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Defining Quality Child Care: Multiple Stakeholder Perspectives

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Multiple perspectives regarding the definition of quality child care, and how child care quality can be improved, were examined using a focus group methodology. Participants were representatives from stakeholder groups in the child care profession, including child care center owners and directors (3 groups), parents (3 groups), child caregivers (3 groups), policy makers (1 group), and social service providers (1 group). Qualitative analysis revealed 6 components of quality that were consistently discussed across all participant groups: (a) communication and rapport, (b) caregiver practices, (c) staff characteristics, (d) finances and resources, (e) visibility and involvement, and (f) professionalism. Analyses highlighted differences among stakeholder groups and the complex interplay among quality components. Findings are compared to previously documented perspectives on child care quality, and a conceptual model is presented that (a) summarizes findings about how proximity to child impacts definitions of quality and (b) highlights the central role played by child care center directors. Implications for child care practice and policy are discussed.

Recent research on early brain development has found that environments that stimulate and support children’s development are critical from the earliest ages. Children from such environments are more likely than their peers to have higher
IQs and cognitive performance, improved language, fewer instances of grade retention, decreased need for special education, higher reading and math achievement scores, higher levels of formal education, and delayed parenthood (Behrman, 1999; Brooks-Gunn, Klebanov, & Liaw, 1995; Duncan & Brooks-Gunn, 2000; Yoshikawa, 1995). As it becomes increasingly common for parents of young children to join the workforce, it becomes more likely that children’s early care is outside the home, in child care settings. Thus, their positive developmental outcomes are dependent on the quality of those early child care settings (Cost, Quality, and Child Outcomes Study Team, 1999). When child care works, children—particularly children from low-income families—benefit in the short term with high self-esteem, high achievement motivation, and smooth adjustment to school, and in the long term with less antisocial behavior, lower rates of premature pregnancy, and less reliance on welfare as adults (Davis & Thornburg, 1994). It is extremely important, therefore, to define what quality child care is.

Currently, child care policy makers are expanding the scope of regulable features of child care quality as reflected in recent differential quality/tiered licensing initiatives (e.g., Oklahoma’s Reaching for the Stars program; Norris, Dunn, & Eckert, 2003). The definition of quality, therefore, may need to be broadened (Love, 1998). The current study was designed to provide a forum in which an enriched definition of child care quality could be developed by listening to voices that are not typically heard. The ultimate goal of this research is to inform public policy so that child care quality will be facilitated and children will be better prepared socially, emotionally, physically, and cognitively as they begin formal schooling. Yoshikawa and Hsueh (2001) suggest that public policy research will be strongest when a multisystem methodology is used. Our study draws on the perspectives of child care stakeholders from multiple levels of the ecological system, including the family, the child care setting, the community and its service agencies, and political institutions.

Quality is a dynamic concept and can mean different things to different people (Evans & Schaeffer, 1996). Among the perspectives that can be used to define quality are the following (Farquhar, 1989): that of experts in the field of child development (who ask, e.g., “What facilitates optimal child development?”), that of a parent (“What is best for my child?” “What best fits my needs as a worker and parent?”), that of child care staff (“What allows me to succeed in my role as a provider?,” “What gives me satisfaction in my work?”), that of social policy and funding (“What is the role of child care in this society?,” “Who pays for child care if it is to be successful?”), and that of government/regulatory and social service agencies (“What kind of child care system works best for the needs of the state or country?,” “How can community and family needs be met by child care?”). Although there is overlap among these perspectives, stakeholders representing each perspective also may offer unique insight.

Katz (1995) proposed a model that represents these various perspectives on child care quality (see Figure 1). Katz described the top-down perspective as being the one commonly used in research, namely, the perspective of the researcher or
child development expert. The three other important perspectives on quality have been largely ignored, however, including the bottom-up perspective (e.g., the child’s view), the outside-in perspective (e.g., the parent perspective, the community perspective), and the inside-out perspective (e.g., caregiver perspective, center director perspective). Although the current project focuses on the outside-in and inside-out perspectives on child care quality, we begin our review with literature representing the bulk of empirical studies in this area, namely those done from the top-down perspective.

Quality From the Top-Down Perspective

The overwhelming majority of child care quality research articles have focused on the structural and process features of programs that have been identified by researchers as significant components of quality. Structural characteristics are quantifiable and regulated and include stringent health and safety requirements, good caregiver-to-child ratios, child development or early childhood education and training, and staff wages and turnover (Blau, 2000; Burchinal, Howes, & Kontos, 2002; Cryer, 2003; Jones-Branch, Torquati, Raikes, & Edwards, 2004). Good things go together in child care, and programs that pay better have better trained teachers in infant and preschool classrooms and better ratios in toddler classrooms (Phillips, Mekos, Scarr, McCartney, & Abbott-Shim, 2000).
Process features of quality, in contrast, are those “aspects of the classroom environment as experienced by children—their interactions with teachers and peers, and the materials and activities available to them” (Phillips et al., 2000, p. 476). Process quality is often reduced to a single score on environmental rating scales such as the Early Childhood Environmental Rating Scale (ECERS) or a measure of caregiver sensitivity such as the Caregiver Interaction Scale (Cryer, 1999; Kontos, Howes, Shinn, & Galinsky, 1995; Phillips et al., 2000; Phillipsen, Burchinal, Howes, & Cryer, 1997).

Structural features of quality such as high staff-to-child ratios and educational levels of staff are associated with higher ratings of environmental quality and better teacher–child interactions (Blau, 2000; NICHD Early Child Care Research Network, 1996; Phillips et al., 2000; Phillips, Howes, & Whitebook, 1992; Phillipsen et al., 1997). Clarke-Stewart, Vandell, Burchinal, O’Brien, and McCartney (2002) found a relation between recent high levels of training among caregivers in family child care homes, caregiver sensitivity, and provision of rich learning environments. Burchinal et al. (2002) also reported this link between the structural indicators of caregiver training, education, experience, and sensitivity in family child care homes.

In summary, definitions of quality from the researcher’s top-down perspective often include lists of structural features of programs such as ratios, teacher training and education, staff wages, and turnover; or scores from standardized measures of process quality, such as environmental rating scales (e.g., the ECERS). Scarr, Eisenberg, and Deater-Deckard (1994) reported that the best indicator of process quality was teachers’ highest wage, as the other measures of structural quality were not as strongly correlated with scores on environmental rating scales.

Quality From the Outside-In and Inside-Out Perspectives

Most of the research that has been conducted from a perspective other than top down has focused on the outside-in approach, particularly one that focuses on parents’ perceptions of quality. In fact, studies from the inside-out perspective are rare and tend to be done in conjunction with an outside-in perspective (e.g., comparing caregiver to parent views). Hence, we review literature on definitions of quality from the outside-in and inside-out perspectives together. The researcher-driven definitions of quality described in the preceding section permeate much of the work examining parents’ perspectives on child care quality. A notable example of this influence was the direct modification of the ECERS into a questionnaire “to assess the degree to which parents valued specific aspects of child care” (Cryer & Burchinal, 1997, p. 42). Each of the original items on the 7-point ECERS instrument were transformed into questions in which parents used a 3-point scale (1 = not important to 3 = very important) to rate various features of child care for their child. Items addressed health and safety concerns, availability and arrangement of play materials, and interactions. Median scores for all but one of the 35 items on the infant/toddler version and all 37 items of the preschool version were 3, clearly
showing that parents also valued the same features of quality child care. Unfortunately, parents were not asked specifically how they would define quality, so experts do not know how those parents’ definitions of quality might have differed from those of researchers.

