CHILDREN, CAREGIVING, CULTURE, AND COMMUNITY:
UNDERSTANDING THE PLACE AND IMPORTANCE OF KITH AND KIN CARE
IN THE WHITE MOUNTAIN APACHE COMMUNITY

by
Shannon Michelle Anjeanette Sparks

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As members of the Dissertation Committee, we certify that we have read the dissertation prepared by Shannon Michelle Anjeanette Sparks entitled “Children, Caregiving, Culture, and Community: Understanding the Place and Importance of Kith and Kin Care in the White Mountain Apache Community” and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

Mark A. Nichter  
Date: November 1, 2007

Trudy Griffin-Pierce  
Date: November 1, 2007

Jennie R. Joe  
Date: November 1, 2007

Mimi Nichter  
Date: November 1, 2007

Final approval and acceptance of this dissertation is contingent upon the candidate’s submission of the final copies of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Dissertation Director: Mark A. Nichter  
Date: November 1, 2007
STATEMENT BY AUTHOR

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Shannon Michelle Anjeanette Sparks
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DEDICATION

I dedicate this dissertation to parents, children, and caregivers everywhere, especially …

to my own parents, Rodney and Carol Sparks, for their unending support and belief in me;

to my son Ellis, for giving me a whole new perspective on caregiving, and for his unwitting sacrifices during this prolonged writing process;

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ABSTRACT

The use of family, friends, and neighbors ("kith and kin") as caregivers for young children is a common practice in many cultural minority and impoverished communities in the U.S. Such caregivers often serve as trusted, familiar, affordable, and accessible sources of care, however, the quality of such "informal" child care is often questioned. This, I contend, is a consequence of the application of narrow constructs of quality derived from the values, practices, and experiences of the dominant class and culture.

This dissertation details the roles that kith and kin caregivers fill in the White Mountain Apache community in east-central Arizona, and the functions such caregiving performs. Being in the care of kith and kin is important in giving children a sense of "place" within their extended family and the community. It teaches them their relations as well as the role and importance of family and community and reciprocity, and builds and reinforces family and community networks. It places children in the hands of grandmothers and other individuals with high cultural capital, hence providing a space, time, and opportunity for cultural learning. Kith and kin caregiving thus assists in the preservation of Apache language and culture by providing not only a context for cultural transmission and access to those with the greatest cultural knowledge and linguistic competence, but also by reinforcing a pedagogical role central to Apache culture and emphasizing the importance of family.

While important, such functions of kith and kin care are ones not easily accounted for in existing constructions of quality. In order for standards of quality to have any meaning or utility in cultural minority communities, I argue that we need to
encourage the development and utilization of culture and context specific definitions of caregiving quality and the inclusion of community standards. Constructs of quality must also speak to the well-being of children in their own communities and cultures. For Native communities, the incorporation of Native culture and language into child care programming and settings is essential to the health, maintenance, and cultural survival of these communities.
CHAPTER 1
INTRODUCTION

• Introducing Monica …

The roots of this project date back to 1994. I was working with my close friend and colleague Lisa on a project examining local conceptions of disabilities in young children on the Fort Apache Reservation in east-central Arizona.¹ In the course of this work, we came to know a 26-year-old White Mountain Apache mother named Nettie² and her extended family. At the time, Nettie and her husband Frank had four young children ranging in age from one to six (they have since had a fifth child together). They lived together in a plain but clean three-bedroom HUD house only about a quarter of a mile away from where Nettie was raised.

Nettie was the middle of nine children, and maintained very close ties with her parents and siblings. Several of Nettie’s siblings still lived at home, and the others were spread out across a number of other not-too-distant communities on the reservation. Her parent’s home was the gathering place and emotional center of the family, and most days Nettie and her children spent at least some time there. Nettie’s parents’ house was conveniently located just off the road leading from the highway to Nettie’s street, and while doing our fieldwork we quickly learned to first look for Nettie at her parent’s home before driving on.

¹ This study, known as the “Apache Children’s Potential Project” was conducted by the Native American Research and Training Center (NARTC) at the University of Arizona between 1993 and 1996; Jennie R. Joe, Ph.D., was the P.I.
² All names used in this dissertation are pseudonyms, and any identifying characteristics in these individuals’ stories have been changed to protect these families’ privacy.
It was because of Nettie and Frank’s second child – four-year-old Monica – that we met Nettie and her family. When Monica was two, complications resulting from a severe case of otitis media left her with a significant hearing impairment. As a four year old, she could only communicate three things to her mother – that she was hungry or thirsty, that she needed to go to the bathroom, and that she was tired. Seeking resources, Nettie started attending a support group on the reservation for parents of children with disabilities. It was at one of these meetings that Lisa first met Nettie and tried to recruit her into the study.

Nettie did not immediately express an interest in participating. After the meeting, however, she caught up with Lisa outside and asked her for a ride to her parent’s house. Upon arriving there, Nettie surprised Lisa by saying that she was going to go inside and ask her father for permission to participate in the study. After awhile, her father Clendon came out and spoke at length with Lisa while Nettie remained inside talking with her mother Lorraine. When Nettie came back out, she told Lisa she was willing to be interviewed for the project.

From reading up on the Western Apache, Lisa and I knew that it was a matrilineal society, but this interaction still caught us off guard. We found it striking that, in spite of the fact that Nettie was married and had a family of her own, she felt it important to seek the advice and counsel of her parents before proceeding. Nettie did not discuss the study with her husband before agreeing to participate, even though he was an active part of Monica’s life.

Over the next several months, as we came to know Nettie and her family better, we gained a better appreciation for just how central a role Nettie’s parents played in her
and her children’s lives. Monica was nearing the age when she should enter kindergarten, and the family was struggling with the decision of how best to educate her. Remaining on the reservation would mean trying to educate Monica within the context of a system not prepared to deal with a hearing-impaired child. However, the other option — sending Monica to the Arizona Schools for the Deaf and Blind (ASDB) in Tucson³ — would mean long-term separation from her family and culture.

After a brief, unsuccessful attempt to mainstream Monica in a kindergarten class on the reservation, Nettie and her parents decided that it was in Monica’s best interest to attend ASDB. This was a difficult decision for the family, both because they were separating a very young child from the security and warmth of the family, but also because they recognized that they were removing her from her culture. Lisa, who by this point had become extremely close to Monica, was asked to participate in the decision, but once again Nettie’s husband Frank was not involved.

Just a few months after her fifth birthday, Nettie, Clendon, Lorraine, and Lisa took Monica to the dorm at ASDB and helped her unpack and settle in. As they walked back to the car, Lorraine was visibly upset. Talking to no one in particular, she asked, “Who is going to do her hair now? They won’t do it right!” Then, steeling herself, she added with some finality, “She’s not Apache anymore. This is her culture now. We have to accept it.”

* * * * * * *

³ Tucson is a four hour drive from the Fort Apache reservation. Apache children who attend ASDB generally only have the opportunity to return home two weekends per month and for the summer break.
In the years since, Lorraine has often made comments that I have found very illuminating. However, what she said in the ASDB parking lot was so poignant that it has stalked me ever since. Monica would always be a loved and valued member of the family, but – by living away from her family and community – she could never be “Apache” in the same sense as her siblings and the rest of her family. For the Apache, relationships – to family, to community, to place – are pivotal. Cultural learning is embedded in relationships, the self is defined in relation to others, and cooperative participation is central to identity (Basso 1996; Hermes 2005; Nevins 2004; Wax 1972). Children learn what it means to be Apache through lived experience in the context of family and community. As Lorraine recognized, it would be virtually impossible for a child – especially one with language barriers – to live away from the community and still be culturally Apache.

With Monica at ASDB, and Lisa and I in Tucson, we became an important resource to the family. We became Monica’s substitute family in Tucson, taking her out of the dorms on the weekends she did not return to the reservation, and occasionally driving her home. We attended her IEP\(^4\) meetings alongside her family. Through participating in Monica’s care, we came to know the entire family and were incorporated into Nettie’s extended family network. This relationship was reinforced through invitations to participate in important family and community events, and the occasional presentation of gifts. Nettie and her parents eventually formalized and cemented this

\(^4\) IEP is short for Individualized Education Plan. The IEP is a quasi-contractual agreement created yearly “to guide, orchestrate, and document specially designed instruction for each student with a disability based on his or her unique academic, social, and behavioral needs.” IEP meetings include the teacher, student, and parents; here, the student’s progress over the past year is reviewed, concerns are discussed, and educational goals are set for the upcoming year (http://www.ldonline.org/ld_indepth/iep/ed449636.html).
relationship by asking us to become godparents to Monica and her younger sister Melissa, integrating us into the family as fictive kin.

I had always been intrigued by the central role that Lorraine and Clendon played in the decisions surrounding Monica. The roles and responsibilities that Lisa and I were asked to take on over time further peaked my curiosity, both on a personal and academic level. As I spent more time in the community over the years, I realized that such involvement was the norm rather than the exception. Grandmothers, aunts, and, to a lesser extent, other relatives commonly take responsibility for children and are involved in their care. As with Lisa and I, friends and neighbors are occasionally asked to participate as well.

Such patterns of caregiving and responsibility are rooted in traditional Apache culture, but serve somewhat different functions today. The assistance with child caregiving that family and others provide is, of course, an important resource for mothers seeking employment outside the home, and shared responsibility for children can serve as an important safety net in times of material scarcity or family disruption. But for the Apache, the use of family, friends, and neighbors as caregivers for children is also important in the production and maintenance of “community,” and it is this connection which I explore in this dissertation. It integrates children into their extended family and community and gives them a sense of “place,” while simultaneously providing a space and opportunity for cultural learning. It also strengthens ties within the community and within families by strengthening and reinforcing networks of exchange and reciprocity.
APACHE CHILDREN, APACHE CAREGIVING

At its heart, this dissertation is about children and caregiving. But is also inherently about community, cultural survival, and resiliency. Children are the means through which the community maintains and reproduces itself, socially and culturally, as well as physically, and it is at least partially through the care of young children that the networks are created and reinforced that help bind the community together.

The focus of this dissertation is modern patterns of child caregiving in Western Apache communities, specifically the use of family, friends, and neighbors (“kith and kin”) as caregivers for young children. The Western Apache comprise five major subtribes – White Mountain, San Carlos, Cibecue, Northern and Southern Tonto – that historically occupied much of what is now east-central Arizona. Several reservation communities in Arizona are today home to the Western Apache; the Fort Apache Reservation – home of the White Mountain Apache Tribe – was the site of this research. It is the Western Apache generally, and White Mountain Apache more specifically, of whom I speak throughout this dissertation, although for the sake of convenience I often use the more general term “Apache” in my discussions.

For the Western Apache, caregiving has always been a community endeavor. Children are highly valued by parents, grandparents, and other family members, and their care and welfare are the responsibility of the family as a whole. Historical accounts mention the importance of the extended family in the care and socialization of children (Goodwin 1942; Stockle 1991), and today such individuals continue to play a significant role. This is not to imply that patterns of caregiving, and the forms of social organization, economics, and residence patterns that influence caregiving, are static. On the contrary,
Western Apache culture has been in constant flux, changing and adapting in response to contact with settlers, missionaries, armies, and government representatives, and the corresponding imposition of the Western legal system, obligatory attendance at government schools, and adoption of Western technology (Basso 1970a). In response to many of these same external pressures, child caregiving has changed and adapted as well.

**Apache Caregiving, Past and Present**

The sharing of caregiving and child-rearing responsibilities by several persons was traditionally – and continues to be – a custom honored and practiced by tribes throughout the U.S. (Cross 1986; Red Horse 1980). Details on specific caregiving practices among various tribes, including the Western Apache, however, are rather sparse; child-rearing practices are occasionally discussed, but caregiving is rarely addressed independently.

Goodwin (1942) provides some insights into historical caregiving practices among the Western Apache. He notes that matrilocal residence patterns ensured that children were constantly in the presence of a number of maternal relatives, most importantly grandparents and aunts. These individuals assisted in collectively caring for children in their “family cluster,” or matrilocal extended family grouping. Shared child care enabled mothers with small children to engage more easily in economic activities and be productive members of the extended family. Grandmothers, for instance, less physically able to travel extensively, often stayed home and cared for the young children while older children and mothers roamed long distances to gather food and fuel (Stockle

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5 Western Apache culture is explored more in depth in Chapter 2.
1991). It was also not uncommon for maternal grandmothers and aunts to take in children who had been orphaned.

Some of the best insights into child caregiving in the early twentieth century come from White Mountain Apache elder Eva Watt. In her recent memoir (Watt 2004), she talks about her experiences growing up in the 1910s and 1920s, in particular the important role her grandmother played in her life. As Eva (Watt 2004:4, 40) comments,

My grandmother Rose went everywhere with us. It seemed to me like she was with us all the time. ... She was the one that raised me, her and my mother. She was always taking care of me.

As Eva’s remembrances make clear, her grandmother’s involvement was not limited to what we think of today as “child care” – she was intimately involved in Eva’s daily care and upbringing. Eva further notes that, on a number of occasions, she went to stay at her grandmother’s home for weeks or even months at a time, simply because her grandmother had “no small children, so she like[d] to have me there” (Watt 2004:51).

Many individuals with whom I have spoken similarly recall grandmothers and other relatives who were central caregivers in their lives, however it is no longer as common as it was. Social and economic changes in the twentieth century have changed the reality of caregiving on the Fort Apache reservation. For one, the extended family has declined in social and economic importance, a consequence of the rise in importance of wage work and modern housing trends which have made it less common for families to live in close proximity to their extended families. While not fully independent socially or economically, the nuclear household now predominates.
The emergence of the nuclear family in contemporary society has, as Mead (1957) notes, diminished the involvement of the extended family in caregiving, leaving more of the responsibility in the hands of the mother and father. Chickadonz (1974:54), doing her research in the early 1970s, saw evidence of such a shift on the reservation:

Mothering appears to have become less stable and effective today in the midst of this rapidly changing society. The supportive system of the extended family appears to have lost much of its effectiveness and the establishment and maintenance of the family rely much more closely on the individual strengths of the parents.

The expectations surrounding child caregiving and the role of caregivers have to some extent shifted as well. Childrearing and caregiving have been increasingly viewed as the responsibility of the parents, specifically the mother, rather than tasks to be undertaken collectively by the extended family. More and more, the involvement of others has not been expected, but rather something specifically sought (or offered) when dictated by need.

The need for caregiving assistance is these days strongly tied to maternal employment. In 2000, more than 42 percent of women on the reservation with children under six were employed, and the majority of these women use relatives or acquaintances to assist them with child care. This is not to imply that relatives and others only assist with child caregiving today if the mother is employed. Relatives in particular will watch children when parents want to run errands, and it is not uncommon for them to take over care of a child for longer periods. However, modern residence and employment patterns, along with compulsory schooling, mean that children do not spend

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6 Census data used in this dissertation come from the Census 2000 American Indian and Alaska Native Summary File (AIANSF) (U.S. Bureau of the Census 2003a), unless otherwise indicated. Reported data include only those individuals living on the Fort Apache Reservation who self-identified as "Apache" on the 2000 census forms.

7 Census 2000 AIANSF, Table PCT80, Fort Apache Reservation (Apache alone or in any combination).
as much of their time in the presence of the extended family, and these individuals are not as integrally involved in the care of children as in prior periods.

At the same time that, as Bahr (1994:239) notes, the need for traditional forms of caregiving is being “heightened by the modern pattern of women’s employment outside of the home, … high rates of single parenthood and of alcohol abuse,” the ability of kin networks to support and assist parents has been strained. Many of those who regularly assisted with caregiving in the past are unavailable today because they do not live nearby, they have competing responsibilities, or they have problems of their own that leave them unfit to provide care. Women’s employment and alcoholism, for instance, have not only increased the need for caregiving assistance, they have reduced the number of available caregivers.

In spite of these challenges, kin-based networks are still the most important source of caregiving assistance in the Fort Apache reservation community. Such caregivers are important because they provide support for those needing to work or complete school, and for families who otherwise need caregiving assistance. But they are also important for their role in strengthening extended family networks and building and maintaining community.

**Caregiving, Culture, and Community**

A cornerstone of Western Apache culture has always been interdependence and cooperation. Traditionally, the strongest reciprocal obligations existed between individuals and their maternal relatives. These individuals, as Basso (1970a:13) notes,
“were expected to cooperate with one another at all times, protect each other’s interests, and share surplus food and material goods.”

Although the Apache community has undergone considerable change, the affairs and welfare of related families and households in general continue to be intertwined (Basso 1970a). They are linked by networks of exchange and reciprocity of which caregiving always has been, and continues to be, an important part. Kith and kin caregiving brings together family and community members, creating bridges and reinforcing bonds between individuals and groups. And, like other services and goods that are exchanged, caregiving creates and fulfills obligations within these networks, affirming, strengthening, and reproducing these networks, and building social capital. It assists in creating an integrated, resilient community.

“Community” is a concept that is central to this dissertation and which I use throughout. Community has many meanings and many levels, and I use it in different ways in different contexts. It can refer to a collection of individuals within a defined physical space, as when I speak of the White Mountain Apache community or one of the recognized communities or housing settlements on the reservation. However, it can also refer to the sense of community and interdependence that is produced through common interests and cooperative endeavors, and it is this meaning that is more central to the current discussion.

Being in the care of kin is important in giving children a sense of “place” within their extended family and the community. It teaches them who their relations are as well as the role and importance of family and community and reciprocity. It also helps
children start building their own networks by creating close ties and relationships with others beyond their immediate family.

Kin are also central in helping children learn what is necessary to function and belong in the community. Traditionally, grandmothers and other elders “educated” Apache children, teaching by example and words, and instilling in them a sense of identity (Bahr and Bahr 1993; Watt 2004). Today, it is these same individuals who are generally best positioned to pass on the language and teach children what it means to be Apache, for it is with them that the language, stories, and culture remain strongest.

For Apache children, learning is embedded in everyday experiences and a richly relational context (Bahr and Bahr 1993; Hermes 2005). Participation in mundane, everyday activities sustaining of family life, such as chopping wood or making bread, is viewed as central to learning and knowing the Apache language (Nevins 2004). Similarly, hearing the stories associated with different places in the Apache landscape and “drinking” from these places is important in the production of wisdom and learning to make good life decisions (Basso 1996).

The realities of modern life limit the opportunities, however, for these experiences and limit access to individuals with the necessary cultural knowledge. Young children no longer dependably spend their days in the company of relatives, and television and school compete for their time and attention. For children to be truly culturally competent – to know the language, the stories, the traditions, and be able to adeptly navigate the cultural terrain – they must have access to cultural “experts” and have sufficient time to spend in their company.
Kith and kin caregiving helps place children in the hands of grandmothers and other individuals with high cultural capital, hence providing a space, time, and opportunity for cultural learning. The involvement of these individuals in the socialization of children is also important because it preserves their pedagogical relationship to successive generations and maintains the authority of the elders (Nevins 2004). Kith and kin caregiving hence assists in the preservation of Apache language and culture by providing not only a context for cultural transmission and access to those with the greatest cultural knowledge and linguistic competence, but also by reinforcing a role central to Apache culture and the importance of family.

TWO WORLDS

Apache children today grow up in a very different world than their parents and grandparents. In essence, they grow up in two worlds. There is the Apache world of their family and community, but also the world of mainstream America that they encounter on television, in the schools, and outside the borders of the reservation.

On the Fort Apache reservation, as in many tribal communities, there is a tension between these two worlds, between looking inward versus looking outward, between preparing children to succeed in the Apache community versus the world outside the reservation. Individual families, and the community as a whole, struggle to balance these two languages and cultures. They must assess the relative value of traditional knowledge versus knowledge that comes from formal schooling for today’s children. They must also decide whether to emphasize Apache or English, or help children work toward proficiency in both.
In his book “Surviving in Two Worlds,” Darryl Wilson recalls his aunt’s words: “We must speak the white man language to survive in this world, but we must speak our language to survive forever” (Crozier-Hogle and Wilson 1997:xxii). White Mountain Apache tribal leaders similarly see the necessity of preparing children to live with one foot in each world. They recognize the importance of knowledge that comes from formal schooling, for “surviving in the contemporary world requires the acquisition of contemporary skills” (Basso 1996:147). At the same time, however, they emphasize it is critical not to lose their traditional knowledge and language. As a former tribal chairman commented to Keith Basso (1996:38), “Our children … don’t know the stories about what happened at these places. That’s why some get into trouble.” Others stress, as did Monica’s grandmother, that if children are not learning the language, they are not learning what it means to be Apache (Adley-SantaMaria 1997b). Surviving in the modern world may necessitate modern skills, but survival as a People necessitates the maintenance of Apache language and culture.

Unfortunately, although the Apache language is still heard everywhere on the reservation, the majority of children today are not learning to speak it (Adley-SantaMaria 1997b). While the White Mountain Apache Tribe itself is committed to maintaining its language, not all parents today view this as a priority. Additionally, children do not spend as much time in contexts traditionally associated with learning language and culture; now their days are dominated by school, television, and peer groups where they hear primarily English. Needless to say, many in the community find this alarming. In reaction, the Tribal Council has passed resolutions encouraging the teaching of Apache in the schools, yet even these efforts have met with some resistance because they utilize foreign pedagogical models that are not family centered (Nevins 2004).
The only child I know today who is fluent in Apache is a cousin of Monica’s. Prior to entering school, she was spoken to exclusively in Apache, and she spent many hours each day in the care of her maternal grandmother and aunt. These individuals were selected as caregivers specifically because they shared her mother’s commitment to teaching her the language and traditions. Their use as caregivers was also important in that it provided an opportunity for the traditional family-centered pedagogy which “teaches language by cultivating awareness of the social world in which speaking is possible” (Nevins 2004:278).

Kith and kin caregiving – intentionally or unintentionally – often provides opportunities for cultural learning that might not occur elsewhere. It places children with individuals and in a context that can facilitate such learning. Thus, in this Apache community, this form of caregiving is as much about the production of culturally and linguistically competent children and community building as it is about “child care.”

The purpose of child care, and what exactly constitutes “quality” caregiving, are issues that have recently been the subject of much debate at the federal level. These days, child care is simultaneously viewed as something that should support maternal employment and enhance children’s development (Lowe and Weisner 2001; Scarr 1998). “Quality” has come to be associated with Western socialization and educational practices believed to support later success in school (Cryer 1999; Holloway and Fuller 1999). Recent initiatives such as Good Start, Grow Smart have only served to further stress the role of early non-parental care settings in promoting school readiness (The Bush Administration 2002).
Kith and kin caregiving in the Apache community is certainly critical in supporting maternal employment, particularly given the scarcity of other child care options. It is also, I argue, important in supporting children’s development — not necessarily in preparation for later success in school, but as Apache individuals.

Current conceptualizations of quality do not work well in general for informal types of child care such as kith and kin care, and they certainly are not formulated to recognize or support such culturally specific domains of child development and caregiving. Caregiving which is community-centered or, for example, concerned with producing culturally-competent children, requires a completely different conceptualization of quality. Recognition of these deficiencies has led to some criticism and revisions of definitions of quality, and tribes have been encouraged to develop their own minimum standards for centers and providers. Many of these, however, are modeled after federal standards, and — while allowing room for various cultural practices — they do not specifically include such cultural practices in their standards.

In contrast, in Canada it has been emphasized that such minimum standards for child care should reflect First Nations values and traditions (McKenzie 1991). The first priority of Native child care must be that it be based on an understanding of aboriginal cultures and languages. Central to this is the recognition that the care of young children is the responsibility of the extended family and community, and that elders should specifically be involved. A child’s early years generally, and child care specifically, are

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8 The U.S. Department of Health and Human Services’ Child Care Bureau, in consultation with tribes, tribal organizations, and tribal child care programs, has developed model “minimum standards” for both tribal child care centers and family child care homes. It is important to note that tribes individually have the option of adopting these model standards or developing their own. Additionally, they may exempt relative caregivers from these minimum standards. Nonetheless, the standards that tribes adopt are an important indication of how caregiving quality is being conceptualized and defined overall within tribal communities.
recognized as important to “revers[ing] the trend of assimilation … into the dominant Canadian culture” and providing opportunities to preserve Native language, traditions, and identity (Native Women's Association of Canada 1986:2 cited in McKenzie 1991:9).

Hence, in addition to supporting employment and children’s development, a third explicit goal of Native child care in Canada is the provision of culturally relevant care “to facilitate the continuation of aboriginal traditions and languages in the new generation” (McKenzie 1991:12).

For Apache children today to be culturally and linguistically competent, it is exactly these kinds of opportunities which must be created. Kith and kin caregiving is important in the Apache community precisely because it provides opportunities for preserving the language and culture that other forms of child care on the reservation currently do not. While some tribal child care centers in Canada have developed innovative programs utilizing Native teachers, elders, and language immersion programs (McKenzie 1991), most in the U.S. – like those on the Fort Apache Reservation – are still more Western in design. Early childhood programs – including child care – that support Native culture and language are essential to the health, maintenance, and cultural survival of these communities, and constructs of caregiving quality must speak to the well-being of the tribal community as well as the child. As the Native Women’s Association of Canada (1986:7 cited in McKenzie 1991:12-13) reported before the Canadian House of Commons in 1986:

Our children require day care facilities so that we can break the cycle of poverty, we can break the cycle of alcoholism, but most important so we can pass on our culture, values and language. Without day cares designed by us for our children, in which our elders tell our children their history and assist in the teaching of our children their traditional languages and values, we will only continue to suffer racism, assimilation, loss of languages; our children will be more alienated as they grow up; the cycle will continue …
I moved to the White Mountain Apache community in 2001 specifically to explore these connections between caregiving, culture, and community that had first peaked my interest nearly seven years earlier. My association with Nettie and her family had been integral in raising for me specific questions about the role of kith and kin, and my inclusion in their extended family network helped make the research possible. Nettie and her family took me under their wing and took an interest in my research. They got me involved in the community and suggested families that I might want to talk with. They introduced me to tribal council members as well as the woman who would ultimately sponsor my research. Most importantly, by having made me a godparent, they had made me part of their family, giving me a legitimacy and connection to the community I could not have achieved otherwise.

From my previous experience in the community, I knew that the use of non-parental caregivers, for both short- and long-term care, was extremely common. Data from the Apache Children’s Potential Project that Lisa and I worked on in the mid-1990s indicated that only around 12 percent of mothers did not use kith and kin caregivers for their children. Children are frequently seen in the care of grandparents and other relatives – at the grocery store, at basketball games, at the clinic, etc. It is also commonplace for children to be living with individuals other than their parents – two of the eleven children who participated in a Culture Day Prince/Princess pageant I attended, for example, said they were being raised by their grandparents, as were several other children I knew in the community. Bahr (1994), in the early 1990s, found
that 17 percent of all children on the Ft. Apache reservation resided with a grandparent caregiver.

Throughout this dissertation, I primarily use the term “kith and kin caregivers” to refer to those individuals who provide the informal, non-parental caregiving which is the focus of my research. “Kin” can reference any of a number of members of the extended family, and “kith” are friends and neighbors who serve as surrogate family members or quasi-kin (as I have). When contrasting these caregivers with parents, they also tend to be described as “alternative caregivers.” On the reservation, kin far outnumber kith as caregivers for young children, yet enough non-relatives function in the role of caregiver to warrant their inclusion and discussion.

Kith and kin caregiving arrangements tend to take two forms, although – as I will discuss in Chapter 4 – these are not seen as categorically different in the Apache community. Arrangements that serve to supplement care provided by the parents – commonly thought of as “child care” or “babysitting” – are collectively referred to as supplemental care. Supplemental caregivers may care for the child within their own home, or go to the child’s household to provide care. In some instances, such caregivers may even live with the parent(s) and child in an extended family household.

Whereas supplemental caregiving involves the temporary or short-term care of a child while the primary caregiver is unavailable, surrogate caregiving entails a longer-term, more permanent transfer of caregiving responsibilities. Generally in the United States, surrogate caregiving, or “foster care,” is thought of as involuntary, the result of abandonment, abuse, neglect, or a problem in the child’s home environment (Bowers and Myers 1999; McLean and Thomas 1996; Minkler 1998; Scannapieco and Hegar
1999; Wilson and Chipungu 1996; Woodworth 1996). Many surrogate arrangements in the Apache community, however, are voluntary. They are initiated by the parent, the caregiver, or even the child, and are seen as benefiting one or more of the involved individuals. In cases where a mother works late shifts or far from home, such caregiving may even serve as a form of extended child care arrangement.

My interest in kith and kin caregiving centered upon understanding the roles such caregivers fill and the functions such caregiving performs in the community, and hence why this type of caregiving was so common. As a medical anthropologist, I was particularly interested in one aspect of kith and kin care – specifically, caregivers’ involvement in health production and health care seeking for the children in their care. Caregiving behaviors are the major determinants of child health (Guldan, et al. 1995), yet little attention has been paid to the impact of non-parental caregivers on children’s health. In addition, alternative caregivers inevitably must deal (at least occasionally) with sickness, yet little is known about their role in decisions regarding treatment or their involvement in seeking/providing treatment.

**Research Questions**

To understand alternative caregivers’ involvement in children’s lives, it is first necessary to understand the contexts within and conditions under which caregiving is negotiated and arranged, and the roles and responsibilities of the caregivers to the children in their care. Important in this discussion is whether the caregiving arrangement is supplemental or surrogate, whether the arrangement is voluntary or involuntary, whether care responsibilities are shared with the parents, and the extent to which the parents and caregivers were previously acquainted or engaged. More broadly, it is
important to understand how alternative caregivers are viewed within the community, what community expectations are for such caregivers, and how caregiving fits into the overall interactions and exchanges between individuals.

My goal was to examine the various cultural, ecological, and personal factors influencing caregiving practices and decision-making. I wanted to gain an understanding of how caregiving fits into daily life and the social fabric of the community, as well as the effect that both supplemental and surrogate arrangements have on families and the larger community. I also wanted to understand what roles these caregivers play in the community, in families, and in the lives of the children they care for, including – but not limited to – their roles in health production. As Lowe and Weisner (2001) have emphasized, it is only when beliefs, values, and practices about caregiving and parenting are considered in conjunction with social, institutional, and material resources, as well as issues of identity, agency, and competing family interests, can caregiving decisions and practices be understood.

Data was gathered through a combination of open-ended, in-depth interviews with parents and caregivers, informal discussions with community members, and observation in a variety of community settings. Parents and caregivers of young children were asked to recount their personal experiences with supplemental and surrogate caregiving across their lifespan, as well as their opinions on various forms of caregiving. While caregiving is an issue that affects families of older children as well, my interests center on the caregiving needs and experiences of those whose children are not yet in school, thus interviewing was primarily limited to parents and caregivers of children five

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9 Here, I am using “ecological” in the same sense as Lowe and Weisner’s (2001) to mean social, legal-institutional, and material resources.
and under. Interviews additionally asked parents to focus upon one specific child (referred to as the “focal child”), exploring the various caregiving arrangements the child had been in since birth, and any problems, changes, or issues relating to these arrangements. Caregivers were similarly asked to focus upon one child in their care, recalling the origins of the arrangement as well as their responsibilities in relation to the child, any problems they have experienced, and their expectations for the future.

Specifically, interviews and informal discussions with individuals in the community were aimed at addressing the following questions:

- **Informal Caregivers and Caregiving:** Which individuals in the White Mountain Apache community, in addition to the mother, consistently assist in the care of young children? Which individuals serve as supplemental caregivers, as surrogate caregivers, and in what contexts? What roles do these individuals play in these children’s lives, what specific responsibilities do they have in relation to children in their care, and what do they do on a day-to-day basis with these children? How are arrangements negotiated and caregiving compensated, and how does caregiving fit into the broader interactions between individuals and families?

- **Community Caregiving Attitudes and Patterns:** What are the local community’s attitudes toward different types of caregivers, especially regarding perceived levels of competence, preferred alternative caregivers, and characteristics of “good” or “quality” caregivers? What services/information might help caregivers provide better care to children? Why do certain families not utilize alternative caregivers? How have patterns of caregiving changed in this community over the past century?
• **Caregivers, Caregiving, and Child Health:** How does caregiving change when a child is sick? In what contexts, and to what extent, do caregivers participate in decision-making regarding treatment or health care seeking for children in their care? How does caregiving change by severity and chronicity of illness? How does the care of other children under the same caregiver change when one of the children becomes sick?

**Methodology**

It is common practice today for tribes in the U.S. to require prior approval of any research to be conducted among their People, although the approval process varies from group to group. At the time I conducted my research, the White Mountain Apache Tribe (WMAT) required any prospective researcher to obtain sponsorship from one of the various tribal departments, and then appear before the Tribal Council to describe the research and seek approval of the project. After relocating to a community just off the northern edge of the reservation in March 2001, I spent several weeks making and renewing contacts within various tribal departments and seeking an appropriate and willing sponsor for my research. Given the focus of my research on young children and caregiving, the newly formed WMAT Division of Early Childhood Development was a very appropriate sponsor, and the Executive Director graciously offered to sponsor my research. We got the opportunity to appear before the Tribal Council at the beginning of June, and received permission to proceed with the project.

The project, which we referred to in the community as the “Informal Child Care Study,” commenced shortly thereafter and continued through May 2002. The summer months were spent raising awareness of the project in the community, finalizing the
research instruments, and initiating recruitment. It was also during this period that I conducted interviews with four tribal administrators regarding the tribal child care programs, child care administration and funding, and child care subsidies. Interviewing of parents and caregivers was initiated in the fall and continued over a nine-month period.

**Interviews**

To be eligible for inclusion in the study, individuals had to be the parent/guardian or caregiver of a child five or under. Those interviewed fell into four categories: (1) parents/guardians currently using a supplemental caregiver to help care for one or more of their children, (2) parents/guardians *not* currently using supplemental caregivers for their children, (3) individuals currently serving as supplemental caregivers for one of the parents/guardians already interviewed, and (4) individuals currently serving as a surrogate caregiver for one or more children.

The focus of my recruitment was the parents/guardians and surrogate caregivers (supplemental caregivers were to be recruited through the parents). My original goal was to interview 30 parents/guardians who were using supplemental caregivers along with one supplemental caregiver being used by each of these parents (for a total of 30 supplemental caregivers), 20 parents who were not using supplemental caregivers, and 20 surrogate caregivers. In addition, given the unique issues, considerations, and challenges faced by those seeking care (and caring) for young children of varying ages (i.e., infants, toddlers, preschoolers), I wanted to recruit roughly evenly from these age groups (in terms of the focal child).
Recruitment, for a number of reasons, proved to be quite a challenge. Originally, I intended to primarily recruit through existing community contacts and, once the project was underway, rely upon snowball sampling. Ultimately, however, these methods were of only limited success. In an effort to reach a broader segment of the reservation population, I placed an advertisement in *The Apache Scout*, the Tribe’s biweekly newspaper, which ran for two months. Flyers were sent out to child care subsidy recipients and with the Division of Early Childhood Development paychecks. I also placed flyers in a number of community gathering places, such as the IHS hospital in Whiteriver, tribal headquarters, employee bulletin boards at the casino/hotel complex, the Head Start centers, the Child Find and Education buildings, the Basha’s grocery store in Whiteriver, and several neighborhood convenience marts and Laundromats. It was this last method that was ultimately the most successful.

To be classified as “currently using supplemental caregivers,” parents/guardians had to have the focal child in a regular or frequent arrangement (i.e., at least one time per week) with one or more caregivers. In addition, the caregiver had to be a family member, a friend/acquaintance, or a neighbor – individuals using the day care center were not eligible. Individuals were classified as “not using supplemental caregivers” if their child(ren) were not currently being cared for regularly by someone other than the parent(s)/guardian(s). (The occasional use of a non-parental caregiver, or the regular use of such a caregiver in the past, was considered acceptable.)

Surrogate caregivers must have a child five or under living with them that was not their biological or legally adopted child, and for whom they took primary (although not necessary complete) responsibility. Such arrangements could be the result of informal
arrangements among family/friends or more formal, initiated by social services or the court system. In addition, such arrangements could be viewed as permanent, temporary, or their duration considered uncertain or open by the individuals involved.

Parents turned out to be much easier to recruit than surrogate caregivers. It is possible parents were simply more likely to hear about the study, or more willing or able to participate. Also, “child care” is a topic of interest to many in the community, and something about which they were anxious to express their views. Surrogate caregiving, in contrast, is harder to describe and not viewed by many as a topic of concern. As will be discussed in Chapter 4, it is not uncommon for children to be in the care of others for months or even years. Such care is seen as quite natural, and rarely as something worthy of note. Quite often in fact, during the course of other interviews, I would learn that the individual I was interviewing was also serving as a surrogate caregiver to a child.

Supplemental caregivers were initially recruited exclusively through parents/guardians that had already been interviewed in an effort to create matched pairs of parents using supplemental care and their caregivers. These caregivers could be any age, and could live in the same or a different household from the focal child. They could provide care for children informally or consider it a home-business, and they could be caring for other children in addition to the focal child. Parents/guardians using supplemental caregivers were asked, at the conclusion of their interviews, for permission to speak with one of the individuals providing child care for them. Most were willing, but
understandably reluctant to give me their caregiver’s phone number or house number\textsuperscript{10} without first talking about it with the caregiver themselves.

This method thus complicated efforts at recruitment by placing parents/guardians in the role of “gatekeepers,” controlling access to the supplemental caregivers I was interested in interviewing (Goodson 2001 also discusses this phenomenon in terms of “circles of protectiveness”). Given the busy lives of most of these parents, they often forgot to mention the project to their caregivers or simply did not bother, having no real incentive to do so. Consequently, I spent quite a bit of time trying to get back in touch with the parents/guardians I had already interviewed in an effort to gain access to their supplemental caregivers. In the end, I only succeeded in interviewing supplemental caregivers for a little over half of the parents/guardians (using supplemental caregivers) who participated in the project. To supplement these interviews, I independently sought out a few other supplemental caregivers to interview.

Efforts to re-contact parents/guardians and interview their caregivers were complicated by some idiosyncrasies of phone and cell phone service in the community. Census data from 2000 indicates that only around 54 percent of homes on the Fort Apache reservation had standard telephone service.\textsuperscript{11} Many individuals I interviewed did not have a landline, or only had one intermittently due to non-payment of their bill, and no one had answering machines. Consequently, attempts to contact individuals often involved multiple phone calls or trips to their house.

\textsuperscript{10} Houses on the Fort Apache Reservation are identified by the name of their housing settlement/community and a house number, rather than a street address (for example, River Falls, house #25).
\textsuperscript{11} Census 2000 AIANSF, Table DP-4, Fort Apache Reservation (Apache alone or in any combination).
In addition, cell phone ownership and usage blossomed while I was in the field due to a deal struck between the Tribe and one of the local cellular providers. For $25, individuals could receive a free cell phone and 200 minutes of service per month for 25 months. While in theory this should have made interviewees easier to contact, in reality it complicated efforts. Unlike standard cell phone plans where individuals are simply billed for any extra minutes when they go over their monthly allotment, with this plan the cell phones were simply cut off for the remainder of the month once their monthly allotment was exhausted. Hence, I could reach individuals via cell phone at the beginning of the month, but most had run out of minutes within two or three weeks and were unreachable.

In the end, I conducted a total of 55 interviews with parents/guardians and caregivers from approximately 15 communities spread throughout the northern and central parts of the reservation. When categorized as to the primary focus of the interview, it breaks down as such: 21 interviews with parents/guardians who were using supplemental caregivers, 12 with parents/guardians not currently using supplemental caregivers, 12 with supplemental caregivers, and 10 with surrogate caregivers (see Table 1).

12 It seems that, as cell phone usage has increased in the community, landlines have decreased. Cell phones were cheaper, and most individuals did not see any need to have both a cell phone and a landline.
13 This subsidized offer/phone was limited to one individual per household, hence not everyone could take advantage of it.
14 I restricted my interviews to this area of the reservation, which includes Whiteriver and its surrounding communities as well as Hon-Dah and McNary, for two primary reasons. First, these were the communities that were within an hour of my residence, and the communities within which I had contacts. Second, other communities on the reservation such as Cibecue are generally considered more traditional and have access to fewer caregiving resources (there is, for example, no child care center on this part of the reservation). While it would be interesting to investigate caregiving patterns in other WMA communities as well, I thought this would be best left to a future project.
In actuality, however, many individuals I interviewed did not neatly fit into a single category. Eight of those I interviewed as “supplemental” caregivers were simultaneously functioning as surrogate caregivers for another child. Likewise, two “surrogate” caregivers I spoke with were also serving as supplemental caregivers for one or more children. Additional “primary” and “supplemental” caregivers came to light in the course of other interviews as well. In each of these cases, questions were asked from multiple interview guides in order to fully explore the individual’s various caregiver roles and responsibilities (see Appendix A for copies of the interview guides for primary, supplemental, and surrogate caregivers). Ultimately, 34 interviews were conducted with individuals who would be considered primary caregivers (22 utilizing supplemental caregivers and 12 not using supplemental care), 15 interviews with individuals functioning as supplemental caregivers, and 18 with individuals functioning as surrogate caregivers (see Table 1).

Table 1: Total Interviews by Category

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<th>Interviews by Primary Categorization</th>
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<tr>
<td>Supplemental caregivers</td>
<td>12</td>
<td>3 *</td>
<td>15</td>
</tr>
<tr>
<td>Surrogate caregivers</td>
<td>10</td>
<td>8 *</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>55</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 1 surrogate caregiver  
* 1 primary caregiver not using supplemental caregiver; 2 surrogate caregivers  
* 8 supplemental caregivers

Also important to note is that these are fluid categories; individuals move in and out of various roles and hence categorizations not uncommonly change over time. For
instance, one mother not using (and with no plans to use) supplemental caregivers at the time of the interview found herself needing child care several weeks later after taking a job. A surrogate mother who believed the arrangement to be permanent told me upon running into me several months after the interview that the child had gone back to her biological mother. In another case, I found that a long-term supplemental caregiving arrangement had dissolved before I had the opportunity to interview the caregiver as a result of the mother losing her job. An individual’s categorization for the purposes of this study represents their situation at the point in time of the interview; it is useful from the standpoint of framing their current circumstances, but is not meant to be taken necessarily as a long-term characterization. Caregiving needs and caregiving arrangements are subject to change, and hence so are individuals’ roles as caregivers.

### Table 2: Primary Caregiver Interviews by Age of Focal Child

<table>
<thead>
<tr>
<th>age of focal child</th>
<th>Using Supplemental Caregivers</th>
<th>Not Using Supplemental Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year (infants)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>1-2 years (toddlers)</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>3-5 years (preschoolers)</td>
<td>6 *</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

* The two additional interviews I conducted with supplemental caregivers focused on children in this age group (the parents/guardians were not interviewed in these two instances).

While in general it was easier to find individuals to interview who were using supplemental caregivers than those who were not, finding parents/guardians who used supplemental caregivers for their infants was challenging. Children under one year of age are much less likely than older preschool-age children to be in regular caregiving arrangements (U.S. Bureau of the Census 2005), hence it is not surprising that this age group was underrepresented in my interviews on supplemental care (see Table 2).
Preschoolers are also underrepresented, although to a lesser extent, which I attribute to the almost universal Head Start attendance by reservation children in this age group and the corresponding reduced need for supplemental care.\footnote{As will be discussed in Chapter 4, Head Start essentially functions as “child care” by providing several hours of reliable non-parental care each (week)day. For many families, Head Start attendance removes or reduces the need for other forms/sources of supplemental care.}

All individuals with whom I conducted interviews were paid $20 for their time. Interviewees were generally interviewed in their homes, although some expressed a preference for another location, such as their place of employment or the restaurant in town. In one case a telephone interview was conducted after the interviewee had been forced to cancel multiple times. Interviews ranged in length from approximately 30 minutes to three hours, but generally averaged somewhere between 60 to 90 minutes. Efforts were made to tape record all interviews, although this proved possible in only about half of the cases. Several interviewees stated that they preferred not to be taped, and in other cases there was too much background noise (usually from the television\footnote{Television is a constant presence in many households in the community. A number of mothers I interviewed, in fact, used the television or a video to keep their children entertained while we talked.}) to make tape recording possible. In all cases, detailed notes were taken during the interview. Taped interviews were transcribed and all data (interview notes, transcriptions, and demographic data) were entered into NVivo and coded for thematic analysis.

In all the interviews, general information was collected on household size and composition, marital status and the extended family, education, income and employment, and their own caregiving history. Parents/guardians were asked what was most important to them when looking for child care, as well as what qualities they looked for in a caregiver and what they would consider the “ideal” caregiving arrangement for
their child. Those currently using kith and kin caregivers were also asked to give a
detailed history of both past and current caregiving arrangements for one child five or
under in their household (the focal child). Those individuals not using supplemental
caregivers were asked why they do not currently use outside caregivers, if they had ever
utilized them in the past and, if so, why their caregiving patterns had changed. All
primary caregivers were also asked questions regarding children’s illnesses and health
care options used with children, and the extent to which alternative caregivers
participated in health care decision making and treatment-seeking for children in their
care.

Supplemental caregivers were asked to discuss their child care experiences and
their needs as child care providers. They were asked about the children they were
caring for both currently and in the past and, for the focal child, to describe how the
arrangement came about, how they viewed their duties and responsibilities in relation to
this child, and the benefits and drawbacks of the relationship for them as providers.
Also, these caregivers were asked about their role in both health-care decision making
and treatment seeking for the focal child, and how they handled caregiving when the
child was ill, particularly if there were other young children in their care.

Surrogate caregivers were asked how the caregiving arrangement came about
and if this was a responsibility they undertook voluntarily. These caregivers were asked
to describe how long the child had been in their care, how much longer the arrangement
was expected to continue, and any benefits or hardships this caregiving arrangement
brought to them. In cases where the arrangement was voluntary, caregivers were asked
to describe how duties and responsibilities related to the child were divided between
themselves and the primary caregiver. These caregivers were also asked to discuss how they handled illness episodes and treatment-seeking for the children in their care.

Older caregivers (both supplemental and surrogate) were also asked to discuss how child care and caregiving have changed over time. These individuals were asked to recount who helped take care of their children when they were young parents, as well as who assisted their parents in taking care of them when they were young.

Observation, informal discussions, and key informants

Interviews were supplemented and informed by extensive observation and informal discussions with other individuals in the community. Everywhere I went on the reservation, I took the opportunity to observe caregiving. I observed who children were in the company of, who was watching them, carrying them, playing with them, and otherwise interacting with them. Such observation took place at the grocery store, community basketball games, “tailgate,”

17 family gatherings and outings to which I was invited, as well as special community events such as pageants, fairs, and Sunrise Ceremonies.18 I also had informal discussions about caregiving with numerous individuals I ran into across the reservation who did not fit the profile for inclusion in the study. Many of these were parents whose children were older, but who had used kith and kin caregivers for their children when they were younger. Others were older individuals who had served as caregivers in the past, but were not presently doing so. These discussions centered upon many of the same topics which I covered in

17 “Tailgate” is the informal prepared food sale that takes place in the Basha’s grocery store parking lot in Whiteriver every day at lunchtime. Community members cook “traditional” Apache foods such as frybread, Indian tacos, and Apache burritos ahead of time, and then sell these and other items such as sodas. Although a few individuals have simple stands, most sell these items out of coolers in the back of their pick-up trucks, hence the name “tailgate.”

18 The Sunrise Ceremony – the traditional girl’s puberty ceremony – will be discussed in Chapter 2.
interviews. Their experiences and insights both enhanced the data coming out of interviews and brought to my attention issues which had not come up previously.

Living in the community in closer proximity to Nettie and her family, I also became more important as a caregiver myself. During my time in the field, I regularly cared for Monica and Melissa. Melissa frequently spent weekends at my house and even longer periods during the summer; Monica would stay with me sometimes as well when she was home from ASDB. At Nettie’s request, I also attended community meetings discussing educational and transportation issues for the hearing-impaired children on the reservation, and I chaperoned several field trips for Melissa’s class. Through caregiving, I became an active participant in the family and fully embedded in Nettie’s network, the focus of requests for assistance and the recipient of gifts. In effect, I became a participant in the very phenomenon I was studying, which provided a wealth of insights and understandings I might not have achieved otherwise.

Nettie and her mother also became invaluable to me as key informants. In addition to sharing with me in detail their life stories, including the various antecedents and intricacies of their own caregiving needs and roles as caregivers, they also became a sounding board for me. I bounced various ideas off of them and, while being careful to protect anonymity, sought their assistance to clarify points that came up in the context of other discussions and interviews. My understanding of their own caregiving experiences also influenced the directions my research took and the questions I asked. A third, unrelated individual whom I met in her capacity as a child care administrator was also important as a key informant. She was particularly helpful in providing me with an
understanding of the history of formal care on the reservation and the local politics influencing the administration and funding of child care programs.

**DISSERTATION LAYOUT**

This dissertation follows the tradition of circumstantial ethnography – “ethnographies attentive to circumstance and the nested contexts within which people live out their daily lives” (Lock and Nichter 2002:14). As such, much of it is descriptive, focused on contextualizing caregiving in this community, and trying to convey the intricacies and subtleties of kith and kin caregiving and the considerations and decisions that lead to these arrangements.

This study of informal caregiving is, to borrow a phrase from Zinsser (1991:4), “a study that is told through stories.” Stories of Western Apache children, their families, and their caregivers, and details of their caregiving arrangements, open and are sprinkled throughout many of the following chapters. Given the sensitive nature of many of the topics addressed in this study, and my desire to protect these families' privacy, I use pseudonyms for both the people and communities I discuss. I also want to emphasize that the stories told and conclusions presented herein should not be uncritically generalized to any other tribal group or Native Americans as a whole.

Chapter 2 provides the reader with a historical and contemporary overview of the Western Apache. I begin the chapter with a brief history of the Western Apache, discussing the move onto reservations and emphasizing those social and economic changes most relevant to the discussion of caregiving. Following this is a detailed physical, social, cultural, and economic description of the modern Fort Apache
Reservation community (the field site). The chapter concludes with a profile of the interviewees, their households, and families.

Chapter 3 seeks to contextualize and frame kith and kin care within the broader ideological and policy issues influencing child care and caregiving in the United States today. I begin this chapter by tracing historically the development of the “mother care is best” ideology and the institution of child care and then examine how Federal policy has influenced caregiving ideology in recent years. From there I move on to a discussion of how Federal policy has historically affected the experience of child-rearing and cultural reproduction in Native communities and how recent policy shifts continue to affect caregiving. In the final section, I present data on modern child care patterns and trends, and examine the contemporary usage of kith and kin care.

The following two chapters focus specifically on kith and kin caregiving in the Apache community. Chapter 4 discusses caregiving “choice,” examining the various factors influencing caregiving need and caregiver availability, as well as the place of parental and child preferences and caregiver needs in negotiations and decisions concerning caregiving arrangements. Chapter 5 focuses on the practice of kith and kin caregiving, looking at how these caregiving arrangements function on a day to day basis and how caregivers are compensated, if at all. It also discusses strategies parents have for making kith and kin caregiving work for them, and how they deal with caregiving failures. Finally, it looks at the impacts, positive and negative, that such arrangements have on parents and children, as well as the caregivers and their households.

Chapter 6 examines the role of alternative caregivers, specifically kith and kin, in children’s health production and illness management. Included is a discussion of
therapeutic options and how they are variously used by parents and caregivers, as well as the specific responsibilities caregivers take in terms of therapy management, health care seeking, and caregiving during illness and convalescence. Children’s health management is also used as a window to provide insight into how networks operate, both in terms of how resources are marshaled and responsibility is shared.

Any investigation of kith and kin caregiving would be incomplete without a discussion of the networks of exchange and reciprocity of which caregiving exchanges are an integral part. Chapter 7 hence focuses on contextualizing kith and kin caregiving and discussing the mutual importance of networks and caregiving to one another. Integral to this discussion is the concept of social capital; strong social capital, a consequence of active participation in strong networks, provides access to caregivers, and the use of such caregivers further builds social capital and the resiliency of networks.

Strong networks are particularly important for their role in providing access to highly valued caregivers, such as those who could be considered cultural “experts.” Since a child’s early years are the most critical to socialization and cultural assimilation, the cultural identification and knowledge of early caregivers takes on a special importance. Chapter 7 thus concludes with a discussion of the importance of caregivers with strong cultural capital in the production of culturally competent children and cultural survival.

Chapter 8 takes on the issue of caregiving quality. There is a serious disconnect between the aspects of care (or qualities) that Apache parents value in their caregiving arrangements and modern conceptualizations of caregiving quality. Current definitions
and measures of quality are quite narrow; their application to kith and kin and minority caregiving settings is misguided and potentially harmful. I argue instead for culture and context specific definitions of caregiving quality, and the inclusion of community standards.

Finally, Chapter 9 discusses the policy implications of this research, emphasizing the importance of respecting the diversity of caregiving practices in this country and recognizing that these practices often represent community strengths. It also discusses the need to think more broadly about child well-being, and to encourage and facilitate the development of locally designed, directed, and controlled child care policies and programming which respect, reflect, and integrate the culture and values of the community.
CHAPTER 2
THE WESTERN APACHE

The Western Apache are the westernmost of the several Apachean, or Southern Athapaskan, groups who historically occupied the American Southwest. The Southern Athapaskans are linguistically related to Athapaskan-speaking peoples in Alaska, Canada, and northern Canada, and are believed to have migrated into the Southwest from the north sometime between 1000 and 1500 A.D. (Basso 1970a; Kaut 1957).

These “Proto-Apacheans” were nomadic hunters and gatherers who lived in small scattered encampments. It is believed these encampments “were composed of bilocal or matrilocal extended families that periodically detached themselves from the larger group to follow herds of game and exploit floral resources” (Basso 1983:464). The activities of each camp were directed by an older man, but beyond the extended family political organization was minimal. Descent was probably bilateral, although it has been suggested that the Southern Athapaskans brought with them the vestiges of an archaic matrilineal system (Basso 1983).

By the late 1500s, the Southern Athapaskans had differentiated into several smaller groups and spread over an area extending from northwestern Texas to central Arizona. In the centuries that followed, in relative isolation from one another, these groups adapted to local conditions and continued to diverge culturally and linguistically. On the basis of these territorial, cultural, and linguistic distinctions that these groups themselves recognize, anthropologists have divided the Apacheans into seven major
tribes – the Jicarilla Apache, Lipan Apache, Kiowa Apache, Mescalero Apache, Chiricahua Apache, Navajo, and Western Apache (Basso 1970a; Basso 1983).

WESTERN APACHE CULTURE AND HISTORY

Goodwin (1935:55) designates the Western Apache as:

… those Apache peoples who have lived within the present boundaries of the state of Arizona during historic times, with the exception of the Chiricahua, Warm Springs, and allied Apache, and a small band of Apaches, known as the Apache Mansos, who lived in the vicinity of Tucson.

It is uncertain when the ancestors of the Western Apache first penetrated Arizona, but by 1700, they had moved into the area they occupied historically, which includes the upper drainage of the Salt and Gila rivers in the desert foothills and mountainous regions of east-central Arizona (Goodwin 1942). By 1850, they had differentiated into the five distinct Western Apache divisions – the San Carlos Apache, Cibecue Apache, White Mountain Apache, Southern Tonto Apache, and Northern Tonto Apache.19

It is not easy, nor necessarily productive, to talk about a “pre-contact” Western Apache culture. Little information is available on the Western Apache before 1800; prior to that time, Europeans rarely ventured north of the Gila River (Spicer 1962), allowing the Western Apache to remain relatively isolated and unknown. In addition, no reliable ethnographic information on the Western Apache was collected prior to the early 1900s (Basso 1983). Also important to note is that the Western Apache were still developing and evolving from an earlier common Proto-Apachean system even as early contacts with Europeans were already taking place (Basso 1983). As Basso (1983:466) notes, it

19 While anthropologists distinguish between the Northern and Southern Tonto Apache, the Tontos themselves “have always regarded themselves as a single entity, undifferentiated internally except for distinctions based on local group and clan affiliations” (Basso 1983:463).
is “highly probable that certain spheres of Western Apache culture, most notably religion and material culture, were influenced by ideas and techniques acquired from outside sources,” both European and Native.

**Pre-Reservation Life**

Some of the earliest Apache contacts with Europeans were with the Spanish, which proved to be very important in the continuing development and evolution of the Apachean economic base. Over the course of approximately 150 years, beginning in the late 1600s, several of the Apache groups came to depend very heavily on raids into Sonora to acquire goods and to supplement their food supply (Goodwin 1942; Spicer 1962). Several of these Apache groups, including the five Western Apache divisions to varying extents, hence made raiding and warfare an integral part of their lives and economies (Spicer 1962).

Essential to the development of raiding was the acquisition of the horse. Brought to the Southwest by the Spaniards, the horse became important as a beast of burden and means of transportation, as well as a food source (Basso 1983). By the seventeenth or eighteenth century, the Western Apache also practiced agriculture, although this never replaced hunting and gathering as the primary modes of subsistence (Basso 1983; Goodwin 1942). Agriculture was important enough, however, to cause a shift from year-round nomadism to the pattern present at contact of periods of sedentary residence near the agricultural fields, and it has also been suggested as a reason for the development of unilineal descent groups, a feature not shared by most other Apachean groups (Basso 1983; Kaut 1957).
The farming techniques adopted by the Western Apache were most likely acquired from the Navajo or Western Pueblos (Basso 1983), and Puebloan influence has also been suggested as a reason for the development of matrilineal descent groups (Kroeber 1937). The adoption of agriculture also proved important in how the Western Apache were regarded by outsiders. Spicer (1962) points out that sedentary agriculturalists, such as the Pueblos and Pima, were considered to be more “civilized” than more nomadic groups; in contrast, those who relied primarily on raiding and warfare, such as the Chiricahua Apache, were viewed as more “savage.” Of all the Apaches, the Western Apache were the most involved in agriculture and had a relatively better relationship with the federal government. However, the average Anglo-American who came into the region did not distinguish the Western Apache from other Apache groups. Consequently, the hostility towards Apaches generally and the perception of them as “savages” affected the Western Apache as well, with important implications for their later treatment.

**Social organization and economy**

While we speak of the Western Apache collectively, in pre-reservation periods the five divisions that make up the Western Apache never formed anything like a unified political entity; instead, they considered themselves quite distinct from one another, with each inhabiting clearly defined territorial boundaries (Basso 1970a; Basso 1983). These divisions had varying degrees of contact and intermarriage; between some there was actually very little contact and instead some degree of mutual suspicion (Basso 1983; Goodwin 1942).
While the five Western Apache divisions were culturally and linguistically similar, there were also significant differences with respect to population, size of territory, dependence upon agriculture, and use of the horse (Basso 1983). The White Mountain Apache were the easternmost group, and the largest with respect to population and territory. They also utilized the horse to a greater extent than the other divisions, and were second only to the Cibecue Apache in terms of intensity of agriculture. The Cibecue and San Carlos Apache, located respectively to the northwest and southwest of the White Mountain Apache, were similar in size and territory controlled. The two Tonto Apache divisions, located on the northwestern edge of Western Apache territory, were the smallest and also ranked lowest in the use of the horse and agriculture (Goodwin 1942).

Each of these divisions was made up of from two to five bands. Although bands had a greater degree of internal unity than divisions, they also did not participate in any sort of joint political action (Basso 1983). Each band possessed its own clearly defined hunting grounds, and bands were thus units more in a sense of these territorial limitations and minor linguistic distinctions (Basso 1983; Goodwin 1942).

Bands were composed of what is considered the most important segments of pre-reservation Western Apache society, the local group (Basso 1970a; Basso 1983). As Basso (1983:470) notes, local groups “were the basic units around which the social organization, government, and religious activities of the Apache revolved.” Local groups had a high degree of internal cohesiveness; there was contact between neighboring local groups and occasionally even intermarriage, however, most everyday contacts occurred within the context of one’s own local group. Each local group had exclusive
claims to a farming site, although not all members of the local group owned or shared in farms at these locations (Basso 1983; Goodwin 1942).

Each local group was composed of from two to ten gota, or family clusters. Generally speaking, the family cluster was simply a large matrilocal extended family, composed of three to eight nuclear households (gowa). Most gowa were occupied by a married couple and their unmarried children, and contained at least one female who was a descendent or sibling of an older woman in the family cluster, although exceptions were quite common. Every family cluster was under the leadership of a headman, generally the father of the grown and married women of the family cluster, whose responsibility it was to organize and advise its members. While a family cluster might be separated from the local group and function as a self-sufficient unit for long periods of time, members of the family cluster were very interdependent, cooperating in gathering, hunting, and farming, as well as in other activities such as the construction of dwellings (Basso 1983; Goodwin 1942).

Unlike bands and local groups which were generally known by the territories they occupied, the family cluster was identified by the clan of its core lineage. As Basso (1983:471) notes, the “persons belonging to the matrilineage that formed the core of a family cluster shared membership in the same clan.” The sixty Western Apache clans were not regionally localized; instead, members of the same clan were scattered across Apache country, “creating an extensive and intricate network of relationships that cut across bands and local groups, but at the same time served to join them together” (Basso 1970a:9).
By creating such networks, clans were important in extending reciprocal obligations beyond the local group and facilitating cooperation for projects that were beyond the scope of the family cluster alone (Basso 1983). Another primary function of the clan was to regulate marriage. Marriage between members of the same clan or closely related clans was prohibited, and the overwhelming majority of marriages occurred between individuals of unrelated clans (Basso 1983; Goodwin 1942). Marriage into one’s father’s clan, however, was permissible and perhaps even preferred (Goodwin 1942).

Most marriages occurred within one’s own local group, and this appears to have been the favored arrangement (Basso 1983; Goodwin 1942). As Kaut (1957:63) notes, hunting and gathering success was highly dependent upon familiarity with the local group’s territory, and a man hunted best on his home ground “because he garnered power from the very ground itself – a power which he lost when he entered other hunting grounds.” Women generally married before the age of 18, and men in their early 20s. Most often the husband went to live with his wife and her extended family, although it was not uncommon for an elder or only son to bring his wife to live with his family instead (Basso 1983).

The preference for matrilocality was tied to the fact that, while the Western Apache engaged in farming, their subsistence economy was based primary on hunting and gathering. It has been estimated that approximately 75 percent of their yearly diet consisted of meat or undomesticated plants (Goodwin 1935). And, as Kaut (1957:63) emphasizes:

Matrilocality required that the woman remain in the area to which she had been educated in terms of farming and gathering activities. Gathering activities,
especially, required a very specific knowledge of rough terrain which could only be gained over a period of many years.

The importance of gathering, and the large territory over which such gathering took place over the course of a year, meant that the Western Apache were almost constantly on the move. The only exception was the winter months when gathering activities came to a virtual standstill. April marked the beginning of the yearly cycle, and was the time when families left their winter camps in the river valleys and traveled north into the mountains to their agricultural fields. Irrigation ditches were repaired and the arable land, divided into a series of plots controlled by matrilocal kin groups, was prepared and planted. As soon as the first sprouts appeared in May, the focus shifted to hunting and gathering (Basso 1983; Goodwin 1935; Goodwin 1942).

Women spent the next several months embarking on frequent gathering expeditions to take advantage of ripening floral resources. As Basso (1983:469) notes:

[Gathering] expeditions involved from eight to a dozen women all of whom were related by close ties of matrilineal kinship. Normally such a group consisted of three to four fully adult sisters and their married and unmarried daughters. These women and their families lived together year-round and helped work one another's fields, thus forming an enduring social unit that functioned conspicuously in all economic pursuits except raiding.

Older individuals, the disabled, and young children remained behind at the farm sites, cultivating and protecting the crops. Men spent part of the summer months hunting, although the best hunting was in the late fall. Toward the end of September, as the domesticated crops began to mature, hunting and gathering was temporarily suspended and everyone returned to the farm sites for the harvest. The late fall was spent drying and storing part of the harvest, hunting and preserving large game, and gathering nuts
and berries. In November, families left their farm sites and returned to their winter camps (Basso 1983).

From December through March, the focus of economic life shifted from hunting and gathering to raiding. Raids were organized in response to a shortage of food, and generally involved a group of five to fifteen men from the same local group. Women, who did not participate, spent this time tanning hides, making clothing and participating in other domestic tasks. Older girls generally assisted the women in these tasks, while boys spent part of their time in pursuit of small game (Basso 1983; Goodwin 1942).

Socialization and education

Up until about eight years of age, Apache children were not very actively involved in the economic life of the group. Instead, their days were primarily filled with play. Children of similar age within the same family cluster tended to naturally form mixed-gender play groups. Their play largely modeled important aspects of adult life, such as marriage and affinal obligations, hunting and farming, raiding, cooking, etc. (Goodwin 1942).

Observation and modeling, rather than direct instruction, was the primary pathway through which children learned. Children learned necessary skills and right from wrong principally through observing their elders and other adults in the family cluster and playing at what they saw others do. Adults might point out errors in others to illustrate right from wrong, but they rarely corrected children, and direct instruction was not used at all for children under eight (Goodwin 1942).
Responsibility for the socialization and education of children fell not simply to the parents, but rather was collectively assumed by the larger kin group. Maternal relatives generally – even those not residing in the same family cluster – were an important resource for children and could be depended upon for assistance and advice even into adulthood. Aunts, uncles, and grandparents within the family cluster interacted with children on a daily basis and were important sources of guidance and support. Grandmothers often enjoyed quite close relationships with their grandchildren and tended to be rather indulgent with them; in return, grandchildren commonly provided for their aging grandparents as adults (Goodwin 1942). Maternal grandmothers, in fact, spent more time with children than anyone other than the mother, a fact that – due to mother-in-law avoidance – somewhat shut fathers out of the full spectrum of family ties (Golston 1996). During the summers, when the young children remained at the farms while their parents left to hunt and gather, grandmothers and other elders assumed a particularly central role. Bahr and Bahr (1993:363) note that, in assisting their grandmothers with tasks, children were taught by example and words and in this context told “the lore of the tribe and passed on tribal culture and values.”

Around 11 or 12, both children’s play and instruction became more gendered. As girls neared puberty, they started accompanying their mothers and the other women in their family cluster on their gathering expeditions, and learning the techniques and knowledge necessary for wild plant gathering. It was also around this same age that they began to learn how to cook and dry meat, as well as how to make clothes, build wickiups, and make baskets (Goodwin 1942).

\[20\] The wickiup was the dome-shaped thatched dwelling traditionally built by the Apache.
Boys were given their first bow and arrow by their fathers or a maternal grandfather or uncle around the time they were seven or eight and instructed in its use. Shortly thereafter, they began to hunt small game, and around the time they were ten they started to help with the horses. In general, however, boys began assisting with adult tasks later than girls. As Goodwin (1942) explains, the division of labor between the sexes and the fact that boys married later than girls permitted them a longer period of adolescence. Boys were not taken on their first deer hunt until they were 15 or 16. As in other endeavors, boys learned much of what they needed to know about hunting through observing others. This, combined with the fact that they did not yet know hunting ritual, left them at a decided disadvantage in their early hunts. Hunting ritual was viewed as critical to a hunter’s success but also too dangerous for “bungling youth” to meddle with, hence boys started to learn simple ritual practices only after they started hunting (Goodwin 1942:475).

