



## Seven New Hampshire Communities Lead the Way Toward Improved Equity in Family Services

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# Table of Contents

Acknowledgments.....	1
Executive Summary .....	2
Introduction .....	4
Methodology and Data.....	4
Findings.....	6
Study Limitations .....	13
Recommendations.....	13
Next Steps for the ECEM.....	15
Appendix A: Demographics of Focus Group Participants .....	16
Appendix B: Lessons Learned from Community Leaders and Service Providers .....	17

# Acknowledgments

This work was generously supported by the Endowment for Health of New Hampshire. We are grateful for their support, and especially for their partnership in each phase of this work.

We would like to thank the co-researchers who co-designed and co-implemented this research study, as well as co-analyzed and confirmed the research findings—this work would not be possible without your expertise and partnerships. Specifically, we would like to acknowledge: Martha Alvarado, Chief Paul Bunnell, Wanda Castillo, Amina Chiboub, Keya Doyle, Sherry Gould, Hamisi Juma, Joslyn Kuchinski, Logan Levesque, Sandra Pratt, Padmashree “Dee” Rimal, and Sandra White. We would also like to thank the Early Childhood Equity Movement advisory board for their dedication, contributions, ideas, and support of equity in New Hampshire family services, including: the co-researchers listed above, Bobbie Bagley, Eva Castillo, Lynn Clowes, Jackie Cowell, Bruno D’Britto, Karen Emis-Williams, Rute Ferreira, Pastor Junior, Meredith O’Shea, Wendy Perron, Vera Sheehan, and Patricia Tilley.

**Funded by:**



# Executive Summary

In 2021 and 2022, the Endowment for Health, community members across New Hampshire, and Child Trends worked together to form the Early Childhood Equity Movement (ECEM). The ECEM is a collaboration that aims to address and improve access to services such as early care and education, health care, and other family services (e.g., housing or SNAP/EBT) for racially and culturally diverse families in New Hampshire across three phases.

This report will detail the process and findings from Phase 1, which aimed to highlight what is working, what is not working, and what families identify as needs in accessing services. It also briefly outlines steps we are currently taking in Phase 2 to collectively create dissemination materials and considers future recommendations for Phase 3—making changes based on the lessons learned through this movement.

## Findings

Themes from the virtual conversations (i.e., focus groups) with participants emerged as either community strengths or community challenges. The following sections summarize findings across virtual conversations; however, the full report includes group-level variations across community strengths and challenges.

### Community strengths

- Families appreciated and felt relief in having access to services, particularly those that fulfilled basic needs such as the provision of food or interpretation services.
- Families with refugee status shared how coordinated initiatives led by a resettlement agency helped them navigate obtaining services and provided useful information and interpretation services.
- Families mentioned the importance of kind, empathetic, and accommodating providers in facilitating a positive experience with services.
- When families face difficulties in accessing services through the state and federal government, they can rely on family members, friends, and local churches for support.

### Community challenges

- Families shared experiences of discrimination due to their race, gender, economic status, immigration status, or English language skills. These experiences garnered mistrust in services and discouraged families from seeking out care or additional support.
- Families reported that navigating systems to access services can be confusing and frustrating.
- Services are limited and inaccessible, due to barriers such as long waitlists, exclusive eligibility criteria, and high costs for child care and health care.
- Families shared concerns about a lack of follow-up from providers and the quality of service, particularly with the accuracy of virtual health care diagnostics for their children.
- Families noted how the problems in these systems have been exacerbated by COVID-19 in recent years.

## Recommendations

The recommendations offered in this report are potential activities to promote in future phases of this movement. Our recommendations are appropriate for organizations that provide and advocate for social

services (e.g., child care, health care, housing, etc.) in New Hampshire; they are framed as opportunities for these organizations to reflect on their roles in perpetuating challenges and improving strengths, and as actions the ECEM can take to continue this movement. These recommendations align with the themes highlighted by families and co-researchers in virtual conversations, and take into consideration additional conversations with direct service providers and advocacy groups to contextualize what are feasible and necessary actions (the details of these conversations can be found in Appendix 2 of the full report).

- **Organizations should acknowledge their roles in healing or perpetuating discriminations.** The ECEM has an opportunity to engage with organizations, systems, and people in New Hampshire to address the structural and institutional racism and discrimination that continue to prevent families from accessing services and care. Organizations and agencies serving families should acknowledge the role they play in healing or perpetuating discrimination, and partner with communities to reflect upon biases, develop policies and plans to reduce biases, and implement solutions together.
- **Expand the range of services and develop supports for families.** Service agencies should work alongside ECEM to expand available slots for existing services and broaden the range of services available to additional members of the community. By focusing on achieving short-term goals, such as “braiding” funding sources, service agencies can achieve long-term changes, including increasing the number of case managers, de-siloing fragmented services, and tackling other accessibility issues.
- **Improve coordination across services and communities.** Resettlement agencies and their initiatives were a valuable source of support for immigrant families. The ECEM should continue to deepen partnerships with those agencies and push for coordinated services for all ethnic and racial marginalized groups in New Hampshire.
- **Campaign for kindness.** Kind and caring providers improved the experiences of parents/caregivers in attaining and accessing services. As the sphere of influence for the ECEM continues to grow and involve more stakeholders, an initiative of kindness can support cohesion and collaboration while ensuring that families, the centerpiece of this movement, are treated with the respect and dignity that they deserve.

## Methods

Child Trends partnered with community leaders (also referred to as co-researchers) to host virtual conversations (i.e., focus groups) with families from the following groups: African American, Arabic, Native American, Nepalese, Portuguese, Spanish, and Swahili. In total, 11 focus groups were hosted with 66 parents/caregivers from major New Hampshire cities (i.e., Manchester, Concord, or Nashua).

