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Child care use, preferences and access constraints among Native American, immigrant, refugee and Spanish-speaking families in New Mexico

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ABSTRACT

This qualitative study examined the child care usage, preferences, and access constraints experienced by diverse parents and primary caregivers in New Mexico in 2020 and 2021. It also investigated the accommodations or compromises families made in response to constraints. Recruitment focused on families with at least one child under age five in four groups of interest: Native Americans, Spanish speakers, Asian immigrants, and African and Middle Eastern refugees. The study found substantial commonalities across the groups, in that all struggled to access child care that they perceived as both affordable and high quality. Difficulties with transportation and finding care available during non-traditional hours emerged as challenges across populations. Families expressed distinct child care challenges and preferences grounded in their cultures, with Native American caregivers reporting limited care options for infants and toddlers on tribal lands, and a desire for care based in indigenous language and practices to help stem systemic cultural loss. Spanish speakers reported fewer access constraints than immigrant and refugee populations who spoke other languages, due in part to the widespread use of Spanish in New Mexico's communities and care settings. Families who did not speak English or Spanish described linguistic access barriers and expressed preferences for linguistically and culturally concordant care, including care that would provide foods and care grounded in Muslim culture. Findings have implications for policymakers seeking to incentivize and support a child care supply that will meet the needs of diverse families.

1. Introduction

Sustained access to child care has been shown to support multiple dimensions of family well-being, including women's labor force participation (Landivar et al., 2021) and support for children's development (Lee et al., 2018). Yet families' access to care is often constrained, with constraints felt unevenly across population groups and contexts (Meyers & Jordan, 2006). New Mexico provides a unique setting to study equitable access to care: state leaders have adopted expansive child care access policies, the state's population is racially and ethnically diverse, and childhood poverty rates are among the nation's highest (New Mexico Voices for Children, 2023). In that context, this study examines child care access for Spanish speakers, Native Americans, Asian immigrants, and refugees from African and Middle Eastern countries.

For Spanish speakers, past research suggests New Mexico is a favorable context for child care access. Spanish is widely spoken (U.S. Census Bureau, 2023), and New Mexico is the state that serves the largest share of its eligible Hispanic children with child care subsidies (Hill et al., 2019; Ullrich et al., 2019). New Mexico also has linguistically supportive child care subsidy access policies, such as application materials available online in Spanish, and allowing English language classes as a qualifying activity (Hill et al., 2019). Examining the child care access experiences of Spanish speakers in New Mexico can help both to understand the family experiences behind New Mexico's comparatively high access rates for Hispanics, and to identify constraints and challenges that remain for Spanish speakers even in a favorable policy context.

Child care access for Native American families is not well studied, and New Mexico's large Native American population (New Mexico Voices for Children, 2023) makes it an opportune setting to investigate care access for this population. New Mexico encompasses 23 tribal areas, including portions of the Navajo Nation and 19 Pueblo communities. Native American care access was understudied prior to COVID, and this

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population's access was disproportionately affected by the pandemic nationally (Smith & Ehrle, 2022).

Finally, smaller minority communities in New Mexico may encounter distinct linguistic and cultural barriers to care access. We therefore include perspectives of refugees from Middle Eastern and African regions, and of Asian immigrants. Equitable access to care for immigrants is essential for study due to their growing numbers nationally. In 2021, 26% of U.S. children had at least one immigrant parent, up from 19% in 2000 (Ward & Batalova, 2023). Further, access to early care has been shown to increase school readiness for children of immigrants (Lee et al., 2018), and to provide immigrant parents access to social and human capital (Boit et al., 2021).

Across all focal groups, this study examines families' child care preferences and actual care circumstances, any constraints they encounter to accessing care, and the accommodations they make as a result of those constraints.

1.1. Literature review

Scholars consistently find families are constrained in their access to child care by factors including affordability, transportation, care supply, and alignment between work schedules and hours of available care (Carrillo et al., 2017; Chaudry et al., 2011; Friese et al., 2017; Harknett et al., 2022; Meyers & Jordan, 2006; Sandstrom & Chaudry, 2012). Additionally, constraints are uneven among families with different income levels and characteristics (Meyers & Jordan, 2006; Smith & Owens, 2022). This study conceptualizes child care access and constraints by drawing on the strengths of two existing frameworks. First, we follow Friese et al.'s (2017) dimensions of access to early care and education. Friese and colleagues conceptualize access along five dimensions: affordability (families' cost burden, including access to subsidies and public programs); meeting parents' needs (whether programs meet families' practical needs around factors like hours of operation); supporting child development (whether programs are of high quality and support children's holistic developmental progress); reasonable effort (whether families have to search extensively, drive long distances, or complete complicated paperwork to access care); and characteristics of children, families and communities (emphasizing equity of access for families across dimensions such as race, ethnicity, and language).

Second, we draw on the *accommodation model* of family child care decision-making, which incorporates insights from economics, psychology and sociology (Chaudry et al., 2010; Meyers & Jordan, 2006). The model assumes families are purposive in choosing care, but make choices in a dynamic context that is informed by their social networks and characterized by limited information and significant time, employment, and financial constraints. The accommodation model has implications for equity, as it suggests patterns of care use among families with different cultural, racial, linguistic, and economic contexts are less reflective of underlying differences in preferences than they are of accommodations to differential constraints. These ingrained patterns of constraints and subsequent accommodations, in turn, preserve existing social and income stratification in the United States (Meyers & Jordan, 2006).

The two frameworks are used here to inform a comprehensive model for investigating equitable access to care. Friese et al.'s framework defines access to care, and the types of constraints that may impede access. The accommodation model then grounds our analysis of families' child care decision-making and the accommodations or compromises they make in the face of access constraints. Within each access dimension, we report what families are experiencing, followed by what they would prefer. We conceptualize "preferences" as the care families say they would arrange in the absence of constraints. This includes whether families would prefer to use any non-parental care, as well as the characteristics of quality they would select for in a care setting if not constrained. We conceptualize "accommodations" as the ways in which families' preferred care arrangements are compromised by constraints, including consequences for their employment, care selection, and economic stability. Our study contributes to knowledge about equitable access to care through its emphasis on populations that have historically been underserved and whose care access and accommodations are less well documented. We avoid explicit comparisons of access across groups, and instead assess equity by investigating the severity and nature of constraints and accommodations experienced by families in our populations of interest—all of which face some degree of structural disadvantage that may affect their access to care.