Preadolescents and teens learned not only important practical skills on these hunting and gathering expeditions, they were told stories associated with places they passed on their travels. These stories described historical events associated with geographic features of the landscape, knowledge of which was viewed as important to children’s moral development and the acquisition of wisdom. Such storytelling was a frequent and integral part of their movements through their territory:

Whole Apache families … spent weeks and months upon the lands — tending cornfields, roasting agave, hunting deer, and journeying to remote cattle farms where they helped the horsemen build fences and corrals. The families traveled long distances — old people and children alike … And wherever they went they gave place-names and stories to their children. They wanted their children to know about the ancestors. They wanted their children to be wise (Basso 1996:125).
Many of these stories, as Basso (1996:28) explains, were “concerned with descriptive social acts, with everyday life gone out of control, and each conclude[d] with a stark reminder that trouble would not have occurred if people had behaved in ways they knew they should.” These oral narratives worked – and continue to act today – by establishing enduring bonds between individuals and features of the landscape, leading people who had acted improperly to reflect critically on and correct their misconduct. The land, in essence, “stalked” individuals, making them live right. In addition to being “mnemonic pegs,” these geographic features of the landscape were also recognized as the “footprints” or “tracks” of the ancestors; knowledge of these places was hence seen as important to “knowledge of the self, to grasping one’s position in the larger scheme of things, including one’s own community, and to securing a confident sense of who one is as a person” (Basso 1996:34).

**Religion and ritual**

Western Apache world view does not make a distinction between things “natural” and “supernatural” in the same sense as in Western cultures. Mythological figures, for example, are considered every bit as tangible or real as the sun or rain. Instead, the Western Apache universe is partitioned into three classes of phenomenon: (1) *hinda*, things that are capable of their own movement, such as mammals, birds, plants, and cars; (2) *desta*, objects that are immobile or incapable of moving on their own, including all topographical features and most items of material culture; and (3) *godiyo*, things that are “holy.” This third category includes, among other things, ceremonials and myths, mythological beings, celestial bodies, and the many varieties of *diyi+h*, or supernatural power (Basso 1970a:36).
The concept of “power”\textsuperscript{21} is central to Western Apache cosmology yet difficult to define. Basso (1966:150) describes power as:

… one or all of a set of abstract and invisible forces which are said to derive from certain classes of animals, plants, minerals, meteorological phenomena, and mythological figures within the Western Apache universe. Any of the various powers can be ‘acquired’ by man … and used for a variety of purposes.

Powers\textsuperscript{22} were theoretically available to anyone, but most individuals did not possess them. Acquiring a power required a huge investment of time, energy, and money which few could afford. In addition, power – while valuable and useful – could also impose burdensome responsibilities and be potentially dangerous if misused or treated with disrespect (Basso 1970a; Basso 1983).

Power could be acquired in one of two ways – power, acting on its own, could select someone to be its “owner,” or an individual could select a power and set out to learn the appropriate chants and prayers necessary to control it (Basso 1970a; Basso 1983). A medicine man (or shaman) was someone who had acquired a power and “manipulate[d] their power on the behalf of others, primarily to diagnose and cure sickness” (Basso 1970a:38). Witches (or sorcerers) also possessed power, but instead manipulated their power in private to cause sickness, insanity, misfortune, or death. Still others used their power for more personal ends, such as finding lost objects, increasing their chances for a successful hunt, etc. (Basso 1970a; Basso 1983).

Some, but not all, medicine men took it upon themselves to acquire the specialized knowledge necessary to perform ceremonials. Basso (1970a) defines a ceremonial as a gathering of any size at which a medicine man sings chants.

\textsuperscript{21} For a more in-depth discussion of power, please see Basso (1970a).

\textsuperscript{22} Basso (1970a) lists 28 distinct powers, including “Rain Power,” “Bear Power,” “Moon Power,” “Root Power,” and “Changing Woman, her power.”
Ceremonial knowledge could only come through instruction from an established medicine man. Such instruction, which focused on the acquisition and mastery of a large corpus of chants, was costly and time consuming, in some cases lasting several years. As Basso (1983) emphasizes, however, the rewards and benefits of acquiring a ceremonial were significant, both for the individual and his local group, and far outweighed the costs.

Medicine men essentially functioned as mediators between humans and the powers surrounding them, and they used ceremonials to communicate with the powers and maintain, enhance, or restore harmony (Debacher 1980). Functionally, ceremonials fulfilled three purposes: (1) they could be therapeutic, designed to restore well-being to an individual or a group of individuals; (2) they could be protective, with the intent of preventing any future occurrence of misfortune; or (3) their objective could be to gain an advantage over an adversary or ensure the successful outcome of some event, such as a hunt, warfare, gambling, etc. (Debacher 1980; Everett 1971; Goodwin 1945). Curing rituals, which will be discussed in Chapter 6, constituted the majority of Western Apache ceremonials, but as Basso (1970a:53) points out, there were also numerous minor ceremonies that were “held at childbirth, at the start of long and difficult journeys, at planting and harvest time,” as well as “a considerable amount of essentially private ritual carried out in connection with the manipulation of powers.”

The best known and perhaps most elaborate ceremony, however, was the girls’ puberty rite or nai’es, commonly referred to as the Sunrise Ceremony or Dance.23 This four day ritual was traditionally held the summer following the start of the girl’s menses.

23 While providing no details, Basso (1970a) mentions that there also used to be a boy’s puberty ritual that has since passed out of existence. By the time of the earliest recorded ethnography, a boy’s first raiding party was instead the time when he became the center of ritual interest.
and was given to invest a young girl with the qualities considered essential to adulthood and insure the life long health and well-being of Apache women (Basso 1966; Basso 1970a).

As Basso (1970a:64) explains:

… the primary objective of the puberty ceremonial [was] to transform the pubescent girl into the mythological figure istsanadležé (“Changing Woman”). At the request of the presiding medicine man, and “traveling on his chants,” the power of Changing Woman enter[ed] the girl’s body and reside[d] there for four days. During this time, the girl acquire[d] all the desirable qualities of Changing Woman herself, and [was] thereby prepared for a useful and rewarding life as an adult.

In essence, the power of Changing Woman gave the girl “longevity and the physical capabilities of someone perpetually young” (Basso 1970a:65). The ritual itself symbolically isolated the four life-objectives the Apache view as most important – physical strength, even temperament, prosperity, and sound healthy old age – and conferred these upon the young girl (Basso 1970a).

The Sunrise Ceremony was also central in reinforcing existing kin obligations and establishing new ones. The expense and work involved in giving the ceremony necessitated the assistance of kinsmen, and the obligations which kinship entail were put to a critical test. Matrilineal kin and clan members, for example, were expected to contribute large quantities of food and prepare the danceground. “By stressing the need for close cooperation,” Basso (1970a:71) notes, “ceremonials do much to reinforce clan solidarity. And by demonstrating the practical advantages of extended kinship, they help confirm the utility and effectiveness of the existing social order.”

The puberty ceremonial also established new reciprocal obligations between the girl’s family and clan and those of the woman chosen as the girl’s sponsor. The sponsor
played a critical role in the ritual, supporting and guiding the girl through the ceremony, and was also expected to contribute financially; she had to be unrelated through clan ties, and someone of good character. In essence, by inaugurating a binding relationship between the sponsor and the girl and her family, the ceremony made kinsmen out of people who were unrelated, creating obligations just as demanding as those based on matrilineal kinship, and thus increasing the number of people an individual could rely on for support (Basso 1970a).

As recently as 1920, almost every Apache girl had a Sunrise Ceremony (Basso 1970a), yet since then this ritual – like many others – has declined in prominence. Social and economic changes that have come in the wake of the establishment of the reservations have been largely responsible for this trend. Poverty and the weakening of clan ties, for example, have made ceremonies harder for families to afford. Demand has also attenuated, a consequence of the increasing influence of Western culture and Christian religious sects on the reservation.

The Move to Reservations

The Western Apache, due to their rather remote location, remained free from sustained intrusions onto their lands far longer than many other Native American groups in the U.S. Shortly after the acquisition of New Mexico and Arizona, however, Anglo settlers and prospectors began pouring into these areas. Conflicts over land and the discovery of gold near Prescott in 1863 resulted in increased hostilities between the Anglos and Western Apaches. After an especially brutal massacre of Western Apache women and children by enraged citizens from Tucson in 1871, the government decided
to implement a new peace policy, the central feature of which was the collection of all Apaches on reservations (Basso 1983; Spicer 1962).

Figure 1: Map of Western Apache Reservations

Four reservations were quickly established from 1871 to 1872, three of which were designated for the Western Apache. These included a large area around Camp Apache (later Fort Apache) for the White Mountain and Cibecue Apache, an area around

Source: adapted from http://ag.arizona.edu/edrp/tribes.html
Camp Grant for the San Carlos Apache,\(^{24}\) and Camp Verde for the Tonto Apache and Yavapai. The fourth reservation, in western New Mexico, was intended for the Chiricahua (Basso 1983; Spicer 1962).

The concept of the reservation, which had slowly developed out of an earlier policy of isolation, dominated thought about Indians at the time the U.S. acquired New Mexico and Arizona. First developed to move the Plains Indians out of the way of white expansion in the mid-eighteenth century, the reservation had become increasingly popular as a “solution” to the inevitable conflicts that resulted from Anglo expansion and the flooding of Indian lands. Thus, when imposed on the Apache, the concept of the reservation as a policy and a solution already had a long and deep history (Spicer 1962).

Only a few years after the establishment of the Apache reservations, however, the Department of the Interior implemented a new policy. Rather than occupying separate reservations – and remaining on their traditional lands – it was decided that the Western Apache, Chiricahua Apache, and Yavapai should all be clumped together on the San Carlos Reservation (Basso 1983; Spicer 1962). The rational behind this “removal program” was the belief that centralizing all of the Indians would make them easier to control. In reality, however, it only created problems (Basso 1983).

Most of the groups being relocated to the San Carlos Reservation had never been associated with each other, and consequently there was a great deal of tension and suspicion (Basso 1983). Their traditional economic pattern was also disrupted. The

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\(^{24}\) The areas originally set aside for the White Mountain, Cibecue, and San Carlos Apache were significantly larger than their contemporary reservations and not officially separate. The Fort Apache Indian Reservation, which was officially established by Executive Order on November 9, 1871, originally encompassed more than six million acres, and included the San Carlos Indian Reservation. However, between 1873 and 1896, a series of orders and acts reduced it in size by two and one-half million acres, and in 1897, the two reservations were officially separated by an act of Congress (Debacher 1980; Perry 1993; Watt 2004).
forced resettlement uprooted many Western Apache bands from their ancestral territories, and agents discouraged the old habits of hunting and food gathering that required scattering out across the reservation (Spicer 1962). Agricultural endeavors were “coercively encouraged” (Everett 1971:44), but the land at San Carlos that could be irrigated for farming was insufficient to support all the Indians then located there (Spicer 1962). As a result, wage work became increasingly common and vital as a means of support, and more than half of the reservation’s Indians needed rations to survive (Basso 1970a; Goodwin 1942).

In the mid-1880s, most of the Cibecue and White Mountain Apache were allowed to move back north to their original reservation. While those who returned pretty much resumed their old lifestyle of hunting, gathering, and small scale agriculture (Goodwin 1942), their forced move to San Carlos had started in motion some lasting changes. For one, some of the former distinctions between bands and local groups had been undermined, a consequence of being grouped together with different local groups, bands, and tribes. The economic functionality of the extended family had also been damaged as a result of the introduction of manufactured goods and wage work, starting a gradual slide away from self-sufficiency (Basso 1970a).

The boarding school era

Not long after the Apache were placed on reservations, it became apparent that the national program of isolating Indians had been shortsighted. As the Anglo population expanded, isolation was becoming patently impossible, and policy makers recognized there was nothing left to do but consider ways and means of integration (Spicer 1962). The new general consensus was that acculturation was best achieved
through individuation and freeing Indians from the bondage of the tribe, and boarding schools were seen as the ideal tool.

The first boarding school for Apache youth was established at San Carlos in 1887. This school was originally intended for boys only, but was quickly expanded to accommodate girls as well. A decade later, another boarding school was opened on the Fort Apache Indian Reservation (Watt 2004), and the Lutherans set up a school at Peridot, north of the San Carlos agency, in 1893 (Spicer 1962). In 1900, a government boarding school was established at Rice which functioned as the main educational institution on the San Carlos Reservation for the next 30 years (Watt 2004).

Spicer (1962) reports that a large proportion of Apache children attended these schools; attendance was mandatory, and while some families sent their children willingly, much attendance was coerced. Police – many of whom were themselves Apache – were constantly on the lookout for children who were not in school, and those they found were captured and sent immediately (Watt 2004). In order to be near their children, many Apache families chose to set up permanent residences near the schools, which had the effect of further disrupting the old seasonal movements of the local groups and family clusters (Basso 1983).

According to Spicer (1962), the schools the Apache attended employed the common techniques of the time such as harsh discipline, separation of the sexes, and the exclusive use of English; children’s experiences were quite often negative and runaways were common. By removing children from their families and communities for nine months out of the year, the boarding schools were also responsible for disrupting traditional patterns of education and family life more generally. While the Western
Apache were perhaps not affected to the same extent as some other Native communities, the legacy of the boarding schools has been, as will be discussed in Chapter 3, quite devastating.

**Culture Change in the 20th Century**

The last hundred years have brought significant change to the Western Apache. Boarding schools were only the first step; in seeking to assimilate the Western Apache to Anglo society, the federal government also actively promoted the development of a wage-based economy and encouraged missionaries and the establishment of churches (Basso 1983). The pace and extent of change on the San Carlos and Fort Apache Reservations, however, differed to some extent, largely due to the extreme isolation of the latter. As Everett (1971:52) notes:

> … in comparison to other Western Apache groups, the resident Fort Apache population underwent a rather unique form of acculturation to the Anglo world, a process which tended to be non-violent, minimally coercive, selective, and generally of limited influence with respect to the destruction of an essentially Apachean way of life.

While the White Mountain Apache and San Carlos Apache tribes are still quite culturally similar, their communities and economies today are distinctive, differences which can be traced to their rather unique historical trajectories since the mid-1880s.

In both communities there has been a shift from a hunter-gatherer economy to one based on wage employment. This shift, however, occurred significantly later on the Fort Apache Reservation. It was only around the turn of the century that men at Fort Apache started working for wages in significant numbers (Basso 1983); Everett (1971) notes, in fact, that seasonal movements associated with subsistence activities continued well into the first quarter of the twentieth century. Some men found work on the
reservation cutting hay, working as cowboys, and working on the railroad; by the 1920s, some Apache were also raising their own cattle and working in the newly established lumbering operation on the reservation (Basso 1983; Watt 2004). Others left the reservation for work, either leaving their families behind or moving them with them as they followed word of job prospects around the state.25 (Watt 2004).

The introduction and rise in importance of wage work led to some significant social changes. Whereas in pre-reservation times, subsistence activity was carried out by a group of kinsmen who shared food and other resources, the new cash and wage economy placed value on individual work and fostered the attitude that profits were only for those who could earn them, thus reducing income sharing (Basso 1983; Goodwin 1942; Parmee 1968). This, in conjunction with the need for families to move to find work, led to the emergence of the nuclear household as the primary economic unit and a decline in both the economic and social importance of the family cluster or extended family.

As schools and trading posts became more central aspects of Apache life around the turn of the century, permanent settlements began to form around them, effectively ending the pattern of “wintering below” and bringing into existence the modern “community.” Those who settled in these communities were not necessarily from the same local group or band, and hence, as Basso (1983:484) explains, “distinctions between bands and local groups were blurred then obliterated.” At the same time, “the clan system assumed greater importance than ever before … as clan members whose

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25 Eva Watt comments in her book that her family “traveled all over,” helping out relatives and seeking wage employment. She talks about her father’s and brothers’ employment working on major projects such as Roosevelt Dam, the Apache Trail, and Mormon Flat Dam, as well as more informal engagements working for individual farmers helping repair fences or picking and harvesting (Watt 2004).
local groups had formerly been separated by great distances found themselves in daily contact” (Basso 1983:484; Kaut 1957).

Initially, in response to the social and economic changes being experienced by the Apache population, the ceremonial system flourished. In the first quarter of the century, several extremely influential shamans emerged who founded cults that “expressed discontent with existing conditions” (Basso 1983:486; Kessel 1976). However, by the 1940s, some of these same changes were causing the traditional ceremonial system to weaken. In particular, families were finding it harder to afford ceremonies. In the pre-reservation period, raiding and year-round hunting provided the surplus necessary to feed everyone during ceremonies, but by this period such ceremonial feasts depended largely upon purchased goods. And while the clan system, with its network of reciprocal obligations, could generally help defray such costs (Basso 1983), by the 1930s and 40s the clan system was starting to break down (Goodwin 1942). As a result, ceremonies – particularly those lasting more than one night and those not associated with healing – fell into a period of decline (Basso 1983).

Around the same time, Christian missionaries began to have more success on the reservation. Missionaries had been present on the Fort Apache Reservation since about 1900, but prior to 1920 they were virtually ignored. Their first converts were largely younger Apaches who had attended boarding school or worked off the reservation; these individuals had not only had more exposure to Anglo culture and Christianity, they had developed a strong desire for Anglo possessions and perceived that the church and prayer could help them acquire such things. Other converts followed, however. There were certain aspects of Christianity that some Apaches found
very attractive, in particular the fact that Christian prayers – unlike Apache ceremonials – cost nothing. Most Apache “converts” continued, however, to participate in Apache ceremonials, largely because Christianity, as Apaches understood it, made no effective provision for curing (Basso 1970a).

This changed with the arrival of fundamentalist faith healers in the late 1950s. In a series of tent meetings, these fundamentalist preachers “proclaimed that Jesus Christ could heal sickness of any kind” (Basso 1970a:96). For those who were already marginally involved with Christianity but found it unsatisfactory because of its lack of emphasis of curing, this message carried tremendous importance. Also significant was the fact that several of these preachers were themselves Apache. For the first time, Christianity was being presented to Apaches by Apaches in their own language, and it contained provisions for healing. Services also mirrored aspects of Apache ceremonies that individuals found important – they began at night and lasted several hours, included music and singing, and encouraged participation. For all of these reasons, the Miracle Church, as it came to be known, quickly gained popularity and was firmly established on the Fort Apache Reservation by the late 1960s (Basso 1970a).

The rise in influence of the Christian sects on the reservation led to further weakening of the ceremonial system. In general, missionaries discouraged participation in traditional ceremonies; the fundamentalist faith healers were even more strict, insisting that converts “turn completely from the ‘medicine man way’ and seek help exclusively through Christ” (Basso 1970a:96). While not all converts adhered to these restrictions, those who did were quite often not only reluctant to participate in traditional ceremonies themselves, they often refused to assist others with preparations for events
that conflicted with their beliefs (Basso 1970a). In some cases, this meant neglecting certain obligations to kinsmen, hence weakening to some extent the cooperative networks that had long been a central feature of Western Apache life.

Poverty and alcoholism, two unintended but significant consequences of the social and economic changes thrust upon the Apache, further strained these cooperative kin-based networks while simultaneously reinforcing their necessity. Unemployment and underemployment have been chronic problems on the Fort Apache Reservation since the introduction of wage work. Everett (1971) reported that in the late 1960s, only about 50 percent of the Fort Apache Reservation work force was employed. Incomes were also low; even with public assistance benefits, half of the families on the reservation in 1969 had annual incomes of less than $1,000 (Basso 1983). In this environment, assistance from relatives – in the form of income sharing and other gifts – continued to be important to survival (Everett 1971).

Hence, by the late 1960s, the nuclear household as a unit had undoubtedly grown in importance, but it had not become fully independent economically – its welfare was still intimately bound up with that of other nearby related households (Basso 1970a; Basso 1983). As Everett (1971:63-4), whose work dates to the late 1960s, comments, “Cash, groceries, farm produce, and durable goods – all of these [were] differentially allocated to households in terms of their relative positions in an economic network of cooperative sharing.” Work in this period continued to be cooperatively shared among kin as well; as Basso (1970a:26) notes, women of the same matrilineage were “together almost constantly – washing clothes, grinding corn, collecting firewood, cooking, and helping tend each other’s children.”
**Changes in caregiving**

As Basso (1970a) hints, the care of children up through the 1960s continued to be largely a cooperative endeavor. A number of individuals I spoke with who grew up in the 1950s and 1960s related stories that emphasized the natural involvement of the extended family in their upbringing. Rolanda, for example, a single 38-year-old mother of one – and grandmother of two – recalls being cared for by not only her parents but her aunts and uncles as well, noting that “they all lived together in one big family.” Following in this tradition, Rolanda shares a house with her daughter and her two grandchildren and, on her own initiative, has taken over the majority of responsibility for her one-year-old grandson from her daughter.

Comments from others, however, hint that around mid-century caregiving attitudes and practices began to shift. As the nuclear household became the more prevalent domestic unit, communal caregiving became less commonplace, for the simple reason that other members of the extended family were less likely to consistently be present. Childrearing and caregiving, rather than something to be undertaken collectively by the extended family, was increasingly viewed as the responsibility of the parents, specifically the mother. More and more, the involvement of others was not expected, but rather something specifically sought (or offered) when dictated by need.

Those who raised their children in the 1960s, 1970s, and 1980s, when asked who had helped them watch their children, were more likely to comment that they had not worked when their children were young, and hence had watched their children themselves. Kith and kin were not involved to any great extent because the parents did not see a *need* for their involvement. This is not to say that grandmothers and other
relatives did not interact with and participate in their lives – generally they did, and continue to do so, though to varying extents. However, the expectations that this generation of parents have about caregiving and the role of kin are somewhat different from those of their own parents and grandparents.

It is important to note though that while caregiving attitudes have changed, other factors – such as the rise of maternal employment and alcoholism – have simultaneously served to reinforce the need for familial involvement. As will be discussed in the following chapters, relatives are often the first (or only) choice of employed mothers who need caregiving assistance. Kin also function as a critical safety net for children whose parents have problems with alcohol; in some cases, such children are even raised by relatives. Tina, who was a new mother in her early 20s at the time I spoke with her, told me that her aunt took her away from her mother when she was a baby – and later adopted her – because of her mother’s drinking.

Tina was fortunate in that she had a strong extended family network to take over her care. Not all are so lucky. Alcohol can not only render parents unfit to care for their children, it can also weaken such kin-based safety nets. Narcise, an outspoken mother of eight who grew up in the late 1960s and 1970s, recalls that her parents, as well as her aunties, were constantly drinking. Her grandparents were the only ones she and her cousins could turn to for help. As a consequence, she recalls spending quite a bit of time caring for her younger siblings and cousins. To escape her unstable home, she lived with her grandparents for awhile and attended boarding school out of state for a number of years, dreading the summers when she had to return home. Because of her
“awful” childhood, she decided early on to raise her children very differently than how she herself was raised.

Alcohol problems, while perhaps more pronounced today, are certainly not new. Some of the older individuals I spoke with also recalled their parents’ struggles with alcohol and how it impacted them as children. Marlene, for example, a 62-year-old widow struggling to raise her nine-year-old adopted daughter who has Fetal Alcohol Syndrome, told me that she and her brother quite often would have to watch their younger siblings because their parents were drinking. Today, however, families overall have a more difficult time compensating for such caregiving failures because more of the individuals who could serve as substitute caregivers do not live nearby, have competing responsibilities, or have problems of their own that leave them unfit to provide care.

Narcise, for example, cited the proximity of her grandparents as her saving grace. “Back then,” she noted, “everyone lived close together. So if our parents were to go to town or go drink, our grandparents were always there.” Shirley, a retired mother of seven who grew up in the 1940s, also emphasized how close kin lived and its importance for caregiving. As Shirley explained, “I stayed with my grandma ‘cause my mom was sick – she had a nervous breakdown and I stayed with my grandma nights … but it was only about from here to the house, her camp26 [a distance of about 30 feet].” When Shirley was four and her grandmother died, she started living with her cousin instead, who happened to reside in the same camp as Shirley’s mother. As she noted, although she lived in the same camp as her biological mother, it was her cousin who cared for her and whom she called “mother.”

26 “Camps” refer to either individual or extended family encampments. In the time period that Shirley is referring to, such camps were generally permanent.
Today, most parents with young children still report that they have kin living nearby. With few exceptions, the parents I spoke with noted that they saw their relatives frequently, in many cases daily. What has changed are notions of what constitutes “nearby” – relatives may live in the same or neighboring communities, but it is increasingly rare to find extended families clustered together in neighboring camps or households as was typical not so long ago. Kin are generally within easy driving distance, but not necessarily within walking distance. As a result, children still see their relatives – at least certain ones – relatively frequently, but they are not as accessible and not as constant a presence in their lives as they used to be.

THE WHITE MOUNTAIN APACHE TRIBAL COMMUNITY

Today, the majority of the descendants of the White Mountain Apache and Cibecue Apache bands who returned to the Fort Apache Reservation in the 1880s are members of the federally-recognized White Mountain Apache Tribe (WMAT).27 This tribe constitutes one of the largest reservation-based Indian communities in the state of Arizona, and indeed the nation, with a population of 10,73928 residing on the Fort Apache Reservation in 2000. The population is disproportionately young, with a median age of 20; nearly 11 percent is under the age of five.29

The WMAT is governed by a popularly elected tribal council, which consists of the Tribal Chairman, Vice Chairman, and nine Council members elected from four

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27 Former distinctions between bands have all but disappeared and hence are not relevant to this study.
28 This was the total number of individuals residing on the Fort Apache Reservation in 2000 who identified themselves as “White Mountain Apache” for census purposes; the total population identifying more generally as “Apache” was 11,232. The total 2000 reservation-based population, which includes a number of non-Native and non-Apache individuals, was 12,383 (Census 2000 AIANSF, Table DP-1, Fort Apache Reservation). The Tribe’s official web site estimates its total tribal enrollment, which includes WMAT individuals living off the reservation, at 15,000 (http://www.wmat.nsn.us/wmahistory.shtml).
29 Census 2000 AIANSF, Table DP-1, Fort Apache Reservation (Apache alone or in any combination).
districts. The administrative structure of the tribe is, as Joe and Miller (1998) note, similar to that of a county government, and consists a number of semi-autonomous departments including education, health, social services, legal, human resources, etc.

The reservation today encompasses 1.67 million acres in east-central Arizona and abuts the San Carlos Reservation along most of the length of its southern border. It ranges in elevation from 2,600 feet in Salt River Canyon in the southwest to over 11,400 feet on the sacred peak of Mount Baldy to the northeast. The landscape varies from highland desert in the lower elevations to ponderosa pine forest in the north along the Mogollon Rim, and is accented in places by strikingly red dirt, beautiful vistas, and deep, narrow canyons. The reservation is predominately rural and is traversed by only a few small two-lane highways and a network of dirt roads.

**Communities**

The population of the Fort Apache Reservation is spread across a number of small to moderately sized communities. Approximately half of the population is located in and around Whiteriver, the tribe’s administrative center and government seat. Within short driving distance are the communities of North Fork, Fort Apache, Canyon Day, Seven Mile, and East Fork. Other population centers include Hon-Dah and McNary on the reservation’s northern edge, Cibecue in the western part of the reservation, and Carrizo and Cedar Creek, located between Whiteriver and Cibecue.

The larger communities contain a number of residential settlements, with colorful and descriptive names such as Chinatown, Lifesavers, Over the Rainbow, Jurassic Park, Cradleboard, Dark Shadow, Knott’s Landing, etc. As Basso (1996:151) points out, these
are, in essence, modern day (English) place-names; behind each is a story, “amusing and light-hearted, which provides an account of its origin.” While not identified on any maps or signs as such, these community names – and their associated stories – are well known to reservation inhabitants, and are the primary references used when describing a place of residence. One of my biggest challenges in the first months of fieldwork, in fact, was trying to identify the location of these various residential clusters. Some refer to settlements that include hundreds of houses, while others such as Lifesavers – named for the distinctive array of pastel colors the houses are painted – include only a handful of houses clustered in a larger community. Street addresses are virtually absent; instead, houses are identified by the name of the housing settlement/community and a house number.

Figure 2: Modern Fort Apache Reservation

Source: adapted from [http://www.wmat.nsn.us/rezmap.shtml](http://www.wmat.nsn.us/rezmap.shtml)
While in some areas there are clusters of older homes, the vast majority of housing on the reservation – over 80 percent\(^{30}\) – has been built since the 1970s. With few exceptions, these are single-family, HUD-style homes; they tend to be rather plain, utilitarian, and uniform, differing primary in terms of their paint color. While this proliferation of modern housing settlements has done much to improve the problems with substandard housing that existed in the late 1960s (Basso 1983), it has not alleviated the chronic housing shortage on the reservation. In 2003, the waiting list for housing maintained by the WMAT Housing Authority totaled over 1,400 families (Office of Policy Development and Research 2003). To address this problem, the tribe in 1999 approved the construction of 300 single-family homes in new residential settlements on the outskirts of existing communities. This construction effort was underway while I was in the community, and an additional 100 unit development is in the planning. Upon completion, these homes will be available to families on the waiting list on a lease-purchase basis (Office of Policy Development and Research 2003).

The reservation has also seen a significant amount of other construction since the early 1990s. At the end of 1993, the tribe opened Hon-Dah Casino. The original casino was only 8,000 square feet, but it has since been increased to 42,000 square feet,\(^{31}\) and a hotel, conference center, and RV Park have been added. In part utilizing revenues from the casino, the tribe has also focused on infrastructure development, building a new Tribal Headquarters, fire station, activity center, and alcohol treatment facility in Whiteriver in the 1990s. More recently, the tribe has added a number of multi-purpose community centers, a youth center, and a local campus for the regional

\(^{30}\) Census 2000 AIANSF, Table DP-4, Fort Apache Reservation (Apache alone or in any combination).
community college, and replaced an aging elementary school and the old day care center with larger and more modern facilities.

At least partially as a consequence of this new development, Whiteriver is a community of contrasts. Expensive, aesthetically-pleasing new construction stands next to old run-down buildings. Cars and trucks zip through town on the highway, yet it is also not uncommon to see individuals on horseback on the side of the road. Older Apache women wearing camp dresses32 and speaking Apache walk alongside kids wearing modern styles and speaking English.

While boarding school is still an option for Apache children, the reservation has its own well-developed local educational system. The Whiteriver Unified School District operates three elementary schools, a middle school, and a high school in and around Whiteriver. Cibecue has its own K-12 community school. In addition, the Indian Education Division of the Bureau of Indian Affairs (BIA) operates two schools on the reservation – John F. Kennedy Day School in Cedar Creek, with grades K through 8, and the old Theodore Roosevelt Boarding School at Fort Apache, now a day school for grades 6 through 8. The Lutheran Church also operates a K-12 mission school at East Fork, which many children attend as well. For those wanting to pursue higher education while remaining on the reservation, Northland Pioneer College offers classes and two-year degrees locally at both its Whiteriver campus and in the off-reservation community of Show Low, thirty miles to the north.

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32 “Camp dresses,” as they are known today, are the attire traditionally worn (at least post-contact) by Apache women. Today, they are seen primarily during ceremonies, although many older Apache women continue to use them as everyday attire. They consist of a full blouse with either three-quarter length or long sleeves worn over a very full, ankle-length skirt, and are generally made of a cotton print calico fabric accented by ribbon around the neck of the blouse and bottom of the skirt.
In spite of this diversity of options, educational attainment on the reservation is low and dropout rates are high (Basso 1983). Only 50 percent of the adult population has a high school diploma or GED, and only two percent have a bachelor's degree.\textsuperscript{33} For many, formal education is simply not a priority – it is not perceived as significantly improving an individual's opportunities on the reservation, and hence is not highly valued. Those who attempt to pursue postsecondary education – especially those who leave the reservation to attend college – quite often find themselves ill-prepared pedagogically and further hampered by culture shock.

Part of the problem, as Parmee (1968) points out, is that the Apache educational system has long been – and in some ways continues to be – seriously out of touch with the needs of the students and the larger community, and the realities of life on the reservation. While no longer as blatantly assimilationist, the educational system on the reservation is still based on a Western model and promotes Western values. It has in recent years been more accommodating, integrating Apache history and attempting to confront the threat of traditional language loss. However, as Nevins (2004:270) notes, even some of these efforts, such as school-based Apache language education programs, have been met with ambivalence because they are “perceived by some as threatening to replace Apache pedagogical practices and to undermine relations between younger and older Apache generations.”

Language loss is, understandably, a huge concern in the community. There is, as Adley-SantaMaria (1997a cited in Nevins 2004:271) notes, the widespread perception that children are not learning Apache in “unprecedented numbers.” Children generally

\textsuperscript{33} Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination). These numbers are for the adult population aged 25 and over.
understand at least some Apache, but English is the only language many speak. Data from Census 2000, for example, indicate that over 65 percent of children 5 to 17 speak English only.\footnote{Census 2000 AIANSF, Table PCT-38, Fort Apache Reservation (Apache alone or in any combination).} Only 28 percent of children and adults under 30 speak Apache (Adley-SantaMaria 1997b).

Apache is still used and heard throughout the community; the tribal radio station KNNB, for example, primarily broadcasts in Apache, and over 90 percent of households have at least some members who speak Apache.\footnote{Census 2000 AIANSF, Table PCT-41, Fort Apache Reservation (Apache alone or in any combination).} However, there are striking inter-generational differences in language competency and use. Among elders, Apache is by far the preferred language; in fact, a not insignificant number speak English “less than well.”\footnote{Census 2000 AIANSF, Table DP-2, Fort Apache Reservation (Apache alone or in any combination).} Among younger adults, however, the story is quite different. While a full 95 percent of those 40 and over speak Apache, only 41 percent of those under 40 – and only 28 percent of those under 30 – can speak Apache (Adley-SantaMaria 1997b).\footnote{Census 2000 data indicate that 23 percent of adults age 18 to 64 speak English only (Census 2000 AIANSF, Table DP-2, Fort Apache Reservation (Apache alone or in any combination)).} Consequently, for many young children – particularly those with younger parents – English is increasingly not only the language of pop culture and school, but also the primary language spoken at home.\footnote{English is the primary language spoken at home in two out of every five households (Census 2000 AIANSF, Table DP-2, Fort Apache Reservation (Apache alone or in any combination)).}

**Families and Households**

Although interrelated, the family and the household are distinct – and culturally defined – concepts. As Netting, Wilk, and Arnould (1984:xx) explain, households are “task-oriented residence units” whereas families are “kinship groupings that need not be
localized.” Both families and households on the Fort Apache Reservation differ appreciably from the American archetype – conceptually and concretely as well as in terms of their composition and interrelationships. For example, even though the family cluster is largely a thing of the past, extended family households in the Apache community are not uncommon and related households continue to be relatively interdependent (Bahr 1994).

Households can be conceptualized both structurally and functionally – they are dwelling units, but they are also a unit of economic cooperation and the primary site of reproduction and socialization (Kunstadter 1984; Wilk and Netting 1984). Apaches use both structural and functional elements in their conceptualizations of households, but do not rely on either absolutely. Households tend to have loosely defined, rather permeable boundaries, with household membership best described as fluid and changing (Bahr 1994). Generally those residing in the same structure comprise a household, however there are exceptions. A change of household is largely viewed as a personal decision and a rather unremarkable event. In some cases individuals living elsewhere are still considered household members, particularly if the move is temporary and/or they are still tied to the household economically. At the same time, while households generally do pool resources and share responsibilities such as socialization and caregiving, this is not universally true. It is also not uncommon for related households to cooperate economically, assist each other when in need, and protect one another’s interests – though to a lesser extent than was true historically – hence making the family in some cases a more logical unit of analysis.

39 Thirty percent of WMAT individuals residing on the reservation in 2000 noted that they had changed residence at least once between 1995 and 2000 [Census 2000 AIANSF, Table DP-2, Fort Apache Reservation (Apache alone or in any combination)].
Households on the Fort Apache Reservation tend to be larger than the typical U.S. household, with an average of 4.0 persons per household on the reservation in 2000 compared to an average of 2.6 for the U.S. as a whole (see Table 3). They differ in other significant ways as well. The large majority – over 83 percent – are family households, meaning that two or more members of the household are related by birth, marriage, or adoption. While this percentage is significantly higher than for the U.S. as a whole, significantly fewer Apache households – 44 versus 52 percent – are headed by a married couple. Even more striking is the discrepancy in female-headed households, which comprise almost 33 percent of households in the Apache community, but only 12 percent nationally.

<table>
<thead>
<tr>
<th>Table 3: Fort Apache Reservation Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family households</td>
</tr>
<tr>
<td>Headed by a married couple</td>
</tr>
<tr>
<td>Female-headed households</td>
</tr>
<tr>
<td>Average household size</td>
</tr>
</tbody>
</table>

Source: Census 2000 AIANSF, Table DP-1, Fort Apache Reservation (Apache alone or in any combination)

Nuclear family households dominate, but cross-generational and multi-nuclear households are quite common as well. While census data does not provide statistics on nuclear versus extended family households, it does note that almost 17 percent of

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40 Apache families on the reservation are also comparatively large, with an average of 4.4 persons versus 3.1 for the U.S. as a whole [Census 2000 SF1 (Summary File 1 data set), Table DP-1, United States; Census 2000 AIANSF, Table DP-1, Fort Apache Reservation (Apache alone or in any combination)].
41 Census 2000 AIANSF, Table DP-1, Fort Apache Reservation (Apache alone or in any combination).
43 Census 2000 SF1, Table DP-1, United States; Census 2000 AIANSF, Table DP-1, Fort Apache Reservation (Apache alone or in any combination).
44 Multi-nuclear households include individuals such as cousins, aunts, or uncles, in addition to the primary nuclear family.
reservation household members in 2000 were categorized as “other relative,” meaning they were related to the householder, but were not the householder’s spouse or child. Although there are endless variations, a commonly observed extended family household includes a mother and her child(ren), and one or more grandparents.

Women in this community tend to start having children relatively early, not uncommonly in their teens. In the Apache community, teen pregnancy is generally not viewed as “problematic,” “misguided,” or “reckless” (Davies, et al. 2001:97).

Traditionally, the passage from girlhood to young womanhood was marked by the Sunrise Ceremony (Golston 1996); those having children in their mid- to late-teens are hence not seen as ill-prepared “teen mothers” but rather culturally adult women starting their own families. Motherhood, as Deyhle and Margonis (1995:143) discuss in relation to the Navajo, “offers young women a place within matrilineal networks” and confers status upon them. So unusual is it for a woman not to have children by her mid-20s that my own identity – as a childless woman in her early 30s – was suspect until I became pregnant during the course of my fieldwork.

A legally committed relationship is not, as Deyhle and Margonis (1995) note, a prerequisite for having children. Young mothers, instead of looking to men for support, tend to depend upon their matrilineal networks – their mothers in particular – to provide for themselves and their children. Some mothers go on to marry later, but many do not. As the 2000 census data indicate, 38 percent of women and 45 percent of men had

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45 Census 2000 AIANSF, Table DP-1, Fort Apache Reservation (Apache alone or in any combination).
46 It is important to note that not all girls have Sunrise Ceremonies today, a function of rising costs, religious influence, and changing beliefs. Some have abbreviated, less expensive one-day ceremonies, but many forgo the ceremony today altogether.
47 Most young women, in fact, have significant experience caring for children, an upshot of assisting in the care of younger siblings and cousins while growing up.
never been married, although only a small minority of adults have never had children. Only 42 percent of adults were currently married.48

Not having a father has generally not been considered risky because children almost always have multiple individuals – grandmothers and aunts primarily – who function as “mothers.” Mothers discourage their daughters from being dependent upon men because, as one comments, “you never know when they might leave you.” Instead, “men are seen in fluid terms; they are a desired part of the family, but the dependable foundation remains in the hands of the women” (Deyhle and Margonis 1995:141). Men have been further marginalized by the economic importance of welfare; as will be discussed in Chapter 3, the requirements of many welfare programs actually act in some cases to discourage stable partnerships with the mothers of their children. Men might provide pampers49 or some other material assistance after the birth of their child, but if they are not in a committed relationship with the mother of their child, it is generally not anticipated that they will provide long-term financial support.

This is not to imply, however, that Apache men are not active participants in – and contributors to – their families and community. Some men, as will be discussed in later chapters, take a very active role in the care and support of their children. Others dutifully attend to their obligations to their own relatives that are an inherent part of the matrilineal Apache society, obligations as strong as, if not stronger than, those to their partners or children. Men who can find work – which in some cases requires leaving the reservation – contribute economically. Others may assist by cutting firewood and fixing

48 Forty-two percent of the adult Apache population on the reservation was currently married [Census 2000 AIANSF, Tables DP-2 and QT-P18, Fort Apache Reservation (Apache alone or in any combination)].
49 The term “pampers” is used generically in the Fort Apache reservation community to refer to disposable diapers.
cars, and contributing goods and labor for larger events such as Sunrise Ceremonies or wakes. Some even continue to play what was traditionally an important role in the lives of their sisters’ children. All of this, however, is complicated by the realities of the reservation economy and the pervasiveness of alcoholism. Alcohol abuse – while certainly not limited to men – has had the unfortunate effect of making men less dependable in terms of support and contributions (Basso 1983); in some cases, rather than being a source of assistance, they are instead an emotional and economic drain on their families.

It is not uncommon for young Apache mothers – particularly those who are not in stable relationships with the fathers of their children – to remain in their parents’ household for a number of years while their children are small. Such “subfamilies,” in fact, are found in almost 14 percent of households, with 50 percent of these consisting of a mother and her child(ren). As Deyhle and Margonis (1995:143) note for the Navajo, young Apache women are not “pushed out” of their natal household to start an “independent” adult life with a partner or spouse; rather, many are encouraged to “stay in.” Such young mothers, more than others, have the advantage of their natal household’s financial resources and caregiving assistance to support them in finishing their education, pursuing employment, or raising their children full-time. Even those

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50 The assistance of kin is, in fact, critical for such events. The costs associated with a Sunrise Ceremony, for example, can run in the thousands and thus cannot be born by the sponsoring family alone. The extended family is expected to assist with the preparations for such events and contribute food and goods for the feasts, as well as for the exchanges and giveaways associated with the Ceremony.

51 The Census Bureau defines a subfamily as “a married couple (with or without children) or a single parent with one or more never-married children under the age of 18, residing with and related to the householder, but not including the householder or the householder’s spouse” (http://factfinder.census.gov/home/en/epss/glossary_s.html).

52 Census 2000 AIANSF, Tables PCT32 & PCT34, Fort Apache Reservation (Apache alone or in any combination).
young mothers who do wish to set up their own household may find this hard to accomplish given the housing shortage and long waiting list for housing.

Many young mothers who spend their children’s early years in their parents’ households do eventually move out. Some set up their own households while others move in with other relatives or partners who may or may not be the father of their children. Such moves do not, however, necessarily lessen their ties to – and dependence upon – the household they just left. In some cases, however, such moves take young mothers to distant communities, leaving maternal networks less accessible and putting these young mothers at a disadvantage. This is especially a danger for those who set up their own residence, due to the location of the new housing settlements. The housing situation has, consequently, been to some extent responsible for further weakening the matrilineal networks that used to be the backbone of Apache families.

Table 4: Fort Apache Reservation Children’s Residence

<table>
<thead>
<tr>
<th>Type of Household</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In household headed by married couple</td>
<td>48%</td>
</tr>
<tr>
<td>In female-headed household</td>
<td>44%</td>
</tr>
<tr>
<td>In household headed by a single mother</td>
<td>22%</td>
</tr>
<tr>
<td>In male-headed household</td>
<td>8%</td>
</tr>
<tr>
<td>In grandparent-headed household</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: Census 2000 AIANSF, Table PCT11, Fort Apache Reservation (Apache alone or in any combination)

The centrality of mothers and their maternal networks in the care of children, and the more marginalized role of men, is reflected in the statistics on Apache children’s residence (see Table 4). While almost 70 percent of children under 18 in the U.S. in 2000 lived in family households headed by a married couple, this was true of only 48
percent of Apache children. However, Apache children were almost twice as likely to live in female-headed households with no husband present (44 percent versus 23 percent for the U.S. as a whole). Almost as many Apache children, in fact, lived in female-headed households as married couple households. In contrast, only eight percent of Apache children under 18 were in male-headed households with no wife present, a rate very similar to that of the U.S. as a whole.53

While in the majority of cases, Apache children were in households headed by one or more of their parents, in 2000 more than one in four were living in households headed by some other relative. Seventy percent of these children were in grandparent-headed households. Apache children were, in fact, almost as likely to be living in a grandparent-headed household as one headed by a single mother.54 Mothers (and occasionally fathers) are, as discussed above, commonly members of these households as well, but this is not always the case. Significantly, two-thirds of the 18 percent of grandparents who shared a household with a grandchild had primary responsibility for one or more grandchildren.55 In contrast, in the U.S. as a whole, only one in twelve children in 2000 lived in households headed by grandparents or other relatives.56

The reasons behind such living arrangements are multiple. While the residence patterns of most children simply mirror those of their parents, in other instances children may live with a grandparent or other relative at the request of that individual or – as will be discussed in Chapter 4 – such residence decisions may be the child’s. As Greenfeld (1996:492) explains, Apache “individuals of any age have the right to make their own

53 Census 2000 SF1, Table P19, United States; Census 2000 AIANSF, Table PCT11, Fort Apache Reservation (Apache alone or in any combination).
54 Census 2000 AIANSF, Table PCT12, Fort Apache Reservation (Apache alone or in any combination).
55 Census 2000 AIANSF, Table PCT36, Fort Apache Reservation (Apache alone or in any combination).
56 Census 2000 SF1, Table P28, United States.
decisions with respect to personal action, and ... it is rude and improper to directly order
or force them to do something against their will.” This includes children: they are given
the space to make their own decisions and do not need permission to act on their own
(Greenfeld 1996).

Such respect for children’s decisions and wishes is not unique to the White
Mountain Apache, nor is it limited to decisions about residence or caregivers. Similar
traits have been variously described among the Blackfoot as “individualism” (McFee
1972), “inviolability of the individual” among the Navajo (Downs 1972), “unstructured
freedom of choice” among the Lakota Sioux (Medicine 1983), and “personal autonomy”
among Alaska Natives (Sprott 1992). All express the same general idea that "children
are ... little individuals whose rights and wishes should be respected" and who "have the
right to make their own decisions" (McFee 1972:96-7, 99).

In a similar vein, Apache caregivers are reluctant to directly correct or reprimand
children, actions seen as insulting and condescending (Basso 1996). Instead, children
are allowed to learn their own lessons through trial and error, and are expected to glean
lessons about right and wrong from stories they are told about coyote and the ancestors.
Adults do on occasion, however, indirectly reprimand children through stories, in
essence “exploit[ing] the evocative power of place-names to comment on the moral
conduct” of the person and allowing the story to work on their mind (Basso 1996:80).

Such socialization and education continues to be a community effort, something
permitted and facilitated by the persistence of multi-generational households and the
close relationships between children and their grandparents and other relatives.
Children are still brought up to place great value on relationships with others in the family
and the community (Wax 1972). Much cultural learning, in fact, continues to be embedded in these relationships (Hermes 2005). Consequently, children learn to define themselves in relation to (and in a relationship with) others, rather than in relation to work, careers, or money (Wax 1972).

Economy and Employment

Native Americans have among the lowest labor force participation rates and highest rates of unemployment and poverty of any ethnic minority group in the U.S. (Clark and Waismantle 2003). Census 2000 data show that, nationally, unemployment rates for Native Americans were twice the national average. In the state of Arizona, Native Americans were unemployed at a rate more than three times the state average; in some reservation communities, the unemployment rate was more than six times the state average. Correspondingly, the percentage of Native American families falling below the poverty line in 1999 in the U.S. as a whole was more than double the national average of 9.2 percent. The rate for Native American families in Arizona was slightly more than three times the state average of 9.9 percent.

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57 Census 2000 SF4 (Summary File 4 data set), Table DP-3, United States; Census 2000 SF4, Table DP-3, United States (American Indian or Alaska Native alone or in any combination). Income data reported in Census 2000 are for 1999.
58 Census 2000 SF4, Table DP-3, Arizona; Census 2000 SF4, Table DP-3, Arizona (American Indian or Alaska Native alone or in any combination). For example, the unemployment rate for Apaches residing on the San Carlos Reservation was over 35 percent (the state unemployment rate was just under six percent). Apaches residing on the Fort Apache Reservation had a significantly lower unemployment rate of 25 percent.
59 The poverty threshold varies by family size and the number of children under 18. In 1999, it was $13,423 for a family of three, including two minor children; for a family of four, including two minor children, it was $16,895 (http://www.census.gov/hhes/poverty/thresh99.html).
60 Census 2000 SF4, Table DP-3, United States. The overall poverty rate for American Indians and Alaska Native families in 1999 was 21.8 percent; for Blacks and African-American families it was 21.6 percent.
61 Census 2000 SF4, Table DP-3, Arizona; Census 2000 SF4, Table DP-3, Arizona (American Indian or Alaska Native alone or in any combination).
While not universally true, reservation communities generally have poverty rates significantly higher than the national or state averages for Native Americans, a consequence of the perennial difficulties of promoting and sustaining economic development on reservations (Cornell and Kalt 1992). In 1999, nearly 46 percent of Apache families on the Fort Apache Reservation fell below the federal poverty threshold (see Table 5). This was slightly lower than the overall poverty rate on the neighboring San Carlos Apache Reservation, but slightly higher than those found on several of the other large, rural reservations in Arizona.

Table 5: Fort Apache Reservation Income and Poverty Status

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Median household income</td>
<td>$17,005</td>
</tr>
<tr>
<td>For married couple with children</td>
<td>$28,750</td>
</tr>
<tr>
<td>For single mothers</td>
<td>$10,512</td>
</tr>
<tr>
<td>Below poverty threshold</td>
<td>46%</td>
</tr>
<tr>
<td>Families with children under 5</td>
<td>57%</td>
</tr>
<tr>
<td>Single mothers with children under 5</td>
<td>70%</td>
</tr>
</tbody>
</table>

Source: Census 2000 AIANSF, Tables DP-3 & PCT123, Fort Apache Reservation (Apache alone or in any combination)

Families with children – single-parents in particular – are disproportionately affected by poverty. Nationwide, poverty rates are higher for families with children under 18, and highest for families with children under five. Almost 57 percent of Apache families on the Fort Apache Reservation with children under five, for example, fell under the federal poverty threshold in 1999, the highest rate for any of Arizona’s large

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62 Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
63 Census 2000 AIANSF, Table DP-3, Navajo Nation Reservation and Off-Reservation Trust Land (Navajo alone or in any combination); Census 2000 AIANSF, Table DP-3, San Carlos Apache Reservation (Apache alone or in any combination); Census 2000 AIANSF, Table DP-3, Tohono O’odham Reservation and Off-Reservation Trust Land (Tohono O’odham alone or in any combination).
reservations. Even more striking, however, is the fact that over 70 percent of single mothers with children under five on the reservation fell under the poverty threshold (see Table 5). The median income of Apache families headed by single mothers in 1999 was only $10,512, nearly three times less than that of families with children headed by a married couple. Interestingly, families headed by single Apache fathers had a median income that was even slightly lower than those headed by single mothers.

The median household income in 1999 on the Fort Apache Reservation was just over $17,000 (see Table 5). Wages comprise a large percentage of this income, but it is certainly not the only source. While nearly three in four households had earnings in 1999, more than one in four received public assistance. One in five received SSI, and some households with older individuals received social security and/or retirement income. Housing costs are relatively low – the majority of households spent less than 15 percent of their total household income on housing – but food and transportation are more costly. Non-monetary assistance programs such as WIC, food stamps, and

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64 Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination); Census 2000 AIANSF, Table DP-3, Navajo Nation Reservation and Off-Reservation Trust Land (Navajo alone or in any combination); Census 2000 AIANSF, Table DP-3, San Carlos Apache Reservation (Apache alone or in any combination); Census 2000 AIANSF, Table DP-3, Tohono O’odham Reservation and Off-Reservation Trust Land (Tohono O’odham alone or in any combination).
65 Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
66 Census 2000 AIANSF, Table PCT123, Fort Apache Reservation (Apache alone or in any combination).
67 Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
68 Ibid. Under “public assistance,” the census includes only cash assistance benefits such as Temporary Assistance for Needy Families (TANF), General Assistance (GA), and Aid to Families with Dependent Children (AFDC) (http://www.census.gov/population/cen2000/phc-2-a-B.pdf).
69 Supplemental Security Income (SSI) is “a nationwide U.S. assistance program administered by the Social Security Administration that guarantees a minimum level of income for needy aged, blind, or disabled individuals” (http://www.census.gov/population/cen2000/phc-2-a-B.pdf).
70 Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
71 Census 2000 AIANSF, Table DP-4, Fort Apache Reservation (Apache alone or in any combination).
72 The Special Supplemental Nutrition Program for Women, Infants, and Children; the goal of this program is to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.
commodity foods serve as important nutritional safety nets for families on the reservation. Extended family networks also serve a critical function in redistributing income and goods to families or households that are struggling economically.

Because of the reservation’s unique natural resources, the WMAT has enjoyed more opportunities for economic development, and hence fared better economically, than some neighboring tribes. The Fort Apache Reservation includes some of the richest timber resources and wildlife habitats in the state. The timber industry – one of the oldest employers on the reservation – continues to be a major source of wage work, both through logging activities and the two Fort Apache Timber Company (FATCO) sawmills, located in Whiteriver and Cibecue. It also produces revenue for the tribe through the sale of FATCO’s timber products, both locally at the tribe’s retail Hon-Dah Home Center and regionally. The reservation is also renowned for its deer and elk hunting, activities which bring in over $600,000 a year in revenue from hunting licenses. There are also numerous lakes and more than 400 miles of streams, offering some of the best trout fishing in the area.

As the tribe has worked to actively develop these resources, tourism and recreation have assumed even greater economic importance. A very important revenue producer and source of seasonal employment is the tribally owned and operated Sunrise Ski Resort, the largest ski resort in the state, and its associated lodge and ski shop. Hon-Dah Casino and Resort, incrementally built in the 1990s, is an increasingly popular

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73 The Food Distribution Program on Indian Reservations (FDPIR), commonly known as the “commodity foods” program, provides monthly food packages to low-income American Indian households on or near reservations. It serves as an alternative to the Food Stamp Program (households cannot participate in both programs), and tends to be utilized by those who lack easy access to food stamps offices or authorized grocery stores, or live in areas where the cost of food is inordinately high (http://www.fas.org/nutrition/Ca-De/Commodity-Foods.html; http://www.fns.usda.gov/fdd/faqs/fdpirfaq.htm).
tourist destination and a large local employer. More recently, the tribe has expanded its Apache Culture Center and Museum, located at historic Fort Apache, and is working to develop Fort Apache as a tourist destination.

Another important source of local employment is wildland firefighting. The reservation is home to the Fort Apache Hotshot crew, one of only five Type 1 hotshot crews sponsored by the BIA, and the BIA Fort Apache Agency firefighters. Although such employment is seasonal and somewhat unpredictable – often taking individuals away from home for weeks at a time at a moment’s notice – it is also a very good source of income. Ironically, the need for such income was what led one Cibecue resident and firefighter to start a small fire north of that town in June 2002, which quickly grew and merged with another fire to become the devastating Rodeo-Chediski fire. Ultimately, the fire blackened nearly a third of the reservation and crippled the tribe economically by burning the Ponderosa pine on which the timber industry depends and killing the deer and elk that brought in significant revenue (Claitor 2002; Tobin 2005).

While the reservation’s natural resources are important to the tribe economically, the industries providing the most employment are education, health, and social services. A full 60 percent of those employed on the reservation are classified as government workers,74 a category that includes BIA and tribal government employees. However, due to the low levels of educational attainment on the reservation, a significant number of these positions are filled by outsiders. Non-Apache individuals, for example, hold over a quarter of the education, health, and social service positions on the reservation, and almost 35 percent of managerial and professional positions. Apaches do, however,

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74 Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
hold the vast majority of sales and service positions, along with those in forestry, farming, production, construction, and maintenance.\textsuperscript{75}

In spite of the tribe’s comparatively wide range of employment opportunities, unemployment and underemployment are still significant problems. In 2000, less than half of the adult population was considered to be in the labor force, and a quarter of those in the labor force were unemployed\textsuperscript{76} (see Table 6). In addition, many of those who are employed do not have dependable full-time employment year-round. A number of the available jobs, such as those at the ski resort or associated with wildland firefighting, are seasonal, and some other positions are only part-time.

<table>
<thead>
<tr>
<th>Table 6: Fort Apache Reservation Employment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>In labor force</td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>Unemployed</td>
</tr>
<tr>
<td>(24.6% of labor force)</td>
</tr>
<tr>
<td>Not in labor force</td>
</tr>
<tr>
<td>Females in labor force</td>
</tr>
<tr>
<td>Employed</td>
</tr>
</tbody>
</table>

Source: Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination)

In an effort to produce more jobs and stimulate the reservation economy, the tribe has adopted a “buy local” policy, contracting for example with tribally-owned businesses for the construction of new housing developments and buying the majority of the needed timber, cement, and gravel from tribal industries (Office of Policy

\textsuperscript{75} Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (comparison of total reservation population versus Apache alone or in any combination).

\textsuperscript{76} Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
Development and Research 2003). While this has certainly been beneficial, it does not address some of the barriers to labor force participation. Transportation, for example, is an issue for many. Over a quarter of households have no car,\textsuperscript{77} and many others do not have reliable transportation. While certain employers, such as the ski resort, run shuttles that pick up and drop off employees, there is no public transportation system on the reservation and hence most individuals must find their own way to work.

For women, child care is often a major barrier to seeking and maintaining employment. One in three adult WMAT women on the reservation are employed, a rate only slightly lower than for men\textsuperscript{78} (see Table 6). Since caregiving responsibilities predominately fall on the mother, employed women are more likely than employed men to require caregiving assistance during their hours of employment. In some cases, partners or spouses may be able and willing to watch the children while the mother is working, but this is not always possible or practical. In almost half of the families with children under six in 2000, for example, all the parents in the family were in the labor force.\textsuperscript{79} Most employed mothers, single mothers in particular, have to seek caregivers elsewhere. Finding caregiving can be doubly challenging for the many mothers in the community who work what would be considered “non-standard” schedules. A significant number of positions at the casino, hospital, sawmill, and grocery store, for example, involve at least some evening, night, or weekend hours. As will be discussed in Chapter 4, this seriously limits caregiving options, since the day care center and home care providers only provide care during “standard” (daytime, weekday) working hours.

\textsuperscript{77} Census 2000 AIANSF, Table DP-4, Fort Apache Reservation (Apache alone or in any combination).
\textsuperscript{78} Census 2000 AIANSF, Table DP-3, Fort Apache Reservation (Apache alone or in any combination).
\textsuperscript{79} Ibid.
Child Care Programs and Infrastructure

The WMAT has worked hard to provide child care options for its tribal members, but has faced a number of logistical and financial challenges. In an effort to improve accessibility and service provision for parents, the tribe was moving to restructure and streamline its early childhood programs just as I was initiating this project. All programs aimed at young children and their families, such as WIC, Child Find, CCDF, Head Start, and the Day Care Center, were relocated to the newly created Division of Early Childhood Development. Prior to this they had been spread across a number of departments, making coordination of services difficult and access challenging for parents. Other barriers to effective service provision, however, such as inadequate funding and a large (and often sparsely populated) service area, have been more difficult to address.

CCDF and child care subsidies

Tribal child care programs are entirely funded by CCDF appropriations, which for FY 2001 totaled a little over $800,000, and approximately $860,000 for FY 2002. This money funds the day care center as well as child care subsidies for tribal members.

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80 The Child Find Program, funded by a grant from the Bureau of Indian Affairs (BIA), is focused on the early identification (between birth and age five) of Apache children with special needs.
81 The Child Care and Development Fund is a federal block grant program providing funding to tribes and states to assist low-income families, families receiving temporary public assistance, and those transitioning from public assistance in obtaining child care so they can work or attend training/education. CCDF is managed by the Child Care Bureau under the U.S. Department of Health and Human Services.
82 Head Start is a federally funded program designed to promote school-readiness by enhancing the social and cognitive development of low-income children through the provision of educational, health, nutritional, social and other services.
83 This creation by the WMAT of a single department dedicated to early childhood programs was the first of its kind in Indian Country, and has since been lauded and mimicked by other Nations.
84 Interestingly, CCDF is a capped entitlement; it is not intended to fund at levels adequate to meet the needs of all eligible low-income families in the U.S. (Blau and Tekin 2001).
Individuals who qualify as low-income and need financial assistance for child care to allow them to work or attend school or training programs are eligible for subsidies. The director of the Department of Early Childhood Programs estimated that for FY 2000, approximately 370 families received child care subsidies.

All TANF recipients are automatically eligible for child care subsidies, as are teen parents in high school and working parents with disabled children. After these, other low-income families are considered if funds are available. Perpetual budget shortfalls, however, have meant that quite often higher income families never actually receive subsidies, although they technically might be eligible. Parents are responsible for a co-pay of from one to five dollars, based on their income. Individuals receiving subsidies can use them to pay for center-based care or family home care, which includes both home care providers and informal in-home care provided by kith and kin.

At the time I was working in the community, funding for subsidies was tight. With half of FY 2002 left to go, the individual administering CCDF told me they were looking at having to limit subsidies to TANF recipients and teen moms, and drop the rest of the recipients from the program (someone else mentioned that this had happened the previous year as well). At least one mother I interviewed mentioned that this had happened to her. She noted that she could not afford to send her child to the day care center without financial assistance, and hence had to pull him out of the center when she lost her subsidy.

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86 Tribal members are eligible for child care subsidies through both the state Department of Economic Security (DES) and the tribe. Subsidies for those eligible through DES are paid by the state, although the tribe may pick up part of the co-pay for the individual.
Chaghache day care center

The Chaghache Day Care Center, located in Whiteriver, is the sole formal day care center serving the Fort Apache Reservation. Chaghache, which celebrated its thirtieth anniversary in 2001, started as a little clubhouse of parents who needed childcare. They got the pastor’s wife to watch their children, and did bake sales and other fundraising to pay her. It was only many years later that outside funding was received to support the center’s operations (in the early years, such funding came from the BIA).

Chaghache is well utilized, but enrollment is limited by space. At the time I was in the community, enrollment was capped at 100. The center has five programs – infants, toddlers, preschool, Montessori, and after-school care – which range in cost from $12 to $18 per day, depending upon the program. Due to limited space, children who miss more than two weeks straight are disenrolled to make room for other children. Technically, the center was also available for drop-in use, but parents were rarely able to take advantage of this since the center was almost always at capacity.

Because of the limited space at Chaghache, a quite lengthy waiting list existed.87 The director of the center estimated that, in the fall of 2001, there were around 12 children on the waiting list for each classroom. Within the community, this waiting list was quite legendary, and frequently misunderstood. Numerous parents described being on the waiting list for months or years; many had a idea (though not always an accurate

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87 Interestingly, the waiting list disappears during the summer. Enrollment at the center drops significantly over the summer, and they are able to invite everyone who is on their waiting list to enroll. The center director attributes this summer enrollment drop to parents using older siblings, who are themselves out of school for the summer, as caregivers for their younger children who attend the center during the school year. In the fall, however, a waiting list inevitably redevelops.
of where they were on the waiting list, but little idea of when a slot might open, or even of who had priority for openings. Several parents who would have liked to use the day care center commented that they never even bothered putting their names on the list, figuring they would never get in anyway.

A new facility opened to replace the existing day care center in the summer of 2002 shortly after I finished the research for this project. Demand had been steadily increasing for several years, and it had been long recognized that the center needed to expand; the old building, which did not even have room for the Montessori and after-school programs, was simply too small. It was anticipated that the new center would have a capacity of approximately 150 children.

Parents I talked with were encouraged by the impending opening of the new center, but questioned whether it was really sufficient. Even with the 50 percent increase in capacity, it would barely accommodate all of the children already on the waiting list. Many parents expressed a strong desire for day care centers in other communities on the reservation; because of the size of the reservation, Chaghache was really only a practical option for those living in and around Whiteriver. Several casino employees emphasized the need for a center in the casino complex, something which they noted had been discussed for years. Individuals in Cibecue, McNary, and Canyon Day also noted that day care centers would be useful in their communities. Additionally, given the number of teen mothers in the community, and the frequency with which they

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88 One father, whose wife was forced to quit her job because they could not find dependable child care, thought that they were around number 400 on the waiting list! Obviously, this was inaccurate (since the waiting list has never approached that length), but it does demonstrate the limited understanding of the waiting list in the community.

89 One individual I spoke with who worked at the casino commented that it is not uncommon for employees to call in “sick” because they are unable to find someone to watch their children that day.
drop out of school due to a lack of child care, many stressed the urgent need for a child care center on the grounds of the high school targeted specifically to the needs of this group of parents.

**Home care providers**

Home care providers are another available, but seriously under-utilized, regulated child care option on the reservation. Potential providers must fill out an application from the tribal CCDF program, and undergo a background check and a health and safety check. Home care providers are allowed to care for up to five children at a time, two of which can be infants. These providers are eligible to receive subsidies, and are reimbursed according to a standard rate set by the tribe’s CCDF office.

In the fall of 2001, there were only 11 active home care providers on the reservation – five in the Whiteriver area, five in Cibecue, and one in McNary. Few of these were at capacity. In the past there had been as many as 30 or 40 providers, but several failed to attend the mandatory trainings and had to be dropped from the roster, and others only provided care seasonally. The two home care providers I spoke with during the course of my research were truly impressive caregivers, both in terms of their knowledge and dedication as well as their deep care and concern for their children in their care. They had both been involved with the program for years, and were caring for a number of children referred to them through CCDF.

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90 Relative caregiver’s homes are exempt from the health and safety check.
While these two individuals got involved with the home care provider program to take advantage of the program’s resources and referrals (after years of providing informal in-home care), many other caregivers apply only after learning (generally from a parent) that children already in their care qualify for subsidies. Most home care providers receiving subsidies in FY 2002 were, in fact, related to the children in their care. Generally, these individuals were not interested in taking in more children through the program; their involvement was simply aimed at allowing the parents to take advantage of subsidies (and ensuring that they themselves get paid for their services). Even for those who do it full-time, being a home care provider does not really provide a livable wage. As one noted, she would like to make some money, but ends up spending a substantial amount of her caregiving income on food for the children and other business related expenses (such as toys, equipment, and improvements).

**Head Start**

Head Start is not truly child care, but it is important to this discussion because of how it impacts demand for caregiving in the community. While nationally only around three percent of three- to five-year-olds are enrolled in Head Start (U.S. Bureau of the Census 2000), attendance on the Fort Apache Reservation (at least in Whiteriver and its surrounding communities) appears to be nearly universal. Head Start is a popular program; every one of the parents I interviewed confirmed that their children were either currently enrolled in Head Start, had already graduated, or that they planned to enroll them when they were old enough.