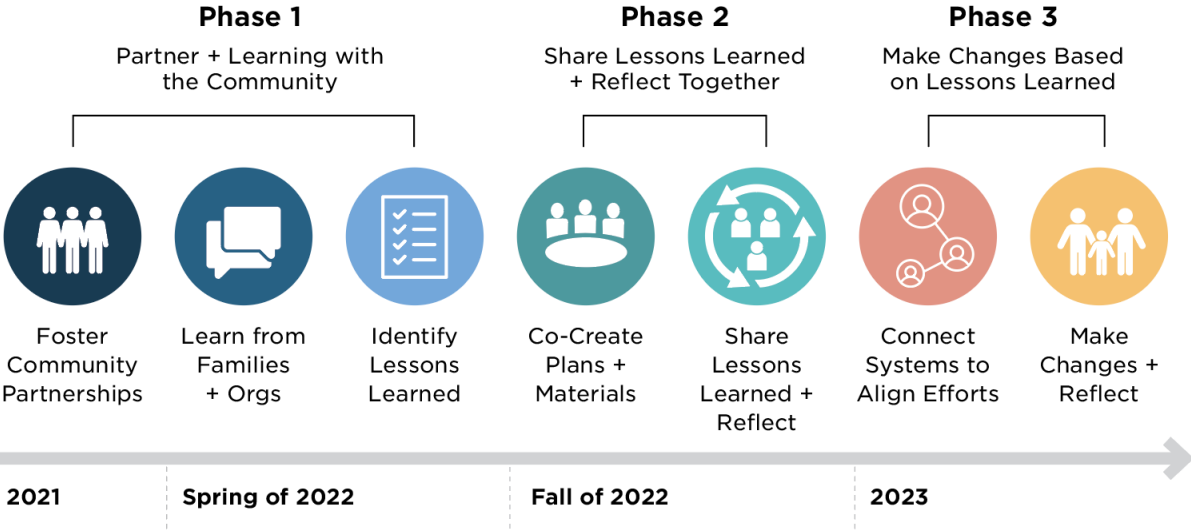
Following the virtual conversations, Child Trends collaborated with co-researchers to code the transcripts and identify relevant themes from what families shared.

# Introduction

The Endowment for Health aims to build momentum within New Hampshire communities towards collective and coordinated changes that positively impact the lives of diverse children and families. This effort addresses inequities in service delivery by talking directly with families from historically marginalized backgrounds and/or those impacted by inequitable access to or experiences with early childhood services in New Hampshire. By involving community members as learning partners, the movement grows and sustains beyond one organization. Further, this movement will encourage community members and organizations to support one another to promote the wellbeing of diverse children and families.

In 2021 and 2022, The Endowment for Health, community members within New Hampshire, and Child Trends collaborated on the Early Childhood Equity Movement (ECEM) to reimagine how to support diverse children and families within three cities in New Hampshire—Manchester, Concord, and Nashua—and with Native American tribes across the whole state. The goal of the ECEM is to improve access to services, such as early care and education, health care, and other family services (e.g., housing or SNAP/EBT) for diverse families. The ECEM is organized into three phases; see Figure 1 below. The purpose of this report is to summarize the work completed through Phase 1 (June 2022), describe lessons learned, and offer recommendations for future phases of the movement.

**Figure 1.** Phases of Early Childhood Equity Movement in New Hampshire



# Methodology and Data

Child Trends worked closely with the Endowment for Health to establish an advisory committee that consisted of Early Childhood and community leaders who were involved in multiple stages of the study. In addition to their role as advisors, community leaders (also referred to as co-researchers) worked directly with the research team to collect and analyze data.

## Participants

To identify the population for this study—families most impacted by inequitable experiences with and access to early childhood services—Child Trends employed a multi-phase approach. They held conversations with the advisory committee and reviewed data from the following sources: 1) Integrated Public Use Microdata Series (IPUMS)<sup>i</sup> using the 2019 American Community Survey to identify the birthplace of people living in Manchester, Concord, and Nashua; 2) demographic data from the New Hampshire Department of Health and Human Services<sup>ii</sup> on refugees living in the state of New Hampshire; 3) administrative data from the New Hampshire Department of Education on the languages spoken by children in the Manchester, Concord, and Nashua school districts.<sup>1</sup>

From these conversations with the advisory committee and the review from the above data sources, seven groups based on race, language spoken, or tribal affiliation emerged as those most impacted by inequitable experiences with and access to early childhood services. Co-researchers represented the seven groups that we focused on in this study: African American, Arabic, Native American, Nepalese, Portuguese, Spanish and Swahili<sup>2</sup>.

## Data collection

Eleven focus groups were conducted with a total of 66 parents/caregivers in New Hampshire from the seven groups (see Table 1 for number of participants by group). Participants for each focus group were recruited through existing relationships<sup>3</sup>. Specifically, co-researchers identified and connected the research team with parents/caregivers who they knew and met the following criteria: a) lives in Nashua, Manchester, or Concord<sup>4</sup>; b) takes care of at least one child under the age of eight; and c) has tried to navigate early care and education, health care, or other family services (e.g., housing, food stamps) within the past two years. However, because Native American tribal populations in New Hampshire primarily live outside of these cities, Native American parents were exempt from the first criteria; they could live anywhere in New Hampshire and still participate. To support recruitment efforts, Child Trends developed flyers and a one-pager in Arabic, English, Nepalese, Portuguese, and Spanish that co-researchers could share with parents/caregivers who were interested in learning more about project.

**Table 1.** Number of focus group participants (by group)

Background/Language Group	Number of Participants
African American	22
Arabic	6
Native American	5
Nepalese	9
Portuguese	5
Spanish	14
Swahili	5

<sup>1</sup> W. Perron, personal communication, March 19, 2021

<sup>2</sup> Our team recognizes that the included languages span across multiple countries and cultures. For this study, language-specific groups were open to anyone who identified as a primary speaker of the language. We also gained the perspectives of groups who primarily spoke English by including African American and Native American families.

<sup>3</sup> Except for the African American focus groups where our co-researchers experienced difficulty recruiting enough participants. In addition to existing relationships, we also recruited participants more publicly by sharing flyers via social media and community listservs.

<sup>4</sup> The only exception to this criterion were Native American parents/caregivers who could live anywhere in New Hampshire.

Focus groups lasted about 60-75 minutes and were facilitated via video platforms by 1-2 co-researchers and a member of the Child Trends research team.<sup>5</sup> Focus group questions were developed in partnership with the advisory committee, translated into Arabic, Nepalese, Portuguese, or Spanish so that the focus group could be held in the participants' native language, and slightly modified for each group to ensure the language was inclusive and relevant to parents/caregivers. Across all groups, parents/caregivers were asked questions related to their experiences accessing and using early care and education, health care, and other family services (e.g., housing, food stamps), such as how they learn about available services in their community and positive or challenging experiences they've had when using those services. At the end of the focus groups, parents/caregivers were also asked to complete a demographic survey (see the table in Appendix A for participants' demographics by group). Each parent/caregiver received a \$50 virtual or physical gift card for participating in the interview.

