [as a Hmong person]. Who we are, and that there are other Hmong caregivers outside of my family.” – **Hmong caregiver**

However, several interviewed caregivers and providers talked about a lack of cultural attention in the present ECE system. More specifically, caregivers and providers talked about a lack of curricula and educational materials that reflected their cultural backgrounds, a lack of infrastructure for care models that were more culturally-relevant (e.g., family or intergenerational care), and the lack of cultural diversity among care providers.

Hmong and Tribal caregivers and providers spoke of the absence of cultural materials in available ECE settings, including culturally-relevant foods, books, and holiday observances. Others spoke of culturally-relevant materials being tacked on to current curricula rather than embedded or woven into the curricula with intention.

“I often see [culture] as a tourist approach, where it's just added on... and I'm really trying to get our staff to incorporate. So with our first language grant, we made children's books ourselves.” – **Tribal provider**

Tribal and Hmong providers noted difficulty in finding funding to acquire cultural resources or to engage in cultural activities:

“Having extra money to bring in a consultant or buy materials to do certain things that are culturally-appropriate is really hard, because you've got to pay your staff their living wage, which is already hard to do.” – **Tribal provider**

“One thing that is a challenge is culture sometimes seems to be supplemental to people, and therefore, is not sustainable, when you're always expecting someone else to do it instead of building this capacity.” – **Tribal provider**

One Hmong provider recognized so much value of culturally-rooted curricula, that they put in their own time and energy to develop activities, although for the benefit of predominantly white families at the center:

“Well, I started using, speaking in Hmong to my kids. I work with three-year-olds. I have about ten kids in my class at a time. And I've just been counting with them. I've

slowly started to build on my books. I have a few Hmong books, and they've been catching on counting with me, and they're understanding now that I speak a different language. ...they're used to it now, and the parents love it, and they love seeing all that.” – **Hmong provider**

For the provider, this sharing of their cultural and linguistic background made teaching more enjoyable and meaningful. Their work also brought an added benefit of encouraging the child care owners to attend to and support more diversity efforts.

Caregivers and providers, especially from the Tribal communities, noted that the current state system, including regulations and quality standards, could come into conflict with more culturally-rooted models of care:

“The process almost feels disrespectful. I know our elders have great stories and knowledge—how can I ask them for a background check and not disrespect them?”  
– **Tribal provider**

“The ECE system is trapped in one way of thinking regarding care, learning and teaching. A child is a teacher too, parents are experts and teachers as well. Learning should be naturalistic.” – **Tribal provider**

Further, Tribal providers suggested that the current system lacked cultural sensitivity with respect to ECE. A Tribal provider noted the prescriptive nature of public education and the role it often played in cultural genocide, and affirmed that ideas of child care “quality” were a local determination that was influenced by historical trauma:

“I know that Indian people struggle with [public education] because of the trauma and the history and all the things that have happened that just make us extra cautious.”  
– **Tribal provider**

These histories and experiences may be influential to how state agencies and technical assistance providers engage with child care providers and with families.

For some caregivers, their preference for a family care model (including care provided by friends and neighbors) was connected to cultural traditions and values for the care of young children. Additionally, family care could offer the benefit of shared cultural backgrounds and the trust and mutual expectations associated with this. They felt that these providers reflected and instilled in their children shared cultural values and served as an extension of their immediate family. As such, these caregivers strongly suggested that the family care model should be designated by the state as a formal child care provider option and, accordingly, facilitate proper compensation and recognition for their time, care, and expertise. Family members and friends already providing care could also be supported to advance their education and skills:

“Culturally there are providers who represent our culture but just don’t have education in developmental skills or no accessible language in developmental education.”