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91 Many studies, however, do consider Head Start and other preschool programs a form of formal child care. For purposes of this study, however, I consider it a form of “school” because is so viewed and classified by community members.
WMAT Head Start is funded to serve 252 children between the ages of three and five and their families. While the main Head Start facility is located in Whiteriver, there are also smaller facilities in McNary and Cibecue. Preschool children whose families are below the poverty line are automatically eligible, but 49 percent of children may be over-income.92

Parents whose children are enrolled in Head Start thus have a block of time every day (Head Start is a part-day program) where they have free and dependable “care” for their children. Some parents find this sufficient for their child care needs, while others combine Head Start with Chaghache’s preschool program or other informal caregivers. In any case, Head Start definitely reduces the overall need in the community for child care for children in this age range. A number of tribes across the nation have started to offer Head Start and child care at the same site as a service to parents who need to work full-time (Krohn and Charter 1993). The WMAT, since I finished my research, has done this as well, creating a Head Start/Child Care partnership where 100 children receive full-day, year-round services.93

INTERVIEWEES

Given that this research focused on a certain subset of the White Mountain Apache community – namely, primary and alternative caregivers of young children – the 55 parents and caregivers interviewed for this study are not truly representative of the

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92 At-a-Glance Comparison: Tribal Child Care and Development Find (CCDF) and Alaska Native/American Indian Head Start (http://www.hsnrc.org/AIAN/Workshops/Showcasing%20Quality%20Tribal%20Head%20Start-Child%20Care%20Collaborations/Hardy,%20Grace_Showcase%20Fast%20Friends!_Handout1_Sat_IV_6.pdf)

93 Tribal Child Care Technical Assistance Center (TriTAC) Effective Program Strategies: Child Care/Head Start, White Mountain Apache Tribe (http://nccic.org/tribal/effective/whitemountain/hgcc.html).
reservation community as a whole (see Table 7). This sample is, for example, older and more highly educated, with employment rates that exceed those reported by the Census Bureau, all differences that make sense given the research topic. It is also predominantly (93 percent) female, which is unsurprising given the relatively gendered nature of caregiving in Apache society. I believe, however, that these interviewees are overall representative of the reservation population to which the research speaks – those who are involved the care of children five and under.

Table 7: Comparison – Interviewees vs. Total Fort Apache Reservation Population

<table>
<thead>
<tr>
<th></th>
<th>Interviewees</th>
<th>Reservation Population (2000 census data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Attainment (HS diploma/GED)</td>
<td>71%</td>
<td>50%</td>
</tr>
<tr>
<td>Employment Rate Total</td>
<td>60%</td>
<td>36%</td>
</tr>
<tr>
<td>Employment Rate Female</td>
<td>60%</td>
<td>34%</td>
</tr>
<tr>
<td>Income Total Earnings</td>
<td>76%</td>
<td>75%</td>
</tr>
<tr>
<td>Income Public assistance</td>
<td>13%</td>
<td>22%</td>
</tr>
<tr>
<td>Currently Married</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Household Size</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

The interviewees ranged in age from 16 to 69, with a median age of 30. Forty-two percent identified themselves as currently married, and another 18 percent noted that they were with a long-term partner. Twenty percent were single, 15 percent either separated or divorced, and five percent widowed. Two out of three reported that they currently resided with a partner or spouse.

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94 Census 2000 AIANSF, Tables DP-1, DP-2, and DP-3, Fort Apache Reservation (Apache alone or in any combination).
95 The Census Bureau reports average household size. The statistic reported here for the interviewees, however, is the median due to an outlier that was skewing the mean (one household had 25 members; the second largest household in the sample had 12).
As noted in Chapter 1, interviewing was confined to communities in the central and northern areas of the reservation, primarily Whiteriver and its surrounding communities, and Hon-Dah and McNary. Approximately 45 percent of interviewees lived in Whiteriver or communities to its north, such as Jurassic Park, Cradleboard, or North Fork. An equal number were from communities to the south of Whiteriver, including East Fork, Seven Mile, Fort Apache, and Canyon Day. The remaining 10 percent were from Hon-Dah and McNary. The vast majority of the interviewees (93 percent) were raised on the reservation. However, two out of three also reported that they had spent some time off the reservation during their lives; several in fact mentioned that they had attended off-reservation boarding schools, most commonly Sherman Indian School in Riverside, California.\textsuperscript{96} In most cases, their time off the reservation amounted to only a year or two, but a few had spent the majority of their lives off the reservation.

<table>
<thead>
<tr>
<th>Table 8: Comparative Interviewee Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Caregivers</strong></td>
</tr>
<tr>
<td>Median Age (Range)</td>
</tr>
<tr>
<td>25 (16-40)</td>
</tr>
<tr>
<td>High School Diploma or GED</td>
</tr>
<tr>
<td>71%</td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>65%</td>
</tr>
<tr>
<td><strong>Supplemental Caregivers</strong></td>
</tr>
<tr>
<td>Median Age (Range)</td>
</tr>
<tr>
<td>58 (24-68)</td>
</tr>
<tr>
<td>High School Diploma or GED</td>
</tr>
<tr>
<td>67%</td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>40%</td>
</tr>
<tr>
<td><strong>Surrogate Caregivers</strong></td>
</tr>
<tr>
<td>Median Age (Range)</td>
</tr>
<tr>
<td>44 (27-62)</td>
</tr>
<tr>
<td>High School Diploma or GED</td>
</tr>
<tr>
<td>78%</td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>61%</td>
</tr>
</tbody>
</table>

Overall, the educational level and employment rates of the interviewees were relatively high, although there were some inter-group differences noted in Table 8 that will be discussed in the subsections below. Fifty-six percent of interviewees had

\textsuperscript{96} I did not specifically ask interviewees if they had attended off-reservation boarding schools, though several volunteered this information when asked whether they had ever lived off the reservation. In their interviews with Apache parents in the mid-1990s, however, Joe and Miller (1998) found that anywhere from 33 to 45 percent of their sample had spent an average of 2.3 to 3.7 years at off-reservation boarding schools.
achieved a high school diploma, and an additional 15 percent had received a GED. One in three had gone on to pursue some form of postsecondary education – either college or vocational/trade school – although very few had received a degree. At the time of the interview, 60 percent of the interviewees were employed or in school full-time; 76 percent of spouses/partners were employed as well. It is my belief that the focus on supplemental caregiving (child care, in essence) is at least partially responsible for the high employment rate found in the sample. Given that the most frequently expressed need for child care is employment, it is to be expected that this sample has higher than average employment rates.

The various churches and religious sects found on the reservation were also well represented in this sample. Approximately 33 percent self-identified as Protestant (most frequently Lutheran), 20 percent as Pentecostal, 11 percent as Catholic, and five percent as Mormon. Slightly more than 30 percent did not align themselves with any religion. Just under half reported participating in traditional ceremonies. While this varied to some extent by age – older Apaches were somewhat more likely than younger ones to participate in traditional ceremonies – the most significant differences were by religion. All of the Catholics, for example, noted that they at least occasionally participated in traditional ceremonies, while almost none of those who identified as Pentecostal did, findings that mesh well with the Apache Children’s Potential Project data we collected in the mid-1990s (Sparks 1997). Participation in traditional ceremonies was more mixed among both Protestants and those reporting no religious affiliation.

While interviews were generally conducted with individual parents and caregivers, my interests focused more broadly on their households and families. All of
those interviewed were part of family households; 65 percent lived in extended family households, and 35 percent in nuclear households. These households ranged in size from two to 25, with a median of five. They included anywhere from one to 10 adults, with a median of three, and zero to 14 children, with a median of two and a half. These statistics on household size were very consistent across the different categories of caregivers. Just under 30 percent of the households were female-headed.

Most of the interviewees lived in reservation HUD housing. All were of the same general design; single-story houses with anywhere from two to four bedrooms, with an unfenced yard and a clothesline in the back. The majority are wood heated. Approximately two-thirds of the housing units on the reservation are owner-occupied, and the remaining third are rented.97 The majority of interviewees’ houses were clean and well-kept, although a few were obviously in need of repair. A few individuals lived in significantly older (non-HUD) houses or trailers that were in pretty bad condition; one, for example, had broken windows and gaping holes in the floor, and a non-functional refrigerator. While I did not specifically ask interviewees about housing costs, Census 2000 data shows these to be relatively low; only around three out of every five houses has a mortgage or rent payment, and the median payment is under $300 per month.98

Three out of four households had earnings from employment. The vast majority of interviewees and their spouses/partners were tribal employees, working in a range of positions in tribal government and tribally run programs. Indian Health Service and the school district were also common employers. While some individuals were in professional positions, most were salaried workers. One in three worked in either

97 Census 2000 AIANSF, Table DP-4, Fort Apache Reservation (Apache alone or in any combination).
98 Ibid.
education, health, and social services, the most common industries reported by the Census Bureau as well. Entertainment and recreation, forestry and timber, and construction were other popular industries, although each accounted for less than 15 percent of reported jobs.

Interviewees reported total household incomes ranging from $205 per month to $4,500 per month, with a median of approximately $1,700 per month. For a number of reasons, however, I question the reliability of many of these estimates. In many cases, the person with whom I was speaking was not the head of household and did not have a good sense of the household’s finances. Some could report their own and/or their husband/partner’s income, but had no sense of other household members’ income. Others could provide an estimate of the household’s income after deductions (such as taxes, housing payments, insurance, etc.), but did not know the gross income. Hence, reported income figures were not always accurate or comparable. Based on the interviewees’ estimates, however, just over 50 percent of their households fell below the federal poverty thresholds for 2002, the year the majority of the interviews were conducted. Another 41 percent fell below 200 percent of the federal poverty thresholds for that year. Only eight percent were above 200 percent of the poverty thresholds.

One out of four reported some other form of income, either from public assistance, social security, SSI, retirement, or child support. Public assistance also seemed to be a source of confusion; few seemed familiar with TANF, instead speaking of the obsolete AFDC program. In addition, interviewees were not asked about GA, hence public assistance may be underreported. More than half reported receipt,

\[99\] \url{http://www.census.gov/hhes/poverty/threshld/thresh02.html}.
however, of non-monetary forms of assistance: 53 percent of interviewees reported receiving WIC, and 36 percent were either enrolled in the food stamp or commodity food programs.

Primary Caregivers

The primary caregivers I interviewed (31 mothers and 3 fathers) ranged in age from 16 to 40, with a median age of 25. Slightly more than 70 percent had earned either a high school diploma or GED. At the time of the interview, 65 percent of the interviewees were employed. Three-quarters had a spouse/partner in the household, and 71 percent of these were currently employed. Seventy-six percent of these households received at least some of their household income from employment, but an equal number also received some form of assistance. The median household monthly income for all the primary caregivers collectively was around $1,600.

The interviewees had from one to five children at the time of the interview, with a median of two. Many of the mothers in my sample had started their families quite early; they were anywhere from 15 to 35 when they gave birth to their first child (the median age was 18). Sixty-eight percent had been under 20 when their first child was born; 39 percent had been under 18. It is interesting to note that the “oldest” first-time mother among the interviewees had not been raised on the reservation; while a tribally-enrolled member, she had spent most of her life in a large urban Western city. The second-oldest first-time mother had been only 27 at the birth of her first child.

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100 Here, I am including all forms of assistance, monetary or non-monetary, including public assistance, WIC, food stamps, and commodity foods.
All primary caregivers reported that either they or their husbands/partners (or both) had family “nearby.” Sixty-five percent of these families could be considered “matrilocal,” meaning that they reside in close proximity to the maternal grandparents (or their equivalent).\(^{101}\) In addition, 53 percent of the primary caregivers lived in extended family households, almost all of which were multi-generational (e.g., child, parent(s), grandparent(s)). In many cases, however, neither the interviewee nor their husband/partner was head of household. Thirty-nine percent of the primary caregivers were part of a subfamily within a household headed by an older relative, generally a parent or grandparent. While many of these subfamilies included both parents, half consisted of only the mother and her child(ren).

Table 9: Significant Differences between Those Using and Those not Using Supplemental Caregivers

<table>
<thead>
<tr>
<th></th>
<th>High School Diploma or GED</th>
<th>Employed Mother</th>
<th>Matrilocal Help with Child Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using Supplemental Caregivers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Using Supplemental Caregivers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were several notable differences between those families who were, and those who were not, using kith and kin caregivers that I want to emphasize (see Table 9). Interviewees utilizing supplemental care were, for example, more than twice as likely to have earned a high school diploma or GED. There were significant differences in

\(^{101}\) I am using a slightly modified/updated construction of matrilocal here. I consider a family to be matrilocal if, by their own definition, they live close to one or both of the wife/mother’s parents (or whoever raised her). They do not necessarily have to be living in the same house (or “compound” as was true historically), but they generally are within walking or short driving distance. Comparable data is not available on patrilocality, due to the fact that most of the interviewees were not men.
employment rates as well. While fathers in those families using supplemental care were only slightly more likely to be employed than fathers in families not utilizing supplemental caregivers (78% vs. 63%), the mothers were substantially more likely to be employed outside the home (82% vs. 0%). Similarly, in 77 percent of families using supplemental care, all parents in the family\textsuperscript{102} were employed; this was not the case for any of the families who were not using supplemental care. Correspondingly, those not using supplemental caregivers had a median monthly household income approximately $300 below that of those using supplemental caregivers.

<table>
<thead>
<tr>
<th>Table 10: Relationship of Caregiver to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Relative</td>
</tr>
<tr>
<td>Supplemental Caregivers</td>
</tr>
<tr>
<td>Surrogate Caregivers</td>
</tr>
</tbody>
</table>

These differences in employment rates could account for the differential utilization of supplemental care. It could be argued that those not using supplemental caregivers simply did not need them – the mothers, and in some cases the fathers, were not employed and hence able to stay home full-time and take care of their children themselves. In contrast, many of the women utilizing supplemental caregivers were employed outside the home, and many had spouses or partners who were also employed. Most had little choice but to find someone to provide child care to accommodate their work schedules.

\textsuperscript{102} Hence, in two parent families where both parents reside in the same household, both parents are employed. In single-parent families, that (one) parent is employed.
However, it is also possible that those who were not using supplemental caregivers had not sought employment because they did not have ready access to caregivers. Those using supplemental caregivers were more likely to live in close proximity to the mothers’ family, a significant difference given the predominance of maternal kin among supplemental caregivers (see Table 10). Additionally, while 82 percent of those who used supplemental caregivers noted that they had family members living nearby (maternal or paternal) who helped them with child care, this was true of only 50 percent of those not using supplemental caregivers (another 18 percent and 42 percent, respectively, noted that they had family who would sometimes help with child care). However, those not utilizing supplemental care were more likely to live in a multigenerational household (58 versus 45 percent), a circumstance which would be expected to provide them with easier access to supplemental caregivers. Most likely, the direction of causality varies. Low educational attainment may result in fewer employment prospects and hence less need for supplemental care. In other cases, however, a lack of available caregivers – or access to dependable, trustworthy caregivers – may force individuals to drop out of the labor force.

**Supplemental Caregivers**

The 15 supplemental caregivers ranged in age from 24 to 68, with a median age of 58. All except for one were women. While slightly more than half of these caregivers were married, seven of these women were single head of household. Approximately half provided child care to only one child, while the other half cared for anywhere from two to five children. More than three-quarters were maternal relatives of the children in
their care, and 60 percent were the child’s grandmother. Almost half were maternal grandmothers.

As demonstrated in Table 8, the supplemental caregivers I interviewed had significantly lower rates of employment than interviewees in the other categories. However, since individuals employed outside the home would be less likely to be available to fill a caregiving role, this difference is to be expected. Only two of the supplemental caregivers I interviewed, in fact, were employed outside the home. Two others, however, brought in income by providing child care professionally, and another baked cornbread and sold it out of her home. Some other caregivers received some informal income in exchange for the provision of caregiving. While in a few cases this made a significant contribution to the household’s monthly income, generally – as will be discussed in Chapter 5 – such compensation was often rather negligible.

Most of these families depended upon the income of other adults in the household. Four of these caregivers had spouses who were employed (several other spouses were retired). In addition, two-thirds of these households included other adults, generally the interviewees’ grown children, many of whom contributed financially. As a result, approximately 70 percent of these households received at least some income from employment. The balance depended on income from retirement, social security, or SSI, and assistance from kin, generally their children. A quarter also received some form of non-monetary assistance. Overall, the median monthly household income for these caregivers was around $1850, approximately 15 percent higher than the figure calculated for primary caregivers.
Surrogate Caregivers

The 18 surrogate caregivers I spoke with ranged in age from 27 to 62, with a median age of 44. As with the supplemental caregivers, all except for one were female. Half were married at the time of the interview and another resided with a long-term partner; three others considered themselves single, four were separated or divorced, one was widowed. Three-quarters were high school graduates or had completed their GED, and just under half were employed outside the home.

While most of these individuals (72 percent) served as a surrogate caregiver to only one child, three had two children in their care, and two were surrogate caregivers to three children. Most of these individuals were either grandmothers (50 percent) or aunts (28 percent) of the children in their care; approximately a third were paternal relatives, and two-thirds were maternal relatives. Almost 40 percent were the maternal grandparent of the child(ren) in their care (see Table 10). Almost all of these caregivers were mothers themselves, and approximately one-third still had young children of their own in their household. In addition, half were also serving as supplemental caregivers to anywhere from one to five other children.

There were a number of significant differences between those surrogates who also functioned as supplemental caregivers, and those who did not. To begin with, those who also served as supplemental caregivers were significantly older than those who were only serving as surrogates (these groups had median ages of 58 and 42, respectively). These individuals were also significantly less likely to be employed outside the home – only one of the nine who served in both roles worked outside the home, whereas 78 percent of those serving as surrogates only did. Similarly, while 78
percent of surrogate households reported at least some employment income, those serving in both roles were slightly less likely to report any household earnings. (The median income did not, however, vary significantly between these two groups.) Those serving in both roles were also somewhat less likely to receive assistance.

As discussed in the previous section, the difference in employment rates can be explained by the nature and demands of the supplemental caregiving role. The variability in receipt of assistance is potentially attributable to the nature of the surrogate arrangements. Surrogate caregivers who have had children placed with them through social services are eligible for a variety of services and assistance, although caregivers generally must be rather persistent to access these resources. Of those caregivers serving in a dual role, only one had had a child placed with her through social services; all of the other arrangements were “voluntary” and arranged informally within the family. In contrast, several of those serving only in the role of surrogate caregivers were caring for children that had been formally placed with them, and hence were eligible for more forms of assistance.

* * * * * *

The last 150 years have brought numerous changes to the Western Apache, including reductions in territory and confinement on reservations, a shift from a hunter-gatherer subsistence economy to a wage-based economy, and a corresponding move from a nomadic seasonal round to a sedentary lifestyle in permanent communities. With these changes, distinctions between local groups and bands have disappeared and clans diminished in importance. The extended family is still important, but individuals are less likely to live in immediate proximity to and interact daily with other members of
the matrilineal line. At the same time, the nuclear family has grown in importance although it is not fully independent economically or socially.

In spite of these changes, children on the Fort Apache Reservation today are still more likely to live in extended family households than their U.S. counterparts; they are also more likely to live in female- or grandparent-headed households. A higher percentage of children also live below the poverty line. Housing shortages, high rates of unemployment and underemployment, low median incomes, and the frequency of single motherhood all contribute to these patterns.

Caregiving in the community has similarly changed. Because of changes in economy and family structure, the extended family in general plays a less central role in the care and socialization of young children. Grandparents and other relatives do still participate in children’s lives (in numerous ways that can be integrally important to moderating the impact of poverty), but they are less likely to be integrally involved in the daily care of children. Regular caregiving today is more often in response to an explicit need on the part of the parent or child, such as maternal employment, neglect, etc. This being said, kith and kin caregiving is still the predominant form of child care, at least partially due of a dearth of other (formal) child care options on the reservation, although – as will be discussed in Chapter 4 – preferences play an important role in choice of caregivers as well.
Chapter 3

Contextualizing Caregiving: Ideology, Policy, and Child Care Practice in the U.S.

In the previous chapter, I discussed the cultural and demographic contexts, both historical and modern, within which Apache caregiving is situated and practiced. However, while an understanding of Apache culture and community certainly helps contextualize caregiving practice, it does not fully account for the forms it takes today. For this, it is necessary to examine how child care, and informal care specifically, has been ideologically constructed and framed at the national level, and how federal policies have both intentionally and unintentionally influenced and constrained caregiving options and choices.

Hence, this chapter provides an ideological and political framework for understanding the contemporary usage of kith and kin caregiving in the U.S. I start with a discussion of historical shifts in ideologies surrounding mothering and caregiving, and corresponding changes in the views, availability, and use of non-maternal care. I then move to policy, examining how policies at the national level — including those directed specifically at Native populations — have affected caregiving and mothering, specifically who cares for children, who uses what types of care, and how caregiving practices are evaluated and “good” mothering is defined. Finally, I contextualize kith and kin caregiving within the larger child care realm by presenting data on modern caregiving usage and discussing how the utilization of various types of care varies by age, employment status, income, and ethnicity.
IDEOLOGY, POLICY, AND CARE

Informal caregiving that takes place within extended family and community networks is cross-culturally a very common form of child caregiving.\(^{103}\) In certain cultures, it is the preferred – and in some cases only – form of caregiving available. However in others, such as mainstream American society, it represents only one of many options, and one that is not always viewed very positively.

Non-maternal care generally, in fact, has a storied history in the United States. While maternal care has generally been ideologically constructed as “best” for children – at least for “good” (read middle- and upper-class) mothers – views of non-maternal care have been more varied. In some periods, responsibility for children has been placed almost exclusively in the hands of the mother (Witherow 1998), and non-maternal caregiving environments correspondingly characterized as unnatural, dangerous, or lacking (Lamb and Sternberg 1992; Whaley, et al. 2002). During other periods, however, non-maternal care – at least certain types – has been viewed more positively.

As this section will demonstrate, the preferred settings and caregivers in different periods are closely related to the societal needs and ideologies of the era. At those points in history when women’s workforce participation has been discouraged, for example, the “mother care is best” ideology has generally been very powerful. When maternal employment has been necessary (e.g., during wartime) or desired (e.g., for welfare moms), non-maternal care has been framed as more beneficial and desirable.

\(^{103}\) Out of a sample of 186 societies, Barry and Paxson (1971) found that in only 46 percent were infants cared for primarily or exclusively by the mother; after infancy that proportion dropped to under 20 percent. In over 50 percent of these societies, children past infancy spent less than half of their time with their mothers and in nearly 40 percent, individuals other than the mother played an important caregiving role in infants’ lives.
Even in such periods, however, not all non-maternal care has been viewed as equivalent; care settings perceived as “growth-enhancing,” for example, or which focus on preparing children for later (educational) success are often stressed, while the value and quality of other forms, such as informal care, tend to be questioned.

It is important to emphasize, however, that while ideology influences caregiving practice, it is not determinative. Economic and workforce realities often lead to patterns of caregiving that diverge quite significantly from the dominant ideology. In addition, not all segments of the population embrace the ideological views held by the dominant culture or class. For example, while the dominant cultural model sees parental care within the context of the nuclear family as normative and devalues the involvement of the larger extended family, many ethnic minority communities have a tradition of interdependence with, and shared caregiving within, extended family networks.

**A Historical Overview of Caregiving in the U.S.**

The Western ideal of motherhood has long been represented by the classic visual image of a mother holding a child (Hochschild 1998). Historically, however, mothers have not always been expected to play a central role in the care of their children (Gathorne-Hardy 1973). In Europe during most of the seventeenth and eighteenth centuries, upper-class urban families commonly placed their newborn infants with wet nurses in the country for the first year or so of their lives (Sussman 1977). Fostering of children from weaning until five or six years of age was common as well in England into the nineteenth century. Even in cases where upper- and middle-class children remained in the household with their parents, their care was entrusted to nannies and children saw their mothers for only short periods every day (Gathorne-Hardy 1973). Even today, such
practices are common in some non-Western settings: in Hong Kong, for example, many mothers farm out care of children to "experts" until they reach school age (Martin 1997).

In colonial America, the division of family roles into breadwinning father and caregiving mother had not yet occurred; child rearing, as well as economic production, was shared by men and women. Mothers provided physical care and taught obedience and submission; fathers supervised children while working, and were responsible for their moral and religious instruction and for training their sons (Cancian and Oliker 2000). The nature of daily routines and home based work, however, left little time for the attentive, emotional caregiving that later became the essence of "good mothering" (Ryan 1983).

Mother care is best: The rise of “intensive mothering”

The end of the eighteenth century brought a change among the White bourgeoisie in Western Europe and North America; discourse and public sentiment began to create an atmosphere of obligation where women were to be mothers first and foremost, breastfeeding and providing care for their children themselves (Badinter 1981). This transformation was tied to the rise of industrialization and the subsequent encapsulation of women and children in the household (Glenn 1994) as well as the rise of social childhood and increased concern about the physical health of children (Ariès 1962; Gathorne-Hardy 1973). “Childhood came to be seen as a special and valued period of life,” and children as “innocent beings in need of prolonged protection and care.” This new construction of childhood “required a complementary conception of motherhood as a serious responsibility, one requiring total devotion” (Glenn 1994:14).
This "intensive mothering" ideology differed in two significant ways from earlier constructions – the responsibility for mothering now rested exclusively on the shoulders of the biological mother, and mothering was to constitute her primary if not sole mission during the child’s early years (Glenn 1994; MacDonald 1998). The husband, wife, and children together constituted a household (Schneider 1980), and the husband’s role of sole breadwinner complemented his wife’s role as sole caregiver. It came to be that mothers could not escape the mothering role without inviting moral condemnation, and those who challenged the dominant ideology were defined as abnormal (Badinter 1981).

**Infant schools, kindergartens, and day nurseries**

The earliest institutions of organized or “formal” child care were never intended to serve the population as a whole. They targeted primary poor, disadvantaged children – children whom it was believed were receiving less than ideal care in their own homes. The first of these came to the U.S. in the mid-1820s. Known as “infant schools,” they provided care to children that ranged in age from approximately two to four. These schools originated in urban areas of Europe, where they were designed to provide care to children whose mothers needed to work outside the home and to help children growing up in poverty (Silver 1965). Not long after appearing in the U.S., their appeal broadened: once middle-class mothers heard of the educational benefits of these schools, they demanded them for their own children. As a result, infant schools quickly spread throughout the country; by 1840, for example, approximately 13 percent of all children under four in Massachusetts were attending such schools (May and Vinovskis 1977).
Infant schools flourished for several decades, but by 1860 their popularity had declined in response to fears about the detrimental impact of early intellectual activity on children’s development (May and Vinovskis 1977). Private kindergartens were introduced in the latter part of the 19th century; in contrast to infant schools, they did not stress reading or writing, instead focusing on play activities (Ross 1976). Initially, the majority of children attending kindergartens were from middle- and upper-class families, but by the early 20th century a number of communities had integrated kindergartens into their regular public schools in an effort to make such institutions available to disadvantaged children (Allen 1988). Despite this, however, only a small number of children nationally were served by these institutions (Ross 1976).

The first true day care centers, known as day nurseries, were designed to provide all-day care for children of working mothers. They first appeared in urban areas in the middle of the 19th century, and generally were supported by parents’ fees or private benevolence (Kerr 1973; Rothman 1973). Those funded by the wealthy, however, were not necessarily established to enhance the welfare of the poor, but to protect themselves by removing children from the street and preventing them from turning to crime (Lamb and Sternberg 1992). Many day nurseries as well as kindergartens were started by settlement houses, and settlement workers often linked valuable social welfare services for mothers to these nurseries (Rothman 1973; Steinfels 1973). At their height in 1916, however, only 695 licensed day nurseries existed in the United States, and these did not even come close to meeting the existing child care needs in these early decades (Getis and Vinovskis 1992; Rothman 1973).
Government provision of child care

Following the brief popularity of the infant schools, responsibility for care and socialization was once again placed in the hands of the mother. Government policy in the early 20th century reinforced the idea that home care was best for children. Child care, rather than a public responsibility, was viewed as a private or individual concern, and in practice the federal government avoided involvement in the provision of child care (Lamb and Sternberg 1992).

The Great Depression and World War II temporarily ended this practice of government disengagement with child care. In 1933, early into the New Deal, the Federal Emergency Relief Administration (FERA) began to establish emergency nursery schools; the following year, the nursery school program was transferred to the Works Progress Administration (WPA) (Kerr 1973). Unlike former programs, the primary purpose of these nursery schools was to supply jobs for unemployed teachers, nurses, cooks, etc., not to provide child care to working mothers or educational opportunities for the children, although the WPA did emphasize the benefits these nursery schools provided to the children enrolled (Federal Works Agency 1941; Rothman 1973; Steinfels 1973). At the height of the WPA nursery school program, schools could be found in every state, in cities and small towns, with a total of 1,900 nationwide (Steinfels 1973; U.S. Advisory Committee on Education 1939). Although the government had spent almost $11 million in federal funds on this program by 1938, demand for child care always far exceeded the supply (U.S. Advisory Committee on Education 1939).

This federal commitment to funding nursery schools, however, was never intended to be permanent, and as the mobilization for World War II produced full
employment, the nursery schools were disbanded (Tank 1980 in Getis and Vinovskis 1992). The government was soon forced to recommit itself to publicly funded day care, however, by the need to encourage women to work in wartime industries while male workers were deployed (Lamb and Sternberg 1992). A 1942 amendment to the Community Facilities Act (the Lanham Act) allowed funds to be funneled to areas where a lack of child care facilities strained war production; child care centers were only established in “war impact areas” however, and they were never intended to serve all families or communities (Steiner 1976; Tank 1980 in Getis and Vinovskis 1992). A few industries also became directly involved in the provision of child care during the war, however most women involved in wartime production experienced difficulty finding suitable child care (Getis and Vinovskis 1992).

Immediately following the war, the government terminated federal funding for child care and returned to a policy of noninvolvement (Getis and Vinovskis 1992). As servicemen returned to their pre-war jobs, women were encouraged to return to the home. “Rosie the Riveter” was supplanted by the newly emerging mythology of the traditional American family, and women were subtly led back into domestic roles and responsibilities (Lamb and Sternberg 1992; Lamb, et al. 1992). A sexual division of labor once again divided the family responsibilities of mothers and fathers, and motherhood was seen as “morally and practically incompatible with labor force participation” (Vogel 1993:40). Popular propaganda reinforced this maternal role, and emphasized the “dangers” maternal employment posed to the mental development of their children (Kessler-Harris 1982; Tank 1980 in Getis and Vinovskis 1992). Indicative of the times, in Dr. Benjamin Spock’s 1957 edition of his immensely popular and influential book *Baby and Child Care*, the focus was entirely on maternal care. Only in
the last section entitled “Special Problems” were working mothers as well as non-maternal caregivers discussed (Chaudry 2002).

Because the termination of federal funding had resulted in the demise of most day care programs, those women who remained in the workforce experienced increased difficulties securing day care (Getis and Vinovskis 1992). By 1959, it is estimated that day care facilities were available for less than two and a half percent of children of working mothers (Kerr 1973); the majority of working women’s children were instead in the care of relatives, friends, or neighbors, or simply left on their own. Thus, while it is true that ideological and economic forces of the late 1940s and 1950s resulted in the majority of White middle-class children being cared for exclusively by their mothers, this was certainly not true for minority children and children from impoverished homes (Lamb, et al. 1992).

**Child care, welfare, and education**

Little change in policy occurred at the national level until the 1960s when the government showed renewed interest in child care in the context of a comprehensive program designed to reduce welfare rolls. Child care was used as an incentive to encourage low-income mothers to seek employment and move toward financial independence (Michel 1998). The Johnson administration also proposed early educational intervention with children to help break “the cycle of poverty.” The resulting program, Head Start, aimed to improve impoverished children’s chances for success by providing them with “readiness skills” that were believed to be necessary to do well in school. Originally designed as a summer-long program aimed largely at impoverished inner-city children in female-headed households, it has grown into a year-round
community-based program serving approximately three-quarters of a million children a year (Lamb, et al. 1992; U.S. Bureau of the Census 2002b). Neither of these programs, however, was ever intended to provide child care for children of employed, middle-class mothers (Lamb, et al. 1992; Michel 1998).

Broader governmental support for day care not coupled with welfare was proposed in 1971 when Congress passed day care legislation, but it was vetoed by President Nixon on the grounds that “government support for child care and day care services would represent an unwarranted and unacceptable intrusion into the area of private, family responsibility” (Lamb, et al. 1992:212). Nixon argued that “for the Federal Government to plunge headlong into supporting child development would commit the vast moral authority of the National Government to the side of communal approaches to child rearing over the family-centered approach” (Nixon 1971:46059). So pervasive was this ideology stressing family responsibility for children that government support for child care fell into a long period of decline, and successful legislation aimed at expanding child care support was not debated within Congress again for another 20 years (Lamb, et al. 1992; Michel 1998).

**Federal Policy and Caregiving Ideology since 1990**

Discussions of child care at the federal level over the last forty years have generally remained linked to issues of welfare and education. While the specifics of policy have changed over time, the broad priorities and perspectives are remarkably similar. Child care today, at least from the federal perspective, is seen primarily as a workforce issue and as a source of educational enrichment. Specifically, as Lowe and
Weisner (2001:14) discuss, the intent of child care policy and funding since the mid-
1990s has been to:

(1) increase parental engagement in wage work by reducing the costs associated
with child care, or
(2) increase children’s exposure to educationally enriching care settings such as
those ostensibly offered by center-based care settings.

The focus on child care as a workforce issue gained force in the late 1980s.
There had been increasing recognition on the part of policymakers, even dating back to
the Johnson Administration, that helping parents on welfare pay for child care was
essential to help them move from welfare to work (Holcomb, et al. 2006). With the
passage of The Family Support Act in 1988 and the Child Care Development Block
Grant in 1990, parents who were receiving welfare and were working or enrolled in
education or training programs were for the first time guaranteed child care assistance
… established the current federal role in child care. It made child care subsidies
a key element of the welfare reform agenda and created two child care
entitlements – one for welfare recipients who were required to work or attend job-
related activities, and one for a year of child care subsidies for those leaving
welfare because of increased earnings …

The second piece of legislation established the CCDF and expanded funding to provide
child care assistance to low-income families not on welfare (Holcomb, et al. 2006).
Significantly, these two pieces of legislation also mandated that parents receiving this
publicly subsidized child care assistance must have access to all legal forms of child
care, including kith and kin care (Kith & Kin Meeting 1999).

Welfare reform measures passed in 1996 – the first significant overhaul of the
welfare system in decades – had major implications for child care provision, policy, and
The aim of the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA) was to move from the prior cash entitlement program for poor families with children that dated from 1935 to a system that substituted work for welfare (Collins, et al. 2000). It consolidated AFDC, the Emergency Assistance (EA) program, and the Job Opportunities and Basic Skills Training (JOBS) program into a new single block grant program – Temporary Assistance to Needy Families (TANF) (ACF Office for Public Affairs 2004; U.S. Department of Health and Human Services 1997). In tribal communities, the former tribal JOBS programs were replaced with Native Employment Works (NEW), the purpose of which was to make work activities available to tribal communities and TANF recipients (ACF Office for Family Assistance 1998).

In essence, PRWORA turned welfare into a program of temporary assistance (ACF Office for Public Affairs 2004). Unlike prior programs, it imposed a time limit on recipients; families may receive a maximum of five years (or less at state discretion) of cash aid under TANF. In addition, all recipients must work as soon as they are job ready, or no later than two years after coming on assistance (ACF Office for Public Affairs 2004; U.S. Department of Health and Human Services 1997). Single parents must participate in work activities for at least 30 hours per week; work requirements for two parent families are somewhat higher (ACF Office for Public Affairs 2004). (It is important to note, however, that time limits do not apply to TANF recipients on reservations with unemployment rates of at least 50 percent (U.S. Department of Health and Human Services 1997).) AFDC, in contrast, had some work requirements, but mothers with children under three were exempt.
As Holcomb et al. (2006:1) note, “child care subsidies that help defray some of or all the cost of child care have consistently been an integral part of federal and state welfare reform efforts,” including the 1996 welfare reform legislation. Importantly, while PWRORA overall has increased child care funding, child care subsidies are no longer considered entitlements. Most states have continued to prioritize families on welfare and those transitioning from welfare to work, however, providing them with federal child care assistance in the form of vouchers through the CCDF program (ACF Office for Public Affairs 2004; Holcomb, et al. 2006; U.S. Department of Health and Human Services 2002).

The renewed emphasis on the role of child care settings in early learning and school readiness is a product of one of the current administration’s stated priorities. The Bush Administration’s Good Start, Grow Smart (GSGS) initiative specifically emphasizes the role of non-parental care settings in early childhood in providing children with the social, emotional, and cognitive skills they will need to be prepared to enter school. The stated goals of this initiative include (The Bush Administration 2002):

1. strengthening Head Start, primarily by increasing accountability and implementing a national training program,
2. partnering with states to improve early childhood education, and asking states to develop quality criteria for early childhood education that align pre-school with state K-12 standards, and
3. providing information to parents and early childhood teachers and caregivers highlighting early childhood education research.

One of the most significant outcomes of this initiative, however, has been to shift the focus of early care almost exclusively to education, and to lay the responsibility for school readiness at the feet of all caregivers, both informal/lay and formal/professional.
Informal care in the modern era: a question of “quality”

Child care provided by informal, or kith and kin, caregivers first began to receive attention from policymakers with the passage of The Family Support Act. It was not until the passage of PRWORA in 1996, however, that kith and kin caregiving surfaced as a major policy issue. In the wake of welfare reform and other changes in child care subsidy policies, it was anticipated that more families would be utilizing kith and kin caregivers, in many cases with the assistance of federal dollars. As Porter (1998:4) notes, “it was clear that welfare reform, and the new Temporary Assistance for Needy Families (TANF) program, would generate a tremendous need for child care as thousands of women would be required to participate in education and training or find work in order to receive assistance.” And because of the limited supply of regulated child care, it was anticipated that this new increased need for child care would be largely filled by unregulated, informal kith and kin care.104

This possibility raised a number of concerns. At the time that welfare reform legislation passed, little was known about kith and kin care, and experts and policymakers were worried about the quality of care in such settings and the safety, well-being, and emotional and intellectual development of children being cared for by untrained families, friends, and neighbors (Collins and Carlson 1998; Porter 1998; Porter 1999). Others expressed concerns that “giving legitimacy to a group of caregivers who do not, and probably never will, see themselves as professionals” might threaten the drive toward professionalism in the child care field (Collins and Carlson 1998:5) because

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104 In spite of these concerns, welfare reform did not universally lead to increases in kith and kin care utilization. For example, in 2000 more than 50 percent of children being served nationally under CCDF were in center based care settings (ACF Office for Public Affairs 2004). In some states, large numbers of families do now use subsidies for informal care arrangements, but in many other states the use of subsidies for unregulated care is low (Collins, et al. 2000; Kith & Kin Meeting 1999).
they “lack child care training, are invisible to state authorities, and work for little or no compensation” (Zinsser 2001:1). Some also worried about “the ramifications of allowing public subsidy dollars, which are scarce, but seen as vital to the stability of many centers and regulated family child care homes in low-income neighborhoods, to flow to unregulated sources of care” (Collins and Carlson 1998:5).

Underlying these concerns are two unstated – and problematic – principles. The first centers on what New (1994:73) describes as the “positivist belief that there is one best pathway of [child] development.” Rather than recognizing that there is significant cultural variability in the structuring and interpretation of children’s development (New 1994), and that “other ways of being with children may be just as effective in achieving desired outcomes” (Modigliani 2003:217), “quality” child caregiving has come to be narrowly defined. Rather than recognizing that “significant cultural differences exist in caregiving patterns and priorities throughout childhood, variations that are associated with cultural belief systems as well as environmental constraints” (New 1994:70), the practices associated with quality child caregiving reflect the values, practices, and norms of White, middle-class America (Zinsser 1991).

The second and related principle is that child care should only be provided by trained professionals in regulated settings, particularly when such care is being supported by federal dollars. As Porter (1999:27) notes, care provided by other non-professionals in other contexts is regarded with concern because it supposedly “lacks the factors that contribute to children’s development.” Particularly in the era of Good Start, Grow Smart, when quality early care has come to be equated with preparing children to succeed in school, caregiving provided by kith and kin or any other untrained
providers is being devalued and viewed with concern. In addition, the relational and nurturing aspects of early child care, those very aspects which often lead parents to select informal care settings for their young children, are being discounted and ignored.

As a consequence, in those very communities where policies such as PWRORA and GSGS are being felt the most, local normative practices are being eclipsed by and subjugated to the dominant ideological beliefs of White, middle-class America. Rarely are variations in caregiving preferences and practices between different cultures and social classes valued, or even recognized (Lamb, et al. 1992). Instead, the practices of minority and impoverished parents are being devalued and defined as deviant, with at times disturbing consequences.

**Child Caregiving and the Ideological Reproduction of the State**

Mothering – and caregiving more broadly – is highly politicized because of women’s central role in socialization. Caregiving and child rearing practices have always been of interest to the state, and hence closely surveilled, because of their tie to socialization and the vested interest the state has in the reproduction of the normative family. Women, as mothers and caregivers, are to “participate in the ideological reproduction of the state collectivity” and transmit its culture (Phoenix and Woollett 1991:17). Children are the medium through which culture and society are reproduced, and it is in the context of the family where a “child’s sense of personhood, citizenship, and sexuality [can] be subverted, perverted, or well formed” (Stoler 1995:152). When the family takes a form that is in conflict with state ideology, or when there are concerns about whether mothers are properly instilling the values and beliefs associated with the dominant ideology, the family becomes a political issue (Phoenix and Woollett 1991),
concerns about motherhood and the family are expressed, and “deviant” mothers become the object of surveillance and intervention by the state.

Twentieth century America has been dominated by an idealized view of motherhood derived from the lived experience of the White middle-class. In spite of increases in women’s – specifically mother’s – labor force participation since the middle of the century, the “mother care is best” ideology has remained strong, and mothers are still expected to be the child’s primary caregiver, at least in the early years. This ideology has so dominated the media as well as political and legal doctrine that alternative beliefs and practices have been eclipsed (Glenn 1994). It is, however, a race and class-based ideology that is at odds with the reality of the lives of many poor women, immigrant women, and women of color (Vogel 1993). Those whose beliefs and practices reflect this ideology are constructed as “good” mothers; those who do not – most often minorities and the poor – are viewed as deviating from “good” or “normal” mothering and constructed as pathological (Phoenix and Woollett 1991).

In reality, though, our society has a palpable double standard when it comes to mothering. Not all mothers are encouraged to take this on as their primary role – mother care is, in fact, viewed as best only when the mother is reproducing the dominant ideology. Hence, White, middle-class mothers are encouraged to take primary

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105 See Table 11 in section three of this chapter.
106 Amazingly, this ideology has remained powerful and intact, even in the modern era where full-time, at-home mothering is no longer the dominant practice. By artificially separating the “spiritual” and “menial” aspects of mothering and commodifying mothering tasks, mothers have maintained themselves as the primary caregiver even in cases where most of the child’s waking hours are spent in the care of a substitute caregiver (Roberts 1997). The “sitter” is constructed as someone who “fills in” for the mother, not someone who takes over care of the children – the mother still defines herself as the person who does the “primary childcare” (Cohen 1995:92). By colluding to maintain this myth of exclusive mothering, mothers and alternative caregivers have reduced the complexities of child care to mothering, effacing the contributions of other caregivers and reinforcing the belief that children in non-maternal care are deprived (Ginsburg and Rapp 1995; MacDonald 1998).
responsibility for the care of their children. Poor, immigrant, and minority mothers, in contrast, become the targets of programs which encourage or force them to use alternative care for their children from quite an early age, care which conveniently reproduces the dominant culture (Fuller, et al. 1996b).

Traces of this double standard can be found in both early education initiatives and welfare reform measures. The earliest infant schools and child care programs targeted children of the poor, and modern programs such as Head Start are no different. The intentions of these programs are good – to improve school and life outcomes for these children – but the implication, nonetheless, is that the child’s home environment is deviant, detrimental, or lacking (Trattner 1999).

Even the recent shift away from AFDC hints of this – no longer does the federal government provide direct financial support to poor mothers to enable them to support and raise their own children. Instead, for impoverished women, work is valued above caregiving. Poor mothers are encouraged (or pushed) to enter job training or find employment, and given subsidies to help them afford child care. Subsidies for such child care are presented as a workforce issue, yet the types of arrangements these women are encouraged to use are believed to provide the children with “growth-enhancing elements” that they would not receive in their home environment. Ironically, while the goal of subsidies is to provide access to “high quality” child care, the care to which many of these women actually have access may be less than desirable.

It is important to emphasize that in many minority communities, the ideologies of the White, middle-class are neither practicable nor desirable (Blum and Deussen 1996). The imposition of outside ideologies and practices may actually have the effect of
undermining long-standing adaptive cultural practices. In many Black communities, for example, models of shared mothering are preferred (Blum and Deussen 1996; Stack 1974). As Blum and Deussen (1996:206) explain,

In female-centered networks of the Black community, although motherhood is honored, the honor and responsibility for children are shared among sisters, grandmothers, and 'other-mothers' of the biological mother.

Shared parental responsibility among kin has been characteristic of African-American communities since slavery and is a response to the difficulties faced by impoverished mothers; shared caregiving ensures that children are cared for even if the biological mother does not have the resources to care for her children herself (Stack 1974; Stack and Burton 1994). Shared mothering thus serves as a check on how one assumes the parenting role; children are removed from mothers who are felt to be incompetent and raised by kin (Stack 1974).

Indigenous Nations and minority groups have fought in recent years for the recognition and respect of their own ideologies and practices, and have demanded the right to be judged by their own standards. Both African American and Native American communities have, for example, fought for the use of culturally appropriate standards in judging a family’s “fitness”; they have similarly rallied against the practice of transracial adoption, though with mixed success. While there have been some successes, other legislation and initiatives such as PWRORA and GSGS, with their embedded class- and race-specific ideologies, remind us of how far there is to go.

### THE IMPACT OF IDEOLOGY AND POLICY ON NATIVE COMMUNITIES

Well before this country became a nation, the insensitive precedent had been cast to destroy Indian culture and tribal cohesiveness by removing Indian
children from their families and tribal environments. Continuing separation of Indian children from their heritage is one of the most tragic and destructive aspects of contemporary Indian life. State intrusion into Native American parent-child relationships impedes the ability of the tribe to perpetuate itself, and, ultimately, it unjustifiably results in a coerced assimilation of the First Americans into a larger more homogenous society.107

Native peoples in this country have been subjected over the years to a number of federal policies and programs that have – directly or indirectly – affected child caregiving. While this has been in some cases unintentional, the specific intent of several of these programs has been to disrupt the ability of parents and communities to effectively parent their children and raise them in the culture, hence breaking the link for the transmission of Native culture to the next generation and eroding the cultural base. Such efforts on the part of the federal government have been variously tied to efforts to acculturate Native Americans into mainstream American society or, more drastically, completely assimilate Indians, wipe out their culture, end the federal trust responsibility,108 and free up their lands for Anglo settlement.

The two primary instruments for the forced acculturation and assimilation of Native children have been education and removal. Historically, this involved the forced attendance of children at off-reservation boarding schools and the permanent separation of children from their family, community, and culture through transracial adoption. Both effectively disrupted the intergenerational transfer of cultural knowledge, and attenuated or broke the ties to community of these Indian youth. While forced attendance at

108 The trust responsibility has been called “one of the most important’ concepts governing relations between the United States government and the Indians and ‘one of the primary cornerstones of Indian law.’” While in the early years, this simply referred to the federal government’s responsibility to act as a trustee for Indian land and other property, today its application is broader. Since the 1970s, the trust responsibility is seen as involving not only “the protection of tribal assets and the management of Indian funds and natural resources” but also the “duty to protect … [the] sovereignty of Indian tribes, so there is no further erosion of tribal sovereignty and to support tribes in their efforts to enhance tribal sovereignty’ and to provide community and social services to Indian people” (Prucha 1984:399).
boarding schools is a thing of the past, and legislation has lessened the impact of transracial adoption, tribes today still face challenges in their efforts to care for and rear their children in what for them are culturally relevant and appropriate ways.

**Compulsory Education and the Boarding School**

The idea of Indian assimilation through education has a long history. Education was first proposed in the early decades of the 19th century as a cheaper and more humane way of dealing with the Indian population and opening up Indian land for Anglo settlement. It was hoped that by not only educating, but also Christianizing and acculturating the Indian population to American life and institutions, they would gain the “knowledge and skills necessary for survival in the civilized world” (Adams 1995:21) and become productive and integrated members of American society.

The basis of American Indian education reflects Antonio Gramsci’s (1971) view that educational institutions, as an extension of the state, produce ideological consensus through cultural hegemony. The boarding school was “the institutional manifestation of the government’s determination to completely restructure the Indians’ minds and personalities” (Adams 1995:97). The intent of the federal government’s policy was to undermine the entire belief system of American Indian children, their relationships with their families, and their sense of identity; in Adams (1995:101) words, the schools facilitated “the tearing down of old selves and the building of new ones.” Emphasis was placed on teaching English as well as practical skills and trades, citizenship training, and indoctrinating the children in the American ideal of possessive individualism. As Adams (1995:22) notes, it was desired that Indians “come to respect the importance of private
property, … internalize the ideal of self-reliance, and … realize that the accumulation of personal wealth is a moral obligation.”

Starting in the mid-19th century, day schools were established to pursue these goals in or near a number of reservation communities, and by the 1860s there were 48 such schools in existence. It was soon recognized, however, that these schools were not an effective instrument of assimilation. Their proximity to tribal communities, originally seen as an asset, was cited as the main obstacle to success. By the late 1870s, boarding schools were being touted as a better solution, since they allowed greater institutional control over children’s lives by keeping them in school (and hence away from their home communities) eight to nine months out of the year (Adams 1995).

Boarding schools were part of a larger three-pronged policy shift that was crystallized in the Dawes Act of 1887. Frustrated with the slow pace of assimilation, policymakers now favored abolishing the reservations and “letting the full blast of civilization rush in upon the Indians” (Prucha 1984:207). To this end, reservations were to be dismantled and land allotted in individual assignments to Indian families. Boarding schools were to be established far from the reservations, so that Indian children could be subjected to compulsory education apart from the “barbaric influences” of the Indian communities (Prucha 1984; Spicer 1962). There were also provisions for the suppression of “offensive” Indian religious ceremonies and the institution of some missionary schools on reservations (Spicer 1962).

Assimilationists argued, as Child (1998:13) notes, that “the task of ‘civilizing’ Indian children would be easier and lapses into tribal ways less likely if students stayed away from their homes and relatives until their education was complete.”
Understandably, many parents were resistant to the idea of sending their children to distant schools for much of the year. Hence, while some attendance at boarding schools was voluntary, much was coerced. Congress passed a compulsory education law in 1891, which allowed rations, annuities, and other goods to be withheld from parents who refused to send their children (Adams 1995). In other cases, children were simply “kidnapped” by officials, and stories abound of parents hiding children from tribal police and others assigned to catch them (Adams 1995; Watt 2004).

Once at school, children’s identities were erased. As Hoerig (2002:645) writes, “Children were taken away from everything and everyone they knew. They lost their clothing, their language, their beliefs, and even their names.” Upon arrival, school officials cut children’s hair and changed their dress, hence stripping away all outward signs of tribal life. Children were only allowed to speak English, and were quite frequently kept away from siblings and other relatives. Life at the boarding schools was highly regimented; half the day was spent in academic pursuits, with the other half devoted to learning a trade (for boys) or housekeeping skills (for girls). Children were also assigned daily work duties appropriate to their age (Adams 1995). Punishment was harsh and swift for infractions ranging from speaking their native language to attempting to run away (Child 1998; Hoerig 2002).

At their height in 1895, there were 157 boarding schools across the country. Soon after, however, enthusiasm in official circles for boarding schools began to wane (Adams 1995). In spite of the draconian measures instituted in an attempt to, in the

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109 Such vocational and industrial education prepared children for the “outing” program, where children were hired out to local farm families (Adams 1995). Some families were kind and humane, but others took advantage of the child’s labor, actions which further sowed the seeds of mistrust toward the federal government and its policy of forced education.
infamous words of Captain Richard Pratt\textsuperscript{110} (1973:261), “kill the Indian … and save the man,” full assimilation was appearing an unattainable goal. Reservation day schools once again gained favor, yet boarding school attendance remained a common occurrence through the 1930s, in spite of a number of school closings (Child 1998; Hoxie 1984). Boarding schools in this latter period, however, moved away from an emphasis on forced assimilation in favor of letting children retain more of their cultural identity (Ranney 2002).

The impact of boarding schools

The very aspect of boarding schools deemed critical to their success – their ability to separate children from their families, their lives, their cultures – was also the aspect ultimately most devastating to attendees and their families. As Martens, Daily, and Hodgson (1988:110) emphasize,

> The structure, cohesion, and quality of family life suffered. Parenting skills diminished as succeeding generations became more and more institutionalized and experienced little nurturing. Low self-esteem and self-concept problems arose as children were taught that their own culture was inferior and uncivilized, even ‘savage’.

Such problems were especially acute for those who spent most of their childhoods at boarding schools. Such children, as one boarding school attendee noted, basically grew up on their own. They spent little of the year in the care of their parents, and “the type of parenting or care the school[s] gave was inadequate” (Ing 1991:91). Being separated from any sort of nurturing and parenting role model, attendees not only

\textsuperscript{110} Captain Pratt was the founder of the Carlisle Indian School, established in 1879 as the first all Indian boarding school (Adams 1995).
suffered themselves, they were also left ill-equipped to parent their own children
(McKenzie and Hudson 1985).

Many attendees also felt alienated from their communities and cultures after
many years away. Some completely lost – or were afraid to speak – their languages,
leaving them unable to communicate with family and community members. Ties to
family and community were seriously attenuated, undermining the role of extended
family and kinship networks and threatening the “passing down” process of knowledge
and traditions, and hence cultural continuity (Ing 1991; Medicine 1987). As Barker
(1997:64) notes, “the boarding school robbed generations of Indian children of the
stories of their families and tribes, stories that would have otherwise empowered them
with knowledge, wisdom, survival skills, and a spiritual foundation.”

One important but sad legacy of the boarding schools has thus been to
irrevocably alter the child rearing experience in some Native communities. Many
boarding school attendees as adults were left with neither good parenting skills nor a
strong grounding in their culture, and disconnected from the intricate network of relatives
who could be depended on to help bridge this gap and ease the hardships of parenting.
For many, parenting became a solitary rather than a community endeavor. Ultimately,
these losses of the boarding school attendees became losses for their communities and
their children as well. As Ing (1991:95) emphasizes, many attendees did not pass their
culture or language on to their children because they either lost it themselves or
because, as one commented, “I felt I had nothing substantial to pass on to my children.”
The Apache experience

Little study has been made on the specific impacts of boarding schools in Western Apache communities. Although anecdotal, some of the best insights into the Apache experience come from the recently published life and family stories of White Mountain Apache elder Eva Tulene Watt (2004). Three generations of Eva’s family attended a number of boarding and government schools over a period of more than sixty years, from the late-1800s through the 1960s.

With the exception of Eva’s mother, who attended Carlisle Indian School for one year, all of the boarding schools attended by members of Eva’s family were within Arizona, and most were in the immediate vicinity of either the Fort Apache or San Carlos Apache Reservations. Attendance in the early years was coerced, but the very fact that children were attending boarding schools not too distant from their communities makes their experience different from many other Indian communities. Even though children were not allowed to return home during the school year, their families were close enough, as described in Watt’s (2004) book, to be called in for occasional meetings and sneak food to their children.  

In spite of their proximity, these local schools were no better than their more distant and better known counterparts. Eva’s mother, in fact, recalled the conditions and treatment at Carlisle as better than local boarding schools.  

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111 The proximity of the families to the schools is well illustrated in a story Eva relates about her eldest brother; one time after dislocating his arm at Rice while taming some wild horses, he snuck back to the family camp for a few hours to have his father look at his arm and eat (Watt 2004).

112 Both Eva’s mother and older brothers recalled never getting enough to eat and the use of whipping. Eva’s older brothers also described the use of chili pepper in children’s mouths as punishment for speaking Apache at the boarding school they attended in Rice (Watt 2004).
Carlos, commenting that “lots of children suffered there” (Watt 2004:34). Eva, although she never attended the school at Rice herself, described it as “a crushing experience in all respects” (Watt 2004:312).

Eva’s own experiences with boarding school\footnote{Eva and all but her two eldest siblings attended St. John’s Indian School, a Franciscan facility southwest of Phoenix. Although some of her brothers started school at a younger age, Eva was around 11 before she first went, and she only attended for four years before leaving to help out her mother who was suffering from trachoma. Eva noted that she generally enjoyed her boarding school experience, noting that there was always something to do, and went on to send her own children to the same school decades later (Watt 2004).} in the late-1920s were not nearly as negative, although it is unclear whether this is to be attributed to the era or the school. Yet, while children were overall treated better, efforts at assimilation persisted. Children were given new clothes and Western names upon arrival, and were required to speak English. They were, however, encouraged to return home every summer (Watt 2004). In contrast to the experiences of many boarding school attendees across the country (e.g., see Child 1998), Eva found it easy to settle back into her family, culture, and community after leaving school. It is quite possible, however, that the experiences of other Apache children who either attended boarding school longer or started at an earlier age were significantly different.

**Transracial Adoption and Placement Programs**

While forced attendance at distant boarding schools was, by mid-century, a thing of the past, Indian children were still being forcibly removed from their families with frightening frequency. In these cases, the reason was generally the inappropriate application of “good” mothering standards developed outside the community and modeled on the practices of the White, middle-class. In the late 1970s, Mr. Calvin Isaac,
then Tribal Chief of the Mississippi Band of Chocktaw Indians, testified as to the severity of this problem (Subcommittee on Indian Affairs 1978:191-2):

One of the most serious failings of the present system is that Indian children are removed from the custody of their natural parents by nontribal government authorities who have no basis for intelligently evaluating the cultural and social premises underlying Indian home life and childrearing. Many of the individuals who decide the fate of our children are at best ignorant of our cultural values, and at worst contemptful of the Indian way and convinced that removal, usually to a non-Indian household or institution, can only benefit the Indian child.

Very few children were removed from their families on the grounds of physical abuse; ninety-nine percent were argued on such vague grounds as “neglect” or “social deprivation” and on allegations of the emotional damage the children were subjected to while living with their biological parents. Indian communities were often shocked to find that parents they saw as excellent caregivers had been judged unfit by non-Indian social workers (Subcommittee on Indian Affairs 1974).

Often Indian children were removed from their homes due to a lack of understanding of Indian culture on the part of the social workers and the (mis)use of White, middle-class values to judge the fitness of Indian families. Non-Indian social workers also tended to impose their own norms in such areas as discipline, punishment, and supervision, and utilize theories of child abuse and neglect which were developed outside the Indian community (Atwood 1994; Myers 1981). They did not understand the concept of the extended family network, nor its cooperative role in the rearing of children, and thus were often too quick to accuse parents of neglect for leaving their children in the care of other, perhaps distant, family members114 (Cross 1986).

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114 Smith (1988) recounts the story of Jeanette EagleShield, who lost her six month old baby to such ignorance. While she was at the Mayo Clinic caring for a son who was dying of leukemia, she farmed out her other children to relatives. The social worker handling her case, without ever bothering to find out why
As a consequence of the removal of Indian children from their families on questionable grounds, there were in 1957 almost 1,000 Indian children living in foster homes and institutions who were supposedly “available for adoption” (Howard 1984). In response to this, the BIA, in conjunction with the Child Welfare League of America, started the Indian Adoption Project. Arnold Lyslo (1963:231, 235), the director of this project, felt that “the Indian child in need of adoption had remained the ‘forgotten child,’ left unloved and uncared for on the reservation without a home or parents of his own.” He saw the adoption project as putting “a new emphasis upon early permanent planning for Indian children.” The program targeted children on 14 reservations in six states115 of at least one-quarter Indian blood.

The goal of this program, which lasted from 1958 through 1967, was to promote the transracial adoption of Indian children. Nearly 400 Indian children, approximately fifty percent of which were under the age of one, were adopted into non-Indian families. These early placements were geographically far removed from the reservations; later ones were more often in the child’s home state, but still far removed culturally. In 1967, this program was succeeded by the Child Welfare League of America’s Adoption Resource Exchange of North America (ARENA). By 1972, this program had placed an additional 255 Indian children (Howard 1984). Once adopted, these children became completely assimilated legally and culturally; the birth and adoption records of these children were sealed, the children were deleted from tribal roles, and the BIA’s fiscal responsibility for these children ended (Fanshel 1972; Locust 1994).

she was at the Mayo clinic, sent her a letter threatening to remove her children because she had “abandoned” them. In another case, children were removed when social workers found them living in a traditional one-room hogan without running water.

By the early 1970s, approximately 25 to 35 percent of all Indian children were being separated from their families and placed in foster homes, adoptive homes, or institutions (Byler 1977). These statistics do not include the not insignificant number of Indian children who participated in “educational” placement programs, and were hence away from their families and communities for the majority of the year. The largest of these was run by the Church of Jesus Christ of Latter-Day Saints; the children spent the school year with a Mormon family and the summers at home. By 1978, the Mormons were placing 5,000 Indian children per year in Mormon homes. In subsequent years, however, this number dropped substantially and included only Indian children from previously converted families (Smith 1988).

**Resistance, Reclamation, and Self-Determination**

Both politically and in terms of policy, the 1960s marked the beginning of a period of significant change for Native peoples in the U.S. The assimilationist doctrine was losing power and, because of White guilt over past injustices, support for Indian claims was becoming more widespread. The Kennedy administration brought about a significant reorientation in U.S. Indian policy, based on the idea that “plans and progress for Indians must be the work of the Indians themselves” (Prucha 1984:357).

This period also marked the beginning of a rise in Indian activism. Many Indians, no longer willing to accept their lot passively, were demanding attention to their needs and forcing the notice of both the government and the general public. The symbolic occupation of Alcatraz in 1969 and the more militant actions of the American Indian Movement (AIM), including the tragedy that unfolded at Wounded Knee in 1973, were widely reported and served to bring more attention and sympathy to the Indian cause.
It was Presidents Johnson and Nixon, however, who were really central in, as McNickle (1973:123) points out, “bring[ing] the condition of the Indian people to national attention” and discussions of Native concerns into the public arena. On March 6, 1968, President Johnson, in the first presidential address to Congress to ever focus on American Indian affairs, set in motion the concept of self determination as we know it today (Robbins 1989):

There can be no question that the government and the people of the United States have a responsibility to the Indians.

In our efforts to meet that responsibility, we must pledge to respect fully the dignity and uniqueness of the Indian citizen.

That means partnership – not paternalism.

We must affirm the right of the first Americans to remain Indians while exercising their rights as Americans.

We must affirm their rights to freedom of choice and self-determination.

We must seek new ways to provide federal assistance to Indians – with new emphasis on Indian self-help and with respect for Indian culture.

And we must assure the Indian people that it is our desire and intention that the special relationship between the Indian and his government grow and flourish (quoted in McNickle 1973:124).

Only slightly more than two years later, Nixon argued in his July 8th speech before Congress for implementation of a policy of self-determination (Robbins 1989):

This, then, must be the goal of any new national policy toward the Indian people: to strengthen the Indian’s sense of autonomy without threatening his sense of community. We must assure the Indian that he can assume control of his own life without being separated involuntarily from the tribal group. And we must make it clear that Indians can become independent of Federal control without being cut off from Federal concern and Federal support (Nixon 1970:564).

This momentum towards self-determination was evident in specific policy shifts as well. Regulations published by the BIA in 1974, for example, guaranteed Native children for the first time the right to freedom of religion and culture, the right to freedom
of speech and expression, and the right to freedom from discrimination, a marked shift away from the policies and aims of education in the boarding school era (Prucha 1984).

While nearly every act or set of regulations in this period reflected the philosophy of self-determination, it was with two pieces of legislation in the mid-1970s that self-determination became firmly codified in law.

Public Law 93-638, the Indian Self-Determination and Education Assistance Act, was passed by Congress in 1975. As stated in the preamble (quoted in Prucha 1984:380), this law recognized the obligation of the United States to respect

... the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of education as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities.

Specifically, it allowed, through a process today referred to as “638-contracting,” for tribes to take over from the Federal government the implementation and administration of programs, using the funds that the federal government would have used to operate the program. The Indian Health Care Improvement Act, passed the following year, similarly encouraged and enabled tribes to take over their own health care programs, hence doing for health care what P.L. 93-638 had done for education and other federal Indian programs (Prucha 1984).

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116 It is important to recognize, however, as Esber (1992:213, emphasis in original) points out, that “the meaning of self-determination in Indian affairs is not as clear as the phrase implies. By its title, the policy suggests local community control over decision making; thus, central to its implementation must be the power to make decisions. A common assumption is that Indian communities now have that power. This control, however, is not allowed by the Self Determination Act, nor is it congruent with the structure of federal-Indian relations. In actual practice the government executes its trust responsibility to serve the ‘best interests’ of the Indian people, however those interests are defined and for whom.”

117 Initially, this process was not very effective and contracting, while mandatory if so desired by the tribe, often did not occur. However, significant amendments to this act were passed in 1988 and 1994 which streamlined the process and removed some administrative and practical barriers to contracting.
As Prucha (1984:378) writes, however, “nothing touched Indian self-determination more deeply than the problem of child custody and maintenance of Indian family life.” Reflecting the changes of the era, ARENA was abandoned in 1972 due to growing criticism of the placement of Indian children with non-Indian families. The following year, the BIA contracted with the Jewish Family and Children’s Services of Phoenix (JFCS) to create the Indian Child Welfare Program (ICW), which specifically recruited Indian adoptive families for Indian children. For the first time, adoption policy (under ICW) reflected the Indian community’s philosophy that considered the child “to be part of the community resources belonging not only to the nuclear family, but also to the extended family, community, and tribe” (Goodluck and Short 1980:473)

**The Indian Child Welfare Act**

While the philosophy of the federal government toward child welfare and child custody in Indian country was shifting in the early 1970s, the fact remained that Indian children were still being removed from their homes on questionable grounds by non-tribal agencies. Most of those deciding the fate of Indian families and their children were from outside the culture and hence unfamiliar with the cultural norms in tribal communities. Hence, it was recognized that legislation was necessary to re-establish tribal authority over the adoption of Native American children and set standards for the removal and placement of Indian children from their homes.

In passing the Indian Child Welfare Act (ICWA) of 1978, Congress was acknowledging “that Indian children are the most vital component to the continued
existence of tribes and that as (quasi-)sovereign nations, tribes occupy a unique legal niche. Testimony leading up to the passage of ICWA emphasized the importance of early socialization, noting that “culturally, the chances of Indian survival are significantly reduced if our children, the only real means for the transmission of the tribal heritage, are to be raised in non-Indian homes and denied exposure to the ways of their People” (Subcommittee on Indian Affairs 1978:193).