## Data analyses

Child Trends worked closely with co-researchers to identify key themes in the focus groups. The Child Trends research team began by developing a coding scheme based on the focus group questions. Once the codes were established, analyses occurred in two stages. During the first stage, two members of the Child Trends team coded all focus group transcripts and examined patterns across the data to identify emergent themes. At the same time, co-researchers identified main takeaways or patterns from the focus groups they had led<sup>6</sup>. Once finished, co-researchers shared their main takeaways/patterns with the two Child Trends coders who looked for similarities and/or differences between their emergent themes and the co-researchers' main takeaways/patterns. During the second stage, the two Child Trends coders met with the co-researchers from each group. In these meetings, final key themes for each group were identified by discussing the similarities in the emergent themes and main takeaways/patterns and reaching a consensus on any identified differences.

## Findings

The following section summarizes lessons learned from conversations with families. They are presented as "themes," or perceptions and experiences of families. All themes were reviewed, confirmed, or identified by community members. The lessons learned are organized into two sections: community strengths and community challenges. These two sections include themes from families' experiences learning about services, accessing services, interactions with service providers, as well as their experience with any follow-up service. We found that themes were consistent, regardless of the type of services families received, whether it was early care and education, health care, or other services (e.g., EBT/SNAP). When applicable, we note variations in how themes play out for different racial/language groups.

Not all themes were mentioned in each virtual conversation we had with families. However, a theme not being mentioned by a particular group does not necessarily mean that theme is not applicable; rather, it simply did not come up in the conversations we had with these particular families. The icons in the graphic below (see Figure 2) each represent a different group. The icon is filled with a color if a theme emerged for that particular group; otherwise, the icon is not filled.

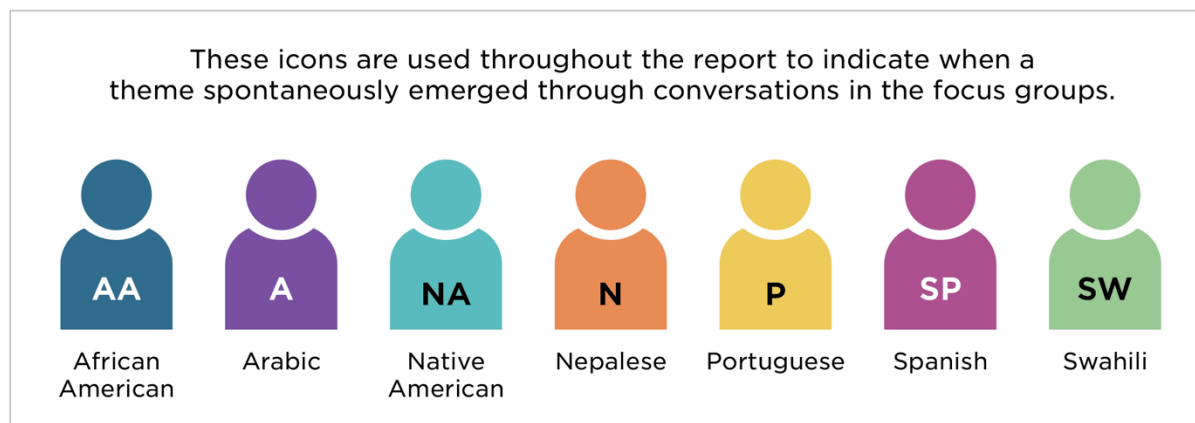
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<sup>5</sup> All co-researchers were trained to conduct human subjects research prior to facilitating a focus group.

<sup>6</sup> To facilitate this process, Child Trends provided all co-researchers with a basic training on how to identify patterns or main takeaways from qualitative data.



**Figure 2.** Background and Language Group Icon to Indicate when Themes Emerged by Group



## Community strengths

We begin with community strengths, as they are the building blocks for change. These strengths existed before, and exist beyond, any efforts of the Early Childhood Equity Movement.

### It is a relief when services and resources are available and accessible.



Families used available services and expressed a deep appreciation for those available services. Services that help families meet basic needs – such as providing food or interpretation services, afforded families some relief. This theme emerged during conversations with African American, Native American, and Nepalese families. For example, a parent from the Native American conversations relayed the following about a service in her community called ‘SHARE’:

*“They [the SHARE program] have options for a food pantry; they help with financial stuff. Every Christmas or Thanksgiving, they give out Thanksgiving and Christmas baskets. They’ll give gift cards to pick up the Christmas toys for the kids, for families that need it. They mainly help with everything that you need.”*

It’s rare that one organization or service can completely fulfill all the needs of a family, but for some families, making that one connection made all the difference and helped them find resources for their other needs. For example, a parent from the conversation with African American families shared her experience with early support services and how these services became a reliable resource in her and her son’s life:

*“My son was born at 24 weeks. And, as a result of being a premature baby in the NICU for four months, we were eligible for and referred to the Moore Center for early supports and services. And so that’s been really useful because when I have questions or I’m not sure of something ... the staff at the Moore Center... have been very helpful in ensuring that we have all of the necessary information so that we can get what we need.”*

### Coordinated, funded initiatives help families navigate complicated systems.



Families who arrive in the United States with refugee status are directed to resettlement agencies, such as the International Institute of New England. These coordinated initiatives pair the families with case

managers who then help families navigate the complex and siloed systems of support. Families who qualify report that these services are very helpful and are a great source of information for learning about other community services (e.g., early education programs, health care services, Medicaid, food stamps, cash or rent assistance, and welfare). In addition, assigning families specific service providers who offer interpretation services, as well as case managers, also helps families navigate the application process so that they can more readily receive the services they qualify for.

Among the families we spoke with the Nepalese, Swahili, and Arabic groups shared that they were paired with staff in refugee supporting organizations (e.g., International Institute of New England and the International Office at Manchester) to receive extra supports. For example, families from the Arabic speaking group shared how pivotal these initiatives were in helping them obtain services for basic needs.