1.1.1. Spanish speakers

Research on the child care preferences and usage of Spanish speakers is entwined with studies of immigrants from Spanish-speaking countries. Studies find Spanish-speaking parents desire high-quality care outside the home to provide support for social and emotional development, opportunities to learn English (Ansari, 2017; Ansari et al., 2020; Vesely, 2013), and preparation for academic success (Rabin et al., 2022). Research in communities with high concentrations of Spanish-speaking immigrants has found families desire access to culturally concordant caregivers who can provide culturally appropriate food, and that some Spanish-speaking immigrants use high-quality center-based child care to drive acculturation for their children (Chaudry et al., 2011; Mendez & Westerberg, 2012). Hispanic families, more broadly, have recently been found to rate trustworthy, high-quality caregivers and safety above cultural and linguistic considerations (Smith & Mercado, 2024). Preferences vary with children's age, with parental care preferred for younger children and center-based care preferred for preschool-aged children (Navarro-Cruz, 2023). It is less clear whether Hispanic families have different underlying care preferences than other groups, due in part to the heterogeneity of the Hispanic population and the difficulty of distinguishing differences in preferences from differences in care use that are accommodations to constraints (Ferreira van Leer & Coley, 2023).

In practice, Hispanic families use parental or relative care more often than non-Hispanic White families (Ansari, 2017; Carlin et al., 2019; Tang et al., 2012). Some research suggests the gap in center-based care use by Hispanic families is closing for preschoolers, but remains for infants and toddlers (Crosby et al., 2016). English proficiency predicts use of center-based care among Hispanic parents (Ackert et al., 2020; Johnson et al., 2017; Rabin et al., 2022), while lack of English proficiency is a barrier for newcomers trying to navigate public programs and access care (Karoly & Gonzalez, 2011; Rabin et al., 2022; Yoshikawa, 2011). Hispanic families are also constrained by cost and transportation barriers (Rabin et al., 2022; Tang et al., 2012; Ward et al., 2011), and by their elevated need for care available during non-traditional hours (Crosby & Mendez, 2017). Though this population is well studied nationally, less research has taken place in New Mexico—a state that enshrines protections for Spanish speakers in its state constitution (N.M. Const. Art. XII, § 10, 2024) and where Hispanics are the largest demographic group (New Mexico Voices for Children, 2023). As the Hispanic population grows throughout the nation (Krogstad et al., 2023), New Mexico provides new and valuable insight into the care preferences, usage, and constraints of Spanish speakers in a context where the Spanish language is better accommodated (Hill et al., 2019) but where Hispanics still lag behind non-Hispanic Whites on many indicators of economic opportunity (New Mexico Voices for Children, 2023).

1.1.2. Immigrants and refugees

Child care access for immigrants and refugees who speak languages other than Spanish has been less thoroughly studied, though some research finds these families make accommodations to balance home culture and language, the acculturative process, and academic goals for their children (Boit et al., 2021; Ward et al., 2011; Yoshikawa, 2011). Survey-based studies find Asian immigrant parents are more likely to use and value center-based care than other immigrant parents, and to select care with a more academic focus (Miller et al., 2013, 2014;

Santhiveeran, 2010). Qualitative child care research about Asian immigrants in the United States is limited, though research in Canada found that Korean and Farsi-speaking parents preferred for young children to receive an education rooted in culture and tradition (Poureslami et al., 2013). Parents from China, Taiwan, and Hong Kong reported more interest in center-based settings to support the social and cognitive development of young children to prepare them for future academic success (Poureslami et al., 2013). In general, immigrant children are substantially less likely to experience nonparental care than non-immigrant children, even after controlling for sociodemographic factors (Karoly & Gonzalez, 2011). Use of center-based care for children of immigrants increases with the age of children and varies by country of origin (Miller et al., 2014). Language barriers have been identified as an obstacle to Asian immigrant parents' access to and understanding of the child care system (Poureslami et al., 2013; Winterbottom, 2013).

Less is known about the child care experiences of refugees in the United States. One study found African and southeast Asian refugee parents desired high-quality center-based care for their children because it provides socialization and aids acculturation, despite concerns about culture and language loss (Ward et al., 2011). Refugee families use child care centers when accessible to support parental employment but also to lessen social isolation and build social capital (Boit et al., 2021). These families are constrained by lack of transportation, language barriers, high care costs, long wait times for child care subsidies, work or training requirements for subsidies, lack of non-traditional hours of care, and lack of support navigating the early care system (Boit et al., 2021; Gross & Ntagengwa, 2016; Morland et al., 2016; Poureslami et al., 2013; Ward et al., 2011). This study adds to the small literatures on the child care access for Asian immigrants and refugee families—populations that are understudied in this domain.

1.1.3. Native Americans

Native American families seeking non-familial care have been found to value care that affirms indigenous culture and language, amid the threat of systemic identity and language loss (Gerde et al., 2012; Romero-Little, 2010) and the inadequacy of many early childhood programs to meet the cultural needs of Native American children (Faircloth, 2015). In general, child care access for Native American families is understudied (Malik et al., 2018). Existing research has identified care selection priorities similar to other groups, such as trust and staff qualifications (Bipartisan Policy Center, 2021). Native American families' perceptions of access to care are a lesser focus in existing literature, as is research on constraints for this population. However, one recent survey of Native American child care experiences during COVID found Native American parents were more likely than parents nationally to use only parental care. The survey also found that child care access limits Native American parents' ability to work, and that the percentage of Native American families providing parental care was higher than the percentage who said they would choose it in the absence of constraints (Bipartisan Policy Center, 2021).

Limited proximity to care is a significant constraint, as Native American families are likely to live in "child care deserts" or areas with limited care supply (Malik et al., 2018). Native Americans disproportionately reside in rural areas (Economic Research Service, 2014), and rural areas are more likely than urban ones to be child care deserts. More than 75% of the rural Native American or Alaska Native population lives in a child care desert (Malik & Hamm, 2017). This study adds to the limited literature on Native American child care experiences. Specifically, it does so in the context of a state that has placed an increased policy emphasis on Native American early childhood opportunities, in ways that will be described in the next section.