ICWA attempted to preserve the Indian community by preventing the separation of Indian children from their families in unwarranted cases and retaining children requiring substitute care within the community (Curry 1994). Specifically, the Act:

- Reaffirmed tribal jurisdiction over child welfare matters involving Indian children living on the reservation;
- Reestablished tribal authority to accept or reject jurisdiction over Indian children living off the reservation;
- Required state courts and public welfare agencies to follow specific procedural, evidentiary, and other requirements when considering substitute care placement or termination of parental rights for children;
- Specified that, in making substitute care and adoptive placements of children, public agencies are to give preference to members of the child’s extended family or tribe and other Indian families;
- Provided for intergovernmental agreements (638 contracting) for child care services; and
- Authorized grants for comprehensive child and family service programs operated by tribes and off-reservation Indian organizations.

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119 Tribes technically enjoy sovereign status and maintain nation-to-nation relations with the federal government, but in reality their sovereignty is limited by the plenary power of Congress. As such, tribes are more accurately described as “quasi-sovereign nations” or “domestic dependent nations.”
120 The National Association of Black Social Workers also took a vehement stand against transracial adoption in the early 1970s, but these objections were never translated into law. This difference has been attributed by some to the different status of African-Americans and Native Americans in the U.S. — the former being a minority group, and the later sovereign (or domestic dependent) nations.
Significantly, ICWA affirmed the right of the tribe – separate and independent of any parental right – to Indian children. Native children, consequently, occupy a unique legal space which serves to protect their connection to their community and their cultural heritage. Not only is it in the best interest of the tribe that children be kept within the tribal community, it is viewed as being in the best interest of the children that their relationship to their tribe and culture be protected.\textsuperscript{121}

While the passage of ICWA was certainly an important step toward protecting Indian children and their ties to their families and tribes, it has not been perfect. There have been problems with implementation, largely due to inadequate training for staff of social service agencies in the requirements of the Act, as well as noncompliance, and a lack of qualified adoptive and foster homes. Amendments to this Act designed to address these and other issues were passed in 1997.

\textbf{The impact of welfare (and other) reforms in Indian country}

The philosophy of self-determination has also been evident in more recent federal legislation, such as welfare reform. PWRORA offered tribes the choice of whether to operate their own TANF programs or to participate in TANF programs offered by the state. Significantly, this was the first time that federal legislation granted tribes the authority to not only administer but design their own TANF programs (Brown, et al. 2001). It also offered tribes greater flexibility than states by allowing them to define their own service area and service population, set their own eligibility standards, determine their own definitions of “work” that will meet TANF work requirements, set their own work

participation rates and time limits for assistance, and set their own penalties for noncompliance (ACF Administration for Native Americans 1999; Brown, et al. 2001).

While the government has framed this legislation as “represent[ing] a major step forward in Tribal self-governance” (ACF Office for Family Assistance 1999), the progress is in many ways more symbolic than substantive. Brown, et al. (2001) note, for example, that the majority of the American Indian TANF population is served by state, not tribal, programs. By October 2001, only 34 tribal entities (representing approximately 170 tribes in 15 states) were running their own TANF programs. This low participation rate by tribes has largely been due to insufficient funding, both for the program itself and start-up. TANF legislation, for example, did not allocate any funds for infrastructure development or initial program implementation, hence putting tribes at a distinct disadvantage in comparison to states who have received substantial federal support for infrastructure buildup over the past 60 years under AFDC\textsuperscript{122} (Brown, et al. 2001).

In addition, while tribes are allowed some flexibility in designing their programs, they are not exempt from the central purposes and aims of TANF (Pandey, et al. 1999), nor are they sheltered from the ideological underpinnings of the legislation. TANF, for example, emphasizes individual personal responsibility, and ignores the characteristics and needs of the extended family or larger group. It is insensitive to cultural variation and the importance of informal economies to survival in tribal communities, and is hence incompatible with the cultural and economic realities of reservation life. As such, PWRORA represents yet another instance of federal legislation imposing the ideology

\textsuperscript{122} Brown, et al. (2001) note, for example, that the Navajo Nation has spent $1.5 million of its own scarce tribal government resources on the development and implementation of its tribal TANF program. Most tribes simply do not have significant amounts of money available to spend on getting their own TANF programs up and running.
and norms of the U.S. onto tribal groups; consequently, it is interpreted by many, including Pickering (2000:149), as “the latest in a line of recurring policies promoting cultural assimilation as the hidden solution to poverty.”

In some ways, PWRORA is for tribes the quintessential wolf in sheep’s clothing. Under the cloak of self-determination, tribes are encouraged – and are often eager – to assume the development and administration of their own TANF programs. However, by appropriating government welfare policy and “buying into” TANF, tribal governments are becoming unwitting participants in the undermining of their own traditional economies and cultural values. Ultimately, as Pickering (2001:38) argues, this is leading to the erosion of sovereignty.

The hard-won right of tribal self-determination is now encumbered with the federally dictated purposes of TANF, imposing such culturally restricted notions as marriage, the nuclear family, and the commodification of child care onto culturally distinct communities. Unstated within the purposes of TANF is the shift in power toward the corporate and political entities controlling capital and job creations that are external to the legal, political, and economic concerns of tribal communities. In this regard, TANF may be viewed as the next step in the suppression of American Indian political sovereignty and cultural integrity.

TANF regulations are also – by valuing work above mothering – effectively imposing a different standard of mothering on (impoverished) Native mothers, one significantly at odds with traditional patterns of caregiving. Whereas mothering in Native cultures is a highly valued endeavor, and extended family and community networks can be expected to step in to assist young mothers in need, one of the “most fundamental cultural premise[s] of TANF is that children should be raised in institutional settings by strangers, and that the responsibility for supporting children is to be borne solely by the parents, not by the larger society” (Pickering 2000:158). In the ultimate irony, Pickering discovered on the Pine Ridge Indian Reservation, that
child care is one of the areas of community service promoted by caseworkers. The state is willing to provide money to a woman to take care of someone else’s children while it pays someone else to watch her children, but will not support her while she cares for her own children. This policy does not increase the recipient’s skills nor increase her economic well-being in any way. The only real effect is to commodify the labor involved in human child rearing and to impose the regime of labor time on yet another aspect of life.

In a similar manner, Good Start, Grow Smart is (as will be discussed more fully in Chapter 8) devaluing the traditional roles of kin – and the importance of the early years – in the cultural education of the youth, emphasizing instead the importance of the preschool years in preparing children for formal (Western) education.

There is also significant concern that a lack of attention to structural barriers will ultimately doom welfare reform on reservations to failure. The premise underlying TANF is that poverty is simply a problem of work effort; force the poor to take jobs, and the problem will be solved (Harris 1993; Zimmerman and Garkovich 1998). On many reservations, however, jobs are extremely scarce, and economic development is not emphasized under PWRORA. In communities like Pine Ridge, in fact, the majority of TANF work requirements are fulfilled through community service placements (Pickering 2000). Because of the lack of jobs, tribal members are coming to dominate the welfare rolls in a number of states as others (non-Indians) transition from welfare to work. As Brown, et al. (2001:2-3) explain in their report on the impact of welfare reform in Indian Country:

Our primary conclusion is that the combination and concentration of obstacles to welfare reform on Indian reservations means that current welfare policies are bound to fail in much of Indian Country. We are particularly concerned by the lack of attention at the policy level to economic growth in Indian Country as a welfare reform strategy. Even if the funding problems with TANF and its related training programs can be solved – itself not an easy task – and even if federal policy were to provide Indian nations with more flexibility and control over the design and implementation of reform, a sobering fact remains: without an economic growth strategy, welfare reform in Indian Country will fail. Either it will drive significant numbers of tribal citizens further into poverty as they lose
support and find no alternatives, or it will force large numbers of them to leave their homelands in search of employment, undermining tribal communities and embittering Indian peoples. Neither outcome is acceptable to Indian nations; neither outcome should be acceptable to the United States.

In Arizona, Pandey, et al. (2002) confirm, a shortage of employment opportunities in or near reservations has been one of the most significant barriers to the success of TANF programs. TANF recipients in reservation communities are also hampered by a lack of education and job experience; consequently, all reservations in the state of Arizona report waiting lists for women looking to enroll in education and work training programs. Significantly, the authors also note that transportation and child care are significant barriers to employment and participation in training programs on reservations. They found that most tribal communities in the state reported increased child care demand in the years following TANF implementation, and that in no tribal community were currently available child care services adequate to meet the existing need.

Native child care, however, is not a problem unique to Arizona. As Brown, et al. (2001) note, child care services are inadequate throughout Indian Country to meet the increased need imposed by welfare reform. In addition, many of the options that are available – such as child care centers or care offered by strangers – are often not culturally appropriate or personally acceptable. On the Rosebud Sioux Reservation, as Biolsi, et al. (2002) explain, there is strong resistance to putting children in the care of anyone other than family, a resistance born of the history of forced removal of children by the federal government, both for education and adoption. Consequently – for all these reasons – in the majority of reservation communities, the bulk of the child care need is being met by family.
MODERN PATTERNS OF CAREGIVING AND CHILD CARE UTILIZATION

As ideology and policy in the U.S. have shifted, so too has the popularity of non-maternal care and the forms of care most used and preferred. The most recent data available from the U.S. Census Bureau\textsuperscript{123} estimates that in 1997, 12.4 million (or 63 percent) of the 19.6 million children under five years of age were in some form of child care arrangement during a typical week (U.S. Bureau of the Census 2002b). This is a significant increase from 1965, when less than 19 percent of children under six\textsuperscript{124} (3.8 million) were in care arrangements (U.S. Bureau of the Census 1982). This increase is largely the result of the growth over the past 40 years in the number of mothers in the work force; in the early 1990s, for example, nearly 6 in 10 women with preschool-age children were employed (Siegel and Loman 1991). Not all child care usage is accounted for by women’s employment, however – almost 30 percent of preschool-age children with non-employed mothers (2.3 million) were also in a regular care arrangement (U.S. Bureau of the Census 2002b).

Labor force participation rates for women have increased dramatically since the 1960s; the greatest increases have been among mothers with preschool-age children, the population most in need of child care when their mothers are employed (U.S. Bureau of the Census 1982). From 1960 to 1970, labor force participation rates for married

\textsuperscript{123}U.S. Census Bureau data from 1985 and later discussed in this chapter comes from the Survey of Income and Program Participation (SIPP), a sample household survey of the noninstitutional population in the U.S. (\url{www.census.gov/main/www/cprs.html}). Census Bureau data from previous years was collected as part of the Current Population Surveys.

\textsuperscript{124}For 1965, aggregate data was reported for children under six years of age. However, more recent SIPP data defines preschoolers as children under five years, and categorizes their data as such.
women with children under six increased 63 percent; from 1970 to 1980, they rose another 49 percent, and from 1980 to 2000, an additional 39 percent (see Table 11).  

Table 11: Labor Force Participation Rates for Married Women with Children under Six

<table>
<thead>
<tr>
<th>Year</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>18.6%</td>
</tr>
<tr>
<td>1970</td>
<td>30.3%</td>
</tr>
<tr>
<td>1980</td>
<td>45.1%</td>
</tr>
<tr>
<td>1990</td>
<td>58.9%</td>
</tr>
<tr>
<td>2000</td>
<td>62.8%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, Statistical Abstract of the United States (1999; 2003b)

A number of demographic, economic, and sociopolitical trends have together been responsible for these sharp increases. The women’s liberation movement led to greater numbers of women entering the workforce, desiring to seek individual fulfillment from employment as well as motherhood. In addition, economic changes have meant that dual incomes are needed to maintain a modest middle-class standard of living, something that previously had been achievable with one income. The divorce rate has also influenced labor force participation rates for women. From the late 1950s until the 1980s, the divorce rate rose continuously, and as a result a growing number of single mothers were forced to seek employment to support their families (Lamb, et al. 1992). More recently, welfare reform has forced more single mothers into the workforce in an effort to shrink the welfare rolls.

125 Interestingly, a recent Brookings Institution report shows that labor force participation rates for women with children under 18 have leveled off since the turn of the century, and have now actually started to decline slightly for married women (Burtless 2004).
All of these factors have together led to huge increases in the number of mothers of young children in the workforce. Not all of these women, however, use alternative care for their children; some care for their children themselves while working. This was true for 15 percent of employed mothers in 1965 but had steadily decreased to three percent in 1999 (see Table 12). In addition, fathers provide a significant amount of child care themselves, ranging over the years from just under 15 percent to 20 percent. As a result, only approximately three out of four women with children under five look to outside caregivers for their children during hours they are employed.

Figure 3: Child Care Continuum

A wide range of caregiving options exist, ranging from exclusive parental care at one extreme to center-based care at the other, and many families utilize more than one of these options simultaneously.\textsuperscript{126} Porter’s (1998) conceptualization of this child care continuum (see Figure 3) is a useful starting point for discussing the numerous options parents have available to them. For those parents who do turn to outside care, relatives

\textsuperscript{126} SIPP data from 1999 indicates that over 28 percent of preschoolers of employed mothers were regularly in two or more child care arrangements per week (U.S. Bureau of the Census 2003c).
provide care that is most similar to that which parents themselves provide, and it is
because of this, as well as issues of cost and convenience, that many individuals rely on
relatives to provide care to their young children. Friends and neighbors, also referred to
as "kith," are used as caregivers for many of the same reasons as relatives, and thus are
often discussed together with relatives as "kith and kin caregivers" or “family, friend, and
neighbor” (FFN) caregivers (Brandon, et al. 2002; Porter 1998; Porter 1999).

Family child care providers, unlike most kith and kin caregivers, tend to view their
caregiving as a business and provide caregiving to a small group of generally unrelated
children in their home. Family child care can be either regulated or unregulated,
depending upon the caregiver’s orientation and the individual state’s licensing
requirements. In general, unregulated providers are limited in the number of children
they can care for; many start providing child care as a way to earn an income while
caring for their own children. These unregulated providers, together with kith and kin
caregivers, are often referred to as "informal caregivers" because they are not part of the
“formal” professional child care system that includes regulated family child care as well
as centers. They are also sometimes referred to as “unregulated caregivers” or “license-
exempt providers” since they are not required to comply with regulatory requirements if
they do not receive subsidies. Regulated family child caregivers, in contrast, view
themselves as child care professionals and are regulated by the state. Group family
child care is an expanded version of family child care; generally, it serves a larger group
of children and employs an assistant (Chaudry 2002; Collins and Carlson 1998; Kith &
Kin Meeting 1999; Porter 1999).
Child care centers and other forms of center-based care provide child care that is viewed as most dissimilar from parental care. Center-based care includes a range of programs, including day care, preschool, nursery school, and Head Start. These programs are generally housed in schools, churches, community-based centers, or independent facilities, and may be run by non-profit organizations, by public agencies, or as private businesses. These programs, along with regulated family child care, form the “formal” professional child care system. However, child care centers, in contrast to the home-like setting of family child care, more generally resemble schools, with children separated into separate classrooms by age and a learning-centered focus (Chaudry 2002; Kith & Kin Meeting 1999).

**Trends in Child Care Usage**

Formal child care is by far the most visible form of caregiving, and thus may be perceived as the most common form. However, in 1999, center-based care accounted for less than one in four caregiving arrangements for preschool-age children of employed moms (U.S. Bureau of the Census 2003c). Center-based care utilization reached a high of 30 percent in 1993, and has fluctuated between 22 and 30 percent since the mid-1980s. These utilization rates, however, represent a significant increase from the much lower rates of 12.7 percent in 1977 and 6.4 percent in 1965 (see Table 12).

Center-based care has grown significantly since the 1960s in response to three factors – the increase of women in the labor force, the increased geographic mobility in the United States, and the growing emphasis on the importance of early learning. Increases in female labor force participation rates have generally led to increases in all
forms of non-parental care, but more specifically, it has resulted in fewer female
relatives, friends, and neighbors being available as caregivers (Brown-Lyons, et al.
2001). This, in conjunction with the increasing numbers of families geographically
isolated from their kin, has resulted in decreases in relative caregiving and increasing
utilization of formal child care.

Also influencing the increase in the utilization of center-based care is the
increased emphasis on early learning and school readiness (Brown-Lyons, et al. 2001).
While the roots of this movement go back to the creation of Head Start in the mid-1960s,
*Good Start, Grow Smart* has brought the issue into further focus. It is also important to
note that today the appeal of growth and learning enhancing day care and preschools
extends to all socioeconomic classes. This educational aspect of many center-based
programs is one of the main reasons that many children of non-working mothers are also
in non-parental care.

Although center-based care utilization has increased substantially over the past
40 years, informal child care still constitutes a larger proportion of child caregiving. In
the 1960s and 1970s, relative and non-relative caregivers together accounted for 60
percent or more of all caregiving arrangements. Since the 1980s, such informal care
has consistently hovered around 50 percent. Relatives and non-relatives maintained
comparable use rates in the 1960s and 1970s, but since the 1980s, trends have been
more varied. In general, both experienced gradual declines since the 1960s, but relative
caregivers have experienced a recent resurgence.

Relative caregivers (excluding parents) in the 1960s were the primary source of
child care for over 32 percent of children. By the 1970s these caregivers accounted for
a little less than 30 percent of all caregivers. Their use dropped sharply in the 1980s, so that by 1988 they constituted just over 21 percent of all caregivers. The use of relative caregivers rebounded in the following decade, however, reaching a high of 29 percent in 1999.

Table 12: Child Care Arrangements of Children under Five with Employed Mothers

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<thead>
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</thead>
<tbody>
<tr>
<td>Parental Care</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother while working</td>
<td>29.2</td>
<td>26.8</td>
<td>23.8</td>
<td>22.7</td>
<td>28.7</td>
<td>22.1</td>
<td>22</td>
<td>22.3</td>
<td>21.5</td>
</tr>
<tr>
<td>Father</td>
<td>14.9</td>
<td>11.8</td>
<td>8.1</td>
<td>7.6</td>
<td>8.7</td>
<td>6.2</td>
<td>5.4</td>
<td>3.3</td>
<td>3.1</td>
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<tr>
<td>Relative Care</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Grandparent</td>
<td>32.4</td>
<td>29.5</td>
<td>24.1</td>
<td>21.1</td>
<td>23.5</td>
<td>26</td>
<td>21.4</td>
<td>25.7</td>
<td>28.8</td>
</tr>
<tr>
<td>Non-Relative Care</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unregulated</td>
<td>31.2</td>
<td>29.9</td>
<td>28.2</td>
<td>28.9</td>
<td>23.3</td>
<td>21.6</td>
<td>28.5</td>
<td>22.5</td>
<td>20.3</td>
</tr>
<tr>
<td>Family Day Care</td>
<td>6.4</td>
<td>12.7</td>
<td>23.1</td>
<td>25.8</td>
<td>23.1</td>
<td>29.9</td>
<td>25.1</td>
<td>21.6</td>
<td>22.1</td>
</tr>
</tbody>
</table>


Overall, grandparents (grandmothers specifically) make up the vast majority of (non-parental) relative caregivers. In the mid-1980s to early-1990s, grandparents generally accounted for around 65 percent of all relative caregivers; in the mid-1990s, this percentage jumped to approximately 70 percent. Fathers are used as caregivers at rates that are slightly higher than grandparents, and for the purposes of this dissertation research are included as relative caregivers (although they are categorized separately in U.S. Census Bureau data). Thus, when rates of relative caregiver use are adjusted to include father care, they reach 50 percent in 1965, and gradually decline through the

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127 For 1965 and 1977, data on grandparent care was not reported separately from other relative care.
128 Unregulated non-relative care is that which is provided by "kith" caregivers.
129 This refers to licensed family day care only. U.S. Census Bureau data did not report licensed family day care separately from other non-relative care prior to 1995.
130 Center-based care includes day care centers, preschools, nursery schools, and Head Start programs.
1970s and 1980s, reaching a low of 36 percent in 1988 before climbing back into the mid-40 percentile range for most of the 1990s. Rates including all forms of informal care (including fathers) have declined over time from a high of nearly three out of four caregivers in 1965, but have generally remained above 50 percent.

Non-relative care accounted for approximately 30 percent of caregiving arrangements for children under five from the mid-1960s through the late 1980s. These percentages dropped in the 1990s, and generally hovered between 20 and 23 percent, except for a spike in 1995. It should be noted, however, that since the U.S. Census Bureau data did not disaggregate regulated family day care from other forms of non-relative care prior to 1995, these earlier estimates of informal care are likely somewhat inflated. U.S. Census Bureau data shows rates of 15.7 and 10.6 percent for regulated family day care for 1995 and 1997, respectively, and the National Child Care Survey from 1990 (Hofferth, et al. 1991) reported a rate of 10.8 percent. Although today almost every state has some form of regulation for family day care homes, licensing and registration standards vary widely from state to state. In 1985 only approximately half the states required family day care providers to become licensed, with an additional quarter requiring registration with the state (Nelson 1990). Regulation of family day care homes was virtually non-existent prior to the 1960s and 1970s (Auerbach and Woodill 1992). Thus, while rates of regulation have been steadily increasing, it is difficult to predict exactly what proportion of non-relative care was in fact regulated family day care prior to the 1990 survey.

The above statistics, while instructive, may to some extent underestimate the true usage of kith and kin caregivers. To begin with, they only include the primary child
care arrangement used by parents for their preschool-age child. Based on varying estimates, anywhere from 28 to 44 percent of employed mothers regularly use multiple caregiving arrangements for their child, averaging 2.2 arrangements per child per week (Capizzano and Adams 2000; U.S. Bureau of the Census 2000; U.S. Bureau of the Census 2002b; U.S. Bureau of the Census 2003c). In general, non-relative care, including center-based care, is used more frequently than relative care as a primary arrangement, and relative care (including father care) is more common as a secondary arrangement, although both are used frequently as primary and secondary arrangements (U.S. Bureau of the Census 2000).

In addition, these statistics are for children of employed mothers only. In 1999, over 30 percent of non-employed mothers\textsuperscript{131} also used at least one regular child care arrangement per week for their preschooler, and 6.5 percent used more than one arrangement per week. These families chose relative caregivers at a rate almost twice that of center-based care and approximately three times that of other non-relative caregivers (U.S. Bureau of the Census 2003c). In particular, large numbers of children are cared for by their grandparents even when their parents are not working or in school; it has been suggested that this is because parents are encouraging their own parents’ involvement in the lives of their children, or possibly because these parents may turn to grandparents for supplemental care because it means little or no cost (U.S. Bureau of the Census 2000).

\textsuperscript{131} This includes mothers in school and mothers looking for work as well as those not in the labor force.
Variability in the Contemporary Use of Kith and Kin Care

Aggregated statistics are useful for examining and understanding broad trends in child care usage, yet they hide an incredible amount of variability that exists at several levels. They give the illusion, for example, that the relative usage of different forms of child care is uniform nationally, while in fact it varies significantly between states as well as between urban and rural areas. In 1997, relative caregiver use ranged from 13 to 32 percent across a sample of 12 states; family child care varied from a low of 10 percent to a high of 20 percent, and center-based care ranged from 19 to 39 percent (Capizzano, et al. 2000). Rural areas generally have much higher rates of kith and kin caregiver use, at least partially because other forms of care are often limited or unavailable.

The use of all forms of child care varies significantly across a multitude of other variables as well; this section, however, focuses specifically on variability in kith and kin care. In general, kith and kin care is more prevalent in ethnic minority communities. Kith and kin caregivers are also more commonly used for infants and toddlers and by economically disadvantaged families, by single mothers as well as mothers who work part-time or non-day shifts or have lower levels of education, and by those who live within extended family households or have relatives living nearby. Issues surrounding accessibility and availability are responsible for a large portion of this variability, although preference also plays an important role.

Differences by child’s age

Kith and kin care is generally very common for young children. It is most prevalent among infants, and usage declines gradually over the preschool years. For

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132 These statistics are for the primary child care arrangement for children under five with employed mothers.
infants and toddlers, grandparents and fathers are the most common caregivers. In 1999, one in three infants was cared for by grandparents and a similar percentage were in their father’s care; overall, relatives provided care to more than three out of four children (see Table 13). For toddlers, percentages of kin care are just slightly lower. By three to four years of age, however, center-based care surpasses grandparents and fathers as the most common source of care. This is the result of the significant increases in center-based care with age, however, and not a consequence of any dramatic decrease in the use of kin caregivers. Overall, though, care provided by all kin caregivers combined still significantly outnumbers center-based care arrangements among three- to four-year-olds (in 1999, over 70 percent of children were in some form of kin care compared to slightly more than 40 percent in center-based care). Care by kith caregivers varies little over the preschool years, and in 1999 only 13 to 15 percent of children were in the care of unregulated non-relatives.

When only the primary caregiving arrangement\textsuperscript{133} is considered, however, relative care emerges as less dominant, especially for older preschoolers. For infants, grandparents and fathers continue to be the most common caregivers, with each serving as the primary caregiver to approximately 24 percent of infants with employed mothers in 1999. For three- and four-year-olds, however, center-based care is the most common primary care arrangement, accounting for almost 28 percent of primary care arrangements compared to 17 and approximately 20 percent for fathers and grandparents, respectively. Even when considering only primary care arrangements, kin care arrangements still outnumber center-based care arrangements, although the

\textsuperscript{133} The primary caregiving arrangement is defined as the arrangement used the most hours per week while the mother is at work. Unless otherwise indicated, the Census Bureau data reported here counts all caregiving arrangements, and because of the frequency of multiple arrangements for children, percentages may exceed 100 percent.
dominance is less dramatic (U.S. Bureau of the Census 2003c). In some states, however, patterns differ somewhat. Chase and Shelton (2001) found that in Minnesota, relatives were the most common caregiver for 46 percent of infants, but only 24 percent of toddlers and 14 percent of three- to five-year-olds. Relatives were the overall most common caregivers for infants, but by the time children were three to five years old, center-based care had replaced kith and kin care as the most common form of caregiving.

Table 13: Variations in Caregiving by Child’s Age (1999)

<table>
<thead>
<tr>
<th>(percentages)</th>
<th>Less than 1 year (infant)</th>
<th>1-2 years (toddler)</th>
<th>3-4 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother while working</td>
<td>5.7</td>
<td>5.3</td>
<td>4.1</td>
</tr>
<tr>
<td>Father</td>
<td>32.1</td>
<td>30.9</td>
<td>27.4</td>
</tr>
<tr>
<td>Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>33</td>
<td>32.6</td>
<td>29.4</td>
</tr>
<tr>
<td>Non-Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unregulated</td>
<td>12.9</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Family Day Care</td>
<td>11.7</td>
<td>13.6</td>
<td>12.6</td>
</tr>
<tr>
<td>Center-based Care</td>
<td>16.6</td>
<td>22.8</td>
<td>41.4</td>
</tr>
</tbody>
</table>

NOTE: Data for children of employed mothers only.
Source: U.S. Bureau of the Census, PPL-168 Table 1B (2003c)

These differences in caregiving by age generally reflect expressed preferences in relation to non-maternal care. Many parents prefer their infants and toddlers to be in home-based care provided by familiar individuals (Collins and Carlson 1998), but by the time their children are three or four, there is more of an emphasis on learning, and preschool program and day care center utilization increases (Fuller, et al. 1996b). Older preschoolers tend to spend fewer hours in kith and kin care, but they are also more likely to regularly be in multiple caregiving arrangements. Thus, kith and kin caregivers
remain a common source of care throughout the preschool years, although it may not be where the older children spend the majority of their time.

**Differences by household income**

It is often assumed that it is the lower cost of kith and kin care relative to other forms of care that is most directly responsible for its use. In general, as household income decreases, kith and kin care usage increases and the use of center-based care declines. However, the relationship is not quite this simple. In 1999, the use of kin caregivers was highest among those living between 100 to 200 percent of the poverty line, and center-based care was lowest among this group (see Table 14). Those below the poverty line had significantly lower rates of father caregiving and moderately lower use of other relative caregivers, but their use of center-based care was slightly higher. Households at more than 200 percent of the poverty line had the lowest rates of (non-parental) kin care and the highest usage of center-based care and regulated family day care, although their use of father caregivers was still relatively high. Care by non-relative caregivers did not vary significantly by income (U.S. Bureau of the Census 2003c).

The lower rates of kith and kin care usage (and greater dependence on center-based care) by those living below the poverty threshold may not so much reflect caregiving preferences as the growing incursion of welfare agencies. The model of preferred care presented by social workers often involves formal child care options – family day care homes for infants and center-based care once the children reach age two or three. Mothers receiving child care subsidies may feel pressured to use these caregiving options, even if culturally or personally kin are viewed as the ideal substitute.
caregiver (Fuller, et al. 1996b). But subsidies, by allowing the purchase of formal child care, may also allow poor mothers access to more stable care than they would have if they only used kin. Mothers below the poverty line are much less likely to have multiple caregiving arrangements (U.S. Bureau of the Census 2003c), suggesting that they have access to more stable child care (or at least to caregiving options that better cover the hours they need care) or are able to more consistently pay for child care. However, as Siegel and Loman (1991) point out, it may simply reflect the fact that many welfare mothers lack any secondary or back-up caregiving arrangement.

Table 14: Variations in Caregiving by Poverty Status (1999)

<table>
<thead>
<tr>
<th>(percentages)</th>
<th>Below Poverty Threshold</th>
<th>100 to 200% of Poverty Threshold</th>
<th>Over 200% of Poverty Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mother while working</td>
<td>24.3</td>
<td>37.7</td>
<td>35.2</td>
</tr>
<tr>
<td>Father</td>
<td>4.7</td>
<td>4.3</td>
<td>4.9</td>
</tr>
<tr>
<td>Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>47.5</td>
<td>56.5</td>
<td>41.4</td>
</tr>
<tr>
<td>Non-Relative Care</td>
<td>31.5</td>
<td>34.5</td>
<td>30.3</td>
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<tr>
<td>Unregulated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Day Care</td>
<td>22.1</td>
<td>20.4</td>
<td>29.6</td>
</tr>
<tr>
<td>Center-based Care</td>
<td>8.5</td>
<td>11.4</td>
<td>14.5</td>
</tr>
</tbody>
</table>

NOTE: Data for children of employed mothers only. Source: U.S. Bureau of the Census, PPL-168 Table 1B (2003c)

Differences by employment characteristics

Non-maternal caregiving is certainly more common among preschool-age children of employed mothers, but non-employed mothers – including those in school or training programs or those looking for work – also use alternative caregivers. In 1999, just over 30 percent of children of non-employed mothers were in a regular non-maternal care arrangements (U.S. Bureau of the Census 2003c), and certainly many more were in
non-maternal care on a less regular basis. Regular non-maternal care arrangements were more common among children age three to five than infants (U.S. Bureau of the Census 2003c), reflecting the increasing concern with learning for children nearing school-age and the fact that many non-employed mothers use child care to enhance their child’s education and development rather than to free up their own time (Kuhlthau and Mason 1996). In fact, the majority of caregiving for infants and toddlers with non-employed mothers is provided by kith and kin, but more than one in three children ages three to four spend at least some time every week in center-based care (U.S. Bureau of the Census 2003c).

Overall, just under 95 percent of preschool-age children of employed mothers in 1999 were in regular caregiving arrangements, and over 28 percent were in multiple arrangements. For mothers employed full-time, only 3.6 percent did not have their children in a regular caregiving arrangement, and this increased only modestly for mothers employed part-time (8.8 percent). Kith and kin care usage was similar for mothers employed part- versus full-time, but father care was significantly more common for children of mothers employed part-time than those employed full-time (38 versus 25 percent, respectively). In contrast, use of center-based care was higher for children of mothers employed full-time (33 versus 24 percent for mothers employed part-time), as was the use of regulated home day care (see Table 15).

Differences can also be found in patterns of caregiving depending on whether the mother works a standard day shift or a non-standard shift, such as evenings, nights, or weekends. Preschool-age children whose mothers work day shifts are much more likely than those working non-day shifts to be in organized care or regulated family day care.
(see Table 15). Father care, in contrast, is more common among those whose mothers work non-day shifts. Once again, (non-parental) kith and kin care usage was very similar among those working day and non-day shifts.

Table 15: Variations in Caregiving by Work Status and Shift (1999)

<table>
<thead>
<tr>
<th>(percentages)</th>
<th>Full-time</th>
<th>Part-time</th>
<th>Day Shift</th>
<th>Non-day Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother while working</td>
<td>28.7</td>
<td>45.6</td>
<td>28.9</td>
<td>44.6</td>
</tr>
<tr>
<td>Father</td>
<td>3.4</td>
<td>7.6</td>
<td>4.2</td>
<td>6</td>
</tr>
<tr>
<td>Relative Care</td>
<td>25.3</td>
<td>38</td>
<td>24.7</td>
<td>38.6</td>
</tr>
<tr>
<td>Grandparent</td>
<td>45.1</td>
<td>45.6</td>
<td>44.4</td>
<td>46.7</td>
</tr>
<tr>
<td>Non-Relative Care</td>
<td>30.2</td>
<td>33.3</td>
<td>30.6</td>
<td>32.4</td>
</tr>
<tr>
<td>Unregulated</td>
<td>29.6</td>
<td>20.9</td>
<td>29</td>
<td>22.6</td>
</tr>
<tr>
<td>Family Day Care</td>
<td>14.4</td>
<td>12.5</td>
<td>13.8</td>
<td>14</td>
</tr>
<tr>
<td>Center-based Care</td>
<td>15.2</td>
<td>8.4</td>
<td>15.2</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>33.1</td>
<td>23.5</td>
<td>34.8</td>
<td>20.9</td>
</tr>
</tbody>
</table>

NOTE: Data for children of employed mothers only.
Source: U.S. Bureau of the Census, PPL-168 Table 1B (2003c)

These patterns of caregiving are influenced by the differing constraints of these varying work schedules. Formal child care options are usually only available during the day, and thus center-based care and home day care are often not available to mothers working non-traditional shifts. Also, many day care centers do not offer part-time or flexible schedules, thus these parents are forced to use fathers and other relative and informal non-relative caregivers to fill their caregiving needs. As a result, a greater proportion of care for children with mothers working part-time and non-day schedules is provided by kith and kin caregivers. Mothers with variable and unpredictable work obligations may also choose to turn to familiar individuals for caregiving – in these cases, unpredictable work may result in needing to start and stop child care frequently, and having a familiar individual as a caregiver can reduce the disruptiveness for the child.
(Collins and Carlson 1998). Non-employed mothers may prefer kin caregivers because it generally involves smaller or no cash outlays (Brandon 2000).

**Differences by family structure**

The use of kith and kin caregivers is heavily influenced by the presence (or absence) of available caregivers. Thus, kith and kin caregiving is more common when households include other adults or when other relatives or quasi-kin live nearby, when these adults are not employed and are available to provide care, when settlements are more compact, and where grandparents have a greater presence (Fuller, et al. 1996a; Hewlett 1991; Layzer 2001). Single mothers are more likely to use kith and kin caregivers (Brandon, et al. 2002), possibly reflecting the greater dependence on the extended family in instances where the father is absent from the household. In addition, larger families are more likely to use relative caregivers than those families with only one or two children (Brandon, et al. 2002; Hofferth, et al. 1991; Siegel and Loman 1991), most likely as a result of the increased financial burden of paying for market care for multiple children. Although many kith and kin arrangements do still involve some sort of compensation, they often are significantly less expensive or involve no out of pocket expenses (Layzer 2001; Pine 1999).

**Other variables**

Relative caregiving is more common when the average price of center-based care is higher (Brandon, et al. 2002) or the alternatives are limited, either in terms of a shortage of slots in regulated care settings or when personal or cultural acceptable options are lacking (Collins and Carlson 1998). For example, many rural areas have
higher rates of kith and kin care than urban areas due to lower availability of formal child
care options but also as a result of differences in community demographics and values
concerning child care (Atkinson 1994). In addition, while kith and kin caregivers are
commonly used as a primary caregiving arrangement, they are depended upon even
more heavily for secondary arrangements (Hofferth, et al. 1991). In particular, they are
commonly used as back-up caregiving arrangements, to be used when primary care
arrangement falls through or when a child is sick and is thus restricted from attending
their primary care setting (Caruso 1992).

Patterns of Minority Caregiving

Significant variation in caregiver usage also exists across various ethnic minority
communities in the U.S. This variability is influenced by child care norms and caregiving
preferences in these different communities, as well as by economic and structural
constraints and the differential influence of government programs such as PRWORA.

The pervasiveness of shared mothering in Black communities, for example, is
reflected in U.S. Census Bureau data on child care arrangements of young minority
children (see Table 16). In 1999, over 60 percent of preschool-age children of employed
Black mothers were in (non-parental) kith and kin care. Shared responsibility for
children among kith and kin is extensive among non-working mothers as well (Stack
1974); over 50 percent of non-employed Black mothers also had a regular child care
arrangement for their preschooler, and approximately three of out four of these were
relative care (U.S. Bureau of the Census 2003c). Among employed mothers, rates of kin
caregiving are even slightly higher for Hispanics but significantly lower for Whites (41.3
percent). For Blacks and Hispanics, grandparents were used as caregivers for young
children more frequently than any other relatives, including fathers, showing the importance of the extended family network relative to the nuclear family. Grandparents were also the most common non-parental caregivers for White, but fathers were overall the most common caregivers.

Table 16: Child Care Arrangements of Children under Five with Employed Mothers by Ethnicity (1999)

<table>
<thead>
<tr>
<th>(percentages)</th>
<th>White (non-Hispanic)</th>
<th>Hispanic</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother while working</td>
<td>38.1</td>
<td>30.8</td>
<td>22.9</td>
</tr>
<tr>
<td>Father</td>
<td>5.4</td>
<td>3.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>32.7</td>
<td>26.9</td>
<td>20.1</td>
</tr>
<tr>
<td>Non-Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unregulated</td>
<td>14.6</td>
<td>14.5</td>
<td>10.4</td>
</tr>
<tr>
<td>Family Day Care</td>
<td>15.6</td>
<td>8.5</td>
<td>7.1</td>
</tr>
<tr>
<td>Center-based Care</td>
<td>31.2</td>
<td>18.3</td>
<td>37.2</td>
</tr>
</tbody>
</table>

NOTE: Because of multiple arrangements, summed percentages may exceed 100 percent.
Source: U.S. Bureau of the Census, PPL-168 Table 1B (2003c)

There are also other significant ethnic differences in caregiver use. While almost 33 percent of White preschoolers were cared for by their fathers while their mothers worked, this was the case for only approximately 27 percent of Hispanic children and 20 percent of Black children. Non-relative care is most common among Whites (30.2 percent of preschoolers) and least common among Blacks (17.5 percent); rates of regulated family day care use among Whites are approximately twice that found in Black and Hispanic communities. Usage rates also vary significantly for center-based care – it is most common among Blacks (37.2 percent) and Whites (31.2 percent), and is used much less frequently by Hispanics (18.3 percent).
Caregiving in Native American communities

In many Native American communities today, shared caregiving within extended family networks of kith and kin continues to be the norm, a tradition reflected in their caregiving statistics. Rates of parental care and relative care for employed Native American mothers are higher than for any other ethnic group (see Tables 16 and 17). In 1999, almost 50 percent of Native American children of employed mothers were cared for by their father, and approximately 73 percent were cared for by a (non-parental) relative; one out of two children were regularly cared for by a grandparent. These higher rates of parental and relative caregiving are partially due, however, to much higher rates of multiple caregiver use among Native Americans; approximately 38 percent of Native American preschool-age children were in multiple arrangements compared to 30 percent of Whites, 22 percent of Blacks, and 21 percent of Hispanics (U.S. Bureau of the Census 2003c).

Rates of non-relative caregiver use by Native Americans are also higher than those of Hispanics and Blacks (28.1 percent of preschoolers versus 23 and 17.5 percent, respectively), but slightly lower than Whites (30.2 percent). Regulated family day care usage (7.5 percent) is comparable to other ethnic minority groups, but care by unregulated non-relative caregivers (“kith”) is more common among Native Americans. Center-based care usage as a whole is comparatively low (24.3 percent) in spite of high Head Start attendance, a difference largely accounted for by low rates of day care center attendance (12.6 percent). Given the lack of sufficient child care facilities on many reservations, it is unclear whether their low usage of formal care is a consequence of availability or preference.
Table 17: Child Care Arrangements for Native American Children under Five (1999)

<table>
<thead>
<tr>
<th>(percentages)</th>
<th>All Mothers</th>
<th>Employed Mothers</th>
<th>Non-Employed Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother while working</td>
<td>27</td>
<td>62.7</td>
<td>--</td>
</tr>
<tr>
<td>Father</td>
<td>21.2</td>
<td>48.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>46.3</td>
<td>72.5</td>
<td>28.1</td>
</tr>
<tr>
<td>Sibling</td>
<td>30.7</td>
<td>50.4</td>
<td>17.0</td>
</tr>
<tr>
<td>Non-Relative Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unregulated</td>
<td>18.8</td>
<td>28.1</td>
<td>12.4</td>
</tr>
<tr>
<td>Family Day Care</td>
<td>5.6</td>
<td>7.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Center-based Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Care Center</td>
<td>17.7</td>
<td>24.3</td>
<td>13.2</td>
</tr>
<tr>
<td>No Regular Arrangement</td>
<td>42.7</td>
<td>7.4</td>
<td>67.1</td>
</tr>
<tr>
<td>Multiple Arrangements</td>
<td>21.8</td>
<td>37.5</td>
<td>11</td>
</tr>
</tbody>
</table>

NOTE: Because of multiple arrangements, summed percentages may exceed 100 percent.
Source: U.S. Bureau of the Census, PPL-168 Table 1B (2003c)

Even among non-employed mothers, approximately one in three preschool-age Native American children is in a regular caregiving arrangement. Seventeen percent of children of non-employed mothers were regularly cared for by grandparents and 11 percent by other relatives. These numbers likely do not reflect, however, the full extent of “shared mothering” since this practice is generally not considered a “regular caregiving arrangement.” Such caregiving is informal and unlikely to be highly structured; it may consist of short-term, occasional caregiving by an aunt while the mother runs to the grocery store, or involve a more long-term arrangement where, for example, a grandmother cares for a grandchild while the mother is away at school. While these situations are not likely to be described as regular child care, they are nonetheless instances of child caregiving, and are central to the experience of child caregiving as it exists in many Native American communities.
Perspectives on mothering and non-maternal care have varied over time in response to the social, economic, and political realities of the day. Today, non-maternal care is generally viewed more positively than in the past; early care programs are, for example, considered important for their roles in supporting parental employment and providing educational enrichment to children. What constitutes “quality” child care, however, has come to be relatively narrowly defined. Programming and settings considered to be high quality generally are more in line with the formal care model and embrace the values, practices, and norms of the White, middle-class. Consequently, they are not always appropriate or meaningful in cultural minority communities.

Many Native people are understandably suspicious of the underlying values and motives of formal models of care, given the long history of forced removal and acculturation of Native children. While compulsory boarding school attendance is a thing of the past, and legislation including ICWA has been critical in forcing the recognition of local standards of child welfare and reducing rates of transracial adoption, requirements under newer programs including PWRORA and GSGS continue to challenge tribal efforts at self-determination by imposing outside models of child care in the name of reducing poverty and improving school readiness.

In spite of the emphasis on formal care models in recent welfare and educational reform measures, utilization of formal child care still lags significantly behind all forms of informal kith and kin care in Native communities. Native children, in fact, have some of the highest reported rates of kith and kin care usage of any ethnic group in the U.S., a pattern attributable to both care preferences and access. The following chapter
discusses the use of kith and kin caregivers by parents in the White Mountain Apache community and the rationale and choices behind their child caregiving decisions.
CHAPTER 4

UNDERSTANDING CAREGIVING DECISIONS: NEEDS, OPTIONS, VOICES, AND CHOICES

Jennifer and Shirley …

Jennifer and her husband Max are the parents of two school-age girls and a three-year-old boy, Josef. They are in their mid-30s and both work full-time jobs in the community, jobs they have been at for a number of years. Jennifer was raised in the same community in which they now live, and continues to live near and see many of her relatives on a daily basis. Her husband, however, was not raised on the reservation, and does not have any relatives in the immediate area.

Like many White Mountain Apache parents, Jennifer prefers to use family to watch her children. For her, it is primarily an issue of trust. Ever since returning to the reservation after a four year stint in the military, Jennifer and her husband have depended almost exclusively upon relatives – primarily Jennifer’s parents – for child care. As Jennifer explained to me, her decision to get out of the military and return to the reservation was, in fact, heavily influenced by her inability to find a babysitter she could trust.

Jennifer’s mother Shirley is the primary one to provide care, although she is assisted by her husband Clendon and her youngest daughter, 18-year-old Ella. Shirley has served as a caregiver for all of Jennifer’s children since they were babies; Josef has been in her care since he was only two weeks old. She no longer provides full-time care
to any of them – the girls are in elementary school, and Josef is in preschool – but they are with her before and after school everyday.

I spent a pleasant April afternoon sitting with Shirley in her backyard listening to her recount stories of caregiving in her family that spanned three generations. Some of these, as with Josef and his sisters, were stories of relatively typical informal child care arrangements. Many others – though not thought of as inherently different by Shirley – entailed a whole other dimension of care, what I refer to in this dissertation as surrogate caregiving.

Shirley herself, as mentioned in Chapter 2, was raised not by her mother, but by her maternal grandmother and an aunt after her mother had a nervous breakdown. Her aunt – who she considers her “mother” – took in not only Shirley and her siblings but a number of other needy children as well. As a teenager, Shirley helped care for a number of these “siblings” while her mother was working, a task that, as she laughingly commented to me, made her wonder “what I did so wrong that I had to be punished that way!”

As an adult, Shirley used a range of caregivers on and off over the years – both kin and non-kin – to help care for her seven children. As she related during our conversation:

Starting out with the first one … my husband wasn’t working when he first came here – he was from San Carlos – and so he watched [the children] while I was at work. I was a telephone operator at that time. My hours were very flexible to do the job. I worked there for a few years and … after he went to work, I was home for awhile … and I took care of my kids. Three of them. Then I had to go back to work, and I left them with my sisters during the summertime. [My sisters] were about 12 and 14, somewhere around there. They took care of [my kids], and I helped them with their school clothes when they needed it. [My sisters] lived next
door – right next door – so we could leave our door open and my kids would go out there and play and they’d stay together all day.

After [my sisters] had to go off to school, then I had babysitters. They were from Canyon Day – some of our church members. [The girls we used as babysitters] had dropped out of school, so I had about three different girls take care of [my kids] at home. [They lived with us during the week] then I’d let them go home on weekends.

Jennifer, she had her grand-aunt take care of her. I had to take her up [to my aunt’s house] … She stayed with her grand-aunt there until she went to school. Then I was home again. During the school hours she was in school, and then she was home with me.

I think that was my last babysitter, my aunt. Other than that it’s just been a household member. Like, Jennifer, when she graduated from high school, she’s the one who took care of [my youngest daughter] Ella. And my granddaughter … [Jennifer] took care of that one too while I was at work.

As Shirley’s children went on to have their own children, she came to play a central role in caring for many of them too. Jennifer’s children are only the latest in a long line of children Shirley has provided child care for over the years. And, as her aunt did for her, Shirley has taken in a few of her grandchildren – like the granddaughter she refers to above – who she felt were not being cared for properly, and raised them herself.

My second daughter … I took care of her baby since she was three-months-old. … [My daughter] started running around leaving the baby at different houses and some people didn’t like taking care of that baby there. So they’d call me, and so one day I told [my daughter] I’m not giving the baby back. That’s the last time you’re getting that baby back … from now on you’re not getting her back or I’ll turn you in …

So I took that girl over … and I was working at that time. And I never went over for social services help or anything, I just raised her on my own. … Ever since then, I just got the welfare for her, and then her brother came [to me] also.

They both call me mom. That girl, she gets disgusted with her mother when her mother tries to claim her or anything. … And my daughter, she’s still not settled down. The policemen [have dropped] her other two girls off with me a couple of times … and I told those policemen to take them back, I’m not taking no more for her. She hasn’t learned … two children I’ve raised for her. … I’m not taking no more for her.

* * * * *
Many of the White Mountain Apache women I spoke with, like Shirley, recounted stories of intergenerational kin caregiving. As children, they had been cared for by relatives or close family friends, and as parents most had used such caregivers for their own children. As teens or adults, many had served as caregivers to other children, most commonly their younger siblings, nieces or nephews, or their own grandchildren. In fact, almost without exception, these women had, like Shirley, experienced kith and kin caregiving from multiple perspectives, filling different roles as they passed through different life stages.

While the experience of kith and kin care in the Apache community is quite ubiquitous – almost everyone at some point in their lives participates in such an arrangement, either as a child, a parent, or a caregiver – the process of selecting or becoming a caregiver, and the form these arrangements take, tend to be very individualized. Parents like Jennifer actively pursue specific individuals as caregivers; others may only turn to kith and kin caregivers as a last resort. Similarly, caregiving is for some a desired and chosen role, one eagerly sought out or undertaken at least at certain points in their lives. However, at other times or for other individuals, caregiving can instead be a source of conflict or stress, as Shirley hints. This is particularly true in those instances when such responsibility is thrust upon an unwilling or unprepared individual.

Caregiving decisions and caregiving arrangements are idiosyncratic because the needs, resources, and options available to parents vary both across families and over time. The needs, prior commitments, and desires of potential caregivers vary as well, and influence caregiving decisions and the forms caregiving arrangements ultimately
take. Even children’s preferences may be influential. Ultimately, caregiving arrangements and the decisions that lead to them can only be understood by examining the needs, resources, desires, and agendas of these multiple players who, to varying extents, all have a voice in decisions about caregiving. This chapter thus focuses on exploring the decision-making process and understanding the intricacies of “choice” through the voices and lives of individual community members.

CAREGIVING DECISION-MAKING AND CAREGIVER “CHOICE”

In the White Mountain Apache community, where non-parental care has always been commonplace, kith and kin were historically – and continue to be – the most common source for child caregiving. Yet not all parents today use kith and kin caregivers. In addition, the reasons parents seek caregiving assistance, and the challenges some face in finding acceptable caregivers, have also changed somewhat over time. How then can we explain the emergent caregiving patterns that we see today?

Caregiving choices are idiosyncratic, shaped by the context in which families are situated. Child care decisions and routines are influenced by cultural values, beliefs, and associated practices regarding child rearing, socialization, identity, and the role of the family (“cultural factors”) as well as the social, legal-institutional, and material resources present in the community (“ecological factors”) (Lowe and Weisner 2001; Zinsser 1991). Specifically, as Lowe and Weisner (2001:10) note:

- Child care routines have to fit the configuration of financial, material, institutional, social, and time resources characteristic of each family at a given period in time;
Child care choices have to “make sense”—be personally and culturally meaningful—given parental goals and values as participants in a local community;

Parents have to balance their choices among the often-conflicting interests present in the family;

Parents struggle to ensure that their child care arrangements are at least somewhat stable and predictable for the parents’ and children’s sakes.

Child care choices do not simply reflect preference or need; parents balance preferences, resources, and family interests and make decisions that work and make sense given the ecocultural context the family finds themselves in at that moment (Lowe and Weisner 2001).

When Apache parents make choices about caregiving, they are guided by cultural norms, values, and expectations as well as real life contingencies, evaluations of the caregiving capacity of others in one’s network, and in some cases a child’s own preferences for particular people. Parents’ specific caregiving needs define a pool of potential caregivers and, within this pool, preferences for certain types of care and certain caregivers help delineate choices. Individuals’ perceptions of caregivers as trustworthy and/or desirable take into account family history and composition and further influence decisions.

As any parent knows, however, seldom is the process of finding or selecting caregivers perfectly smooth. Parental preference may not coincide with available caregivers or individuals involved in decision-making may have different preferences or conflicting needs. Most often, caregiver selection entails a process of negotiation and mutual accommodation, where all involved have at least some degree of agency. As a result, caregiving choices often reflect tradeoffs between the perceived needs of the
child, the parents, and the larger family, as well as the constraints of available child care options (Brown-Lyons, et al. 2001).

At times, this process can lead to relatively ideal arrangements with preferred caregivers that accommodate everyone’s preferences and needs. In the worst case, options may be so limited that there really is no “choice.” Whenever possible, parents will refuse to use caregivers they see as undesirable or unfit, but those with few options may have little choice. Similarly, while caregivers can technically refuse to provide care for a child, many like Shirley, faced with grandchildren that are being parented inadequately, may feel they have little choice but to take children in.

**White Mountain Apache Caregiving Continuum**

Essential to understanding choice is understanding the forms that caregiving arrangements take in the community. Chapter 2 addressed the various formal care options; this section focuses on the variety of forms that kith and kin care can take – specifically, supplemental and surrogate care – and how they variously function to provide care for young children.

In Native American communities such as the White Mountain Apache, supplemental and surrogate care are viewed as functionally synonymous, varying primarily in terms of the caregiver’s level of involvement in the child’s life, the degree to which responsibility for the child is shared between the parent(s) and caregiver(s), and with whom primary responsibility for the child rests. Caregiving is envisioned as a continuum, ranging from exclusive parental care at one end to exclusive care by a non-parental caregiver at the other extreme (see Figure 4).
Supplemental and surrogate arrangements further vary in terms of the household structure and physical residence of the parent, caregiver, and child (see Figure 5). In supplemental care arrangements, the caregiver may live in an extended family household with the child and parent(s), or she may reside separately. With surrogate arrangements, the parent(s) generally live in a separate household from the one the child and caregiver share, although extended family households are occasionally seen as well with informal surrogate arrangements.

**Figure 4: White Mountain Apache Caregiving Continuum**

Surrogate care in the White Mountain Apache community, while not quite as ubiquitous as supplemental care, is also common. In the early 1990s, Bahr (1994) found that 17 percent of all children on the Ft. Apache Reservation resided with a grandparent caregiver, and this figure does not include children in surrogate arrangements with other relatives. No data exist on the overall prevalence of surrogate caregiving in the community; using census data, however, it can be estimated that somewhere between
one in five and one in six children under 18 on the reservation today are in surrogate care.\textsuperscript{134, 135}

**Figure 5: White Mountain Apache Kith and Kin Caregiving Arrangements**

![Diagram showing different caregiving arrangements](image)

Note: “Different HHs” means that the child is in the same household as the parent or caregiver, but not both. “Same HH” means that the child, parent, and caregiver all live in the same household.

In many Native American communities, surrogate caregiving constitutes an informal yet culturally validated practice. Changes in household residence – for children and adults – are neither uncommon nor exceptional. Children may move freely or at

\textsuperscript{134} The upper-bound of this estimate was calculated by assuming that, as with the grandparent-headed households (see footnote 139), 69 percent of children in households headed by someone other than the parent are primarily the responsibility of that household.

\textsuperscript{135} While surrogate arrangements are also common in some other ethnic minority communities, they are much less common in the U.S. overall. In 2001, just over three percent of children under six lived in a household where neither parent was present; half were in the care of a grandparent and another quarter lived with other relatives (U.S. Bureau of the Census 2002a). For example, of the 158.9 million children in the U.S. under 18 in 2000, only 5.8 million (3.6%) lived in grandparent-headed households, and 2.4 million (1.5%) were primarily the responsibility of the grandparent (Source: Census 2000 SF 3, Tables PCT8 & PCT9, United States).
times even float between two or more households; this is generally not the result of
cchildren feeling uncomfortable or unwanted in these homes, but rather from more than
one caregiver wanting to care for the child. It is not expected, nor necessarily desirable,
that the parent be the sole caregiver. Surrogate care is, as Bahr (1994:233) comments,
“one of the great strengths of Apache families, a traditional pattern of responsibility and
care that continues to serve families and protect children.”

Surrogate caregiving arrangements vary in terms of the formality and perceived
permanency of the arrangement. Formal surrogate arrangements involve a transfer of
custody (either temporary or permanent); the child resides full-time with the caregiver,
and generally the parent is completely absent. Formal arrangements are generally the
result of state intervention and a consequence of perceived neglect or (occasionally)
abuse; custody and residence decisions are at the discretion of social services and/or
the courts. In contrast, informal surrogate arrangements, which constitute the majority of
surrogate care,\textsuperscript{136} are entered into voluntarily and have a greater variety of forms. These
may be initiated by the parent, caregiver, or child, and generally serve a specific need
and/or accommodate the desires of one or more of the involved individuals. Informal
arrangements vary significantly in terms of the involvement of the parent and tend to be
indeterminate in length, likely to change as circumstances or the needs or desires of the
involved individuals change.

\textsuperscript{136} Of the 18 individuals I interviewed who were serving as surrogate caregivers, only four had had children
placed with them by social services or the court system. Three of these placements were the result of
parental neglect, and one was due to the special health care needs of the children (premature twins) that the
mother was unable to meet.
What determines type of care used?

Where on this continuum a family’s caregiving arrangement falls depends largely on their caregiving needs. Individuals who are employed or in school are the ones who most commonly need regular supplemental care. Loretta, a 30-year-old married mother of three, uses her mother Ida as a caregiver for her three children while she and her husband work. Ida cares for the two preschoolers around 40 hours per week, and the older child everyday after school. Even through Loretta works at the day care center, she prefers to use her mother as a caregiver. As Loretta explains, her mother is unemployed – and hence needs some income and something to do – and she loves taking care of her grandchildren. Loretta also really likes that her mother has a big yard for the children to play in, and that she is teaching the children to speak Apache (Loretta’s husband is not Apache, so the children rarely hear the language at home). And, as Loretta points out, her mother’s house is conveniently located right on her way to work.

Like Ida, most supplemental caregivers live either in the same community or one relatively close to the children for whom they provide care. Approximately one out of every four families interviewed for this project, in fact, used caregivers with whom they shared a household. Irene, a 29-year-old single mom, has been relying on her 68-year-old mother Edith, with whom she lives, for child care on and off for several years. Edith first served as a caregiver for Irene’s son Linton when he was three-months-old. Irene had recently moved back in with her mother, and Edith says she volunteered at that point to watch Linton because she realized her daughter was having a difficult time balancing her son and her job. Edith provided full-time care for Linton for a little more than a year, until Irene quit her job. At the time of our interview, Linton was three. Irene
had gone back to work for tribal administration four months prior, and Edith was once again providing full-time care for Linton. Irene and Linton had remained in Edith’s household during this entire period, and even when Irene was not working, Edith says she “babysat” for Linton quite a bit.

As Irene’s example illustrates, even mothers who are not employed or in school utilize caregivers, though generally not on as regular a basis. These mothers most often rely on kith or kin to watch their children for a few hours each week while they run errands or when they have appointments. Juna, a 33-year-old married stay-at-home mom with five young children, does most of the caregiving herself, but noted that she relies on her sister for occasional babysitting. She prefers to leave her children with her sister when she needs to go to the clinic herself or needs to take one of her children; she’s concerned that if she took the other children along, they would get sick too. Other parents noted that they prefer to leave their children with caregivers when they run errands, especially if they need to go “up the hill.” Several of the establishments where families prefer to shop, such as Wal-mart, are in the off-reservation communities of Pinetop-Lakeside and Show Low, which are up to 45 minutes away. Parents whose children do not tolerate long car rides well, or who are concerned about taking a young child out in cold weather, may prefer to leave their children with a babysitter during these weekly or bi-weekly shopping trips, as do those who simply find shopping without their child easier. In these cases, caregiving is arranged on an “as needed” basis.

Some parents such as Juna have a standard caregiver upon whom they depend whenever they need a babysitter, but others tend to approach different caregivers depending upon the specific circumstances that day. Richanda, a 22-year-old single
mother with a six-month-old son, still lives with the grandparents who raised her, and relies upon them for caregiving assistance when she needs to take a shower or do stuff around the house. When her son was first born, his father would come around occasionally to bring pampers or help out, but Richanda commented that she had not seen him for a while. In those instances when Richanda needs to leave the house to run errands, she generally leaves her son with her cousin or brother who live just down the road; however, if her son is asleep and she just needs to run out for a few minutes, she will ask her grandparents to watch her son instead.

Surrogate care arrangements may at times function similarly to supplemental care, providing care to children whose parents are working or in school, albeit for longer stretches at a time. Erma, a 55-year-old married grandmother and home care provider, is currently serving as a surrogate caregiver to her eight-year-old grandson Raymond while his mother is in school down in Tucson. Raymond’s mom visits frequently, but it is Erma who is responsible for him on a day-to-day basis. Once his mother completes school, it is anticipated that Raymond will return to living with her. Interestingly, this is not the first time Erma has taken on a temporary surrogate role; years before, she served as a surrogate caregiver for another of her grandsons, who has since gone back to living with his mother.

Farrah, a 21-year-old divorced mother, described to me how a form of surrogate care had allowed her to work at the tribal ski resort until it closed for the season. The Sunrise Ski Resort is approximately 45 miles from the community where Farrah lives; on days she worked, Farrah not only had to leave extremely early, but she was often gone more than 12 hours. Thus, on the weekends as well as any weekdays she worked, her
five-year-old daughter Bethany would stay with Farrah’s great-aunt, 43-year-old Aleah.
Bethany would, however, stay with her mom on the few days during the week her mom did not work.

Interestingly, this surrogate arrangement, while effective at accommodating Farrah’s work schedule, had actually come into existence for another reason. In talking with Aleah, she mentioned that Bethany had stayed with her on and off since she was an infant. Then when Bethany was three, her parents went through a divorce. It was this event that first led to Aleah functioning as a surrogate caregiver for Bethany.

Her [Bethany’s] mom had just gone through a divorce and it was very hard on her [Farrah] and I think it was very hard on Bethany. And she just felt comfortable at my house. And ever since then she just stayed with me. … I think that was a lot on Bethany even though she was small. She kept asking for her dad, you know. And then when she was with her mom she was saying, take me over to Farrah’s. And that’s why they kept bringing her. And she felt comfortable here. And even when her mom came to pick her up she wouldn’t go with her. … And her mom … it’s really hard to control her [Bethany]. Her mom can’t really control her. Yeah, she was hitting her mom and, you know, I could control her and she did good around me so they just … she just stayed with me.

In Farrah’s case, even though the reason she needed caregiving assistance changed, the same surrogate arrangement filled her needs in both cases. It is not uncommon, however, for parents to change the type of care arrangement they use for their children, or the specific caregiver, as their needs change. Richanda, for example, mentioned that she wanted to get a job after her son turned one. While she used her grandparents, her cousin, and her brother for short-term babysitting, she said she was
going to use her mother who stays home caring for her own three-year-old daughter to provide the more regular child care she would need once she started working.\textsuperscript{137}

**Who are the caregivers?**

Just as there are many caregiving forms and configurations, there are many different individuals who provide this care. There are, however, definite trends regarding care provision. It is, for example, highly gendered; while fathers and occasionally other male relatives do serve as caregivers, caregivers are overwhelmingly female. In addition, caregivers are more likely to be maternal rather then paternal relatives. These trends are at least partially attributable to the matrilineal descent system and the traditional caregiving roles assigned to women generally, and specific maternal relatives in particular. Today, however, the overrepresentation of maternal relatives is also a consequence of the frequently unstable relationships that exist between the young parents and the associated tenuous connection between the child and the extended family on the father’s side.

Many caregivers are part of what would be considered the elder generation – grandmothers, great-aunts, and occasionally grandfathers and even great-grandmothers. One-third of the families interviewed as part of the Apache Children’s Potential Project (ACPP) mentioned in Chapter 1 indicated they used grandparents as supplemental caregivers for their children; just under 30 percent used other adult relatives. Traditional roles and their relationship to the children provide unique motivations for serving as caregivers. The fact that individuals from this generation are

\textsuperscript{137} Changes in caregiving arrangements and the factors that precipitate these changes are discussed in more detail in Chapter 5.
more likely to be retired or otherwise not working makes them available to provide care in greater numbers than the majority of other potential caregivers.  

Grandmothers in particular are recognized as being very important in the care and socialization of children, and are expected to play a large role in children’s lives, both as physical caregivers and custodians of culture (Bahr 1994). While grandparents more commonly serve as supplemental caregivers, a not insignificant number function as surrogates – in 2000, 12 percent of White Mountain Apache children under 18 were in grandparent-headed households where the grandparent was the primary individual responsible for the grandchild.  

A significant number of caregivers also come from parent’s generation. Aunts are the most common caregivers in this group, but uncles, second-cousins, friends, and neighbors also provide care to young children. Given that this is the “productive” generation, the availability of these individuals to provide care is often moderated by their work status and work schedules. Fathers, in many cases, are also considered as alternative caregivers; when they are so classified, they rank among grandmothers and aunts as some of the most common caregivers. Given their unique relationships to the children they care for, and hence their unique motivations for providing care, it is generally best to consider them separately.

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138 It should be noted, however, that many grandparents in this community are quite young and still working. These individuals consequently face greater restraints on their time than older grandparents.  
139 In 2000, 963 of the 5,133 Apache children under 18 on the Fort Apache Reservation – 19 percent – lived in a grandparent-headed household; in 69 percent of these cases, the grandparent reported that (s)he was responsible for the grandchild [Source: Census 2000 AIANSF, Tables PCT12 and PCT36, Fort Apache Reservation Apache alone of in any combination)].  
140 Although friends and neighbors are discussed here, in some cases they may be significantly older than the parents, and hence may be more appropriately considered part of the elder generation. ACPP data shows that only about four percent of families looked to these individuals as caregivers.
Teenagers and preteens, and sometimes even younger children, also serve as caregivers on occasion. These individuals are often older siblings of the children, but they may also be cousins or the younger siblings of the parent. These caregivers' availability is restricted due to school attendance, hence their care provision tends to be seasonal. Most sibling care takes place in the summers when the caregivers are out of school, although some also provide care in the afternoons during the school year. They also tend to be approached quite frequently to “babysit.” Older teenagers will provide care on their own, but younger caregivers will generally provide care under the supervision of adults or when adults are nearby. The age at which unsupervised care provision is considered appropriate varies widely by family and also on the basis of the caregiver’s experience.

With the exception of young siblings or cousins and, of course, fathers, virtually all of these individuals can serve as surrogate as well as supplemental caregivers. In voluntary surrogate arrangements, the individuals serving as caregivers are almost always relatives, although other individuals close to the child, such as godparents, do occasionally fill this role. With involuntary, formal arrangements, however, the variety of placements is somewhat broader, and can include other non-relatives or the group home.

**Determinants of (and Limits on) Caregiver Availability**

While there are a wide range of individuals who can potentially serve as caregivers, few families have all such individuals available to them. Some parents seem to have a wealth of caregivers available to them, while others struggle to find one. Although not universally true, the number of potentially available caregivers is largely a
function of the size and strength of the parent’s extended family and community-based networks and their position within these networks.\textsuperscript{141}

Generally, those who are most successful in finding child care are those with deep roots in the community and a number of relatives nearby. Individuals who have spent their entire lives (or at least the majority of it) on the reservation and who also have large numbers of family and friends in the community tend to have stronger networks from which to draw potential caregivers. While this does not ensure that a satisfactory caregiver will be found, it certainly makes it more likely. Those who were not raised on the reservation or with little family in the immediate vicinity tend to have the most problems finding informal caregivers.

One of the first mothers I interviewed had precisely this problem. Georgina is a 37-year-old Apache woman who grew up in California and only moved to the reservation as an adult. Her parents and much of her extended family – the very individuals that most Apache women look to first when seeking caregivers – remain in California. A few relatives, including an aunt, do live on the reservation; Georgina noted, however, that she is not very close to these individuals since she was not raised in the community, and consequently she does not see them as “available.” Georgina’s husband was raised on the reservation, but his relatives live in a relatively distant community and they do not help with child care except for occasional babysitting. As a result, Georgina has struggled for years to find acceptable and reliable child care for her two-year-old son Ethan.