*“When we first came here to the U.S.A., they [International Institute of New England] directed us first to health care place and then to each family, they assigned a primary care doctor for us. The organization helped us sign up to all the financial help, Medicaid, and food stamps.”*

### Relationships matter: Kindness and connections are appreciated and go a long way.



Almost all conversations we had with families (i.e., families from African American, Arabic, Native American, Nepalese, Portuguese, Spanish) pointed to kind and helpful providers as critical to having a positive experience with services. They described providers as helpful, accommodating, empathetic, and knowledgeable. For example, an African American parent shared that her relationship with her child’s pediatrician had been very meaningful and that losing that pediatrician as a provider was upsetting, despite still having access to the service:

*“My two kids I’ve had them with the same pediatrician for a while now, and I’ve always loved everything about her. She’s always worked with me. She’s always tried to make things as convenient with me as possible. Unfortunately, she literally just left in February and it’s like devastating to me because I have to find a new pediatrician, but if I needed anything or a resource, she would go and help me.”*

These kind and helpful providers were even more pivotal when families with limited English proficiency needed services that were fully or mostly available in English. For example, a parent from the Spanish conversation shared how Head Start staff at her son’s center put forth effort to communicate with her, which helped her to feel more welcomed:

*“When my son started Head Start people were very friendly, the teacher was also very friendly. Even though I could not speak English very well she tried to communicate with me. She was very nice. I can understand and speak English better now. Just like where my other son was last year. The staff is very nice, and they are very good teachers too.”*

### Community connections are helpful when services fail to reach families.



When families were unable to access needed resources and services through the state and federal government, they often turned to family members, friends, and churches for support. These community connections serve as a helpful resource to families who may need child care support so that they can work or need access to food in order to feed their families. Families from the African American, Native American, and Spanish conversations emphasized how these community connections have made it possible for them to be able to work or save money. For example, an African American parent shared:

*“My wife has a friend that works as a nurse in a hospital. So, I guess she's a primary source of information for her. Whenever she's curious about something or has a question or an issue she feels she needs professional advice for, she's her first go-to person... [my wife] says she doesn't really like always spending for unnecessary sessions and things like that. And she has a friend that really helped without really charging for services.”*

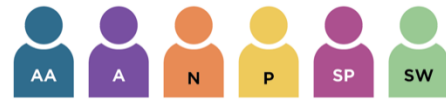
When immediate connections are limited, families sometimes rely on their networks or other trusted connections for recommendations. For example, when a parent from the Native American group had an unexpected child care interruption, the parent turned to the community for help:

*“Well, my youngest is seven, so for two years he's been in the school system, but we did have to, we need some afterschool care sometimes. Our grandparents help a lot, but we've recently had to try and find somebody in the area to help a couple days. I mean, the hospital offers to us a membership to care.com, and it does background checks and stuff like that, but for us, we actually went on the community website and just asked for people in town who they knew that needed just an extra couple bucks, who was trustworthy.”*

## Community challenges

In this section, families describe community challenges in their own words. Overall, families' day-to-day experiences appeared to be most affected by limited and inaccessible child care, although families also reported deeper rooted challenges and feelings of discrimination and mistrust within the health care system. This is not to say that families do not experience discrimination and mistrust within other systems and services; rather, in the conversations we had, families typically raised this issue during conversations about health care.

### Experiencing discrimination and mistrust creates unwelcoming environments.



The goal of equitable service delivery is to offer the actual services families need *and* to foster a sense of belonging, so that families feel comfortable using the services. Almost all the groups of families (i.e., Arabic, African American, Nepalese, Portuguese, Spanish and Swahili) we spoke with, reported experiences of discrimination due to their race, gender, economic status, immigration status or English language skills. This discrimination varied depending on the background/language of the group. For example, African American families reported direct discrimination related to race and social economic status. Whereas Portuguese and Spanish speaking families reported discrimination related to immigration status or English language skills.

A parent from the African American conversation explained how her identity, along with historical and systemic racism, have amplified discrimination.

*“Getting health care [services] is really, really annoying. So, you're trying to get more information and [inquire] about the mission of their personal services, how good it is but because I'm black, and I get discrimination even, even if I have the money to pay for this particular services.”*

Families from the Arabic, Nepalese, Spanish, and Swahili conversations reported feeling unwelcomed because of their limited English language skills since no service provider or interpreters were available to communicate with them. They also shared that they had difficulties completing paperwork like applications or understanding documents like health care bills since they are often only available in English. A parent from the Spanish conversation shared how she struggled to communicate her needs and how the staff's reaction to her communication problems made her feel unwelcome:

*“Sometimes the doctor tells you to call the doctor on duty if you have an emergency after hours and want a consultation. I have called several times and they answer in English, and I say I need to talk to the doctor*

*and ask for an interpreter and they just say, “we don’t speak Spanish” and hang up on me. I have complained to the clinic because they have done that several times. They just tell me that this is a company that answers at night. I told him, yes, but they are paid, you are paying them, and they are there to treat customers, and not like that. Sometimes it can be a more serious emergency and they just answer and tell you that they don’t speak Spanish and hang up on you, without even asking what you need.”*

Families from the Spanish and Portuguese groups discussed how discrimination related to citizenship status often discouraged them from receiving services they were entitled to. A parent from the Spanish speaking group shared that her experiences were so upsetting that she chose not to seek services at all:

*“Unfortunately, I have to say, when it comes to help... I’m legally in this country, I have all my documents but I’m not a citizen. In this case, in the assistance offices, they are very racist against people who are not from here. They do not help us. They gave me insurance for my children because I am a woman who worked, well, at least 40 hours. It is very, very difficult even for health insurance. It is quite difficult for me because many question it [citizenship status]. The truth is that [many] Central Americans do not go to seek those benefits for the reason that one is discriminated against from the start, and they tell us we are not eligible.”*

Finally, many African American fathers commented that they felt overlooked because of their gender. They shared that they felt like they were not taken seriously when they tried to access services like health care for their families because they are male.

## Systems are difficult to navigate and cause families confusion and frustration.



Families from every group we spoke to talked about their difficulties navigating complex and siloed service systems. Families reported that they felt confused and encountered difficulties during every phase of the application process which led to feeling frustrated with the system. Families were also unable to find information online and reach someone by telephone to answer their questions. In the absence of accessible services, families sometimes rely on their personal network, which leaves room for incomplete or inaccurate information. Families mentioned that the biggest issue was filling out paperwork or applications to determine eligibility for services. This process is lengthy and confusing which can delay families from obtaining services or discourage them from seeking services altogether.