1.2. Current study

This study adds to existing knowledge in two broad ways. First, this research includes the perspectives of both users and non-users of nonparental child care, and of parents both in and out of the paid workforce. Prior qualitative research on families' child care preferences and accommodations has usually involved participants who use some form of care, with less known about those who do not work or who have never enrolled with a provider. This population is important to study because research has identified links between child care availability and cost and maternal labor force participation (Landivar et al., 2021; Ruppanner et al., 2019). This suggests that one way families accommodate the constraints of the child care market is through mothers leaving the workforce altogether. By explicitly recruiting families with young children regardless of their current or past care usage, the study is better positioned to capture the breadth of accommodation taking place for diverse families as they consider not just what type of care to use, but whether to use care at all and whether it makes economic sense for them to work.

A second contribution of this study is its setting in New Mexico, which has some of the nation's most expansive policies to support access to care. New Mexico in July of 2021 raised income eligibility for child care subsidies to the nation's highest level, at 350% of the federal poverty level (FPL). This set eligibility at about $92,000 annually for a family of four, with graduated phase-out up to 400% FPL. At the same time, the state increased the rates paid to care providers for families who receive a subsidy (Office of the Governor, 2021; Parks, 2022). The state also established a cabinet-level department dedicated to early care and education in 2020 and created a new position of Assistant Secretary for Native American Early Education and Care. These policy measures, accompanied by state spending (Parks, 2022), have been adopted partly in response to New Mexico's childhood poverty rates, which are among the highest in the nation (24.5%) (New Mexico Voices for Children, 2023). Understanding access in this context can illuminate the constraints to equitable access that persist in a state with some of the nation's most expansive policies to support access to care, but also persistent economic challenges.

This study uses qualitative methods to examine: (1) Families' child care preferences and actual care circumstances; (2) Constraints to care that may account for any differences between preferred and actual arrangements, and (3) The ways families accommodate any constraints to accessing their preferred arrangement. Qualitative methods were chosen to allow families maximal opportunities to describe their child care decision-making processes in rich detail.

2. Materials and methods

2.1. Data collection

The authors partnered with community-based organizations with strong relationships with each focal population for support with culturally specific recruitment, data collection, and translation and interpretation services. See Appendix A for additional recruitment details. Individuals were eligible to participate if they were the parent or a primary caregiver for a child age five or younger in New Mexico. Data were collected through semi-structured group interviews. In cases where a sole participant attended a scheduled session, data were collected through individual interviews. Data collection was phased by participant group and occurred between September 2020 and December 2021. Efforts were made to limit burden on families during peaks of COVID infection, in the context of the complete closure of New Mexico's 23 tribal communities for the duration of the COVID public health emergency. Recruitment continued until saturation was reached for each group, based on regular meetings between senior research staff and data collection leads examining whether new information was emerging from continued data collection. Authors also followed guidance from prior scholarship on suggested sample sizes for subpopulations in qualitative research (Bernard, 2013).

The interview protocol comprised 11 open-ended questions such as "what are your perceptions about the quality of care in your

community?" Topics included child care use, what parents valued when selecting care, perceptions of child care quality, and families' experiences with affordability and availability of care. The protocol was translated into Spanish and interpreted into Chinese, Vietnamese, Korean, Filipino, Dari, Swahili, and Arabic. Interviews were conducted by phone or on Zoom and audio recorded. See Appendix A for additional data collection details. Forty-four group interviews with 107 participants were conducted, with group size ranging from one to five participants, averaging 2.4 per group. These comprised 21 group interviews with 36 Spanish-speaking participants, seven group interviews with 27 Asian parents, six group interviews with 22 African and Middle Eastern refugee families, and ten group interviews with 22 Native American families. Every participant was offered a $20 gift card. The protocol was approved by the University of New Mexico Institutional Review Board (#01220).

2.2. Data analysis

Audio files from interviews were transcribed and imported into Nvivo (R1.6) software for coding and analysis. The research team used an initial coding structure based on the study questions, extant literature, and the data collection team's initial impressions about themes raised by participants. Codes under each node were developed based on emergent themes. For instance, codes under "what families value in quality care" included low adult-to-child ratio, focus on child learning/development, and support for home religion/culture. Tables 2–4 show nodes and codes organized by research question. See Appendix A for additional data analysis details. The six-person coding team consisted of four junior and two senior researchers, who followed the team-based coding process described by Giesen & Roeser (2020) over four coding iterations. Coding was phased across focal populations, with researchers completing coding for each population before moving to the next. Data from Asian immigrants and refugee participants were coded and analyzed in one process focused on newcomers belonging to cultural and linguistic groups that are small minorities in New Mexico. Combining these groups enabled analysis of cross-cutting themes for families that do not belong to historically established Hispanic and Indigenous communities. Although overall results for these participants are presented together, differences that emerged during analysis are discussed in the Results section.

For each study population group, thematic memos were written summarizing each major code's content and emergent themes. These memos were written by individual researchers, then reviewed by the entire analysis team. Matrices that mapped the code memos onto the dimensions of Friese et al.'s access framework were created for each study population, then synthesized by three senior authors. A final synthesis that examined commonalities and differences across all groups was conducted with particular attention to issues of culture, language, and rurality.

2.3. Participant characteristics

Of the total 107 participants, 34% were Spanish-speaking, 46% were immigrants or refugees speaking languages other than Spanish, and 20% were Native American. Just under half of Spanish-speaking families (47%, $n = 17$) lived in the urban centers of Albuquerque or Santa Fe, which are several hours from the U.S.-Mexico border. The rest of the Spanish speakers (53%, $n = 19$) lived in the southern border region of the state, and all but three of these border-area participants lived in rural areas. All immigrant families who spoke languages other than Spanish lived in New Mexico's largest city. Asian immigrants comprised just over half of the participants in this population and spoke Chinese, Vietnamese, Korean, or Filipino. Refugee participants made up the remainder of this study population and spoke Dari, Swahili, and Arabic. Finally, Native American participants primarily lived on tribal lands or in rural communities (64%, $n = 14$), with smaller numbers who lived in small cities bordering tribal lands ($n = 4$) or lived in larger urban centers ($n = 4$). These participants represented 11 distinct tribal nations (Navajo Nation; Pueblos of Acoma, Laguna, Ohkay Owingeh, San Felipe, Santa Clara, Zia, and Zuni; and the Hopi, Kiowa, and Athabascan Tribes). See Table 1 for summary participant characteristics.