\textsuperscript{141} Chapter 7 provides a more in-depth discussion of the role and place of kith and kin caregiving in family and community networks characterized by exchange and reciprocity.
Caregiver proximity

Even parents who do have strong extended family networks may struggle with child care, especially when available caregivers live in communities that are too far away to be practical. As noted in Chapter 2, historically mothers generally lived and raised their children near their families; today, because of housing and employment pressures, it is not uncommon for young families to live more distant. Whenever possible, parents seek caregivers who reside in the same community as them or one very close by. For those without reliable transportation, proximity is a particularly critical issue.

A few interviewees, however, related driving amazing distances to access caregivers. The financial and lifestyle pressures of such commutes make such arrangements difficult to sustain in the long run. For Lena, a 40-year-old married mother (and grandmother) residing on the northern edge of the reservation, it was enough to compel her family to move. Lena and her current husband grew up in the same community southwest of Whiteriver and the majority of both their extended families remain in their home community. Although her two children from her first marriage are grown, she needed child care for her youngest child from her second marriage – two-year-old Eli – who was not yet in Head Start.

At the time of our interview, Lena and her husband had just starting using a neighbor with a young child of her own to provide child care for Eli during the hours they were both working. While this neighbor was in many ways an excellent caregiver, there were two issues: the neighbor was only available to watch Eli through the end of the summer, and Lena expressed a strong preference for using a relative instead. Up until about six months prior, Lena and her husband had in fact been using a relative – Eli’s
paternal grandmother – who still lived in the community where they were raised. The problem was the distance. Lena’s husband had to leave the house every morning at 5 am in order to drive Eli the 40 miles down to the grandmother’s house and then backtrack 20 miles to his job in Whiteriver by 7 am. They did this for almost a year before deciding that they simply could not afford the amount of money they had to spend on gas. In the intervening period they struggled with child care, cycling through the day care center, Lena’s brother, and a cousin of Lena’s before seeking out the neighbor’s help. A few months before I spoke with Lena, she and her husband had put in an application for a house in a new development that was only a few miles from the grandmother’s house, and they had just been notified that their application was accepted. They were hopeful that they could move into their new house and have their son back in the grandmother’s care before the arrangement with their neighbor came to an end.

**Meeting needs and meshing schedules**

While extended family and community networks provide a pool of potential caregivers, there is no guarantee that someone will be available to provide care during the needed hours. Different parents have varying needs both in terms of total hours as well as specific schedules. While those just needing occasional caregiving may have some flexibility, those who are in school or working generally have very specific days and times when they need caregiving assistance.

The most accessible caregivers are generally those who are not employed. This is not to imply that individuals who work never serve as caregivers; many do, especially those employed part-time or seasonally. However, individuals who are not working
generally have more flexible schedules and can more easily accommodate the parent’s caregiving needs.

Even caregivers who do not work, however, may have other constraints on their time or availability. Some travel and are hence periodically unavailable. Others may already be providing care to a number of children, and feel their hands are full. One young mother I interviewed found this to be the case. Raysha, a quiet, 16-year-old first time mom, lives with her aunt, her 12-year-old sister, and her five-month-old son Dion in a rather run-down old house. Her boyfriend – Dion’s father – does not live with them, but takes Dion on weekends. After Dion was born, Raysha decided to take some time off from school. When I talked with her, she told me she was planning to go back to school at the end of the month, but was having a difficult time finding a caregiver. Raysha really wanted her mother, who lives in a neighboring community, to care for her son while she was at school. Unfortunately, her mother was already providing full-time care to three of her other grandchildren, one of which, Raysha explained, was “mean” to Dion. While Raysha really wanted her son to be with someone she knew and was comfortable with, she also wanted her son to be the only child in the individual’s care. She was concerned that a caregiver watching other children would be too distracted and not watch him closely. Raysha’s network was rallying to help her explore other options, but had not found anything at that point. When I talked to Raysha’s mother a month later, I learned that she did finally find an acceptable and workable arrangement by splitting care between her father and another unrelated individual.
Challenging schedules

Parents who work “standard” schedules have the widest variety of caregiving options. Not only can they use kith and kin caregivers, they could pursue formal child care options if they so desired or if kith and kin care was unavailable. Those who need assistance with child care in the evenings or on the weekends, however, generally have no other option than kith and kin, as do those who work shift schedules or irregular hours (Porter 1998; Porter 1999).

Individuals with variable schedules or work hours that start extremely early or extend into the night generally face the greatest challenges in finding caregiving arrangements. Those working night shifts find in-home caregivers to be extremely advantageous since this allows them to avoid disrupting their child’s sleep. Others like Farrah, the young divorced mother who worked at Sunrise, seek to minimize the disruption to their child by going instead with surrogate care.

It is not uncommon for those with unusual work schedules to be forced to piece together complicated caregiving arrangements involving a number of different individuals. Abieta, a 44-year-old mother of three and grandmother of one, works alternating shifts at the hospital. Some days she works 6 am to 4:30 pm, other days her shift lasts from 4 pm to 2:30 am. In addition, her days off sometimes fall on weekends, other times on weekdays. Abieta’s household includes her husband, who works a standard daytime weekday shift, her 18-year-old daughter who is in her last year of high school, her 12-year-old son, and her four-year-old grandson Darien. Darien is the son of Abieta’s eldest daughter; both he and his mother lived with Abieta after his birth, but his mother has since moved out, leaving Abieta with primary responsibility for Darien.
Abieta says her schedule makes it extremely challenging to arrange consistent and dependable child care for Darien. When she works the late shift, she can watch Darien during the day, and then her husband and teenage daughter can take over when she goes to work. On weekends, her husband can provide care. Her challenge has been arranging care on those weekdays when her shift starts at 6 am. It is too early to drop Darien off with a caregiver on the way to work, so her daughter often dropped him off on her way to school. Until recently, Darien’s other grandmother had been providing care on these days, but she had been forced to go back to work. Abieta had been looking for another caregiver, but emphasized that her unusual schedule made it difficult.

Sometimes, in cases like Abieta’s, non-standard schedules allow spouses or partners to share caregiving responsibilities when their days or hours of employment differ. This can be an effective way of reducing the hours of outside care needed; rarely, however, does it completely eliminate the need for supplemental child care. Lena, for example, who was moving her family back to her natal community to ease their child care difficulties, told me that her current work schedule allowed her and her husband to share their son’s care between them on Saturday through Tuesday. Lena is off Sunday through Tuesday, and her husband is off weekends, thus they only needed child care for three full days per week.

In a similar manner, Marvene, a 21-year-old married mother of two preschool girls, shares child care responsibilities with her husband Evans. Marvene works a standard work week in her job in tribal administration, but Evans’s days off from his job at the grocery store vary from week to week. Thus, Marvene is home with the children on the weekends, and Evans watches the children on whichever weekdays he has off.
To fill in the remaining days, they have sought help from a number of different relatives, including her in-laws with whom they live, but at the time of the interview it was a cousin of Marvene’s who was providing child care the other days.

*Seasonal work and seasonal care*

The seasonal nature of many of the jobs in the White Mountain Apache community likewise influences child care needs. Families where at least one member is employed seasonally, for example, may only need to look to outside caregivers for part of the year. Such is the case for Brenna, a 36-year-old mother of four, and her family. Brenna lives with her partner Rick, their two children who are both under two, and one of Brenna’s two teenage daughters from a previous relationship (the other lives with her father on the far side of the reservation). Brenna works variable shifts at the casino that often include some nighttime hours. Rick works at the ski resort seasonally, from approximately late fall through early spring. During the months Rick is not working, he assumes responsibility for the children while Brenna is working. However, during ski season, they have to look to outside caregivers. Brenna does not have any family living nearby, but a large part of Rick’s family, including his mother, live in the next community over. Every year, when Rick returns to work, his mother assists with child care, watching Brenna and Rick’s two young children on those days when they are both working. And every spring, when Sunrise closes for the season, his mother returns her caregiving responsibilities to Rick and takes a much needed break.

Other seasonal jobs, wildland firefighting in particular, create their own caregiving challenges. During fire season, wildland firefighters can be called out with only a few hours notice and may be gone three weeks out of every month. When I met 31-year-old
Linda, her husband Nolando had been working as part of the Hotshot crew based out of Fort Apache for a number of years. While Linda appreciated the income that Nolando earned while out on an assignment, his career in wildland firefighting made their lives a little crazy and unpredictable. Linda worked full-time for the tribe, and needed regular care for her and Nolando’s three girls, ages seven, five, and two. During the winters, Nolando cared for the girls full-time; during fire season, he cared for them when he was home. However, when he was called out to a fire, Linda’s mother took over care of the three girls, sometimes on a moment’s notice.

Single mothers working seasonal jobs such as firefighting may have to get a little more creative in terms of their child care arrangements. One young mother I interviewed, 21-year-old Eva, told me that her own mother Josephine had worked as a wildland firefighter when she was young. As with Nolando, this required Josephine to be gone frequently in the summers, often for weeks at a time. Eva said that her aunt and grandmother traded off caring for her and her siblings when their mother was gone, creating an effect which Eva jokingly called “bed-hopping.”

Individuals who are employed seasonally, or who are off from school for the summer, can also serve as valuable sources of child care in their off months. As I noted in Chapter 2, many families take advantage of the summer holidays to utilize older children as caregivers for their younger children, who are also out of school. This can be especially helpful since Head Start does not operate in the summers, leaving some families of preschoolers with additional seasonal caregiving needs.

Several individuals I spoke with reported using kith or kin who worked seasonal jobs to assist with child care for at least part of the year. Evette, a 25-year-old mother of
two boys, ages six and one, used two different relatives to piece together care throughout the year. Evette, her boyfriend, and their children share a house with Evette’s father, her cousin, and her cousin’s newborn child. Evette works part-time in the mornings and needs child care during those hours; her boyfriend is off on Mondays and Tuesdays and occasionally watches the boys on those days. When I talked with Evette in early April, she had just returned to using her children’s paternal great-aunt Lupita as a caregiver. Lupita works at the ski resort, and had just come off her season there. During the winter when Lupita is working, Evette uses her children’s paternal grandmother as the caregiver. While the grandmother is perfectly happy to watch the children, she also works part-time, and hence prefers not to serve as the children’s caregiver year-round.

Another mother, 30-year-old Lolita, made use of the seasonal availability of several individuals to piece together child care for the youngest of her three children, three-year-old Tyroy. Lolita works full-time days at the casino, and her husband works construction, leaving them with a minimum of 40 hours of child care need a week. Lolita’s uncle is off work during the winter, and Tyroy spends that time in his care. During the summers when Lolita’s 14-year-old daughter is not in school, she helps with child care but does not do it full-time. During the rest of the year, Lolita seeks caregiving assistance from one of her cousins.

WHAT DO PARENTS WANT? VALUED QUALITIES AND CAREGIVING PREFERENCES

Parents invariably have strong preferences in regards to caregivers and caregiving options as well as very specific qualities that they look for in potential
caregivers. These preferences derive both from personal values and beliefs as well as shared community and cultural values. They are also, however, influenced by the very practical needs of parents and their concerns about the welfare of their children.

The qualities a parent values are incorporated into individual conceptions of ideal or preferred care, and thus play a significant role in child care decisions. Preferences influence whether parents pursue kith and kin care or other forms of child care. They also can encourage parents to approach certain caregivers and avoid others. Certain caregiver qualities are considered so important that their absence almost certainly removes a potential caregiver from consideration. An individual’s “fitness” to provide care is judged on the basis of the qualities they possess or lack.

In my discussions with White Mountain Apache parents, I asked them to describe the qualities that mattered to them most in a caregiver for their children. The qualities mentioned most frequently are discussed below. While many parents went on to associate valued qualities with kith and kin caregivers, most of the qualities they specified are not unique to this type of care, nor do they characterize every caregiver. In addition, while I attempt in this discussion to address these qualities separately, many were intertwined in parent’s narratives and are not so easily disentangled.

**Valued Caregiver Qualities**

**Trust**

By far, the quality that came up most frequently in discussions with parents was trust. More than three out of every five parents I interviewed cited “trust” as one of the most important qualities they looked for in a caregiver for their young children. As one
Apache mother commented, you are “putting your children’s lives” in another person’s hands; hence, it is important that you be able to trust the caregiver to take good care of your children and keep them safe.

Parents in other studies have also been found to cite trust as an important variable in relying on kith and kin for child care. “Trust” can have many meanings and nuances – it can signify familiar relationships and surroundings where a child will feel secure or an individual who feels a genuine warmth for the child; it can also indicate that the caregiver shares the parent’s values (Emlen 2000).

Discussion with parents in my study too showed “trust” to have many meanings. Marie is a 38-year-old mother of five girls ranging in age from 6 months to 21 years; the three youngest are all under four years old and are the product of her relationship with her long-term partner Max. Max works full-time but Marie does not work, and hence she does most of the caregiving herself. Until recently, she had been home alone all day with her three young daughters, and she emphasized that she needed caregiving assistance to get anything done around the house. Her two older daughters, ages 15 and 21, had rejoined the household just prior to our interview, and Marie said they were a great help. As Marie joked, “now I can actually go to the bathroom and close the door!” Any potential caregiver, she emphasized, had to be someone she could trust. As she explained,

Someone who takes good care of the girls … I don’t like diaper rash on the baby, so someone who changes diapers often. Someone who won’t just leave her alone with a bottle in her mouth on the sofa … she might choke! Someone really dependable who takes good care of kids.
As with Marie, “trust” for many Apache parents is closely tied to familiarity with the individual, on the part of the parent as well as the child, and knowing that the child will be well cared for and safe with that individual. Parents want to be sure that a potential caregiver has the best interests of their child in mind and that their child is comfortable with that individual.

This overarching concern with trust was, as parents explained, one of the primary reasons that they preferred their children to be in the care of relatives or, in some cases, close friends. Marie, for example, would only entrust her youngest children to the care of her older daughters or her mother or sister, both of whom lived only a few doors away. Kith and kin are certainly not the only individuals who can be trusted, but many parents feel that they can trust relatives more readily than other individuals. As another mother lamented, you never really know whether you can trust an individual. Relatives, because they are better known, are generally seen as a safer option. Some parents commented that the only individuals they would ever trust to care for their children were relatives; for others, only very specific relatives – generally their own mothers – were to be trusted.

For these reasons, a willing maternal grandmother is, for many, the idealized caregiver, especially for very young children. As working-class mothers in one study explained, a mother trusts her own mother as she would trust no one else – “grandmothers and other close relatives [are] assumed to be bound to the best interests of the child by deeply emotional and lifelong love” (Zinsser 2001). Close relatives, especially grandparents, are presumed to not only provide better care, but to understand the children better than anyone else as well (Porter 1991).
Trust is also central to opinions about formal care options. Brown, et al. (2001) note that Indian parents are often distrustful of large child care centers, even when they are run by community members. They are structures representative of a different culture, filled with caregivers with whom parents are generally not intimately acquainted. Some Apache parents in fact expressed concern as to whether their children would be cared for well enough at the day care center. Others, however, preferred to use the day care center because they trust the care received there more. Here, trust is once again tied to multiple issues – the fact that care at the day care center is consistently available and predictable, that caregivers are held to certain standards and regulations and subject to oversight from center administration and the state, and that parents know at all times where their child is.

*Trust and drinking*

Conversations about trust were so commonly intertwined with concerns about drinking as to deserve separate discussion. Several individuals specifically contrasted “trust” and “drinking” in their discourses, implying that individuals who drank were unreliable and unfit to care for children. Whether an individual drank or not seemed to be a minimum requirement in determining whether an individual was trustworthy and fit to provide care. Even relatives – generally considered more trustable than other individuals – were only considered worthy of trust if they did not drink.

For some individuals, this considerably shrank the pool of relatives who could be considered as caregivers. For Arnita, a 29-year-old mother of three, it meant refusing her own sister’s offer to serve as a caregiver. Arnita is reluctant to let her sister watch her two-year-old son because her sister has a drinking problem. Instead, Arnita and her
partner depend on his father and sister to provide care. As Arnita noted, what is most important to her in selecting a caregiver is knowing her son will be OK; because her sister drinks, she could not be sure of this. Jennifer, whose story opens this chapter, similarly will not let two of her sisters watch her children because they drink. This decision came as the result of a bad experience. Jennifer had approached one of her sisters to watch her children on an occasion when her parents were unavailable. Her sister agreed, but then jeopardized the children’s safety by taking them with her to the bar and not using a car seat for the baby.

As Jennifer makes clear, concerns about caregivers who drink are tied primarily to concerns about children’s safety and the quality of care and level of attention they would receive from the caregiver. Individuals who are drinking cannot be expected to pay enough attention to children to ensure they are safe, nor are they likely to put the needs of the children in their care first. However, as another mother’s story demonstrates, not drinking – while certainly a minimum requirement for trust – is certainly not the only factor that should be considered. Brenna, the 36-year-old mother who uses caregivers seasonally during the months her husband is working at Sunrise, commented that she previously had a non-relative caregiver for her youngest daughter whom she had trusted, as she said, specifically because she did not drink. However, one day when she went to pick her daughter up, she discovered that for some unknown reason, this individual had shaved all her daughter’s hair off! Both she and her boyfriend were very upset by this, especially considering that they were paying the caregiver “good money.” Brenna commented that, “my boyfriend got after me after that and I took my kids to their [paternal] grandmother.” Her experience with this babysitter had caused
her, as she put it, to “not trust anyone with my kids.” Significantly, the grandmother was exempt from this general lack of trust.

Grandmothers, in fact, generally seem to be individuals who are considered inherently trustworthy when it comes to caring for and protecting the welfare of their grandchildren. As one grandmother noted, her son and daughter-in-law asked her to watch their kids because “they don’t trust anyone around here because everyone drinks.” But, she noted, they trusted her. Not all grandparents were individuals, however, that had always been worthy of such trust. Several parents told me that their own parents had drunk heavily and been generally neglectful when they themselves were young; as they aged, however, and especially when they became grandparents, they put the alcohol aside and became, both in the eyes of their children and the community, trusted and upstanding individuals. As grandparents, these individuals could be trusted to provide excellent care for their grandchildren, even if the same could not have been said of them in their younger years.

**Experience**

Another caregiver quality highly valued by parents was experience. Experience with children was closely tied to trust as well – someone who has raised or cared for many children can be better trusted to provide good, age appropriate care to a child. Some parents specifically articulated that they wanted someone who was an experienced caregiver to watch their child. Others, however, expressed this preference more subtly, through their preferences for grandmothers and others with years of

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142 Quintero (2000) describes this process of “aging out” among Navajo males. One important factor in cessation of drinking cited by these men were the responsibilities associated with raising children.
experience raising children of their own, and their unwillingness to use anyone lacking experience with children.

Richanda, the 22-year-old single mother who wanted her mother to watch her six-month-old son when she goes back to work, told me that she only trusts family members to care for her son, and it is her mother whom she trusts the most. For Richanda, her faith in her mother as a caregiver is tied to her mother's experience. She noted that her mother has raised a lot of kids, and thus has a lot of experience. Interestingly, however, she did not raise Richanda; as noted earlier, Richanda was raised by – and continues to live with – her maternal grandparents.

Grandmothers in particular are acknowledged as being experienced and knowledgeable caregivers, and as such are generally trusted above all other caregivers. Experience with children, however, is certainly not limited to grandparents or others with grown children. Other individuals, even those without children of their own, are on occasion selected as caregivers on the basis of their experience in caring for children. Belinda, a 30-year-old single woman with an adopted nine-year-old daughter, has been caring for children ever since she was 12. At the time I spoke with her, she was working full-time at the casino and, in her off-hours, serving as a supplemental caregiver to her sister Danetta’s two children, ages four and two, and her cousin’s two children, ages four and 18 months. In addition, her 14-year-old niece was living with her for the school-year. Belinda said her cousin had just recently sought her out as a caregiver, after her previous arrangement with another of Belinda’s sisters came to an end (this sister was expecting her first child and decided she needed the time to prepare for her own child). She believes her cousin sought her out specifically because of her years of experience
caring for children and the fact that she has taken the effort to take CPR and a number of early childhood development classes.

Shared values and practices

Parents not only want a caregiver who is experienced, they want someone who will take care of their child in the same way they do. In other words, they want to be sure that the caregiver shares their basic values and practices related to child rearing and child caregiving. This is yet another reason why a grandmother is often the preferred option; as one mother noted, she knows how her mother raised her, and she knows her mother will do the same with her daughter.

For minority parents, the use of kith and kin as caregivers helps ensure that the caregiver shares their cultural values, traditions, practices, and language\textsuperscript{143} (Fuller, et al. 1996a; Pine 1999). In the White Mountain Apache community, this specifically is not as large of a concern. Relatively few outsiders live on the reservation,\textsuperscript{144} and virtually no one goes off-reservation in search of child care, thus any potential caregiver most likely shares, at least broadly, the same cultural heritage. However, families within the community do differ in terms of the religion they practice, the extent to which they value and participate in traditional ceremonies and culture, and the importance they place on

\textsuperscript{143} Those who are part of the dominant ethnic group and culture can generally assume that both formal and informal caregivers in their community share their basic value set. However, those who are members of historically subordinated racial ethnic groups often feel it necessary to seek out members of their own ethnicity, both to create a racially safe environment for their child and to ensure their child is enveloped in their culture (Uttal 1998). While the Apache community has experienced in the past — and to some extent continues to experience — prejudice and discrimination, this comes from outside the reservation community. All caregivers whom the individuals I interviewed used were members of the reservation community, and all but one — an older white woman who had lived in the community and provided child care for over 20 years — were Apache. Even the day care center was staffed entirely with community members.

\textsuperscript{144} Only approximately 10 percent of those who live on the Fort Apache reservation are not Apache; only six percent are not Native American (Source: Census 2000 AIANSF, Table PCT1, Fort Apache Reservation).
their children speaking Apache, and the use of a related caregiver increases the likelihood that they have analogous practices and views.

**Dependability**

Parents are also concerned that their caregivers, and hence their caregiving arrangements, are dependable. More than one out of every three parents either explicitly mentioned that one of the main qualities of an ideal caregiver is that they are reliable or dependable, or expressed their satisfaction with a current arrangement by emphasizing that it was dependable. Even more noted that previous arrangements had failed because caregivers were unreliable. For many, dependability was also tied up with trust – a caregiver can not be trusted if they are absent when a mother goes to drop off her children.

Relatives were generally viewed as being more dependable than non-relatives. Arnita, the 29-year-old mother of three who refused to use her sister who drank as a caregiver, commented that she had “ventured out” before in search of child care, but “those were the ones that wouldn’t be there” when she needed child care. Now she tries to keep caregiving within the family and, as noted earlier, was using her partner’s father and sister as caregivers at the time of our interview. Many parents had arrangements with kith and kin that were very reliable, but approximately one in four described either intermittent or constant problems with child care falling through. Intermittent problems could be dealt with by finding back-up caregivers or taking an occasional day off work, especially if it was a particularly well-liked and trusted caregiver, but more regular problems made caregivers impracticable and unusable.
For some, formal care options presented the ultimate in dependable care, but in actuality occasional problems with availability affect all forms of child care. Individuals using home care providers reporting occasionally needing to find alternate arrangements when a caregiver was ill or had a family crisis. Even those using the day care center occasionally needed to find back-up care, either when their child was ill or the day care facility closed for the day.

**Familiarity**

Many parents also expressed – though not all explicitly – that they wanted to use caregivers who are familiar individuals. They want to be able to leave their child with an individual the child knows well and is comfortable with. Generally, this concern with familiarity leads to the use of relatives or other individuals who are active participants in their networks as caregivers. Evelyn, a married 26-year-old mother of two who lives in a multi-generational household that includes her mother, commented that her seven-month-old son was afraid of many people but was comfortable with her mom. Her decision to use her mother as her son's caregiver was based largely on this consideration, although the fact that her mother was very dependable, in the same household, and available when she needed caregiving assistance was also important. Other individuals, such as godparents, friends, and neighbors, may also be familiar to a child, and several parents using such individuals as caregivers mentioned that the child's familiarity with the individual had been an important consideration in their decision.

This concern with familiarity is not solely for the child’s benefit, however. Parents prefer to use an individual who they know well and are comfortable with. Familiarity is implicit in considerations of trust, and familiar individuals are more readily assessable in
terms of their suitability as caregivers. Parents are more likely to know whether a familiar individual drinks and whether they are dependable. It is also easier to judge whether a familiar individual shares the parent’s values and hence what a child will be exposed to in that individual’s care.

Environment

Less commonly mentioned, but still important for many Apache parents, is the caregiving environment. Generally this referred to the physical environment in which the child was cared for – parents wanted to be sure that the neighborhood was safe and that the caregiver’s house was clean. In some cases, their concerns were not limited to safety but also included enrichment – they wanted the caregiver’s home to have a fenced yard where the children could play and a number of toys. References to the moral environment came up occasionally as well. Parent’s concerns with alcohol use mentioned above focused primarily on the physical safety of the child, but there were also some references to the questionable values of individuals using alcohol. One mother, a member of an Assembly of God church, specifically referenced concerns about religion, emphasizing that she didn’t want any “devil worshippers” watching her child.

Education

A handful of parents also mentioned that they preferred that their children were in an environment that was educationally enriching. These parents were specifically interested in a child care setting that would help prepare their children for school, and because of this most either used or preferred formal child care. The fact that the staff at
the day care center “taught” their children, in addition to providing care for them, was seen as a definite benefit. As one parent emphasized, she wanted her son to learn and “not be kicking back all day at a relative’s house.” More than one parent explicitly contrasted the educational benefits of day care with the more typically custodial care that kith and kin were viewed as providing. Another commented, “My son learns more in day care. With the family, he is just running around, watching TV.”

Because almost every child in the community attends Head Start, educational issues in relation to child care are not as prominent as they might otherwise be. Parents’ views of what is important change as their children age; many are not as concerned about the educational aspects of care prior to the age that their children are enrolled in Head Start. Many, but not all, parents are content with “custodial care” while their children are infants and toddlers; they are generally unconcerned about whether caregivers teach their children their colors and ABCs while in their care. For other families still, the cultural lessons and language exposure received in the care of relatives are more important than preparation for formal (Western) education.

**Caregiver Qualities, Preference, and Choice**

When parents have a number of options or individuals from which to choose, caregiving preferences help guide their decisions. Such preferences, however, must be balanced against the needs and wishes of other involved parties, and may be irrelevant when choices are limited or non-existent. Preferences thus influence, but do not

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145 Here, custodial care simply refers to the practice of physically providing care to children. These days, custodial care is almost always characterized as being undesirable or of inferior quality, due to the belief that it does not “enrich” children. It is not my intention, in using this term, to characterize kith and kin care negatively in any way. In fact, as will be discussed in Chapter 5, kith and kin care can be quite enriching as well, although in a somewhat different sense.
necessarily predict, what caregiving option or caregiver is ultimately used. Conversely, the use of a particular caregiver or form of care does not necessarily mean it is preferred; instead, it may reflect a lack of options or financial or other considerations.\(^{146}\)

These qualities that parents find important in caregivers are integrated into perceptions of caregiver fitness. Not all of these qualities are given equal weight, however, nor do all parents define or evaluate fitness in the same way. All parents have definite, though somewhat individualized, ideas about what constitutes “minimal standards” of care. Parents will generally not use a caregiver whom they perceive as unfit to provide care, although in situations when caregiver choice is extremely limited, parents may find they have no other choice.

Most parents, for example, would never consider using a caregiver who drinks, out of concern for their child’s welfare. Frequent and/or unanticipated caregiving failures are also generally considered unacceptable. A caregiver’s health and age are sometimes also considered when evaluating their fitness. Some parents question the fitness of older caregivers, for example, out of concern that they did not have the stamina to serve as full-time caregivers or that chronic health problems could interfere with the caregiver’s ability to care for young children.\(^{147}\)

The majority of parents associated the qualities they preferred with kith and kin caregivers. Apache parents generally consider relatives to be more trustworthy and

\(^{146}\) Uttal (1999) points out that in some cases the use of kith and kin caregivers may reflect money problems, a lack of other caregiving options, or the economic needs of other individuals in the extended family network rather than a preference for this type of care.

\(^{147}\) It should be noted, however, that the caregivers often did not agree with these assessments. Some older caregivers admitted that they often felt tired at the end of the day, but they still felt they could function effectively as caregivers. Many caregivers with chronic health problems likewise felt that these problems did not interfere with them caring for children.
dependable than other caregivers or forms of care. They are familiar individuals whose caregiving experience is more easily assessed, and are more likely to share the parents’ values. They are, as Biolsi, et al. (2002:141-2) discuss in relation to parents on the Rosebud Sioux Reservation, “… concerned about outside influences and prefer to have their children cared for by family members who will not only be vigilant over the children’s welfare, but will also be in a position to pass on their own values, traditions, and family history.”

As several parents made clear, however, not everyone in the community wants relatives, friends, or neighbors to care for their children. Some prefer formal care. Because formal care was not the focus of my research, however, and because of the limited number of slots at the Chagnache Day Care Center, it is difficult to judge to what extent formal day care is preferred in this community. Many interviewees expressed interest in formal care, lamenting the fact that the day care center was always full or that there were not more centers spread throughout the various communities on the reservation. At the same time, however, many complained about the expense of child care at Chagnache. In truth, the day care charged only a few dollars more per day than what the average individual paid a kith and kin provider for care; in addition, many of the slots at the day care center were subsidized, with the result that some parents paid quite a bit less for day care than they might for informal care. These perceptions regarding the expense and availability of slots, however, kept many parents from even investigating formal child care more fully as an option.

On the other hand, not all those who use the day care center prefer this form of care. Some view it as a last resort, only to be used when no suitable kith and kin
caregivers are available. The day care center director commented, in fact, that many people who use the day care center do so because they cannot find relatives to care for their children. This hypothesis is further supported by the trend, noted by the director, of parents pulling their children out of the center during the summers, and using older brothers and sisters as caregivers instead. This tendency may be at least partially economically-motivated, but it may also reflect a preference for relative care.

Other parents use neither kith and kin caregivers nor formal child care options, instead “choosing” to do all the caregiving themselves. For some, this is a conscious, intentional choice – they want to care for their children themselves, and they make the necessary arrangements to enable them to do so. For many others, however, it is not the preferred option, and not really even a choice. Instead, it is what they are forced to do when no other safe or dependable option is available.

Vertie, a 44-year-old married mother of three grown children and surrogate mother to her 23-month-old twin grandsons, left a high-profile position within the tribe to stay home and care for her grandsons after they came into her care. The twins, who were born extremely premature at 25 weeks, have chronic respiratory problems and are particularly prone to getting sick. While she would love to find an alternative caregiver for the twins, she feels she must limit their exposure to outsiders, particularly other children. Hence, any alternative caregiver, in addition to having the knowledge and skills to care for the twins, could not have any other children in their care, and the search for someone meeting these criteria has proved futile. Her decision to be the sole caregiver

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148 Since I did not interview parents using formal day care for their children, this supposition cannot be independently confirmed.
was tied to the fragility of the boys’ health, and her belief that no one else would work as hard to protect their health as she would.

Other parents cared for their children themselves because they trusted no one else. Twenty-four-year-old Tony, for example, lives with his girlfriend and their four-year-old daughter in a very large household (approximately 24 individuals) which includes his mother as well as numerous siblings and their families. In spite of the wealth of potential kin caregivers in the same house, Tony told me that he didn’t really trust anyone else in the household with his daughter. He felt that his siblings did not watch their own kids that well, citing as evidence the fact that many of the other children in the household had been sick and in the hospital recently. However, since neither Tony nor his girlfriend was employed at the time, there was not a pressing need for alternative care, and they simply shared caregiving responsibilities between them.

Parental care is certainly not indicative of a distrust of kith and kin, nor does it preclude significant involvement of kith and kin in children’s lives. Thirty-one-year-old Linda, whose husband Nolando works as part of a Hotshot crew, told me several months after I first spoke with her that she had recently quit her job in order to spend more time with her daughters. Although she was then providing the majority of care for her two-year-old daughter Shanae, she noted that her daughter frequently asked to go visit the grandmother, aunts, and uncle who had served as caregivers for her since the time she was three-months-old. Sometimes Linda would simply drop Shanae off at their house, and other times she would stay and they would all visit.

Several mothers who indicated they were not using supplemental caregivers explicitly stated that staying home and taking care of their kids was a priority for them, at
least for the first few years. Such was the reason 22-year-old Richanda gave for not yet seeking employment; she didn’t want to miss her son’s first steps and thus was not going to look for a job until he was at least one.

Sometimes kin helped mothers out financially to allow them to stay home and care of their children themselves. Twenty-five-year-old Denyse, a single unemployed mother living on her own with her two-year-old son, explained that her mother gave her money to pay for rent and utilities so that she didn’t have to work. Denyse’s job, according to her mom, was to take care of her son. Others wished they were so fortunate – Fernanda, a 36-year-old married mother of three who was working two jobs at the time I interviewed her, commented, “I wish I was rich so I could stay home with the kids.”

CAREGIVER EXPECTATIONS AND MOTIVATIONS FOR PROVIDING CARE

Thus far, this chapter has focused primarily on the parent’s perspective. Parents generally seek out those individuals who they perceive as best fitting their caregiving needs and preferences, however, these must be balanced against the needs, desires, and obligations of the caregivers themselves. What is it, then, that motivates an individual to serve as a caregiver?

Motivations for providing care to young children are as varied as the individuals providing care. In some cases, the motivations for providing supplemental and surrogate care differ. Often, however, they are very similar, and hence caregivers’ motivations for providing these two forms of caregiving will be discussed here together.
Caregivers almost always play an active role in negotiating arrangements; rarely do they simply acquiesce to the wishes of the parents and children. Potential caregivers consider the needs and resources of the parents and child, and balance these considerations against their own preferences, needs, and resources. Cultural and familial expectations about caregiving, as well as the potential caregiver’s relationship to their child, also influence these individuals’ decisions about providing care.

Multiple Pathways to the Role of Caregiver

There are many different pathways that lead to an individual serving in the role of caregiver. An individual may agree to serve as a caregiver when approached. Caregivers may also be the driving force in initiating caregiving arrangements. Some actively seek out a child to care for on a long-term basis; others volunteer to serve as supplemental caregivers when they sense their assistance is needed.

While many caregivers are able to detail the circumstances under which they became caregivers, for some – especially those who have been providing care for many years – the specifics of the situation had faded from memory, or may have never been that important. One 61-year-old grandmother, when asked how she came to be caring for her two grandsons who live with her and for whom she takes primary responsibility, simply said that she “just got them.” Another, a 48-year-old grandmother who was the head of a very large extended family household including a grandson whom she had adopted, joked, “I guess I was made for this – to stay here [and take care of the grandkids] and let [my children] have fun.”
Caregiving expectations

Many caregivers, grandmothers in particular, do have a sense that caregiving is something they were “made” to do. They expect – and, in many cases, eagerly anticipate – that they will provide care to their grandchildren in some form or another. Whether this caregiving role grows out of a desire or a need to care for and protect their grandchildren, their identities are often closely intertwined with the care of their grandchildren. Many even credit their well-being to the joy and satisfaction that this role brings to them.

Many parents likewise expect grandmothers to serve as caregivers for their grandchildren. One group of mothers I spoke with unanimously agreed that grandparents were expected to care for their grandkids, but they emphasized that the grandparents really enjoy having their grandkids around and want to be caring for them. These mothers also noted that grandparents are often better than moms at parenting, and that grandchildren may be even closer to their grandparents than their parents.

The centrality of this caregiving role means that, as Stack and Burton (1998) emphasize, the life-course of individuals and the life-course of families are interdependent and intertwined. Grandmothers like Helen and Vertie may be so invested in the welfare of their children and grandchildren that they quit jobs in order to provide care and fill the role within the family that they desire and/or find necessary. Grandparents, through this role and others, keep families together and functioning.

This expectation that grandparents will serve as caregivers is so engrained in some families that the caregiving relationship is just assumed; as one mother commented, she just “volunteered” her mom to watch her kids instead of asking.
Similarly, caregivers can become very upset if they feel that this role is being denied to them. As 21-year-old Charlena related to me, her 63-year-old aunt (who largely raised her) was mad at her when she enrolled her one-year-old son in the day care center. Charlena was worried about the effect providing full-time care would have on her aging aunt’s health, but, realizing how important providing child care was to her aunt and that her aunt needed the money, she eventually relented and acquiesced to her aunt’s wishes.

Motivations for Providing Care

Caregivers rarely have a single motivation for providing care. Some caregivers provide care out of a desire to assist the parent and/or child, while others cite personal motivations. Yet for many, it is a combination of altruistic and personal motivations to lead them to providing care.

Different types of caregivers do tend to have quite different motivations, however, for providing care. Relatives, for instance, are more likely to provide care because it is in the best interests of the family. The caregiver may still benefit personally, but their primary motivations tend to be quite selfless. Unrelated individuals, in contrast, are more likely to be motivated by other factors, such as money, although close friends, godparents, etc., are likewise motivated by a desire to assist the family.

Altruistic motives

Helping the parent

Many Apache caregivers said they were taking care of a child out of a desire to assist the parent. Across studies of kith and kin care, this is, in fact, one of the most

In the White Mountain Apache community, “helping out” generally means providing supplemental care while the parent is working or in school. Narcise, the married 37-year-old mother of eight whom I first introduced in Chapter 2, told me that she takes care of her two-year-old granddaughter Makayla because she wants to help her daughter Odell and she likes being around kids. Narcise only watches Makayla, however, during the hours Odell is working.

Other caregivers, however, find that the most effective way of helping their children is to provide surrogate care. This is especially true when the parent is attending school off the reservation. Stella, a married 29-year-old mother of four, told me this was why her oldest son Jessi lives with her mother Audrey (Jessi’s maternal grandmother). Before Jessi was born, Stella had been attending an off-reservation boarding school (she was only 16 when Jessi was born). Stella returned to this school with Jessi when he was about six-months-old. After just three weeks, however, Audrey drove out to the school and took Jessi back with her to the reservation. Audrey, who also had her first child at a young age, had never had the chance to finish high school, and she wanted to make sure the same thing did not happen to her daughter. Although Stella has since graduated and returned to the reservation, Jessi continues to live with his grandmother. Stella and her husband’s younger three children, however, live with them.

Some other grandmothers like Erma, the 55-year-old home care provider, indicated they were providing surrogate care to grandchildren while the parents attended
college away from the reservation. In such cases, it was generally anticipated that the child would live with the parent again once they returned to the community. Others like Jessi, however, remain in the grandparent’s household, either as a result of the child’s preferences or an unwillingness on the parent’s or grandparent’s part to disrupt what had become a stable and comfortable arrangement for the child.

Individuals also may volunteer to take in a child to help parents who are struggling with family crises, health problems, or have jobs with schedules that are not easily accommodated by standard child care. Vana, a married 35-year-old mother who herself was raised by an aunt, currently provides surrogate care to three children in addition to raising her four own children. She took in her nephew Patrick when he was first born; his mother (Vana’s sister) was having problems with high blood pressure after his birth, and the doctor wanted someone else to care for the baby for the first two weeks. Vana had at that point been married for several years and unsuccessful in having children; she thus took Patrick in “as her own.” Patrick ended up staying with Vana for six months, and then went to live with his mother. Soon after, however, Patrick’s mom got pregnant again and the problems with high blood pressure returned. Vana volunteered to care for Patrick again, and he has lived with her ever since.

Another of the children in Vana’s care came to her as the result of domestic problems at home. Kania, Vana’s three-year-old niece (who is also her goddaughter), had been living with Vana and her family for a year at the time of our interview. Kania had been staying at Vana’s house on the weekends ever since she was born; when Kania’s parents starting having marital problems, they asked Vana if she could take
Kania in for a while. Kania now calls Vana and her husband “mom” and “dad,” and Vana is relatively confident that Kania will stay with them; she says Kania is like her own child.

Helping the child

Some caregivers decide to provide full-time or permanent care to children they feel are in need or are not being cared for properly. As Shomaker (1989) notes, grandmothers will, when necessary, simply take responsibility for grandchildren they think are not being parented adequately. It is for this reason, 48-year-old Nettie told me, that she is caring for her grandson Lorenzo. Nettie is a divorced mother of eight and head of an extended family household that includes all but one of her children, their spouses/partners, and eight grandchildren including Lorenzo. Before Lorenzo was born, his mother had been living off the reservation, but she came back to live with Nettie (her mother) after she discovered she was pregnant. When Lorenzo was about a year old, however, his mother left again, leaving him with Nettie. Nettie gets mad at her daughter because she doesn’t take care of her son, but at the same time Nettie says she enjoys taking care of Lorenzo. Significantly, it was Nettie’s idea for Lorenzo to stay with her when his mom decided to leave.

In some instances this role is undertaken a little reluctantly; a few caregivers who took in grandchildren they felt were not being cared for properly either resented being forced into the role of full-time caregiver again or felt that the responsibility was putting too great a strain on them. Emmie, a 58-year-old married mother of five grown children who had been providing surrogate care for two of her grandchildren for many years, discussed the events that had led to her taking in a third grandchild, three-year-old Dena. Both of Dena’s parents have problems with substance abuse, and Dena had
been removed from the home because of neglect. This extremely active child had come into Emmie’s care four months prior to our interview; at other times in her short life Dena had been in other relatives’ homes, foster care, and the group home on the reservation. Emmie expressed concern about her ability to care for Dena, mentioning her behavioral problems and commenting that Dena makes her very tired. She also, however, emphasized that “that child needs me.” She related an image that had stayed with her of her granddaughter in the group home: she walked into the group home, and Dena was sitting in a walker, just staring off into space and listless. She commented, “I don’t want her to go through all these things again even though it’s hard for me. … I look at [my grandchildren], and I just get overprotective of them.” At the same time, however, she is resentful of being placed in this situation:

Sometimes I feel frustrated and all that stuff, because ... and I think I know I’m not supposed to be thinking like this, but I get frustrated because here I’m taking care of Dena and the mother’s just healthy and young and she’s just running around, and she’s doing nothing ...

Recognizing, however, that the well-being of this grandchild and two others rests in her hands, she said, “I pray for myself to give me health so I can take care of the kids.”

A number of grandmothers relayed such a feeling of responsibility for grandchildren that they felt were not being cared for properly by their parents. Apache grandmothers have been aptly described elsewhere as the “caretaker of last resort.” Grandparents, more than any other individual, bear the “ultimate responsibility for the physical well-being of their families” (Bahr 1994:234). No matter how it affects them, grandparents will take upon themselves responsibility for children that they feel need their assistance. In some cases, this means taking grandchildren in permanently; other
times, it simply involves temporarily taking responsibility for a child until the parent can once again care for the child or a different (stable) arrangement can be found.

In Emmie’s case, she doubted that she would care for Dena permanently; if the mother did not straighten herself out, Dena would most likely go into a permanent placement with someone else. Caring for Dena was a definite hardship for Emmie; her primary concern was that Dena was well cared for, and in her mind, she was not the best person to do this.

Vertie, the 44-year-old grandmother who left her job to care for her premature twin grandsons, similarly would prefer to not have to care for her grandsons permanently. Caring for the boys full-time has been extremely stressful; keeping up with the boys and protecting their health is physically and mentally demanding on Vertie, and the loss of her income and the expenses associated with their care have caused the family problems financially. Vertie would really like the twins’ mother to shape up and raise the boys herself, but she recognizes that the mother is not currently capable of providing the level of care the boys need. In frustration, Vertie exclaimed, “I did my job raising kids!” However, she immediately emphasized that she will do what is best for the boys, noting that “if I have to take care of the twins and raise them, I will.”

Personal motives

Caregivers reasons for taking in children are often not simply benevolent; quite often there are benefits for the caregivers themselves. Vana’s decision, for example, to serve as a surrogate caregiver to her nieces and nephews stemmed from her desire to provide a stable and nurturing environment for the children, but taking in these children
also gave her something personally. Her nephew was the child that she so desperately wanted and had been unable to have herself; having Kania around helped ease her through the difficult loss of her own child the year before.

Other individuals serve as caregivers simply because they enjoy taking care of children, particularly those who are special to them, and they get an immense amount of satisfaction from helping them learn and grow (Zinsser 1991). Many commented that caring for children gives them a purpose and an increased sense of well-being. For others, the benefit may be financial, or simply the knowledge that the children are in good care.

_Peace of mind_

Several caregivers commented that they found having specific children in their care reassuring, because this way they could be sure that the child was being well cared for. As Bahr (1994) notes, grandparents often worry about those grandchildren who are not with them and are not well-supervised at home. Parents – particularly those who are young and inexperienced – may for a number of reasons not be in a position to provide optimal care to their children. They may drink or be under a significant amount of stress due to a divorce or other major life change, they may be unstable financially, or they may simply be irresponsible. Forty-four-year-old Abieta is, for this reason, glad her grandson Darien is in her care, even though her alternating shifts at the hospital have made arranging child care difficult. Darien’s mother, she noted, likes to drink and party, and is not really prepared to settle down and be responsible for a child. Abieta knows she is providing Darien with the stability that his mother is currently incapable of providing, and
Sixty-eight-year-old Edith also expressed concern about her grandson’s welfare. Although Edith’s 29-year-old daughter Irena and her three-year-old grandson Linton have been living with her virtually since his birth, Irene had been talking recently about getting her own place. Edith said she worried sometimes about who would take of her grandson if her daughter decides to move out. Although Edith describes herself as providing child care, in truth, she does just about everything for her grandson. She fixes him breakfast everyday when he wakes up, and then gives him a bath. She takes him on errands with her, plays with him, and fixes him lunch and dinner every day. Linton even sleeps with her. Another of Edith’s daughters told her she shouldn’t let Linton move out if Irene goes, but Edith – like many other grandmothers – said she would not feel right imposing her will and keeping the child with her if this was not something the child and parent wanted. So, instead, she worries about the future and the well-being of her grandson.

A child to care for

While some surrogate care arrangements are primary for the benefit of the parent or the child, many are often initiated by the caregivers themselves, generally out of a desire to have a child to care for. In some cases, these are young women who are childless themselves, but in others, they are older women or couples whose own children are grown (Goody 1969).
Several grandmothers told of approaching their daughters, asking if they could raise one of their grandchildren themselves. Narcise, the married 37-year-old mother with three teenage boys still at home who also provides child care to a number of her grandchildren, told me during the course of the interview that she and her husband have really been wanting to adopt more children – preferably twin boys – but they have not had much luck finding any available children. Later, she told me that her daughter Odell, whom I had interviewed previously, was pregnant again (with her second child), and that Odell had told Narcise that if the baby is a boy, Narcise and her husband can raise him.

Another grandmother, 38-year-old Rolanda, jokingly told me that she “stole” her grandson Presley from his mom. Rolanda is single and has only one child – her grown daughter Terilyn – and told me she had always “wanted a little boy to watch after.” When Presley was born, Terilyn’s first child was not quite one yet, and Rolanda simply took over caring for Presley. Rolanda situation is interesting and somewhat unusual in that Rolanda’s household includes both Presley and Terilyn. Although Presley’s mother is also in the household, Rolanda takes primary responsibility for Presley, while Terilyn takes primary responsibility for her older child, two-year-old Taryn.

Not all grandmothers are quite as successful in convincing their children to let them raise one of their grandchildren. Although grandmothers may feel very comfortable asking to serve as the primary caregiver to one of their grandchildren, parents do have a right to refuse the request. Twenty-one-year-old Eva, whose mother worked as a wildland firefighter when she was young, told me that when her first son was born her mother really wanted to raise him full-time. In their family, this appears to be somewhat of a tradition – Eva’s mother gave her oldest child to his grandmother to raise when he
was just two weeks old. Although Eva did not accede to her mother’s wishes, her mother does provide child care for her son while Eva and her boyfriend are working.

While some grandparents such as Narcise, Rolanda, and Eva’s mom actively seek out children to raise, other individuals simply take advantage of situations which present themselves. Thirty-six-year-old Fernanda and her husband, for example, have three children ranging in age from 8 to 14, but have also been wanting to adopt another boy. When Fernanda’s sister gave birth to Alex five months ago, they thought this was their chance – Fernanda says her sister is an alcoholic, and Fernanda and her husband were afraid she wouldn’t care for the boy properly. They approached her sister and asked if they could take Alex, and she agreed. Although Fernanda says the mother is still heavily involved in her son’s life, she is not the primary caregiver. As a result, Alex has a more stable home environment, and Fernanda and her husband have the little boy they wanted.

Other surrogate arrangements have even more fortuitous beginnings. Bernice, a 44-year-old divorced mother of four, first met little Kalem when he was not quite two. Kalem is the child of Bernice’s ex-husband’s and his (deceased) second wife. Kalem’s mother died when he was one; after her death, Kalem’s father brought him over to Bernice’s house a couple of times per month. Over time, Bernice and her teenage daughters “fell in love with Kalem” and they decided they wanted Kalem to stay with them. Bernice says her ex-husband (Kalem’s father) drinks, and thus wasn’t really in a position to be able to care for him anyway. Bernice has a large household full of children and grandchildren, and wasn’t specifically looking to care for any additional children;
Bernice and her daughters, however, really enjoy having Kalem with them and decided to take him in permanently.

*Caregiver well-being and sense of purpose*

Both in the context of surrogate and supplemental care, caregivers talked about how caring for children gives them a sense of purpose and makes them feel needed. Several caregivers remarked that they either had “nothing to do” or that there was nothing to do in the community; caring for children gave them something to do, something they enjoyed that made them feel valued.

Such comments should not be taken to mean that these individuals truly have nothing to occupy their time; some of these caregivers work full-time, others are busy managing households. However, as Porter (1998) comments, many such individuals feel as though they have an empty space in their lives, and children fill this gap. Others have similarly noted that caring for children gives these individuals a greater purpose for living and makes them “feel alive and young” (Gattai and Musatti 1999; Jendrek 1993). As one Apache grandmother commented, “I am starting my life all over again, my life goes on with them. I was born today [when my grandchild was born]” (Bahr and Bahr 1993:362).

Because children are central to many women’s identities in this community, those without children in their home may feel something is missing, even if their lives are otherwise busy. Aleah, for example, commented that the two children she has taken in are “her life;” at 43, she works full-time in a position she enjoys, but she is divorced and her own children are grown and live out of state. Like Aleah, many caregivers even
seem to find the company of such children preferable to other kinds of company (Gattai and Musatti 1999). Grandkids keep caregivers company and keep them “young at heart;” with children around, caregivers don’t have time to worry about themselves. As Bahr and Bahr (1993) report, caring for and teaching children may even be seen as “renewing.”

For some, caring for grandchildren is more important and gratifying than employment. In one case, a grandmother who had been searching for a job decided to stop looking when presented with the option of caring for her granddaughter. Others, like 44-year-old Helen whose story opens Chapter 5, even quit jobs in order to provide child care.

Grandchildren are also, for some grandparents, a living reminder of and connection to their own lost children. Twenty-one-year-old Charlena, who was herself raised by her aunt, mentioned this in explaining why her oldest child, three-year-old Bert, lived with his paternal grandmother. Charlena told me that she and Bert had both lived with the paternal grandmother until the previous year; Charlena then moved out, but Bert stayed. The grandmother was anxious for Bert to stay with her because Bert’s father – her only son – had passed away, and Bert provided a living connection to her lost son. The arrangement also was beneficial to Charlena, because she has two younger children to care for, yet it was really the grandmother who was responsible for the arrangement.

Even home care providers, many of whom ostensibly provide child care for financial profit and consider it a business, have additional motivations for providing care. As 55-year-old home care provider Erma commented, “I can’t say I’m really doing it for
money, because I don’t make enough.” She told me, in fact, that she was considering looking for an additional job in the fall to give her and her husband a little extra money. The real reason she cares for children, she emphasized, is because they keep her young and, as she so eloquently stated, “they are the gold at the end of my rainbow.”

CHILDREN’S VOICES IN DECISIONS OF CAREGIVING AND RESIDENCE

Parents and caregivers may be the primary ones making decisions about caregiving and negotiating arrangements, but Apache children have a significant voice in these decisions as well. Just as parents have preferences for certain caregivers, so do the children themselves. To the extent possible, Apache parents pursue caregiving arrangements that not only fit their own needs, but accommodate the wishes of their children.

Children occasionally play a role in the choice of supplemental caregivers or care arrangements, but their voices are most evident in decisions surrounding surrogate care. Children not only express preferences about caregivers, they often make their own decisions about residence and in some cases even initiate arrangements. As discussed in Chapter 2, such autonomy – even in relatively young children – is a cultural trait recognized not only among the Apache, but several other Native groups as well. Children have the right to make their own decisions, in matters of caregiving as well as other arenas of life, and their wishes and decisions are respected (Greenfeld 1996; McFee 1972).
Autonomy in Decisions of Residence

Twelve-year-old Wayne, the eldest of five siblings, lives with his maternal grandparents. At the time I met Wayne and his family, he had been living in his grandparents’ household for approximately two years. Wayne’s parents and grandparents both live in a small community south of Whiteriver, and their houses are within walking distance of one another. In speaking with Wayne’s mother, she related that Wayne had made the decision to live with his grandparents on his own. Wayne, she explained, prefers staying with his grandparents because of his strained relationship with his father.149 Wayne’s mother and his siblings spend a lot of time at the grandparents’ house, so Wayne sees them nearly every day, and his mother continues to provide for him materially and coach his basketball team; he does not, however, live with them. His mother also commented that she believes he enjoys this arrangement because his grandparents do not make him do chores, and she complained about the lax standards set by the grandparents. She did not, however, question his right to make his own decision about where to live, nor did she suggest he should return home.

A rather surprising number of surrogate caregiving arrangements are initiated or prolonged by the children themselves. Even children as young as three and four express preferences about household residence, and these are generally respected and accommodated by family members. Older children like Wayne may actively seek to move to another household for various reasons, and their decisions are rarely questioned.

149 Greenfeld (1996:502-3) notes that such avoidance behavior, including moving out, is not uncommon. As he explains, “rather than create direct and open conflict, one should avoid the person and create harmony by refusing to confront the issue directly.”
Jake, who was nearly 10 at the time of our interview, lived at the time with his maternal aunt Ursula. Interestingly, it was another aunt Vierra who was actually his legal guardian. Over the years, Jake had shifted household residence a number of times; when he was very young, these decisions had been the responsibility of the caregivers, but the current arrangement was Jake’s decision. Not long after his birth, Jake’s mother had left him with his aunt Ursula, and she took responsibility for him for awhile. When he was still quite young, however, Ursula’s sister Vierra got married and subsequently took custody of Jake. Ursula left the reservation for several years, but subsequently returned. Two years prior to the interview, Vierra, Jake and the rest of their family stayed with Ursula while they waited for their own house across the street to be completed. When Vierra and the rest of the family moved into their new home, however, Jake decided he wanted to stay with Ursula. He liked living with her, and decided he wanted to remain in her household to watch over her since she is single and would otherwise live by herself. Ursula emphasized that she likes having him there – she says he keeps her company and makes her happy. She says it is up to him how long he stays with her; sometimes he will decide to stay with his grandmother or with Vierra for a few days, but for now he is content to live primary with Ursula.

Younger children generally are not instrumental in setting up surrogate care arrangements, but they often do express preferences about with whom they want to live. This is most commonly seen in instances where children spend their early years in multigenerational households (which include, most commonly, the child, the mother, and the maternal grandmother) or in the care of multiple individuals (like five-year-old Bethany, discussed earlier in this chapter, who split her time between her mother and her great-aunt while her mother was employed at the ski resort).
As discussed in Chapter 2, it is not uncommon for young mothers to remain in their natal household for a number of years after the birth of their first child. Many mothers in this community are quite young when they first become mothers and often unmarried as well. Many are not prepared to establish their own household immediately, and find living in a multigenerational household beneficial to themselves and their child. After a few years, however, the mothers frequently move out to establish their own household. Not uncommonly, the child simply decides he prefers to remain in the more familiar household of the grandmother rather than accompany his mother to her new household.

Such was the case with Abieta’s grandson, four-year-old Darien. When Darien was born, his mother still lived with Abieta and her husband, and Darien and his mother continued to live in their household for the next couple of years. When Darien was two-and-a-half, however, his mother decided to move out and establish her own residence. Initially, Darien’s mother took him with her to her new house, but he cried, so she brought him back to the grandmother’s house. Later, she tried again, but Darien was not happy there; he made it clear that he wanted to be at his grandmother’s house. So for the time being, Abieta explained, he just stays with her, although he still sees his mom regularly and even goes to her house to visit occasionally. Abieta loves taking care of Darien – she calls him her “little man.” Like many other surrogate caregivers though, she is unsure how long he will choose to remain in her household. Abieta emphasized that she would love for Darien to stay with her, but that it ultimately was not her decision. As she commented, “he may stay here and he may go live with his mom.”
While common, this autonomy given to children in making decisions about caregivers and residence is certainly not universal. There are many instances where these decisions are made by the parents or caregivers on behalf of a child. Of course, this occurs when the child is too young to make such decisions himself, but it also occurs when those responsible for the child believe it is in the best interests of the child. A parent would probably not accommodate a child’s preference if there was a good reason not to. Most often, though, children’s preferences seem to lead them to stable and dependable caregivers, such as grandparents. Likewise, a grandmother or other responsible caregiver might insist a child stay with them if they felt the child would be in danger remaining in the parent’s care.

Preferences for Supplemental Caregivers

Children’s voices are evident in some supplemental care decisions as well, but not to the extent typically seen with surrogate care. This is not to imply that parents respect children’s preferences less in this context – rather, it is simply that supplemental arrangements tend to be less flexible. Supplemental care arrangements, as discussed earlier, are generally shaped and dictated by parental need and caregiver availability; suitable caregiving options are often limited, leaving little room for accommodating a child’s preferences. Surrogate care, in contrast, is more often born out of the desires or wishes of the involved parties instead of any caregiving need, and hence is more flexible.

Four-year-old Darien, during the course of my interview with his grandmother Abieta, actually suggested a potential supplemental caregiver. Up until a few weeks prior to our interview, Darien’s paternal grandmother had been serving as his regular
caregiver during those times when both Abieta and her husband were working. But then, as Abieta bemoaned, this grandmother had been forced to go back to work full-time, and was no longer available to provide child care. Since then, Abieta had been using her own mother (Darien’s great-grandmother) as a supplemental caregiver, but felt she was too old to do it consistently. While we were discussing Abieta’s unusual work schedule and caregiving needs, Darien piped up and suggested asking his “aunt” (Abieta’s niece) to watch him. Abieta said she thought this was a good suggestion, and said she would ask her niece about it.

Younger children may express preferences through their actions rather than words. A couple of parents commented that they had pulled their children out of the day care center after they had screamed or cried while there or otherwise indicated they were not happy. Another mother commented that she tried to avoid using her mother as a caregiver for her son since he had indicated to her that he was afraid of this grandmother.

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A variety of diverse factors go into decisions regarding caregivers and caregiving in the White Mountain Apache community. Parental needs and caregiver availability are limiting factors, but ultimately a number of other variables figure into negotiations and decisions concerning caregiving arrangements. Parents, caregivers, and children all have roles and agency in the decision-making process.

Parents generally have strong preferences for particular caregivers or types of care, preferences that are founded on the basis of the particular qualities they value in
potential caregivers. These valued qualities – which include trust, experience, dependability, familiarity, etc. – guide parental decisions, but they are not determinative. Conversely, caregiver use does not always reflect preference; it can instead reflect a lack of options or other considerations.

The needs, desires, and obligations of caregivers also figure significantly into caregiving decisions and the negotiation of arrangements. Different caregivers may have quite different motivations for providing care – some are altruistically motivated, others personally or economically; some seek out caregiving roles, others have them unwillingly thrust upon them. Children’s wishes and preferences also have the power to influence and shape caregiving arrangements, and older children in particular may have quite a bit of say in decisions of residence.

As will be discussed in the following chapter, the day to day reality of kith and kin caregiving is similarly complex. Kith and kin care itself can take a number of forms and have a number of functions. It may simply serve to keep children busy while their parents are otherwise occupied or be a site of important cultural lessons. It may be compensated in a variety of ways, or seemingly be provided “free of charge.” Such arrangements may be stable and consistent over time, or continuously in flux, a source of instability and stress. And, depending upon the context and details of the arrangement, they have the potential to impact the parents, the caregivers, and the children in a variety of ways, some positive and some negative. Chapter 5 thus focuses on communicating the richness and variability of kith and kin care and the myriad of ways it affects those involved.
CHAPTER 5

THE PRACTICE AND EXPERIENCE OF KITH AND KIN CARE

• Mona and Helen ...

Mona was one of the first women I met after I moved to the Fort Apache Reservation in 2001. I first encountered 20-year-old Mona during the course of seeking tribal sponsorship of my research, and later interviewed her and spoke with her informally multiple times. Mona became a good friend and important key informant who, due to her position within tribal administration, was knowledgeable about the history and contemporary specifics and realities of child care and child care funding in the community. Over time, I also came to know the history behind her own long-term caregiving arrangement for her four-year-old son Darren.

When Darren was born, Mona was only a sophomore in high school and her boyfriend Harrison was a senior. Around the time of Darren’s birth, Mona moved in with Harrison and his parents and older sister. Harrison was able to finish out high school and graduate within a few months of Darren’s birth, but Mona still had several years of school ahead of her. She did home schooling to finish out her sophomore year, but was determined to return to the local high school for her junior year. Doing this, however, required her to search for someone to provide child care for Darren. Harrison had received a college scholarship and was heading off to college out-of-state. Harrison’s mother, 44-year-old Helen, had been helping them out with child care when she could, but worked as a teacher’s assistant and hence was not available during the hours Mona needed assistance.
Given the prevalence of maternal grandparents serving as caregivers in the community, Mona’s parents would have seemed the natural choice. Even though she was living with her boyfriend’s family, Mona was and continues to be extremely close to her own family, and sees them almost every day. Mona noted, however, that she was reluctant to approach them – both of her parents are employed full-time and they are still raising Mona’s three younger siblings. Though not available to serve as caregivers, Mona explained that her parents are Darren’s legal guardians. After Darren was born, they had themselves appointed as guardians due to Mona’s youth and because it allowed them to cover Darren under their health insurance.

In the end, Harrison’s mother Helen decided to resign from her job to take care of Darren while Mona was in school. As Helen explained, she had been helping take care of Darren since “day one” and had become quite attached to her only grandson. She was also extremely concerned about Mona being able to finish high school, and did not really want to turn Darren over to another caregiver.

In those early days, Mona was not really in a position to pay Helen for child care, nor did Helen expect to be paid. Yet even now, when Mona has an excellent job and is doing well financially, Helen still refuses to be paid for child care. Mona commented that she had recently tried to give Helen some money for groceries and bills in an attempt to contribute to the household financially (she and Darren continue to live with Helen and her family) but Helen would not take it.

Mona suspects that Helen’s refusal to accept money is due to her close relationship to her grandson. Mona freely admits that Darren is closer to his grandmother than he is to her. Ever since Darren was around six months old, he has
spent significantly more time in the care of Helen than Mona. In the early days, he was with his grandmother from the time he woke up in the morning until Mona got home after school; some days he saw his mom little if at all. Helen absolutely treasures the time she spends with Darren. They are so close, Mona noted, that when Darren started Head Start the previous year, Helen could not stand being away from him for even those few hours a day and ended up volunteering in his class.

Even now, Helen spends more time with and takes more responsibility for her grandson than Mona does herself. Helen gets Darren up in the morning, dresses him, and puts him on the bus to Head Start. She waits for him when the bus drops him back off in the afternoon, and cares for him until Mona gets home from work. Helen also takes responsibility for Darren on the nights that Mona is in class, and on the occasional weekends when Mona is traveling for work. The only time Darren is in the care of anyone other than Helen or Mona is when Helen needs to run an errand or go to the diabetes clinic; on those occasions, Helen has her own mother (Darren’s great-grandmother) who lives nearby help out for an hour or two.

One definite advantage of this, as far as Mona is concerned, is that Darren is learning to speak Apache. Mona, like many young Apaches, does not speak Apache very well, yet it is very important to her that her son learns the language. Helen and her husband are both fluent speakers, as is Darren’s great-grandmother, so Darren hears Apache throughout the day. He is also being raised traditionally – they used a cradleboard for Darren as a baby, and he is in an environment where traditional healing and ceremonies are a common part of everyday life.

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Mona, as even she will admit, has been very fortunate. Child care for her has really never been a struggle or a source of concern. She has what many in the community would consider the ideal caregiving arrangement – a relatively young grandmother living in the same household who has dedicated her life to the care of her grandchild, and a dependable back-up caregiver just a few blocks away. This arrangement has facilitated Mona’s educational attainment and allowed her to develop professionally and secure a desirable job. For her son, it has allowed him to grow and thrive in an environment with multiple “mothers,” surrounded by kin from whom he can learn the culture and language. And for Helen, caring for her grandson has brought her joy and a sense of purpose.

Success securing kith and kin child care support varies considerably across the White Mountain Apache community. Some Apache mothers have stable and dependable caregivers they can access, while others struggle constantly to find an arrangement that will work. Those with strong and dependable family networks tend to have the most stable arrangements and the best probability of finding back-up caregivers when their arrangements do fall through. Those without well developed or maintained networks are more likely to find child care to be a constant struggle.

The caregiving arrangements themselves also take a wide variety of forms. Some Apache caregivers, like Helen, describe themselves as integrally involved in the lives and well-being of the children they care for, while others see their roles and responsibilities as more limited. Some are paid to provide care while others exchange child care for goods or services. The form such arrangements take is a product of, among other things, the child’s relationship to the caregiver, how the caregiver perceives
his or her role, and the function and place of the arrangement within existing family and community networks.

This chapter explores the forms that kith and kin care arrangements take and the functions these caregivers perform, and how parents make caregiving arrangements work over time. It also explores the effect that kith and kin caregiving arrangements have on the parents, the children, and the caregivers, as well as their families and households more generally. Many of these issues are central to discussions about caregiving quality and how caregiving is situated in kinship and community networks of support and exchange, topics which are the foci of Chapters 7 and 8.

THE DAILY EXPERIENCE OF KITH AND KIN CAREGIVING

Kith and kin caregivers, at a broad level, all perform the same role – they care for children in the parents’ absence. But what does kith and kin care actually look like on a day-to-day basis? Quite often, it closely resembles parenting. Like Helen, many women who provide such care see their work as an “extension of mothering” (Zinsser 1991:158), not “child care.” The activities they engage in with children are similar to those that parents engage in, and their interactions are best characterized as familial rather than pedagogical.

In other ways, however, kith and kin care arrangements display an immense amount of variability. Some caregivers limit their role to occasional child care and take on a minimal amount of responsibility; others play a more central role in the life of the child than the parents themselves, and take on the majority of responsibility for the child. Some of these differences are dictated by outside factors, such as the form of the
caregiving arrangement (i.e., supplemental vs. surrogate care), but others are more influenced by the caregiver’s relationship to the child and their perception of their role, and their own child-rearing practices and values.