For example, a parent from the Native American conversations shared that the burden of completing excessive paperwork is the reason they stopped pursuing Medicaid support:

*“We do qualify for that, but it’s similar to what [another participant] was saying. Part of the reason we don’t go that way for the kids is because there’s so much paperwork to turn in to them. It’s a lot of work for the person that’s using those services, which can be very challenging when you have little kids.”*

Without a clear understanding of the full process to complete service requirements, feelings of frustration set in towards a seemingly obscure, never-ending path. The systems are so unclear and complicated that families not only see the service requirements as a barrier but also see the system as an intentional deterrent for them to receive services. A parent from the Spanish conversation describes the emotional impact of her experience as she tried to maneuver through requirements:

*“So much paperwork is not good, it is not necessary. Sometimes they make it complicated, they don’t give you the information. They only tell you “This is what you have to bring,” and if you don’t, they close the case. Mostly, I think they make things complicated for you; the letters arrive late. I don’t even bother anymore...”*

## Most services feel out of reach as they are limited and inaccessible.



Even when families overcome the hurdle of navigating complex systems, services seem limited and inaccessible, and therefore, out of reach. Families from all the different groups reported that the services felt out of reach because of the cost, eligibility criteria and inconvenience. For example, while services are technically offered to families, there are long waitlists, especially for specialized health care and developmental services. Child care slots are also limited and make those services feel out of reach for the average family. Additionally, many times there is a mismatch between how/when services are offered and the families' needs, resulting in families not being able to receive much needed services.

When services are delayed, problems are exacerbated. For example, there is a prolonged wait time to receive learning services for families with a developmentally delayed child, and families also need an evaluation before receiving those services. The real cost of stalled services at each phase is exponential delays for children and families – developmental delays worsen over calendar years waiting for evaluations. A parent from the Native American group describes her struggle to have her son evaluated for autism, a first step to receiving services.

*"We have been on a wait list for Boston Children Hospital going on four years right now to have one of our sons evaluated for autism. We were at the top of the list a couple months ago and we keep calling back, and calling back, and calling back, and we haven't heard [anything]. The reason we chose Boston Children Hospital is because of our experience with some of the local places that are doing these assessments, children over there gets stuck on those wait list, and they're loooong wait lists."*

The cost of child care and health care services were mentioned as a recurring challenge in conversations with all families. Due to limited financial resources, families were often led to make difficult choices between core services and basic needs. For example, a parent from the conversation with African American families shared her struggle when deciding how to prioritize limited funds:

*"When my son wanted to go to school and I didn't want to be like selfish because I'm like, it's good that your kid shows an interest in school. It's an awesome thing, but I have to spend \$400. I would love him to go to school, but to spend \$400 that I don't have when it's not mandatory, I'm like, we're going to have to just set up a classroom room in the house somewhere. I want you to have the education that you want, but when you're not obligated to do it and it's like by choice, it's like who wants to spend \$400 by choice that they don't even have weekly."*

## Inconsistencies in quality of service and follow-up create worry.



Those families who manage to receive services worry about inconsistencies in the quality of those services and the follow-up to understand the progress they have made. Families from most groups (African American, Arabic, Native American, Nepalese, Portuguese, Spanish) shared this concern regarding quality and follow-up mainly around health care services. Families from the African American, Spanish, and Swahili groups expressed concerns around the quality and accuracy of telehealth services as it relates to health care diagnosis. As a parent from the African American group illustrated in the quote to follow, some health care services are appropriate to be delivered completely via telehealth without compromising in quality, while other services require hands-on examination that is not possible when done virtually:

*"I think developmentally, they've [doctors] seen my son one time on the camera since he was born, and checking-in virtually isn't, I don't think, necessarily the best way to be able to assess his development,*

*considering it's a more hands-on experience, I would say. So, I know that they have charts, and they can see his records and everything but it's a bit of a disconnect."*

These concerns are further complicated when service providers change over time. The risk of changing providers is that information may be lost along the way; ultimately this may result in a decrease in the quality of service the families receive and may end up hurting the children and families' health. As a parent from the Swahili group shared, sometimes these health problems don't surface until it's too late.

*"The other challenge is when a primary care provider refers your child to a different doctor that does not usually see him or her on a regular basis. One of the issues I've encountered is seeing a different provider and being prescribed the wrong medication. So, when you go back to your regular child's primary care provider, they'll tell you the medication you were prescribed is wrong."*

Families also shared that they start to worry when there is no follow-up after they receive services. Apart from medical emergencies, families shared that they either never received follow-ups or had to call service providers directly and multiple times to receive a follow-up. A parent from the Portuguese group shared how this lack of follow-up comes off as cold and uncaring:

*"No, they only call if I call them first. In the case of [my son] they only return calls. I do think the doctor should show more interest. Call to find out if he's doing okay, if he is going to therapy, they don't care. Only if I call to schedule an appointment, they do set it up, but besides that, they never ask how is he doing, is he going to the therapies, is he being followed up in school? No, they have never asked."*

## COVID-19 stressed already problematic systems.



The community challenges discussed above were described by families as persistent issues over time. When we were all impacted by the COVID-19 pandemic, systems that were already problematic for families were stressed even more so. Peaks in community and regional COVID-19 outbreaks, along with nationwide staff shortages, limited services available to all families. Families we spoke with from the African American, Arabic speaking, Native American, Nepalese speaking, Spanish speaking, and Swahili conversations described challenges with child care closings, extended waitlist for health care and developmental services, and difficulty reaching a real person to answer their questions. For example, a parent from the Swahili speaking group shared:

*"It was terrible during COVID. If a child had a cold, not related to COVID, they sent him home [from school]. And the child will be required to stay home for 2 weeks. And because parents had to work it was difficult to arrange for the care for those 2 weeks where a child has to stay home."*

Beyond challenges due to sickness and staff shortages, the families we spoke with also had difficulty transitioning to virtual services. Families struggled to balance child care and work with children at home. They also had problems navigating online systems, particularly those families with limited computer experience and skills. A parent from the Arabic speaking group shared her journey during the abrupt shift from in-person to virtual services, which required her to familiarize herself quickly with technology:

*"Mine [experience] was a little harder especially since I have younger kids. It was very hard on me because the applications [for services] were bigger and I had to do it all online and I was so tired, especially since I'm not used to do it all the time. It was a big challenge, but I would take it in a positive way, I learned more about the technology but for my generation I always liked paper and pen better."*

# Study Limitations

The COVID-19 pandemic has deeply affected nearly everyone's professional and personal lives. Unsurprisingly, the co-researchers and families we talked to noted the impact of COVID-19 on the use of and access to services. Similarly, the pandemic required flexibility in this research study and related activities. All co-researcher training and data collection for the study occurred virtually, which may have restricted the quality and quantity of research training and data collected. Additionally, while the co-researchers played a pivotal role in recruiting and connecting with families, it was difficult for the Child Trends team to contact and connect with families directly because we were not local to the area (which may have increased study attrition). Lastly, the pandemic also likely stretched the study timeline, adding an additional four to six weeks to our expected workplan. Recognizing the added burden to families in navigating work and family during the pandemic, we remained nimble in scheduling co-researcher and advisory board meetings only as frequently as needed and at times that matched their availability.