Other studies have included instruments to measure parents’ ratings of the importance of various features in child care primarily by using items previously identified by researchers as components of high quality. Ispa, Thornburg, and Venter-Barkley (1998) found that parents rated provider warmth and attentiveness, health and safety features, and appropriateness of the daily programming higher than hours and location of the facility when selecting care. Hours and location, however, were also important considerations for parents, even though they are not typically identified by researchers as important components of quality, as the mean for this subscale was 3.7 on a 5-point scale.

Liu, Yeung, and Farmer (2001) asked Australian parents of children older and younger than age 3 to rate the importance of 20 items that addressed the importance of an educational setting for their children in child care and the educational qualifications of the teaching staff. There were no differences in parental responses by the age of their child, as all parents wanted educationally qualified staff offering appropriate caregiving in a home-like atmosphere that addressed all areas of development while preparing their children for school. A third of the parents felt that the major focus on child care should be on meeting the needs of parents. The survey also included an unidentified open-ended question; however, only two references were made in the article to parental responses to the question. A few parents commented on how valuable male staff would be to a child care setting. The authors also indicated that many comments were made by parents about the professional background and education of the staff.

These comments about education and training were similar to comments made by parents in focus groups in Minnesota when asked about characteristics they associated with quality child care (Ceglowski & Davis, 2004). Parents were able to give specific examples of good practice in the areas of meeting the needs of individual children, planning activities, and providing positive interactions that they attributed to provider training. On the other side, they were also able to give specific examples of negative experiences with the child or the setting when providers had little education or training.

Researchers in England conducted 56 semistructured interviews with mothers of young children to discover mothers’ beliefs and values about important qualities of child care (Duncan, Edwards, Reynolds, & Alldred, 2004). Women with partners were purposely selected from two communities to represent different ethnic, racial, lifestyle, income, and job status groups. The rich data analyzed in this study provided a much more complicated picture about quality child care from a parent’s perspective.

Two groups of women interviewed had a strong sense of self as employed women: middle-class White and African-Carribean women. These two groups
sought child care that would meet both their needs and those of their children. In contrast, working-class White mothers held more traditional family beliefs even though they were employed, so they sought child care that met the needs of their children by offering a mother substitute (often with relatives). Mothers who were lesbians or strong feminists as well as all African-Carribean mothers valued child care programs that would offer their children group acceptance and a sense of belonging. Parents from lower income households, regardless of race, commented that they had to include cost of care in their equation of quality. Although these interviews documented that family values and personal beliefs influenced child care choices and perceptions of quality, Duncan et al. (2004) also commented that there was variability within the groups. Policy makers, teachers, and program administrators can not develop one-size-fits-all initiatives, strategies, or programs when attempting to provide quality child care for parents.

One study, also conducted in England, included the voice of parents and policy makers as representative of the outside-in perspective. In addition, this study included three groups of insiders—owners of proprietary child care programs, teachers in child care, and family child care providers (childminders; Mooney & Munton, 1998). Focus groups were held and audiotaped to document the various understandings of quality that were held by the different stakeholders. Even though they were able to identify common themes from the transcripts, the authors also commented on the variability within and across the groups.

Similar to definitions of quality held by researchers and other professionals from the top-down perspective, participants across the five groups in this study identified continuity of care as a feature of quality (Mooney & Munton, 1998). All groups also made comments about the importance of training, but their perspectives on this feature were colored by their group membership. Policy makers mentioned that training was important but difficult to fund. Teachers thought they needed training on child development, whereas owners thought that senior staff needed management training. Parents felt training was important for center staff but not as important for childminders, and childminders commented on the difficulty of finding training that addressed their specific context. Similar to the researcher perspective, members of the various groups also discussed the importance of salary and working conditions to quality.

However, this awareness of the importance of salaries was tempered by the reality that parents cannot pay unlimited rates (Mooney & Munton, 1998). Both owners and parents commented that child care choices and beliefs about quality were tempered by the financial realities of families. All groups also realized that the low salaries were part of the low status image of child care professionals, and owners commented that this led to high turnover. Higher professional status was recognized as another feature of higher quality child care by the stakeholders in this study. Directors interviewed in a study in Minnesota also talked about the interrelationship between low salaries and the difficulty recruiting and retaining educa-
tionally qualified staff. Similar to the comments made by policy makers in England (Mooney & Munton, 1998), directors in Minnesota mentioned the challenge of finding financial resources to support needed professional development and education (Ceglowski & Davis, 2004).

All of the groups in the study in England (Mooney & Munton, 1998) made comments about the importance of parent/provider partnerships as a feature of child care quality. Their comments again reflected specific group membership. The policy makers believed parental involvement was important to quality. Owners and childminders echoed this sentiment but commented on how difficult this was to actually do successfully. Classroom teachers commented that they valued parents’ input, and parents said they felt communication with the teacher was important but sometimes difficult. Although not a typical variable in the child care quality research literature, parent involvement has been shown to be associated with process quality in child care centers (Ghazvini & Readdick, 1994; Norris et al., 2003).

Summary

Although tremendous congruence does exist between various stakeholders and their perspectives of quality, each participant also brings his or her own unique flavor to the discussion. The challenge as experts develop an increasing number of tiered quality strategies and work to establish an integrated system of early care and education will be to honor the various voices that are vital to the effort. The purpose of this study was to extend researchers’ understanding of child care quality by listening to voices from the various perspectives that are typically ignored.

METHOD

Procedure

Focus groups served as the primary data collection method to obtain a descriptive understanding of quality child care. The purpose of focus groups is to understand how people think or feel about a service such as child care, to discover how they understand and value that service, and to learn the language used when speaking about that service. Focus groups conducted with open-ended questions allow participants’ ideas to surface that may differ from the narrow research perspective most often reported in the literature and have been shown to be a valid method of assessing group consensus or disagreement (Morgan & Krueger, 1993). Focus groups are particularly useful in helping participants’ formulate their opinions about a subject that they may not have been asked about before (Anderson, Kohler, & Letiecq, 2002). Additionally, focus groups provide a more natural environment than an individual interview because, during a focus group, an individual influ-
ences and is influenced by others as in real life. This methodology was chosen to encourage participants from various backgrounds to share ideas and perceptions with one another and thus generate a broad range of possible factors related to the quality of child care to enable a comparison across groups, not between groups. For the current study, a social research bureau specializing in focus group methodology was consulted and provided guidance throughout the project.

**Participants**

Data from 11 focus groups were gathered. All focus groups were drawn from the same large, midwestern metropolitan area. The research team solicited the names of potential participants from the director of a cooperative education program for child care providers in the area. Also, the research team met with the director of a child care resource center to get the names of all licensed child care homes in the same metropolitan area. Policy makers and social service providers were chosen randomly from a list of possible participants generated by contacts within the community and from suggestions made by the director of a bureau for social research.

