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Laura MA Dysart
McMaster University, laura.dysart@gmail.com

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Factors that influence the use of an Aboriginal early learning drop-in centre by carers of urban Aboriginal children as perceived by service providers of the service, users of the service, and non-users of the service: A pilot study

Laura Dysart, B.Sc

McMaster, University

McMaster University MASTER OF SCIENCE (2011) Hamilton, Ontario (Health Research Methodologies)

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ABSTRACT

Background – Universal family drop-in centres (drop-ins) are open to all children between the ages of zero and six and their carers regardless of ethnoracial make up and socioeconomic status. Provincially-funded drop-in centres offered by Aboriginal organizations address the need for culturally sensitive services for urban Aboriginal children (UAC) meanwhile promoting early learning opportunities for all children. Knowledge of factors that influence Aboriginal carers' use of a culturally sensitive drop-in centre will inform policy-makers about the structures and resources required to ensure equitable access to drop-in centres for UAC.

Objectives – A pilot study to: 1) assess the feasibility of identifying and recruiting UAC with children between the ages of zero and six for optimal identification of the population in need of services; 2) describe the factors that influence the use of an Aboriginal early learning drop-in centre by carers of UAC between the ages of zero and six as perceived by service providers, users of the service, and non-users.

Methods – A qualitative descriptive study was conducted. A purposeful sample of 12 participants was selected. All service providers were invited to participate. Snowball sampling was used for users; convenience sampling was used for non-users. Semi-structured interviews with all participants were used to collect data. Directed content analysis was used with the Availability-Affordability-Acceptability framework for access to services to analyze interview data. Interviews between groups were compared and contrasted to confirm findings. During the research process, field notes of observations and reflections were recorded to address feasibility issues.

Results – Of the 12 eligible carers approached, 10 carers consented. Of the ten, nine carers were interviewed (4 users; 5 non-users). Recommendations for large-scale study protocol were: use of three categories of carers (current users; previous users; non-users); include non-Aboriginal carers of UAC in the sample population; recruit carers who live in the same neighbourhood where the service is located; provide detailed instructions for recruitment to gatekeepers. Key findings of the factors influencing use of the service were proximity of service to carer's home, the carer and child having unstructured time, the type of Aboriginal-based content offered at the service, the carer's trust of service providers, presence of social support, and carer's sense of safety.

Conclusions – This pilot study suggests that conducting a large-scale study to identify factors that influence the use of an Aboriginal-based universal family drop-in centre as perceived by carers of urban Aboriginal children and service providers of the service is feasible with some methodological modifications. Recommendations for change are outlined.

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DECLARATION OF ACADEMIC ACHIEVEMENT

The following is a declaration that the content of the research in this document has been completed by Laura Dysart and recognizes the contributions of Dr. Gina Browne, Dr. Susan Jack, and Dr. Stephen Birch in both the research process and the completion of the thesis.

CHAPTER ONE
Introduction

The purposes of this thesis are two-fold. Firstly, to conduct a pilot study exploring the issues that arised while identifying and recruiting carers' of urban Aboriginal children into a qualitative research study about use of an Aboriginal early years family drop-in centre to identify methodological issues in the conduct of a qualitative descriptive study. Secondly, as part of this pilot study, descriptive qualitative data will also be collected to identify preliminary factors that influence the use of an Aboriginal early learning drop-in centre from the perspective of carers of urban Aboriginal children between the ages of zero to six and providers of this service.

The introductory chapter of this thesis is a review of the literature that includes descriptions of: 1) the health status and health needs of urban Aboriginal children in Canada; 2) the divergence between the needs of carers' of urban Aboriginal children and the current and future objectives of publically funded early childhood education and care (ECEC) services; and, 3) definitions of access that will be used in this study.

The second chapter of this thesis describes the objectives of the pilot study and a description, rationale, and detailed account of the methods for the qualitative descriptive study. The third chapter of this thesis reports preliminary qualitative findings about the factors that influence carers' use of an Aboriginal early learning drop-in centre of the pilot study. The term preliminary qualitative findings is used because of methodological limitations used in the conduct of this inquiry and refers to the completed analysis of the data collected.

The final chapter of this thesis discusses the feasibility of conducting a qualitative descriptive study and lessons learned, compares the findings from the preliminary analysis with current literature about use of services by Aboriginal populations, provides recommendations for a large-scale study describing factors of use of an Aboriginal-based universal, family drop-in centre by carers' of urban Aboriginal children, and finally, reviews the methodological limitations of the study. As a pilot study, it would be premature to provide recommendations to the organization to improve access based on the preliminary qualitative findings.

Background

According to the 2006 Census, 47,000 First Nations children across Canada under the age of six live off-reserve, and Ontario is home to the largest percentage of these children across all provinces and territories (Bougie, 2010; Guevremont, 2010). For the past decade, the Ontario government has funded universal programs and services that foster early learning in children between the ages of zero and six years (Ministry of Children and Youth Services, 2010). Minimal research has been conducted exploring the factors that influence the use of a universal family drop-in centre by carers' of urban Aboriginal children [Human Early Learning Partnership (HELP), 2008]. Research exploring the needs of Aboriginal mothers shows that for many Aboriginal mothers, a culturally sensitive service is an important factor in their decision to access care [Best Start Resource Centre (BSRC), 2006; BSRC, 2010].

Objective

The objective of this qualitative descriptive study is to describe factors that influence the use of one provincially-funded universal family drop-in centre offered by an urban Aboriginal organization from the perspectives of carers of Aboriginal children and providers of this service.

Literature Review

Urban Aboriginal children in Ontario

There are approximately 1.2 million Aboriginal people living in Canada, of which nearly 700,000 are First Nations people, individuals who self-identify as North American Indian (Statistics Canada, 2010a). Ontario contains the highest percentage of First Nations people across all provinces and territories, and First Nations people comprise about two-thirds of the total Aboriginal population in Ontario followed by the Métis people [Ontario Trillium Foundation (OTF), n.d.; Statistics Canada, 2009]. In Ontario, over three-quarters (77.2%) of off-reserve First Nations, Métis, and Inuit people live in urban areas (OTF, n.d.). In Canada, approximately 9% of the Aboriginal population is under the age of four, almost double the percentage of the non-Aboriginal population, and Aboriginal children comprise 5.5% of all children in Canada (Butler-Jones, 2009; Statistics Canada, 2008a). Of the First Nations children under the age of six living off-reserve, 78% live in urban areas (Statistics Canada, 2008b).

There is a paucity of research examining the health needs of urban Aboriginal people and, in particular, urban Aboriginal children (Browne, MacDonald, & Elliott,

2009; Health Council of Canada (HCC), 2011; Wilson & Young, 2008; Young, 2003). In 2003, the House of Commons published a report on the challenges faced by urban Aboriginal children in Canada as expressed by individuals providing health, social, educational services to carers of urban Aboriginal children. The principle challenges identified were the over-representation of urban Aboriginal children in the child welfare system, and high rates of school drop-out (Longfield & Godfrey, 2003). Indeed, provincial and territorial annual reports between 2000-02 show that 40% of children living in out-of-home care during that period were Aboriginal and it has been estimated that in 2003, there were nearly three times the number of Aboriginal children in the care of child welfare authorities than there were in residential schools during the height of their operation (Blackwood, 2003 as cited in Blackwood & Trocmé, 2005; Farris-Manning & Zandstra, 2003). Children under government care are more likely to enter the correctional system and to not complete high school (CBC News, 2008 as cited in Browne et al., 2009).

The health-related issues identified by the House of Commons report and a scoping review examining the needs of Aboriginal people identified high levels of infant mortality and infant disability, such as Fetal Alcohol Syndrome and Fetal Alcohol Effects, among urban Aboriginal children (Carter, 2004; Longfield & Godfrey, 2003). In a scoping review of the health of urban Aboriginal people (National Aboriginal Health Organization, 2009) confirmed previous reports of the high levels of Aboriginal children in the child welfare system and infant mortality in urban Aboriginal children. In the Aboriginal Children's Survey, self-reported health of urban Aboriginal children up to the

age of 14 was near that of the non-Aboriginal population (Aboriginal Children's Survey as cited in Browne et al, 2009). Regardless of self-reported health status, urban Aboriginal children were more likely to experience an injury requiring medical attention, require hospitalization for acute lung infections and are less likely to have access to a doctor than their non-aboriginal counterparts (Browne et al, 2009; Canadian Institute for Health Information & Canadian Population Health Initiative, 2004; Guevremont & Kohen, 2007; Trocmé et al., 2005).

Discussion about the health of urban Aboriginal children in the literature predominately focuses on the intersecting social determinants of health that put urban Aboriginal children at greater risk for experiencing current and future detrimental health outcomes. The social determinants of health are the living conditions that influence the health of individuals. There are 14 social determinants of health: income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety net, heath services, aboriginal status, gender, race, and disability (Mikkonen & Raphael, 2010). In 2005, the Health Council of Canada reviewed how Aboriginal people in Canada experience multiple challenges associated with various social determinants of health including poverty, housing, income, and education. As identified above, one of these 14 social determinants of health is being Aboriginal (Mikkonen & Raphael, 2010). Being Aboriginal is associated with a lower health status (Garner et al., 2010). For example, Aboriginal people living off-reserve experience systematically lower health status compared to their non-aboriginal counterparts, regardless of socio-economic

status and health behavior (Tjepkema, 2002). In addition to the traditional social determinants of health discussed in mainstream reports (Heath Council of Canada, 2005; Mikkonen & Raphael, 2010), Browne et al. (2009) identified specific social determinants of health that are associated with urban Aboriginal people, such as the ongoing effects and implications of colonialism, violence against Aboriginal women, and the role of Aboriginal Health Centres to provide culturally-sensitive services.

Urban Aboriginal children and their carers face multiple challenges associated with the social determinants of health. Almost half (49%) of First Nations children living off-reserve come from low-income families (Statistics Canada, 2008b). They are also more likely to live in a lone parent household than non-Aboriginal children and 27% of First Nations children living off-reserve have mothers who are between the ages of 15 and 24 (Statistics Canada). More than half (57%) of Aboriginal women living off-reserve have attained high school education and the average income of Aboriginal women living in urban areas is 72% of the average income of non-Aboriginal women (Mikkonen & Raphael, 2010). Aboriginal people living in urban areas are four times more likely to experience food insecurity and to live in overcrowded housing than non-Aboriginal people (Mikkonen & Raphael; Statistics Canada, 2008a). Urban aboriginal children are also more likely to live in poor neighbourhoods and have limited access to primary care services and high quality public services (Browne et al., 2009; Richards, 2001). Aboriginal people in urban settings also face social exclusion and social isolation due to discrimination and racism (Jaccoud & Brassard, 2003; Newhouse, 2003). However, this

thesis is focused on the importance of the early years as this determinant coexists with many others in the Aboriginal population (McCain & Mustard, 1999).

The importance of the first six years of life

Early childhood development refers to the brain and biological growth that occurs from conception to age six (Maggi et al., 2005). Research suggests that the social environment and personal experiences during this period shape or influence key biological systems that will produce long-term consequences on health, well-being, learning, and behaviour (Center on the Developing Child, 2010a; Hertzman & Boyce, 2010). Furthermore, research suggests several models in which exposures and experiences accumulate over the course of an individual's life to influence their risk for developing ill health and may influence the socioeconomic gradients in health observed across populations (Ben-Shlomo & Kuh, 2002; Davey-Smith, 2007; Hertzman & Boyce, 2010).

The first model describing how early childhood affects later health experiences is a cumulative one in which exposure to risk factors have an additive effect over the course of an individual's life to put them at risk for developing ill-health (Davey Smith, 2007; Hertzman & Boyce, 2010). These exposures can be correlated, such as chronic poverty, or they can be independent in nature, such as early-life socio-economic status and adult health-related behaviours, like drinking and smoking (Davey Smith; Hertzman & Boyce). Research using cohort data collected in the UK from the late 1940s and late 1950s suggests that all-cause mortality and broad cause-of-death groups like cardiovascular

mortality act in a cumulative manner (Davey Smith et al., 1997). A subcategory of the cumulative model known as clustering, similar to the pathway model (Hertzman & Boyce), describes risk factors that are related in a dependent manner so that presence of the first exposure increases the likelihood of subsequent exposures (Davey Smith; Hertzman & Boyce). The second model describing how early experiences influence later health is a critical period or latency one in which an exposure must occur during a certain period of time, often during fetal development, to produce permanent developmental changes (Davey Smith; Hertzman & Boyce).

The role of high quality early child education and care

Early childhood education and care (ECEC) refers to "an integrated, multifunctional approach to policies and services that is inclusive of all children and parents, regardless of employment or socio-economic status" (Friendly & Browne, 2004, p. 1). High quality ECEC is considered by some an additional social determinant of health because it works to prepare children for school, reduce problem behavior, promote cognitive development and social competence, and introduce good health-related habits in young children (Canadian Nurses Association, 2005). Research has shown that high quality ECEC services produce positive effects that persist into later life, especially, but not exclusively for low-income children (Anderson et al., 1994; Espinoza, 2002; Masse & Barnett, 2003 as cited in Friendly & Browne, 2004; Osborn and Millbank, 1987). They also benefit communities if they involve children from diverse populations by teaching tolerance and acceptance of differences (Friendly & Browne).

The Harvard University Center on the Developing Child (n.d.) lists six characteristics for an effective ECEC service: 1) qualified and appropriately compensated personnel; 2) small group sizes and high adult-child ratios; 3) language-rich environment; 4) developmentally appropriate "curriculum"; 5) safe physical setting; and, 6) warm and responsive adult-child interactions. In addition to these six characteristics, high quality ECEC services should be able to respond to diverse populations, including children with disabilities, and support carers in a variety of ways (Friendly & Browne, 2004).

From a review of the literature on family drop-in centre programs, the University of British Columbia's Human Early Learning Partnership (HELP, 2008) lists five aspects of program effectiveness: 1) curriculum and pedagogy; 2) daily schedule and routine; 3) use of physical space; 4) accessibility; and 5) child-child and child-adult interactions. While there is little research examining what constitutes an effective early childhood program for multiethnic and aboriginal populations (Greenwood, 2004; Pascale, 2009; Takanishi & Bogard, 2007), Letourneau et al. (2005) found that low-income urban Aboriginal carers had less verbal interaction with their children than low-income non-Aboriginal carers. Nevertheless, Letourneau et al. concluded that the overall interaction quality was not different between the two groups (Letourneau et al., 2005).

Culture plays an important role by influencing concepts of best practice (Ball, 2003) and quality of care (Greenwood, 2004). Euro-western early childhood programming designs may not incorporate the beliefs and values of children and carers from culturally diverse backgrounds and Aboriginal groups (Greenwood). For example, early childhood programs designed and implemented by aboriginal communities include

the characteristics of holism (support of the body, mind, and spirit of children), ecological contextualism (culturally safe, socially supportive communities for families), community specificity, and integrated program delivery (Ball, 2003).