Our method for recruiting interview participants is another potential study limitation. We used the "snowball sampling" technique, where co-researchers are asked to identify potential participants through known contacts. While this method allowed us to connect to families more easily, it may have introduced bias in the sample. The study's participants, compared to others, may have been better connected or more involved (e.g., through connections to active community members, such as co-researchers). However, speaking to families with strong community connections may also be considered a strength of the study design, as these families may have been better able to speak to the strengths and needs of the whole community.

# Recommendations

The recommendations offered in this section are potential activities to promote in ECEM Phase 3. Recommendations align with the themes (community strengths and challenges) voiced by families and with family and co-researcher solutions offered during virtual conversations. Themes often overlapped and were interconnected, so we tried to offer holistic ideas. The recommendations align with multiple themes, addressing challenges and/or building on community strengths. These recommendations also take into consideration the full process of service delivery from the perspective of families (e.g., families' experiences learning about, seeking, and receiving services, as well as follow-up after services). Finally, we realize that challenges reported by some families are experienced nationwide due to the rippling effects of COVID-19 (e.g., labor and resource shortages). We hope the pandemic and its constraints improve soon, although we acknowledge that many of the challenges present during COVID-19 existed for families even before the pandemic.

## **Organizations should acknowledge role in healing or perpetuating discriminations**

There is a long history of racism and discrimination in the United States. Structural and institutional racism and discrimination have had, and still actively have, direct and lingering effects on the groups of families we spoke with. The ECEM has an opportunity to encourage various organizations, systems, and people within New Hampshire to acknowledge the potential role they can play in healing past inequities or perpetuating further discrimination. Organizations and agencies serving families (or those influencing policies, procedures, and systems that affect families) should partner with communities to reflect on biases, develop policies and plans to reduce those biases, and implement solutions together. Beyond bias training, organizations and agencies may consider hiring staff members whose skills and demographics reflect the community's needs, developing feedback loops to stay in touch with neighborhood needs, and creating a

task force specifically for reducing inequities across systems<sup>7</sup>. Hearing directly from communities would inform accommodations agencies can make to meet those needs. As we learned from the families we spoke with, agencies could provide interpreters during service delivery, simplify paperwork and procedures required to obtain services, and offer paperwork in multiple languages.

## **Expand the range of services and develop supports to help families navigate services**

We learned from families that services were limited and navigating systems to receive services was difficult. Service agencies should work to expand available slots to existing services and expand the range of services offered to serve additional members of the community. While this recommendation is very resource intensive (e.g., requires additional funding, staff, and facilities) there are intermediary steps and short-term goals that can advance long-term change. For example, service agencies can “braid,” or share, funding to jointly open additional slots to families. The ECEM can also be a resource in making connections across systems to strategically set and achieve shorter term goals in the effort to expand services for families. As services expand, it would be helpful to have more case managers (or trained support staff) to help families locate needed services and navigate systems. All the groups we spoke with expressed a desire for a one-stop-shop resource center, through which families could call someone directly or see a provider in-person (as a complement to the existing online resource). Families also identified many problems with accessing and using services (e.g., technology gaps, long delays, complicated processes, costs, transportation, telehealth, etc.). The ECEM can encourage service providers to partner with families to identify ways to bridge accessibility issues.

## **Improve coordination across services and communities**

Resettlement agencies, and those supporting refugee initiatives, were instrumental resources for immigrant families. The ECEM should deepen partnership with those agencies to stay abreast of community needs, new immigrant groups, and to help agencies meet the families’ strengths and needs. Ideally, coordinated services should be the standard for all ethnic and racial marginalized groups. Towards that goal, the ECEM can help agencies and organizations continue developing and deepening partnerships to increase the number of family referrals for additional services. Once a family finds a reliable service provider or organization, they often return for other needs and trust those referrals. We also learned from interviews with advocacy leaders and service providers that there is a desire to strengthen networks. ECEM can help agencies and organizations develop systems to connect and further support each other.

## **Campaign for kindness**

One of the most consistent lessons learned across all groups of families was that positive relationships with service providers matter. Kind and caring providers left lasting impressions on families and were key for whether families used and recommended services. This is important because all groups of families indicated that they learned about services through “word of mouth” within their networks. These recommendations and positive relationships with service providers were important for all families, but particularly pivotal for families with limited English proficiency, whether providers spoke the families’ native language or not. Families perceived kind providers as welcoming, and this was often the determining factor for families to use services. We recommend that the ECEM “campaign for kindness” in family service delivery. The ECEM already involves organizations and agencies at multiple levels and spheres of influence in New Hampshire, and affiliation with ECEM will increase with every phase. Kindness in family service delivery can be part of the teaming agreement or one of the mottos so that agencies and organizations can be reminded of this

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<sup>7</sup> See case study 6 as an example within health care systems

<https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf>



simple truth – kindness matters. The recommendation to “campaign for kindness” includes and extends beyond kindness so that people are treated with respect and dignity. With the understanding that service provider kindness directly affects whether families seek and use services, organizations and agencies can agree that kindness be a part of the job description for service providers. ECEM organizations and agencies should continue to hire and train staff to be as welcoming as they are knowledgeable.