There were a total of 92 participants with an average of 8.3 participants per group. The majority of participants were Euro-American. The groups had the following composition: three groups of child care center owners and directors (ns = 3, 5, and 11), three groups of parents (mothers and fathers; ns = 12, 11, and 4), three groups of child caregivers (ns = 22, 4, and 4), one group of policy makers (n = 8; 5 at the city level and 3 at the state level), and one group of social service professionals (n = 8 representatives from the community agencies, parent support agencies, public schools, etc.). Table 1 provides information about the configuration of the focus groups.

**Recruitment**

Every fourth facility on the generated list of licensed facilities (including family home and center child care settings) was called to solicit willing participant directors, owners, caregivers, and parents. Once participants confirmed a date, they were given a reminder call 1 week prior to the appointment and again the day preceding the meeting. The previously mentioned social service professionals and policy makers were all invited to attend a focus group and, once confirmed, were called and sent reminder letters scheduled to arrive 2 days prior to the confirmed date of the focus group.

**Focus Group Questions**

The questions used to guide the focus group discussions were based on a protocol developed by Ceglowski (see Ceglowski & Davis, 2004) and supplemented by
our review of the literature, our knowledge of the metropolitan area, and information from the consultant from the social research bureau. Questions were piloted with a group of child caregivers from a child development laboratory at a local university. The pilot guided redesign and reorganization of the questions before conducting the first focus group.

**Data Collection**

Each of the 11 focus groups met for approximately 2 hr, and their discussion was audiotaped for transcription. Groups met either at a child care center, in a conference room on a local campus, or in a conference room of a bank. Lunch or a light dinner was provided to promote a relaxed environment and encourage interaction within the group. Each focus group was conducted in the same manner using techniques described by Krueger and Casey (2000). The facilitator of the focus group discussion was a trained graduate research assistant who conducted the pilot study and each of the 11 focus groups. The facilitator began by giving an overview of the study, explained informed consent, and discussed the importance of maintaining the privacy of comments made. Participants were told that their answers would be kept confidential. For example, caregivers knew that the directors would not know whether they attended or what was said, and, similarly, parents were as-

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### TABLE 1
**Focus Group Composition**

<table>
<thead>
<tr>
<th>Group</th>
<th>No. Participant</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td>4</td>
<td>All women; from 2 centers</td>
</tr>
<tr>
<td>Caregiver</td>
<td>4</td>
<td>All women; from 1 center serving children from low-income families</td>
</tr>
<tr>
<td>Caregiver</td>
<td>22</td>
<td>All women; from various centers around a metropolitan area</td>
</tr>
<tr>
<td>Parent</td>
<td>4</td>
<td>All mothers; from 4 different centers</td>
</tr>
<tr>
<td>Parent</td>
<td>11</td>
<td>All mothers; from 1 center serving high-income families</td>
</tr>
<tr>
<td>Parent</td>
<td>12</td>
<td>11 mothers and 1 father; half had children in family child care homes and half in centers</td>
</tr>
<tr>
<td>Director/owner</td>
<td>3</td>
<td>All women; from 3 different centers</td>
</tr>
<tr>
<td>Director/owner</td>
<td>5</td>
<td>4 women and 1 man; from 3 different centers</td>
</tr>
<tr>
<td>Director/owner</td>
<td>11</td>
<td>All women; from 10 different centers</td>
</tr>
<tr>
<td>Policy maker</td>
<td>8</td>
<td>6 women and 2 men; from Chamber of Commerce, House of Representatives, Head Start, United Way,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Service Council, and a child care resource center</td>
</tr>
<tr>
<td>Social service</td>
<td>8</td>
<td>All women; from YMCA, parent and child center, Community Service Council, Success-by-Six, the</td>
</tr>
<tr>
<td>professional</td>
<td></td>
<td>public school system, and a community college</td>
</tr>
</tbody>
</table>
sured that their child care providers would not know what they had said in the focus group. The facilitator asked each question in the order listed in the Appendix. After participants appeared to be finished discussing one question, the facilitator continued to the next question on the list.

Data Analysis

The unit of analysis was the category of responses, not the individuals within each group. Individual statements of the participants and the focus group leader were recorded, but individual participants were not identified in the transcript. However, because the focus groups were homogeneous (one group consisted of all caregivers, another of all parents, etc.), it was possible to compare their respective comments in the course of analysis.

Data analysis consisted of three phases and was conducted by a team of three researchers: two of the study’s authors (Harrist and Thompson) and a professional with a master’s degree in child development. In the first phase, the verbatim focus group transcripts (prepared by the social research bureau) were reviewed independently by members of the research team in order to identify thematic categories (see Strauss & Corbin, 1990). Categories were written on index cards (one per card, including examples, salient quotes, and a tally of the number of times the category was mentioned if it recurred). The cards were marked to identify the stakeholder group from which the data came. In the second phase of data analysis, the research team met and compared thematic categories to check for consistency and to make sure that unique categories were not overlooked. Team meetings were held after coding was completed for each stakeholder group data (e.g., the caregiver transcripts were independently coded, then the team met; next the parent transcripts were coded, and the team met for a second time). During a team meeting, the original categories were collapsed into overarching categories. In the third phase, the coauthors met to organize categories according to those that were common across stakeholder groups and those that were not. Further analyses involved exploring the meaning of the categories across stakeholder groups, investigating differences across stakeholder groups and why those might exist, and discovering any other patterns that had emerged when examining the data.

RESULTS

Results are summarized in three sections. The first, “Defining Components of Quality,” summarizes the commonalities that emerged across all focus group discussions as stakeholders identified and discussed what makes child care high quality. The second, “Contextual Impact on Meaning-Making About Child Care Quality,” highlights patterns of meaning-making identified across and among multiple
stakeholder perspectives and presents our analysis of what might account for those patterns. The final section, “Tensions and Interplay Among Components and Contexts,” presents findings about how participants’ proposed mechanisms for improving quality via various components were sometimes in conflict or interacted in complex ways.

Defining Components of Quality

The qualitative data analysis resulted in the identification of six primary thematic categories, or what we have termed quality components. These were labeled (a) Communication and Rapport, (b) Caregiver Practices, (c) Staff Characteristics, (d) Finances and Resources, (e) Visibility and Involvement, and (f) Professionalism. Quality components were considered by the research team to be recurrent themes in the focus group discussions. When analyzing the groups’ discussion about these quality components, we noted that dialogue addressed three questions: (a) what the component meant to participants (i.e., the definition or description of the component that emerged across group discussions); (b) why participants felt this component was important (i.e., why the component was a significant predictor of quality child care); and (c) how change might occur vis-à-vis this component, including which stakeholders (caregivers, directors/owners, parents, social service professionals, policy makers, community, or business) participants felt could use this component to improve child care quality and the mechanisms proposed for improving child care quality. The following summary of findings is organized around these three questions as they apply to each quality component.

Communication and Rapport

What are communication and rapport? Communication and rapport was identified by all groups as a key quality component and was discussed in response to most focus group questions. The issues that were discussed in regard to the communication and rapport component generally involved positive working relationships and the positive emotional climate that exists in a high-quality child care environment. Communication and rapport was described as existing in multiple relationships: among staff, directors, and owners; between parents and caregivers, parents and directors, and parents and owners; and between caregiver and child. Thus, it was a multifaceted quality component, but one that appeared to be foundational to the stakeholders.