– Hmong provider

In the absence of providers with shared cultural backgrounds, whether family or otherwise, interviewees noted that a different kind of provider training was needed to meet families’ cultural needs. For instance:

“Children are relational-based, different relationships based on their family, their personality, their temperament, and teachers need to be trained in adjusting and knowing and observing and understanding and getting to know the family culture and the family to help support that child.” – Tribal provider

“...if we can’t represent our children’s identity through our teachers, we can train ECE providers to be culturally aware and represent the children through food, books, curriculum or even posters in the classroom.” – Hmong caregiver and provider

## Communication and Language

Caregivers and providers from all demographic groups noted issues of communication in the ECE system. This included a lack of available information in people’s primary languages, especially Spanish and Hmong, to assist caregivers in finding care and accessing subsidies, and to assist providers in licensing, regulations, YoungStar, and other necessary information for their centers. Providers also saw need for curricula available in their primary languages.

Caregivers and providers identified issues with accessing and understanding information, with some noting that they needed to navigate multiple websites to find information and that in some cases, the information across sites was conflicting or confusing. Providers mentioned issues with websites related to licensing and ECE credits in the Registry, Child Care Resource & Referral agencies, Department of Public Instruction special education guidance, YoungStar ratings and processes, and continuing education requirements. Providers for children with disabilities had additional sources of information to work through, such as Birth to 3 programs and public school therapy programs, and had to consider how to integrate these with child care services:

“The children that I have right now, their delays are significant enough that they can easily qualify for the in-school programs, but again, those are all in school. So from town I’ve got a 40-minute drive to bring them to the school therapies if we want to do that... Birth to 3 was much more helpful because they would not only come to your house, but they were able to work with two kids and not just one kid at a time... They [the kids] didn’t have to be two years behind [before receiving public school services]...” – Rural white provider

Caregivers and providers also noted that there was a lack of available personnel to offer information or answers to questions, especially people who reflected their backgrounds and had shared language and cultural competencies. For some Hmong and Latinx caregivers especially, this contributed to a lack of trust and sense of isolation as they navigated their work.

For some caregivers communication issues were present in the day-to-day as well, as they felt that providers who did not share their language and cultural backgrounds were not as forthcoming in their communications with them. For example, one caregiver noted that their provider failed to notify them about an playground accident with their child, when this standard of practice was being followed with other families. Multiple caregivers noted a desire for more information from providers about the skills their children were learning so that they could reinforce learning at home.

Providers noted interest in accessing peer-based professional development or support, but this also was challenging. For example, a provider in a family child care center said:

“It would be nice to have more emotional support. We don’t always have a lot of time to meet other providers and talk about issues and solutions. That becomes challenging because it’s hard to, you know, work until 5:30, 6:00, and then say, ‘Alright, now we go talk about daycare with somebody.’ But it would be nice to have that relationship and that person you can... you know. ‘This child is doing this, what do I do? Help me.’ There are some online Facebook groups, but it’s just not the same as in person and the support groups.” – **Rural white provider**

Caregivers and providers also noted reasons why children should have access to ECE in their primary or heritage language. For children who speak a language other than English at home, caregivers and providers felt that care provided in their primary language would better promote their continued child development and school readiness. For Tribal and Hmong caregivers and providers, in particular, language integration into ECE was important for its cultural connections as well. Providing care in their languages promoted the continued use and preservation of the language and English-only care could undermine these goals:

“They speak the Hmong language at home and English at preschool—they’re losing language.” – **Hmong caregiver**

Whether through family care, bilingual or language immersion programs, integration of their languages supported efforts for culturally-relevant care. Caregivers and providers noted that culturally-relevant curricula and materials, including stories and foods, were more valuable and meaningful when presented in their languages.