## Next Steps for the ECEM

The goal of Phase 1 of the Early Childhood Equity Movement was to partner with community members, co-design and co-implement the research study, and co-analyze findings to identify potential activities to improve equity in family services in New Hampshire. Consistent with the approach in Phase 1, our dissemination stage, Phase 2, continues to employ equitable practices with co-researchers by co-developing dissemination materials in the native languages of participating families. Specifically, we are working with co-researchers to design, develop, and produce a summary of findings (i.e., one-page summaries and recorded videos in the native languages) to share with families who participated to reflect on the lessons learned. We will also cofacilitate a webinar with our co-researchers to share findings with community organizations such as advocacy organizations, service providers, and other state and community agencies. The purpose of sharing family stories and lessons learned with community organizations is to co-strategize about the supports, procedures, and systems that build on community strengths while addressing the community’s needs. Phase 3 will involve working with co-researchers to align efforts across systems, push for lasting change, and implement collaboratively designed strategies to continue the Early Childhood Equity Movement for families and children in New Hampshire.

# Appendix A: Demographics of Focus Group Participants<sup>8</sup>

Focus Group Participants by Race, Language, or Tribal Affiliation								
	African American	Arabic	Native American	Nepalese	Portuguese	Spanish	Swahili	
<b>Gender</b>								
Male	9	-	2	4	-	-	-	
Female	13	6	3	5	4	14	4	
<b>Race/Ethnicity<sup>9</sup></b>								
Black/African American	22	-	-	-	-	-	4	
White	-	5	5	-	2	2	-	
Asian	-	-	-	8	-	-	-	
Hispanic, Latino, or Spanish origin	-	-	-	-	2	13	-	
American Indian/Alaskan Native	-	-	4	-	-	-	-	
<b>Education</b>								
Eighth grade or less	-	3	-	2	-	3	-	
Some high school but no diploma or GED	-	-	1	2	-	-	3	
High School graduate or equivalent	-	-	-	3	1	7	-	
Some college	4	-	1	1	2	2	-	
Associate degree	5	-	1	-	-	-	-	
Bachelor's degree	10	3	1	-	-	1	-	
Some graduate work	-	-	-	-	1	-	-	
Master's degree	2	-	1	-	-	-	-	
Professional or Doctoral degree	1	-	-	-	-	-	-	
<b>Income</b>								
Less than \$25,000	-	1	2	1	2	6	3	
\$25,000 to \$49,999	2	1	-	2	2	6	-	
\$50,000 to \$74,999	9	-	1	-	-	1	-	
\$75,000 to \$99,999	8	-	1	-	-	-	-	
\$100,000 to \$124,999	3	-	1	-	-	-	-	
Participant didn't know	-	1	-	6	-	-	1	

<sup>8</sup> Out of the 66 parents who participated in the focus groups, two opted out of completing the survey. Additionally, some parents preferred not to answer certain questions.

<sup>9</sup> Participants were asked to select all the racial/ethnic groups that they identified with.

# Appendix B: Lessons Learned from Community Leaders and Service Providers

To gauge a high-level response to our findings from the focus group and contextualize organizational challenges in providing care, ten interviews were completed with five advocacy organizations and five service providers. The Child Trends team worked with the advisory committee to identify a mix of advocacy and family-serving organizations in New Hampshire to interview. Recruitment was led by the Endowment for Health who reached out to known contacts at each organization via email and phone calls with information about the study and the purpose of the interview. All interviews were one hour or less and were conducted in English by a member of the Child Trends research team via Zoom or phone. As with the focus groups, interview questions were developed in partnership with the advisory committee based on what families would want to know from these organizations. Questions were slightly modified based on if the organization was an advocacy organization or direct service provider; however, they mostly focused on the organization's work and participants' perceptions on the challenges that different families in their community may face when accessing or using family services, including their reactions to our initial focus group findings. Each interview participant received a \$50 virtual or physical gift card for participating in the interview.

Child Trends began the interview analyses by developing a coding scheme based on the interview questions. Two members of the Child Trends team coded all interview transcripts. Once the codes were applied, the two coders examined patterns across the data and identified key themes.

The following section summarizes lessons learned from conversations with community service leaders and service providers. These lessons are presented as "themes," or perceptions and experiences of community leaders and service providers.

## Advocacy organizations

We spoke with the directors of four advocacy organizations who had been in their role between two to five years. The groups' concerns extend across multiple domains, but the most pressing issue that they are advocating for in New Hampshire is early childhood education, especially access, affordability, and health care.

While the organizations represented here work with diverse populations, with a particular focus on recent immigrants and refugees, the composition of their membership was not uniformly diverse. Many of the organizations interviewed recognized that leadership staff did not represent the families they are advocating for and acknowledged that this is an area for improvement. However, we did see advocacy groups with a diverse membership in their committees that included members from different races and ethnicities, genders, age groups, political views, and immigration statuses. Despite a mostly homogenous membership, most of the advocacy groups shared that they have access to interpreters and the capacity to translate materials into different languages as needed to accommodate participation and community engagement across groups.

Many of the advocacy groups that were interviewed shared that they shaped their advocacy goals to the needs of the community. These organizations incorporate guidance from community members through advisory groups and encourage members to share their personal stories and challenges in legislative meetings and activist events. However, organizations explained that actual community input on the direction of advocacy campaigns was limited due to the constraints of funding. While some may try to incorporate family input in the advocacy process by soliciting feedback in surveys, recruiting community

members to participate in committees, and offering compensation for participation, to maintain funding, advocacy groups must prioritize their own agendas.

## Direct service providers

The remaining six interviews engaged several direct service providers in administrative roles that had been working in New Hampshire communities for up to 32 years. While these organizations provide support to communities in a variety of ways, their family services include afterschool programming and care, mental health services (e.g., therapy, counseling, psychiatric support), autism care and support, meals and access to food banks, case management, and overall, acting as family resource centers. According to these agencies, families most often learn about services through word of mouth, online searches and referrals from schools, medical offices, or other agencies. However, organizations also mentioned that they have outreach and advertisement campaigns that involve tabling at events, distributing flyers, and speaking on radio.

While the direct service providers aim to serve a diverse set of families, including across languages, cultures, and socioeconomic status, most explained that in their experience, New Hampshire has limited diversity which is reflected in the composition of the families they serve. However, half of the direct service providers recognized that they serve a growing population of refugees, and that the communities they work with are increasing in diversity, particularly language diversity. In addressing this growing language diversity, many of the direct service providers explained that they have agreements with on-demand interpretation services such as the Language Bank, although several direct service providers explained that they rely on informal translation methods for communication (e.g., bilingual staff, bilingual members, Google translate), at times not having funding for formal interpretation services.