Why are communication and rapport important? The rationale provided for the importance of communication and rapport included the belief that team work is more effective than independent work; that supportiveness and respect improve job satisfaction and ultimately retention of staff; and that mentoring and
leadership facilitate growth and success. Participants also discussed how communication improves accountability. Finally, they noted that communication and rapport are reciprocally related: Communication improves rapport, and rapport paves the way for open communication.

**How can communication and rapport improve quality?** Caregivers, directors, parents, and social service professionals were all identified as having the potential to improve child care quality via communication and rapport. Many ideas were presented about how improving communication and rapport might improve quality. For example, participants discussed how rapport requires mutual respect and an attitude of partnership, and that this is crucial if parents and caregivers are working toward a common goal (e.g., in toilet training). Ideas for positive communication and rapport strategies that directors could use were at the level of management-type decisions, such as supporting professional development of staff by mentoring and providing training and development materials, and using good management skills, such as hiring the best staff possible and letting staff members go who aren’t meeting expectations. Participants also felt that directors could provide leadership by following responsible business practices, including being trained in business skills and being flexible and accountable. Other suggestions for directors were at the level of one-on-one interaction, such as conveying support by complimenting staff when they do well, or being patient and sympathetic regarding staff personal problems. Participants noted that rapport and positive communication are easier to establish when leaders have a positive attitude, a sense of humor, and creativity, and when they are open to suggestions.

The importance of having frequent meetings also was highlighted. Frequent staff meetings allow directors to know what is happening with the children, and frequent parent meetings allow staff to be responsive to their needs. Participants also felt directors could support parents by offering parenting classes and facilitating parent involvement (e.g., analogous to a primary school’s parent–teacher association). In addition to discussion of these formalized communication settings, however, participants also mentioned the importance of informal communication, such as caregivers telling parents about their child’s day at pick-up time. For example, one caregiver stated that teachers “need to be able to communicate with parents in a way that’s not threatening to them, because here we are taking care of their children, but they still are their children.”

Parents were described as bearing some responsibility for communication and rapport development. For example, parents could inform caregivers about the child’s life at home, about problems as they arise, and about parents’ own needs, so that parent education can be targeted to real needs of families. Parents also could convey appreciation and support to caregivers. Finally, they could talk to other parents to gain support and perspective on their situations. As one director put it, parents “need to give you support but they don’t. They feel like, they’ve dropped their
child off, and they’re your responsibility. When they pick them up, it’s like, ‘Well, why did you let that happen?’ or, it’s very hard.”

It was suggested that program owners use communication and rapport to improve quality by attending staff and parent meetings, which would allow them to check on the functioning of the program, get feedback, and inform staff/parents of policy changes in person. Owner–parent communication was seen as something that facilitates responsiveness to family and community needs, such as the need to develop an after-school care program.

Finally, participants felt social service professionals could better promote their services, letting programs and businesses know what services are available. Social service professionals also were perceived as having the potential to offer both instrumental and emotional support to child care staff via affirmation, a positive attitude, and a willingness to help. One caregiver described the need for social service professionals to be connected to particular child care programs:

Well, first I think that they should come into a classroom or a center and be there, experience what goes on—you know, the difficulties, the things that come up in. You know a lot of people that do those things I feel probably have no experience in the field. They need to come in, step in our shoes, and then it might be a little easier to write those regulations or understand why some aren’t always the best. There’s different situations that if you’re not actually familiar with those circumstances, I think it’s kind of hard for them to stand up and say, “Okay, this is what is expected,” but have no clue what you’re doing.

Caregiver Practices

What are caregiver practices? The second quality component, caregiver practices, referred to effective behaviors, work habits, and attitudes of child care providers. It included following safety guidelines; implementing developmentally appropriate practices; interacting in a nurturant, responsive manner; as well as being fun loving, creative, expressive, and parent-like. All groups identified caregiver practices as a key quality component, and it was a recurrent thread throughout other discussions. One social service professional said:

I think they have to have knowledge about developmental characteristics being changed and to know what is appropriate to provide the care that is needed for that age. And also, to recognize when a child is not developmentally on target—to seek out some help for that child.

Why are caregiver practices important? Caregiver practices were seen as important for several reasons. Participants expressed their beliefs that nurturant interactions facilitate socioemotional development, providing the child with a sense of security. Parents noted that this reassures them that their child is in a parent-like
relationship. Developmentally appropriate practices were described as desirable not only because they facilitate child social development but because they also promote school readiness. Safe and healthy practices were described as important because they protect children and also because they reassure parents that it is okay to leave their children in the child care setting.

**How can caregiver practices improve quality?** When asked how child care quality could be improved via caregiver practices, participants suggested that training, education, and experience (e.g., through improved retention of staff) could improve developmentally appropriate practices. Furthermore, they agreed that an improved working environment (e.g., support, salary, benefits) would allow nurturant caregivers to remain in the field rather than look for alternative fields of employment.

**Staff Characteristics**

*What are staff characteristics?* The third quality component, staff characteristics, referred to a profile of individual caregivers as well as child care programs and included caregiver training and education, child-to-caregiver ratio, and turnover rate. This component was identified by all stakeholder groups as a key quality component and was common throughout discussions.

*Why are staff characteristics important?* Staff characteristics were considered important for multiple reasons. Participants expressed the belief that trained and educated caregivers are more likely to follow developmentally appropriate practices, to provide a stimulating curriculum, and to be aware of individual differences and special needs of children and families. Having a low child-to-caregiver ratio was believed to increase attentiveness to each child, facilitate attachment, and ease safety concerns of parents. Similarly, low turnover facilitates secure caregiver–child relationships, reassures parents, promotes consistency in practices, eases the director’s burden.

*How can staff characteristics improve quality?* Caregivers, directors, and owners were all seen as stakeholders who could improve quality through changing staff characteristics. Training was frequently mentioned as a mechanism of change. For example, training of caregivers was seen as important because it increases their knowledge and understanding of standards and expectations within the field, thus facilitating professionalism (another major component that emerged). Owners’ training also was discussed as crucial: Participants believed that owners need to be trained regarding child development, curricular and policy issues, and business issues such as liability. Training of owners should include learning good management practices, such as how to hire qualified, skilled direc-
tors; the need for running background checks on potential employees; and how to facilitate accreditation.

Participants also noted that training includes not only formal continuing education, but learning through experience. They also stressed the fact that caregivers must apply what they have learned in their practice for training to have an impact. Participants did not lay all of the burden of change on caregivers, however; they stated that directors need to be responsible for making sure accreditation and safety guidelines are followed, and that owners could facilitate professional development and training of staff as well.

**Finances and Resources**

*What are finances and resources?* Finances and resources was the fourth quality component that emerged from stakeholder discussions. The finances and resources component included discussion of funds, costs, equipment, and supplies for use and/or maintenance of child care facilities and staff. It was identified by some groups as a key quality component and was a recurrent theme in response to all questions about improving quality. As simply stated by a social service provider, “Quality costs money.”