Who is responsible for providing services for urban Aboriginal children?

In Canada, four departments of the federal government are responsible for providing early learning services for Aboriginal people: the departments of Health Canada, Human Resources Development Canada, Indian and Northern Affairs, and Public Health Agency of Canada. However, there are jurisdictional issues that complicate matters concerning how services are provided to Aboriginal people living off-reserve (Browne et al., 2009; McCain, Mustard, & McCuaig, 2011). In his 2009 report on the state of public health in Canada, the Chief Public Health Officer Dr. David Butler-Jones stated: "…public policy that incorporates the lifecourse approach can be considered 'prevention policy', identifying opportunities for creating ideal conditions for health and wellness at critical points across the lifecourse" (p. 9). The federal, provincial, and territorial "Early Childhood Development Agreement" was introduced in 2003 to promote health, strengthen early childhood development, and support all Canadian families and communities to access early childhood care (Butler-Jones, 2009).

In the 2003 House of Commons report on urban Aboriginal children's needs, the first recommendation was for the federal government to designate a government department to be responsible for coordinating programs between all levels of government for Aboriginal people, both on- and off-reserve. A multi-government approach was also

supported by front line service providers to Aboriginal communities from across the country in the 2011 Health Council of Canada report "Understanding and Improving Aboriginal Maternal and Child Health in Canada." Front-line service providers felt that federal, provincial, and territorial governments should work together to provide funding, policy development, education and knowledge dissemination to support community development and capacity building (Health Council of Canada, 2011).

In their report to the World Health Organization (WHO), Maggi et al. (2005) argue that the broad socio-political environment and social policies of a developed country can directly and indirectly influence early childhood development. By maintaining systems of socio-political and health inequality, the government continues to expose certain populations, such as the Aboriginal people of Canada, to poverty meanwhile limiting the resources available to these populations to create programming that will support healthy early childhood development in their children. Indeed, the 2003 House of Commons report learned that funding for the Aboriginal Head Start program was not indexed, which resulted in the inability of the current programs to supply services while paying for the rising costs of resources caused by inflation.

Focusing on the public policies that influence children's health in Canada, Raphael (2010a) outlines several social determinants that directly and indirectly influence children's health. For example, for the issue of food security, not only does he recommend the development of poverty-reduction policies and the promotion of healthy food policies, he also argues for providing affordable housing and affordable child care. Family policies, including policies in the development of available, quality ECEC, along

with economic security policies, are the primary public policy domains that influence early childhood development (Raphael, 2010a).

In the WHO's 2008 report "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health early childhood development and ECEC were incorporated into a larger framework about social inequities and health inequities across the lifespan. One example provided was the issues of gender socialization and gender bias that starts at the beginning of life (including its influence on the presence and accessibility of maternal education to marginalized and at risk populations) and is associated with the long-term development and health of girls (WHO). The WHO argues for a continuum of care provided through a multi-sectoral approach that includes producing equitable social policies, and providing accessible social programs, public health programs, and health care services to the entire population (WHO).

What should early childhood education and care services for urban Aboriginal children look like?

The Best Start Resource Centre, an Ontario government funded program to support service providers in the production of what was thought to be components of an effective health promotion programs for carers of newborns and young children. The Best Start Resource Centre has published two documents about how to provide care for Aboriginal mothers and children for non-Aboriginal service providers [Best Start Resource Centre (BSRC), 2006; BSRC, 2010]. From a review of the literature, key

informant interviews with Aboriginal service providers and Elders, and focus groups with Aboriginal parents and carers, the authors defined Aboriginal early learning, outlined strategies for service providers working with Aboriginal carers, and described factors that were important for Aboriginal parents and guardians (BSRC, 2006; BSRC, 2010). Aboriginal early learning is holistic and is involved in the development of the intellectual, physical, emotional, and spiritual aspects of an individual (BSRC, 2010). To provide care to Aboriginal families requires an understanding of the history of colonialism and oppression against Aboriginal people in Canada, the concept of health and well-being for Aboriginal people, and knowledge of culturally-based approaches to parenting (BSRC, 2006; BSRC, 2010). Regarding carers of urban Aboriginal children, non-Aboriginal service providers were told to recognize the diversity in the types of relationships urban Aboriginal people have with their culture as well as the isolation that an urban setting may foster (BSRC, 2006). It also warned against "Pan-Indianism" which is an erroneous assumption that all Aboriginal people come from the same, or even a single, culture (BSRC, 2006, p. 40).

Based on research about early childhood education and care services in remote and rural Aboriginal communities, Ball (2009) recommends that supporting family wellness is the pathway to supporting a child's health and development. Identifying the needs of the community takes place through the integration of community services and the collaboration of service providers. By working together, they can identify needs, goals, and service history of children and carers – leading to continuous and better coordinated services (Ball).

One of the recommendations made by the 2003 House of Commons report on the needs of urban Aboriginal children was that Aboriginal service providers should play an integral role in program development, implementation, and evaluation. By including Aboriginal service providers and communities in the development of programming for urban Aboriginal children and their carers, they are able to produce programs that are designed and provided in a way that aligns with the cultural values and beliefs of the community (Greenwood, 2004). Indeed, culturally sensitive programming is an important characteristic to appropriate services for many Aboriginal people (Browne et al., 2009; Health Council of Canada, 2011).

Current early childhood education and care services for urban Aboriginal children in Ontario

There are three publicly-funded ECEC services that target urban Aboriginal mothers and children between the ages of zero and six in Ontario. The Canada Prenatal Nutrition Program (CPNP) is a community-based program, funded at the federal level and delivered through the Public Health Agency of Canada (PHAC). The CPNP is a program for socially disadvantaged mothers, irrespective of their Aboriginal status. It can be accessed by off-reserve Aboriginal mothers and Health Canada offers a separate stream of funding for on-reserve Aboriginal mothers. When applied to Aboriginal mothers, its goal is to improve the nutritional health of pregnant Aboriginal women and Aboriginal mothers and infants, reduce the incidents of unhealthy birth weights, and promote and support breastfeeding (PHAC, 2011a).

Aboriginal Head Start in Urban and Northern Communities (AHSUNC) is another federally funded community-based program delivered by the PHAC (PHAC, 2011b). It is a pre-school for Aboriginal children between the ages of 2 and 5 years and designed to prepare children for school, promote and support the role of parents and guardians as teachers and carers in children's lives, and foster a sense of community (PHAC, 2011b).

Provincial jurisdictions also fund, coordinate and deliver health promotion and early childhood education programs to their local populations. Within Ontario, the Ministry of Children and Youth Services coordinates the Aboriginal Healthy Babies and Healthy Children (AHBHC), which is part of the Ontario government's interdepartmental Aboriginal Healing and Wellness strategy (Ministry of Community and Social Services, 2011). It is provided by the Ministry of Children and Youth Services and it targets Aboriginal mothers and children between the ages of zero and six years. Its goal is to support healthy development in infants and children until the age of six, connect carers with appropriate community-based services related to healthy early childhood development, and to support new parents primarily through a mixed model of home visiting that incorporates both paraprofessional home visitors and public health nurses (Ministry of Children and Youth Services).

However, the CPNP, AHSUNC, and AHBHC were government programs that began in the mid- to late-1990s. Since then, an important report published in 1999 by the Ontario government has influenced the type of ECEC services that are currently being funded by the Ontario government.

The role of The Early Years Report in shaping early childhood education and care services

The 1999 report "The Early Years: Reversing the Real Brain Drain" by Hon. Margaret Norrie McCain and Dr. Fraser Mustard played a significant contribution in the discussion of policy and programming for early childhood development in Ontario and subsequently around the world. In their report, McCain and Mustard (1999) interpreted the work of Doug Willms who, using data collected from the National Longitudinal Survey of Children and Youth (NLSCY), created a "vulnerability index" for four and five year-olds. The index was created from the results a Peabody Picture Vocabulary Test as a measure of learning, and carer accounts as a measure of behaviour. According to McCain and Mustard, Willms examined the percentage of "vulnerable" children in each family income group categorized by quartiles and found that despite having the greatest proportion (36%) of "vulnerable" children in the lowest quartile of family income, "vulnerable" children could be observed in all the quartiles (between 22% and 28%) (McCain & Mustard, 1999, p. 92). In other words, children are at risk of persistent learning and behavioural issues that may influence their educational achievements later in life regardless of family income. McCain and Mustard (1999) reasoned that because of the size of the affluent class (i.e., three quartiles of children vs. the lowest quartile of children) early childhood education programs should be available for all families regardless of income-level.

One of the initiatives that the 1999 report spawned in Ontario was the development of the Ontario Early Years Centres.[1] The Ontario Early Years Centre (OEYC) is a universal family drop-in centre for children between the ages of zero and six years and their carers. The goals of the program are to prepare children for school and create a safe environment for the community. It functions by providing both carer/parent and child-oriented programming services, connecting carers to community-based programs, monitoring current services, identifying gaps in the need for services, and then providing those services to the community (Ontario Early Years Centre Program Orientation and Resource Guide, n.d.).

One of the benefits of a universal ECEC service is that it can support infants and adolescents with unrecognized or hidden risk factors for mental health and developmental issues (Browne, 2004). However, research in health care has shown that individuals who utilize a service are not always those who could most benefit from its use (e.g., Eyles et al., 1993; Newbold et al., 1995). Despite being a universally available service, carers and

[1] The Ontario Early Years Centres were developed in direct response to the 1999 Early Years Report (Norrie McCain & Mustard, 2002). Since then, the Ontario government has implemented several universal ECEC services: The Best Start Plan in 2005, which did not pass the initial pilot project stage because of discontinued funding; Parenting and Family Literacy Centres offered by the Ministry of Education, and in 2010, the full-day early learning kindergarten (Health Nexus, 2007; Pascale, 2009). Currently, the Ministry of Children and Youth Services is in the process of developing Child and Family Centres (Ministry of Children and Youth Services, 2011).

children from different socioeconomic backgrounds may not respond similarly to the same intervention or have universal accessibility (Birch, 2010). Indeed, as discussed above, many Aboriginal carers prefer to use culturally sensitive services. Without identifying the population who would most benefit from use of OEYCs, providers risk implementing "inappropriate care," which reduces the effectiveness of the program (Lavis & Stoddart, 1994). Furthermore, with limited space, staff, and materials, OEYCs become a more efficient use of resources when those who could most benefit from its use are using it because the same quantity of resources will be producing greater improvements in the outcomes of interest in the population (Lavis & Stoddart).

In 2008, HELP released an evaluation of the then pilot program StrongStart BC, a provincially funded school-based family drop-in centre program in British Columbia. It used a similar model as the OEYC of play-based learning and was staffed by early childhood educators just like the OEYCs. Carers who participated in the program reported improvements in their child's communication, learning, social, physical, and emotional development. Benefits carers obtained from attending the drop-in centre included: developing new parenting skills (e.g., how to discipline), learning how to build routines and speak to their children at home; learning how to play with children for learning; developing social networks; increased understanding of ages and developmental stages; enhanced child-carer attachment; and, connection to other cultures and services in the community (HELP).

The evaluation identified Aboriginal carers as a hard-to-reach population, stating that while half of the drop-in centres were located in neighbourhoods with high

Aboriginal population, there was still low, and irregular attendance by them (HELP, 2008). One of the limitations of the evaluation was the under representation of multicultural carers of children providing feedback. Furthermore, Aboriginal carers who did participate in the evaluation stated that they were more comfortable attending special events and programs exclusively for Aboriginal carers that took place outside of centre hours (HELP, 2008). The recommendation of the report to improve attendance by carers of Aboriginal children was to collaborate with Aboriginal leaders and Aboriginal agencies to produce culturally sensitive programming.

Access to early childhood education and care services

The results of a large (N = 3008) online consumer panel of parents from across Canada found that 59% of mothers and 47% of fathers felt that universal drop-in parenting resource centres like the OEYC were very important; however, only half of mothers and 37% of fathers felt that it was available to them, and only 36% of mothers and 38% of fathers actually used them (Crill Russel et al., 2011). This same report also reported barriers to the use of programs, citing the results from previous research conducted by Invest in Kids' Foundation. Barriers were categorized as: logistical (geographical/registration process too difficult); interest (lack of appeal); experience (negative perceptions); work/family (not having enough time or energy); and, father-specific (father not feeling welcome) (Crill Russel et al.). Both mothers and fathers of children 5 years of age and younger listed high cost, inconvenient times of programs, lack

of interest, and lack of time to take part in local programs as the top four barriers to use (Crill Russel, et al.).

However, there are limitations to the Crill Russel et al. study. All participants of this report were part of an online consumer panel, which was voluntary to take. The survey was 34 minutes in length, and available in English and French only. Eight-five percent of participants were married or common-law, and over half of partnered fathers (58%) and mothers (54%) had college degrees. Furthermore, demographic information about the race, ethnicity, and primary language spoken at home were not reported.

The theoretical perspective: Health economics, welfare economics

Health economics is the discipline of economics applied to the issue of health (Mooney, 1986). It is grounded on the fact that there is scarcity of resources (Culyer, 1985). As a result, decision-makers in both the government, and in community-based organizations, must make decisions about how those resources are to be allocated. Every decision made is associated with the sacrifice of the benefits that could have been received by an alternative use of those resources (Mooney).

The purpose of health economics is to achieve efficiency, which refers to getting the most out of the resources that are available (Culyer, 1985). The branch of welfare economics defines efficiency using the concept of economic welfare, which is a value-laden judgment made by society that encompasses our values about standard of living (Culyer). In economic welfare, efficiency is determined by the pareto criterion which states that there is efficiency when resources are distributed in such a manner that

reallocating them would result in the increase in economic welfare of one person at the expense of another person (Laidler, 1974). A situation where efficiency has been attained is considered a pareto optimal situation (Laidler). Efficient allocation of resources is achieved by ensuring that the value of what is being produced by using available resources in one particular way is greater than the value of what is being produced by alternative uses of the same resources.

With respect to programs, interventions, and services, efficiency can only be achieved if that program, intervention, or service is an effective one (Gafni, 2011). Effectiveness refers to the evaluation of benefits and risks to clients of an intervention when compared with other interventions to deal with the same issue (Gafni). As a result, knowing who most benefits from use of the program, intervention, and service, becomes important not only from a clinical or health perspective, but also from an economic perspective for the purpose of achieving efficiency.

Equity is a value-laden term that refers to situations where, because of societal values, we deem them to be unjust (Birch & Abelson, 1993). In health economics, the issue of equity influences concepts of efficiency by influencing the distribution of resources across a population so that it is not only efficient, but it is also just (Mooney, 1986). Welfare economics is the theoretical perspective used in the following study.