Table 1
Key characteristics of study participants.

	Total (n)	Mothers (n)	Fathers (n)	Grandmothers (n)
Spanish speakers	36	33	1	2
Asian immigrants	27	24	3	0
Refugees	22	18	4	0
Native Americans	22	18	3	1
Total	**107**	**93**	**11**	**3**

3. Results

The results are presented in two main sections. The first is organized according to Friese et al.'s access framework (Friese et al., 2017), examining each dimension of access according to what participants reported they experienced and what they would prefer (research question 1). The second section describes families' constraints to care access (research question 2) and the ways they accommodate these constraints (research question 3). Findings are abbreviated when they largely confirm prior research, and discussed more expansively when they are novel to the study's context and populations and address identified gaps in the literature. Tables 2–4 present coding nodes, codes and selected themes by population, organized by research question.

3.1. Access by domain

3.1.1. Affordability

What Families Experience. Families across populations perceived that care was not affordable, and that lower cost options were of lower quality. One Asian participant said, "I'm concerned [about] the ratio of the teacher to students as well, but low ratio, you have to pay more." Participants noted especially high costs for infant care and for families with multiple children in care, saying care costs disincentivized parental employment. Families across groups discussed the importance of child care subsidies or other public funding (such as Head Start or state-funded pre-K) in helping them afford care, although some group differences emerged, which will be detailed later. Overall, 26 participants, or 24% of the overall sample, had ever used a child care subsidy. The authors did not attempt to determine the eligibility status of individual participants.

What Families Would Prefer. Participants said more affordable care was needed in their communities, and some specified that affordable care needed to be of high quality. Families were not seeking "discount" care with lower quality standards at lower cost, but rather quality care that they could afford. This was especially true for higher cost infant and toddler care. Families also said they wanted more transparency in how child care assistance eligibility was determined as well as income eligibility criteria that would not penalize them for modest increases in pay.

3.1.2. Meeting families' needs

What Families Experience. A slim majority of participants (51%, $n = 55$) had used some form of non-familial care, either at the time they were interviewed or prior to COVID. Of these participants, 49 had used center-based care of some kind, and six had used a non-relative home-based provider. Some families ($n = 15$, or 14% of the overall sample) who used non-parental care prior to COVID had stopped using it due to provider closures or perceived risks of infection. An additional six participants reported that COVID altered their plans to search for and begin using formal care, opting to keep children home instead. Three

Table 2
Nodes, codes, and key themes related to families' actual care usage and preferences.

Nodes	Codes	Shared Themes	Spanish-speaking Families	Immigrant and Refugee Families	Tribal Families
-Attributes of Care Used	-Care setting (e.g. center, parental)	-COVID changes to care setting	-More home-based care	-Varied care settings -Fewer relatives available -Work obligations necessitate care -Home care used for children with special needs	-More parental and relative care -Home care used for children with special needs
- Preference for Care Type/Setting	-Care type preference -Preference by child age -Child special needs	-Care type preference varies by child age	-Trust in family to provide care -Mistrust of quality of center-based care	-Home care preferred until preschool -Relative care desired -Desire care equipped to meet special needs	-Mistrust of non-tribal formalized care -Desire care equipped to meet special needs
-Components of Quality Valued by Families	-Focus on education -Teacher-child interactions -Staff training -Adult-to-child ratios -Cleanliness & safety -Learning materials -Support for home religion/culture -Support for language development -Nutritious food -Communication with family	Families value: -Support for child development -High-quality trained staff -Individualized attention to child -Cleanliness & safety -Language & cultural preservation -Linguistic & cultural match to provider supply	-Acculturation for school readiness -Language access to child's provider	-Preservation of cultural identity and language -Acculturation for school readiness -Religious/cultural food accommodation -Language access to child's provider	-Tribal language development & revitalization -Preservation of cultural identity

Table 3
Nodes, codes, and key themes related to constraints to care access.

Nodes	Codes	Shared Themes	Spanish-speaking Families	Immigrant and Refugee Families	Tribal Families
-Availability/ Access	-Familiarity with care options -Care search -Ability to find desired care -Satisfaction with care	-Limited family awareness of options (word of mouth) -Limited care supply -Burdensome enrollment & subsidy paperwork -Lack of providers prepared for special needs care	-Limited language access to information	-Limited language access to information -Unfamiliarity with U.S. care systems -Lack of programs in home languages -Lack of Muslim cultural support in care -Reliance on social agency navigators	-Limited full day care options -Limited infant/toddler care options
-Affordability	-Expensive/difficult to afford -Affordable with subsidy -Perceptions of subsidy eligibility -Unfamiliar with subsidy assistance -Barriers to subsidy	-Care unaffordable without subsidy -Unfamiliarity with subsidy assistance -Perceptions of ineligibility for subsidy	-High cost of subsidy copays -Low awareness/use of subsidy -Limited language access in some parts of state	-Unfamiliar with U.S. bureaucratic processes -Subsidy paperwork burden (language) -Prior negative experience with assistance programs -Low awareness/use of subsidy (Asian only)	-Restrictive income thresholds for subsidy & Head Start -Subsidy receipt meaningless in absence of providers -Subsidy paperwork burden
-Location & transportation	-Distance from home -Access to public transit	-Transportation barriers	-Inadequate public transit options -Need for provider-supplied transportation	-Limited access to private vehicle/ driver's licenses -Inadequate public transit -Access limited to providers within walking distance	-Job sites are distant from homes on tribal lands -Care sites are distant from homes on tribal lands
-Days/hours of operation	-Care hours adequate -Need more or different care hours	-Non-standard care hours unavailable		-Prevalence of non-standard work hours -Extra care hours needed to accommodate transportation constraints	-Prevalence of non-standard work hours -Extra care hours needed for travel time -Lack of full-day care

participants (3%) had unclear care arrangements. The remaining 46% (n = 49) of participants reported that one parent provided full-time care or that they used informal care provided by family members. Some families said parental care was an affirmative choice, while others said they would prefer to use nonparental care if costs were lower. Participants also described a variety of attitudes toward grandparent care. Some said they felt most comfortable keeping care within the family. Others said grandparent care was necessary but suboptimal, as aging relatives were often in poor health, easily fatigued, and unable to keep up with young children and provide them with enriching interactions. Some participants expressed feelings of guilt about the strain on grandparents or great-grandparents who, in some cases, drove long distances to provide care or retired from paid work earlier than they otherwise would have, among other sacrifices to help with care.