**Allocation of Responsibility for Children**

Parents generally do not assume sole responsibility for children, nor are they expected to. In almost all of the families I spoke with, responsibility for children was shared among multiple family members or quasi-kin. In some cases, this simply means that multiple individuals are responsible for keeping an eye out for a child. However, financial or material responsibility for a child may be taken over or shared by kith and kin as well, and such individuals may also assume some responsibility for duties surrounding education and health. The degree to which and specifically which aspects of a child’s care are shared, however, varies dramatically from family to family.

In discussions with supplemental caregivers, these individuals most often spoke of their responsibilities in terms of making sure that the child’s needs are met. Primarily, this referred to a child’s physical needs – caregivers spoke of changing diapers, feeding the children, making sure they nap, and sometimes even bathing them. Others also referenced the child’s health and safety, emphasizing their duty to make sure that the children were kept safe and did nothing that might get them sick.

Some caregivers described responsibilities going beyond physical caregiving. One caregiver commented that it was her duty to see that the children in her care are happy. Others see it as their responsibility to instill traditional values and instruct

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150 Caregiver responsibility for health production and health care seeking for children in their care is addressed more fully in Chapter 6.
children in the Apache language and other aspects of their culture. In general, however, supplemental caregivers do not perceive themselves as solely responsible for these aspects of a child’s care – they perform these duties in parallel or in conjunction with the parents (or other primary caregiver).

Surrogate caregivers, in contrast, are more likely to have responsibility for specific aspects of a child’s care mostly or completely transferred to them, although other responsibilities may be shared or continue to reside with the parents. Formal surrogate care arrangements generally involve the transfer of most, if not all, responsibility for the child from the parents to the surrogate caregiver. Allocation of responsibility for children in informal, voluntary arrangements is much more variable.

Several surrogate caregivers noted, for example, that while the child lived in their home, the parents were still heavily involved in the child’s life and a large amount of the responsibility for the child’s needs remained in the hands of the parents. Such is the case with Wayne, the 12-year-old boy who made the decision to live with his mother’s parents because of his strained relationship with his father. As noted in the previous chapter, despite the fact that he resides with his maternal grandparents, he sees his mother and many of his siblings just about every day because of his natal family’s close relationship with (and physical proximity to) the maternal grandparents. His parents purchase the majority of his clothing and provide for many of his other material needs, but Wayne generally eats with his grandparents and hence they assume this cost. Wayne’s parents also carry him on their health and dental insurance plans, and take responsibility for his health care appointments. Individuals from both households make the point of participating in parent-teacher conferences with Wayne’s teachers.
Other caregivers emphasized that they had taken over the majority of responsibility for a child; generally this occurred in cases where the parent was very young or irresponsible or temporarily away from the community. Forty-four-year-old Abieta and her husband, for example, have assumed most of the responsibility—financial and otherwise—for their four-year-old grandson Darien since his mother moved out to establish her own residence when he was two-and-a-half. Abieta noted that her daughter receives federal assistance in relation to Darien and occasionally uses it to buy things for Darien, but she does not pass the money on to Abieta. And, with the exception of occasional visits, Abieta’s daughter does not participate in Darien’s care. Instead, Abieta’s household and the paternal grandmother share his physical care. Because her household is financially secure and Abieta feels Darien is better off in her care, neither of these things concerns her. Interestingly, in cases such as this where the mother is not in a position to satisfy many of the child’s daily needs, she may reserve special tasks for herself. Abieta’s daughter, for example, had taken over responsibility for planning her son’s upcoming birthday party.

In some instances, parents may remain integrally involved in the physical care of their child even though someone else has taken over primary material responsibility. Gary, a 53-year-old married father of four, moved his 17-year-old niece Josephine and her two-and-a-half year-old daughter Nicole to the community and took over legal custody of both of them in an effort to assist Josephine in obtaining her GED. Nicole was born just after Josephine completed middle school. Josephine wanted to return to school, but Nicole’s father was working and her own mother was, as she put it, “doing her own thing,” so Josephine did not have anyone to watch Nicole. Gary heard that she was having problems, and wanted to help. Over the years, Gary has taken responsibility
for (and custody of) several of his nieces and nephews – including Josephine and her
brother – who he saw were not being well cared for. Josephine had lived with Gary and
his family when she was about nine or ten, but had then gone back to live with her
mother; her brother, in contrast, had been formally adopted by Gary and his wife. Gary
said that he had always regretted letting Josephine return to her mother, who was not
really in a position to parent. By taking in Josephine and Nicole, Gary saw an
opportunity to help Josephine get her life back on track and atone for his past mistake.
His intention was to support Josephine and her daughter financially and assist with the
day-to-day physical care of his “granddaughter,” hence allowing Josephine to attend
classes. He does not intend nor want to take over primary responsibility for Nicole, and
will turn over legal custody of Nicole to Josephine once she proves she can provide for
herself and Nicole on her own.

While some caregivers inevitably took exclusive responsibility for one or more
aspects of a child’s care, others described situations where responsibility was spread
across multiple individuals or households. Shared responsibility for children lessens the
burden on any individual household, reallocating the costs and responsibilities (as well
as the benefits) of child caregiving across kin and the larger community (Gordon 1987).
Such a pattern may be very adaptive in a community where the resources of any one
household may be limited. For example, Farrah and her great-aunt Aleah, who served
as a part-time surrogate caregiver for Farrah’s daughter Bethany while Farrah worked at
the ski resort, would trade off staying home with Bethany when she was sick. Other
surrogates likewise noted that they shared responsibilities with the parents. Fernanda,
the mother of three who had asked to raise her sister’s newborn son Alex right after his
birth, noted that her sister still shared in Alex’s care. After Alex was first born, for
example, Fernanda, her husband, and Alex’s mother each took turns staying home from work to take care of Alex for the day. Alex’s mother also took care of him financially, buying him pampers, clothes, and anything else he needed every payday. But otherwise, she tried to stay out of the way, leaving decision-making relating to health care and other issues to Fernanda.

Financial responsibility for children in surrogate care can be rather complex. Informal caregivers generally are not eligible to receive benefits for children in their care. Several caregivers mentioned that the child’s parents were still receiving AFDC or other benefits for the child although the child was not living with them. Most often the parents would use at least part of this money to buy things for the child, but they generally did not pass the money on to the surrogate caregiver. In rare instances, a third individual or household will contribute money to the surrogate caregiver to assist with expenses associated with the care of the child. Such was the case with 10-year-old Jake, who had decided on his own to live with his unmarried aunt Ursula. Not only did Jake’s aunt Vierra (Ursula’s sister), who is his legal guardian, use the AFDC money she received as his guardian to buy him things, Jake’s grandmother (Ursula’s mother) contributed money every payday to assist with expenses.

Financial issues can, at times, be a source of conflict between parents and surrogate caregivers as well. Some surrogate caregivers complain that the parents continue to get financial assistance for the child but do not use that money to help them financially, while they themselves are ineligible for benefits because the arrangement is informal and they do not have custody. There can also be conflicts over who claims the child for tax purposes or for the commodity food program. The surrogate caregiver may
want to claim the child if they are spending a significant amount of money on the child, yet the child’s parents may feel that is their right.

**Activities and Interactions with Kids**

With kith and kin care, children tend to simply blend naturally into the daily activities of the household. Whether an individual agrees to "watch a child" for a relative or provide long-term surrogate care, such caregiving most often occurs in the context of other household activities. Informal caregivers rarely plan special activities to do with the children in their care, as is commonly the case in formal child care settings. Instead, caregivers – like parents – integrate children into the flow of daily life.

**Letting the day roll**

Caregivers engage in a range of activities with children. Several described letting children play in the yard or going for walks with them. One caregiver mentioned that he took his granddaughter with him every morning to feed the cows and their other animals. Most caregivers, however, emphasized that they purposefully did not plan activities to do with the children – they preferred, as one caregiver commented, to “let the day roll” and let the children lead the way.

This preference for letting children do what they want is closely tied to the autonomy given to Apache children in all areas of life. The concept of autonomy among Apache children is discussed in Chapters 2 and 4.

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151 Children may be guided, but they have the right to make their own decisions as to what they want to do (Greenfeld 1996; McFee 1972), and hence caregivers tend to let children do what they want.
Caregivers make sure children’s needs are met, but they do not try to plan activities for them.

Home care providers, though generally perceived as more “child-oriented,” expressed similar caregiving philosophies. One home care provider noted that meal time and nap time are scheduled, but otherwise she just does what the child seems interested in. Erma, the 55-year-old surrogate and home care provider with whom I spoke at length, went even further, commenting that she doesn’t like to control the day by scheduling activities; she feels this limits the kids. Instead, she likes the kids to have flexibility – she lets them do what they want, and “lets the day fall into place.”

Such freedom does mean in some cases that children spend more time in front of the television than is preferable. Many caregivers, however, described interacting with the children in a variety of ways. Erma, for instance, talked about dancing with the children and playing music for them (both in English and Apache), reading to the children, playing soccer and volleyball outside with the children, and walking with them over to the pond.

**Teaching and culturally-mediated learning**

What Erma and several other caregivers emphasized most, however, was their responsibility to “teach” the children in their care. For some, what was important was preparing children for school, and these caregivers tended to emphasize teaching children their ABC’s or colors (Erma, for instance, said she taught the children their colors from the Chef Boyardee lids). More often, however, caregivers were referring to
culturally-mediated learning that serves to instill cultural values and teach children who they are and what it means to be Apache.\textsuperscript{152}

As one grandmother noted, “It is my responsibility to teach [my granddaughter] everything – to talk Apache, teach relationships to everyone, to answer all her questions.” Language instruction in particular often falls to older caregivers such as grandparents since many of the younger parents either do not speak or emphasize their traditional language.\textsuperscript{153} Of those I interviewed, nearly 70 percent said their children spoke English only, although one in three of these noted that their children did understand at least some Apache. Less than 15 percent said their children spoke Apache. Many grandparents lamented the fact that their grandchildren did not speak Apache and tried to make language exposure a priority, but also noted that their efforts were often thwarted by television and the dominance of English in the schools. As one noted, she tried to focus on Apache, but then “Blues Clues and Winnie the Pooh took over.”

Other caregivers emphasized moral and cultural lessons that came to children through their participation in everyday activities that themselves have meaning. Erma, the 55-year-old surrogate and home care provider, remarked that she teaches the children through everything they do. She teaches the children respect for their elders by having them interact and help with her elderly brother who suffers from dementia. They learn responsibility for the environment through picking up cans along the highway. She has them carry wood for her, emphasizing that “helping each other makes a complete

\textsuperscript{152} Both culturally-mediated learning and cognitively-mediated learning (which is more generally associated with the context of schools) are discussed in more detail in Chapter 7.

\textsuperscript{153} As noted in Chapter 2, only 28 percent of Apaches under age 30 on the reservation can speak Apache whereas 95 percent of those 40 and over can speak the language (Adley-SantaMaria 1997b).
circle." Another caregiver similarly noted that she teaches the children in her care right from wrong through being a good example herself.

Such lessons are not always even intentional. Much cultural knowledge is simply passed to children through the observation of activities in which they participate with their caregivers. Children often see their caregivers gathering traditional plants and preparing traditional foods. They may see their caregiver assisting in preparations for community events. I observed such a thing in the context of preparations for a Sunrise Dance; several grandmothers had gathered down by the river to cook for the upcoming Ceremony and many had brought their grandchildren. The children were not actively participating – most were instead playing – yet the experience and their presence was nonetheless important in the process of cultural learning.

**Household responsibilities and shared caregiving**

Caregivers, like parents, have to reconcile caring for children with their other responsibilities. Many supplemental caregivers said that they tried to do all their household chores either before the children arrived in the morning or after they left, or else during naps. Some will take children with them when they need to run errands, especially if the errands are nearby, but many caregivers (as well as parents) prefer keeping the children around the house.

Surrogate caregivers, however, do not have the luxury of putting off household work until the children go home. Some of these individuals noted that they tried to get work done before the children wake up in the morning, but they were also more likely to be forced to juggle caregiving and chores.
This is not to imply that all supplemental caregivers are completely focused on the children while they are there. While some mentioned that they tried to do this, others admitted that they let the kids run around while they did housework, or they looked to other household members to watch the children when their attention needed to be elsewhere.

Shared household care is, in fact, extremely common. While the grandmother, for instance, may be recognized as the caregiver, adult children or older grandchildren who live in or are visiting the house will share caregiving tasks. This allows caregivers to accomplish other tasks or simply take a much needed break.

Lorraine, the 59-year-old grandmother of Monica whose story prefaches this dissertation and who also serves as a caregiver for her two-year-old granddaughter Shanae, said this was the only way she manages to get her work around the house done. At the time I spoke with her, two of Lorraine’s adult children and one of her grandsons were living in her home. This son and daughter were quite often the individuals actually watching over or playing with Shanae, although Lorraine was always cited as being the girl’s caregiver. Also, when a number of the grandchildren were playing out in the yard, the older ones were called upon and expected to watch out for their younger siblings or cousins. Such moderately supervised sibling caregiving occurs quite commonly, not only in the context of the home, but also at community events such as basketball games or ceremonies.

Shirley, the 63-year-old grandmother whose story opens Chapter 4, likewise finds the assistance of her husband and teenage daughter invaluable. They watch the three grandchildren Shirley cares for while she goes to pay bills or takes a few hours to
mingle with her friends. Shirley emphasizes that single-handedly providing full-time care for grandchildren can take its toll, and the assistance of her husband and daughter is what keeps her sane.

Without them, I would probably be in the looney house by now. I'm not sure if I could make it. I would probably be sitting on the floor rolling the ball around all of the time.

Cash or Trade? The Complexities of Compensation

Some caregivers such as Shirley prefer not to be paid. Caregiving has always been a communal affair in her family – Shirley’s grandmother and cousin helped raise her, and she has raised and provided child care for many of her grandchildren. Her daughter Jennifer often helped care for her youngest sister, and Shirley now helps Jennifer by providing child care for her three children. Shirley, in turn, always calls Jennifer first if she needs something, but she does not expect nor want to be otherwise compensated.

Other caregivers, including Lorraine, are paid regularly to provide care. Data from across the United States indicates that anywhere from one- to three-quarters of parents pay for kith and kin care. Grandparents are less likely than other relatives and non-relatives to be paid, and they also tend to receive less money (Brandon, et al. 2002; Folk 1994; U.S. Bureau of the Census 2002b).

In the White Mountain Apache community, some form of compensation for kith and kin caregivers is quite common. Of those parents interviewed for this project, three-quarters provided some sort of monetary compensation in exchange for caregiving.
Slightly more than half paid their caregivers regularly, but one-third had at least one caregiver whom they did not pay regularly or whom they often did not pay the full amount they had negotiated.

Table 18: Form of Compensation by Relationship of Caregiver to Child *

<table>
<thead>
<tr>
<th>Relationship of Caregiver to Child</th>
<th>Cash Payment</th>
<th>Exchange</th>
<th>Not Compensated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>regular</td>
<td>irregular</td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Great-aunt or uncle</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Aunt</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Second cousin</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Non-relative</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Due to multiple caregiving arrangements and in some cases multiple forms of compensation for a single arrangement, the forms of compensation detailed in this table exceed the total number of primary and supplemental caregivers in this study.

Rates of compensation, while overall quite high, varied significantly by caregiver (see Table 18). Grandparents were the least likely to be paid regularly for the provision of care; non-relatives, in contrast, all received cash compensation. The pattern of compensation for aunts was quite similar to that of grandparents. Compensation for other relatives varied, but in general they were paid for care more often than not. Interestingly, parents using multiple caregiving arrangements quite often compensated their caregivers differently, for example, paying one regularly and not paying the other or compensating them in some other way.

Overall, the rate of cash compensation I found in this community was somewhat higher than is found nationally. In the U.S. in 1997, only 51 percent of parents with children in some form of child care were making payments for that care. Cash was provided in exchange for grandparent care in only 15 percent of the cases; cash payments were made to other relatives in 28 percent of the cases. Overall, cash payments were made to all kith and kin providers in 47 percent of the cases (U.S. Bureau of the Census 2002b). Native Americans as a group (in 1999) made cash payments for child care (any form) only 24 percent of the time (U.S. Bureau of the Census 2003c, PPL Table 5). My findings may accurately reflect the compensation patterns for kith and kin seen in this community – and hence be a sign of the importance of caregiving in redistribution of cash resources within family and community networks – or it may be a sign that paid kith and kin arrangements are over-represented in my sample.
Half of the grandparents who served as caregivers were paid, but only about one in five were paid regularly. One in four grandparents noted that they were not specifically compensated for care provision, generally at their own insistence. A similar proportion provided child care in exchange for goods or services, either alone or in combination with some sort of monetary combination. As these grandparents and the parents whom they were assisting explained, they “help each other out” or “do favors for each other.” Parents spoke of buying their own parents food, gas, and furniture, and doing other things such as running errands, chopping wood, house-sitting, cooking, and fixing cars. While assistance with caregiving was in some cases specifically reciprocated through the provision of certain goods or services, generally they were all simply part of the ongoing mutual assistance and exchanges that characterized these relationships.

As with grandparents, half of the aunts serving as caregivers to children in my sample were paid, half of these regularly and half irregularly. One-quarter did not ask to be compensated. One aunt noted that she and her sister traded babysitting back and forth and hence did not pay each other. Another, an 11-year-old aunt who provided care for her two-year-old niece during the summers, was compensated in multiple ways – her niece’s mother paid her, but also bought her things that she knew she needed or wanted.

Almost all of the great-aunts and uncles in my sample serving as caregivers were compensated regularly. The only one who wasn’t was 53-year-old Gary, the great-uncle who was specifically caring for his niece’s daughter while his niece was in classes to
help her finish out high school. Of the second cousins serving as caregivers, one was paid regularly and the other traded babysitting back and forth.

Of those in this community who provided monetary compensation, the average payment for full-time care was around $100 every two weeks, or $10 per day. There were, however, modest variations based on the relationship of the caregiver to the child. Non-relatives were paid the most, up to $15 per day or $150 per week. Grandparents tended to be paid a little less than average, around $75 to $100 every two weeks. A number of parents – especially those using grandparents – commented that they could not currently pay the full amount they had agreed to, and instead each payday were paying what they could afford which in some cases was just a token amount.

Such flexibility in terms of compensation or payment is one reason that kith and kin care is attractive to some parents. While formal sector child care almost always involves some sort of monetary payment, care by kith and kin providers (especially grandparents) is much less likely to involve the transfer of cash (Folk 1994). Many studies, in fact, cite these lower out-of-pocket costs associated with kith and kin care as one of the primary reasons for its use, particularly in economically disadvantaged communities (e.g., Brandon 2000; Siegel and Loman 1991).

**Factors affecting compensation**

Whether caregivers are compensated financially for their care provision depends largely on the nature of the relationship between the caregiver and the child’s parents as well as the caregivers’ motivation for providing care (Porter 1998). The type of

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155 Caregivers were commonly paid every two weeks; tribal payroll occurred on a biweekly basis, and parents tended to pay the caregivers upon receiving their own paychecks.
arrangement is important as well – surrogate caregivers are not paid, although others may contribute money to help with expenses. Individuals providing supplemental care for purely altruistic reasons generally do not want to be paid, nor do those who share a household with the parent and child for whom they provide care. Others may expect to be paid, even if the amount is nominal, or agree to provide child care in exchange for goods or services (Bruinsma 2001; Folk 1994; Porter 1998).

When the caregiver, parent, and child all live in the same household, the exchange of money may simply not make sense. Households generally pool their resources to cover expenses, hence inter-household transfers do not have much of a purpose. Of the five mothers interviewed who currently lived in the same house as their caregiver, none were paying for child care at the time of the interview. Irene, the 29-year-old single mother who had been relying on and off for several years on her 68-year-old mother with whom she lives to care for three-year-old Linton, had a standing agreement with her mother to pay her $100 every two weeks in exchange for providing full-time child care, but had been unable to afford to pay her anything since her boyfriend quit his job. Irene said she also used to buy stuff for her mom or the household, but now she can’t afford to do this either; all of her paycheck goes toward her car payment and bills. Irene’s mother, however, seemed relatively unconcerned that she had not been paid in several months, and even noted that she occasionally uses her own money to buy pampers or other things for her grandson.

On the other hand, when money does exchange hands, keeping caregiving within kin networks can be a way of providing a form of paid employment for relatives or keeping limited financial resources within family networks (Brandon 1995; Chaudry
Twenty-one-year-old Charlena, for example, felt quite a bit of pressure to use her 63-year-old aunt who had raised her as a provider rather than the day care center—even though Charlena works there—because her aunt was not working and needed the money. Other mothers encouraged family caregivers to become certified home care providers so that they would become eligible to receive child care subsidies. In this way, the provider would be paid, yet the parent would incur minimal out-of-pocket costs. As Evelyn—the married 26-year-old mother of two who lives in a multi-generational household that includes her mother—noted, once her mother was approved as a home care provider, she would be paid (through CCDF) for providing child care; Evelyn would only be responsible for a small co-pay.

Some mothers, like 20-year-old Mona whose story opens this chapter, commented that they tried to pay the caregivers for child care or at least compensate them for their expenses, but the caregivers refused to accept any money. Many caregivers who are not paid do accept (or even expect) favors or goods in exchange for providing child care. Like Jennifer, the 36-year-old married mother of three whose story opens Chapter 4, parents who use related caregivers often “swap stuff.” In the past, for example, Jennifer and her husband have fixed her parents’ truck and bought them a dinette set in exchange for child care.

Wylene, a 25-year-old recently divorced mother of three, similarly does not pay her mother for child care. Up until about nine months prior to our interview, Wylene had never worked and had always taken care of her children herself. However, after her divorce, she was forced to get a job; she now works 12-hour shifts at the hospital. Her mom watches her seven-year-old daughter after school every day, but her four-year-old
daughter and one-year-old son are with a home care provider during the day (her mom too works at the hospital and hence is not available to provide all day care). Rather than paying her mother for child care, Wylene helps her out in other ways – for example, she will "get her soda or baking powder, or cook for her when she is working." Wylene does, however, pay the home care provider who provides child care for her two preschool-age children.

It is not uncommon for parents to compensate different caregivers or caregiving arrangements in different ways, or even for expectations or arrangements regarding compensation to change over time. Stella, the 29-year-old married mother of four whose oldest child Jessi lives in a surrogate arrangement with her mother Audrey, uses a variety of supplemental care arrangements for her three younger children. Stella’s 10-month-old daughter is cared for by her godmother during work hours, but her five-year-old and nine-year-old stay with her mother in the afternoons after they get out of school. While she regularly pays the godmother who watches her youngest child, Stella generally does not pay her mother to watch her middle two children. Most of the time, her mother simply gets Stella to buy her gas or other things she needs; occasionally, they will even swap child care for house-sitting. Interestingly, Stella does provide money to her mother every payday to compensate her for expenses associated with caring for 13-year-old Jessi. This, however, has not always been the case. When Audrey first took over caring for her Jessi, Stella was still in high school. Audrey’s primary concern then was that her daughter finish school; consequently she did not ask for nor expect anything in exchange for her provision of care. Now that Stella has graduated and works full-time, however, she does help out financially with Jessi.
Even in the context of a single arrangement, cash and non-cash compensation are not necessarily mutually exclusive. Brenna, the 36-year-old mother who works variable shifts at the casino, and her partner Rick, who works seasonally at the ski resort, pay Rick’s mother regularly for providing child care for their two small children, but they also chop wood for her. Since their children spend so much time at their grandmother’s house, and she burns her wood to keep them warm, Brenna and Rick feel it is their responsibility to replenish it.

DEALING WITH CAREGIVING CHALLENGES AND CHANGE

Some individuals, such as 44-year-old Helen who was introduced at the beginning of the chapter, provide child care to specific children from the time they are only a few months old until they enter school (or even beyond). Others may, over the years, even be the sole caregiver to all the children in a specific family. Such a pattern, however, is relatively unusual. Most children, over the course of their preschool years, are cared for by several different caregivers. Parental caregiving needs change, available caregivers change, and arrangements fall through. Consequently, caregiving arrangements occasionally must change as well, and most families report using multiple caregivers, either simultaneously or sequentially, to piece together child care for their children.

Stability and Change over Time

This tendency toward flux and change with kith and kin care arrangements is sometimes viewed with concern. Studies of informal caregiving arrangements have often found them to be unstable or unreliable (Siegel and Loman 1991) and less
dependable than formal child care options (Bruinsma 2001); in one study of low-income mothers, the majority using informal providers reported that they had had to change their caregiving arrangement in the last 90 days, most commonly because their primary caregiving arrangement had fallen through (Siegel and Loman 1991). This lack of stability is cited as being problematic for both the parents and children, and is one reason why kith and kin care is often viewed as inferior to formal child care. Other studies, however, have found informal care arrangements to be more stable and of longer duration than other forms of care (Hofferth, et al. 1991), and point out that even in instances where the arrangement does not endure, the relationship with the caregiver often does (Kith & Kin Meeting 2000).

Change, however, should not be equated with instability. While approximately one in five parents I talked with noted multiple changes in caregivers in their child’s early years, the majority of these involved relatives who were already familiar individuals in the child’s life. Only two reported cycling through a number of unfamiliar individuals while struggling to find a stable, long-term arrangement. The majority of the Apache parents I spoke with had one or more caregivers who could be more or less depended upon to consistently provide care. While some did change caregivers over time, both out of choice as well as necessity, the new caregivers were generally well-known to the child and the changes overall caused little disruption.

**Causes of Caregiving Changes**

Caregiving changes are often the result of changes in the lives of the caregiver or the parents themselves. Parents may have preferences for different types of care at different ages, families may move, or the need for care may change. A parent may stop
or start working or their shift may change; caregivers may also change jobs or start new jobs whose hours interfere with their caregiving obligations. Older caregivers in particular may develop health problems that make it difficult if not impossible to provide care for young and energetic children. Parents may also choose to change caregivers if a caregiver is not dependable or they are not happy with the arrangement, or if a more convenient arrangement or more preferred caregiver becomes available.

**Needs change**

For some mothers like 29-year-old Irene, the need for an alternative caregiver comes as goes as jobs come and go. When Irene was working, her mother Edith was always the one to watch her son; when Irene was not working, she would once again take over primary responsibility for her son, although Edith still helped out quite a bit. For her three-year-old son Linton, the transitions have been virtually seamless. Since these three individuals lived in the same household, Linton and Edith continued to interact daily whether or not the grandmother was the designated “caregiver.”

Parents may not always approach the same caregiver when they go back to work. Twenty-one-year-old Marvene and her husband Evans, who have two preschool-age daughters, used to use Evans’s mother, with whom they live, as their caregiver. She watched their older daughter after she was born and Marvene was trying to finish high school. She also served as a caregiver for both of the girls just after the second one was born and Marvene was working. Marvene was then out of work for six months, and did most of the caregiving herself. When she found another job about a year before our interview, she and her husband decided to approach his cousin instead. Marvene offered no explanation as to why they were no longer using her mother-in-law as their
regular caregiver; she did note, however, that her mother-in-law will still occasionally babysit for them.

**Available caregivers change**

Marvene may have approached a different caregiver simply because her mother-in-law was not available during the hours she needed assistance. Caregivers themselves sometimes find it necessary to re-enter the workforce, leaving parents to find another caregiver. Marvene, in fact, was in the midst of changing caregivers once again for this very reason. Evans’s cousin had just taken a temporary tax season job that left her unavailable to provide child care for a few months. Marvene’s cousin agreed to temporarily watch the girls in her place. The expectation was that the girls would return to Evans’s cousin, however, once her temporary job ended.

More commonly, parents are forced to search for permanent replacements for caregivers who are no longer available. Abieta, the 44-year-old mother and grandmother who serves as a surrogate caregiver to her four-year-old grandson Darren, turned to her elderly mother for assistance when her regular caregiver for Darren had to go back to work full-time. Because of her mother’s age, however, she did not consider this a permanent solution, and continued to look for another caregiver. Other caregivers similarly expressed concern over the impact of full-time caregiving on older caregivers or those with health problems, and for some this was the impetus to try to find other sources of child care.
Satisfaction with arrangement

Parents are also likely to make changes in their caregiving arrangements if they are unhappy with a caregiver, or if a better option becomes available. While many of the parents interviewed expressed that their preferred caregivers were relatives or other close individuals, this was not true of everyone, even if they happened to be using kith and kin caregivers at the time. Some preferred a different type of care (such as day care), while others simply preferred a different caregiver. In other cases, the desire to change arrangements stemmed from specific problems or conflicts with the current caregiver.

One women I spoke with, 36-year-old June, had used a number of different child care arrangements over the years for her youngest child, eight-year-old Thomas, none of which she considered ideal. A number of her complaints concerned her sister. One issue concerned language; June was teaching her young children Apache, but her sister’s children only spoke English. Given the number of hours Thomas was in child care per week, she was concerned that her efforts at passing her language on to her child were going to be nullified. June also complained that she often did not know where to find Thomas when she went to pick him up. Her sister would take him along on errands without informing June, and at times would even drop him off at their mom’s house. This in particular upset June; she did not want her mother to have to watch her children – being one of nine children herself, June felt that her mother had raised enough children. Finally, she thought that her sister wanted to be paid too much for child care – $100 every two weeks. June’s sister would even insist on being paid on those occasions when she had dropped Thomas off at their mother’s house. Finally, the sister asked her to find someone else to serve as a caregiver, and June was only too
happy to comply. Initially she found a friend to provide child care, but June felt the area was too dangerous and she was uncomfortable leaving her son there. After that, she went to the day care center. Thomas has now been there for three years. She has a child care subsidy, but over the years the amount of the co-pay has crept up. She now feels that the amount she pays is too high for the number of hours her son is there (he is now only there after school), but she really likes knowing where Thomas is at all times, something she could not depend on with her sister.

Conflict was undoubtedly present in a number of caregiving arrangements, and the cause for others ending, but June was one of the only parents who spoke directly about conflict or disagreements with a caregiver. Indeed, conflict was notably absent from both parents’ and caregivers’ discussions of caregiving arrangements. This was not entirely unanticipated – as Basso (1996) notes, Apaches are reluctant to criticize someone directly, hence it is unsurprising that conflict with caregivers was rarely mentioned in these narratives. In a number of cases, my questions to parents about the cause of caregiving changes were met with avoidance – which Greenfeld (1996) identifies as a common response to conflict – which leads me to suspect that some sort of conflict which the parents were unwilling to discuss with me led to the change in caregivers.

Using Multiple Caregivers to Cover Caregiving Needs

In cases where caregivers are hard to come by, parents frequently use multiple caregivers to piece together child care.156 After struggling to find caregivers for her five

156 This is a pattern commonly seen in families and communities where resources are scarce and networks are stretched thin. Chaudry (2002), who examined child care arrangements of low-income families in New
month-old son so she could return to high school, 16-year-old Raysha, for example, finally managed to scrape together child care by using her father in the mornings and another (non-kin) caregiver in the afternoons. Families may alternate caregivers seasonally or use multiple caregivers in any given week or day; some use different caregivers for different children. The use of multiple arrangements makes it possible to work around caregivers’ schedules, and is also a mechanism for ensuring that too much burden is not placed on any one caregiver.

Families with a number of children, for example, may be reluctant to ask one individual to provide care for all of them. When 29-year-old Stella’s youngest daughter Raelynn was born, her mother was already providing after school care for her two children in primary school and full-time surrogate care to 13-year-old Jessi. When it was time for her to go back to work, Stella felt she needed to find someone else to watch Raelynn. She wanted to find someone who stayed home, didn’t watch any other kids, and lived close. She ended up asking her daughter’s godmother one day when she came over for a ride, and the godmother agreed. Stella says the godmother is very dependable, and she “wouldn’t change [the arrangement] for the world.”

Arnita, the 29-year-old mother of three who refused to use her alcoholic sister as a caregiver, noted that she and her partner spread the responsibility for their two-year-old son Christin across multiple caregivers. Arnita went back to work when her son was four-months-old, and another of her sisters Valida started watching Christin. After four months though, it became evident that Valida did not have the time to be the sole alternative caregiver. Arnita tried to get Christin into the day care center at this point, but

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York City, likewise found that parents are frequently forced to patch together child care to meet their basic needs when caregiving options are limited.
was wait-listed. While waiting for an opening, Arnita traded off using Valida and her partner’s sister for child care. This went on for ten months until Christin got into the day care center. Three months later, however, he was kicked out of the day care center because of sketchy attendance. Arnita then went back to using multiple kin caregivers – this time, splitting caregiving responsibilities between her partner’s sister and her partner’s dad, who had recently been laid off. This was the arrangement she had at the time of our interview; it was dependable and she trusted the caregivers, but she had decided to once again put her son on the wait list at the day care center, thinking he would learn more there.

Parents may also use multiple arrangements as a way of accessing an especially preferred individual who is not able to provide care full-time. Danetta, a 25-year-old married teacher and mother of two, wanted to use her cousin Belinda as a caregiver for her four-year-old daughter Linell, considering her to be a very experienced and trusted caregiver. Linell, however, gets out of Head Start early in the afternoon, while Belinda does not get off work until 3 pm. To fill this gap, it was arranged that Belinda’s mother would watch Linell until Belinda got off work, and then Belinda would pick Linell up and care for her until Danetta’s work day ended.

**Caregiving Struggles and Caregiving Failures**

Every family with young children faces the occasional time when their regular child care arrangement falls through. Those lucky enough to have available relatives, friends, or neighbors who can provide back-up care on short notice can weather these
incidents relatively easily. Others, however, may be forced to take the occasional day
off work to watch their children themselves. Stories abound of individuals driving around
from house to house after their regular provider didn’t show, desperately trying to find
someone who could watch their son or daughter for the day. For some families,
caregiving problems are only an occasional annoyance; they find it relatively easy to find
regular caregivers and generally enjoy satisfactory and dependable caregiving
arrangements. For others, however, finding dependable child care is a constant
struggle.

**Occasional caregiving problems**

Occasional problems are not uncommon with kith and kin care; such care tends
to be more prone to unpredictable failures due to the often informal nature of the
arrangements and the fact that caregiving may simply be one of the many sometimes
conflicting family responsibilities of the caregiver. For example, 36-year-old Jennifer, as
I described in the opening of Chapter 4, relies upon her parents to provide child care for
her three children. In general, Jennifer really likes having her parents watch her children
– she trusts them with her kids and it gives the children a lot of contact with their
grandparents, something Jennifer missed out on as a child. In the year prior to our
interview, however, Jennifer said there had been several times that her parents had to
cancel on her at the last minute and she had been left to scramble for child care.

Jennifer’s youngest sister Ella, who still lives at home, has some ceremonial duties
related to the tribe, and depends on her parents for transportation when she must travel.
Unfortunately, she tends to wait until the last minute to inform her parents about these
trips, and thus they are forced to cancel on Jennifer at the last minute. Up until recently,
another of Jennifer’s sisters had always been available to provide back-up child care, but she moved out of state. As a result, Jennifer has had to take time off from work the last few times her parents were unable to watch her children.

Many mothers recalled such instances where their regular caregiver had cancelled on them – often at the last minute – and they had thus been forced to take time off from work, generally without pay. As noted in Chapter 2, the day care center technically does emergency child care on a drop in basis, but since the center is generally full, this is rarely an option. One woman I talked with told me she had taken a day off work a few months back to watch her niece’s child for the day. Sharol’s niece and her niece’s boyfriend, both of whom were still in high school, had shown up on her doorstep early in the morning; they had been driving around looking for someone to watch their daughter so they could go to school. Sharol felt sorry for them; they had been on the day care center’s waiting list for months, and their “regular” caregiver was not dependable.

Having multiple caregivers or back-up caregivers available can be beneficial in those occasional but inevitable instances where a child care arrangement falls through. Although 20-year-old Mona, whose story opens this chapter, usually depends on her four-year-old son’s paternal grandparents for child care, she told me that she had recently turned to her own mother for child care assistance for a few weeks. The paternal grandparents had experienced a family tragedy, and she wanted to relieve them of this responsibility for a period – she felt that they were simply going through too much to worry about watching their grandson.
Illness, on the part of the child or caregiver, can also interrupt arrangements. Those whose children attend the day care center must find back-up care if their children are sick, and these individuals almost always turn to relatives or neighbors for help. One mother also mentioned that she had been forced to find another arrangement for a few days when the home care provider she used had to have surgery. Although the provider gave her plenty of notice, she waited until the last minute to find other arrangements, eventually turning to her mother for assistance.

Many parents unfortunately exacerbate their caregiving problems by waiting until the last minute to arrange or negotiate child care. Those who wait until the last minute to try to enroll in the day care center are almost always confronted by the long wait list, and thus end up scrambling to arrange something with a relative or neighbor. Even some individuals who prefer kith and kin care may find care difficult to arrange at the last minute, like 16-year-old Raysha when she tried to go back to school. Some, however, with strong and flexible family networks may be able to arrange care with little advance notice. When Juna, a 33-year-old married mother of five children ranging in age from one to 16, started a new job, she simply called her sister Melinda and announced, “I’m dropping Kyrel off.” Melinda thought her sister just wanted her to watch one-year-old Kyrel while she ran errands; she only found out later that she needed regular child care. Melinda says she doesn’t mind, however, especially since it doesn’t involve too many hours per week. Also left unnegotiated was whether Melinda would get paid – she commented that she might get some money for watching Kyrel, but her sister had not yet paid her anything for her first week of care provision.
Chronic caregiving struggles

The same factors that influence caregiver availability, as discussed in Chapter 4, are strongly tied to caregiving failures. Parents without strong extended family networks, or who lack access to such networks, are typically those for whom caregiving arrangements are a constant struggle. These individuals are more likely to have to settle for less than ideal caregiving arrangements, and hence are more prone to chronic caregiving failures and having to constantly search for stopgap or new arrangements.

Georgina, the married 37-year-old Apache mother who was not raised on the reservation (and hence does not have a strong network upon which to draw for caregivers), has struggled with child care for her two-year-old son Ethan for years. Georgina started searching for child care not long after Ethan was born. Her first choice was the day care center, but she had to wait several months to enroll him there due to the long wait list. He stayed there for approximately eight months until she had a disagreement with the day care staff and was asked to remove her child. After this, she used her friend Farah who lives nearby, but sought another caregiver after she went to drop off Ethan one day and Farah wasn’t home. She found another babysitter, but her son would not eat there and started losing weight. She pulled him out after a week and returned to Farah. Soon after this she also tried a local home care provider; she used this provider for two months, but was concerned about the quality of care. Child care was becoming more of a struggle, and she says the final straw came the week she had to use three different caregivers (Farah, the home care provider, and her in-laws) to cover her child care needs; she found a serious bruise on her son, and because he had been with so many caregivers, she had no way of knowing who or what had caused it. She decided to quit her job and take care of Ethan herself. She said that this was a
financially stressful move, but it has worked for her and her husband. Now she is taking classes at the community college, and manages to cover the few hours a week she needs child care with assistance from Farah and her cousin’s wife. She told me she planned to take more classes the following summer, however, and would be needing more hours of child care, so she has once again placed her son’s name on the wait list at the day care center.

Forty-year-old Lena too had cycled through a number of caregivers for her two-year-old son Eli in the period of only a few months. After deciding that the cost of commuting daily to the paternal grandmother’s community was unsustainable, Lena and her husband decided to try other, more local caregiving options. At first, they put Eli in the day care center in Whiteriver; he was there for almost a month, but then Lena pulled him out because he always cried when he was there. Lena’s brother, who lives very close to them, then volunteered to watch Eli. He served as Eli’s caregiver for several months, but then there was some sort of conflict between the caregiver and Eli, after which he was no longer willing to watch Eli. Lena then used a cousin of hers who lives in a neighboring community for a day before asking her neighbor Kathryn (who has a granddaughter she cares for who is the same age as Eli) if she would provide child care for Eli until the end of the school year. This struggle to find dependable and reliable care, as noted in Chapter 4, was the primary motivation in Lena and her husband’s decision to move back to the community where they were raised and Eli’s grandmother still lives.
HOW KITH AND KIN CARE AFFECTS FAMILIES AND HOUSEHOLDS

Families who are faced with such challenges in securing child care experience on a day-to-day basis some of the downsides of kith and kin care, such as the potential for unsteady or undesirable arrangements. Yet while kith and kin caregiving can impact parents and children negatively, it quite often has positive effects. The mediating factor, in most cases, is the stability and dependability of the caregiving arrangement.

Caregivers also have the potential to be affected positively or negatively. Surrogate care, because it involves a great commitment of time and resources, generally has the potential for a greater impact on the caregivers’ lives than supplemental care. The outcome for caregivers is influenced by their resources as well as their age and health status. The conditions under which caregiving arrangements come about – for example, whether they are voluntary – can also be a significant factor for both caregivers and children.

Impacts on Parents

Good and dependable caregiving arrangements with trusted caregivers are an invaluable commodity. They can open up a world of opportunities for parents, allowing them to pursue employment or further their education. Conversely, chronic child care problems such as those experienced by 37-year-old Georgina can have a significant impact on job and school attendance and performance. Many are forced to quit their jobs or school. Others who would like to work but cannot find a dependable caregiver often simply stop looking for employment. Poor child care prospects can thus, in the short term, prove to be extremely stressful. In the long term, by limiting employment and
educational opportunities, they can significantly hamper the economic well-being of the family.

As will be discussed in Chapter 7, the use of kith and kin can also strengthen ties to and increase a parent’s participation in extended family networks. Strong networks mean strong families and strong communities, and involvement in these networks can bring benefits to parents as well as caregivers. Such involvement is not without its potential downside, however; enmeshment within family networks can lead to reciprocal obligations to kin that are perceived as excessive or burdensome.

**Impacts on Children**

Care by a loving relative is generally recognized as being good, especially for young children. Hence the popularity of child care by grandparents, who are perceived as having the best interests of the child at heart. Having a familiar relative as a caregiver can also be beneficial in the case of involuntary surrogate arrangements, by helping ease the transition for the child.

Not all view kith and kin care as having a positive impact on children, however. A great deal of concern has been expressed based on the perceived instability of kith and kin care arrangements. The frequent changes of caregivers associated with problematic arrangements are seen as a cause for concern. Other criticisms have focused on the educational aspects of care provision, arguing that kith and kin caregivers generally do
not have the resources nor engage in the types of activities with children that are viewed as preparing them to succeed in school.\footnote{158 The topic of child care and education will be addressed more fully in Chapters 7 and 8.}

**Changing arrangements and issues of stability**

For children the concern with instability is tied to issues of attachment. Frequent changes in caregivers have been associated with a number of negative developmental outcomes, including insecure attachment and problems with trust, increased aggression and other behavioral problems with peers, and greater emotional insecurity (Howes and Hamilton 1993). The important variable here appears to be the stability of the relationship with the individual providing care, however, and not simply the stability of the care arrangement (Phillips, et al. 1992; Scarr, et al. 1990). Stability in relationships with individuals providing care can positively affect the security of children’s attachments, temperament, confidence, self-awareness, and social understanding, whereas disrupted or insecure relationships or frequent changes in care involving unknown or unfamiliar individuals can lead to insecure attachments and other negative developmental outcomes (Thompson 1998; Thompson 2001).

*Continuity of relationships*

For parents such as 37-year-old Georgina, who are forced to cycle through an array of unfamiliar individuals in an attempt to piece together child care, there might be cause for concern about the effect of such frequent changes on their young child. In general, however, caregivers in this community are people who the children have frequent contact with outside of the caregiving arrangement and are thus known and
familiar individuals in the children’s lives. For almost all of those interviewed, the
caregiver was someone that was familiar to both the parents and the child. Such
consistent, caring relationships are important for children’s development (Porter 1998).
In the case of family members, the caregiver and child have a relationship which existed
prior to the initiation of the caregiving relationship and will continue long after that
individual no longer serves as a caregiver for the child. In the few instances where an
unrelated individual was used as a caregiver, the caregiver was in all but two instances
someone such as a neighbor or godmother who was familiar to the child.

Having a familiar individual as a caregiver can reduce the disruptiveness for the
child in those cases where frequent changes are necessary or inevitable (Collins and
Carlson 1998). For instance, although 40-year-old Lena was forced to change
caregivers five times in as many months, all of these individuals, with the exception of
two, were relatives. Even the neighbor who was serving as her son’s caregiver at the
time of our interview was someone who the child knew, liked, and was comfortable with
before the caregiving arrangement ever began. The frequency with which parents work
seasonal jobs means that it is not uncommon for children to enter and exit caregiving
arrangements multiple times in a year. Kith and kin are better able to accommodate
such changes, and can ease these transitions for children by putting familiar individuals
in the position of caregiver.

Even the two home care providers who were interviewed emphasized that while
they might not know a child prior to beginning to care for him, they maintained
relationships with many of the children they cared for far beyond the time they ceased
serving as the child’s caregiver. One home care provider proudly commented that she
had watched several of the children she has cared for graduate from high school, and was now caring for the daughter of one of the children she cared for two decades ago. These continued ties and lasting relationships between the child and caregiver provide a great deal of stability and continuity for the child. Relationships are not disrupted every time a caregiving arrangement changes – even though an individual may no longer serve as a caregiver for a child, that person often continues to be a regular presence in the child's life.

**Impacts on Caregivers and Households**

A number of factors mediate the impact of caregiving on the caregiver and their household. The age and health of the caregiver are significant factors – caregiving can be a significant strain on elderly individuals or those with health problems. The type of arrangement also makes a difference. Part-time supplemental care will generally have less of an impact on the caregiver than full-time care. Surrogate care has the potential to be even more of a strain on caregivers and their households, especially in cases where the arrangement is involuntary. The impact of surrogate caregiving is further mediated by the caregiver's perception of the situation, their resources and coping mechanisms, and the events that precipitate the need for caregiving (Bowers and Myers 1999; Gatz, et al. 1990).

Many caregivers find caregiving to be an enjoyable and worthwhile endeavor. As discussed in Chapter 4, caring for children may give caregivers a sense of purpose or make them feel needed, or the children may simply keep them company. But there can be downsides as well. Caregivers commonly find that they have to alter their plans and
routines and that they have less time to get everything done. They may also end up with less time for and contact with friends (Jendrek 1993).

Aleah, a 43-divorced mother and surrogate caregiver, noted that her own 71-year-old mother Clarilynn had experienced the positives and negatives of providing surrogate care. Clarilynn’s great-grandson Aaron lived with her for several years, and in many ways she found his presence useful. He helped her around the house and served as her eyes and ears, telling her what was on the news or when someone was at the door. Caring for him, however, eventually became too difficult both physically and financially, and she was forced to find another relative to take him in.

**Caregiver health and well-being**

A number of parents expressed concern about older individuals serving as supplemental caregivers, believing that keeping up with young children would be too hard on them. For some individuals I interviewed, such concerns led them to consider other child care arrangements. The most concern, however, was directed towards older women like Clarilynn who were serving as surrogate caregivers.

The surrogate arrangements that are most stressful on the caregiver are those initiated by the courts or social services. Even in communities such as this with long traditions of surrogate caregiving, devastating social problems may force individuals – usually grandparents – into unanticipated or unwanted caregiving roles under very different circumstances than their forefathers (Burton and Dilworth-Anderson 1991). Many of these children suffer from emotional, behavioral, or health problems that

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159 Shomaker (1989:2) has similarly noted that, among the Navajo, grandchildren often serve as helpers, in essence functioning as the “eyes, ears, hands, and feet for their frail grandparents.”
caregivers are unprepared to deal with emotionally, physically, and economically. Caregivers forced to take on children under such circumstances may be particularly vulnerable, and not uncommonly these individuals’ physical and psychological health suffers as a result (Minkler and Roe 1993).

Grandmothers like Emmie and Vertie, whose stories were told in Chapter 4, emphasized how difficult these unanticipated roles were for them. Although 58-year-old Emmie had long provided surrogate care to two other grandchildren, she found caring for her three-year-old granddaughter Dena unexpectedly difficult due to her turbulent past, and questioned her ability to be able to care for her much longer. Forty-four-year-old Vertie, who had taken it upon herself to care for her two-year-old twin grandsons who had been born extremely premature, commented that she simply no longer had the energy to keep up with twins, especially ones with such significant health problems. Both of these caregivers, however, were more concerned about the children than themselves, and were determined to do whatever was in the best interests of the children. As Minkler and Roe (1993) emphasize, however, even caregivers who derive a deep sense of satisfaction from their unanticipated caregiving role may suffer costs to their health and general well-being.

Those individuals for whom caregiving is a voluntary role quite often find the experience meaningful and rewarding and, consequently, beneficial to their psychological (Giarrusso, et al. 2000) and even physical well-being. Gattai and Musatti (1999:38) noted in their sample of Italian caregivers that being with grandchildren “seemed to have an enlivening effect on the grandmothers;” as one noted, her relationship with her grandchild made her “feel alive and young.” Almost all of those
caring for their grandchildren noted an increase in self-esteem, and for some of the Italian grandmothers the relationship almost seemed to have an anti-depressive function.

Apache grandmother caregivers I spoke with expressed similar sentiments, noting that their grandchildren “keep them going” or “keep them young at heart.” Others noted that they really enjoyed and valued their grandchildren’s company and that they missed them when they were not around. One parent said that her mother liked to have the grandkids around the house because she lives by herself – as she joked, “they keep her company, busy, crazy!”

Several emphasized that watching their grandchildren keeps them active and doesn’t let them slow down. Caring for grandchildren, as one mom noted, keeps her parents from sitting around in front of the television. The importance of staying active and busy, and the place of grandchildren in accomplishing this, was a recurring theme. As one caregiver commented, “If not for them, I might have put on the old shoes and croaked already!”

My good friend Lorraine, who is Monica’s grandmother and has cared for a number of her grandchildren over the years including two-year-old Shanae, had a long discussion with me linking caregiving, activity, and health. The conversation started with her expressing concern about her husband. He had started to talk about retiring, and she was worried that if he did, he wouldn’t have anything to do but sit around the house. She emphasized that, “when you don’t stay busy, that’s when you start getting old real fast.” This concern, while directed at her husband, was also integrally tied to her decision to provide child care. Caring for Shanae keeps her active and moving, and thus
keeps her from getting old. She credited this activity with helping control her diabetes and high blood pressure. She reasoned that in the past, when people in her community were more active, these diseases were never a problem. Hence staying active by caring for her grandchildren was her way of staying healthy and keeping young.

Even in instances where a caregiving arrangement is stressful, it may indirectly benefit the caregiver’s health. As Schwartz (2002:445) notes, some grandparent caregivers pay more attention to their health needs “to ensure they can continue to meet their caregiving responsibilities until the children are grown.” Emmie, the 58-year-old grandmother serving as a surrogate caregiver to three-year-old Dena and two others, alluded to something like this, stressing that her own health and well-being were more of a concern now that she was solely responsible for three of her grandchildren.

**Financial security and needed services**

Caregivers and their households may be adversely affected financially by providing surrogate care, especially in those cases where the arrangement is involuntary. Forty-four-year-old Vertie received SSI for the twins because of disabilities resulting from their premature births, but she had to quit her job to care for them and hence the household had lost her income. She noted that without the SSI they would really be in the hole, and as it was they were just barely getting by. Seventy-one-year-old Clarilynn, who for years cared for her great-grandson Aaron, got SSI for herself but that was her only source of income. Aaron’s mother received child support from the father, but never passed any of this money on to Clarilynn. As a result, Clarilynn paid for everything for Aaron herself out of her paltry assistance income.
Caregivers such as 43-year-old Aleah, who provides surrogate care to two children, and 35-year-old Vana, who is raising four children of her own and serves as a surrogate to three others, have made out much better financially, something they both attributed to knowing how to navigate the system. Both have worked for years as advocates for children, and consequently have extensive knowledge about available services and the procedures necessary to access them. Both also pointed out that their mothers, who have likewise served as surrogate caregivers, have had a much more difficult time accessing needed services and resources. Getting what you need requires not only knowledge of what is available, but also connections and a lot of determination. Aleah noted that her mother, like many other older members of the community, is hesitant to speak up for what she needs. Vana commented that her mother has had a difficult time negotiating the tribal bureaucracy to get services like WIC and AFDC.

Supplemental caregivers, since they ultimately have less responsibility for the children in their care, generally are not affected as much financially. Several mentioned that they did spend quite a bit of money on children in their care, but none indicated that this was a significant stress to the household.

Several caregivers (both supplemental and surrogate) providing full-time care, however, did express a need for some sort of respite care or child care relief. Some wanted somewhere they could drop children off when they needed to run errands or go to the doctor. Many though simply expressed a need for a break or for some time for themselves. One 61-year-old grandmother, Jessie, who provides child care to her son’s two daughters, noted she got a much needed break from caregiving during the summers, for which she was very thankful. Her son, she explained, works seasonally at
the ski resort and takes over care of the girls in the months he is off. Vertie, the 44-year-old grandmother providing surrogate care to her twin grandsons, was not so lucky. For months she had been trying to find someone who could come help care for the twins while she did household cleaning and ran errands, but had been unable to find anyone. She noted that the twins’ mother had only taken them three times in the previous six months – while these instances had allowed Vertie to accomplish some things, but never gave her a chance to get fully rested.

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Kith and kin caregiving arrangements in the Apache community take a form that varies significantly from other forms of child care and present their own unique challenges. Care in these settings is, in general, more familial than pedagogical and integrated into the daily flow of the household. Kith and kin caregivers tend to be reluctant to structure the child’s day and activities, instead preferring to “let the day roll” and follow the child’s lead. They are also less likely than other care providers to be directly compensated; many such caregiving arrangements are instead simply part of the ongoing mutual assistance and reciprocity that characterize many kin relationships. The form compensation takes and how responsibility for different aspects of the child’s care is allocated are largely a function of the child’s relationship to the caregiver, the caregiver’s perception of his or her role and motivation for providing care, and the function and place of the arrangement within existing family and community networks.

Many aspects of the practice and experience of kith and kin care discussed in this chapter may in fact look familiar to anyone acquainted with informal child care in other ethnic minority or low-income communities. Some features of Apache caregiving
arrangements I have discussed are somewhat unique – the autonomy permitted children and the extent to which responsibility for children is shared, for example. But, as in many other communities, the use of kith and kin care is not uncommonly reactionary, driven by employment-based needs and/or a lack of other options. And, because of the informal nature of such care, Apache kith and kin arrangements are – as others – more prone to problems and failure than some other forms of care.

Nonetheless, there is a certain distinctiveness to kith and kin caregiving in the Apache community, evident not so much in how it looks but why this type of care is favored. The use of kith and kin as caregivers for children is, for many, integral to building and reinforcing an internal sense of cohesion and identity and producing culturally competent children. Kith and kin caregiving is hence not just about child care – it is about the production and maintenance of the cultural and relational community. And, as will be discussed in Chapter 7, this is facilitated though immersion in the physical and cultural environment and relationships that are central to what it is to be Apache, something most naturally accomplished when children are in the care of kith and kin.
CHAPTER 6
THE ROLE OF CAREGIVERS IN HEALTH PRODUCTION AND ILLNESS MANAGEMENT

• Revisiting Monica …

By the time I first met Monica’s, she had already been hearing impaired for two years. As I explained in the introduction to Chapter 1, Monica’s hearing impairment was the consequence of complications resulting from a case of acute otitis media. Otitis media is, unfortunately, a very common cause of illness and IHS clinic visits for Apache children (Todd and Bowman 1985; Zonis 1968). It is also a recognized cause of hearing impairment among Apache and other Indigenous children (Bowd 2005; Fischler, et al. 1985; Zonis 1968).

While I knew at a general level what was behind Monica’s hearing loss, it was only after I had known Monica and her family for years that I heard the story behind this illness episode. As do many parents, Monica’s mother attempted to treat her at home with over-the-counter medications when she first developed a fever. Relatively quickly, however, her fever spiked and she decided to take Monica to the walk-in clinic at the IHS hospital in Whiteriver. The doctor noticed that, in addition to her high fever she had inflammation of the middle ear, and prescribed antibiotics for the infection and Tylenol to keep the fever at bay.

160 Nationally, American Indian and Alaska Native children have rates of otitis media-associated outpatient visits and hospitalization that are on average from 1.5 to 3 times higher than the general US population of children (Curns, et al. 2002). The Apache are recognized as having particularly high rates and severe manifestations of otitis media (and chronic otitis media), a difference which may be attributable to a genetically determined eustachian tube difference (Todd and Bowman 1985).
Monica’s fever proved difficult to control over the next several days and her condition seemed to deteriorate rather than improve. Her grandparents, who are relatively traditional, took Monica to a medicine man. Monica’s parents, upon hearing that one of the local Miracle Church’s congregations was holding a prayer meeting at a neighbor’s house, took Monica over there to be prayed over. As her mother Nettie later explained, although they don’t necessarily subscribe to the teachings of the Miracle Church, she knew the woman sponsoring the prayer meeting, it didn’t cost anything to have them pray over Monica, and it didn’t hurt to try, “just in case.”

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In the end, Monica developed febrile seizures and had to be flown out to Phoenix Indian Hospital to be treated. While the outcome was certainly not what any parent would want for their child, Monica’s parents and grandparents had pursued just about every therapeutic option available to them. Their initial resort was biomedical, but when that did not appear to be working they also sought out a traditional healer and even tried charismatic faith healing although it was not part of their belief system.

As I had been intrigued by the prominent role Monica’s grandparents had played in decisions of how best to educate her, I was interested in their involvement in her health care. The decision to seek out a medicine man to treat Monica had been theirs, and they had paid for his services. This led me to wonder how common the involvement of kin and other caregivers was in health care seeking and decision making for children, and in what other ways they were influencing the health of children in their care. Broadly, to what extent (or under what circumstances) does the locus of responsibility for
children’s health reside at the level of the larger community rather than that of the individual family?

All individuals who provide care to a child influence the health of the child in their care in myriad ways. Child health is largely a product of the child’s environment and the protective and promotive health care the child receives. It is also a function of the caregiver’s response to routine illnesses that all children experience. For those children who spend a significant amount of time in the care of non-parental caregivers, health and well-being is as much a function of the characteristics and practices of their alternative caregivers as their parents (Engle, et al. 1996).

As was discussed in the previous chapter, supplemental and surrogate Apache caregivers take varying degrees of responsibility for, among other things, health care decision making, health care seeking, and the care of children while they are sick. Yet even in cases where alternative caregivers do not participate in such activities, they can still influence the health of children in their care simply because the skills, knowledge, status, and resources of a caregiver play important roles in determining the health status of a child.

The purpose of this chapter is twofold. First, health is one area where alternative caregivers can have a significant – and very concrete – impact on the children in their care, and this chapter explores their role in health production in the community. Included is a discussion of the therapeutic options available to caregivers in the community and how they are differentially used by caregivers in relation to children. But an examination of how illness episodes are handled also provides an important insight into how kith and kin networks operate, both in terms of how responsibility is shared and
how resources are marshaled, as well as under what circumstances these networks falter. Hence, this is a secondary focus of the chapter.

CAREGIVERS AND THE “PRODUCTION” OF CHILDREN’S HEALTH

Responsibility for child health, in many communities, is collective rather than individual. In addition, child health is not solely a product of the parent’s actions but instead is produced by multiple members of a household or extended family through routine participation in health related activities. The mundane activities of daily life are important for health outcomes, and the “production” of healthy children requires on the part of family and household members an investment of time and resources, the application of home-based knowledge and available technology, and the weighing of choices and opportunity costs (Nichter 1995).

Health has multiple determinants, a point emphasized by the framers of the household production of health (HHPH) model (Berman, et al. 1994; Nichter 1995; Schumann and Mosley 1994). Berman, Kendall, and Bhattacharyya (1994:206) define the HHPH as “a dynamic behavioral process through which households combine their (internal) knowledge, resources, and behavioral norms and patterns with available (external) technologies, services, information, and skills to restore, maintain, and promote the health of their members.” Household members, as well as different households, are not necessarily cohesive units – they may have varying levels of knowledge, different amounts of time, and different opportunity costs, which together amount to the provision of different levels of care. As such, this approach requires a consideration of intra-household dynamics, work requirements, power structures, time allocation, decision making roles, household economics, and resource distribution and
inequality in examining health production (Castle 1993; Nichter 1995; Popkin and Doan 1991; Schumann and Mosley 1994).

In the Apache community, decisions about health care are not the sole responsibility of the individual, but quite often involve other members of the household or the larger extended family network. In his study of medical decision making in the White Mountain Apache community, Everett (1971) notes that decisions about what treatment to seek are quite often heavily influenced by others. In the case of children, parents and other caregivers, as well as other (particularly elder) family members, may all participate at various levels in the care of sick children and in decisions about their treatment.

Alternative caregivers in the Apache community are involved in health production and promotion in a number of different ways. They play an important role in recognizing when a child in their care is getting sick. They may be involved in decisions about when and where to seek treatment for a sick child; some even take responsibility for seeking such care. Alternative caregivers are also not infrequently involved in caring for children while they are sick and convalescing. While in general surrogate caregivers take more of a role than supplemental caregivers in health care decision making and health care seeking for the children in their care, such involvement varies significantly by the individual and family.

An assumption commonly found in the literature on caregiving and children’s health is that alternative caregivers are less effective than parents at protecting and promoting the health of the children in their care. Older caregivers are presumed to possess outmoded information about nutrition, illness, and effective treatments. Younger caregivers are depicted as lacking sufficient knowledge and experience.
However, research has suggested that non-parental care is not necessarily less advantageous to a child's health and well-being than mother care, nor is there a consistent relationship between who provides care and the health status of a child (Castle 1995; Engle 1989). Numerous factors, including caregivers' work requirements, daily routines, social roles, personal qualities, needs, and attitudes (de Vries 1987), all serve to differentially influence the health of children under their care.

The impact a caregiver has on the health and well-being of a child is dependent upon the amount of time the child spends in the individual's care, the degree of responsibility that caregiver has for the child, and the extent to which they are forced to multi-task when the child is in their care. Surrogate caregivers, because they generally assume greater responsibility for the children in their care, are more likely than supplemental caregivers to have a significant impact on the health of the child in their care. Also important are the caregiver's knowledge and experience, their access to resources (including time and money), and their power and/or status in the household or community. In some cases, the resources that alternative caregivers have at their disposal may be such that they are in a better position to protect and promote the health and well-being of the children in their care, as Shomaker (1989) notes in relation to Navajo grandparents serving as surrogate caregivers.

ILLNESS CAUSATION AND RESOURCES FOR ILLNESS MANAGEMENT

Individuals in the White Mountain Apache community have a range of therapeutic modalities and practitioners available to them. These include traditional Apache healers (herbalists and medicine men), biomedical practitioners (also referred to as “Anglo” physicians), and charismatic faith healers. In the course of any given illness episode, an
individual may seek treatment from one or more of these practitioners, either based on their own preferences and/or beliefs as to the cause of their illness or the advice of a trusted individual.

In general, decisions about who to approach for treatment are tied to beliefs about disease causation. Level of acculturation also affects decisions, because beliefs about disease causation vary significantly by the degree to which the individual is acculturated (Everett 1971). Older, more traditional Apaches are more likely to seek out medicine men for treatment than younger, more acculturated community members, who are more likely to resort to biomedical practitioners (although this is by no means universal). Other factors, including the resources an individual has access to – such as money, insurance, etc. – as well as personal experience with certain practitioners or modalities, also influence treatment decisions. At times, such practical considerations may overshadow beliefs about causation, leading to treatment decisions that appear to contradict personal beliefs.

Apache Illness Taxonomy

For the Apache, illness is subsumed under the larger category of “trouble,” which includes serious (incapacitating) and minor (non-incapacitating) illnesses as well as witchcraft (Debacher 1980). Serious illness can be, as Basso (1970a:45) notes, … the direct result of behaving ‘without respect’ towards things that are godiyo (‘holy’). More specifically, sickness occurs when an Apache violates one or more of the taboos surrounding objects from which power derives or in which it has come to reside.
Not all forms of “trouble” are tied to the concept of power; minor illness and some serious illness are recognized as having more mundane causes, such as intense or sudden cold, bad food, or “germs.” However, two classes of “trouble” are inherently associated with power – one category of serious illness, which translates roughly as “power-caused” illness, and witchcraft.

As explained in Chapter 2, power is an attribute of certain classes of animals, plants, and objects within the Western Apache universe which are said to possess it (Basso 1966; Basso 1969). When an individual eats, drinks, inhales, or touches something that has come into contact with a power, serious illness can result. Examples include eating beef from a cow struck by lightning, drinking from a stream in which a bear has been swimming, inhaling smoke coming from wood on which a deer urinated, or stepping on a rattlesnake skin (Basso 1970a). Alternatively, power can enter the body as a result of human perpetrated witchcraft and similarly cause illness (Basso 1970a; Debacher 1980).

Once a power has entered the body, it may produce symptoms very quickly, or lie dormant for years. Such illness can only be diagnosed with certainty and cured by a medicine man. Traditionally, once the power causing a particular illness was identified by a medicine man through a diagnostic ritual, a medicine man possessing that specific power was sought. Today, however, as Debaucher (1980) notes, a lack of qualified medicine men has led to more relaxed considerations, such as the general reputation and competence of the medicine man, rather than the specific power he possesses.
Available Therapeutic Modalities

The sources of treatment available to Apaches have changed significantly over time, as has the relative popularity of each form. For many reasons, the use of traditional medicine continues to decline, while dependence on both biomedicine and, to a lesser extent, charismatic faith healing increases. And, while many individuals do seek the services of doctors and other healers, it is also important to recognize that a significant amount of illness management takes the form of self-treatment. Only those illnesses that do not respond to home remedies, or are initially interpreted as serious, are ever brought to the attention of doctors/healers.

Traditional Native healing

In those instances when traditional Apache healing is viewed as the best option, individuals have a number of choices available to them. Individuals can treat themselves, using various herbal remedies or other ritual paraphernalia. They may also seek the assistance of another individual knowledgeable in such affairs, either a close friend or relative or an herbalist (Everett 1971).

It appears that knowledge of traditional herbs and their uses is slowly being lost. Few individuals spoke to me about collecting herbs for therapeutic purposes. Those few who did mention using traditional herbs were some of the older caregivers in my sample. The mothers I spoke with for this project were relatively young; while a few mentioned that they had mothers, grandmothers, or aunts with such knowledge who could give them advice, none possessed such knowledge – or attempted to use traditional herbs – themselves.
In those cases where self-treatment (or, alternatively, other treatment modalities) are ineffective, or the illness is judged as more serious, individuals can seek out a medicine man. Medicine men are usually approached with psychological issues, which are more commonly judged as having a supernatural cause, or physiological ailments of lesser severity or which are not responding to other treatments. The point of therapeutic ritual, as Everett (1971:39) notes, is the

… restoration of normalcy with respect to a dysfunctional state of affairs. In the case of illness, the Apache shaman or medicine man diagnose[s] the ailment by discerning a set of action possibly interpreted by a supernatural power as disrespectful and likely to have evoked the malevolent wrath of the offended entity.

The medicine man, functioning as a mediator between humans and the powers surrounding them, uses ceremony to communicate with the offended power and restore the proper order (Debacher 1980).