Access to early childhood education and care services to reduce health inequity

A major health policy goal is to ensure that there is access to care to reduce health inequities, defined as the unfair and/or preventable differences in health status in a

population (Commission on the Social Determinants of Health, 2008). Articles and reports that examine the impact of the early years on life-course trajectories generally include a recommendation of access to quality early childhood education and care services (e.g., Butler-Jones, 2009; Centre on the Developing Child, 2010; Commission of the Social Determinants of Health, 2008; Hertzman & Boyce, 2010; Ministry of Children and Youth Services, 2010b; McCain & Mustard, 1999). Therefore, improving accessibility to universal family drop-in centre services to urban Aboriginal communities could also contribute towards the reduction of health inequity in Ontario.

There is a growing movement in support of universal ECEC programming over targeted programming under the rationale that the majority of "vulnerable" children in Canada are not from low-income families (Raphael, 2010b). However, research examining universal services shows low turn-out of carers of Aboriginal children to these services. Based on multiple reports stating the importance of culturally sensitive services for carers of Aboriginal children and previous research examining utilization patterns of health care services, universal ECEC services provided by mainstream organizations may not be as accessible to carers of Aboriginal children as targeted programs for Aboriginal populations.

Definition of access as individual empowerment to use services

There is no universally accepted definition of access in the literature. However, feeling empowered from the use of services is important for Aboriginal carers (BSRC, 2006). Empowerment at a family level includes carers' involvement in identifying their

strengths and service needs (BSRC, 2010). Furthermore, results from the evaluation of the StrongStart BC family drop-in centre program reinforce the fact that regardless of whatever barriers to use that may or may not exist, use of the program by carers of Aboriginal children was influenced by their comfort, or empowerment, to use the program (HELP, 2008).

The AAA framework proposed by McIntyre, Thiede, & Birch (2009), which incorporates the theoretical perspective of welfare economics, defines access to health care as "the *empowerment* of an individual to use health care and as a multidimensional concept based on the interaction (or degree of fit) between health care systems and individuals, households, and communities" (McIntyre et al., 2009, p. 179). The three dimensions of access in this framework are availability, affordability, and acceptability. Availability refers to factors that influence the degree of fit between the supply of services and the demand for those services made by the population in need of service. The supply of services refers to whether the location of the service, the hours of operation, the days of operation, and the type, quality, and the quantity of service fits the needs of the population. It also includes the ability and willingness of service providers to supply these services in the way that will meet the demand by the population in need. Affordability refers to the full cost of using a service and in relation to the family budget. Acceptability refers to factors that influence the degree of fit between the expectations, attitudes, beliefs, and preferences of the individual and the service providers (McIntyre, et al.). These dimensions of access can interact to produce overarching factors that influence use of a service.

The AAA framework was designed for use in health care service research so need is defined as "the capacity to benefit among similar individuals with the particular condition" (McIntyre et al. 2009, p. 180). The effectiveness of the service is determined by its ability to improve health-related well-being; however, in the case of preventative and palliative care services where no treatment exists, the effectiveness of the program is based on its ability to enhance peace and comfort (McIntyre et al.). This framework will be adopted to describe and understand accessibility to universal ECEC programs by carers of urban Aboriginal children through the perceptions of carers of urban Aboriginal children between the ages of zero and six and service providers of the ELDC.

However, there is little published research available that uses this framework to describe factors that influence access to a community-based health promotion program (Chuma et al., 2010a, Chuma, Okungu, & Molyneux, 2010b, Kruk et al., 2010). The three studies that have used this framework were conducted in developing countries (Chuma et al., 2010a; Chuma et al., 2010b), and one study only explored the dimension of "availability" outlined in this framework (Kruk et al., 2010). Furthermore, all three studies used a mixed-methods approach to data collection, including focus groups, surveys, semi-structured interviews, and in one instance, geographic information system coordinates (Chuma et al., 2010a; Chuma et al., 2010b; Kruk et al., 2010). This study would be the first to be conducted in a developed country using a qualitative research design.

In Summary

There is a growing population of urban Aboriginal children in Ontario about whom there is little empirical research exploring their health status and health needs. More disturbing there is a dearth of research on the interventions or programs that are known to be effective in addressing or preventing the problems of Aboriginal children and carers. Research on the social determinants of health suggests that urban Aboriginal children are an at-risk group who are more likely to experience poverty, food and house insecurity, social exclusion, and social isolation. Furthermore, research on early childhood development suggests exposure to these determinants put urban Aboriginal children at greater risk of experiencing detrimental health and well-being in the future.

Based on the experiences of service providers for Aboriginal children, Aboriginal communities, and Aboriginal carers, services for Aboriginal people should be culturally sensitive and recognize the culturally-based definitions of health, parenting, and early learning in which many Aboriginal people believe. However, there has been a movement towards the funding of universal early childhood education and care services in Ontario since the 2000s. In the evaluation of a universal early childhood education and care program in BC (HELP, 2008), researchers found low turn-out of Aboriginal families, suggesting that a universal model may not be as accessible as targeted programming for urban Aboriginal families because it does not incorporate the culturally sensitive programming which many carers of Aboriginal children seek from services.

Research Questions

Urban Aboriginal people are predominately located in the Southern regions of Ontario, particularly in the cities of Hamilton, Greater Toronto, Ottawa, London, and Windsor, which contain a considerable number of urban Aboriginal people (OTF, n.d.). Of these cities, Hamilton and Toronto are the only ones to have an Aboriginal organization offering an OEYC (Ministry of Children and Youth Services, 2010). The percentage of the population in both Hamilton and Toronto living below Statistics Canada's low income cut-off is greater than the average percentage in Ontario as a whole (OTF, 2008a; OTF, 2008b). However, the percentage of Aboriginal people living in Hamilton is around three times the percent living in Toronto (approximately 1.5% versus 0.5%) (OTF, 2008a; OTF, 2008b).

The organization delivering the early learning drop-in centre under investigation is a licensed non-profit charity that offers Aboriginal-based early childhood programming in Hamilton, Ontario. It operates an AHSUNC, a daycare program for all children between the ages of 2.5 and 5 years, and it also operates an OEYC known as the Early Learning Drop-in Centre (ELDC). This centre offers programs using two modes of service delivery: a drop-in centre and a mobile, and outreach program. The ELDC is open to all children between the ages of zero and six years and their carers, and provides the same mandated services as all other OEYCs except that it incorporates the Ojibwe and Mohawk languages and cultures into its programming. In addition, the outreach program visits mainstream OEYCs located throughout the city and offers aboriginal-based storytelling and song sessions.

The research questions guiding this pilot study were: 1) Is it feasible to identify and recruit purposeful samples of carers of urban Aboriginal children?; 2) What are the factors that influence the use of an Aboriginal early learning drop-in centre by carers of urban Aboriginal children as perceived by carers of urban Aboriginal children between the ages of zero and six who use this service, those carers who do not use this services, and service providers of this service.

Relevance

The relevance of the research questions are as follows: the reason for the identification and recruitment question is because vulnerable populations, including Aboriginal women, and low-income mothers are known to be hard-to-reach populations (e.g., El-Khorazaty et al., 2007, Black, 2009; Yu, 2009). Furthermore, ethnic mobility, the phenomenon by which individuals and families experience changes in their ethnic affiliation, have influenced the growing urban Aboriginal population observed in Canada (Guimond, 2003). According to Guimond (2003), there are two types of ethnic mobility: intergenerational mobility and intragenerational mobility. Intergenerational mobility occurs to children with parents of different ethno-cultural backgrounds who may be identified by two or more ethno-cultural identities. It has been suggested that 41% of ethnic drifters are North American Indian children of mixed heritage. Intragenerational mobility occurs with changes to self-identification over time, influenced by personal circumstance, socio-political events, and the introduction of policy and legal decisions, such as the 1985 amendments to the Indian Act (Guimond). Intragenerational mobility is

believed to have contributed to the 60% growth observed in the urban Aboriginal population in the last two decades.

There is little known research exploring the differences between different forms of Aboriginal identification. One study that explored income gaps that categorized Aboriginal people into three groups (registered; self-identified; Aboriginal ancestry) found that all three groups had a statistically significant lower income than their British-origin counterparts, suggesting that even those who do not self-identify as Aboriginal but who have Aboriginal ancestry have not fully assimilated into mainstream society (Pendakur & Pendakur, 2011).

Due to the anticipated difficulty in accessing this population for research purposes, the first purpose of this pilot study was to determine the feasibility of completing identifying and recruiting carers of urban Aboriginal chidlren. The second purpose is to describe factors that influence utilization to a universal, Aboriginal-based family drop-in centre by carers of urban Aboriginal children. Finally, if the first three questions can be answered the final question is one of identifying the population in need. As mentioned above, a service can only be efficient if people who could most benefit from use of it are actually using it (i.e., the population in need) (Lavis & Stoddart, 1994). Due to the anticipated difficulties in identifying and recruiting carers of urban Aboriginal children, the focus of this pilot study will be on the identification and recruitment of this population in order to describe the population who would most benefit from use of the ELDC.

Aboriginal-based universal family drop-in centre services appear to be a compromise between providing ECEC services to all Canadian carers of children and involving Aboriginal communities and organizations in the production of universal ECEC services for the diverse urban Aboriginal population (Guimond, 2003). There is no known research exploring the issue of accessibility to an Aboriginal-based universal drop-in centre that is open to all Canadian carers of children regardless of ethnicity, race, and socioeconomic status. This study will provide a foundation for future research exploring receptivity of carers of Aboriginal children in the conduct of research and in describing factors that influence the use of an Aboriginal early learning drop-in centre by carers of Aboriginal children.

CHAPTER TWO
Methods

Research Methods

Qualitative description, as described by Sandelowski (2000, 2010) was used to guide study decisions around sampling, data collection and analysis (Sandelowski, 2000, 2010). Qualitative description is useful for obtaining "straight and largely unadorned answers" about the phenomenon under investigation (Sandelowski, 2000; p. 337). This is the most appropriate method for this study because it refrains from interpreting findings into a deeper meaning. In other words, the intent is to produce factors without imposing deeper meaning that is not relevant to this sample of carers and service providers (Sandelowski, 2000).

Setting

Hamilton is the third largest city in Ontario and the ninth largest city in Canada (OTF, 2008a). According to the 2006 Census, the Aboriginal population comprises approximately 1.5% of the total population in Hamilton and almost 18% of Aboriginal people living in Hamilton are under the age of ten (Statistics Canada, 2007a). A little over a third of Aboriginal people living in Hamilton, who are fifteen years of age and older, do not have a high school certificate or equivalent, and one quarter have a high school certificate or equivalent (Statistics Canada, 2007b). The median income of Aboriginal people living in Hamilton is just over $19,200 (Statistics Canada, 2007a). For all families living in Hamilton, 74% were married-couples and their median income after tax in 2005

was around $68,000 (Statistics Canada). For all families living in Hamilton, almost 14% were female lone-parent families and their median income after tax in 2005 was approximately $34,500 (Statistics Canada).

The ELDC is located in the northern region of the city where 5.2% of the population identifies as Aboriginal with the surrounding census tracts ranging from 2.9 – 5.9% (Statistics Canada, 2010b). Fourteen percent of residents in this census tract are under the age of ten (Statistics Canada). Almost 43% of residents in this census tract who were older than 14 years of age did not have a high school certificate or equivalent (Statistics Canada). The median income after tax in 2005 of residents from this area who were over 14 years of age was a little above $18,200 (Statistics Canada). Of the families in this area, 49% of families were married-couples and the median income after tax in 2005 of married-couples with children was a little over $56,600 (Statistics Canada). Of the families in this area, 38% are female lone-parent families and their median income after tax in 2005 was a little over $21,500 (Statistics Canada).

The Aboriginal Early Learning Drop-in Centre (ELDC)

The ELDC is located in a rented, single, multipurpose room at a municipal recreational facility. There is access from the room to a shared walk-in kitchen. The drop-in centre is a take-down site, which means that the first and last half-hour of the program are spent assembling and disassembling it into an adjacent storage closet.

The drop-in centre occurs twice a week for a total of ten hours per week. Hours run from 9:30am to 2:30pm. In the summer, hours are extended by two hours and run

from 9:30am to 4:30pm for a total of 15 hours per week. Between April 1, 2010 and September 15, 2011, the drop-in centre ran 138 times for a total of 730 hours.

Sampling & Participant Recruitment

In qualitative research, the purpose of sampling is to collect data that will produce an *in depth* description of the phenomenon of interest from participants (Patton, 1990). Purposeful sampling is used in qualitative research to identify "information-rich cases" and there are a variety of sampling strategies that can be used depending on the purpose of the study (Patton, p. 46).

This study involved the recruitment of three unique data sources: providers, users of the service, and non-users of the service. As primary suppliers of care, issues of willingness and ability to offer services can be best understood from the experience of the staff (i.e., service providers) of the ELDC. All three service providers who were currently staffing the ELDC were invited to participate in this study. An e-mail invitation (Appendix A) was sent to the director of the organization who forwarded a formal invitation to all service providers along with a digital copy of the letter of consent (Appendix B). The e-mail briefly explained the purpose of the study and attached was a digital copy of the letter of consent. All three interviews for service providers were scheduled through e-mail correspondence with the program manager. This modification of intended recruitment methods raises ethical issues discussed later.

Carers of urban Aboriginal children who currently or previously used the ELDC were the second group of participants (i.e. users) in this study. Inclusion criteria were that

the carer cared for an urban Aboriginal child and that they had used the ELDC at least once regardless of the time of use (i.e., currently or previously used), that they were sixteen years of age or older and that they could speak and understand English. One third of First Nations children living off-reserve are raised by four or more people, so all carers, which may include kin and non-kin, were eligible to participate in this study (Guevrmont, 2006). As a pilot study, the estimated sample size was six participants. Snowball sampling was used to sample and recruit users. Each service provider was requested to invite carers of Aboriginal children who used the ELDC to learn more about the study. Users who were interested in participating were contacted by phone by the researcher. The purpose of the study and interview process were discussed and a formal invitation to participate in the study was extended. After the invitation was accepted, the participant and the researcher scheduled the interview at an agreed upon time and location.

The final group of participants invited to participate were carers of urban Aboriginal children who do not use the ELDC (i.e., non-users). As a pilot study, the estimated sample size was six participants. Convenience sampling was used to sample and recruit non-users. A contact from the organization providing the ELDC was requested to invite carers of urban Aboriginal children between the ages of zero and six years who did not use the ELDC but who did use the organization's other services. The inclusion criteria were that the carer, which may include kin and non-kin, care for an urban Aboriginal child between the ages of zero and six years but who had never used the ELDC, that they were sixteen years of age or older and that they could speak and

understand English. Non-users who were interested in participating in the study were contacted by phone by the researcher. The purpose of the study and interview process was discussed and a formal invitation to participate in the study was extended. After the invitation was accepted, the participant and the researcher scheduled the interview at an agreed upon time and location.