Families across groups described transportation and care hours as critical factors and constraints they considered when choosing care. Participants described limited access to cars, public transportation, or passable roads. Families also reported unmet need in their communities

Table 4
Nodes, codes, and key themes related to accommodations to constraints.

Nodes	Codes	Shared Themes	Spanish-speaking Families	Immigrant and Refugee Families	Tribal Families
Affordability	-Affordability compromised care preference -Affordability compromised pursuit of goals	-Stress of unstable informal care arrangements -Use of lower quality care -Workforce participation decisions -Reduced work hours -Delayed educational attainment -Family financial security	-Maternal workforce exit	-Two-generation female workforce exit -Reliance on elder care (Asian) -Relative care as quality compromise -Delayed maternal career goals (Asian)	-Two-generation female workforce exit -Reliance on elder care -Relative care as quality compromise -Familial group strain -Deferred marriage -Reduced care hours -Delayed maternal career goals
Location & transportation	-Location/transportation compromised care preference -Location/transportation compromised pursuit of goals	-Stress of unstable informal care arrangements -Use of lower quality care -Reduced work hours			-Family relocation
Days/hours of operation	-Days/hours compromised care preference -Days/hours compromised pursuit of goals	-Stress of unstable informal care arrangements -Use of lower quality care -Workforce participation decisions -Reduced work hours -Lost work opportunities -Job loss			
Quality/Supply	-Family satisfaction with care choice -Inability to find care -Use of care that does not meet family needs -Different/individual care needs	-Workforce participation decisions -Compromised child education/development -Forgone developmental supports for child with special needs	-Inability to engage as partner in child's care (language barrier with provider)	-Inability to engage as partner in child's care (language) -Use of care that does not provide supports for home culture & language	-Use of care that does not provide supports for home culture & language -Family relocation to better access special needs care

for care available in the evenings and on weekends. Across populations, families described a care supply that did not meet the needs of parents working in retail, food service, health care, nail salons, and other sectors with nontraditional hours that were common in their communities.

What Families Would Prefer. Participants' care preferences were shaped by factors including child age, with a preference for center-based care emerging more strongly for three- and four-year old children and care within the family preferred more often for infants and toddlers. Transportation assistance and conveniently located care emerged as unmet needs, especially where participants expressed care preferences that differed from their actual arrangements. Families also expressed a need for extended and flexible care hours, available year-round.

3.1.3. Supporting child development

What Families Experience. Across groups, families who had used non-familial child care spoke more positively about the quality of care in their communities and the social and cognitive benefits of care than those who had not. Families who had selected external care for their children described things they liked including: experienced and responsive staff, clean and safe settings, and learning activities that prepared children for school. However, participants across groups described a lack of child care providers equipped to care for children with special needs.

What Families Would Prefer. Families across groups valued care that would support children's learning and social development. Participants invoked the importance of the early years and said experienced, well-trained, mature, and attentive caregivers were essential. Across groups, families said they look for low staff turnover and professionals who will communicate regularly with families. Cleanliness, safety, and access to adequate, high-quality food while in care were also valued. Families used apparent cleanliness of facilities and security procedures as heuristics for quality, pointing to features like security cameras and procedures for signing children out.

3.1.4. Reasonable effort

What Families Experience. Families' ability to find care was conditioned by child age. Care options for children under three, and especially infants, were limited. The ease of families' care search was conditioned by where they lived; families in rural areas often had not searched for care because of very limited options in their area. Families in cities more often said they had compared multiple options when selecting care. Families across populations expressed low awareness of the child care subsidy program. Some participants had heard of the program but assumed they would not qualify, and some knew of the program but thought it was poorly understood by other families in their communities. Learning about child care subsidies was haphazard for participants, who often heard about it from friends and family, or from their providers. Few participants had direct experience applying for a subsidy. Those who had applied described the process as burdensome. One Native American participant said of their experience applying for assistance, "You finish one task and then all of a sudden they're like, you need—the program's been updated and now you need this and this, A, B and C. You accomplish those steps and then you find out, okay, well actually, there's 1, 2 and 3 now. It's just frustrating to take time away from work to fill out the documents you need. After a while, your workplace, your supervisor gets frustrated because you're taking so much time just to figure out child care."

What Families Would Prefer. Participants across groups described a preference for streamlined paperwork and stronger communication with families about child care subsidies. This included advertising about the program at multiple points of referral, including information on how to apply. One Spanish-speaking participant said, "It would be good to publicize [the subsidy program] more to know. I also didn't know anything about the city when I arrived here. … they should promote it more because it is essential for someone with children who needs that help." Participants said they would prefer fewer enrollment forms and clearer information throughout application and enrollment about what those processes would entail, eligibility, copay amounts, and the number

of care hours families are awarded. Participants who did not speak English described a need for interpretation and translation supports to help them access subsidy systems.

3.1.5. COVID context

COVID altered families' child care usage and preferences in multiple ways. These included provider closures or reduced hours, and loss of supports like transportation vans that were suspended during COVID. Additionally, some participants withdrew their children from care due to concerns about exposure to the virus. Most participants who had used center-based care prior to COVID described these changes as strains and were eager to get back to their care arrangements as public health conditions allowed. However, a few said COVID closures and the subsequent flexibility to work from home allowed them to provide parental care that they preferred for their children while also earning income. Others, especially among the urban immigrant and refugee groups, said the pandemic had shortened waitlists for infant care. In general, COVID-related changes were less pronounced among families who were already relying mostly on parental or family care—a more common arrangement among Native American and Spanish-speaking participants.