*Why are finances and resources important?* Participants discussed the impact of finances and resources on a variety of features of the child care system, many of which overlapped with the other five components. For example, they pointed out that caregiver pay and benefits are clearly related to retention, that funding can facilitate caregiver training and continuing education, and that funding facilitates proper regulation; each of these was part of the staff characteristics component. Most stakeholders agreed that child care costs need to be decreased for families, especially those with low incomes, and that quality should not be available only to wealthy families. There also was lively discussion of how government funding should be viewed as a long-term investment: If early childhood education were to become a legislative priority (receiving funding on an equal or greater level than K–12 education), future educational and societal problems would be lessened. One parent stated this view by comparing child care to other important professions:

> It’s almost an absurd comparison, but we pay firefighters good money—not that we shouldn’t have firefighters—but we pay firefighters good money to sit around and hope that there’s not a fire. And they get incredible retirement packets and wages and opportunities and job interns, and what do we pay our child care providers? That are doing that, that, that, you know who are watching our kids 10 hours a day? They’re not hoping that our kids are going to grow up; they are helping the kids grow up. They’re engaged in this, and they get diddly squat.
How can finances and resources improve quality? Directors, owners, policy makers, social service professionals, community, and business were all seen as stakeholder groups who could improve child care quality by changing existing finances and resources. In general, participants believed that financial incentives and rewards for attaining high quality would increase motivation for achieving high quality among child care staff. Specific roles of various stakeholders were discussed. For example, it was suggested that owners need to be responsible (and creative) about the use and provision of resources (e.g., supplies). Social service professionals could work with other agencies, public schools, and for-profit groups to mobilize financial and volunteer resources. They also could increase resources by offering training and helping with third-party assessments of curricula. It was suggested that community members and businesses could partner with programs (e.g., “adopt-a-program”), sponsor children (e.g., provide scholarships), and help fund local child care.

However, there was the most consensus in discussion of government involvement. All participant groups seemed to agree that government programs needed to be developed or improved. It was suggested that government programs are needed to provide resources (e.g., equipment) to both private and public child care programs. Investment, rebates, tax incentives, grants, and subsidies were considered possible means of obtaining resources. As described by one caregiver in the study, “Education and child care are a low priority in legislation. They’re low priority. And we need some type of legislative bill passed to update this or something, because nothing is being done right now. It’s low priority.”

Visibility and Involvement

What is visibility and involvement? The fifth quality component that emerged, visibility and involvement, referred to the salience of the program in the community and of stakeholders within the program. It included availability of directors and owners to caregivers and parents, inclusion of directors and owners in the classroom, and advocacy for the profession outside the workplace. This component was not mentioned as a key quality component, but it was common throughout other discussions. Stakeholders who were seen as potentially using visibility and involvement to improve child care quality included parents, directors, owners, and policy makers, as well as members of the community and business world.

Why are visibility and involvement important? This component was considered important for different reasons, depending on the stakeholder involved. For example, parent involvement facilitates development of caregiver–parent relationships and allows parents to know what is going on with their child outside of the home (see discussion of the communication and rapport component, above). Visi-
bility of directors within the child care facilities was seen as important because it promotes their knowledge of what is going on in the classroom; they need to “look, listen, and be there” as opposed to staying only in the office or being out (e.g., driving the bus). It also was seen as beneficial for owners to be visible (e.g., to visit a local facility if they work for a national organization and to make home visits with caregivers to get to know families). This would allow them to let parents know who they are and enhance their awareness of local needs. Participants believed that policy makers’ involvement leads to a better understanding of child care issues. Finally, there was a great deal of agreement that visibility and involvement in the form of advocacy is needed to change public perception of the child care profession. One social service professional said:

I would say after leadership, that’s a good one, uh… listening, listening and looking, listening to parents, listening to staff, looking, coming out from behind wherever they sit and being a part of that world so that they can engage and embrace it personally.

**How can visibility and involvement improve quality?** Many examples were given of ways in which stakeholders could improve quality via visibility and involvement. For example, it was suggested that parents could increase involvement (and therefore quality) by volunteering in the classroom, being visible in the room (instead of just “slipping in and out”), participating in program activities, reading “care sheets” about their children, returning phone calls, and speaking directly with caregivers. Participants believed directors could do a better job of advocating for child care issues at the state level.

Participants felt that increased involvement of policy makers would improve their understanding of education, developmental, and diversity issues so that policy could better reflect the needs of those in poverty and of various ethnic and disability groups. Involved policy makers will learn the realities of the child care business and the economic necessity of child care policy at the state level. For example, our participants pointed out that, in Oklahoma, there is a large “working poor” population who can not afford to pay for child care but who are overqualified for financial assistance from the state. Another situation salient in Oklahoma (and other states) at this time is the dilemma of illegal immigrants offering home child care but not participating in government-sponsored programs, even though they are eligible. Books and other resources often are unavailable to Spanish-speaking home providers; thus, the quality of care the children receive may be compromised.

Stakeholders expressed the belief that community members need to work to improve child care quality by lobbying, “cutting the legislature’s knot,” and “being a voice.” They could also be involved by volunteering (e.g., reading, playing, visiting) and monitoring child care (e.g., reporting problems). Finally, business could improve quality via visibility by setting up and supporting programs that pair cli-
ents with children (e.g., nursing home residents as surrogate grandparents). A policy maker in our study suggested that

... not only is it on the public officials, but all of us who are involved in this need to be, to be changing the way we talk about [child care]. I think that in most states you see that are successful, they have, they have very coordinated messages and they also have very coordinated messengers. And I think that clearly the states that are moving ahead with this very planned and massive scale, tie this—quality child care, quality early learning—to education and education to economic development.

**Professionalism**

**What is professionalism?** The final quality component that emerged, professionalism, referred to caregiver and public perceptions of child care as a valued profession, along with concomitant behaviors and attitudes appropriate to the profession. A frequently stated comment about this component of quality was that, “This is not just babysitting!” The professionalism component was not mentioned as a key quality component, but it was frequently discussed in response to other focus group questions.

**Why is professionalism important?** The rationale given for why professionalism is lacking in many child care settings is that society does not seem to value early childhood education, therefore quality of care is not seen as an important issue. Furthermore, participants believed that the general societal view is that child care is not a necessity for families, and that this societal attitude is reflected by policy makers and government officials. The consequence of this attitude is that child care is not valued as a profession, the pool of potential workers is narrow, and pay and job satisfaction are low. One director in the study described the situation as follows:

Yeah, so there’s so little respect. We had that unwritten code of ethics that kind of applies on one hand that we are a disrespected industry because [of] how little money there is to go around, so we’re basically viewed as one of the bottom rungs. When on the other hand, you’ve got all this research that shows we may possibly be the most important job in the world when it comes to enhancing lives, enhancing future adults, and creating—we have it in our hands, but we’re also looked down upon...

**How can professionalism improve quality?** Participants believed that caregivers, directors, and policy makers could all impact professionalism to improve child care quality. Professional self-perceptions among caregivers could promote commitment to the job; consistent, dependable, stable work habits; and a message of caring about the job and, therefore, about the children. Commitment to the profession among caregivers also should increase job satisfaction and retention,
which were identified as significant parts of the caregiver practices quality component. A higher level of expectations for staff from directors could promote professional behavior, such as being on time for work.