Factors that influence the use of the service by carers of urban Aboriginal children was examined for this study because the ELDC is an universal family drop-in centre offered by an organization designed to support urban Aboriginal children and their carers. Furthermore, because of their at-risk status and the importance of culturally-sensitive care for Aboriginal carers, the carers of urban Aboriginal children were selected as the population in need of the ELDC (BSRC, 2006; BSRC, 2010; Browne et al., 2009; Longfield & Godfrey, 2003). Focusing only on the experiences and perceptions of carers who have used the service would limit the scope of data to those who are empowered and choose to use the service. As a third source of data, the experiences and perceptions of carers who have not used the program were also collected, and the unique factors that influence carers' who do not use the ELDC were compared and contrasted with those of carers who use the ELDC and service providers to identify factors that influence use of the service by carers of urban Aboriginal children.

Data Collection

The most appropriate data source to describe empowerment is accounts of the experience of using or attempting to use care from individuals themselves (Creswell,

2007). Each individual in a population experiences a different level of empowerment as a result of personal experiences engaging with services, which is best explored through one-on-one interviews with individuals (Creswell).

To explore and describe participants' experiences of providing or using ECEC services, the needs of carers of urban Aboriginal children, the factors that influence carer's use of early childhood education and care services, and the experience of supplying care at the ELDC, semi-structured one-on-one interviews were conducted. Semi-structured interviews are interviews with an outline of predetermined questions, known as an interview guide, to ensure that all participants are asked the same questions in the same manner for ethical and analytical reasons (Patton, 2002). They also allow the researcher flexibility to ask questions beyond the interview guide to further understand or explore emerging concepts, and to probe themes more deeply (Patton). Semi-structured one-on-one interviews are most appropriate because the personal experiences and preferences for use of early childhood education and care services were expected to vary between participants (Creswell, 2007).

Three unique interview guides (see Appendix C) were developed for each group of participants and questions were developed to explore factors based on the dimensions of access outlined in McIntyre et al. (2009). The initial structure of the interview guide was based on the recommendations described by Patton (2002). Patton (2002) describes how to structure questions into an open-ended format to reduce the chances of single-worded responses and leading questions, methods for introducing questions to reduce the possibility of misinterpretation and approaches to transitioning between questions, such

as “How has this program met your needs?” instead of “Has this program met your needs?” which was used in interviews with carers and allows the researcher to assume changes. To explore topics and issues that arose in each interview in following ones specific questions and probes about previously discussed topics were added to the interview guide over the course of data collection.

The AAA framework was used to guide development of interview questions. The AAA framework outlines topics and areas where the researcher will find factors that influence accessibility to a service recognizing three dimensions of access (i.e., availability, affordability, acceptability) (McIntyre et al., 2009). It also postulates that these dimensions will interact to create overarching factors, such as sexism, that limit the use of a service (McIntyre et al.).The focus of the interviews was on identifying and describing factors that influence use of early childhood education and care services. To explore this concept further, additional questions were used to identify and describe carers’ likes and dislikes about the services they were currently using, how their needs were being met by use of the services, and recommendations for change to services to better meet their needs. Non-users were also asked about their decision not to use the service. The interviews with service providers included questions about the experience of supplying the ELDC. Probes were used to further explore, structural (e.g., location, time) and personal (e.g., preferences) factors that would influence use of services (Patton, 2002).

Each participant was involved in one face-to-face interview and participants decided their preference for the purpose of member checking, which is a process to

improve the reliability, credibility, or internal validity of the results of a qualitative study by reviewing an interim report of the results with the participants (Mays & Pope, 2000). Each interview was scheduled to be one hour in length, at a place of their choice, including the recreational centre where the ELDC is located and the organization's preschool site. Interviews were recorded with two digital recorders to protect against loss of data due to malfunction or battery issues.

Field notes were collected prior to and after each interview. Field notes described the environment, personal reflections, observations, and reoccurring themes or topics from the interviews. Data from field notes were used in a write-up to create reflective remarks (Miles & Huberman, 1994). Reflective remarks explore and describe issues that might be important during analysis, such as concerns about the quality of the data, and they are also useful for memoing (Miles & Huberman).

Anonymous demographic questionnaires were administered at the time of the interview to describe the participants and identify characteristics that might influence the data collected (see Appendix D). Information collected from providers was about gender, length of time they worked at the drop-in centre, length of time as early childhood educators, and their ethnicity. Information collected from carers was about their gender, highest level of education attained, current employment status, the number of children currently under their care, and their relationship to those children. Users of the program were also asked about how long they used the program and how frequently they used the program.

To further describe which type of families use the ELDC and the content supplied at the ELDC, data about user demographics and characteristics and activities at the ELDC were collected. This data was retrieved from summary information about the users who accessed the ELDC between April 1, 2010 and September 15, 2011. Summary information came from registration and sign-up sheets that were filled out at the drop-in centre or at affiliated programs and were collected on a voluntary basis. Affiliated programs are workshops, or events associated with the drop-in centre that did not occur at the drop-in centre (e.g. outreach sessions). Information collected were the total number of unique children and carers who used the drop-in centre, and the total number of visits to the drop-in centre. This information was also categorized into annual quarters. Other information collected regarded the postal codes and preferred language spoken by users. Postal codes were categorized by the researcher based on their location in electoral districts and their location in census tracts. An online calendar from the organization's official website listing organized activities was also used to collect information about the quantity and type of organized activities that took place at the ELDC and that are affiliated with the ELDC between April 1, 2010 and September 15, 2011.

Data Analysis

Recorded interviews were transcribed verbatim. Interview data were stored and managed using MS Word. Use of qualitative description with the AAA framework produced a multi-dimensional description of the factors that influence the use of the ELDC by carers of urban Aboriginal children. The analysis focused on the identification

and descriptions of factors that attracted and maintained use of the ELDC and/or childcare services by carers of urban Aboriginal children, factors that prevented and dissuaded the use of the ELDC and/or childcare services by carers of urban Aboriginal children, and the structural and content-related factors the influenced what was offered at the ELDC and how it was offered.

Data were analyzed using directed content analysis (Hsieh & Shannon, 2005). Content analysis is the recommended approach to data analysis in qualitative descriptive studies (Sandelowski, 2000) because it is a systematic approach for describing and categorizing codes to "enhance understanding of the data" (Elo & Kyngas, 2005, p. 108). Codes are labels that assign meaning to chunks of data, specifically, to the transcript data (Miles & Huberman, 1994). Directed content analysis is a type of content analysis used to extend and validate an existing theory about the phenomenon of interest (Hsieh & Shannon, 2005).

The transcripts were read multiple times to develop a familiarity with the text and to produce an overall meaning of the interviews and to create a descriptive summary of the findings (Elo & Kyngas, 2005; Miles & Huberman, 1994). Line-by-line deductive coding using pre-determined codes based on the three dimensions of access comprised the primary level of coding (Appendix E) (Hsieh & Shannon, 2005; Miles & Huberman, 1994). Data that could not be deductively coded were set aside. The secondary level of coding produced inductive codes that identified themes within each dimension of access and produced codes for data that had not been coded deductively. Codes were identified as relating to either barriers and facilitators to use or supply by service providers, users,

and non-users. The final level of coding compared and contrasted codes between each group of participants, evaluated the relevancy of codes to the research question (i.e., are these codes describing a factor that influences use of the ELDC?) and codes that did not were removed (e.g., codes that described features of ECEC services that were liked by both users and non-users since those features did not influence use of the ELDC). With the remaining relevant codes, the final level of analysis was completed with the development of a conceptual framework which illustrated the relationship between factors that influenced use of the ELDC with an emphasis on facilitators of use rather than barriers.

As mentioned above, comparing and contrasting codes between participants was used to derive meaning from the results (Miles & Huberman, 1994). Participants were categorized based on particular characteristics (e.g., users vs non-users; self-identifies as Aboriginal vs. non-Aboriginal; lives close the ELDC vs lives in another neighbourhood) to explore the differences between concepts.

The summary chart on languages spoken was synthesized into four categories (English; Aboriginal; Asiatic; Other) to explore the observations made by service providers and users that a large Caucasian and Asiatic population uses the ELDC. Aboriginal languages categorized within this study consisted of: Mohawk, Ojibwe, and Cayuga, Asiatic languages spoken by users of the ELDC between April 1, 2010 and September 15, 2011 were Mandarin, Chinese, Korean, and Vietnamese, and other languages included Russian, Polish, French, Spanish and Arabic.

Rigor

Representativeness refers to the accuracy of the results of a study to the true phenomenon (Miles & Huberman, 1994). Credibility refers to the accuracy of the results of a study to the sample population (Miles & Huberman, 1994). Sources of error that reduce the representativeness of a study include sampling non-representative informants, generalizing from non-representative events and drawing inferences from non-representative processes (Miles & Huberman, 1994). Strategies used to improve the representativeness and credibility of the study were data source triangulation, contrasting and comparing, and member checking. Triangulation by method, a subcategory of triangulation [Denzin (1978) as described by Miles and Huberman (1994)] is the use of multiple sources of types (i.e., interviews and documents) and sources (i.e., service providers, users, non-users) to identify areas of data convergence and divergence. Furthermore, areas of convergence and divergence in the data were also explored through data analysis by making contrasts and comparisons. For this study, issues about the supply of services and characteristics of users were explored through triangulation with documents. Member checking, the process of reviewing the analysis, interpretations, conclusions from an interview with the interviewee, is used to test the credibility of the results (Creswell, 2007). In this study, service providers were given a composite summary of the results from their interviews to review for accuracy.

Ethics

As recruitment criteria for carers required that they cared for at least one urban Aboriginal child between the ages of zero and six years, ethical considerations as they relate to the ethical conduct of research with First Nations peoples were addressed in this study.

Ethics approval was obtained by the Hamilton Health Science/Faculty of Health Science Research Ethics Board (Student Research Committee). Since the focus of this study was on identifying the factors that influence the use to a universal family drop-in centre by carers of urban Aboriginal children, the ethics board required a letter of approval from a representative of the organization to state that they were aware of the study and that they agreed with the focus of the study on Aboriginal families.

A letter of approval was provided stating that the organization was aware of the study; however, although the drop-in centre reflected Aboriginal culture, because of their funding, they could not provide a letter that stated they would like to see Aboriginal families using the services over other populations. Communication with the research ethics board was required to provide further rationale and clarification which occurred over the course of two weeks before an official proposal was submitted.

Approval for the study was also obtained by the organization's board of directors. Throughout the development of the study protocol communication was maintained with a representative of the organization to help guide methodological and pragmatic decisions of the research process [Canadian Institutes of Health Research, Natural Sciences and

Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (CIHR-NSERCC-SSHRCC), 2010]. For example, the representative shared concerns about the use of focus groups due to previous experience using this method of data collection for carers who use their services. A research brief containing the preliminary qualitative findings was produced and given to the organization for their use (CIHR-NSERCC-SSHRCC). In order to engage with the service providers of the ELDC, the researcher volunteered at the drop-in centre for several weeks prior to the start of the study (CIHR-NSERCC-SSHRCC).

Participants were approached by a contact from the organization to learn more about the study. Participation was voluntary. Users and non-users were given the option to have the interview at either the ELDC, the preschool location, or at a coffee shop that was easily accessible to both the carer and the researcher. Most participants chose to use the preschool location or the ELDC. Since these participants speak with each other, unwittingly participants' anonymity was violated by themselves despite efforts made by the researcher to ensure confidentiality. The purpose of the study, a description of the data collection process, and personal benefits and risks were discussed with participants and consent was obtained (Appendix B). Permission to digitally record the interviews was also obtained. Before the interview, participants were informed of their ability to withdraw from the interview at any time and that they had the option to not answer any question. The digital recordings were transcribed on the same day that interviews were conducted and audio recording of the interviews were destroyed afterwards. Transcripts were anonymized and any identifying information was removed. All digital data were

stored on a password protected hard drive. During use, all hard copies of the data with identifying information were stored in a locked office, and will be destroyed one year after completion of the study. Digital anonymized data (i.e., transcripts) will be stored for ten years on a password protected external hard drive as is the standard approach to handling data.

CHAPTER THREE
Findings

Findings from preliminary data analysis

Participants

Three providers participated in this study. Providers have worked at the ELDC for an average of 5.3 years (range, 5 to 6 years), and have been working as an early childhood educator for a median of 6 years (range, 5 to 21 years). One provider self-identified as Aboriginal.

Four users of the drop-in centre participated in semi-structured one-on-one interviews. Interviews lasted between 15 to 31 minutes with a median time of 19 minutes. All carers were female, and their average age was 26.5 (range, 23-31). They all cared for at least two children under the age of six years, and only one cared for a child seven years of age or older. All carers identified as the mothers of the children who are six years of age and younger. Three carers self-identified as Aboriginal and one did not. The highest level of education attained was college by two carers, high school or equivalent by one carer, and other by one carer. Half of the carers were employed part-time, and the other half were stay at home mothers.

All users have been using the ELDC for at least four years. Half the carers used the ELDC at least three times a month, while the other half had not used the drop-in centre in at least a year.

Five non-users of the drop-in centre participated in semi-structured interviews. Interviews lasted between 12 to 36 minutes with a median time of 20.5 minutes. Carers were both female and male. All but one carer provided age, and the average self-

identified age of carers was 27.5 (range, 24-30). The highest level of education completed by three carers was high school or equivalent; for the rest it was college. Three of the participants were stay at home carer, one was self-employed, and the last was unemployed. Non-users cared for between one and two children 6 years of age or under. Four carers identified as biological carers of the children and one identified as a step-carer.

Interviews were scheduled during hours of operation at the ELDC and in a booked room adjacent to the drop-in centre. Three of the four interviews with users took place in a private room at the recreation centre where the ELDC is located. Interviews with one user and four non-users took place in a private room at the preschool location. One non-user chose to have the interview at a coffee shop near where they lived and did not bring his or her children.

Three of the five non-users did not live near the ELDC, one currently lived in the same neighbourhood as the ELDC and one had previously lived there. Based on the preliminary analysis of the interviews, living in the neighbourhood influenced the type of responses participants provided. Those who had never lived in the same neighbourhood as where the ELDC is located cited transportation and location as the barriers of use of the service with little further depth provided. Non-users who had lived in the neighbourhood but had decided to not use the service provided rich information about their experiences and decision to not use the ELDC.

In addition to the questions explored in the interview guides for users, one question was altered. In both interview guides with users and non-users, the additional

question "What factors affect your use of the ELDC/the programs you currently use?" and probes were used to explore each dimension of access (i.e., location, hours, days, content of services) and any additional topics raised in previous interviews.

Summary of the results

Of the twelve carers eligible to participate in this study, nine carers consented to participate, achieving a recruitment rate of 75%. Methodological issues that arose during data analysis related to the categorization of carers (users; non-users), their location of residence in relation to the location of the ELDC (self-identifies as living in the same neighbourhood as the ELDC; self-identifies in a different neighbourhood as the ELDC), and self-identification (self-identifies as Aboriginal; self-identifies as non-Aboriginal).