## Geography and Transportation

Many caregivers spoke of challenges related to geography and transportation, as the location of their homes, workplaces, and care options and their capacity to readily move between them were significant in their lives. For Tribal and white caregivers living in rural areas, they spoke of challenges related to accessing care within a reasonable distance of their homes or workplaces. Combined with the relative lack of options (of group child care centers as well as family child care centers), caregivers sometimes faced difficult decisions for care and their employment. For example:

**“If it’s a young mom or a young dad who’s trying to get a job but they don’t have transportation, trying to figure out how they’re going to get their child to a child care place and then get themselves to work, that has been a huge issue.” – Tribal provider**

However, more suburban- or urban-located caregivers also identified issues of the location of care options and transportation. Some caregivers spoke of choosing care options in their neighborhood because they could not transport their children elsewhere, despite concerns about quality. Others drove children considerable distances to access care sites they preferred, which took extra time from their day and added stress:

**“I have three kids: one in the public school system, one in Head Start and one in Early Care. I work 30 minutes away and have to wake up super early to drop them off. I always feel bad because I have to wake them up very early for my commute, and when I drive back to pick them up it’s traffic hour, and to stop at all three schools – sometimes I barely make it to pick them all up on time.” – Black caregiver**

One caregiver noted that their child care provider had established late fees for arriving late for pick up, so that their issues of transportation sometimes presented a financial dilemma as well:

**“...daycares in general charge a late fee of \$1 a minute after you’re late. So it was more of a stressor for me because either I had to be out of my workplace at a certain time, otherwise, I’m paying dollars later than what I can pay. Or I’m stressing to speed my way to get there right before it, or, you know, things like that. So it was a, it’s a big stress.” – Black caregiver**

Altogether, transportation was a barrier for many caregivers for accessing affordable and quality care, whether in rural or more urban contexts.

Like families and business owners across the state, interviewed caregivers and providers reported negative impacts from the ongoing COVID-19 pandemic. These included concerns related to their family's health and safety, the financial security of their household or their child care businesses, and stress and mental well-being. For many, vulnerabilities they were already experiencing – such as poverty, underemployment, and existing health issues – became aggravated by the pandemic:

“My family has been greatly impacted by [COVID]. Our income definitely went down a lot because the business [child care provider] is our core income.” – **Latinx provider**

“When COVID hit and you haven't seen anybody in your family in three months, that really takes a toll on you. And how do you be happy about providing activities and things for children and families when you are depressed?” – **Tribal provider**

“That's really hard, because it's hard on me, because I have PTSD, depression, and anxiety. So it's really hard with this whole COVID and just being at home with them 24/7.” – **Black caregiver**

“I was planning on bringing my kids to a daycare. Because of COVID and not being able to meet the teachers in March or understand their procedure, I wasn't comfortable bringing my kids to daycare. I didn't get my summer job, I was worried because that [income] was going to go towards health insurance...” – **Hmong caregiver**

Providers noted particular challenges COVID-19 presented to their child care operation. Some providers had to close their centers and were uncertain when they would be able to reopen. Other providers were open but had to navigate new safety guidelines and restrictions, additional reporting, acquisition of new supplies like masks and hand sanitizer, and finding the funding to pay for increased costs. Some admitted to not feeling comfortable being open, but felt they had no choice, given the economic precarity of their business and the needs for care among essential workers.

A number of providers lowered fees to attract families and help those who had lost income due to the pandemic. Some providers also expanded the ages of children they cared for, to meet the needs of families' with older children when schools had closed and to bring in extra revenue. These providers noted how they then had to quickly modify their programming, staffing, and group dynamics accordingly.

Providers expressed worries about ensuring the health of their staff and the children under their care, and concerns about how to maintain staffing if their workers became ill with COVID-19. For some interviewees, concerns included the potentially negative developmental impacts on children:

“You know, it’s a big adaptation, and with us switching child care centers, when [my daughter] met her new teachers, they all had masks on, you know. I mean, it sounds silly, but it really is a big deal when you meet someone, you’re developing a relationship, and here, you’re talking to a cloth. So I felt kind of bad because she was so kind of nervous and scared.” – Rural caregiver

Other interviewees talked about the difficulties they encountered in trying to answer children’s questions about the virus, explaining safety protocols and ensuring children follow them, and attending to children’s fears and anxieties. A few interviewees had either contracted the virus themselves or had a family member who did, so they also had to attend directly to their health and safety in addition to caring for children.