The willingness to consider using traditional medicine varies significantly by community, as well as by individual family. Everett (1971) noted that he found a significant difference between the communities of Whiteriver and East Fork – those in Whiteriver tended to look to Anglo causes for illness, whereas the opposite was true in East Fork. While I also interviewed individuals in both these communities, I did not find much of a contrast, which could potentially be interpreted as evidence of East Fork’s increasing acculturation in the intervening 30 years. Watt (2004), in her book, notes that hardly anyone uses traditional healers today. It is possible that communities like Cibecue, widely judged as the most traditional, continue to use traditional medicine with greater frequency.
Even within more acculturated communities such as Whiteriver, however, individuals do still utilize herbalists or medicine men on occasion. A little more than half of the parents and caregivers I spoke with reported having resorted to a traditional healer for their own ailments over the years, but only one specifically talked of having been afflicted by a power-caused ailment. Melinda, a 24-year-old married mother of three, told me that she had been diagnosed with rheumatoid arthritis the fall before I interviewed her. At the time, she was in so much pain that she couldn’t even carry around her two-year-old daughter; sometimes she couldn’t even get up. Her mother was very concerned, and paid to have a medicine man do a ceremony. He said that her ailment was due to lightning power – she had bought wood that had been struck by lightning and had used it to make a fire over which she cooked tortillas. Through both the smoke from the fire and the tortillas which she later ate, lightning power was able to enter her body and affect her. Melinda notes that before the weekend-long ceremony, she had to take Percoset to function; immediately following its conclusion, however, she noticed she felt better, and she has been relatively pain and symptom free ever since.

Children are occasionally taken to traditional healers, but with much less frequency than adults. Only seven individuals personally had used traditional healers for their children. In some cases this was for physical ailments, such as seizures or ear infections as with Monica; in others, medicine men were consulted when children had seen ghosts or witchcraft was suspected. One mother related that she and her boyfriend had gone to a medicine man while she was pregnant because of some strange occurrences they were afraid might affect the baby:

When I was pregnant … we went to see a medicine man and got prayed for because … well, they thought [it was] witchcraft, because … my boyfriend and I … we bumped a kid on the road. And then in that same car, we hit a bull, a
really big bull. And then we got struck by lightning in that same car... So we were wondering what was going on with that car. So at that time we did ... we got prayed for. And the vehicle [got prayed over] too. And it happened when we were together, you know, every single time. It was in [my boyfriend's] parent's van. We would both be in the car ... And we bumped a person, a little boy ... And I was like, how could we ... he just ran in the road. And then the bull. We were coming around a corner and ... we weren't going very fast ... and then this big ol' head was right in the road. ... we hit the back, the bottom of [the bull]. And then we got hit by lightning about a month after that. So, at that time we did [go to a medicine man]. The baby was still in my womb at that time. All three of these things happened while I was pregnant. And it was like when I was really huge pregnant too ... And we just thought that that wasn't right. Something was wrong. So at that time we did [go to a medicine man] ... for the baby. To protect it.

A few other individuals I spoke with knew of other children for whom traditional medicine had been used although they had never done so themselves. One knew of a case where a child who stuttered badly was taken to a Sunrise Ceremony to be prayed over.\textsuperscript{161} A handful of others said they would consider using traditional medicine for their children if they thought it would help, but the majority said they would not.

The reluctance to use medicine men is tied not only to acculturation and the influence of biomedicine, but also the rise of Pentecostal churches on the reservation. In contrast to the Lutheran and Catholic churches who are in practice more tolerant of traditional Apache beliefs and ceremonies, the Pentecostal sects generally prohibit participation in traditional religious activities, including healing ceremonies (Debacher 1980). They offer, however, an alternative to traditional healing in the form of Christian faith healing, which will be discussed below.

In some cases, even those who would prefer to seek treatment from a medicine man find it difficult to do so. Complex curing rituals can be time consuming and

\textsuperscript{161} At the point in the ceremony where the pubescent girl has been transformed into Changing Woman, she is believed to have the power to heal. Participants and observers will line up before her and ask for their ailments to be alleviated, and the medicine man who is leading the ceremony will guide the girl in blessing these individuals with sacred cattail pollen and healing them. (For more information on the Sunrise Ceremony, please see Chapter 2.)
prohibitively expensive and necessitate the cooperation of numerous kinsmen and the provision of food and other material items; even simple diagnostic rites can be costly (Debacher 1980). Many such individuals lacking the financial resources to consult a medicine man end up going to the hospital since care there is free (Everett 1971). In other cases, it is the shortage of healers that is the problem. The chants required to control a power require both a significant time and financial investment to acquire (Basso 1970a); consequently, fewer individuals today are becoming medicine men, leaving those desiring a traditional Apache healer with ever decreasing options.

Biomedical treatment

By far, the most common therapeutic option utilized by the Apache today is biomedicine or, as it is referred to sometimes, “Anglo” medicine. Those in Whiteriver and its surrounding communities generally seek free health care at the Indian Health Service (IHS) hospital located in Whiteriver, although an increasing number of tribal members with insurance or who are enrolled in Arizona’s state Medicaid program (AHCCCS)\(^{162}\) seek care from private practitioners in the off-reservation communities of Pinetop-Lakeside and Show Low. Quite a bit of biomedical treatment also comes in the form of self-treatment at home with over-the-counter (OTC) medications.

Provision of health services to tribes is a treaty obligation of the United States government. In the early years, such services were primarily limited to controlling the spread of infectious disease, and were in the hands of the War Department. Since the 1950s, health care has been the responsibility of the Indian Health Service, although

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\(^{162}\) At the time I was working on the reservation, there was a big push to get tribal members enrolled in AHCCCS before new (higher) income eligibility cutoffs went into effect.
many tribes today contract with the government to manage their own health service programs. Health services today are comprehensive and community-oriented, and emphasize both curative and preventative elements of care (Indian Health Service 2005).

The IHS hospital in Whiteriver, opened in 1979, is a 49-bed facility which includes both in-patient care and an out-patient clinic. Services include general medical, pediatrics, obstetrics, and dental, as well as a number of specialty clinics/programs and an ambulatory surgery unit. Those requiring emergency medical care are generally transported to larger medical centers in either Phoenix or Tucson. Community opinion as to the quality of care received at the IHS facility varies; some are very satisfied, yet many have complaints, particularly concerning the lengthy waits they are quite often forced to endure at the walk-in clinic.

While it is possible to make appointments with doctors at IHS, most people needing care (especially for their children) instead utilize the walk-in clinic. The mostly commonly mentioned ailments for which parents sought care for their children were high fever, bad colds, ear infections, and acute respiratory infections (ARI), including pneumonia and RSV. Parents or other caregivers could accompany children to the clinic – the only apparent requirement was that they have the child's IHS chart number in hand (mothers, I discovered, often have these memorized). The biggest hassle was the wait: many parents I interviewed complained that, at busy times, they might have to wait up to three hours to be seen at the walk-in clinic. Based on the number of such complaints, long wait times appear to be a common occurrence. (It is important to note that patients see a triage nurse shortly after arrival, and serious cases are seen more quickly.)
Others complained that the pediatricians usually just give sick children OTC medications like Tylenol and Benadryl and send them home. Such clinical interactions are frustrating for parents, especially those who have waited a long time for their children to be seen. As a consequence of this style of medical treatment, most parents attempt to treat their children at home with these same OTC medications before resorting to the IHS clinic (Everett 1971).

Many of those who are unhappy with the lengthy waits and/or the care they receive at the IHS facility – and who have the option to do so – seek care instead from private physicians off-reservation, most commonly at the Blue Ridge Clinic in Pinetop. Generally these are individuals who are tribal employees and as such have the option of purchasing private health insurance through the tribe; others are those enrolled in AHCCCS. Blue Ridge’s popularity is at least partially due to the presence of two tribal members on staff. While care at IHS is free, those who choose instead to see providers covered by the tribal insurance have a five dollar co-pay for doctor visits, and a three dollar co-pay for prescriptions. Noted drawbacks of the Blue Ridge clinic include the long drive (the clinic is approximately 25 miles from Whiteriver) and the fact that Blue Ridge is not open as late in the evening as the IHS clinic.

While there were a few individuals who used Blue Ridge clinic exclusively, and a few others who used IHS exclusively despite having other options, most of those with insurance noted that they used Blue Ridge in combination with IHS. Some would only travel to Blue Ridge if the wait times at IHS were bad; one tribal member explained that she would use IHS on weekdays, but Blue Ridge on the weekends, commenting that the waits at IHS were particularly bad on Saturdays and Sundays. (Patients also have to
wait to be seen at Blue Ridge at times, but the wait times are generally under an hour.)
Another said she would only go to IHS if she was already going into town for another reason; otherwise, she would go to Blue Ridge.

Many parents would start at the IHS clinic, since it is free and – at least for most individuals I interviewed – closer to home. Then, if the IHS pediatricians only gave them OTC medications or the parents were unhappy with the diagnosis, they would take their children “up the hill” to Blue Ridge. Arnita, a 29-year-old mother of three children ranging in age from two to ten, explained that she and her partner usually starts at IHS if one of their children needs to be seen by a doctor, but if they don’t agree with what the doctor says, they will take the child up to Blue Ridge. Melinda, the 24-year-old mother of three who suffers from rheumatoid arthritis, takes a similar approach. As she explained, she always starts at IHS when the kids needs a doctor, but if the IHS pediatricians just give the child Benadryl or Tylenol, she takes them up to Blue Ridge.

A parent’s satisfaction with their IHS visit seemed at least to partially depend upon which pediatrician they saw; some of the doctors were pretty universally perceived as more concerned and competent than others. Appointments could be made with specific pediatricians ahead of time, but parents seemed to rarely do this; those utilizing the walk-in clinic simply had to see whoever was available, resulting in a remarkable lack of continuity of care for children. Nonetheless, a few parents expressed strong preferences for IHS; one expressed her belief that the doctors at Blue Ridge were in it only for the money, whereas those at IHS were more dedicated and, being in many cases recent medical school graduates, knew “all the latest stuff.” Opinions of the Blue Ridge pediatricians varied to some extent as well, and parents who utilized this clinic
were also not guaranteed to see the same pediatrician from visit to visit. No one, however, had any significant concerns about the care they received at Blue Ridge and, tellingly, no one reported taking a child to IHS for a second opinion after starting at Blue Ridge. Those who regularly sought care first at Blue Ridge tended to use that clinic exclusively.

In contrast, a few individuals had serious complaints about IHS regarding potentially critical misdiagnoses. Two parents noted that their infants were diagnosed as having the flu when in fact they had pneumonia; another who was said to have “only a cold” in fact had RSV. Melinda, one of the parents who regularly follows IHS with Blue Ridge if she does not agree with the IHS pediatricians’ diagnosis or treatment, noted that her skepticism was borne of experience: when she took her youngest daughter to IHS as an infant with a high fever and rapid heartbeat, one of the doctors started to send them home. Instead of leaving, Melinda called one of the other doctors at the hospital who goes to her church and asked him to look at her daughter; he suggested she be kept for observation. Within hours her condition had deteriorated to the extent that she was flown out to Phoenix Indian Hospital, where she was hospitalized for three days. The following year, the same daughter had RSV, but the doctor at IHS said it was just a bad cold and would not test her oxygen saturation. As Melinda recounted:

I gave her [breathing] treatments like four times that whole morning. And then Tylenol ... she was still burning up. And I kept on taking her over here [to IHS] and they said, “Oh, it’s just a bad cold.” And I go, “It’s not a bad cold! I know this ‘cause my son had RSV.” And they go, “No.” And I said, “Well, test her!” And they go, “Oh, everything’s normal. Nothing’s wrong. She just has a really bad cold.”

And my husband said, “Well, let’s just take her up [to Blue Ridge] and see what they say.” So we took her up, and ... she was OK, she was all happy and
everything. They checked her O₂ stats and it was at 81.\textsuperscript{163} [The nurse] was my cousin’s girlfriend, and she said, “That can’t be right.” So she did it again, and it was 81. She said, “Wait a minute,” and she left us in the screening room and the doctor came in and said, “OK, I’m going to call the ambulance to pick you up and drive you to Navapache\textsuperscript{164} right away.” And we go, “Why?” And he said, “It’s 81 … it’s supposed to be in the 90s.” … We got taken in the ambulance to Navapache but they had no rooms so they brought us back down here [to IHS] and she got admitted.

And [the doctors at IHS] asked, “How come you took her up there [to Blue Ridge]? Why didn’t you bring her here?” And I said, “Well, ‘cause all you said down here was that she had a bad cold.” And the whole time she actually had RSV.

Stella, a 29-year-old married mother of four, nearly lost her youngest son to such a misdiagnosis. When her son was about a year old, he got really sick and his breathing was labored. She took him to IHS, but they tried to send her home:

They told me there was nothing wrong with him so they send me home, right? But I knew something was wrong with my son. … He had pneumonia and asthma attack at the same time. And they were like, “No, there’s nothing wrong with him, but if he gets any worse, you know, bring him back and we’ll check. He just has the common cold. Take him home.”

And as we were leaving the hospital I told my husband, “Can you just please take me to Navapache?” And he was like, “Navapache? You want to go up there?” And I was like, “Yes!” I said, “Just drive me up there. I know there is something wrong with him.” And he was wheezing so bad and breathing trying to catch his breath and by the time we got close to Hon Dah, he passed out from it. So then we turned on our emergency lights and just zoomed it to the casino, ran inside, and asked if someone can call 911. And I waited for the ambulance there. And he was just totally blue all the way around his lips and his eyes began to roll back and I didn’t know what to do. And my husband was like, “What is going on?” I said, you know, “IHS told me there’s nothing wrong with him but I knew there was something wrong with him.”

Twenty-year-old Mona told me that her son Darren was similarly misdiagnosed when he was only a month old. Not satisfied when told by IHS that her son only had the flu, Mona took Darren up the hill immediately to Navapache where he was diagnosed

\textsuperscript{163} Her blood oxygen level was at 81% when they did an oxygen saturation test. Oxygen saturation rates on room air below 92\% are considered candidates for hospitalization (Steiner 2004).

\textsuperscript{164} Navapache Regional Medical Center in Show Low is the closest non-IHS hospital to the Fort Apache Reservation and is the referral hospital for Blue Ridge and other clinics in Pinetop-Lakeside and Show Low.
with pneumonia and subsequently admitted. Mona did this even though she did not have insurance at the time; four years later she was still struggling to pay off this hospital bill but does not regret her decision. Because of their experiences, both Stella and Mona expressed reluctance to use IHS again. As Stella explained,

I don’t really take my kids down here [to IHS]. My cousin lost her child for the same thing … high fever, but they didn’t know what was wrong. And he went into convulsions with seizures and died. This was just last year, and he was just a year going on two. And I told my cousin, “You had tribal insurance and you could have took him to Navapache or Blue Ridge. You would have never lost your child.”

Charismatic faith healing

Faith healing has a relatively short history in the White Mountain Apache community, but in that time it has gained a significant following. Two Christian religious sects on the reservation practice faith healing: the Assembly of God church and the Miracle Church. While the Assembly of God churches practice faith healing, it is not their primary emphasis; the Miracle Church, in contrast, is primarily a charismatic faith healing sect (Everett 1971).

Fundamentalist faith healers began appearing among the Apache shortly before 1960. Although Christianity was nothing new to Fort Apache residents, this movement had a special appeal. Whereas other Christian religions made no provisions for healing, these faith healers proclaimed that Jesus Christ could heal sickness of any kind. In addition, several of the faith healers were themselves Apache. Hence, for the first time, Apaches were presented with a form of Christianity that incorporated healing, a very important point given the centrality of healing to the traditional Apache system. And, for the first time, religious ideology was being presented to Apaches by Apaches, and
services were being conducted in the Apache language, in effect recreating aspects of Apache religion within the confines of Christianity. By the late 1960s, this movement was firmly established in the community (Basso 1970a), and even today the popularity of the Miracle Church continues to grow.

For Christian converts, Pentecostal preachers may in fact be taking over some of the roles traditionally held by medicine men. As Debaucher (1980) notes, members of the Miracle Church sometimes turn to their preacher for assistance in cases where traditionally a medicine man would have been the appropriate source of aid. Illness and misfortune in these cases are attributed to demon possession or a hindered spirit, rather than witchcraft or contact with a power. The Miracle Church also offers a variation on the Sunrise Ceremony, sometimes referred to as a “Massage,” which incorporates elements of this important puberty ritual but maintains a fundamentally Christian base.

A number of individuals I spoke with mentioned using faith healing or having their children prayed over; some did so only in cases of severe illness, but others would do so anytime their child was sick or the felt their child needed guidance. Others turned to faith healing for conditions (such as Monica’s) that were not responding well to biomedical treatment, or that were not seen as strictly within the biomedical realm. Shirley, a 63-year-old mother and grandmother whose family had been central in bringing the Miracle Church movement to the Fort Apache Reservation some fifty years ago, explained that when her youngest daughter started having seizures at six-months-old, they took her first to a faith healer. Others sought out faith healers to help children who had seen ghosts or to rid their houses of ghosts. Some of these individuals (like Shirley) were members of faith healing churches, but others (like Monica’s family) were
not, though they were generally Christian. Because there are not any costs associated with such prayer, even those who are not strict adherents may take advantage of such services “just in case” they are effective, generally while pursuing other therapeutic options as well. Others simply make use of private prayer and devotions, in some cases asking close family and friends to do the same.

**ILLNESS AND THERAPY MANAGEMENT FOR CHILDREN**

All of the above mentioned therapeutic modalities are utilized, at least occasionally, for children who are sick. But how are such decisions made about not only what treatment to seek, but when to seek such treatment? Who are the individuals that are involved in decisions about therapy management – in particular, how central are alternative caregivers to the decision making process? And how important are these caregivers in other aspects of care tied to illness episodes, including illness recognition, health care seeking, and care of the children while they are sick and convalescing?

**Illness Recognition**

Important to health maintenance for children is the ability to recognize when a child is sick. Early signs of illness quite often consist of slight behavioral changes rather than outwardly evident disease signs, and hence are only likely to be evident to someone very familiar with the child (Berman, et al. 1994). To recognize vague illness signs, such as a child’s complaints, irritability, or lack of appetite, a caregiver must be very familiar with his or her charge and aware of subtle changes in behavior. Alternative caregivers less familiar with the child might not recognize illness as quickly, thus delaying treatment.
A number of Apache parents noted that they depended upon such subtle behavioral clues to determine when their child was getting sick, especially in pre-verbal children. Some say their children become sluggish or inactive, others that their cheeks or faces get red, or that their children get fussy or are simply “not themselves.” One commented that her two-year-old daughter has a “sick face,” and that this is her primary clue her daughter is not feeling well. Such signs might escape the notice of caregivers who do not spend a lot of time with the child, whereas symptoms such as a fever, runny nose, cough, or diarrhea are not as vague and more generally recognizable.

Experience is also important in illness recognition. Because of this, alternative caregivers who have raised children of their own can at times be even better at recognizing illness than the child’s parents. This is especially true with a first child, when parents are themselves young and inexperienced. One grandmother who cares for her three grandchildren while their mother works noted that she can sense better than her daughter when the kids are sick (her daughter agreed). She was the one who recognized when her infant grandson had a serious virus (for which he was subsequently hospitalized), and when her granddaughter had strep (her mother thought she was “faking”). She was also the one who noticed when her granddaughters needed glasses. As she joked, having raised seven of her own children and two grandchildren, she has had “plenty of practice” in recognizing when a kid is sick. Another grandmother commented that, likewise, she “just knows as a mother” when it is time to take her granddaughter to the doctor. Conversely, young caregivers such as teens or other caregivers without children of their own may not have a sufficient knowledge base from which to identify illness.
Another related issue concerns symptom interpretation. While certain symptoms are generally recognized as markers of certain illnesses or, more specifically, as indicators of illness severity, symptoms are not always interpreted in the same way by different individuals. Symptom interpretation is at least partially tied to experience; for example, knowing when a cough is mild or possibly indicative of a more severe underlying problem like asthma or a lower respiratory infection like RSV. Symptom evaluation may be complicated even more in cases where children experience more than one illness simultaneously and thus present confusing symptom sets (Nichter 1994). How an individual interprets symptoms is also influenced by their beliefs about illness causation. With seizures, for example, one individual might associate these with epilepsy or some other medical condition, whereas a more traditional Apache might see witchcraft as the possible cause (Debacher 1980).

**Medical Decision Making and Illness Management**

While Apache parents do occasionally make medical decisions for their children independently and handle all aspects of their care themselves, in many cases other family or household members share in these responsibilities and tasks. Such participation may be expected and/or welcomed, or only grudgingly tolerated. Young and inexperienced mothers are commonly given advice from their own mothers and grandmothers about handling childhood illnesses. As one mother commented, she didn’t know anything about children when her daughter was born, and her mother gives her a lot of advice. Older, more experienced parents may need less advice, but other family members may nonetheless still participate in medical decision making.
As Everett (1971:97) notes, the process of interpretation and labeling is, in a sense, “community medicine.” Those individuals involved in symptom interpretation and diagnosis, as well as the selection and evaluation of treatment, collectively comprise what is referred to as the therapy management group (TMG) (Janzen 1978; Janzen 1987). Depending on the age, experience, and belief systems of those individuals constituting the TMG, very different conclusions may be reached concerning relevant symptoms and the appropriate course of action.

In making decisions about treatment, the TMG considers the type of symptom and its severity, as well as the hypothesized causal agent. Such information influences not only who is approached for treatment, but also how soon treatment is sought. Because acculturational differences affect interpretations of symptoms and hypothesized causal agents, it is not uncommon for differing opinions to exist within the TMG as to the most appropriate course of action. Decisions are also influenced by non-medical considerations such as the cost of treatment and the financial resources available for treatment, and distance and available transportation (Everett 1971).

**Therapeutic modalities used for children**

In almost all cases, children who are sick are at least initially treated at home using OTC medications. Parents almost always reported using the same medications they were frequently given at IHS – Tylenol for fever, Benadryl for clogged sinuses, and Pedialyte for diarrhea. Certain symptoms, like a high fever, may lead parents or caregivers to seek medical assistance more quickly, but in most cases a “wait and see” attitude is adopted. In those instances where outside treatment is sought, it is almost always biomedical in nature.
The explanation for this almost exclusive dependence on biomedical practitioners is twofold. First, the parents of today’s young children are themselves relatively young and highly acculturated, and as such are most likely to interpret illness symptoms within a biomedical framework. While they might be open to other interpretations from members of the TMG, they are not likely to view the symptoms in such a way on their own. Even some grandparents involved in medical decision making are only in their 30s and 40s and rather acculturated themselves, and accustomed to looking to physicians to handle most health complaints.

This is not a sufficient explanation, however, for this pattern. As Everett (1971:153) points out, back in the late 1960s, even in more traditional communities, children were most commonly brought to doctors for treatment. As he notes,

... it appears that parents tend to make medical decisions for their children which are most expedient. This means, in most cases, consulting an Anglo physician, even where culturally appropriate rules based on symptomology and causation indicate otherwise.

As this makes evident, even when a traditional healer would be the “appropriate” therapeutic option, it is not necessarily the one selected. This is not to say that children in this period were never brought to medicine men for treatment; they were, but at rates much lower than that for adults in the same communities (Everett 1971).

In those cases where traditional healers are used for children today, it is quite often a grandparent or other related elder who suggests or pursues this option. Eva, the 21-year-old mother whose own mother worked as a wildland firefighter when she was young, commented that when her young son had an earache that lasted two weeks, the grandmother paid for a medicine man ($125). The medicine man did a prayer and sang
a few songs over him. In some cases, however, it is the parents who decide to seek care from a traditional healer. Lena, the 40-year-old mother who was moving her family back to their natal community to be closer to a preferred caregiver, noted that when her oldest daughter (who was nine at the time) got sick and they didn’t know what was wrong with her, they went to a medicine man for help. He concluded that someone had looked at her in an evil way and treated her appropriately; subsequently, she got a little better.

Often, when the decision is made to seek out a medicine man or faith healer for a child, such therapeutic options are pursued either simultaneously with or – as in the above two cases – after biomedical options have been pursued. Debacher (1980) notes that it is not uncommon for multiple pathways to be pursued in an effort to effectively treat an illness, the most common pattern of multiple resort being biomedical followed by either a traditional or faith healer. Some of this is, as Debacher emphasizes, attributable to dissatisfaction with the outcome of the initial health care resort and the inability of Western medicine and practitioners to effectively treat the non-physical components of illness. Other times it is simply economics; traditional healers are quite expensive, hence this option may be left until all other avenues are exhausted. However, multiple options may also be pursued because of different ideas about the cause of the illness by different members of the TMG, or – as in the case of Monica – in an effort to try all possible options and hence “hedge your bets.”

Shirley, who turned first to a faith healer when her now 18-year-old daughter started having seizures as a baby, ultimately pursued just about every therapeutic option available to her:
When Ella was about six-months-old … we just came home one day and she just limped over … We were playing ball, she wanted to play ball. She just limped over on me and her eyes just rolled back and … what happened? I had never seen that happen before and it scared me.

The first thing we did was run to the church people and then we took her to the hospital and it continued on, you know … off and on. It wasn't continuous. Then [the seizures] kept getting closer together it just kept scaring me that this was going to do it the rest of her life, so we went down to the medicine man for their prayers. I took her to the medicine man and they prayed for her and church people prayed for her and the doctor did what he could for her. We made requests to all the churches around here.

What the medicine man told me was that she was going to find her own medicine to heal herself. We were making wood one time … we always go out to the woods to make our firewood, you know. We were out there for that reason. [Ella] was out playing … we put a quilt down for her and told her to stay there and play and she wandered off. We kept watching her, and finally I went over there to where she was … and she was really digging in the ground and eating this plant. “What are you doing?” I asked. “I'm eating these. They taste good.” … So we found out that was her medicine to make her well.

Why she had seizures I don't know. They never did find out. The doctor said she was going to have to take [her seizure] medicines for life, you know. That she was going to have seizures all her life but she … she was out of it within two years I think. She didn’t have no more seizures. We took her down to St. Joe’s [Hospital in Phoenix] and they did all sort of tests and she was normal. She never had no more seizures.

Given that Shirley has herself used traditional herbs and healers as well as faith healers at different points in her life, the pursuit of multiple healing modalities for her daughter was unsurprising. It is important to note though that she was further pushed to pursue every possible option by the loss of an older daughter to a childhood illness not long before Ella’s birth. Ella’s recovery, however, she attributes solely to the herbs Ella found as a child, and continues to collect to this day.

I was told about one instance where a medicine man was the first – and only – therapeutic option sought. Monica’s grandmother, Lorraine, mentioned that one day when she was caring for her two-year-old granddaughter Shanae at her house, Shanae started screaming and crying and pointing at something visible only to her. The following day, Lorraine and her husband, who is himself a medicine man, took Shanae to
a traditional healer for treatment. Such sole reliance upon medicine men or faith healers is only seen, however, in cases such as this that are obviously outside the biomedical realm.

**Caregivers' involvement in health care seeking**

Kith and kin caregivers certainly give advice as to treatment and, at least in some cases, participate in health care decision making. But when do such caregivers actually take responsibility for seeking treatment for a child in their care?

There appears to be a significant difference between supplemental and surrogate caregivers in terms of the level of responsibility taken for health care seeking. Where surrogate caregivers will take children in their care for medical treatment, this is rather uncommon with supplemental caregivers. (As noted above though, caregivers will take children to traditional healers, and in fact may be more likely to do so than parents.) A few supplemental caregivers noted they had taken in infants and toddlers for their immunizations and well-baby check-ups, but virtually none had taken a child for whom they provided care into the clinic for treatment when they were sick.

In some cases, such decisions are purely practical. Some caregivers care for multiple children, hence seeking treatment for one would necessitate bringing the other (well) children along. At least one parent was concerned about exposing the caregiver, her mother, to “the germs” at IHS, and hence preferred to take her kids in to the clinic herself.

The health care system itself, however, seemed to present few barriers to non-parental caregivers seeking care for children, at least in the case of IHS. None of the
caregivers who had sought health care services at IHS for children in their care mentioned required paperwork posing a problem, nor service providers expressing reluctance in treating a child presented by someone other than the parent. Nor did it seem to create any additional delays, so long as the caregiver arrived with the child’s IHS chart number in hand. Parents did indicate, however, that non-parental caregivers could not so easily seek treatment at Blue Ridge clinic for a child in their care. While at IHS either a parent or caregiver could seek treatment for a child, Blue Ridge required the presence of the insurance holder or signed forms authorizing the individual to seek treatment for the child.

In practice, most caregivers would treat mild cases of illness themselves, and call the parents if they felt the child needed to be seen by a doctor. This is the arrangement that virtually all of the parents seem to prefer; if their child was sick enough to need a doctor, they – if at all possible – wanted to be the one to take their child. Only two parents noted that their caregivers ever took the children for treatment. One commented that she occasionally got her son’s caregiver, his paternal grandfather, to take him to the clinic when she did not have enough leave time to take off work herself. However, she emphasized that she still preferred to take her son in herself, at least partially because she felt the grandfather didn’t know how to ask questions of the doctor.

Another of the supplemental caregivers, 68-year-old Edith, noted that she was willing to take her three-year-old grandson Linton to the doctor if he got sick while in her care. But – as was discussed in Chapter 4 – Edith, who shares a household with Linton and his mother and provides the majority of his care on a day-to-day basis, plays a more
substantial role in her grandson’s life than most supplemental caregivers, taking on some responsibilities generally only seen in surrogate arrangements.

Surrogate caregivers, in fact, are much more likely to take on responsibility for health care seeking. In those cases where the arrangement is court-ordered or the parent is not in the picture, the surrogate caregivers almost always take primary responsibility for all aspects of health care. With informal surrogate arrangements, however, there tends to be more variability. The parents or the caregivers may take primary responsibility for seeking health care for the child, or the responsibility may be shared among multiple individuals.

In the case of 12-year-old Wayne, who made the decision on his own to live with his grandparents, his parents retain him on their insurance and are usually the ones who seek care for him. Farrah, the 21-year-old divorced mother who has utilized a surrogate arrangement with her 43-year-old aunt Aleah over the years to assist her in caring for her five-year-old daughter Bethany, noted that she generally takes responsibility for seeking health care for Bethany. Aleah, however, quite often accompanies them when they go to IHS and will take Bethany on her own if Farrah is unavailable. Aleah, who works for the tribe, had even expressed to me the desire to get Bethany on her insurance so they could use Blue Ridge clinic as well. Another surrogate caregiver mentioned that she occasionally begs the mother to take her son to the clinic, but usually ends up taking her grandson herself. Like the parents, though, most of the surrogate caregivers who take primary responsibility for the children in their care prefer to handle health care themselves.
Caregiving during Illness and Convalescence

Supplemental caregivers are much more likely to care for a child while they are sick than to take the child for treatment. For parents who are using caregivers in order to allow them to work or attend classes, such willingness of the part of caregivers to care for sick children is very important. Day care centers and home care providers, because they care for large numbers of children, generally do not allow sick children to attend. Individuals with no alternative but to stay home with sick children are generally forced to take leave from work without pay, which can be financially stressful for the household.

Almost all of the kith and kin caregivers I spoke with indicated that they were perfectly willing to continue watching the kids in their care even if they were sick. Most, being mothers themselves, had plenty of experience treating childhood illness and comforting sick children. Only one, in fact, mentioned she was uncomfortable with this (at least in the case of more serious illnesses) due to the fact she had lost one of her own children to a childhood illness. Most of the mothers were likewise comfortable leaving their children with the caregivers, so long as the children were only mildly or moderately ill. They would drop the children off with their prescriptions and/or OTC medications, leaving instructions for their use, or let the caregivers use their own judgment in medicating them. One mother also commented that, on those days when one of her children is sick, she will go back to her mother’s house at lunchtime to check on the child.

Parents’ willingness to leave their sick children with caregivers has to do with their level of comfort with, and trust in, these caregivers. One mother noted she would be comfortable leaving her two-year-old son with his grandmother or uncle if he were
sick, but not with someone else (for example, the neighbor who served as his regular caregiver). As discussed in Chapter 4, close relatives – and grandmothers in particular – are believed to better understand the children in their care and have their best interests at heart. They are also individuals who, because of a shared history, are more likely to share the mother’s values and practices, and handle the illness episode in a manner in which the mother would be comfortable. As another explained, she is comfortable leaving her little girl with her grandmother when she is sick because her “mom is a mom and she knows what to do, [for example] when to make her stay in bed.”

When children are more seriously ill, however, these mothers almost universally noted that they would want to stay home with their child themselves. This was the case even if it meant taking leave without pay to do so. Most commented that their employers were understanding, and willing to let them take time off in such instances. A few mothers wanted to stay home with their children every time they got sick, even if it was just a cold, but they were in the minority. One, however, pointed out that in some cases a different caregiver or environment might actually be beneficial for a sick child. Marie, an older and very experienced mother of five, noted that when her second youngest child came down with RSV when she was only nine days old, she sent her to stay with her mother and her sister. As she explained, their house was warmer (Marie’s has only an old wood stove) and there were no other children there to potentially pass on other illnesses to the baby.

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In the case of Marie, the strength of her kin network was an integral factor in enabling her to provide her infant daughter with a more healthful environment in the first
few weeks of her life. Such networks can help young mothers more generally in protecting the health of their children through ready access to more experienced caregivers who can help identify symptoms and provide treatment advice. In other instances, strong networks are responsible for parents having access to child care they can use when their children are sick, allowing them to continue working or attending classes.

Strong networks open up the possibility of wider involvement in health production and health care decision making for children. Caregivers and other kin not uncommonly give advice to parents during specific illness episodes. While they rarely participate in the seeking of biomedical care for a child, they are generally quite willing to care for a mildly or moderately sick child. As the above examples suggest, caregiver involvement is most often beneficial, rather than a cause for concern. Caregivers bring with them a wealth of knowledge and experience which can be useful in identifying symptoms and judging illness severity. Caregiver involvement does not appear to lead to delays in needed treatment, as is sometimes feared. While older caregivers are more likely to recommend or pursue, for example, traditional medicine, it is never used to the exclusion of biomedicine in instances where biomedical treatment is clearly indicated. Caregiver involvement may at times even assist in the delivery of preventive health measures, as in those instances where caregivers take infants for well-baby visits and immunizations.

Children’s illness episodes, however, provide a rallying point for the network. Even in the case of minor illnesses, a number of close kin may provide advice. With more serious illnesses, or illnesses that do not readily respond to the initial therapeutic resort, more individuals from the network may become involved, becoming functional
members of the TMG or facilitating access to other therapeutic modalities and/or practitioners. Illness can hence bring the network together, strengthening ties by calling in owed obligations and creating new obligations to others in the future.

Those without strong networks are left to make therapeutic decisions independently and navigate treatment options on their own. They do not have elders with years of accumulated knowledge and practical experience to help advise them or assist in health care decision making. They also are more likely to lack child care providers willing or able to care for their children while they are sick, creating additional stresses for parents in terms of missed work or school. While health outcomes may not be significantly different for those without strong networks, the assistance of caregivers and other kith and kin may attenuate the overall impact of childhood illness on the family as a whole.
A recurring theme throughout earlier chapters has been the importance of family and community networks to the establishment and maintenance of stable and successful kith and kin caregiving arrangements. Decisions about caregivers and caregiving can only be fully understood in the context of the family and community networks of exchange and reciprocity of which caregiving is an integral part. Such networks are the source of caregivers, and it is those who are part of strong networks who have the best caregiving outcomes. Such parents can find the caregivers they need, their children are in stable and loving arrangements with familiar individuals, and the caregivers have access to the resources and support they need to be successful care providers.

Kith and kin caregiving is, however, equally important to the functioning of these networks. Caregiving is a central and integral component of networks of exchange and reciprocity and caregiving exchanges are key elements in the ongoing affirmation and reinforcement of these networks. These networks are, in turn, critical to community functioning and the resiliency of families. This chapter discusses the importance of networks of exchange and reciprocity in this community and examines the place and importance of caregiving within these networks. It also addresses the role of social and cultural capital in decisions and negotiations surrounding caregiving, and considers the importance of kith and kin caregivers to cultural survival.
KITH AND KIN CAREGIVING IN THE CONTEXT OF FAMILY AND COMMUNITY NETWORKS

Child caregiving does not take place in a vacuum. Kith and kin caregiving in the White Mountain Apache community is situated within the context of extended family and community networks. And caregiving, like other goods and services, is something that is negotiated and exchanged within these networks. As Brandon (2000:194) notes, “kin-provided child care [in the U.S.] is a discrete manifestation of that regular, ongoing form of extended family help and operates within a larger exchange process of receiving as well as giving.” Consequently, caregiving practice and decisions and access to caregivers cannot be understood outside of the contexts of these networks and the kinds of resources and obligations that exist within these networks.

Networks of Exchange and Reciprocity

In her 1974 book All Our Kin, Carol Stack discusses the exchange of goods and services, including the care of children, within the social-cultural network of the urban Black family. In the community which she refers to as ‘The Flats,’ she found “extensive networks of kin and friends supporting, reinforcing each other – devising schemes for self-help, strategies for survival in a community of severe economic deprivation.” These networks involved alliances of individuals swapping goods and services – “food stamps, kids, clothing, money, and everything else” – on a daily, almost hourly, basis (Stack 1974:28,35).

While seemingly voluntary, such exchanges are in reality “given and reciprocated obligatorily” and are central to maintaining alliances (Mauss 1990:3). Such exchange creates bridges and reinforces bonds between individuals and groups, expanding
access to resources and building the resiliency of the network and the individuals within. Individuals and families, as multigenerational collectives, work out family responsibilities and reallocate resources, weighing the needs and goals of individuals against those of the group (Stack and Burton 1994; Stack and Burton 1998). Consequently, the needs of the group or specific individuals may at times supersede others. In addition, reciprocation – rather than “tit-for-tat” – may be generalized or less immediate, taking place, for example, over the life course of the individual.

Apache kin networks and exchange

In the White Mountain Apache community, such networks are likewise ubiquitous. Historically, these networks centered around the matrilineage and focused on collective activities, food production and domestic tasks in particular. Much has changed in the past century, but the existence and importance of such kin networks has not. The affairs and welfare of related households continue to be closely intertwined, and kin networks continue to be critical to survival, particularly in the marginal economic conditions that exist on the reservation today (Berman 2003). As Biolsi et al. (2002:146-147) explain:

By far the most important strategy for making ends meet … is relying on the generosity of kinspersons and friends in one’s personal network. This is not borrowing in the formal sense of a debt to be paid back, but reciprocity between people who care about each other and trust each other.

Obligations within these networks tend to be, as Lamphere (1977:42) writes in relation to the Navajo, diffuse and non-specific “where the exact nature and timing of requests and counter-requests are not calculated and need not be exactly equivalent.” Everett, writing about the Apache in the early 1970s, emphasized the redistributive
function of these networks and their importance as an adaptation to the seasonal availability of employment and other economic resources. Cash, goods, and food were allocated to households in need and these households, in turn, were obligated to later reciprocate. “Cash or groceries given at one time,” he explains, “are reimbursed upon later request. Labor contributed in agricultural activities is redeemable in kind at harvest” (Everett 1971:64).

Today, exchange and reciprocity continue to be central to relations between related households, and they are also quite prominent at the individual level. Cooperative networks still generally center around kin, though not always the matrilineage. Changes in residence patterns and the resultant scattering of kin at times limit the participation of certain relatives. Such networks may also include on occasion friends, neighbors, or quasi-kin as well.

Collective activities do still occupy a place in these networks, but they are more limited to special occasions such as Sunrise Ceremonies and wakes. The successful staging of these events requires not only significant labor but amassing large quantities of food and goods, something only possible, as Berman (2003) points out, for those participating in a circulating system of informal exchange. More common within these networks of kith and kin, however, are the day-to-day exchanges of the type described by Stack. Money is borrowed, rides are given, goods are purchased, wood is chopped, cars are repaired, advice and emotional support are provided. One of the most important commodities that is exchanged, however, is caregiving.
Caregiving as a Commodity of Exchange

Children and caregiving are, in fact, central to the relations and exchanges that take place within family and community networks. Caregiving, especially in communities with few other child care options, is a valued service that quite often is in high demand. When child care takes place within such networks of kith and kin, it becomes simply one of many goods and services that are exchanged. Mother’s decisions to use (or not use) such care are influenced by the pre-existing relations and dynamics within these networks, and are made “alongside other decisions about giving help to, and in turn, accepting help from, kin” (Brandon 1995:23).

While at one level caregiving may be considered simply a commodity of exchange, it is in other ways rather unique. Children, and hence their care, are not like other forms of reciprocity; children are seen as an investment and thus individuals may participate in their care without the expectation of equivalent or immediate reciprocity. Alternatively, the anticipated reciprocation may take a less concrete or material form, as in the production of a culturally competent child who may emerge as a community leader in his or her adult years and hence position the family similarly. Also important to note is that concern about children’s well-being may ultimately trump other considerations in decisions regarding exchanges potentially involving caregiving.

It is also true, however, that when caregiving is situated within such networks, decisions about child care cease to simply take into account the needs of the parent and child. The needs or desires of others in the extended family network may be considered or even given priority. As noted previously, many surrogate arrangements in the Apache community are a direct consequence of the desires of the caregiver, and even
supplemental caregiving decisions quite often take into consideration other’s needs. As several individuals I spoke with noted, there can be a great deal of pressure to use kith and kin caregivers, especially when it keeps scarce financial resources within networks (Chaudry 2002; Pine 1999).

Through the informal circulation and care of children, the exchange and distribution of money as well as other goods and services is facilitated (Stack 1974). Cash compensation may serve, for example, to redistribute money to members of the network with less disposable income. It is also through the care of children that networks are expanded and reinforced. Caregiving establishes a bond of mutual trust, and parents and caregivers both may use this bond to integrate the other into their existing networks. Children can also provide connections to new individuals, such as fathers’ families or fictive kin, who can be pulled into networks or provide links to new networks.

**NETWORKS, RELATIONSHIPS, AND SOCIAL CAPITAL**

Given that caregiving is located within these networks of exchange and reciprocity, how do we understand individual’s differential success in securing acceptable and dependable child care? Central to this discussion is the concept of capital. Capital is essentially a power relation, acting “as a social relation within a system of exchange” (Harker, et al. 1990:1). It is a generalized resource which can assume economic and non-economic, as well as materialized and embodied, less tangible forms (Anheier, et al. 1995; Harker, et al. 1990). All individuals within a given
social microcosm or field$^{165}$ have different amounts (and types) of capital at their disposal with which they can obtain access to goods and services.

**What is Social Capital?**

Most important to the present discussion is social capital,$^{166}$ one of several interconvertible forms of capital.$^{167}$ Social capital is described by Siisiäinen (2000:11) as “a resource that is connected with group membership and social networks, … a quality produced by the totality of relationships among actors.” As Bourdieu (1986:248-9) explains, it is

… the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group – which provides each of its members with the backing of the collectively-owned capital.

It is not, as Manderson (2005) emphasizes, a thing in itself, nor is it a property of individuals. Rather, social capital is a property of individual’s relations with one another, produced through social interaction, which inheres in the abstract socio-cultural space of relations between and among individuals (Coleman 1990; Szreter and Woolcock 2004).

Importantly, social capital facilitates the attainment of certain ends which in its absence would not be possible (Coleman 1990). The benefits of social capital accrue to individuals and vary according to the quality and quantity of relationships, the volume of

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$^{165}$ I am using “field” here in the Bourdieuan sense. For Bourdieu, capital can only be understood in the context of fields. Fields are “structured spaces that are organized around specific forms of capital or combinations of capital.” They are also arenas of struggle: “Fields denote arenas of production, circulation, and appropriation of goods, services, knowledge, or status, and the competitive positions held by actors in their struggle to accumulate and monopolize these different kinds of capital” (Swartz 1997:117). This emphasis on conflict, however, limits the usefulness of this concept in more communal settings like the Apache community. In Apache society, the emphasis is on cooperation and the survival and well-being of the collective, whereas in Bourdieu’s formulation, individuals draw upon these resources (capital) “to maintain and enhance their positions in the social order” (Swartz 1997:73).

$^{166}$ In this chapter, I am using a structural, rather than cognitive, conceptualization of social capital.

$^{167}$ Bourdieu (1986) conceptualizes three forms of interconvertible capital: economic, social, and cultural.
capital possessed by each individual to which he or she is connected, and how effectively that individual can mobilize his or her network (Bourdieu 1986; Coleman 1990; Manderson 2005). Hence, those who are well integrated into and active members of social networks are more likely to be able to mobilize and access the collective resources of their networks than those with little or no access to such networks.

Social capital takes different forms, however, depending on whether it stems from family or kin connections, wider social networks or “associational life,” or cross-sectional linkages that span differences in sector and/or power (Harriss and De Renzio 1997). As explained by Szreter and Woolcock (2004:654-655, emphasis added):

**Bonding social capital** refers to trusting and co-operative relations between members of a network who see themselves as being similar, in terms of their shared social identity. **Bridging social capital**, in contrast, comprises relations of respect and mutuality between people who know they are not alike in some socio-demographic (or social identity) sense (differing by age, ethnic group, class, etc). ... We define **linking social capital** as norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalized power or authority gradients in society.”

As they go on to elaborate, the trusting social norms underlying bonding and bridging social capital are able to emerge spontaneously, so long as there is a minimum degree of understanding and shared goals among the participants in the network, since participants are more or less equal in terms of status and power. Linking social capital, however, must be carefully created since the participants are trying to connect across explicit vertical power differentials (Szreter and Woolcock 2004).

**The Production of Social Capital**

These various forms of social capital are all found to varying extents in the White Mountain Apache community, although bonding social capital is by far the most plentiful.
It is the exchange that is central to community life and identity in many Native American communities that is primarily responsible for the production of bonding social capital. “In the process of exchange,” as Stack (1974:44) writes, “people become immersed in a domestic web of a large number of kinfolk who can be called upon for help and who can bring others into the network.” Social networks are endlessly affirmed and reproduced through a continuous series of exchanges which are – either consciously or unconsciously – aimed at maintaining or expanding an individual’s network of social relationships. Exchanges hence not only give individuals within the group access to desired (or needed) resources that, in the absence of the group, they would not have access to, exchange reinforces and reproduces the group and reaffirms its limits (Bourdieu 1986).

Exchange does this by producing a social capital in the form of a capital of obligations (Bourdieu 1986). When people do things for one another, the result is “credit slips” outstanding on both sides of the relationship (Coleman 1988). Individuals who in the past have provided goods or services to others may convert the credit accrued from relationships for other forms of capital. Social capital, as Bourdieu (1986) notes, provides a “credential” which entitles each of the group’s members to credit.

While bonds are created and reinforced – and bonding social capital produced – through the moment-to-moment exchanges between kith and kin that are part of daily life, the more ritualized exchanges that take place at the community level in the form of public gifting or giveaways are important in the development of bridging social capital.168

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168 As I have noted previously, clans historically were important in creating ties and obligations across and between family groupings in the Western Apache community. As clans have declined in importance, such public exchange and gifting has become more important in creating and maintaining such ties and obligations and hence maintaining a sense of cohesion across the reservation community.
Surplus resources are given away in displays of generosity, hence redistributing goods and, in the process, reinforcing ties between families and networks and building social capital. As Berman (2003:38)\textsuperscript{169} describes:

\begin{quote}
Giving reinforces cultural values of generosity and marks the giver as a respected and cooperative community participant. The gifted in turn becomes obligated to the giver. Focalpeople\textsuperscript{170} accrue social standing through giving, and eventually they amass quantities of donations: quilts, blankets, cash, and other items bestowed on them in the public giveaways that take place at funerals, powwows, and social gatherings.
\end{quote}

Such public gifting functions as an economic leveler and a public display of leveling social relations. In the process, economic capital, primarily in the form of goods, is converted to social capital. “Translated in exchange value, gifts of food are,” as Berman (2003:59) notes, “received as ‘payment’ for assistance and given away as ‘surplus value’ and as a display of generosity.” Such individuals may use this social capital as a resource to achieve their own interests (Coleman 1988), or to benefit their larger kin group or community.

The choice of kith and kin as caregivers for children is important in building both bonding and bridging social capital. Placing caregiving within the hands of these individuals actively consolidates and reinforces existing networks; in certain instances, it may also build or reinforce connections with other families or networks, as it did when Lisa and I were asked to participate in Monica’s care. Similarly, utilizing home care providers with whom parents were not previously well acquainted can build bridges to new networks. Using the child care center, in contrast, removes caregiving from the

\textsuperscript{169} Berman (2003) is talking about kin networks on the Fort Berthold reservation in North Dakota, yet her comments are very relevant to the kith and kin networks I am speaking of on the Fort Apache reservation.

\textsuperscript{170} Berman (2003) defines focalwomen as those individuals who emerge through community consensus as central to community relations. These women are central to the production and distribution of goods in the community, and are the primary organizers of community events. They are generally elders, with extensive and valued culturally-specific knowledge, which enables them to mobilize community-based support.
context of these networks and consequently neither helps reinforce nor build connections.

Positioning caregiving within such networks also emphasizes the importance of trust, both in choice of caregiver and in building social capital. Placing your child in the care of another individual is fundamentally a gesture of trust. As discussed in Chapter 4, Apache parents – if they have any choice – will only place the care of their children in the hands of someone whom they trust. Such trust is built over time, the outcome of interactions between individuals in the network, and a successful caregiving exchange further builds trust between the parent and caregiver and within the network.

The reluctance of many to utilize the child care center is similarly framed in terms of trust. Even though the child care center is staffed by community members, most parents have no personal or network connection to these individuals and hence no basis for evaluating their trustworthiness or competence as caregivers. The center is also a product of and representative of the dominant culture, for some reason enough to regard it with distrust.

Because of the history of boarding schools for Native children, Native individuals and communities in both the U.S. and Canada tend to be suspicious of non-kin care, particularly when it incorporates educational programming. As Greenwood and Shawana (1999) report, many Native elders in Canada fear that formal child care programs simply represent an attempt to re-establish assimilationist programming for children. Similarly, Biolsi et al. (2002) note that, on the Rosebud Sioux Reservation,

\[171\] Please refer back to Chapters 2 and 3 for a discussion of boarding schools and their impact, both in Apache communities specifically and more generally.
there is strong resistance to putting children in the care of individuals who are not family; the memory of the boarding school experience is still too fresh. Such concerns, shared by many others in the U.S., have made the creation of linking social capital and trusting relations between formal child care centers and Native parents in some communities more difficult.

The history of Federal-Tribal relations in the U.S. has led to significant distrust of the government and its agents, one legacy of which is a paucity of linking social capital. While tribes do maintain formal relations with the federal government and accept federal funds to administer programs – including child care – that benefit tribal members, a significant proportion of tribal members do not trust the motives or goals of the federal government or the tribal programming it funds. Ongoing tribal struggles to assert their sovereignty, define their own policies, secure adequate funding for health care, and enforce other treaty obligations have only made tribes and tribal members more wary and efforts to build linking social capital more challenging. Individual practitioners, educators, etc., who make concerted efforts to work with and demonstrate their dedication to and concern for the community often come to be trusted by community members, but this does not necessarily change individuals' impressions of the institutions they represent.

The Role of Social Capital in Accessing Caregivers

While economic capital alone can provide access to formal child care, it is not sufficient for accessing kith and kin caregivers. Bonding, and to a lesser extent bridging, social capital are crucial for providing access to caregivers. In general, only those with strong networks – networks that have been long established and continuously
maintained, and in which they are active participants – find such caregivers to be readily available. Such individuals are able to convert the credit accrued from these relationships into caregiving assistance.

While the reservation community as a whole is quite rich in bonding social capital, not all individuals find themselves well integrated into kith and kin networks where this type of capital is plentiful. Individuals who are a part of networks with strong social capital are not only more likely to have access to kith or kin willing and able to serve as caregivers, they are more likely to find more than one potential caregiver. When parents have a choice of caregivers, such choices can reflect allegiances, issues of trust, or preferred characteristics or qualities, such as cultural “expertise.”

Those who have the most difficulty finding suitable and stable caregivers are those without strong networks upon which they can call. Typically, these are newcomers to the reservation or those without family in their immediate community, and those with dysfunctional families or overwhelmed networks. Family members too distant or unwilling to participate in such networks of exchange, or individuals with alcohol or drug problems who tend to make demands on networks without reciprocating, can strain existing networks or leave them out of balance. Also particularly vulnerable are teen moms who, being so young, have not yet had the opportunity (independently of their own mothers) to build networks and social capital, and hence are disproportionately dependent upon their own mothers or siblings.

Sometimes, even those with otherwise strong networks find it challenging to secure acceptable caregiving arrangements. Caregiving can be physically demanding and time intensive; members of kith and kin networks who work or are elderly, frail, or
suffer from chronic health problems may be unable to serve in this capacity. In addition, the goods and services expected in return for the provision of child care may be judged by parents as too costly, either financially or emotionally, and hence the use of certain caregivers viewed as not “worth it” (Bruinsma 2001:4). Unrelated problems or conflicts with network members may also make parents reluctant to approach certain individuals for caregiving assistance.

Not only are strong networks important to securing caregiving, the provision of child care by network members is central to maintaining and reinforcing these networks and building social capital for those providing care. Caregivers, as noted in Chapter 4, have their own reasons for serving in this role. Some caregivers get at least some direct “compensation” – in the form of goods, services, or money – that can be helpful in making ends meet, though this is rarely the sole motivator for providing care. Other caregiver’s actions may seem simply altruistic, aimed at helping out struggling family members. They may view their actions as an investment, strengthening their networks by giving young parents the opportunity to work or further their education, or anticipate future reciprocation, perhaps looking to the parents and the children they cared for to care for them in their waning years (Schweitzer 1983).

Caregivers may also get a sense of purpose and identity through caregiving. For many women, their identity, their very sense of self – as mothers, as grandmothers, as Apache women – is tied to caring for children. Children are viewed as the responsibility of the kin group as a whole, and caring for them is a culturally valued role. As one Native writer explained, “our most important role as women is making sure that our
young ones are taken care of so our future as Dakota people is assured” (Wilson 1996:12).

Caring for children hence increases women’s social capital, and brings them recognition and status within the community. It can also be – for individuals who in their younger years drank heavily and abrogated their familial responsibilities – a way of redeeming moral value and reintegrating oneself into the extended family network. As mentioned in Chapter 4, a number of individuals who as young adults were functionally alcoholic and rather undependable became as grandparents trusted and valued caregivers. Rather than retaining the label of alcoholic for life (as is common in Anglo society), these individuals were able – through caregiving and other actions – to “return to the fold” and serve in a much needed and valued role. And, by serving in this culturally valued role, these caregivers gain something else – cultural capital.

SOCIALIZATION, IDENTITY CONSTRUCTION, AND CULTURAL CAPITAL

Cultural capital refers to a collection of resources which include general cultural awareness and cultural competency, verbal facility, aesthetic preferences, and educational credentials (Swartz 1997). For Bourdieu (1986:243), cultural capital exists in embodied, objectified, and institutionalized states, but it is embodied cultural capital – cultural capital “in the form of long-lasting dispositions of the mind and body” – that I am concerned with here.

\[172\] As noted by Everett (1980:153), “he used to drink” is among the Apache a common and quite meaningful expression. Many Apaches, as Levy and Kunitz (1974) have discussed in relation to the Navajo, are able to stop drinking with little difficulty, even after years of heavy drinking in their youth, which has led some to question the applicability of the disease model of alcoholism.
The acquisition and accumulation of embodied cultural capital begins very early in childhood (Swartz 1997), and continues to some extent throughout an individual’s life. While for adults, this may be a deliberate process aimed at self-improvement, for children the accumulation of cultural capital is quite unconscious, guided by parents and other individuals entrusted to sensitize the child to cultural distinctions.

One concern of parents, when choosing caregivers, is to select someone with the cultural knowledge and resources to assist in this “pedagogical action” (Swartz 1997:76). What parents want for their children, what world – Apache or Western – they want their children to be able to successfully navigate, influences their caregiving decisions. The cultural capital a child embodies is important to their future – it represents what they know and what they can do, and can be later translated into social resources such as power, wealth, and status (Bowles and Jensen 2001). And because differences in cultural capital are at least partially a result of differences in the age at which transmission begins and the length of time free from competing demands (Bourdieu 1986) – in this case, the years free from the competing demands and culture of Western education – an Apache child’s early years are particularly important.

**Socialization and the Embodiment of Cultural Capital**

Individuals are not socialized into the “values of society as a whole”, but rather the specific culture in which they are raised (Bowles and Jensen 2001). The transfer of knowledge and values, and thus the transmission of the group’s culture to the next generation, is an integral aspect of child rearing and starts very early in a child’s life.
The embodiment of cultural capital is the assimilation of an individual’s culture (Bourdieu 1986). As embodied capital becomes incorporated into the individual, it becomes a type of habitus. Habitus is “a set of dispositions, reflexes, and forms of behavior people acquire through acting in society” (Bourdieu 2000:19), a “structured structure” derived from the class and culture-specific experiences of socialization within the family and community. As Swartz (1997:103) explains,

Habitus results from early socialization experiences in which external structures are internalized. As a result, internalized dispositions of broad parameters and boundaries of what is possible or unlikely for a particular group in a stratified social world develop through socialization. Thus, on the one hand, habitus sets structural limits for action. On the other hand, habitus generates perceptions, aspirations, and practices that correspond to the structuring properties of earlier socialization.

While neither determinative of conduct nor strictly individual (Bourdieu and Wacquant 1992), “habitus tends to reproduce those actions, perceptions, and attitudes consistent with the conditions under which it was produced” (Swartz 1997:103). It is part of how society produces and reproduces itself (Bourdieu 2000) – it is how culture is transmitted from one generation to the next.

The Importance of Caregivers and Context

The challenge of socializing a child in the Apache community is that it is a community of competing fields and competing cultures. Apache parents concerned with producing culturally proficient children must work to do so in the face of the overwhelming presence of Western culture – on television, in Head Start, in school, and in the surrounding communities. Such cultural lessons must start early, and hence children need to spend time in the care of individuals best positioned to provide such
cultural lessons. Under these conditions, both the caregiver and the context of early care become critically important.

From a very early age, children are exposed to Western culture. Satellite dishes bring “Blues Clues” and other cartoons into the home, and by age four, most children are attending Head Start. These institutions, like the schools, reproduce the dominant culture (Bowles and Jensen 2001). Most parents, wanting to produce children who can also function in the world outside the reservation borders, value what these institutions have to offer. However, most do not want to sacrifice their own culture in the process. Given the amount of time that Apache children spend in front of the television and in school, there is no doubt that they are being exposed to Western values, culture, and language. What Apache parents must work at, however, is giving their children a strong cultural base in those early years before the force of Western culture becomes overpowering.

Kith and kin caregivers, particularly grandmothers, are critical to this early socialization and education for a number of reasons, perhaps the most important being their high levels of cultural capital. The production of fully culturally competent children can only occur, according to Bourdieu (1986), in families with strong cultural capital, because it is only in these families that children are able to accumulate cultural capital for the entire period of socialization. In Apache families, it is with the elders that culture and language remain strongest, hence it with these individuals that young children should ideally spend time. The use of grandmothers as caregivers facilitates this, and those parents most concerned with giving their children a strong grounding in Apache culture and language may purposefully seek out such individuals to serve as caregivers.
The use of formal day care – modeled as it is after its Western counterpart – both promotes Western values and limits the time children spend in the care of cultural “experts.” Care by kith and kin not only puts children in the hands of those most likely to have strong cultural capital, it emphasizes the centrality of these networks in an individual’s life, itself an important cultural lesson.

**Apache “education”**

In Apache culture, observation, participation, modeling, and imitation, rather than formal instruction, are the central methods through which knowledge is transmitted (Bahr and Bahr 1993; Williams 1994). In contrast to the cognitively-mediated learning (“knowing-that”) that takes place in the context of the school, families participate in culturally-mediated learning (“knowing-how”) with children (Bahr and Bahr 1993). Cultural competency comes through “unfiltered experience” – participation in ordinary, everyday activities which are nonetheless “steeped in meaning …[that is] embedded in the contexts, connections and relationships in which the experiences occurred” (Bahr and Bahr 1993:358-9). In this way, children are passed practical and cultural knowledge and group history, and “gain an understanding of where they came from, who they are, and what is expected of them” (Wilson 1996:14).


… an Apache way of speaking or teaching is accomplished not didactically but through cultivating the learner’s engagement in some aspect of the common immediate environment of meaning, whether this is a metaphor, a story, or the fact of being together in silence.
Language, for instance, is taught through participation in cooperative family activities – baking bread, chopping wood, etc. – by cultivating “awareness of the social world in which speaking is possible.” Knowing how to speak “good Apache,” emphasize elders in the community, indexes involvement with and awareness of family (Nevins 2004:279).

Storytelling, until recently an integral part of Apache family life and important to children’s moral development and acquisition of wisdom, is similarly embedded in a relational context. These stories, associated with specific places on the Apache landscape as discussed in Chapter 2, were traditionally told to children by kin in the course of their seasonal rounds and invoked the ancestors by making moral lessons of their exploits (Basso 1996:125).

Whole Apache families … spent weeks and months away upon the land – tending cornfields, roasting agave, hunting deer, and journeying to remote cattle camps where they helped the horsemen build fences and corrals. The families traveled long distances – old people and children alike, on foot and horseback … And wherever they went they gave place-names and stories to their children. They wanted their children to know about the ancestors. They wanted their children to be wise.

“Listening” within the context of family, as Nevins (2004) explains, confers authority upon the elder, more knowledgeable generation. Hence, storytelling within a familial context was important not only to children’s development but also to maintaining relations of authority within networks and the larger community.

Storytelling was also central to knowledge of self and grasping one’s position within society (Basso 1996) – to instilling “a sense of personal and group identity” (Watt 2004:xxv). Wilson (1996:7), drawing from her own experience being raised within Dakota culture, explains the role and importance of storytelling in identity construction:
The intimate hours I spent with my grandmother listening to her stories are reflections of more than a simple education process. The stories handed down from grandmother to granddaughter are rooted in a deep sense of kinship responsibility, a responsibility that relays a culture, an identity, and a sense of belonging essential to my life. It is through the stories of my grandmother, my grandmother’s grandmother, and my grandmother’s grandmother’s grandmother and their lives that I learned what it means to be a Dakota woman, and the responsibility, pain, and pride associated with such a role.

As Watt (2004:xxv) pointedly emphasizes, “one learned who one was from one’s relatives, and the stories they told, whether centered on kin or not, helped to define one’s place in Apache society.”

**Kin Caregivers and Cultural Survival**

Supplemental and surrogate caregiving, by putting children in the care of others in family and community networks, provides the opportunity for cultural experiences and pedagogical contexts and forms that other care settings do not. Such care takes place in the context of everyday life, and invites participation and modeling. Children learn what it means to be an Apache through the stories they hear, the foods they prepare and eat, the activities in which they participate, and even the context within which they are cared and socialized.

When children are not cared for in the context of the family – when the extended family network is not involved in a child’s life – the opportunity for these cultural lessons is lost. Such children lack access to both the individuals with the greatest cultural knowledge and linguistic competence and the settings within which learning and identity construction traditionally occurred. Consequently, such children are less likely to have a strong cultural and linguistic grounding. They are also less likely to be fully embedded within extended family networks, leaving them “impoverished” in the sense that they lack
a strong connection to the larger kin group and community and a sense of place – of where they belong – within this group of people.

Children given these opportunities are positioned to become the community and tribal leaders of tomorrow. Those who spend time in the care of kith and kin who are cultural experts are the ones who will grow up with strong embodied cultural capital themselves. The cultural capital they have accumulated from birth will bring these individuals status and power as adults. They will be among the ever declining number who are fluent Apache speakers and hence can serve on tribal council, who are familiar with ceremonies such as the Sunrise Dance and can fill vital ceremonial roles and assist with preparation, and who know the stories that define the Apache as a people.

The encroachment of Western culture in its many manifestations has lessened the opportunities for cultural transmission, and the consequences are apparent. Linguistic fluency is becoming increasingly rare. Fewer children know their clan affiliations. And important cultural activities such as storytelling, as Watt (2004) notes, are fading. The deeper repercussions of these losses are likewise alarming. As Nevins (2004:280, 282) relates, “language loss in Apache discourse is envisioned not only as the loss of language itself, but more saliently as a weakening of the relationships from which it springs” resulting in “a crisis in cooperative participation and awareness of others in family life.” Children who do not learn Apache, elders caution, are not simply losing their language – they are not learning what it means to be Apache (Adley-SantaMaria 1997b). And they are getting into trouble because “the land … doesn’t go to work on them anymore. They don’t know the stories about what happened at these places” (Basso 1996:38).
The loss of these stories, Wilson (1996:12-13) warns, is particularly concerning, for they

… are not merely interesting stories or even the simple dissemination of historical facts. They are, more importantly, transmissions of culture upon which our survival as a people depends. When our stories die, so will we.

To ensure the cultural survival of the tribe, children well-grounded in the values, beliefs, and cultural experiences of the Apache – those with strong embodied cultural capital – are needed to continue the transmission of cultural knowledge to future generations and ensure the reproduction of the culture and community. And to ensure this, the most needs to be made of existing opportunities for early socialization of Apache children, such as care by kith and kin.

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Kith and kin caregiving is not simply about child care – it has value and meaning for its participants as well as the larger community. Caregiving is an integral part of the networks of exchange and reciprocity that crisscross the community. Differential success in securing acceptable caregiving arrangements is tied to the strength of an individual’s network and the volume of social capital they possess. Using kith and kin as caregivers allows parents and caregivers to build and strengthen their networks and increase their social capital. It gives caregivers a sense of purpose and identity and, by allowing them to participate in a culturally valued role, helps them build cultural capital. It provides a space for children to learn important lessons about what it means to be Apache, both through their caregivers and the context of their care. And, by providing a space for traditional forms of pedagogy, kith and kin caregiving facilitates the
transmission of the culture to subsequent generations, thus producing children with high levels of cultural capital and helping ensure the future of the community and tribe.

These very aspects of kith and kin care contribute to its popularity in the Apache community. Parents and others in their networks value these aspects or “qualities” of child caregiving, and intentionally seek out caregiving arrangements that facilitate and support them. These are very different qualities, however, from those supported by formal care arrangements, and not ones included in the current national standards of caregiving “quality.” The next chapter takes up this issue of quality, questioning the appropriateness of such center-based quality standards to community-based caregiving, and considering what quality means in the context of kith and kin care and non-Western settings.
CHAPTER 8

(RE-)CONCEPTUALIZING CAREGIVING QUALITY

In early care and policy circles, “quality” has become somewhat of a rallying cry over the course of the last decade. It has also, in the process, become very politicized. Ensuring young children access to high quality child care has come to be seen as a solution to many of society’s ills. The provision of “quality” care in the preschool years, for instance, is viewed as the way to prepare children to succeed in school and in life; it is also viewed as a means for shrinking the welfare rolls, by giving impoverished mothers with young children the opportunity to work.

What it is exactly that constitutes quality care, however, is debatable. Child development research in this country has generally followed the “positivist belief that there is one best pathway of development” (New 1994:73), and convictions of what constitutes “high quality child care” have come to be closely linked to these “universal” developmental principles (Zinsser 1991). However, others argue that conceptualizations of quality currently in use are a product of the dominant culture and class and are hence quite narrow. As Pence and McCallum (1994:121) note, “the current literature on quality care is problematic both in its assumptions of what constitutes desirable developmental outcomes, and in its restricted understandings of diverse environments, social change, and cultural diversity.”