Preliminary data analysis identified six factors that influence use of the service by carers of urban Aboriginal children categorized into two dimensions of access as described by the AAA framework: Availability (location; proximity and convenience of use of the ELDC), Availability (time; the presence of unstructured period of time with child), Availability and Acceptability (desire to learn about Aboriginal culture and engage in a culturally sensitive environment with Aboriginal children), Acceptability (carer's trust of service providers, presence of social support, and finally carer's sense of safety). The dimension of affordability from the AAA framework was not identified as influencing use of the service. Divergence of data between service providers and users occurred during discussion of availability of services, specifically with regards to ability of service providers to offer care at the current location of the drop-in centre and users

perceptions of quality of the environment and services at the current location of the drop-in centre.

Description of the ELDC

Between April 1, 2010 and September 15, 2011, 301 children and 287 carers used the drop-in centre and affiliated programs and there were 1518 and 1167 visits from children and carers, respectively. According to records, winter months had the greatest number of users and the greatest number visits (Appendix F).

According to the service providers, the objectives of the drop-in centre are to support carers with children between zero and six years of age. Support came in the form of providing a safe space at the ELDC, role-modeling healthy parenting behaviours, connecting families to community-based resources, and preparing children for school. Providers described that they work to address the physical, emotional, financial and spiritual needs of the families that access the centre.

Service providers use emergent curriculum and through observation and conversation with children, they learn what children are interested in. With this information, they create resource bins with arts and crafts ideas, toys, and books so that the next time the interest is raised the activities and toys are ready. Another example of how they incorporate emergent curriculum into practice is by replacing, when possible, plastic toys and plastic shelving units with wooden ones to create a natural environment for the children.

Between April 1, 2010, and September 15, 2011, there were 133 additional events, workshops, or activities at the drop-in centre. An additional 80 events affiliated with the drop-in centre, including the outreach program and child-minding, occurred outside of drop-in centre hours at different locations across the city. Appendix F provides a description of the activities.

The most common organized activities that occurred at the drop-in centre were visits from Public Health professionals (33 sessions), physical and outdoor activities (23 sessions), and child-minding (22 sessions), accounting for 58% of organized activities that occurred at the drop-in centre. The most common organized activities that occurred outside of the drop-in centre were Aboriginal-themed activities (35 sessions), child-minding (32 sessions), and male carer-oriented activities (7 sessions), accounting for 93% of organized activities that occurred outside of the drop-in centre. Of the 35 Aboriginal-themed activities that occurred outside of the drop-in centre, 34 were part of the outreach program, where a provider presented traditional story-telling, songs, and dances at other early childhood centres across the city.

Altogether, the organized activities ran for a total of 324.5 hours. Activities that occurred during drop-in centre hours ran for a total of 196.5 hours.

Use of the ELDC by participants

All participants cared for at least one child who participates in the organization's preschool program. Of the nine carers who participated in this study, two participants used the ELDC at least three times a month, one participant was a previous user who

stopped using the ELDC a year ago because of the birth of a new child, and one participant only used the affiliated parenting workshops that took place at the ELDC. One participant had never used the ELDC but used to live in the neighbourhood where it was located; another participant currently lives in the neighbourhood where the ELDC is located but has never used it. Two participants did not use the ELDC but currently use ELDC affiliated programming that occurs outside of the ELDC. One participant had never used the ELDC and did not live in the same neighbourhood as the ELDC.

Needs of participants met from the use of childcare programming

Need is defined as the capacity to benefit where there is evidence that care provides benefits among similar individuals with the particular condition (McIntyre et al., 2009). In instances when there is no treatment, enhancing peace and comfort is linked to the effectiveness of meeting the needs of those individuals (McIntyre et al.). According to users of the ELDC, needs met from using the drop-in centre included: 1) opportunities for their children to access toys and crafts that were not available in their home environment; 2) providing opportunities for carers to access free resources such as free diapers, diaper rash medicine or snacks and meals; 3) information about and role modeling of healthy parenting techniques and; 4) access to childcare so that carers could attend program workshops.. In general, use of childcare programs met the need of carers to get out of the house and it gave their children a chance to socialize with other children. The use of childcare programs for the whole family met the need for families to do something together, it reduced the burden of carers to schedule activities for that day, and it gave

carers a chance to socialize with other adults. The use of Aboriginal-based childcare and family programs by non-Aboriginal carers with Aboriginal children met the need to learn more about their children's culture and a place for those children to begin to learn their native language.

Factors that influence the use of the ELDC as perceived by participants

The factors that influence the use of the ELDC are illustrated in Figure 1. Dimensions of availability and acceptability overlap and integrate to describe accessibility to the ELDC for carers of urban Aboriginal children. Each ring represents a facilitating factor that must be addressed before use of the ELDC by the carer.

Availability (Location)

Availability, specifically the relationship between the location of the service and the location of the population of interest, is the first factor to influence use of the ELDC by carers of urban Aboriginal children. Living close to the ELDC influenced participants' (*n*=3) decisions to first visit, and then continue using, the ELDC. The following quote by a user of the ELDC illustrates the factor of closeness in her decision to use the drop-in centre:

> So I thought "Yeah" because we just live down the street so [][2] its close so I figured I'd come check it out see what it's all about. So I did.

Having the ELDC close to where they lived made using the ELDC convenient for users. Providers also observed that many carers who used the drop-in centre lived in the

[2] [] signifies that a portion of the participant's response has been removed from the quote.

neighbourhood where it was located. Based on a summary of the postal codes of users of the drop-in centre, nearly fifty percent of people who used the drop-in centre lived in the same or surrounding census tracts where the drop-in centre was located (Appendix F). Providers qualified their statements by saying that carers from all over the city use the ELDC and some are willing to make the commitment to travel great distances to visit the ELDC; however, they also felt that the ELDC was located in the right area of the city.

While describing the ideal format for offering the ELDC, one provider said:

> We do want to be in different locations to meet all our families' needs, not all families are living in this area. Our families are throughout the city. [] We love our location; I like this location. It's not just me, but we do have lots of families that live in the area.

Some users (*n*=2) stated that transportation would not be a factor that influenced their decision to use the ELDC if the drop-in centre changed locations. Once the carers benefited from use of the program, transportation no longer became a barrier for use of the program. As one user of the ELDC said:

> I like [the location of the ELDC] because we only live two blocks away but even if it [moved to another location] [] I would still travel [to use it].

Non-users who did not live in the neighbourhood (*n*=6) stated that either distance or issues with transportation were factors that influenced their decision not to use the ELDC. For two participants who used programs affiliated with the ELDC, not only were transportation and distance factors in their decision not to use the drop-in centre, but proximity and convenience were factors that influenced their decision to use ECEC

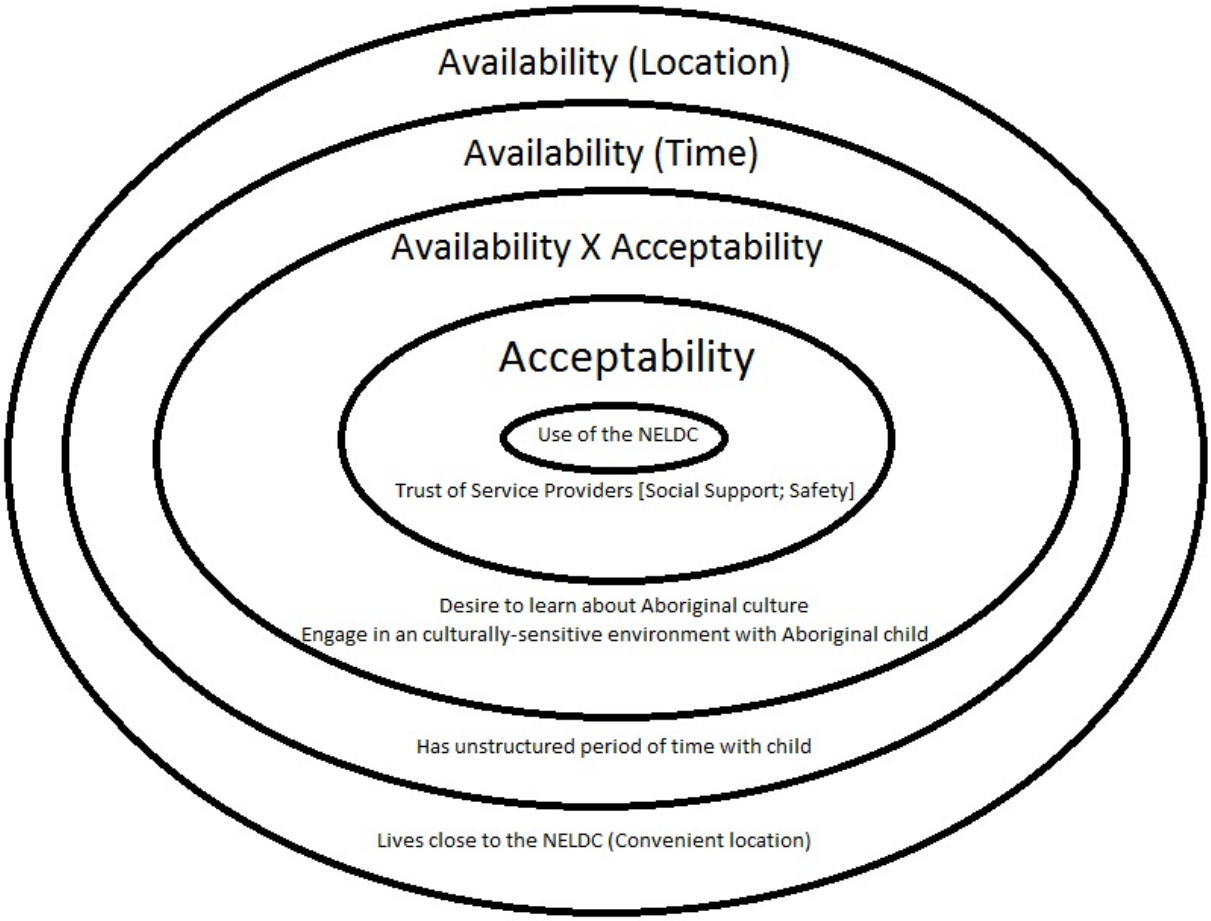

Figure 1.Conceptual framework describing factors that influence use of the ELDC as perceived by participants.

services that were in their neighbourhood. In describing the importance of transportation in influencing her decision not to use the ELDC, one participant said:

> Just because its so far away, but other than that not really nothing [influences my decision not to use the ELDC]. Its just the distance. [] And taking the bus down – its too many buses and its too difficult.

Another participant stated the importance of distance as a barrier to use of the ELDC and proximity and convenience as a facilitator for use of other ECEC services:

> [The ELDC is] good, its good for that area. See I'm in this area so I mostly come over here [to another service], right. If I lived closer there I would go there but there's a lot of families that it works out good for.

Providers also observed that distance and transportation were barriers to use of the ELDC by carers of urban Aboriginal children who use the organization's other programs. Referring to them as "families", the provider states:

> We have some families that come from [organization's name] who their children are already involved in the preschool or the childcare and they still like to come to [the ELDC]. We found that sometimes a lot of families have had a problem with [] transportation [].

As a result, proximity and the convenience of using the ELDC are facilitators to use of the ELDC for carers of urban Aboriginal children, and distance and transportation are barriers to use. For some carers, after using and benefiting from the ELDC, transportation no longer becomes a barrier to use.

Availability (Time)

The second factor to influence use of the ELDC relates to the relationship between the hours of operation and the time that best suits the population of interest. A barrier to use is a busy schedule, or having more important priorities. Both users and non-users (n=6) stated that their busy schedule prevented them from using the ELDC or any other childcare services. Non-users (n=3) often described not having enough time as a barrier to use of any additional early childcare services, including the ELDC. One non-user with older children described it as follows:

> I just stopped using all the [early childhood education and care services] 'cause we never really have the time to do it plus there's the homework that you have to sit and do and dinner and all that. There's just not enough hours in the day to do what the kids want to do especially during the school days.

One previously frequent user of the ELDC says in reference to being busy:

> Its my work schedule now. And to not having enough time at home [] if I was home more, when I wasn't working I'd love to come [to the ELDC] more. I work very random hours and when I do get time home its just spending time with the kids when [my child]'s home from school; its trying to get the school schedule done so it takes a lot of my schedule.

Providers also recognized that being busy was a barrier to use of the ELDC by users of the drop-in centre. One provider observed of carers of urban Aboriginal children who used the organization's other programs that:

> Because they have not just one child, but they have multiple children, so its just kind of difficult with the times that we are open as well as the time that they need to be picking up or dropping off their [] children.

The presence of unstructured time facilitated the use of the program by users (*n*=2). Users liked to use the drop-in centre when they had unstructured time with their child(ren). Unstructured time refers to a period of time when the carer and child lack a routine. Users described their use of the ELDC as "hanging out" and

> I find it more during the school hours because I know that [my older children] are gone from this time to this time, and me and [my youngest child] you know, we do all our other stuff in the middle.

As a result, the child is not socializing outside of their home, and they are without organized activities and it is these periods of time when carers use the program (*n* =3).

The issue of filling their child(ren)'s unstructured time was raised by both users and non-users (*n*=4). Carers, in general, were interested in using childcare programming during periods of prolonged unstructured time, such as during March Break, summer vacation, and winter vacation as it relates to the elementary school schedule. However, personal preferences determined what specific periods of time were considered

"unstructured" by each carer. When describing preference for time of services, one user stated:

> They generally take two weeks off – like they take a big chunk of time off around Christmas, and I don't think that's cool because that's when everybody else's time off, and they're just kids and they're at home for a week, they need to get out there and just sort of have, to keep that social structure.

Both users and non-users (*n*=5) agreed that they wanted to use childcare services during periods of unstructured time. The following quote provided by a user of the program illustrates how users describe unstructured time and their preference for time of programming:

> Yeah, I think it should definitely be open around Christmas because sometimes you can't find things to do with the kids and its hard to entertain your kids at home when they do the same thing every day at home.

The following quote by a non-user demonstrates the similarity between users and non-users in the description of unstructured time and its relation to non-users' preference for time of programming:

> March break to give them something to do. [] They only get [Professional Activity days] once a month whereas March Break is a full week off, but without a routine and all that.

One barrier to use for all carers is having a busy schedule. A facilitator to use of the ELDC for carers is the presence of unstructured time with their children, which many carers are interested in filling with activities.

Availability x Acceptability

The dimensions of availability and acceptability interacted to produce the third factor to influence use of the ELDC: Aboriginal-based content. All carers were interested in bringing their children to culturally sensitive services that exposed them to their culture and language.