For some caregivers, their stress and mental health concerns were further influenced by their cultural backgrounds. For example, a Hmong caregiver spoke of the many demands placed on her that were intensified by the increased needs in their family related to the pandemic:

“As a Hmong Woman, it’s hard to set boundaries. On top of being a first-time parent, the expectation of a Nyab [daughter-in law, sister-in-law] can be hard.”  
– Hmong caregiver

Latinx caregivers spoke of isolation from family and community that added stress and hardship to their lives. Already lacking social support, the COVID-19 pandemic brought further strain that some felt they could not mitigate by turning to others.

Looking at these findings in sum, we see an overall pattern: The current ECE system in Wisconsin is based on assumptions that fit a dominant model of socioeconomically-advantaged, white, monolingual English-speaking, suburban and urban families and the ECE centers they prefer. As such, ECE in Wisconsin systematically underserves any family or provider that does not fit these assumptions, with implications for ECE accessibility, affordability, and quality; the ECE workforce; and COVID-19 impacts and recovery.

As in the DCF Listening Sessions<sup>1</sup>, interviewees spoke of many challenges related to ECE **access**, including transportation issues and a lack of options for families needing care for nonstandard work hours. As in the listening sessions, interviewees indicated that families of color were disproportionately impacted by access issues, but the experiences offered by interviewees here provide more insight to some of these issues. Specifically, some caregivers and providers of color spoke of the importance of having provider options that reflected their racial and cultural identities and having culturally- and linguistically-relevant curricula and materials. For many, these options were lacking.

Additionally, interviewees identified communication issues that challenged access, including too many and confusing websites to navigate and a lack of linguistically- and culturally-competent professionals that they could turn to for information. These communication issues were present for both caregivers and providers.

Interviewees also spoke of challenges with the Wisconsin Shares and subsidy programs that made accessing care difficult. While issues with subsidy programs were also voiced in the listening sessions, here interviewees spoke at length and with emphasis about the issues they experienced and their impacts. From the experiences that they conveyed, it is apparent that eligible families around the state are not accessing subsidy programs because of the intrusiveness that they experience in applying to the program, the high level of requirements to navigate to sustain participation, and the incongruencies participation can present for trying to find care (e.g., YoungStar participating programs with openings in their geographic area) and effectively support their families (e.g., accepting a better-paying job or losing the subsidy).

As in the listening sessions, interviewees reported many issues with the **affordability** of the current ECE system, generally finding the cost of care to be unaffordable. Caregivers noted that they were challenged to make the payments for care, whether or not they received subsidies. They described ways in which this presented difficult decisions about the extent or quality of care they would choose for their children, what household expenses to pay each month, or their

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1 Wisconsin Department of Children and Families. (October 2020). Preschool Development Grant Voices from Wisconsin's Early Care and Education Stakeholders: Listening Session Report. Madison, WI. <https://dcf.wisconsin.gov/files/childcare/pdf/pdg/listening-session-report.pdf>



employment decisions. Caregivers often noted affordability to be the driving factor in their choices for care, out of necessity. However, caregivers as well as providers generally recognized that providers were underpaid.

Interviewees described **quality** in ECE in similar ways to participants in the listening sessions, including descriptions related to child safety, developmentally-appropriate and loving care, well trained providers, and adequate facilities. However, interviewees further emphasized the significance of culturally-relevant care models and linguistically- and culturally-appropriate curricula and materials. Interviewees also described “quality” with respect to a diverse and representative ECE workforce, including providers that they felt they could trust and who communicated and engaged with caregivers effectively. Some interviewees contrasted this with experiences of racism they dealt with as caregivers or providers, or that their children experienced.