Much of the concern about current conceptualizations of quality – and the measures derived therefrom – centers on the appropriateness of their application in non-Western and informal care settings. When existing quality measures are used to
evaluate caregiving in minority communities or kith and kin care settings, such caregiving is invariably appraised as lacking. Rather than taking this as evidence of the inadequacy of these care settings, critics argue that it instead demonstrates the inappropriateness of applying uniform standards of quality across the board, and a lack of accord between local preferences and needs and institutional conceptualizations of quality.

How then should we be thinking about caregiving quality? As will be discussed herein, the types of care and the aspects of the care environment that are valued in the Apache and other minority communities do not fit well with current conceptualizations of quality. Hence, do we need to be talking instead about multiple qualities inherent in different types of care or cultural settings? After providing an overview of the debate over how caregiving quality is currently construed and measured, I discuss how we need to re-conceptualize this idea of quality to be more meaningful and of greater utility in informal care settings and minority communities, Native communities in particular.

THE QUALITY DEBATE

In the early care and education (ECE) community, “quality” is a concept that is “used to describe features of program environments and children’s experiences in these environments that are presumed to be beneficial to children’s well-being” (Love, et al. 1996:5). Overall, the quality of child care in the U.S. is judged to be only “fair” (NICHD Early Child Care Research Network 2000; Vandell and Wolfe 2000), and the quality of kith and kin care is usually considered to be even lower. In one of the few studies
specifically looking at quality with relative caregivers – a multi-site\textsuperscript{173} urban study of caregiving arrangements used by mixed-income White, African-American, and Latino mothers – Kontos and her colleagues judged 69 percent of relative caregivers to be of “inadequate” quality,\textsuperscript{174} and 30 percent as “minimally adequate”; only one percent were rated as “good” quality\textsuperscript{175} (Kontos, et al. 1995). The Three-City Study, which examined quality in settings used by low-income (predominantly minority) families in three urban areas,\textsuperscript{176} similarly found kith and kin care quality to be relatively low; 44 percent of unregulated homes scored as “inadequate,” 44 percent as “minimally adequate,” and 12 percent as “good”\textsuperscript{177} (Coley, et al. 2001).

If kith and kin caregiving is supposedly of such poor quality, then why do so many parents purposely seek out family, friends, and neighbors to use as caregivers for their children? A large part of this disconnect results from a lack of agreement between parents and the ECE community about what is important. The qualities that many parents find important in their caregivers are not the same things that are judged to be essential elements of quality care by the professional community. Parents judge quality according to their values and their goals for their children, as well as their needs and, in some cases, the needs of the larger family and community. Measures of quality used by the ECE community, in contrast, tend to be child-centered and focus on the children’s

\textsuperscript{173} Charlotte, NC; Dallas/Fort Worth, TX; and San Fernando/Los Angeles, CA.
\textsuperscript{174} Both Kontos, et al. (1995) and Coley, et al. (2001) used the FDCRS – a measure originally designed to assess quality in regulated family day care settings – to assess quality (see the “Measures” section of this chapter for a more full description of the FDCRS). This measure produces a global quality scale ranging from 1 to 7, with 1 = care that is inadequate to meet the health and developmental needs of children, 3 = minimally adequate care, 5 = good care, and 7 = excellent care.
\textsuperscript{175} In contrast, only 13 percent of regulated caregivers were considered to be “inadequate,” and three out of four regulated providers were rated as “minimally adequate.”
\textsuperscript{176} Boston, Chicago, and San Antonio.
\textsuperscript{177} Here too, child care centers and regulated homes received better scores. Only 6 percent of centers were rated as “inadequate” and 78 percent were rated as good, while 8 percent of regulated homes scored as “inadequate,” 57 percent as “minimally adequate,” and 35 percent as “good.”
interactions with the caregivers and structural elements of the child care environment (Kontos, et al. 1995). Because these conceptions of quality are based on supposed "universal" norms of child development, they are viewed as objective, timeless, cultureless, and hence universal. Critics argue, however, that quality is instead a relative concept whose definition is socially constructed and changes over time (Holloway and Fuller 1999; Moss 1994).

Mainstream Conceptions of Child Care Quality

This overarching concern with child care quality stems from concerns about children’s development and general well-being. It is generally believed that higher quality child care has positive effects on children’s intellectual, verbal, and cognitive development and well-being, while lower quality care is associated with poorer developmental outcomes (Lamb 1998; Love, et al. 1996), although this view is not universally held (e.g., Blau 1999; Scarr 1998). Higher quality care has been associated with a number of positive outcomes, both concurrent and long-term, including higher cognitive outcomes, better receptive and expressive language skills, better pre-academic skills and school-readiness, improved perceptions of competence, more prosocial and cooperative behavior, better communication skills, better work habits, and fewer behavioral problems (see Cryer 1999; Love, et al. 1996; and Vandell and Wolfe 2000 for excellent summaries of the existing research on quality and child outcomes).

While many of these factors are considered important for later success in school (Cryer 1999), it is harder to assess specifically the long-term effects of child care of varying

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178 These researchers are arguing largely from a family-oriented perspective which, in contrast to the ECE perspective, emphasizes the family as "the primary, superordinate locus of socialization ... [and] assumes the primacy of parents as educators, moral guides, and nurturers of their children" (Holloway and Fuller 1999:100).
quality since children generally spend time in multiple settings in their preschool years (Zaslow 1991).

**How is quality defined?**

Although quality can be defined and conceptualized in many different ways, it has come to have a relatively standardized definition among the professional child care community that is reflected in standardized measurement tools. Broadly, the ECE community defines quality as “a child-centered approach to raising children, with caring adults who are kind and gentle rather than restrictive and harsh and who protect children’s health and safety, while providing a wealth of experiences that lead to learning through play” (Cryer 1999:39). This conceptualization emphasizes three aspects of quality: the dynamic (interactional) and static (structural) features of the care environment, as well as the context of the child care program.

The dynamic features of the care environment are generally referred to as process quality. This includes those aspects of the environment that children actually experience in their programs, most particularly the interactions children have with their providers. These interactions are evaluated on the basis on provider sensitivity, harshness, and detachment; provider involvement with children; and their general attitude toward children. Also included under process quality are child-child interactions; the activities, materials, and space available to children; and how everyday personal care routines such as meals, toileting, and rest times are handled (Cryer 1999; Kontos, et al. 1995).
Structural quality encompasses the static characteristics of the care environment that create the framework for the above processes that children actually experience. These include group size, adult-child ratios, as well as the formal education, specialized training, and experience of the teachers and/or director of the program (Cryer 1999; Kontos, et al. 1995). The program context refers to the quality of the work environment, and includes such things as income and benefits, job stress and satisfaction, as well as work commitment and staff turn-over (Kontos, et al. 1995).

Structural features and the program context are associated with children’s well-being to the extent they provide the conditions to make more positive dynamics possible within the care environment (Love, et al. 1996). Process quality is seen as most directly related to children’s behavior and hence is more directly associated with children’s well-being. Although all of these aspects of the care environment are believed to affect children’s well-being, some are recognized as more central than others. Cryer (1999:42, emphasis added) outlines the six core elements of quality that she says are “recognized as necessary for children’s positive development …”

- **safe care**, with diligent adult supervision that is appropriate for children’s ages and abilities; safe toys; safe equipment; and safe furnishings;
- **healthful care**, where children have opportunities for activity, rest, developing self-help skills in cleanliness, and having their nutritional needs met;
- **developmentally appropriate stimulation**, where children have choices of opportunities for play and learning in a variety of areas such as language; creativity through art, music, and dramatic play; fine and gross motor skills; numeracy; and nature or science;
- **positive interactions with adults**, where children can trust, learn from, and enjoy the adults who care for and educate them;

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179 Obviously, many of these elements of structural quality are not applicable to informal care settings. As will be discussed in the following section, different measures not incorporating all of these elements of structural quality have been developed, but they are still not fully appropriate for evaluating kith and kin care.
• **promoting individual emotional growth**, encouraging children to operate independently, cooperatively, securely, and competently; and

• **promoting positive relationships with other children**, allowing children to interact with their peers, with the environmental supports and adult guidance required to help interactions go smoothly.

**Measures of quality in early care environments**

A number of instruments have been developed to measure quality in child care settings, but one triad – the ITERS, ECERS, and FDRS – has generally become the preferred standard. These measures require direct observation of children and caregivers during times of child activity (Cryer 1999), and include specific things that the evaluator looks for in the caregiving environment. These scales aim to evaluate elements in each of the three areas of quality (process, structural, program context) described above, however, they assess the overall quality of care in a specific setting, not the quality of care received by an individual child (Facts in Action 2003).

These three scales are related, but each is specifically designed for a particular age group or setting. The ITERS (Infant/Toddler Environmental Rating Scale) is designed for use in settings which include infants and toddlers up to 30 months of age. The ECERS-R (Early Childhood Environmental Rating Scale – revised) is aimed at programs with children aged two and a half to four, including day care centers, preschools, Head Start programs, and kindergartens. These instruments each include approximately 40 items organized into seven scales evaluating different aspects of care – space and furnishings, personal care routines, listening and talking/language-reasoning, activities, interaction, program structure, and parents and staff (Harms, et al. 1998; Harms, et al. 1990).
Recognizing that center-based care settings and family day care homes were not equivalent, a variation on the above measures – the FDCRS (Family Day Care Rating Scale) – was developed to take into account the unique features of this environment.

This instrument likewise examines seven aspects of care, albeit slightly different ones – space and furnishings for care and learning, basic care, language and reasoning, learning activities, social development, adult needs, and provisions for exceptional children (Harms and Clifford 1989). Studies evaluating quality of kith and kin caregivers have generally used the FDCRS (e.g., Coley, et al. 2001; Fuller and Kagan 2000; Kontos, et al. 1995), although other researchers have argued that it is not appropriate for these types of arrangements (Kith & Kin Meeting 2000; Vandell and Wolfe 2000).

Limitations of quality measures

A number of limitations of these three measures have been noted. One criticism is aimed at the fact that these measures produce a global composite score; critics note that certain areas may have a greater influence on children’s well-being than others, and the composite score may underestimate effects of certain aspects of the care environment (Vandell and Wolfe 2000). Other measures such as the Observational Record of the Caregiving Environment (NICHD Early Child Care Research Network 2000) and the Caregiver Interaction Scale (Arnett 1989) have been developed that address this limitation by focusing on more specific domains, but they have been used less frequently to evaluate kith and kin care settings. The broader criticism, however, that applies to all of these measures is simply whether the definition of quality upon which these measures are based is valid in the myriad of settings and contexts within which these measures are used.
Problems with Current Constructions of Caregiving Quality

In spite of the ECE community’s assertion that the essential elements of high quality child care are universal and portable, there are some fundamental problems with attempting to apply a single, narrow definition of quality across a range of settings. First of all, formal and informal care settings are in many ways not functionally equivalent. Hence, can standards designed for formal care settings have any utility or meaning in settings such as those seen in the Apache community, where the care being provided by kith and kin is best characterized as an extension of parenting? Second, can standards based on the norms, practices, and values of middle-class America (New 1994) be applied in other cultural settings, or are they inherently culturally-biased? And finally, there is the even larger question of who has the right to define quality (Modigliani 2003). Should we be letting policymakers at the federal level – who generally have little understanding of the needs or values of those in minority communities – set universal standards, or should these decisions and policies be made at the community level?

Quality as “center” biased

Although global quality rating scales, such as the FDCRS, have been used to assess quality of care with kith and kin caregivers, they were not designed for this purpose. These measures reflect the standards for the regulated care settings for which they were designed, and hence do not capture the unique features of kith and kin care that many parents value (Porter, et al. 2003). Kith and kin caregivers do not consider themselves child care professionals (Kontos, et al. 1995), and most provide care only to particular children with whose families they have a preexisting relationship. The care they provide resembles parental care more than that which is typically found in regulated
child care settings; the affective qualities of kith and kin care are, in fact, what distinguishes it from other types of child care (Zinsser 2001).

Kith and kin care and center-based care, in fact, evoke very different models of caring. Providers working in day care centers or other formal care settings are more likely to appropriate the model of schools; care more resembles teaching, the day is fragmented into specific subjects or structured activities, and the focus is on preparation of children for school. In contrast, care in the home emphasizes kinship networks and community contexts, and kith and kin providers tend to emphasize the relational and nurturing aspect of caregiving (Fisher and Tronto 1990; Fitz Gibbon 2002; Gerstel 2000).

Parents often choose kith and kin caregivers because of the qualities this type of care offers that are generally not found elsewhere. Kith and kith providers are more likely to share the parents’ values and cultural background, offer flexible hours, provide support for the parent as well as the child, offer individual attention to the child, and provide a homelike atmosphere; generally, they are also familiar individuals who have an ongoing relationship with the parent as well as the child (Layzer 2001; Porter 2004). While parents value these aspects of the care environment, they are not the same qualities that the professional child care community sees as important (Kith & Kin Meeting 1999).

Current measures of quality do not take into account many of those features valued by parents, and instead look for the same components of quality – the standards developed for licensed child care settings – in all caregiving settings. As Zinsser (2001:125) notes,
Child care quality measures include program features such as activities, materials, schedules, and procedures, as well as conversations and interactions between children and caregivers. Such measures do not work as well in the home of a grandmother caring for two toddlers as they work in a center setting. Comparisons based on aggregated figures can mask the delicate adjustments between individual children, parents, and providers that are so necessary to children’s optimal development. Moreover, structured observations do not capture the full extent of the bond between the relative caregiver and the child – a bond that is broader and more long lasting than the child care arrangement they share.

Quality as culturally biased

The application of these uniform standards is also problematic in another sense. The ECE community views its definition of quality as being “cultureless” – they argue it is “rooted in universal norms of child development” (Holloway and Fuller 1999:99), and thus applicable to all children in all caregiving settings. Children are viewed as universally requiring the same basic inputs for developmental success, thus the same components of quality are believed to apply uniformly across all cultural settings (and types of settings) (Cryer 1999). Those components believed essential for “quality” care were codified by the NAEYC\(^{180}\) in their guidelines for “developmentally appropriate” practice (DAP) (Bredekamp 1987; Bredekamp and Copple 1997), and it is these guidelines that guide standards for high quality child care programs/settings.

DAP stresses child-centered, experiential learning\(^{181}\) (Bredekamp 1987). Children’s play, as well as their interactions with materials and their peers, are emphasized as the primary means of attaining developmental goals; the role of the adult is simply “to act as a facilitator of children’s enriched play and to provide protection,

\(^{180}\) The National Association for the Education of Young Children.

\(^{181}\) The standards for DAP are based on an interpretation of Piaget’s theory of development, which says children learn primarily through solitary exploration of the material world and through interactions with other children (Bredekamp 1987; Holloway and Fuller 1999; Wadsworth 1996).
positive attention, access to information, resources, support, and guidance” (Cryer 1999:41). Guidelines for programs considered to be “growth-enhancing” are very specific, as Love, Schochet, and Meckstroth (1996:5) describe:

In high quality, developmentally appropriate programs, caregivers encourage children to be actively engaged in a variety of activities; have frequent, positive interactions with children that include smiling, touching, holding, and speaking at children's eye level; promptly respond to children’s questions or requests; and encourage children to talk about their experiences, feelings, and ideas. Caregivers in high quality settings also listen attentively, ask open-ended questions and extend children's actions and verbalizations with more complex ideas or materials, interact with children individually and in small groups instead of exclusively with the group as a whole, use positive guidance techniques, and encourage appropriate independence.

Rather than being “cultureless,” these constructions espouse a rather narrow view of quality, one that “largely represents the socialization and educational practices – the cultural models – of the white, American middle-class” (Holloway and Fuller 1999:99). Quality caregiving, according to this hegemonic standard, is equated with such practices as authoritative control and responsive nurturance, and with encouraging independence, individual autonomy, democratic relations, and emotional expressiveness (Cancian 2002; Modigliani 2003). These practices and the associated definition of quality are, as Cryer (1999:41) notes, “often thought of as a best bet for positive child development in areas that are associated with traditional success in later schooling as well as in later life in the mainstream U.S. democratic and capitalist society.”

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182 Authoritative control involves the clear setting of and firm enforcement of rules and standards, the encouragement of the child’s independence and individuality, and open communication between children and parents, with both expressing their own points of view. In contrast, authoritarian control involves the insistence on obedience, respect for authority, and discourages give-and-take between the parent and child. Permissive control involves a tolerant, accepting attitude; punishment is generally not used, and the imposition of controls or authority is avoided (Maccoby and Martin 1983).

183 Responsive nurturance “refers to a combination of warmth or affection, and following the child’s lead, or responding to the child’s cues and listening to him or her” (Cancian 2002:71).
It is important to recognize that the values, practices, and outcomes associated with this mainstream notion of quality are not universally valued – significant differences exist in parental values and goals for their children by culture and class (Lowe and Weisner 2001; New 1994). Developmental norms and processes also vary cross-culturally (New 1994) – some groups, for example, give different age ranges for the attainment of certain developmental goals, while others include culturally-specific developmental norms. The Navajo, for example, have constructed their own developmental chart\(^{184}\) which emphasizes the child’s development of spirituality and a sense of community-belonging, both of which are important issues in a Navajo child’s development (Pence and McCallum 1994), but are not included on Western developmental charts. In addition, Navajo culture integrates all aspects of development – cognitive, moral, and social – into “a unified approach to life experiences and learning” rather than approaching them independently (Deyhle and LeCompte 1994:157).

Values and caregiving practices aimed at supporting these developmental goals are even more variable. While DAP promotes independence, material-centered activities for children, and verbal communication, other cultural groups may place more value on interdependence, people-centered activities, and multiple modes of communication. In other cultures, children may be included in the world of adults, and expected to learn through observation, modeling, and storytelling rather than direct instruction and explanations, and independent play with toys – the independent construction/acquisition of knowledge may not be as highly valued. Emotional control and respect for authority may also be emphasized rather than emotional expression and learning self-control (Modigliani 2003). Rather than being potentially harmful, these

\(^{184}\) See Begay and Begay (1982) for a comparison of Navajo and Western developmental stages.
alternative caregiving practices "represent strategies and scripts aimed at different goals, each of which makes ... moral and pragmatic sense in its own context" (LeVine, et al. 1994:256).

Also important when considering the appropriateness of caregiving practices is the desired outcome. The goal of DAP is the well-being and achievement of the individual child – "the perfection of individual capacity across domains of development" (Williams 1994:159). Achievement is generally equated as school readiness, especially language and cognitive development. While school readiness has become a highly stressed goal for early childhood programs, including child care (Porter, et al. 2003), in the Good Start, Grow Smart era,¹⁸⁵ not all populations within the U.S. view this as an important goal – or at least not the most important goal – of child care. Nor do all cultures place such an emphasis on the individual; some instead focus on the relationship of the individual to the group and cultural well-being. As Weisner (1997:182) notes, "well-being is also the ability of a child to actively and innovatively participate in the activities deemed important and valued by a cultural community.” For parents in such communities, the goal of early childhood care may be the integration of the child in the larger community and the building of cultural competence, rather than individual achievement and development.

**RE-CONCEPTUALIZING QUALITY**

Concepts of caregiving quality need not be as uniform and unyielding as are the current models and measures. As Modigliani (2003) points out, other ways of being with

¹⁸⁵ Please refer back to “Ideology, Policy, and Care” section of Chapter 3 for a discussion of Good Start, Grow Smart.
children can also be quite effective in achieving desired outcomes. In addition, outcomes other than those valued by mainstream American society are valid as well. To be meaningful, concepts of quality need to respect and accommodate local cultures, values, and practices. Rather than devaluing alternative practices and models, we need to recognize that quality can be context and culture specific while still protecting the well-being of the child and promoting the child’s development.

**Quality in Kith and Kin Care Settings**

Much effort in recent years has gone into rethinking quality for kith and kin care settings. Rather than contesting current quality standards, however, these efforts have focused on reframing quality “as a cumulative measure of what children experience across all settings rather than an individual measure of what children experience in a single setting” (Porter, et al. 2003:33). As such, different settings can be valued for, and evaluated on the basis of, their unique contributions, as long as the total experience across all of these caregiving settings fully supports the child’s development (Porter, et al. 2003).

Children generally experience care in a variety of settings (their home, a relative’s home, preschool, etc.) in a given week, each of which provides different experiences and developmental supports (Porter, et al. 2003). Given this, no single setting need provide all the elements believed necessary to support development (Porter, et al. 2003). Certain aspects of quality are viewed as essential – including nurturing, sensitivity and responsiveness, language stimulation, adequate supervision, appropriate discipline, and a safe physical environment (Porter 2004; Porter and Kearns 2003; Porter, et al. 2003; Porter, et al. 2006) – and hence necessary in all settings.
Others, however, need only be present in some settings and, given that each setting is unique and that children experience different qualities in each, the application of uniform standards across all caregiving settings is arguably inappropriate (Kith & Kin Meeting 1999).

The recently developed Child Care Assessment Tool for Relatives (CCAT-R), the first instrument specifically designed to assess quality in kith and kin care settings, integrates this idea of multiple qualities across multiple settings.\(^{186}\) While evaluating those elements of care viewed as essential, it emphasizes caregiver-child interactions and the caregiver-parent connection rather than materials, since it is the relationships between the parent and child and the caregiver that constitute the most distinctive feature of kith and kin caregiving (Porter 2004). Another innovation is that the measure recognizes that cultural experiences are a fundamental aspect of quality, and need to be present in at least some of the care settings in which a child spends time (Porter and Kearns 2003).

**Culturally Appropriate Quality Care**

While the CCAT-R is definitely a huge step forward in terms of evaluating kith and kin care quality in Western contexts, the extent to which it is appropriate for use in cultural minority settings is questionable. The foci of this instrument are six constructs\(^{187}\) which are, at a general level, relevant cross-culturally: (1) support for physical development (including health and safety), (2) support for cognitive development, (3)

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\(^{186}\) The CCAT-R was released in 2005. It has been field tested and validated, but there has not been time for researchers utilizing this tool to begin publishing their data. Nor has it been out long enough to get a sense of how popular it will be among researchers studying kith and kin care, and hence to what extent it will impact policy.

\(^{187}\) For a detailed description of these constructs, please see Appendix A in Porter, Rice, and Rivera (2006).
support for language development, (4) support for social/emotional development, (5) behavior management (including discipline and supervision), and (6) caregiver’s relationship with parents (Porter, et al. 2006). Descriptions of how certain of these constructs are conceptualized and measured, however, indicate that they are biased to some extent toward Western notions of development and normative practice. For example, “encourages independence and autonomy,” one behavior specifically watched for during caregiver-child interactions, would not necessarily be an appropriate evaluative criterion for Native caregiving given the emphasis on cooperation and interconnectedness within Native culture.

To make the CCAT-R appropriate and relevant for use in non-Western cultures, it is my belief that it would be necessary to develop culturally-specific versions that integrate locally relevant values, practices, and outcomes into how the constructs are specifically conceptualized and measured. As critics of current measures have argued, conceptualizations or measures of quality (in kith and kin or formal care settings) that are valid for cultural minority groups must recognize that there are multiple ways of conceptualizing development and developmentally appropriate practices (New and Mallory 1994) that support different valued outcomes. Functional models need to either promote “culturally appropriate quality care” or balance DAP with “community appropriate practice” (Pence and McCallum 1994), recognizing that different communities may have very different, but equally valid and effective ways of achieving valued goals or outcomes.

It is important to note that the developers have not uncritically assumed that the CCAT-R would be applicable in all cultural settings – while noting that the sample used to field test the instrument included a significant proportion of Latinos and African-Americans, they have also emphasized that “it will be important to test it with other cultural groups ... [to assess] whether the CCAT-R’s constructs and measures correspond to the views of quality held by parents in these groups ... and parents’ expectations for the role that relative care plays in supporting their children’s readiness for school” (Porter, et al. 2006:25).
Minimally, this means – as Porter and Kearns (2003) have suggested – that cultural experiences must be recognized as a fundamental aspect of quality. Culture, however, cannot simply be added on as a curricular element. Attempts to teach culture too often lead to its decontextualization (Hermes 2005). Instead, culture must be lived (Boyer 2000). Quality child caregiving must be embedded within the culture of the community and mesh with local child-rearing and pedagogical practices and ways of knowing. And, critically, quality child care must facilitate the transmission of culture and language in a culturally appropriate and congruent manner.

**Caregiving and quality in Native American communities**

Tribes – as sovereign nations – have the inherent right and power to define their own policies and standards, a power reiterated in 2000 in Executive Order 13175. This includes standards for child care and welfare. As discussed in Chapter 3, tribes fought long and hard for the recognition of their inherent right to observe and implement their own social and cultural child welfare standards (Red Horse 2000), a fight which resulted in the passage of the Indian Child Welfare Act. Interestingly, however, the more recent emphasis upon Western-oriented child care quality standards has not met with the same resistance, at least in the U.S. There have been isolated instances at the tribal level of developing culturally-sensitive child care programs integrating traditional values, beliefs, and pedagogical methods, language immersion, and elders (see Child Care Bureau 1996; and McLean 1996 for examples), but there has not as of yet been a

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189 Executive Order 13175 – “Consultation and Coordination with Indian Tribal Governments” – states that “When undertaking to formulate and implement policies that have tribal implications, agencies shall: (1) encourage Indian tribes to develop their own policies to achieve program objectives; [and] (2) where possible, defer to Indian tribes to establish standards.” ([http://www.epa.gov/fedrgst/eo/eo13175.html](http://www.epa.gov/fedrgst/eo/eo13175.html)).
concerted push nationally for the development of culturally or tribally-specific standards.\(^{190}\)

This is in marked contrast to Canada, where tribal groups\(^{191}\) and leaders have successfully fought for programming and standards designed and set by Native groups, not non-Native bureaucrats\(^{192}\) (MacKenzie 1989; Native Women's Association of Canada 1986 cited in McKenzie 1991) and recognition that First Nations\(^{193}\) concepts of child care differ radically from those of non-First Nations peoples (Assembly of First Nations 1989).

As McKenzie (1991:6) explained in a background paper to Parliament:

> Among the First Nations, traditional child-rearing practices have been based on a set of values, passed from generation to generation, that are distinct from those of the majority society … the care of young children has traditionally been viewed as the responsibility of the extended family and community, rather than the duty of the nuclear family alone … [and] the involvement of elders in child care was not only normal but considered important.

Importantly, it is not only responsibility for the care of children that is shared; responsibility for their education and socialization is similarly shared (Williams 1994), and the focus is not so much on individual development and fulfillment as the relationship of the self to others and working to help maintain the health and integrity of the group as a whole.

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\(^{190}\) There do exist separate healthy and safety standards for tribal child care centers and homes but, as the National Indian Child Care Association (NICCA) points out, these standards were developed by the U.S. Department of Health and Human Services (DHHS) “in consultation” with tribes rather than by the tribes themselves – in direct conflict of Executive Order 13175 – and they are not tribally specific (http://www.nicca.us/Forms%20Documents/Advocacy%20Issues%20II.pdf).

\(^{191}\) Including the Native Women’s Association of Canada and the Federation of Saskatchewan Indian Nations.

\(^{192}\) As a consequence of lobbying efforts on the part of First Nations groups, the Canadian government acknowledged in the late-1980s the “need for flexible child care services that are culturally and linguistically appropriate and meet the needs of native people living in a variety of circumstances” (Canada House of Commons Special Committee on Child Care 1987:67 cited in McKenzie 1991:13).

\(^{193}\) Tribal groups in Canada are referred to as “First Nations.”
First Nations child care, as it has come to be conceptualized and framed, must accordingly serve multiple purposes and meet the needs of multiple stakeholders (Greenwood and Shawana 1999). As in other contexts and communities, it must “enable parents to pursue employment and education” (Cooke 1986:87) and offer a stimulating environment to prepare children for school. But it must also provide “culturally relevant child care … to facilitate the continuation of aboriginal traditions and languages in the new generation” (McKenzie 1991:12). For First Nations, this last purpose trumps the rest; as McKenzie (1991:6, emphasis added) notes, “Aboriginal people stress that, while attention must be paid to the child’s physical and developmental requirements, the first priority for Native child care is that it be based on an understanding of aboriginal culture and language.”

Consequently, “quality” in Native communities has a special meaning. As the Assembly of First Nations (1995:14-17 cited in McDonald 2001) emphasized in their 1995 report:

First Nations child care must be addressed culturally and holistically. Child care must encompass First Nations values and traditions. [For this reason, it is essential that] child care programs be placed within the culture of First Nations communities.

High quality child care in tribal communities – whether center or home-based – needs to support and integrate “Native family systems and practices, Native methods of learning, and Native languages” (Native Council of Canada 1990 cited in McKenzie 1991:10-11). Standards should be based on traditional child-rearing practices and values, and programming both involve and integrate the community (Assembly of First Nations 1989; Assembly of First Nations 1995; McDonald 2001). Child care services should be a vehicle for the preservation of Native language and culture (Cooke 1986) and, as the
Native Women’s Association of Canada (1986 cited in McKenzie 1991) has emphasized, an environment for reserving the trend of assimilation rather than furthering it.

**Defining quality in Native communities**

While specific standards for high quality child caregiving must be left to the discretion of individual tribal entities, there are a number of elements that have been reiterated as critical by multiple authors and hence should ideally underlie all child care in Native communities. Those components considered essential to high quality Native child care services are summarized in Figure 6. Several resonate with those core elements or aspects of (Western) child care quality discussed earlier in this chapter and hence are familiar; others, however, are unique and reflect the unique position and needs of tribal communities.

**Figure 6: Essential Components of High Quality Native Child Care Services**

| 1. | Meets the needs of the children, families, and community |
| 2. | Provides a safe, loving, and nurturing environment for children |
| 3. | Fosters all aspects of children’s growth and development |
| 4. | Gives children an opportunity to learn and develop school readiness skills |
| 5. | Facilitates the transmission and preservation of language and culture |
| 6. | Encourages and integrates parental and community participation |
| 7. | Community-based and tribally designed, directed, and controlled |

Sources: Assembly of First Nations (1995), Greenwood (2005), and McDonald (2001)

First and foremost, child care in Native communities needs to **meet the needs of the children, their families, and the community as a whole** (Greenwood 2005). While the specific needs to be met will vary somewhat from community to community, the point to be emphasized here is that it is not just the needs of the parents (e.g., work
support) or children (e.g., developmental support and school readiness) that are to be considered; the needs of the tribal community must similarly be considered and prioritized. And because – as discussed in Chapter 3 – tribal survival is ultimately dependent upon the transmission of tribal heritage (Subcommittee on Indian Affairs 1978), one of the most important considerations from the perspective of the tribal community is the provision of culturally-relevant care that is based on and supports the community’s values, traditions, and beliefs (Greenwood and Shawana 1999; McDonald 2001).

For the children, high quality care should provide a safe, loving, and nurturing environment and foster all aspects of their growth and development (Greenwood 2005). Standards for health and safety should reflect community standards and be set locally. The physical environment and materials should be both age- and culturally-appropriate and reflect traditions and the community; as Greenwood and Shawana (1999:85) explain, materials and equipment should be “a quiet affirmation of who we are.” Rather than segregate children by age, mixed-age groupings should be utilized to allow siblings to remain together and younger children to learn from older ones (Greenwood and Shawana 1999). Programming should “encompass a holistic approach to developing children’s physical, mental, emotional, and spiritual being” (McDonald 2001:39).

Programming should both promote school readiness skills and facilitate the transmission and preservation of language and culture (Assembly of First Nations 1995; Greenwood 2005). Traditional values and beliefs should be the fundamental building blocks of the program; content needs to validate the culture of the community.
Teaching should incorporate storytelling and nature and children should be provided with opportunities to participate in traditional activities. The language of the community should be integrated into all activities (Greenwood and Shawana 1999). As Greenwood (2005) emphasizes, providing children with the opportunity to learn their language and culture is important in helping engender a sense of pride about who they are.

Involvement of parents and the community as a whole should be encouraged and integrated into all aspects of program development and service delivery (Assembly of First Nations 1995; Greenwood and Shawana 1999). Elders and other knowledgeable community members should be involved in the design and development of the child care curriculum and programming. Caregivers should themselves be members of the local tribal community, and special effort should be directed toward encouraging and facilitating the involvement of tribal Elders in both caregiving and program delivery (Assembly of First Nations 1989; Greenwood and Shawana 1999; McDonald 2001). As Beverly Peel of the Federation of Saskatchewan Indian Nations (quoted in Greenwood and Shawana 1999:90) has emphasized, the child care center “should be a place where community members share their gifts with each other and children.”

And, finally, to meet these somewhat unique needs of children and families in different tribal communities, quality child care services must be community-based and designed, controlled, and directed by tribal entities (Assembly of First Nations 1995; McDonald 2001). Not only should programming and materials originate in and resonate with the community, but standards, regulations, and criteria for evaluation and accountability should be determined and set by tribes and their members (Assembly of
First Nations 1989; Greenwood 2005). As with health and safety standards, tribes should be encouraged to develop their own training programs and accreditation. As Greenwood and Shawana (1999) suggest, tribes might consider developing accreditation processes respectful of life experience and criteria and standards for a new category of “community certified caregivers,” hence validating those experiences and skills valued in potential caregivers. Responsibility for the administration and evaluation of child care programs must likewise rest with the tribe and employ local models of governance (Greenwood and Shawana 1999; McDonald 2001).

While these key components of quality are drawn from discussions concerning First Nations formal child care in Canada, they are clearly applicable and transferable to Native child care in the U.S. They are also largely compatible with informal care settings, precisely because the model of care outlined in these quality recommendations is one that is holistic, embedded in the culture and the community, and emphasizes relationships.

These standards certainly resonate with what Apache parents emphasized in their discussions with me. To the Apache, “quality” child care is culturally-relevant care that meets the needs of and supports not only the parents and child, but also the larger family, community, and tribe. It is care that, in addition to providing child care, serves to integrate children into the larger extended family and community, socializes children to be Apache, and builds and reinforces networks and community ties. It is care that assists in the production of culturally competent children and the maintenance of culture and language in the community.
The above guidelines, however, should be only that. While they serve as a useful guide, decisions about specific quality standards and associated programming and regulations must be made at the tribal level, both in the interest of self-determination and to ensure the development of child care that meets the specific needs of that community and meshes with local conceptualizations of quality.

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Concern has been expressed that, in the move to get away from universal measures of child care quality, constructions could end up so relativistic that anything goes. There are inarguably certain minimum basic standards, especially related to safety, that need to exist in all caregiving settings. What is considered optimal care, however, is to some degree relative.

For the concept of quality to have any meaning in Native communities, it must reflect and respect the different cultural orientations and values in these communities. It must recognize the validity of outcomes such as cultural competency, community integration, and cultural survival. Conceptualizations and assessments of quality must look beyond the child. They must acknowledge that caregiving in Native communities is functionally different. They must consider the ability of caregiving arrangements to fulfill these varying functions, which necessitates considerations of the extended family and community in addition to the parents and child.

Apache parents judge quality according to their values and their goals for their children, as well as the needs of the larger family and community and tribe. They tend to value kith and kin caregivers because they are familiar, dependable, experienced
individuals with shared values and practices. Using such individuals as caregivers helps produce children with a strong cultural and linguistic base. It also helps reinforce and maintain the family and community networks which are important to day-to-day life and well-being.

Incorporating community standards for caregiving into conceptualizations of quality is an effective way of ensuring these standards are meaningful and relevant without sacrificing children’s safety. Existing definitions of quality have been constructed and imposed from the top down; constructions of high quality care and DAP have been “shaped by those who own and control economic enterprises and those who shape the policies of the state, in conjunction with managers and professionals who produce knowledge and culture” (Cancian 2002:68). As noted at a recent research meeting, the policymakers are white yet a significant proportion of the child care population is not – hence, a big disparity exists between the policymakers and the “customers” (Child Care Bureau 2002), especially in terms of how quality is construed. Recognizing and integrating local conceptualizations of caregiving quality and “respecting the childrearing standards of diverse communities is,” as Cancian (2002:69) notes, “one necessary step toward creating more democratic standards.”
CHAPTER 9

POLICY IMPLICATIONS AND CONCLUSIONS

Child care is teaching values as children grow. It is an integral part of our plans for self-determination. We always talk about our children being our future. Child care makes sure we make healthy leaders for tomorrow.

– Gilbert Parnell, Skidegate Indian Band, British Columbia, quoted in Greenwood and Shawana (1999:84)

As individuals and as a society, we are always concerned with the well-being of our children. They represent our future, they are our legacy. Their success and prosperity (or lack thereof) is a reflection on us. They are an indicator of our success as care providers and socializers, both individually and collectively.

Individuals and societies do not always agree, however, as to what exactly constitutes “well-being” or what is necessary to achieve it. Parents are concerned with providing their children with the knowledge, skills, and tools to be successful in their community. Societies are concerned with producing children who will be productive citizens and who will uphold and reproduce the social order. Social policy is correspondingly aimed at ensuring the well-being and protecting the best interests of the child, as defined by that society.

In the U.S., we live in a pluralistic society with a great diversity of views and practices related to child rearing and child caregiving. Individuals who are part of the dominant culture and class generally find that their caregiving practices and perspectives on child well-being are in line with the prevailing policy. The experience of cultural minority parents, however, is quite often different. Although their caregiving choices may
make sense locally and be viewed as culturally appropriate, they may find themselves at odds with the dominant cultural views as codified in national standards and policies. All too often, this results in the condemnation and undermining of the very caregiving practices that are adaptive and beneficial in these communities.

Kith and kin caregiving – a practice generally viewed with suspicion from a policy perspective – is the preferred form of care for many in the White Mountain Apache community, one which contributes substantially to the well-being of the community and the families and children of which it is comprised. The use of kith and kin as caregivers strengthens ties within and builds the resilience of the community, and reinforces informal resource networks. It promotes cultural competency by providing a space for cultural learning and teaching children the importance of family, community, and reciprocity. Rather than being detrimental, this practice draws from and builds upon many identified strengths in Native communities, including the extended family, social connections, cultural identity, and reciprocity and mutual assistance (Goodluck 2002), and helps produce successful, balanced children who are central to the future health of the tribal community.

While the value of this practice to the tribal community is clear, federal policies, standards, and regulations leave little room for such locally relevant and beneficial practices. Unfortunately, those drafting policy quite often do not recognize that caregiving practices vary across communities, and that alternative caregiving practices can be just as effective in ensuring the health and well-being of the child. It is my contention that, for the best interests of cultural minority communities and their children to be served, change needs to be effected at multiple levels. Child care policy needs to
change, but so does thinking about child well-being and the purpose and function of child care. Specifically, policymakers need to (1) recognize and respect the diversity of caregiving perspectives and practices, (2) think more broadly about child well-being, and (3) encourage the development of policy and programming that is locally designed and controlled and which integrates and reflects the culture and values of the local community.

*We need to recognize and respect the diversity of caregiving perspectives and practices that exist in the U.S., recognizing the strengths of these practices (and that these practices represent strengths in these communities)*

One lesson of this research is the importance of recognizing cultural variation in caregiving practices and understanding their local value and meaning. The perspective of the dominant culture is evident in policy; this dissertation, in contrast, gives voice to one cultural minority community and the parents and caregivers within. These individuals’ preferences and choices give important insights as to what works and what is important locally, as well as what is considered integral to child and community well-being.

There is significant cross-cultural variation in how child rearing and caregiving are conceptualized. The White Mountain Apache community’s view of child caregiving as a communal responsibility and their preference for kith and kin is neither universal nor unique. Many cultures situate responsibility for children within the extended family or larger kin networks; others, however, view child rearing and care as primarily the domain of the nuclear family. Similarly, perspectives vary as to whether child caregiving is
primarily a private task or a public good, a nurturing or an educational endeavor. Caregiving practices and perspectives vary because they are ultimately the product of each group's unique historical path, culture, and needs.

The existence of differing views of caregiving is in itself not a problem. What is problematic is the imposition of standards that are the product of the dominant culture on cultural minority groups. Our society has the tendency to construct as universal the caregiving and socialization practices and accompanying ideology of white, middle-class society. When viewed through the lens of this dominant ideological model, alternative practices that have value and meaning in other cultural settings tend to be devalued and found lacking. Highlighted are the comparative “deficits” of the alternative caregiving practices; any potential benefits or local value are obfuscated. Consequently, Goodluck and Willeto (2000) argue that we must instead focus on examining these alternative practices within their own cultural settings and how these practices represent strengths within the local community.

As I have pointed out, kith and kin caregiving serves many important functions in the White Mountain Apache community. Goodluck (2002), in fact, has identified traditional kin-based caregiving as an important strength within Native communities. Such care meets the needs of not only the parents, but the children and caregivers as well; it is also central to relations in the community and the perpetuation of the community. It performs an important function within networks, creating and fulfilling obligations and building the social capital of the network. It offers an important counter-

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194 Goodluck and Willeto (Goodluck 2002; Goodluck and Willeto 2000) argue that a strengths perspective, which emphasizes culturally appropriate, positive domains based on resiliency, is more useful and meaningful in discussions of the Native child well-being than the more predominant deficits perspective, which instead focuses on problems and weaknesses within families and communities that presumably need to be addressed.
balance to the formal education system by providing a context and the opportunity for culturally-mediated learning, hence assisting in the production of culturally competent children and thus helping ensure the cultural reproduction and survival of the community.

This form of caregiving also functions as a strength by building the resiliency of families and the community. Goodluck (2002) and Joe (1996), among others, have emphasized the need to examine and investigate those instances where Native women and children thrive in spite of poverty and limited resources. Kith and kin care encourages and facilitates cooperation and exchange, thus helping create and reinforce resource networks that are critically important to well-being in communities such as this where insufficient institutionalized resource networks are in place.

When these practices are devalued instead of recognized for the important functions they serve, it is not just choice that is sacrificed; it is potentially the cultural and economic well-being of these communities. If the goal is to truly improve the well-being of children and build strong, sustainable, and self-sufficient communities, we need to respect these varying caregiving preferences and practices rather than working to undermine them. From a policy perspective, this means – as was discussed in Chapter 8 – framing caregiving quality in such a way as to accommodate local cultures, values, and practices, and moving away from standards that are biased against minority cultures and informal care settings. Practically, this necessitates the development and use of standards for developmentally appropriate practice and quality care that are culturally and community appropriate.
We need to think more broadly about child well-being, understanding it to encompass the well-being of children in their own communities and cultures.

We live in a capitalist, individualistic society where the focus is on individual success and fulfillment. The well-being of children is similarly evaluated in terms of their individual developmental outcomes or educational success. In many cultural minority communities, however, well-being is not so individualistically constructed or evaluated. Instead, well-being is also relational, a product of the individual’s interconnection with the larger kin group, community, and culture.

For conceptualizations of well-being to have any meaning or utility in other cultural communities, they need to incorporate “a more holistic and balanced view of the well-being of children and youth in their own communities and cultures” (Goodluck 2002:9). Child well-being should take into account not only culturally appropriate developmental or educational markers, but also the ability of the child to participate in activities valued by the cultural community (Weisner 1997). In Native communities, as Goodluck and Willeto (2000:15) emphasize, “well-being concepts must incorporate the total context of a culture, its life ways, and traditions.”

Native parents’ concern for the cultural and relational as well as physical aspects of their children’s well-being is one reason that kith and kin care is so favored. As Biolsi and his colleagues (2002:141-142) write, parents in Native communities “are concerned about outside influences and [consequently] prefer to have their children cared for by family members who will not only be vigilant over the children’s welfare, but will also be in a position to pass on their own values, traditions, and family history.” Tribes themselves also have a vested interest – separate and independent of parents – in
protecting the well-being of Native children since children are so vital to the tribe’s continued existence, both physically and culturally. Consequently, their concern is principally with ensuring the cultural and relational well-being of their member children by protecting their relationship to the tribe and culture.

While it is first and foremost important that children be able to successfully participate in their own culture, well-being concepts for Native and other minority children should ideally be tied to dual competency. Cultural minority children in this country are constantly called upon to navigate not only their own cultural community, but the culture that dominates the school system and the world outside their community’s borders. Bicultural children, as Cronin and Jones (1998:85 cited in Greenwood and Shawana 1999:61) emphasize, are better positioned to experience success “in their families – where one set of values and behaviors prevail, and in school – where another set of values and behaviors may be expected.” Tribal communities such as the White Mountain Apache are coming to understand that the well-being of tribal children in the 21st century is linked to competency in both the Anglo and Native cultural worlds, as evidenced through the recognition that both traditional knowledge and knowledge gained in school have importance and value (Basso 1996).

To accommodate these broader conceptualizations of well-being, valued and legitimated outcomes for children need to be broadened. Specifically, they need to go beyond current measures of individual achievement and development – which tend to focus on educational success and Western developmental markers – to include cultural and linguistic competency, cultural and community embeddedness and integration, and culturally-specific developmental norms.
We need to encourage and facilitate the development of child care regulations, policies, and programs that are locally designed, directed, and controlled and which respect, reflect, and integrate the culture, values, and strengths of the community.

Decisions that frame policies and regulations impacting child care environments and programming are ultimately political in nature (Goodson 2001). The debate on quality has been particularly politicized, tied to ongoing shifts in thinking about welfare and early education policy in this country.

As the context and content of early care environments have come to be increasingly seen as critical to children’s later development and success, there have been growing efforts to control and dictate these environments, especially for those children considered to be “disadvantaged.” As discussed in Chapter 3, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has encouraged the placement of children in non-maternal care settings by valuing work above mothering for impoverished mothers; Good Start, Grow Smart (GSGS), in turn, has pushed the focus of preschool and other early care environments toward school readiness. Consequently, more and more children from impoverished and cultural minority communities are spending time in early care environments dominated by conceptions of child development and quality grounded in the cultural models of the white, American middle-class where they are inculcated in the ideology and values of the dominant culture.

Such top-down policies are, however, ultimately paternalistic and assimilationistic. As Nancy Johnson (quoted in Greenwood and Shawana 1999:91) explains:
They are assimilationist because there is no recognition that we are different, have different ways of rearing children, hold a different world view, have different standards in our communities, different ways of thinking and different geographical circumstances.

These policies promote a very narrow view of success, one not shared by many of the communities on which they are imposed, and one which may actively undermine locally adaptive practices in these communities if uncritically applied. Rather than promoting the well-being of children in their own cultural communities, such policies often work against the best interests of the child. Imposing outside models of child development and quality on cultural minority communities ultimately interferes with children’s acquisition of competency in their own culture and, in tribal communities, violates the tenets of self-determination.

Tribes, as sovereign nations, have the right to define their own policies and standards. The passage of the Indian Child Welfare Act (ICWA), as Miller, Hoffman, and Turner (1980) point out, served to give legal sanction to the child care patterns of Native culture. Yet, while tribes have been permitted to establish their own health and safety standards, there has not been the same support for the establishment of tribally-specific standards for quality.

It is essential that tribes and other cultural minority groups be allowed and encouraged to develop their own early child care programs that resonate culturally and which meet locally defined standards of quality. The history of removal and transracial adoption has left a legacy of distrust; standards or programs which impose external values have the potential to threaten cultural survival in much the same way. Programming which is locally designed and controlled and which builds on the strengths and values of the community is more likely to resonate with and have support and buy-in
from the community. Such programming also validates local knowledge and serves as “a vehicle through which cultures can be retained and transmitted from generation to generation” (Native Council of Canada 1990), thus helping to reverse assimilation (McKenzie 1991). Importantly, such locally directed and controlled programming also supports and reinforces self-determination.

Ultimately, the intent of all early childhood policy is to protect and promote the well-being of children. However, if these policies do not build on community strengths and values, the well-being of children – and ultimately their communities – may instead suffer. Policies that promote the well-being of children from a Western perspective to the exclusion of considerations of the well-being of children in their own communities and cultures are ultimately short-sighted. Community-based standards prepare children to succeed in their own communities, and culturally competent and grounded children are essential to building and sustaining strong communities. In the end, children and communities will benefit the most when locally developed and culturally relevant programming and standards serve as the foundation of early childhood care.
Four separate interview guides were used during the course of interviews. The specific interview guide selected depended upon whether it was a parent or caregiver being interviewed, whether the parent was or was not using supplemental caregivers, and whether the type of care being provided by the caregiver was considered supplemental or surrogate. In some cases, where the individual being interviewed fell within multiple categories – for example, the individual was using supplemental care for her own child but was also serving as a surrogate caregiver to another child – more than one interview guide was used during the course of the interview.

INTERVIEW GUIDES

- Primary caregiver, using supplemental caregiver(s)  pp. 392-396
- Primary caregiver, not using supplemental caregiver(s)  pp. 397-401
- Alternative (supplemental) caregiver  pp. 402-405
- Surrogate caregiver  pp. 406-408
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Date __________ Community __________

**Primary Caregiver**

Name ____________________________ Relationship to child __________________________

Gender ______ Age ______ Years of school completed __________

Religion __________________________ Attend/take part in traditional ceremonies __________

Where raised as a child __________________________ Marital status __________

Occupation/where work __________________________ Currently employed ______ Job seasonal ______

Full/part-time ______ Hours/shift worked __________ How long been there __________

If unemployed, how long unemployed? ______ Want to be employed? ______

In good health? ______ If not, explain __________

**Spouse/Partner**

Spouse/partner living in house? ______ Relationship to child __________________________

Occupation/where work __________________________ Currently employed ______ Job seasonal ______

Full/part-time ______ Hours/shift worked __________ How long been there __________

If unemployed, how long unemployed? ______ Want to be employed? ______

In good health? ______ If not, explain __________

**Family**

Number living in household ______ Number of adults (18 and over) in HH ______

List individuals (relationships): 1. __________ 2. __________

3. __________ 4. __________ 5. __________

Do you have any family living nearby? __________

Who/what relation? __________

How often see your family? __________

Ever watch kids/help with child care? __________
Does your spouse/partner have any family living nearby? ______________
Who/what relation? __________________________________________________

How often see spouse’s/partner’s family? ____________________________________

Help with child care? ______________________________________________________

Family ever lived away from reservation? Where? _____________________________ How long? __________

Main source of income? __________________________ Avg. monthly income for HH _________

TANF ______ WIC ______ Food stamps ______ Commodities ______

Receive child care subsidy? ______________ Have vehicle/available transportation? ___________

You/spouse have health insurance through work? __________ Children covered? ________________

Family use traditional methods of healing (herbs, mm, ceremonies)? ________________

Does your family speak Apache or English at home? __________ Children speak which? __________

Is it important to you for your children to understand/speak Apache? ________________

Where did children learn Apache (where want them to learn)? ______________

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Children

Number of biological children _______ Number of children (under 18) living in household: _______

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Any children not live with you (list #)? ______________ Where live? ______________

How long? ______________ Why? __________________________________________________

Whose decision for child(ren) to live in other HH? _____________________________

Any of these children not yours (list #)? ______________ Relationship to you? ___________

How long lived with you? ______________ Why live with you? ________________________

2
Caregiving Attitudes/Practices

1. When you were a child, who took care of you most of the time? Who else helped?

2. Who in your household looks after the children most of the time?

3. Who else in your household helps look after the children?
   
   [prod for father, siblings, other HH members]
   
   When do they help? (during the day? at night? during the week? on weekends?)
   
   What do they do?

4. Who outside of household helps watch or look after your children?
   
   [prod for relatives (especially those mentioned as living nearby), friends, neighbors]
   
   When do they help? (during the day? at night? during the week? on weekends?)
   
   What do they do?

5. When do you usually need help watching the children? Hours (traditional, evening, WE, irregular, etc.)

6. Are your child care needs different during the summer?

7. Would you/have you ever used relatives, friends, or neighbors to help watch your children? Why/why not? (What do you think of this type of care?)

8. Would you/have you used a home care provider? Why/why not?

9. Would you/have you used the day care center? Why/why not?

10. Would you/have you used Headstart? Why/why not?

11. Would you/have you used 21st Century programs (after-school/summer)? Why/why not?

12. What is most important to you when you are looking for someone to help care for your children? What qualities do you find important in a child caregiver?

13. Who/what would be your ideal caregiver or setting for your infant? (You, other caregivers, programs …)

   For your toddler?

   For your preschooler?
Focus Child

Caregiving history/previous caregivers ...

14. How old was _____ when (s)he was first taken care of by someone besides yourself? Who?
   [If says husband, prod for age left with someone outside nuclear family]

15. Who helped you care for/provided child care for ______ when s(he) was younger (infant, toddler,
   etc.)? Ages provided care? How long did you use this caregiver?

16. If have used different caregivers over time, why did the caregiving arrangements change?

17. Does _____ have any health problems/special needs that affect your decisions about child care?

Current caregiver(s):

18. How many hours/week is _____ in the care of other caregivers?

19. Who helps take care of child currently? (all caregivers)
   How often? Where?

20. If not a relative, did child already know caregiver?

21. Why did you use this specific caregiver?

22. How did arrangement come about?

23. Do you pay this caregiver / do you have any sort of reciprocal arrangement with caregiver?
   [Get at expanded role of caregiver]

24. Are you happy with the arrangement? Why/why not?

25. Is there another child care arrangement/caregiver you would prefer?

26. Do you ever have any problems with this child care arrangement (is it dependable)?

27. What happens if _____ gets sick while with the child caregiver?

28. Can you use this caregiving arrangement if child sick?
   [If not, what happens when child sick?]
Illness and Health Care

39. Who usually takes care of the children when they are sick?

31. How can you tell that ______ is sick; what is the first sign (s) he is sick?

32. What is the first thing you usually do when ______ is sick? Then what? (etc.)

33. When/what symptoms mean time to take the child for treatment?

34. Who decides what kind of treatment the child needs / where child should be treated?

35. Do you get advice from anyone regarding treatment? Do you usually follow the advice?

36. Who usually takes child for treatment? Anyone else?

37. Do other caregivers ever help with treatment?

38. The last time ______ needed to be treated outside the home, where did you take him/her?

39. Is this where you usually take ______? If not, where do you usually go?

40. Why do you use this place? (social, physical, and financial accessibility; beliefs about etiology, etc.)

41. How much did you have to pay?

42. What do you think of the services there?

43. Did ______ get well after this? If not, what did you do next?

44. Did you use any other treatments at the same time? Later?


46. Have you ever had any problems accessing health care/treatment?

47. Do you have any other comments? Anything you would like to add?

48. As part of this study, we are also interested in talking to caregivers/child care providers. Do you think your child caregiver might be interested in being interviewed?

49. Do you know anyone else who might want to participate in this study?

50. Notes on environment (inside and outside):
Primary Caregiver (No alternative caregivers)

Name ___________________________ Relationship to child ___________________________

Gender __________ Age __________ Years of school completed __________

Religion __________________________ Attend/take part in traditional ceremonies ___________________________

Where raised as a child __________________________ Marital status ___________________________

Occupation/where work __________________________ Currently employed ______ Job seasonal ______

Full/part-time ______ Hours/shift worked ___________ How long been there ___________

If unemployed, how long unemployed? ___________ Want to be employed? ___________

In good health? ______ If not, explain __________________________

Spouse/Partner

Spouse/partner living in house? ______ Relationship to child ___________________________

Occupation/where work __________________________ Currently employed ______ Job seasonal ______

Full/part-time ______ Hours/shift worked ___________ How long been there ___________

If unemployed, how long unemployed? ___________ Want to be employed? ___________

In good health? ______ If not, explain __________________________

Family

Number living in household ______ Number of adults (18 and over) in HH ______

List individuals (relationships): 1. __________________________ 2. __________________________

3. __________________________ 4. __________________________ 5. __________________________

Do you have any family living nearby? __________________________

Who/what relation? __________________________

How often see your family? __________________________

Ever watch kids/help with child care? __________________________
Does your spouse/partner have any family living nearby? ____________________________

Who/what relation? __________________________________________________________

How often see spouse’s/partner’s family? _________________________________________

Help with child care? _________________________________________________________

Family ever lived away from reservation? Where? _____________________________ How long? __________

Main source of income? __________________________ Avg. monthly income for HH _________

TANF _____ WIC _____ Food stamps _____ Commodities ________

Receive child care subsidy? ______________ Have vehicle/available transportation? __________

You/spouse have health insurance through work? _______ Children covered? ______________

Family use traditional methods of healing (herbs, mm, ceremonies)? ________________

Does your family speak Apache or English at home? _______ Children speak which? ________

Is it important to you for your children to understand/speak Apache? _______________

Where did children learn Apache (where want them to learn)? ______________________

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**Children**

Number of biological children ________ Number of children (under 18) living in household: ______

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Any children not live with you (list #)? ______________ Where live? ______________

How long? ________ Why? ________________________________

Whose decision for child(ren) to live in other HH? ________________________________

Any of these children not yours (list #)? ______________ Relationship to you? ______________

How long lived with you? ________ Why live with you? ________________________________
Caregiving Attitudes/Practices

1. When you were a child, who took care of you most of the time? Who else helped?

2. Who in your household looks after the children most of the time?

3. Who else in your household helps look after the children?
   [prod for father, siblings, other HH members]
   When do they help? (during the day? at night? during the week? on weekends?)
   What do they do?

4. Who outside of household helps watch or look after your children?
   [prod for relatives (especially those mentioned as living nearby), friends, neighbors]
   When do they help? (during the day? at night? during the week? on weekends?)
   What do they do?

5. When do you usually need help watching the children? Hours (traditional, evening, WE, irregular, etc.)

6. Are your child care needs different during the summer?

7. Would you/have you ever used relatives, friends, or neighbors to help watch your children? Why/why not? (What do you think of this type of care?)

8. Would you/have you used a home care provider? Why/why not?

9. Would you/have you used the day care center? Why/why not?

10. Would you/have you used Headstart? Why/why not?

11. Would you/have you used 21st Century programs (after-school/summer)? Why/why not?

12. What is most important to you when you are looking for someone to help care for your children? What qualities do you find important in a child caregiver?

13. Who/what would be your ideal caregiver or setting for your infant? (You, other caregivers, programs ...)
   For your toddler?
   For your preschooler?
Focus Child

_________________________, age ______

Caregiving history/previous caregivers ...

14 How old was ______ when (s)he was first taken care of by someone besides yourself? Who?
   
   [If says husband, prod for age left with someone outside nuclear family]

15 Who helped you care for/provided child care for ______ when s(he) was younger (infant, toddler, etc.)? Ages provided care? How long did you use this caregiver?

16 If have used different caregivers over time, why did the caregiving arrangements change?

17 Does ______ have any health problems/special needs that affect your decisions about child care?

Current caregiver(s):

18 Who is caring for the child currently?

19 Does anyone else ever help (either with regular child care or occasionally)?
   
   How often? Where?

20 If so, how many hours/week is ______ in the care of other caregivers?

21 Are you happy with your current caregiving situation/arrangement? Why/why not?

22 Have you been looking for child care? Have you had problems finding acceptable child care?
   
   Explain.

23 Where have you tried looking / who have you asked? (family? friends/neighbors? CCC? HCPs?)

24 What kind of child care are you looking for? Who would you prefer to watch your child?
   
   What would be your ideal child care?

25 How has not being able to find acceptable child care affected you? (jobs, education, financially, etc.)

26 What problems do you see in the community in relation to child care? What additional resources/services do you think are needed or would you like to see?

27 If not looking for child care, reasons don't use outside caregivers/child care.
Illness and Health Care

Who usually takes care of the children when they are sick?

How can you tell that _____ is sick; what is the first sign (s)he is sick?

What is the first thing you usually do when _____ is sick? Then what? (etc.)

When/what symptoms mean time to take the child for treatment?

Who decides what kind of treatment the child needs / where child should be treated?

Do you get advice from anyone regarding treatment? Do you usually follow the advice?

Who usually takes child for treatment? Anyone else?

Do other caregivers ever help with treatment?

The last time _____ needed to be treated outside the home, where did you take him/her?

Is this where you usually take _____? If not, where do you usually go?

Why do you use this place? (social, physical, and financial accessibility; beliefs about etiology, etc.)

How much did you have to pay?

What do you think of the services there?

Did _____ get well after this? If not, what did you do next?

Did you use any other treatments at the same time? Later?

Where else have you taken _____ for treatment? Have you ever used IHS? Navapache? private doctors? traditional healers/MM? spiritual/faith healers? Would you ever use these for children?

For what kinds of problems/illnesses?

Have you ever had any problems accessing health care/treatment?

Do you have any other comments? Anything you would like to add?

As part of this study, we are also interested in talking to caregivers/child care providers. Do you think your child caregiver might be interested in being interviewed?

Do you know anyone else who might want to participate in this study?

Notes on environment (inside and outside):
Alternative Caregiver

Name ___________________________ Relationship to child _________________

Gender ___________ Age ___________ Years of school completed ______________

Religion ___________________________ Attend/take part in traditional ceremonies ______________

Where raised as a child ___________________________ Marital status _________________

Occupation/where work ___________________________ Currently employed ______ Job seasonal ______________

Full/part-time ______ Hours/shift worked _______________ How long been there ______________

If unemployed, how long unemployed? _______________ Want to be employed? ______________

In good health? _______ If not, explain ______________________________

Family

Number living in household ______ List individuals (relationships): 1. __________________________

2. ___________________________ 3. ___________________________ 4. ___________________________

5. ___________________________ 6. ___________________________ 7. ___________________________

Main source of income? ___________________________ Avg. monthly income for HH _______________

TANF _______ WIC _______ Food stamps _______ Commodities _______

Do you have a vehicle or other available transportation? _______________

Family use traditional methods of healing (herbs, mm, ceremonies)? _______________

Does your family speak Apache or English at home? _______________

Children

# of biological children _______ # of children (under 18) living in HH: _______ Ages ______________

Any children living in HH that are not yours? _______ Relationship to you? _______________________

How long lived with you? _______________ Why live with you? _________________________________
Children in Care

Who helped you watch your children (when they were young)?  

Who helped watch you when you were a child?  

How many children do you help care for currently?  

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Have you cared for other children in the past?  

How many?  

Relationships?  

Child’s age?  

For how long?  

Why no longer in your care?  

Caregiving of Focal Child  

____________________, age ________

1. How did this caregiving arrangement come about? Was this arrangement expected or negotiated?

2. Why do you think the parent asked (chose) you to take care of _____ ?

3. Why did you decide to help take care of _____ ? What do you get out of this relationship?

4. What do you see as your responsibilities in relation to this child?

5. What is the best part about taking care of this child?

6. What is the most challenging or frustrating part of taking care of this child?

7. Do you receive any money, food, goods, or services from the parents in exchange for child care?

8. Do you pay for the child’s food, diapers, clothes, medications, etc.?

9. Have you ever taken care of _____ for longer periods? (for example, overnight, weekends, etc.)
The Caregiving Experience

16. Describe what a typical day is like when _____ is here.
17. How are your days when you are caring for _____ different from days when you are not caring for any children?
18. Do you plan your days in advance when you are caring for children, or do you let these days unfold?
19. What kinds of things do you and _____ do together?
20. How do you balance housework/chores with watching this child?
21. What language do you usually interact with the child(ren) in?
22. Is there anyone else in the house who helps care for this child(ren)? [adults or other children]
23. What are your needs and concerns as a caregiver?
24. Does caring for this child(ren) cause you any problems or hardship?
25. Do you feel you can meet the needs of the children you are caring for?
26. Would you be interested in support groups if they were available? CPR training? Child development workshops? Would you find them useful? Would you use them?

Illness and Health Care

27. What do you do when one of the children you care for gets sick? Do you treat them? Does care revert to the mother? Does it depend on the severity of the illness?
28. Do you/would you continue to take care of the child when (s)he is sick? Or do you/would you only resume caregiving once child is well again? When will you take care of child again?
29. Have you/would you treat a child in your care yourself or take a child somewhere for treatment? Or would you want the parent to take the child for treatment?
30. If you took a child for treatment, where would you take him/her?
Do you ever give the parents advice about what treatment the child should have or where they should go for treatment?

Do you have any other comments? Anything you would like to add?

Would you be interested in participating in a focus group on child care in the Spring?

Do you know anyone else who might want to participate in this study?

Notes on environment (inside and outside):
Surrogate Caregiver

Name ____________________________________ Relationship to child ____________________________
Gender ______ Age ______ Years of school completed ____________________________
Religion ___________________ Attend/take part in traditional ceremonies ___________________
Where raised as a child ________________________ Marital status ____________________________
Occupation/where work ________________ Currently employed ______ Job seasonal ______
Full/part-time __________ Hours/shift worked ________________ How long been there ______
If unemployed, how long unemployed? __________ Want to be employed? ____________
In good health? ______ If not, explain ______________________________________________________

Family

Number living in household ________ Number of adults (18 and over) in HH ______
List individuals (relationships): 1. ____________________________ 2. ____________________________
3. ____________________________ 4. ____________________________ 5. ____________________________
Main source of income? ____________________________ Avg. monthly income for HH __________
TANF ______ WIC ______ Food stamps ______ Commodities ______
Receive child care subsidy? __________ Have vehicle/available transportation? __________
You/spouse have health insurance through work? ______ Children covered? __________
Family use traditional methods of healing (herbs, mm, ceremonies)? __________________________
Does your family speak Apache or English at home? ______ Children speak which? ________
Children

Number of biological children: ________  Number of children (under 18) living in household: ________

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Any children not live with you (list #)? ________ Where live? ________

How long? ________ Why? ________

Whose decision for child(ren) to live in other HH? ________

Which children living with you are not your biological children (list #)? ________

Relationship to you? ________

How long lived with you? ________

Why live with you? ________

Surrogate Caregiving (Focus Child)

__________, age ________

1. How did ________ come to live with you?

2. Is this considered a temporary or permanent arrangement?

3. Whose decision was it for ________ to live with you?

4. How much longer do you expect ________ to live with you?

5. Do you currently have custody of ________? (Legal guardian?)

   a. If not, does not having custody cause you any problems?

   b. Do you want to try to get custody?

6. Do you want to be caring for this child?

7. What are the benefits to you in terms of caring for this child?
Does caring for ______ cause you or your family any problems or hardship? Has it caused any money problems? Are you able to afford food, medicines, and other things you need for yourself/family?

Has taking care of ______ affected your health? Your ability to take care of yourself?

Do you get any financial or other assistance, either from your family or the tribe, to help you in caring for this child?

Do you feel you could ask for help or services if you needed them?

Does anyone else help you in caring for this child?

Would having some assistance with child care or child care relief for a few hours a week be helpful?

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Illness and Health Care

Who usually takes care of ______ when (s)he is sick?

How do you decide if (and when) the child needs treatment outside the home?

Who decides what kind of treatment the child needs / where child should be treated?

Who usually takes the child for treatment? Anyone else?

Where have you (or would you) take ______ for treatment?

Why do you use this place? (social, physical, and financial accessibility; beliefs about etiology, etc.)

Do you have to pay for treatment? Medications? If so, how much? Who pays?

What do you think of the services there?


Have you ever had any problems accessing health care/treatment?

Do you have any other comments? Anything you would like to add?

Would you be interested in participating in a focus group on child care in the Spring?

Do you know anyone else who might want to participate in this study?

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