Participants noted that public awareness of child care issues facilitates policy change. They also were in agreement that the community can show that it values the child care profession by being respectful of child care workers, showing concern for children and families, and being careful near child care facilities (e.g., not speeding). Finally, participants discussed the need for business to understand that child care is major issue for parents. They suggested business personnel engage this issue by seeking feedback from working-parent employees, helping new employees find quality child care, and providing other expressions of support for working parents.

Contextual Impact on Meaning-Making About Child Care Quality

We next examined within- and across-groups patterns in discussion of child care quality components. This analysis led to the identification of several related findings. The next two subsections describe the pattern of findings identified as well as our interpretation of what might account for these findings, focusing particularly on the role of context and stakeholder perspectives in impacting findings.

**Differences Among Perspectives**

Although there were identifiable commonalities in discussions about child care quality components across stakeholder groups, there also were noteworthy differences in the voices we heard. By examining the three most common responses of each stakeholder group across all the questions, a pattern emerged that seems to capture the meaning-making of participants within their divergent contexts. Parent responses tended to center around the nurturant caregiver practices component of quality. Caregiver responses also focused on caregiver practices, particularly nurturant interactions as well as the implementation of appropriate curricula. Policy makers and social service professionals both highlighted the importance of staff characteristics (e.g., training, turnover, and caregiver-to-child ratios) and visibility and involvement (e.g., parent involvement). The one group that was difficult to characterize was the directors/owners, whose responses were quite divergent across questions; at times they aligned with caregiver and parent responses, and at times they were more similar to social service professionals and policy makers.

The finding that parents’ responses were more like caregivers’ than they were like social service professionals’ and policy makers’ is interesting, given that, according to Katz’s conceptual model, caregivers are considered insiders and parents...
outsiders. What might have accounted for the between-group differences we found and the similarity of parents’ and caregivers’ responses? One possibility may have lain in the different goals and values held by the stakeholder groups. Parents and caregivers were both concerned with two goals: one related to the needs and safety of the children, and one related to their own jobs (most parents stated that the purpose of child care was “So I can work,” and all caregivers were, of course, employed in the child care field). Parents in our study valued caregivers who “love children” and who were “parent-like,” characteristics that they, themselves, possessed for their own children. Parents and caregivers therefore had the common primary objective of achieving work satisfaction and stability while protecting and nurturing “their” children. The social service professionals and policy makers, in contrast, may have had child needs as a goal, but it was an indirect goal. Their work focused on mechanisms that ultimately—but indirectly—worked for the good of children.

Another factor that may have distinguished stakeholder perspectives on quality was the power to affect change via respective roles in the child care context. Caregivers, for example, could implement curricula in an appropriate manner, and this was something they valued. Social service professionals, in contrast, could affect change by ensuring that regulations regarding staff characteristics such as caregiver-to-child ratios were followed, and this was a quality component that was important to them.

The last factor that may have accounted for divergent voices—and may have accounted for parents being more similar to caregivers than to the other stakeholders—was the connection to individual children. Parents, of course, had an emotional connection and personal investment in the well-being of their child, and perhaps for their child’s friends or classmates in the child care setting. Although not as intense, caregivers also had an emotional connection and investment in the individual children in their care at a particular child care center or home. Social service professionals and, to an even greater extent, policy makers, were less likely to be connected to particular child care settings and particular children. This issue of proximity to children appeared to be an important one in shaping beliefs about child care quality. One caregiver said:

I personally feel that to be able to give love and nurturing, a sense of being safe when they’re with you. That if something goes wrong, that they know they can come to you and it’s gonna be okay, if they’re hurt, you’re gonna comfort. Just kind of take that place of maybe a parent or somebody in their life that they are safe and secure with.

Perhaps, then, the conceptualization of the child care system as having a single boundary that divides insiders from outsiders is not the most appropriate for capturing the complexity of definitions of child care quality. Our data suggest an alter-
native model, whereby stakeholders are placed on a continuum from proximal to
distal, based on their proximity to a real group of children in a particular child care
setting. Thus, caregivers and parents are the most proximal, social service profes-
sionals are more distal, and policy makers are the most distal (see Figure 2).

**Central Position of Directors**

But where are the directors in this model? We suggest that their position is
quite complex. Recall that we found great variation within director discussions
of the components of child care quality. Their voices were difficult to summa-
rize; at times they were aligned with caregivers and parents, at other times with
social service professionals or policy makers. When trying to understand what
might account for this complexity of responses, it may be important to consider
the multifaceted nature of the director role. The director role is challenging in
that directors must be accountable to each stakeholder group and often serve as a
link between two stakeholders. Directors are responsible for child safety and for
getting children’s needs met, and for facilitating the work of caregivers so that
this happens. Directors need to understand parent needs and interpret those
needs to caregivers. They also must show parents how the child care program
meets their needs, helping them understand their program in ways that parents
might not even think about. Directors are the link between social service profes-
sionals and caregivers (e.g., setting up training), and between social service pro-
fessionals and parents when families are referred for special services. Directors
are responsible for the image of child care in the community and must interact
with community and businesses to ensure positive relations. Finally, policy mak-
ers legislate policy, and directors must act and interact with caregivers to see that
the policy is followed. And directors are the policy makers at their facilities. In
summary, directors play multiple roles that serve as bridges between the proxi-
mal and distal stakeholders. Figure 3 represents this bridging function within our
proposed proximity model.

![Diagram of stakeholder roles and proximity](image-url)
Tensions and Interplay Among Components and Contexts

One final pattern emerged from our data analysis. We found that, in several instances, there were tensions or complex interplay among the definitions of quality components or among the mechanisms proposed for improving quality. For example, there was strong agreement that finances and resources were essential for child care quality. Although the traditional literature does discuss wages and fees, what became clear in our focus groups was how intricately money was tied to most other aspects of quality. The caregiver, social service professional, and policy maker perspective was that many, if not most, existing problems in child care would be alleviated if caregivers’ wages were higher. Caregiver turnover would likely be lower, and health and safety regulations could be better met. Additionally, if child care programs received more income, caregiver-to-child ratios could be better. The parent perspective on finances, however, was that child care was already too expensive for many families (a finding common in recent large-scale research studies; e.g., Peisner-Feinberg & Burchinal, 1997). Directors/owners were caught squarely in the middle of this dilemma: They wanted well-paid employees, but they wanted their service to be affordable enough to be attractive to parents.

Another example of the complex interplay among quality components was the link between finances and resources and staff characteristics. Our data suggested the profession must find ways of providing training that are not expensive and that would allow caregivers to continue their work and serve as a means of recruiting and retaining more highly educated and skilled staff by providing higher wages, benefits, and improved working conditions.

A further example of this interplay was the link between finances and resources and professionalism that emerged in our data. Caregivers could more easily view
work in child care as a career rather than a job if their pay were more aligned with that of other professions, and the public would likely respect child care as a profession if this were the case. Our participants had multiple suggestions for dealing with this tension surrounding finances, many of which involved intervention by the federal or local government.