Interviewees often indicated that their beliefs around what makes for “quality” in ECE are not reflected in the current YoungStar system. For some caregivers participating in Wisconsin Shares, this could mean having to choose between a provider that they trusted and who could provide linguistically- and culturally-relevant, enriching care, and a center with a YoungStar rating that could accept subsidies but without these offerings and which might undermine children’s language, cultural, and identity development. For some providers, YoungStar seemed to systematically undervalue the quality of their programs, including the characteristics that drove caregivers to seek them out (e.g., a racially- and culturally-diverse staff), and by tying YoungStar to Wisconsin Shares, systematically undervalued them financially as well. Some providers spoke of the YoungStar program as a mechanism for large, well-resourced centers to continue to accrue resources, while other providers offering highly-valued quality of different kinds struggle further to survive.

As in the listening sessions, interviewees noted issues of wages, benefits, and support for the ECE **workforce**. Even when caregivers spoke of their issues in affording care, they acknowledged that providers received little compensation and were troubled by this. Interviewed providers, especially child care owners, spoke of challenges recruiting and retaining high quality staff, accommodating the needs of families (e.g., for nonstandard hours, schedule changes, late pick-ups), and for simply staying open. Interviewees noted that providers with valued language and cultural skills did not receive adequate compensation for these assets. Providers also spoke of paying out of their own pockets to find or develop culturally- and linguistically-relevant curricula and materials. Several interviewees expressed desire for a government program that could financially support the linguistically- and culturally-skilled family and friends they turned to for informal care.

Some providers spoke of experiences of racism in the ECE workforce. For owners, these



experiences included patterns of heightened scrutiny from licensing and credentialing professionals. Providers of color reported experiences of greater scrutiny by their white supervisors, wage disparities with white co-workers, and negative interactions with the white caregivers of children in their care.

Interviewees spoke of the many ways that the **COVID-19 pandemic** has aggravated already challenging circumstances. For caregivers, this included partial or complete job loss and significant economic precarity. For many, it has also meant school and child care closures and more time with children at home. Providers have had to close and consider how to re-open safely, including buying personal protective equipment and establishing new staffing levels and safety protocols. Some providers have not been able to re-open and may not ever. For many interviewees, the pandemic has added more stress to stressful lives, undermining their mental health, and making it more difficult to provide love and care to the children around them.

Based on these findings, we encourage these recommendations for consideration:

**1. Support greater access to ECE for caregivers and providers by:**

- Creating publicly-funded or incentivized ECE programs that offer care in evenings, on weekends, and can accommodate variable work schedules;
- Making information for caregivers and providers easier to access and understand through "one-stop" websites, designed with accessibility across language (Spanish, Hmong, and other priority languages) and with diverse ability in mind;
- Ensuring the availability of individual assistance to caregivers through Child Care Resource & Referral agencies, especially from people with community connections and competence in diverse racial, linguistic, and cultural backgrounds;
- Supporting peer-to-peer information-sharing among providers.

**2. Make ECE more affordable for caregivers through:**

- Establishing a single, authoritative source for caregivers to find information and apply for Wisconsin Shares and other subsidies, and that includes consideration of families' financial need through a holistic approach that does not threaten other assistance eligibility;
- Critically reviewing requirements and processes in Wisconsin Shares for racial, cultural, and linguistic bias, and commit to efforts to remedy so that families can readily access subsidies;
- Increasing the pay threshold for families to qualify for child care assistance, so more caregivers who earn incomes above eligibility can access care affordably;
- Building into Wisconsin Shares and other subsidy programs funds to address families' transportation needs, such as free or discounted monthly bus passes or monthly transportation stipend;

**3. Ensure the quality of ECE through:**

- Critically reviewing YoungStar quality standards for systemic racial, cultural, and linguistic biases, and commit to efforts to remedy;
- Investing in the development of culturally-relevant and linguistically diverse curricula

and resources, or providing access to funds and consultants for providers to develop these.