Both users (*n*=4) and service providers (n=3) agreed that the Aboriginal-based teachings and activities offered at the ELDC are for a multicultural audience who may not be familiar with Aboriginal cultures and teachings. As one service provider elaborated, a multicultural audience also includes a range of Aboriginal people:

> And then that's another thing is knowing, first of all, when they walk through the door, are they Aboriginal… well, that's [a] pretty vast statement, right. Well what are you, Mohawk, Ojibwe, are you Cree, are you… you know. And knowing that Aboriginal people, we kind of share common teachings [] the languages are very different, the cultures could be very different, but there's some parts, that culture that we share right. [] When I see those families, say its an Aboriginal family [] they don't always have their culture so they're searching for it and they weren't raised in it. And they might be [] experiencing life in a different way. So I still have to be respectful of that.

As a result, service providers adapt their teachings to be understood by an audience who is unfamiliar with the specific culture of which the teachings and activities originate. The ELDC is mandated to offer Aboriginal-based early childhood and education services but service providers describe the process as "sharing" or "incorporating" rather than teaching. Furthermore, the act of sharing their culture has a personal impact because they become accountable for what they share and must consider the long-term consequences of sharing their teachings. The following quote by an

Aboriginal service provider express the process of sharing and the role of accountability in influencing the Aboriginal-based services that are provided:

> I feel we're always accountable to things – to somebody, to my grandparents or my elders or my teachers, my… because I had teachers other than my family right, that I got taken and was taught gratefully by [] and then to my own family and then there's that part of it. And so I always feel "Where do I go with these things?" or "What's going to happen?"

The service provider further elaborates on the issue of being accountable for what is shared with others:

> "So you're able to do that," or [my teachers] say, "You know, its great that you're able to share that." And they say, "Share as much as you can [] but understand that every time you do that [name] you're going to be accountable now, you make yourself accountable."

For Aboriginal carers (*n*=2) who use the ELDC living in an urban area means that they cannot easily return to their reserves and the ELDC is a space where they can bring their children to stay connected to Aboriginal cultures. They did not use the ELDC to socialize or network with other carers who used it, instead their attention was focused on their children. Although Aboriginal carers liked to use the ELDC because it was an Aboriginal-based service, as illustrated in the quote below, by an Aboriginal user, the ELDC was not a space for all Aboriginal carers interested in learning their cultures:

> [S]o I think [my family] already come[s] from a more knowledgeable stance [than the ELDC]. [S]o I always try to remember that we know a lot more information from the get go so when all the times that I come here… its just like [] primary stuff almost you know what I mean? Just barely, barely, barely, scratching the surface. And its stuff that you usually go to the library and find out this information and me and my kids [] we're kind of past that level of knowledge, so we can probably teach a lot of the lessons.

The user further described how the ELDC was not a space for all Aboriginal carers interested in practicing their cultures:

> As Iroquois we don't smudge a lot [] we're a very simple culture you know what I mean, just generally day-to-day stuff we don't do ceremonies.

Non-Aboriginal carers of Aboriginal children who were unfamiliar with Aboriginal culture (*n*=2) liked to use Aboriginal-based services because it connected and exposed their Aboriginal children to their Aboriginal culture, but carers also felt that the organization and the ELDC taught them about Aboriginal culture. Service providers also observed non-Aboriginal carers of Aboriginal children who used the services to expose their children to Aboriginal cultures, like in instances of adoption. By using the ELDC, one non-Aboriginal carer was able to obtain documents to enroll her child at the organization's other services. The following two quotes by non-Aboriginal carers show the importance of this organization and its services, including the ELDC, in connecting their children to their culture, and also in educating non-Aboriginal carers about Aboriginal culture:

> Yes, [the organization] is [my children's] only tie to the native culture – it's the dad that's native. So it's the only tie. [] Yeah it affects where we live definitely because we were wanting to move out of Hamilton and we can't because there's nothing out there that we can find and I don't want the kids to lose their native so. We're trying as hard as we can to teach our kids as much as we can about the kids' beliefs.

> Me not being native or anything, you can hear rumours. Like when you're not part of any religious group you just kind of hear what TV announces about what those religions believe and stuff like that. So its kind of nice knowing about some of the native culture that gets taught to you [at the organization].

Some Aboriginal carers who did not use the ELDC or used it infrequently (*n*=3) used community-based programs and services where they and their children were able to practice their cultural activities, like Native arts and crafts, drumming, and Indigenous cooking. They also stated that socialization with other carers and staff was a factor that influenced their use of services.

Service providers (*n*=3) all stated how important it was for carers to feel "comfortable" at the ELDC, but they also recognized that with all the available early childhood education and care programs in the area, carers had the option to pick and choose where to go. Developing a rapport by making carers feel comfortable at the ELDC was an important role for all service providers. However, it was recognized by some participants (*n*=2) that some Aboriginal carers felt more welcome at services and programs that were specifically for Aboriginal carers. The following two quotes, one by a service provider, and the other by an Aboriginal carer, respectively, suggest that where some Aboriginal carers feel most comfortable is in a space that fosters a community that is exclusively for Aboriginal people:

> I think a lot of our Aboriginal families, because we have [] there's an [Aboriginal centre], I think a lot of our families feel comfortable going there because its all Aboriginal families. [] And I don't think it has anything really to do with our program specifically, it just um, its like home away from home, you know. [] They just feel comfortable, I think, more comfortable being with their own culture.

> I started going to [the ELDC] when [my child] was three to six months but I never kept going after that. I just went for the [affiliated parenting workshop] and like I was introduced but never went because I like the [Aboriginal centre]. They were

> doing a lot of things that I need to get done too.[3] [] Plus my friend ran [the Aboriginal centre] from high school so it was good to see her all the time.

The ELDC provides ECEC services that incorporate Aboriginal cultures and languages; however, this content is targeted at a non-Aboriginal population. Aboriginal users of the ELDC like the program because they are away from their reserves and it keeps their children connected to Aboriginal cultures. However, they recognize that the Aboriginal content provided is not targeted at them. For Aboriginal carers who do not use the ELDC, socialization with other adults, feeling welcome, and practicing their culture were important factors to use of services, and it has been suggested by service providers and some carers that this is not offered at the ELDC for urban Aboriginal children, in part because it is a multicultural service.

Acceptability

The three acceptability-related factors that influenced the use of the ELDC were: 1) trusting the service provider; 2) social support; and, 3) a sense of safety. For some carers (*n*=5), trusting someone outside of their family to care for their children was an important factor to use of any service. They approached the issue from an initial stance of distrust and required that the service provider gain their trust. For carers, trust was gained by being able to be there with their child at the program, examining the environment of the childcare service, meeting with service providers, watching their children with the

[3] Note: The caregiver later explained that the things that needed to be done were about regalia, which are the dancing outfits worn at powwows.

service providers, and having open communication with service providers. As one carer described her decision not to use the ELDC:

> I know there's the [ELDC] that I could go to it and stay and kind of play with [my child], but I don't really like babysitters either, it makes me nervous around my children, ones that I don't know. I may consider something like [organization's name] because I know some of the staff through [organization's name]. But to drop my kid off to someone I don't know – I don't think I could do it.

Service providers (*n*=3) recognized the importance of building a rapport with carers, stating that it takes "a long time to build that strong relationship." Service providers try to make carers feel comfortable using the drop-in centre by interacting with them, and offering them beverages. They also felt that the environment of the ELDC played a role in creating a space where carers could feel comfortable and spoke at length about the structural limitations they experienced, which is described below.

Social support was a factor in how carers learned about the drop-in centre and whether they used it. The majority of users (*n*=3) of the drop-in centre found out about the drop-in centre from a relative or friend. Some of the carers (*n*=3) described themselves as "shy" and didn't like big crowds so having someone with them was an important factor in their decision to use any type of service. For those who did use the ELDC, having someone to go with them was a facilitator to use of the ELDC.

The final factor to influence use of the drop-in centre was having a sense of safety. Both users and non-users (*n*=4) agree that safety influenced their use of the ELDC. The homes in the neighbourhood where the ELDC is located were described as "run-down," there were concerns about the safety of the parks, and the presence of "sketchy people." The ELDC is also located near a busy road, which was raised by some carers (*n*=2) who

were concerned about young children being too close to traffic. However, users of the program (*n*=2) described the ELDC as a safe place in comparison to the neighbourhood. They also liked that it was clean and that toys were frequently sanitized.

Both carers and service providers described the importance of developing a relationship and trust in order to facilitate use of the ELDC. For some carers, simply having someone to go with to the ELDC was a facilitator to use, and the absence of a social support was a barrier for others. Finally, having a sense of safety about the ELDC was a facilitator to use, whereas, the lack of safety, as a result of the area the ELDC is located, acted as a barrier to use for other carers.

Availability (Ability to offer care at the current location of the drop-in centre)

Service providers spoke at length about the limitations of having a take-down site at a rental space. They felt that it limited the range and variety of services they could offer, it limited the number of carers of urban Aboriginal children and urban Aboriginal children who could use the ELDC, and the type of environment that they wanted to create for families. The size of the current drop-in centre limited the number of carers and children who could use the drop-in centre at the same time, and limited the number of resources that are able to be stored and displayed at the drop-in centre. Providers feel that the room becomes crowded when there is about twenty-one people, five or six adults and 10 to 12 children. Since babies, infants, and toddlers require space to move and interact, the actual capacity of the room is not representative of the number of people who can actually use the drop-in centre at any given time.

The current location does not have the space to accommodate the range of activities service providers would like to facilitate. The limited space prevents service providers from displaying all their toy and book lending resources, and providing early learning activities that require lots of space, such as physical activities.

The rental space also limits the possibilities for decorating the drop-in centre to create the providers' ideal drop-in centre environment. A permanent location would allow them to decorate vertical space and would make it easier to display documentation of children's growth and development since they would not have to put it up and take it down every day. They would like to create a space that is "home-like" and "natural," one that would include couches, plants, and carpets to make the drop-in centre more comfortable for carers and children. It would also be created with natural material, such as wood rather than cement. However, providers have been told that carers and children are happy with the way the drop-in centre is currently set-up.

Users (n=4) liked the set-up of the drop-in centre: the wide variety and selection of toys, arts and crafts, the activity drop-in, such as the painting and sandbox areas. They also liked the resources available at the drop-in centre, such as medicine for diaper rash, diapers, and bus tickets, and they also liked that there were free snacks and meals. Users liked that there weren't a lot of scheduled, formal workshops or activities happening so that they could casually hang out at the drop-in centre. Finally, users liked that it was a small set-up and that it was quiet space.

Pilot Study

Identifying carers of urban Aboriginal children: Eligibility criteria

The researcher instructed contacts from the organization to invite carers of Aboriginal children between the ages of zero and six who used the ELDC, and those who did not use the ELDC to learn more about the study. Since discretion to identify carers of Aboriginal children was left up to the service providers, the researcher did not ask during the formal invitation whether or not the participant self-identified as Aboriginal. Participants of the study all stated that they cared for Aboriginal children; however, three carers did not self-identify as Aboriginal and one carer identified as having Aboriginal ancestry.

The researcher received two lists of contacts separating carers based on their use of the ELDC. From the interviews it became known that some non-users have participated in activities affiliated with the drop-in centre and half of the users interviewed have not used the drop-in centre for at least one year, resulting in further variability in the sample population.

Recruitment and sample size

Recruitment for all participants required a "gatekeeper" to initiate contact between participant and researcher (Creswell, 2007, p. 71). Service providers were recruited through a digital invitation forwarded via e-mail by the director of the organization.

However, the invitation was only forwarded to the project manager who was one of the three participants of the study. As a result, despite requesting contact via phone at the end of the invitation by each service provider, communications and scheduling of interviews of all three service providers occurred via e-mail concurrently in a series of communications over the course of two hours with the project manager.

At the end of each interview, service providers were requested to identify three carers who used the drop-in centre and who would be interested in participating in the study. Through conversation with the service provider at the end of the third interview, the researcher became aware that all three service providers were planning on working together to recruit carers. Another contact from the organization came forward to help with recruitment of non-users. Both service providers worked together to recruit users and non-users concurrently at a social event hosted by the organization.

Each service provider was requested to recruit three carers for a total of nine users to approach for inclusion in this study. Regarding non-users, it was explained that the researcher wanted to have six non-users, therefore requested the contacts of at least ten non-users to approach for inclusion in this study. In the end, a list of five users and seven non-users was provided to the researcher. In total, five users and four non-users were successfully contacted and agreed to participate in the study.

Through additional contact with the project manager while obtaining additional documents and clarifications and discussion with service providers before and after interviews, it was observed that although service providers were willing and happy to support and participate in this study, at the time they had a large quantity of

responsibilities related to their job that left them at times burdened by the additional work brought on by this study.

Additional documents

Additional documents describing users of the ELDC were collected to better describe who was using the drop-in centre. Documents were provided as summaries that were formatted for input into a municipal database that collects information from all Ontario Early Years Centres. Summaries were provided to ensure the confidentiality of users of the program. The only data available referencing Aboriginality was about preferred language spoken by carers, which was collected voluntarily from the registration form in which participants selected English, French, or other with a space to specify.

Data analysis

Characteristics of carers that influenced data analysis were the location that carers currently live, the location where carers used to live, Aboriginal status, and use of the ELDC (see Appendix F). This approach successfully identified some factors to use of the ELDC. For example, in the first interviews with carers, the issue of lack of services during prolonged school breaks (e.g., winter holidays, March break, summer holidays) was an issue that arose through the course of the interviews. Through exploration in subsequent interviews, the code of "absence of structure and routine in child's life" was identified and recognized as a facilitator of use for the ELDC. However, topics that arose

in the final interviews could not be fully explored (e.g., the issue of safety was raised in the final set of interviews).

Data collected from interviews with participants and analyzed with content analysis was not a sufficient method to explore all aspects of the AAA framework. During an interim review of the data collection and analysis process with thesis committee members, additional descriptive data about the size of the ELDC was requested, specifically: description of the size of the drop-in centre, the number of users, and the frequency of visits were collected to corroborate observational accounts provided by participants as well as to provide sufficient detail for the audience of the study to assess the usefulness of the program. Along with the three dimensions of access to health care services described, the AAA framework interprets services as the allocation of resources that is designed to produce health (McIntyre et al., 2009). An ECEC program is also part of the series of services designed to produce and promote health and can also be evaluated for whether the resources that compose the program are being properly used based on the outcomes its produces, and by the number and type of people who use it. Although the aspect of effective allocation of resources from the AAA framework was briefly explored through the limited descriptive quantitative data that was collected and through the description of needs for childcare services that carers provided, it could not be properly assessed due to the limited data available. For example, although there were participant accounts of the relative number of carers of Aboriginal children and Aboriginal children who used the program, from the data available, it was not possible to

determine the actual number of carers of Aboriginal children and Aboriginal children who used the service.

CHAPTER FOUR
Discussion

Summary of Key Findings

Identification and recruitment of carers of urban Aboriginal children into this study was successfully achieved and characteristics of carers of importance were identified. Characteristics of carers to consider in future recruitment of carers of urban Aboriginal children are: 1) carers' self-identification; 2) location of residence in relation to the location of the service; and, 3) frequency of use of the ELDC.