Another conflict we noted in the focus group data was in the discussions of caregiver practices versus staff characteristic quality components, specifically nurturance versus education and training. Although ideally caregivers would embody both of these characteristics, that is not always the case. There are caregivers who are “loving” but not well trained, and others who are well trained but not loving. This raises the question of what should be involved in the training of early childhood professionals (can sensitivity and synchrony be taught?). A further complication comes from the fact that the relative importance of these two components differed depending on stakeholder context, as noted earlier.

A final example of tension or conflict among the findings that emerged in our study had to do with professionalism and the value of child care within a community, state, or nation. Caregivers noted that their jobs were not valued as a profession, whereas directors complained that caregivers did not see themselves as professionals. However, social service professionals and policy makers suggested that there currently exists ambivalence about child care. They expressed the belief that many citizens and politicians believe that child care is not a necessity, that it is inherently bad for children, and/or that mothers should be home with their children instead of in the workplace. Some attributed this belief to living in the “Bible belt.” Some parents also expressed the feeling that their first choice would be to not have their children in out-of-home care. When asked what he or she would do with a magic wand, one parent said, “I’d have [my child] home with me!” If, as our data suggest, professionalism is an important component of child care quality, it appears that there may need to be a very basic change in perception of child care at the societal level. A caregiver in one focus group expressed the societal bias in this way:

I’m sure everybody in here gets real offensive when we’re called just day care or child care people. I teach. I have a curriculum I follow, we don’t just play in my classroom. They’re taught. I think if people would maybe look at it as a whole instead of, “Oh, it’s just day care, you know, they’re not doing anything. They’re just there. Why do they need extra funding? What’s the big deal? It’s just a day care.” Where if they would come in and take a look, we’re not just a day care. We are teaching.

In summary, we heard meaningful similarities and differences as we listened to voices of stakeholders as they discussed the meaning and significance of child care quality. Our data confirmed existing understandings of quality from the top-down perspective but highlighted the multiplicity of components of quality and how the
definition of these components is influenced by the proximity of stakeholders to children in specific child care programs, as illustrated in the proximity model. Our findings also illustrated the complexity of how quality components interrelate and highlighted some apparent tensions or conflicts that exist because of that complexity. Our Discussion will highlight the implications of these findings as they relate to practice, policy, and future research.

**DISCUSSION**

Farquhar (1999) argued that, in the field of early childhood education and care, the prevailing approach to defining quality has been a “psychological approach which focuses on measurable indicators and pre-defined outcomes” (p. 4). Farquhar critiqued this approach by pointing out that it is a positivist approach, that it generally ignores contributions from disciplines other than developmental psychology (e.g., anthropology, sociology, health), and that it focuses on what should happen rather than what is happening. Given that child care policy is informed by the dominant method of research, the lack of understanding of “what is” might present a problem. One alternative to this dominant approach is the stakeholder approach employed in the current study (and in a few others; e.g., Ceglowski & Davis, 2004; Mooney & Munton, 1998; Moss & Pence, 1994). Although difficult to recruit (these were very busy people), once recruited, the participants in our study were eloquent and vocal in their expression of ideas about what quality child care means and how it can be attained; it was as if an untapped resource had been discovered. Our findings do not contradict the current research-based understanding of child care quality, yet by listening to not-previously-heard voices, a richer understanding of quality is provided by these data. Following is a comparison of our findings to past findings, along with discussion of implications for child care practice and policy.

**Comparison of Findings to Existing Literature**

Top-down type of studies of child care (see Scarr, 1998, for a review) have found that staff characteristics and caregiver practices are among the best predictors of positive child outcomes. These include structural variables such as training, caregiver-to-child ratios, and adherence to health and safety guidelines; as well as process variables, such as nurturant, sensitive caregiver practices and the use of developmentally appropriate curricula. In our study, these qualities emerged as two of the six most common components across all discussions. Caregivers, parents, directors/owners, social service providers, and policy makers all recognized the importance of these behaviors and practices in creating a high-quality experience for
young children, an experience that would benefit them socially and cognitively and prepare them for the future.

However, many of these staff issues are constrained by finances (Love, 1998). In our study, finances and resources were perceived to be crucial to attaining and maintaining high-quality programs. Similar to focus group studies in Minnesota and England (Ceglowski & Davis, 2004; Mooney & Munton, 1998), what became clear in our focus groups was how intricately money was tied to most other aspects of quality. Many, if not most, of the existing problems described by our participants would be alleviated if caregivers’ pay were higher. For example, caregiver-to-child ratios could be better, caregiver turnover would likely be lower, and health and safety regulations could be better met. Additionally, the issue of professionalism is tied to money: Caregivers could more easily view work in child care as a career rather than a job if their pay were more aligned with that of other professions, and the public would likely respect child care as a profession if this were the case. However, financial concerns were also expressed by parents (and others) who felt that most existing high-quality child care was too expensive. As one participant said, “Quality costs,” and this has been found to be true in recent large-scale research studies (e.g., Peisner-Feinberg & Burchinal, 1997). Parents want (and need) to pay less, yet child care staff want (and need) to be paid more. Currently parent fees are the primary funding source for early childhood programs, and they are clearly inadequate. Early childhood professionals and advocates have proposed a blended funding stream similar to the higher education financing approach in which revenues are a combination of public, private, and personal dollars (NAEYC Policy Brief, 2001). Research has demonstrated that improving the financial picture for child care with public–private partnerships (e.g., Smart Start in North Carolina) results in improvements in child care quality (Bryant, Maxwell, & Burchinal, 1999).

Thus, our findings validate the importance of these previously identified characteristics of quality; in other words, the outside-in and inside-out perspectives (of parents, staff, etc.) match those of researchers using a top-down approach. However, by listening to the largely ignored voices of stakeholders, we found that additional characteristics were identified as being important components of quality.

Communication and rapport also were identified as crucial to quality by our stakeholders. Although early childhood education training programs (e.g., bachelor degree programs) may include study of the importance of caregiver–parent communication, we found that, with a few exceptions (e.g., Galinsky, 1994), communication is not commonly assessed in early childhood research. When communication is assessed, it is focused exclusively on the caregiver–parent dyad (e.g., Eliker, Noppe, & Noppe, 1997; Endsley & Minish, 1991; Ghazvini & Readdick, 1994). One of our most striking findings is that communication is much broader and more comprehensive than previously conceptualized. It includes communication (and establishing positive relationships) among the child care providers (own-
ers/directors and caregivers), between administration (owners and directors) and parents, and between social service providers and child care providers. Perhaps child care researchers would benefit from using a more complex model of communication, something similar to the Epstein’s (1986) six-level framework for understanding parent involvement in schools of older children. Interestingly, one level of Epstein’s model includes parent–school collaborations at the community level and overlaps with our study’s quality component of visibility and involvement in that it involves partnering and advocacy.