3.2. Constraints and accommodations

Constrained care access had numerous consequences for study participants. Participants across groups said access limitations led directly or indirectly to accommodations including (1) providing full-time parental care, (2) using family members or neighbors as care providers, or (3) using a lower-quality provider than they would have preferred. Several participants said they chose to care for their children at home or with relatives after researching child care options and finding they were not affordable or not available during the hours needed. While some families preferred to provide care within the family, a substantial number described this arrangement as a compromise or accommodation. Participants also described the difficulty of cobbling care arrangements together across extended family and continuously leaning on people to provide care on their days off. One Native American participant described this as a "group strain," saying: "I've had friends watch and cousins watch my children as much as I could. Then it really falls back on the family. Then whoever's in that circle of being able to help provide that informal child care, it becomes like a group strain for something very good that everybody wants to do."

Participants described consequences for their employment and careers, especially for women. These consequences mainly involved mothers leaving the workforce or reducing their hours after their children were born, or after the birth of a second or third child made child care costs prohibitive. This had long-term consequences for mothers' ability to build toward career goals. One Asian participant said, "At some point I was just basically making my money and giving what I was making to child care, all of it. At some point I'm like, 'Well, do I want to stay at home with the kids or should I –?' . . . But then if you think as a woman, then if you start going back into work it's harder." A few participants also described grandmothers retiring early to provide care.

Even when participants did seek work, they could not find or keep jobs that provided the flexibility they would need to accommodate limited child care hours. This led them to forgo opportunities for extra hours or added job responsibilities, slowing their career and earnings advancement. Participants' efforts to pursue higher education were similarly affected. Consequences for participants' personal lives were less common, but severe. One Native American participant said she delayed marriage because of worries about losing her child care subsidy benefit. Participants also described financial consequences for their families, either from paying the high cost of formal care or from lost income due to women leaving the workforce or reducing their hours. Families reported that these costs made it difficult to build family savings or feel economically secure, with some reporting that they took out loans or charged child care costs to credit cards.

3.2.1. Refugees and Asian immigrants

Specific themes and differences emerged among participants who spoke languages other than Spanish. Affordability findings were contextualized by group differences in usage of child care subsidies among different groups of participants. More than half of refugee families (55%) reported that they had used the child care subsidy system at some point, compared to 25% for Spanish speakers, 11% for Asian immigrants and 9% for Native Americans. This likely reflects differences between the groups in terms of time in the United States, income, and refugees being connected with the subsidy program through support organizations. All Asian participants were interviewed after New Mexico expanded eligibility, suggesting that relatively low uptake for this group may be due to lack of knowledge of the program rather than income ineligibility. Differences in subsidy use affected the way different groups described affordability challenges. No refugee participant was paying privately for child care, with all either accessing subsidy or caring for their children at home. Refugee participants described the cost of care as prohibitive without assistance. Among Asian groups, however, participants talked more often about the financial strain of paying for care, or their impressions that the highest quality care was most expensive and therefore out of reach. Transportation was an especially acute issue for refugee families who often lacked a car or driver's license. Although participants were not asked if they had access to a car, eight of the 22 refugee participants (36%) raised the lack of a car during interviews. For these families, all urban, their care search was limited to options within walking distance or on a bus line, which was challenging to navigate with babies or small children.

Participants who were recent arrivals to the United States said more often than others that they would prefer parental care until their child turns three or four, when they would use a center to prepare them for kindergarten. This preference was generally based on cultural norms from their home countries, and a sense that very young children are best cared for by their mothers and that this helps prevent children from losing their home language and culture. However, this preference was constrained by new obligations upon arrival in the United States. These participants reported they needed paid care because they were often separated from extended family and needed to work, attend English classes, or fulfill other resettlement obligations.

Families using center-based care (or who had used it prior to COVID) generally expressed satisfaction with the care, which they felt supported their children's development of social and English language skills and compared favorably to early education options in their home countries. However, families also said they had difficulty finding care that supported their needs around language, culture, and food. Refugee families said they had difficulty communicating with their children's care providers. Even when interpreters were used, families regretted the loss of privacy when discussing their child's health needs or behavioral challenges. Participants in the Asian groups, which had a mix of participants who spoke English and more recent arrivals who did not, also described being unable to find care staffed with providers who could reinforce their children's home language and culture throughout the day. The Asian immigrant families who sought religious care based in Christianity said they were generally able to find it, while Muslim participants reported that they were unable to find explicitly Muslim care options, even in the state's largest city. An unmet need for care that provided culturally appropriate food, such as supporting halal diets, was also raised across these groups.

Some families accommodated the lack of care providers who spoke their languages by keeping children home until they turned three or four, to prevent children from losing their home language and assimilating completely to American culture. A Vietnamese parent said, "[The] first child, the older one… he went to daycare center, so he doesn't speak Vietnamese as [does] the second one. The second one is staying with grandma more than the elder one so she can speak both languages, Vietnamese and English, and for me that's good, to keep two languages for the kid, because the kid is like the blank paper." This position was not

unanimous, with some families reporting that attending child care in English would prepare children for later schooling.

Participants who were new to the United States described difficulty finding and accessing care upon their arrival because they did not understand the early childhood system. Families perceived that systems of paid child care, child care assistance, and state-funded pre-K were complicated and hard to understand. Some said they missed out on early care and education when they first arrived in the United States because they did not know it was available. Recent newcomers to the country frequently noted they had been connected to child care assistance by resettlement navigators, but this experience was mixed. Some refugee families said their navigators did not connect them to early care supports and did not seem to be aware of them. As the interpreter for one of the refugee group interviews translated: "[Participant name] did hear some information about there is some kind of assistance for daycare services, but she didn't know, and the person who told her the information also didn't know how to apply for the grant, so she didn't get enough resources for applying." Even if families did know about child care assistance, they reported that application paperwork was not available in their languages and was confusing even for English-speaking volunteer navigators who helped them fill it out.