A primary concern in focus groups and for co-researchers was legal eligibility for these programs. Although some organizations require members to pay for services, receive referrals for early intervention services, or require clients to have identifiable needs for service, all the interviewed organizations expressed their services are available to families regardless of legal or citizenship status. However, organizations recognized that seeking state financial assistance may be difficult for families depending on their legal status.

## Advocacy and service providers' challenges

During the co-development of the interview process, co-researchers emphasized the importance of sharing the findings from the focus groups and gauging what organizations felt are the difficulties that families in New Hampshire are facing. The following summarizes their responses, including challenges that organizations face in providing or advocating for family services, how they address these challenges, and their thoughts on the preliminary findings shared by community members during the focus groups.

### Logistical barriers to service provision

Families face logistical and systemic barriers to accessing early care and education, health care, and other family services (e.g., SNAP/EBT and housing). The advocacy organizations and direct service providers both acknowledged that social services in New Hampshire were difficult for families to access. In working within these communities, they have observed barriers in affordability (high cost of early care and health care services); financial eligibility (e.g., families just barely not meeting the income cutoff); learning about services (e.g., not knowing what services are available or how to access them); stigma around using social services, particularly in immigrant and marginalized populations; transportation (e.g., inaccessible public transportation and costly rideshare services); administrative burdens (i.e., complicated and time-consuming application processes); general housing instability; and long wait times, often caused by staffing and service shortages.

## Shifts in service delivery during COVID-19

COVID-19 negatively impacted communities but may have positively shifted the landscape for care and services. According to the organizations interviewed, the COVID-19 pandemic had definite negative impacts on the communities they serve, including issues with technological literacy as families and organizations had to suddenly shift to virtual services, an increase in mental health concerns for parents and children, and exacerbated staffing shortages with long waitlists. However, COVID-19 enabled organizations to explore strategies they intend to continue using in the future, such as telehealth and digital communication tools. These strategies have ultimately made their services more accessible, particularly for families with busy schedules or transportation issues who benefit from flexible scheduling options and diverse methods of communication.

## Limited funding makes changes more difficult

To address challenges faced by families, organizations may provide monetary resources, shift priorities in advocacy, or direct families to other services. However, the extent of their support is limited by funding. Many of the direct service providers that were interviewed highlighted their role as resource centers for families as being an additional source of support they provide outside of their usual services to address specific challenges communities face in accessing care. As resource centers, they often personally assist families with applications for aid and programming, share information pamphlets, assign families to case managers to facilitate connections, and direct them to other services. Advocacy organizations shared that they often attempt to incorporate community input in their advocacy priorities. Where possible, direct service providers and advocacy organizations both provide monetary and resource assistance to community members in their networks, including gas cards, food assistance, and case-by-case scholarship and financial assistance. However, when providing resources or shifting advocacy priorities, organizations are limited by available funding sources.

Looking ahead, organizations recognized that areas for improvement in their work may include incorporating more inclusive language practices, such as translating documents and providing information in multiple languages. Organizations also discussed the potential for increasing staff training to be more responsive to community needs, collaborating across organizations, further engaging family input in advocacy, and improving outreach presence, particularly in schools and medical offices. In order to make these changes, organizations stated they need further support in increasing staffing, breaking down silos for partnerships, and obtaining funding—in particular, by building more flexible funding streams that provide organizations with extended timelines to build relationships with communities, and additional resources to administer to families in need.

## Staff realize shortcomings in what families shared

Concerns shared by families in the focus groups were not surprising for organizations. During interviews with organizations, our team shared preliminary findings from the focus groups, including an overreliance on word of mouth when learning about services, and language barriers faced by immigrant families when accessing and applying to services. Overall, interviewees across each organization agreed with these findings. They shared that New Hampshire does not adequately cater to non-English speaking communities and has yet to find the best way to address this need. While the state has attempted to improve how families learn about services with the Welcome Families website, the burden of finding out about services still resides with families. Moreover, with staffing shortages, even if learning about services was made easier for families, the organizations we interviewed shared that they currently do not have the capacity to provide services, which would further extend their waitlist.

## Considerations based on lessons learned from service providers

To implement lasting improvements in the systems that shape the lives of families in New Hampshire, it is important to consider the context in which these organizations and service providers operate. The following summarizes overall challenges shared in the interviews:

- ***There is limited human capital to make organizational changes.*** A common theme throughout the conversations with groups and interviews with service providers and advocacy agencies was the national labor shortage and organizations' ability to provide services. Without a sufficient workforce, direct service providers will be limited in their capacity to address their growing waitlists, expand the services offered to families, or incorporate other recommendations from this brief regardless of any changes in outreach, funding, or advocacy efforts.
- ***Siloed state-level documentation and eligibility requirements enforce the administrative burdens on families and organizations.*** Families shared that excessive and inaccessible application processes for services means that they may often avoid seeking necessary services. The organizations we interviewed echoed these statements, explaining that a large part of the support they offer families involves maneuvering the application systems to attain services. As such, developing a shared system<sup>3</sup> for service eligibility and requirements across the state would relieve the administrative burden on families and reduce staff workload for organizations. We recognize this is another long-term goal that aims to change systemic operations at a state-level; however, achieving systems integration in the application process for social services will reduce redundancies and improve efficiency in providing services.
- ***Cost of care is a prohibitive factor in accessing early care and education.*** Cost is a major challenge in accessing early care and education for our families. Not only are organizations limited in their ability to provide financial assistance, but they also cannot be expected to fix every problem that community members face. New Hampshire is one of six states without government funding for universal pre-K. While they do offer state issued subsidies based on income eligibility, these scholarships are not readily accessible to all families in the community. As the need for early care and education continues to grow, New Hampshire may consider supplementing the cost of pre-K for families in the state, or invest in improving child care methods such as Friend, Family and Neighbor Care (FFN) by offering training on how to support children's learning and development and providing reimbursement for FFN to compensate time and effort.

### Suggested Citation:

Ramos, M.F., Andrews, K., Angeles-Figueroa, J., & Rodriguez, Y. (2022). Seven New Hampshire communities lead the way toward improved equity in family services. *Child Trends*. <https://doi.org/10.56417/5701q6660k>

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<sup>i</sup> Ruggles, S., Flood, S., Foster, S., Goeken, R. Pacas, J. Schouweiler, M. & Sobek, M. (2021) *IPUMS USA* (Version 11.0) [Data set]. IPUMS. <https://doi.org/10.18128/D010.V11.0>

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