Preliminary analysis of data suggested four categories of factors that influenced use of the ELDC: Availability of location, availability in relation to time, the Aboriginal-based content offered at the ELDC, and carers' personal preferences. Specifically, factors that influenced use of the ELDC were proximity of ELDC to carers' residence; availability of unstructured time; level of depth of the Aboriginal-based teachings and activities offered at the ELDC; relationship between service provider and carer; social support; and, carers' sense of safety.

Lessons Learned

Description of the population in need

To apply the AAA framework, it is necessary to first identify the population who could most benefit from use of the service (McIntyre et al., 2009). As mentioned above, carers of urban Aboriginal children were selected as the population who could most benefit from use of the ELDC because of the results obtained from interviews with service providers who stated that they would like see more carers of Aboriginal children

using the service, and previous literature suggesting the importance of culturally sensitive services for Aboriginal people. Preliminary data analyses of the interviews from this pilot study suggest that the sub-population of ethnically-mixed urban Aboriginal children and their carers would benefit most from use of the ELDC.

The preliminary findings of this study suggest that the Aboriginal-based content, which were derived through comparing and contrasting data obtained from non-Aboriginal and Aboriginal carers, and further triangulated with data obtained from service providers suggests that the Aboriginal-based content offered at the ELDC does not offer acceptable services for Aboriginal carers with a strong connections to their cultural heritage and who currently have a community where they can practice and engage in their culture in a "comfortable" or "welcome" environment. Non-Aboriginal carers who were not familiar with their children's Aboriginal culture benefited from culturally-sensitive services for a multicultural audience because the ELDC offered their children a space to connect and learn about their culture and language and it also acted as a gateway to additional Aboriginal-based services. A strong sense of cultural identity has been shown to have beneficial effects on individuals' health, well-being, and behavior (e.g., Anderson et al., 2010; Taylor & Usborne, 2010). This study also identified that Aboriginal carers who have a strong sense of cultural identity but who are isolated from their on reserve communities also benefit from use of the ELDC because it offered a culturally sensitive space to bring their children.

Involvement of Aboriginal organization in the study process

A "gatekeeper" can be a valuable asset to a researcher studying hard-to-reach populations; however, they also have the potential to influence the entire study process by determining who is recruited, as well as who is not recruited, into a study (Groger et al., 1999). Service providers played an important role in the recruitment and data collection phases of this study. Their involvement facilitated recruitment and retention rates because of the strong relationship they fostered with carers who use their services; however, this also influenced who participated and the data collected. As a small organization, this study may have also unintentionally added an additional burden on service providers who already have multiple responsibilities. The additional burden of recruiting carers may have influenced how they recruited carers, since approaching carers all at once would be less time consuming than approaching each individually over the course of a few weeks.

As a result of service providers working together to recruit all carers at a single event, carers who have positive relationships with the organization, and who are actively involved in the organization were more likely to be approached and to agree to participate in this study. The representativeness of the study may have been compromised due to recruitment and sampling of a non-representative sample population of carers who use the organization's services (Miles & Huberman, 1994).

The location of each interview was mutually decided upon by the participant and the researcher; however, conducting interviews at the organization's facilities did compromise the anonymity and confidentiality of some participants in this study.

Sampling and recruitment strategy

Although the study protocol outlined three separate sampling strategies for each group of participants, as a result of the recruitment process, convenience sampling was the strategy used to sample carers, which may have influenced the representativeness of the results (Miles & Huberman, 1994; Patton, 2002). The sample population more accurately reflects a population of carers of urban Aboriginal children between the ages of zero and six who presented to a culturally sensitive early childhood education and care services, specifically the organization's Head Start program. This group of presenters would then be classified as a never, previous, or current users of the ELDC. This ensures that the sample had a similar starting point. It would be a different question to look at all urban Aboriginal families because that becomes a study of carers who differed with and without known use of the service.

The role of the researcher

Qualitative research functions within paradigms that adhere to the belief that there is no one objective truth (Fink, 2000). As a result, truth can change over time, between societies, and between researchers, each individual is influenced by their personal experiences, beliefs, and perceptions, which will influence the data collection and analysis processes in qualitative research (Fink). Reflexivity is an approach to addressing the influence of the researcher on the research process to enhance credibility of the results (Shenton, 2004). It allows a research to become aware of how she or he has shaped the research process through prior assumptions and experiences, which are based on personal

characteristics such as age, sex, and race, all of which may potentially influence the credibility of the findings of the study (Fischer, 2009; Mays & Pope, 2000).

As a novice researcher, and as a non-Aboriginal person, the researcher may have influenced the type and quality of the data collected. Cultural differences may have influenced the data collected as a non-Aboriginal researcher conducting research in a community based around Aboriginal services and Aboriginal culture. Detailed discussion about specific Aboriginal cultures and experiences were discussed in two of the seven interviews with Aboriginal participants. These participants also spoke candidly about non-Aboriginal-related topics, suggesting that they enjoyed talking about the topic in general and were not affected by the fact the researcher was non-Aboriginal. In the rest of the interviews, although the quantity of discussion about culture varied, the level of discussion was limited to generalities in which participants used descriptive words such as “Aboriginal,” “native,” and “Ojibwe.” An Aboriginal researcher may have been able to engage with participants on a deeper level about the intricacies of Aboriginal culture.

Comparison of the preliminary findings with current literature

The results of the preliminary data analysis corroborated current research as well as raised several issues that are not known to be discussed in the literature. Among the ten strategies outlined to promote early learning among First Nation children, according to service providers and users of the drop-in centre, the ELDC offers eight of these strategies (BSRC, 2010). Service providers offered service based in Aboriginal culture, created a welcoming environment for carers, developed relationships with carers,

customized programming to meet the needs of individual families, supported learning at home, respected the diversity of cultures, and shared traditional skills like smudging ceremonies with families. However, according to service providers and users of the program, urban Aboriginal families did not frequently use the ELDC.

The preferences expressed by non-users about socialization, and feeling welcome have been documented in other research examining the use of health care services by urban Aboriginal people. Benoit et al. (2001) conducted a case study about use of an Urban Aboriginal Health Centre by urban Aboriginal women in Canada and found that a non-hierarchical organization of services, and socialization were important features of service for women (Benoit et al., 2001).

The qualitative research examining the experiences of caring for urban Aboriginal children focuses on the experiences of parents and carers who are Aboriginal themselves (BSRC, 2006; BSRC, 2010). However, with a growing population of multiethnic urban Aboriginal children, the experiences and preferences of non-Aboriginal parents and carers of urban Aboriginal children should be explored to ensure that the needs of all urban Aboriginal children are understood and appropriate services are provided (Guimond, 2003). This study suggests that there are non-Aboriginal carers of urban Aboriginal children who are interested and invested in promoting Aboriginal cultures in their children's lives; however, they lack the knowledge to support cultural growth and to foster a sense of cultural identity in their children.

There is no known research examining the experiences of providing care to a multicultural, and multi-cultural Aboriginal population by Aboriginal service providers.

The findings of the preliminary data analysis suggests that the experience of providing care in an urban, multicultural setting by Aboriginal service providers is complex and has both personal and professional implications.

Applicability of the AAA framework

From preliminary data analysis, the data supported the framework in the two dimensions of availability and acceptability. As a provincially-funded program that is free to use, the dimension of affordability, which relates to the full cost to using a service, was not perceived as a factor that influenced use of the service by users, non-users, and service providers of the ELDC.

The issue of awareness of the service was not addressed in this study since all participants were aware that the service existed. However, level of awareness may also include awareness of the type of services offered to carers and children at the drop-in centre. The use of catch phrases and ambiguous or unclear wording to describe the services offered at the drop-in centre may influence a carers' decision to use the service. As a result, perceptions of awareness of the service should be considered in augmenting this framework when applying it to community-based organizations or organizations that function to serve Aboriginal populations.

Recommendations for main study

Three categories: "current users," "previous users," and "non-users"

The broad inclusion criteria for this study raised several issues that must be addressed for a future large-scale study. In this study, participants were categorized as users if they used the ELDC at least once; however, preliminary analysis demonstrated the type of data obtained differed between current users and past users. Furthermore, at least one user could also be considered a non-user because of her decision to discontinue use of the ELDC. For a future study, users of the ELDC should be categorized as either current or previous users, with current users defined as a carer who self-identifies as currently using the ELDC, and a previous user defined as a carer that self-identifies as someone who previously used the ELDC but has decided to discontinue use of it.

Inclusion of non-Aboriginal carers of urban Aboriginal children

The second issue regarding inclusion criteria was the definition of "urban Aboriginal family" and "carers." To explore the range of carers of urban Aboriginal children, self-identified Aboriginal, Aboriginal ancestry, and non-Aboriginal carers of urban Aboriginal children participated in this study. Preliminary data analysis from this pilot study suggests that a universal Aboriginal-based family drop-in centre would most benefit urban Aboriginal children and their carers who have limited connection and knowledge of their cultural identity and/or heritage. The ELDC was also beneficial for urban Aboriginal carers who are isolated from their reserve. A future large-scale study should ensure the inclusion of non-Aboriginal carers of Aboriginal children.

Focusing recruitment of previous users and non-users on carers who live, or used to live, in the same neighbourhood where the ELDC is located

Location and distance to quality services is widely recognized as a barrier to use of services for any population. Based on the preliminary analysis of data, all non-users who did not live near the ELDC but were aware of the drop-in centre cited transportation and distance as barriers to use of the program. Non-users who were aware of the program and who either currently or previously lived in the same neighbourhood to where the ELDC is located provided a greater range and depth of issues that influenced their decision not to use the ELDC.

Although location was recognized as a barrier to use of the ELDC from the analysis of data, further research to explore the relationship between distance to travel to services, acceptable forms of transportation, and quantity, type, and location of acceptable early learning services for carers of urban Aboriginal children would be an appropriate direction for study. This type of information would better identify the influence of location as a barrier to use.

Therefore, previous users and non-users should be selected based on their location of residence with a distinction being made between whether they currently or previously lived in the same neighbourhood as where the ELDC is located.

Involvement of an urban Aboriginal organization

Developing a rapport with the organization played an integral role in the success of this study. Discussion with service providers prior to implementation of the recruitment protocol is advised to ensure that the expectations and abilities of both parties are clearly understood and respected (CIHRNSERCCSSHRCC, 2010). Regarding the recruitment protocol, clear and detailed instructions should be provided to reduce instances of miscommunication and to ensure recruitment of information-rich cases. Arrangements for a child-friendly location or child-minding services located outside of the organization's facilities should be made as an available option for location of interviews.

Study Strengths

All carers who participated in this study had at least one child who used the preschool. By sharing this characteristic, certain themes, such as the importance of Aboriginal-based services, were consistent among carers and allowed for a further nuanced analysis of the code. It also strengthens the representativeness of the findings of the analysis to carers of urban Aboriginal children who use the organization's services.

Use of three categories of participants allowed for comparing and contrasting of data to confirm findings, and triangulation of data sources, which strengthened the preliminary findings of this study (Miles & Huberman, 1994).

Developing rapport with the organization

Developing rapport refers to the process of establishing trust and credibility with the organization (Shenton, 2004). Members of the organization were subsequently identified as gatekeepers who facilitated access and rapport with carers (Creswell, 2007). From an ethical perspective, engagement with the Aboriginal organization is an important component of conducting research with First Nations people (CIHRNSERCCSSHRCC , 2010). In order to develop a rapport with the organization, the researcher volunteered at the ELDC for several months during the development of the research question. As a result of volunteering at the ELDC, the researcher developed a rapport with the service providers who worked there. Due to changes in the staffing of the drop-in centre, the researcher was acquainted with one of the three service providers at the drop-in centre at the start of the research study.

The organization was welcoming to the project and involved in supporting the research study. Empty offices or booked rooms were supplied as space to conduct the interviews; to reduce some burden of participating in the study, the organization provided childcare during the interview time.

Limitations/Methodological Issues

The discussion about use of qualitative research methods in health care research has shifted from the legitimacy of results obtained from qualitative research to determining the rigor of the studies and the representativeness of the findings (Barbour, 2001). As a result, checklists and study protocols that require a prescribed methodology

in qualitative research are emphasized to promote rigor and obtain ethical approval from ethics board but they may be applied differently between researchers or prevent the researcher from adapting to new findings and situations (Barbour, 2001; Eakin & Mykhalovskiy, 2003; Groger, Mayberry, & Straker, 1999). One of the nine characteristics of qualitative research is emergent design, which refers to the changes to the initial research plan that take place as the researcher collects data from the field (Creswell, 2007). Eakin & Mykhalovskiy (2003) argue that current guidelines to assessing the quality of qualitative health research use a procedural approach that is based on the promotion of evidence-based medicine, a concept promoted by clinical epidemiologists who adhere to principles of positivist science. This procedural approach focuses on application of "right" methods to the research question meanwhile de-emphasizing the analytic content of qualitative studies (Eakin & Mykhalovskiy, p. 190). Barbour (2001) argues that the use of qualitative research techniques, such as purposive sampling, triangulation, and multiple coding, will not necessarily result in rigorous research; instead, she argues that an understanding of the broad rationale and assumptions of qualitative research is useful to guide the research process and methodological decisions. Finally, maintaining ethical conduct in research for the protection of human subjects, which has been structured for biological research, has resulted in the production and adherence to a priori study protocols which may limit the ability of qualitative researchers to adapt to the data collected without a substantial amount of time being allocated to seeking amendments from the institutional review board (Groger et al., 1999).

This limitations and methodological issues section will review the limitations to the methodology of the qualitative descriptive study protocol used in this pilot study as well as review alternative perspectives of qualitative methods to recognize the variability that exists between schools of thought about qualitative methodology.

Theoretical saturation

Theoretical saturation is a term derived from grounded theory, a subcategory of qualitative research, and is often considered the point at which data collection and analysis is completed (Creswell, 2007; Rowan & Hurston, 1997). According to Morse (1989), theoretical saturation is achieved when new data supports existing findings without contributing new information or detail. Creswell (2007) defines saturation as the point when "I no longer find new information that adds to my understanding of the category" (p. 240). Other end-points in qualitative research that refer to a similar concept include data saturation, and informational redundancy (Groger et al., 1999; Onweugbuzie & Leech, 2007).

In this pilot study, saturation was not achieved due to the small sample size, and the absence of concurrent data collection and analysis. A sample size that is too small will not produce enough information to adequately achieve saturation of data and the absence of concurrent data collection and analysis meant that codes could not be fully explored in all the interviews (Creswell, 2007; Sandelowski, 1995).

Referring to sample size selection, Conrad (1990) states "The old fieldwork adage probably holds here: you have enough data when you begin hearing the same stories over

and over again" (p. 1258). In her frequently cited article on selecting sample size in qualitative research, Sandelowski (1995) concludes that the sample size is dependent on the purpose of the study, the qualitative method used, and the level of experience that the researcher has in qualitative data collection and analysis. Alternatively, reference to previous similar research for an estimation of sample size is also recommended for use in proposals for qualitative studies (Rowan & Huston, 1997).