3.2.2. Spanish speakers

Language access differed for Spanish speakers, compared to participants who spoke other languages. This is contextualized by the history of New Mexico, which enshrines protections for Spanish speakers in its state constitution and where Hispanic residents are the largest demographic group. One quarter of Spanish speakers ($n = 9$) had used a child care subsidy at some point, which was lower than the refugee group but higher than the Asian immigrant and Native American groups. Multiple Spanish speakers said subsidy copays were too high for their families to afford. Although New Mexico had waived most copays at the time of data collection, participants recalled previous experiences and were not aware of changes. Among families who provided care at home, many had not heard of the subsidy program and perceived that high-quality care would cost as much as they could earn through paid employment.

Spanish speakers used more non-relative home-based care than other groups. Some participants said these settings supported children's development better than centers, since homes have fewer children in care and can provide more individualized attention. This preference was at least partially grounded in a perception by some Spanish speakers (as well as Native American participants) that center-based care was not trustworthy. Families worried children would be ignored in settings with too many children, or that care providers were not well trained. One Spanish-speaking participant said, "In my opinion, I've seen daycare centers for children, and I don't like the way they watch them. I mean, they leave one unattended to see another one, and the other one is crying and—I don't like that. That's why, the majority of the times, that my sister watches [my child]." Many families in these groups made similar decisions, with some noting they would be more comfortable with center-based care after children learn to speak.

Spanish-speaking participants broadly reported they could find providers who spoke their language. Regional variations emerged, however, with families near the U.S.-Mexico border reporting less difficulty than others. Families emphasized the importance of finding Spanish-speaking providers, mainly to enable clear parental communication with children's teachers. Some participants emphasized the value of bilingual care settings for child development, though this was mentioned by fewer participants. This likely reflects New Mexico's context, where Spanish is widely spoken in some communities and children have opportunities in multiple settings to listen and speak in both Spanish and English. The same regional differences emerged regarding child care subsidy enrollment. While several participants reported positive experiences with Spanish-speaking eligibility workers, others noted differences by community. One parent who lived near the U.S.-Mexico border said, "It would be better if there was more assistance with Spanish in most of New Mexico. In Hispanic areas, there is help for those that don't speak English but when we call Albuquerque, we call Santa Fe, we always come up against that barrier."

3.2.3. Native Americans

Native Americans encountered many of the same constraints faced by other participants, in addition to population-specific findings. Native American participants were by far the most rural participant group, with more than three-quarters of participants ($n = 17$) living in rural or tribal lands with severely limited care options. These participants described a complete lack of available care for children under age three in their communities, which meant care options were limited to arranging informal care or driving long distances to other communities. One tribal resident said, "Overall, is there enough? No, because I waitlisted with my first since I was six months pregnant. … We had to drive to another city to get child care." These participants described frustrations with income eligibility criteria for child care subsidies or Head Start more often than participants in other groups. A number of Native American participants described feeling they earned just over the income threshold for public programs or felt penalized because they were married or lived with a partner. This was especially salient for populations in which Tribal Head Start programs with family income limits were among the only available care options, and therefore expanded subsidy eligibility was of limited use. The few Native American participants who had applied for a subsidy described administrative burdens unrelated to language, including difficulty navigating the application website, lack of clarity about the required steps to enrollment, and negative experience when calling for help, such as being hung up on, put on long holds, or spoken to rudely. Families also described challenges scheduling work around early childhood programs that ended in the mid-afternoon. This was especially challenging for Native American participants living on tribal lands, who described long commutes to access employment off tribal lands that added to the hours they needed child care.

Native American families, while describing a general lack of care options, said the limited care that was offered on tribal lands generally affirmed indigenous language, food, and traditions. For participants living in urban areas, culturally affirming care was harder to find, although one participant described finding supportive, culturally competent care from non-indigenous providers. Native American families said they would value care that teaches children their indigenous language and culture, including traditional foods and music. These parents often described themselves as non-fluent in their indigenous language and said culturally affirming care for young children could help preserve cultures in danger of being lost due to systemic erasure. As one tribal resident stated, "I think that's super important, especially now with our culture and language dying, just really incorporating that and having the state and federal government really be cognizant and have more awareness … they're slowly introducing it into public school systems, but daycare as well." Unmet need for special education support was especially prevalent for these participants. Native American participants from rural areas shared stories of friends or relatives who made major life changes such as moving or leaving the workforce to access adequate care for children with disabilities, especially autism spectrum disorder. Native American families, similar to Spanish speakers, expressed a lack of confidence that child care provided in centers was high-quality and trustworthy and referenced direct experiences with care they perceived as low-quality, or stories they had heard in their networks.

4. Discussion

In each of the historically underserved populations that are the focus of this study, families described substantial and sometimes differential constraints to their care access. These constraints varied by group, but

families across populations consistently described accommodations and compromises that limited their care selection, economic stability, and employment. These findings update and affirm the consensus that families are seriously constrained in their access to child care, and that constraints are felt inequitably among families with different characteristics (Chaudry et al., 2011; Meyers & Jordan, 2006; Sandstrom & Chaudry, 2012). Notably, families still faced distinct linguistic and cultural barriers to care access while living in a state with some of the nation's most expansive and well-funded child care support policies (Hill et al., 2019; Parks, 2022). Enhancing families' awareness of the subsidy system may be especially important for those who are disconnected from the child care sector and for those who speak languages other than English and Spanish. This aligns with previous findings that state child care consumer education efforts largely fall short of meeting families' access and information needs (Banghart et al., 2021). Findings also highlight the potential importance of system navigation supports, affirming prior research that has identified the importance of connecting families to child care services through resettlement agencies and other trusted navigators (Gross & Ntagengwa, 2016; Morland et al., 2016; Vanek et al., 2020; Yoshikawa, 2011). Site-specific interventions have found that language interpretation and English language classes can effectively scaffold family engagement for immigrant families in early childhood programs (Mendez & Westerberg, 2012).