Visibility and involvement are not usually assessed in child care quality studies, yet they were repeatedly discussed among our focus group participants. We know from studies of children in primary and secondary school that parent involvement is a key to student academic success (e.g., Honig, 1995; Reitz, 1990), yet visibility is a construct that has not been well-explored in the research arena. One recent evaluation study of a tiered licensing early child care program (Norris et al., 2003) found, however, that use of seven required parental communication/parent involvement strategies was a significant predictor of classroom quality and that lower-rated centers used fewer strategies. This suggests that staff can be trained in facilitating parent involvement and visibility. Another step toward improving parent involvement might be to inform parents about the importance of quality child care and its effects on children. For example, child care consumers need to be aware of the quality in specific programs so they can make informed choices (Love, 1998). This calls for developing guides for parents and other ways of conveying this information on a regular basis, a role that could be assumed by resource and referral agencies. It should also be noted, however, that our participants stressed the importance of visibility and involvement from stakeholders other than parents, such as owners and directors.

Finally, similar to comments made by focus group participants in England (Mooney & Munton, 1998), professionalism was a strongly recurrent theme among our participants. This component of quality more than any other seems to be underrepresented in the child care literature. A notable exception was a study that found that career-oriented family child care providers were more intentional about their practice and offered better quality care than those who saw providing care as just a temporary job rather than a profession (Kontos et al., 1995). Our focus groups members described professionalism in terms of practice and attitude among child care providers and in terms of an attitude of respect within the community, business world, and legislature. Yet the issue of how the profession’s status in society is related to child care quality has not been well examined.

Implications for Child Care Practice and Policy

Some of the ways for improving child care quality identified in the current study, such as those involving the finances and resources component, are not easily ad-
dressed without government intervention or policy change. However, others—like communication, visibility, and professionalism—may be addressed via education. The initial training and continuing education curricula for child care professionals could address the more complex definition of quality that emerged from our participants. For example, communication and rapport building, problem solving, team approaches, and networking skills could be taught and practiced; and communication problems could be mediated. Methods of developing rapport, support, and mentorship could be developed and advanced among child care providers. Currently, programs exist for enhancing parent–caregiver communication, but similar programs could be developed to foster communication among the child care staff (including owners, directors, and caregivers), between child care providers and social service providers, between child care providers and business/community representatives, and between child care providers and legislators.

Similarly, means of achieving visibility and involvement in the child care environment could be taught and promoted via educational programs. Avenues for involvement of parents, directors, and center owners within the classroom could be delineated and their use supported. Perhaps business models could be designed and tested that would allow center directors to better balance hands-on involvement and managerial tasks. Furthermore, visibility via advocacy could be directly taught to child care providers rather than simply encouraged.

As Gallagher and Clifford (2000) reminded their colleagues, however, these educational efforts cannot take place in isolation but must be part of a coordinated, systemic effort to create an infrastructure that supports quality early childhood. As indicated in our proximity model, the director must play a key role in the development and implementation of this infrastructure. As the liaison between the more proximal players (parents and caregivers) and the more distal stakeholders (policy makers and the public), a well-educated and informed director has the power to impact change on multiple levels.

The public perception of child care not being a profession and not being worth investing in might be addressed via a public education campaign to inform private citizens as well as businesses and policy makers. The advertising campaign to educate the public about inoculating children in the United States in the 1990s was extremely successful, increasing inoculation rates from less than 50% to more than 90% (“Health and Human Services unveils,” 1998). Perhaps a similar campaign could be conducted around the issue of early child care. One slant that such a campaign might take was suggested by Brauner, Gordic, and Zigler (2004), who proposed that “one way to foster the link between care and education in the public mind would be to push child care as a vehicle for school readiness” (p. 11). In other words, the public may not see the need for quality early care, but most agree about the importance of school success, so linking the two increases the public perception of child care.
Some staff characteristics—structural qualities like turnover, ratios, and to some degree training and education—are directly related to finances. However, process characteristics—caregivers' nurturance, sensitivity, caring—may be linked less strongly to finances. Although caregiver sensitivity is a long-recognized, critical component of quality child care, it appears to be conceptualized as something that either exists or does not exist within the caregiver. In other words, training of caregivers focuses on teaching them how to engage in healthy, safe, and developmentally appropriate behavior with children but may not address issues of interactional sensitivity and nurturance. Perhaps parent therapy or parent training models (e.g., van den Boom, 1994) could serve as models for the incorporation of interactional training of caregivers. The issue of attitude might be more difficult to address directly, but there might be indirect ways to affect it. For example, if directors are made aware that parents (and other stakeholders) highly value a playful, creative, parent-like, caring attitude among child care staff, this might become a criterion that is part of hiring practices. In the case of staff attitude, if pay were higher, if the public respected their work as a profession, if they got along better with coworkers and parents, and so on, surely more emotional energy would be freed to become positively focused on the children with whom they are interacting.

Regarding implications for child care policy, our data suggest that child care quality will be facilitated if policy makers make some attitudinal changes, for example making child care in early childhood as high a priority as K–12 education, viewing quality child care as a financial investment in the state/country, and viewing child care as a profession. Policy makers are also encouraged to gain a better understanding of child development and of child care as a business (e.g., day-to-day needs, needs of children and parents from diverse ethnic and socioeconomic backgrounds). Finally, policy makers are encouraged to reach out to other stakeholders with an open mind. For example, they might work more closely and responsively with advocates from the child care field, make child care policy and standards of quality more accessible to the public, and implement standards in a fair yet flexible way that allows for diversity in child care settings and needs.

Limitations and Future Research

In the current study, we did not do a systematic comparison between groups. There were some notable trends, however. For example, parents’ responses were very often more explicitly child-focused than were the responses in other focus groups. Parents tended to focus on child outcomes (such as school readiness and social development) as a way of assessing quality, whereas the other groups focused more on staff characteristics. If some of the changes suggested in our findings were addressed—such as improved caregiver–parent communication or increased parent involvement—these divergent perspectives might first be examined systematically so that the shared and divergent values and expectations existing among stake-
holders could be considered. Our design could be further improved by including
children. A recent intriguing presentation of ways to facilitate children’s expres-
sion of their perspectives (Samuelsson, 2004) includes use of transcriptions of con-
versations, videotape of interaction, and photographs to “make the child’s view
visible” (p. 1); such methodology could be used to explore the child’s bottom-up
perspective on quality child care.

Conclusion

Brauner et al. (2004) concluded their 2004 Society for Research on Child Develop-
ment Social Policy Report on child care and education with the following com-
ments, which seem a fitting conclusion to our report, as well:

Child care in the United States must be improved…. In order to put children’s needs
back into this system, our views of child care will need to be altered. Child care is not
merely a custodial service, but a child’s right to an enriching environment…. Yet to
advance this issue, parents, educators, advocates, and researchers will have to come
to consensus over what quality child care means [italics added] and recognize child
care’s potential as an environment for early education and intervention. Only when
this occurs, will the state of child care begin to improve. (p. 13)

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Appendix
Questions Guiding Focus Group Discussion

1) What are the main purposes of child care?
2) What things make child care high quality?
3) Of these characteristics you just described, if you had to choose one key component of quality child care, what would it be? Why?
4) What could caregivers do to improve the quality of child care?
5) What could directors do to improve the quality of child care?
6) What could parents do to improve the quality of child care?
7) What could child care center owners do to improve the quality of child care?
8) What could policy makers and government do to improve the quality of child care?
9) What could social service agencies do to improve the quality of child care?
10) What could business do to improve the quality of child care?
11) What could the community do to improve the quality of child care?
12) If you had a magic wand, what one thing would you do to improve the quality of child care?