#### **4. Strengthen the ECE workforce through:**

- Establishing public or public-private funding streams to increase pay and benefits for ECE providers and to support the economic stability of centers;
- Critically reviewing licensing, regulation, and YoungStar quality standards for systemic racial, cultural, and linguistic biases, and commit to efforts to remedy;
- Enhancing efforts to diversify the ECE workforce at all levels (e.g. administration, staff);
- Providing financial support for family and friends who provide care to children, beyond the family child care license mechanism, as this will always be a preference of some families;
- Organizing and supporting a provider substitute directory to aid in providers and families finding replacement care when needed;
- Creating access to provider-only support groups, including groups for providers of color specifically, and facilitated by mental health professionals;
- Supporting providers' access to BadgerCare for healthcare insurance, and to a shared pool retirement account, with a state-funded match.

#### **5. Ensure ECE recovery from the COVID-19 pandemic through:**

- Providing funding to child care owners to support their capacity to adapt, including purchasing necessary supplies, implementing new safety protocols, and maintaining funding through changes in enrollment and staffing;
- Establishing an emergency financial relief program for providers to access to adapt to COVID impacts and, for the future, when other unexpected events arise and disrupt their economic security.

## Family/Primary Caregiver Questions

1. What is your child care and/or preschool arrangement?
  - a. What's going well, what do you like?
  - b. What could be different, added or enhanced?
2. What do you want for your child? What are the indicators that make you want to seek out that particular child care?
  - a. Why did you choose that option? What helped you decide?
3. What are your expectations for the cost of care for children in your community?
4. Based on your child care and preschool experiences, how does this affect other parts of your life?
  - a. Your well-being and health?
  - b. Your economic situation?
  - c. Other effects?
5. To you, what does it mean to raise a healthy child?
  - a. Probe for each community > Physical, social, emotional wellbeing
6. How has the COVID-19/Coronavirus pandemic affected you as a parent/caregiver?
7. If you could recommend one thing to improve early care and education in your community, what would that be and why?
8. (For Tribal interviewees) Do you feel the current structure of early care and education sufficiently honors tribal traditions and customs?
  - a. How could this be improved or enhanced?
9. Is there anything else you would like to share?

## Provider Questions

1. What does quality early care and education mean to you?
2. What does “healthy development and well-being for children” mean to you?
3. What are your expectations for the cost of care for children in your community?
4. Based on your current position in the early care and education system, what do you like or is going well?
5. Based on your current position in the early care and education system, what do you wish could be different? Why?
6. How does your position in the early care and education system affect other parts of your life?
  - a. Your well-being and health?
  - b. Your economic situation?
  - c. Other effects?
7. How has the COVID-19 or coronavirus pandemic affected you and your position in the early care and education system?
8. If you could recommend one thing to improve early care and education in your community and across Wisconsin, what would that be and why?
9. (If time allows) What supports would benefit the early care and education workforce in your community?
10. (For Tribal interviewees) Do you feel the current structure of early care and education sufficiently honors tribal traditions and customs?
  - a. How could this be improved or enhanced?
11. Is there anything else you would like to share?

## APPENDIX 2: Equity and Inclusion Framework

DCF uses the following Equity and Inclusion Lens as a transformative tool to:

1. Identify systemic and institutionalized racism, bias, disparity, and inequality in practices, policies, procedures, and programming.
2. Analyze data and information for racism, bias, disparity, and inequity in order to:
  - a. Move towards more equitable and inclusive planning, programming, decision-making, and resource allocating
  - b. Ensure that everyone, particularly members of underrepresented groups (communities of color, low socioeconomic populations, vulnerable populations, people with disabilities and other disenfranchised peoples) are included as equal participants at every level of policy, procedure, and program processes.
3. Work to equalize power in decision-making and opportunities for self-governance so that all Wisconsin children and youth are safe and love members of thriving families and communities.