Findings about the limited supply of care, especially infant and toddler care in rural areas, largely confirm previous findings, while also adding to the more limited evidence about care supply on tribal lands, where families reported infant and toddler care is often entirely absent (Malik et al., 2018). Policies that incentivize expansion of a high-quality care supply, especially in rural and tribal areas, could include targeted financial support for home-based providers. This may be especially impactful for this study's populations since informal and home-based care are used disproportionately for the care of infants and toddlers (Carlin et al., 2019) and by families with non-traditional work hours (Carrillo et al., 2017; Harknett et al., 2022; Weber et al., 2018). Scholars have previously outlined recommendations for connecting home-based providers more effectively to resources intended to support small businesses (Adams & Hernandez-Lepe, 2021). Other work has pointed to promising practices for supporting home-based providers including allowing less formal license-exempt providers to receive child care subsidies and food reimbursement, bringing informal friend and family providers into the regulated sector, and providing technical assistance to home-based providers seeking licensure (Lloyd et al., 2024).

States may also consider building the care supply by contracting with providers to provide high-quality infant and toddler slots or care during non-traditional hours for subsidy-receiving families. However, scholars have noted that child care subsidy policies alone are likely inadequate to expand supply without infusions from other funding sources (Adams et al., 2022). Policies aimed at reducing transportation barriers could include incentivizing care providers to offer bus or van transportation for families in places where this is feasible, and partnering with city planners to support public transportation routes that facilitate access between residential areas and care providers. The national Head Start Association has recently undertaken such an effort after finding transportation was a significant barrier to Head Start attendance (Civic Mapping Initiative, 2023). Ongoing evaluation of those efforts may usefully inform whether this strategy could support transportation access to the child care sector more broadly.

Building a care supply that meets families' cultural and linguistic needs, while building trust with communities with long histories of systemic underinvestment (Wiechelt et al., 2019), may present a more complex policy challenge. Policymakers may consider accompanying efforts to expand overall access and quality of the care supply with simultaneous efforts to communicate clearly to families through trusted channels about efforts to improve care quality and especially about features such as caregiver training and experience and adult-to-child ratios. This aligns with previous recommendations that states and localities provide families with easy-to-access information about care availability and quality (Banghart et al., 2021; Henly & Adams, 2018).

Community partnerships may also be beneficial in growing a supply of culturally supportive care. This could include partnering with tribal governments to support their development of culturally affirming care options on and around tribal lands, including settings that incorporate indigenous language, traditions, and stories. New Mexico's tribal communities have a long tradition of providing such care, specifically by using Tribal Head Start programs as a setting for tribal language immersion and revitalization (Romero-Little, 2010). However, our findings and others (Sanchez, 2019) suggest that even in communities with culturally supportive Tribal Head Start offerings, these offerings are limited to children of specific ages and families are constrained from using them by waiting lists, income limits, and hours that do not align with parent work schedules. A supply of culturally appropriate, high-quality care also requires that policymakers create conditions that support educational pathways for an early childhood workforce that reflects culturally and linguistically diverse communities. Cohort models that provide individual supports to early childhood professionals with varied cultural and linguistic backgrounds can help them succeed in higher education (Zinsser et al., 2019), which is essential to ensuring that diverse educators do not remain concentrated in the parts of the early childhood sector with the lowest pay and credentials (Whitebook et al., 2018).

4.1. *Strengths and limitations*

This study includes rich perspectives from a large group of participants, comprising several populations with care access constraints that must be considered for equitable policymaking. The work was conducted in partnership with community organizations that are embedded in and trusted by their communities, elevating the voices of families that can be hard to reach through more traditional approaches. The study's setting during the COVID-19 pandemic may limit its generalizability, given rapid changes to public health conditions and child care policies that took place during and since data collection. The study's phased data collection with different groups over time reflects the challenges of pandemic recruitment and the capacity of partnering organizations at different times to provide translation and interpretation. This phased recruitment may limit the comparability of the groups on care access dimensions that were most directly affected by COVID, as the rollout of vaccines for adults and the reopening of most public schools in New Mexico took place during the study period. The research team has accounted for this as much as possible in analyzing and contextualizing the findings.

The COVID context also necessitated data collection via Zoom rather than in person. This posed limitations in reaching the study populations, some of whom lacked access to reliable internet, sufficient minutes on their cell phone plans, or knowledge of how to use Zoom. Many families with young children were also under unprecedented stress during the study timeframe. This made recruitment challenging and limited the pool of participating families in ways that may have impacted the study's generalizability. The study was also not designed to measure the impacts of COVID, and it was unclear at the project's outset whether child care arrangements in 2020 would reflect a short-term aberration or a more long-term accommodation for families. Most participants talked about the consequences of COVID for their child care arrangements, and those comments were coded for themes. However, the study does not include specific data for each participant on the impact of COVID. This limits the strength of any claims about the pandemic's consequences for specific groups. COVID findings are therefore presented with those limitations. Finally, the authors followed the advice of community partners in not collecting participant data on income, immigration status, or specifics of nativity to avoid questions families might perceive as intrusive, culturally inappropriate, or frightening in a context of heightened anti-immigrant sentiment nationally. Instead of collecting

that data at the individual level, we worked through organizations that serve primarily immigrants as our recruitment vectors. Because of these choices, some participant characteristics that would be analytically useful are unknown.

5. Conclusion

Policymakers seeking to expand equitable access to child care must be continuously attentive to the perspectives of diverse families. This study suggests it may be especially important to partner with diverse communities and tribal governments to build a care supply that meets families' linguistic and cultural needs. Further, clear and intentional policy and communications efforts that emphasize quality will be needed to meet families' preferences and expectations, accompanied by clear communications to reach families who are disengaged from the child care sector and who are unaware of changes to policy and funding contexts.

CRediT authorship contribution statement

Hailey Heinz: Writing – review & editing, Writing – original draft, Supervision, Project administration, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Dana Bell:** Writing – review & editing, Supervision, Project administration, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Darlene Castillo:** Writing – review & editing, Writing – original draft, Project administration, Investigation, Formal analysis. **Rebecca Fowler:** Writing – review & editing, Formal analysis. **Yoselin Cordova:** Writing – review & editing, Investigation, Formal analysis. **Sheri Lesansee:** Investigation. **Andrew L. Breidenbach:** Formal analysis. **Ruth Juarez:** Investigation, Formal analysis. **Bibek Acharya:** Formal analysis. **Alexis Kaminsky:** Writing – review & editing, Methodology, Formal analysis.

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Supplementary materials

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Data availability

The authors do not have permission to share data.

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