The small sample size may have limited the transferability of the results because of the absence of sufficient data to identify and saturate themes and codes that are applicable to a broader population (Sandelowski, 1995; Shenton). Some qualitative researchers argue that despite the contextual nature of qualitative inquiry, findings derived from a qualitative study could potentially be viewed as an example of a phenomenon that occurs within a broader population not simply the sample population (Shenton, 2004). To determine transferability of findings, the researcher must provide sufficient contextual detail of the research study, including the sample size, so that a reader of the study will be able to determine the appropriateness of applying findings to other locations (Shenton).

Due to data collection and analysis issues and pragmatic constraints, the full sample size was not recruited in this pilot study. In total, twelve participants were successfully recruited into the study and although this limitation reduced the quality of the findings, the process of recruitment provided valuable insight into the variability in the population of interest (i.e., carers of urban Aboriginal children) that will be useful for the main study.

As a result of these methodological limitations, it was not possible to achieve saturation in any of the themes identified in the data. Cutcliffe and McKenna (2002) argue that despite the importance of theoretical saturation in marking the completion of a qualitative study, the definitions and descriptions of theoretical saturation provided in the literature do not lend themselves to pragmatic use. The authors argue that the assertion that saturation of data has been achieved requires an element of faith that no new interviews would have disproved their claim (Cutcliffe & McKenna, 2002).

Sampling strategy

For this study, maximum variation sampling would have been the ideal sampling strategy because its purpose is to collect a diverse range of experiences about the phenomenon of interest in order to identify the common patterns despite variation between experiences (Patton, 2002). However, Aboriginal and low-income populations are often described as "hard-to-reach" because they are not connected to social or community networks that are often used by researchers to identify potential participants for studies.

Participant selection

A researcher can only talk to those who can be contacted and who agree to participate in the study (Groger et al., 1999; Miles & Huberman, 1994). Sampling non-representative informants narrows the scope of results and reduces the transferability of the findings by not including the experiences of participants who meet the inclusion

criteria but cannot or will not participate in the study (Groger et al.; Shenton, 2004). Carers of urban Aboriginal children who were not included in this study were those who did not attend the event where participants were recruited; those who could not use the the organization's programs; and, those who did not want to use the organization's programs. Furthermore, all participants had at least a high school diploma or equivalent or some alternative educational training, cared for at least two children, and used Aboriginal-based ECEC services in the community.

Data collection and analysis

Due to time constraints, multiple interviews (n=10) were conducted two to three each in a single day, thereby preventing concurrent data collection and analysis, which is the recommended approach for qualitative data analysis (Creswell, 2007). Field notes were written between interviews to identify recurring topics, which were explored in subsequent interviews. Memos were produced throughout the course of data collection; however, analysis of individual transcripts immediately after collection to produce codes that are explored in subsequent interviews is the ideal approach to data collection and analysis (Creswell). Field notes, comments that are collected prior to, during, and after an interview are accounts of the interviewer's reflections and observations, were written up as reflective remarks and described the experience of conducting each interview, observations about the participants non-verbal cues, and self-reflection about the field notes (Miles and Huberman, 1994; p66). Memoing of transcripts, which is part of the

initial exploration of a database, is used as a reflective tool to identify potential themes or concepts that may be relevant to codes (Creswell, 2007).

In qualitative research, concurrent data collection and analysis is used to explore codes as they arise so that theoretical saturation can be achieved (Creswell, 2007). In this study, interview guides were revised as topics arose through the course of data collection and were explored in subsequent interviews (e.g., preferences for services during extended school breaks). Furthermore, additional member checking as described by Miles and Huberman (1994) as getting information from informants as an approach to confirm findings with carers also did not occur due to time constraints.

Confidentiality/Anonymity

According to the Tri-Council Policy Statement, concerns of individual participants and their community regarding anonymity, privacy and confidentiality should be addressed prior to participation in the research project (CIHR-NSERCC-SSHRCC, 2010). In this study, several efforts to maintain confidentiality and anonymity of participants, including notification of the limitations to anonymity, research protocol designed to recruit each participant individually into the study, and selection of the interview location at an agreed upon location between the participant and researcher.

The small, inclusive community of families who used this organization and service providers influenced recruitment of participants and the ability to maintain confidentiality throughout the course of the study. In phone conversations and during interviews, many participants stated that they were willing to participate in the study

because service providers approached them and the organization approved the study. Through conversations before and after interviews with participants, and as a result of conducting interviews at the organization's locations, some service providers and participants became aware of who participated in the study.

Respondent validation

Respondent validation, also known as member checking, is a process to improve the reliability, credibility, or internal validity of the results of a qualitative study (Mays & Pope, 2000). Sandelowski (1986) describes a credible study as: "when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own" (Sandelowsk, p. 30). The initial design for member checking for this study was the production of a summary of findings from each participant group that participants reviewed to ensure that their experiences were accurately represented in the results and to also allow participants the opportunity to provide feedback in instances when their personal experiences were not included or misinterpreted (Mays & Pope, 2000).

There are several concerns about the use of member checking as an approach for ensuring credibility of research findings. During member checking, the focus for the participant in respondent validation may be on their own individual concerns, whereas the focus for the investigator is an overview of the results (Mays & Pope). Barbour (2001) also warns against researchers who may disregard their own interpretation of findings in order to accept those of the respondents at face value (Barbour).

Similar to member checking, Miles and Huberman (1994) provide multiple approaches to confirming the results or confirming deeper levels of meaning from the findings by "getting feedback from informants" (Miles & Huberman, p. 275). They describe approaches that can be used during or at the end of data collection and analysis. As a result of the low quality of the data collected during the data collection period, "getting feedback from informants" during data collection would be an appropriate method for returning back to participants to explore codes and themes further to achieve theoretical saturation. However, they also warn against causing bias since the process of feeding back the results to participants may alter their behavior and perspectives (Miles & Huberman).

Conclusion

This thesis examined the feasibility of identifying and recruiting carers of urban Aboriginal children and identifying factors that influenced the use of the Early Learning Drop-in Centre (ELDC) by carers of urban Aboriginal children as perceived by service providers, carers of urban Aboriginal children between the ages of zero and six who use the service, and carers of urban Aboriginal children who do not use the service. It found that it was feasible to identify and recruit carers of urban Aboriginal children through gatekeepers who were providers of an Aboriginal early learning organization carers currently use.

Multi-dimensional factors that influenced the use of the ELDC by carers of urban Aboriginal children were associated with the relationship between the location and time of operation of the ELDC and the location and unstructured time of the carer and their

children, the type of Aboriginal content offered at the ELDC, and the carer's sense of trust of the service providers and safety in the neighbourhood and inside the ELDC, and finally, the presence of the social support.

This pilot study provides valuable insight in the production of a future, large-scale study identifying factors that influence use to an Aboriginal-based family drop-in centre by carers of urban Aboriginal children. Regarding recruitment of carers of urban Aboriginal children, characteristics of the sample population that are important to include are the level of use of service (currently using, previously used, never used), self-identification of the carer (self-identifies as Aboriginal, Aboriginal heritage/ancestry, non-Aboriginal), and the location of residence of the carers who were previous and non-users (currently lives within the same neighbourhood as the service, previously lived within the same neighbourhood as the services).

Consideration should also be taken while engaging with the organization offering services. In particular, to assess the burden that will be placed on service providers of small, non-profit, community-based organizations if they are involved in identifying and inviting carers to participate regardless of their desire to support the study. An additional consideration is to appreciate the level of anonymity and confidentiality that is possible within a small, inconclusive community.

Directions for future research identified from this study include: 1) determine the association of location (i.e., distance between service and carer), modes of transportation, type of early learning service (including content, quantity, quality of services), and use of service by carers of urban Aboriginal children; 2) describe the experience of carers of

urban Aboriginal children who are interested in supporting the children's cultural identity but who have limited knowledge of that culture in order to determine how best to support them; 3) describe the experience of Aboriginal services providers who offer early learning services to a multicultural, including the diverse Aboriginal cultures that may be observed in urban settings, clientele. In particular, describing experiences to better understand both the personal and professional implications in order to support these service providers and understand its influence on universal, cultural-based early learning services in a multicultural society.

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APPENDIX A

E-mail sent to gatekeeper to recruit service providers

Hi [Name of Contact]

Attached is a copy of the consent form for the staff members working at the [organization's name] Early Years Centre and below this message is the script to include in the body of the e-mail.

Regards,
Laura

****

To the staff of the [organization's name] Early Years Centre,

My name is Laura Dysart and I would like to invite you to take part in a study I am conducting as part of my graduate degree in the Health Research Methodologies program at McMaster University.

The purpose of this study is to describe the factors that influence use of the [organization's name] Early Years Centres. From this study, I hope to learn from three perspectives, that of the staff members who work at the [organization's name] Early Years Centre, the carers who use the centre, and those families who do not use the centre, what influences the ability of carers to access the [organization's name] Early Years Centre.

Your participation will play an important role to help describe the factors that influence use to the [organization's name] Early Years Centre. For more information about the study and your role as a participant, please view the consent form attached to this e-mail. If you have any further questions, don't hesitate to contact me at: dysartl@mcmaster.ca

If you would like to take part in this study, please contact me at dysartl@mcmaster.ca and list at least two dates that you would be free to meet, your preference for meeting location, and a phone number that I may contact you at.

Thank you in advance for your time and consideration,
Laura Dysart
MSc. Candidate, Health Research Methodology Program
Department of Clinical Epidemiology & Biostatistics
McMaster University

APPENDIX B

Letter of Consent

DATE: _____

LETTER OF INFORMATION / CONSENT for Participants

A study about factors that influence the use of the [Organization's name] Early Years Centre as perceived by providers of the program and carers with children between the ages of zero and six

Investigators:

Principal Investigator:

Laura Dysart
Department of Clinical Epidemiology and Biostatistics
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140
E-mail: dysartl@mcmaster.ca

Faculty Supervisor:

Dr. Gina Browne
School of Nursing
Department of Clinical Epidemiology and Biostatistics
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 x22293
E-mail: browneg@mcmaster.ca

What do I want to learn about?

You are invited to take part in a study that will describe the factors that affect the use of the [organization's name] Early Years Centre. Staff members from the centre and carers of children between the ages of zero and six who speak English and who are 16 years old or older are invited to take part in this study.

A factor is anything that stops someone who wants to use the centre from accessing it. I am hoping to learn about the experience of providing, using, trying to use, and not using the [organization's name] Early Years Centre in order to describe factors that affect the use of the centre.

I am doing this research to complete a graduate degree at McMaster University. My supervisor is Dr. Gina Browne, who studies the use of health care and social service programs. It is up to you to choose to take part in this study. There will be no negative impact on you or your relationship with [organization's name] Head Start if you choose not to take part in this study.

What will happen during the study?

I would like to meet with you for a 1-hour interview in a private area located in a public location. If you agree to take part in this study, I will contact you by phone so that we can pick a time and place to meet.

At the time of our meeting, I will give you a short questionnaire to collect background information (for example, your age, ethnicity, and the number of children you care for). This questionnaire will not ask for any information that can be used to identify you (for example, your name, phone number, personal address).

With your permission, I will record our interview with a voice recorder. I will ask you questions about your experiences and opinions about either providing, or using the [organization's name] Early Years Centre. If you do not use the [organization's name] Early Years Centre, I will ask you questions about your experiences using services and programs for your child(ren).
If you agree, I would like to contact you within three months of the interview to review a summary of the findings of the study. The summary is made up of the findings from multiple interviews. I would like to review the summary with you to check that I have correctly understood and described what is being said by you and other participants.

Are there any risks to taking part in this study?

The risks involved in participating in this study are minimal. You may feel uncomfortable about some of the questions that I ask. You may feel uneasy if there is someone you know at the location of our meeting spot. You may worry about how others will react to what you say about the [organization's name] Early Years Centre.

Please know that you do not need to answer questions that you do not want to answer and you can stop taking part in the study at any time. Below are the steps I am taking to protect your privacy.

- If we begin to discuss a topic that makes you uncomfortable or that you do not want to discuss, we will move on to the next question.
- If we have arrived at our meeting spot and you feel uncomfortable at the location, we can relocate our meeting to a nearby, public location.

Are there any benefits to doing this study?

The research will not benefit you directly. I hope to learn about what factors affect the use, or non-use, of a program for parents and carers of infants and young children. The findings of this study may help the [organization's name] Early Years Centre and other early year programs learn what factors encourage or prevent parents and carers from using their program.

Honorarium

To show my thanks to you for taking the time to meet with me, and for sharing your experiences, you will receive a Tim Horton's gift card worth $5.

Who will know what I said or did in the study?

Every effort will be made to protect your identity and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable through the stories we tell. Since your community is small, others may be able to identify you on the basis of references you make. Please keep this in mind in deciding what to tell me.

After our meeting, I will write our interview onto paper from the voice recording and remove names and locations that could be used to identify you. I will keep the voice recording in a password-protected external hard-drive that only I have access to for 1 year, at which point it will be destroyed.

What if I change my mind about being in the study?

It is your choice to be part of this study or not. You can decide to stop at any time, even after signing the consent form or part-way through the interview. If you decide to withdraw, there will be no negative consequences. In cases of withdrawal, any data you have provided will be destroyed unless you agree that it can still be used. You can choose not to answer some of the questions and still be in the study. Your decision whether or not to be part of the study will not change or stop the way you use services at the [organization's name] Early Years Centre or at [organization's name] Head Start.

How do I find out what was learned in this study?

I expect to have this study completed by the end of November, 2011. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact me via e-mail: dysartl@mcmaster.ca or by phone: 905-746-5822 (Laura Dysart, MSc. candidate)

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about a study being conducted by Laura Dysart and Dr. Gina Browne of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form. I agree to participate in the study.

1. I agree that the interview can be audio recorded.
… Yes.
… No.

2. …Yes, I would like to receive a summary of the study's results.
Please send them to this email address _____
or to this mailing address: _____
_____
_____

… No, I do not want to receive a summary of the study's results.

3. I agree to be contacted about a follow-up interview, and understand that I can always decline the request.
... Yes. Please contact me at: _____
... No.

Signature: _____

Name of Participant (Printed) _____

APPENDIX C

Interview Questions for Service Providers

FACTORS THAT INFLUENCE THE USE OF THE [ORGANIZATION'S NAME] EARLY YEARS CENTRE

1. **Before I begin, I want to bring your attention to the way that I will be phrasing some of my questions and what that means. When I talk about the "use" of the Early Years Centre by carers, I recognize that there must be a *desire* to use the centre so that no matter what the centre might look like, in any way, shape, or form, and no matter who that person is, if the person doesn't *want* to use the centre, they won't. So when I ask about what encourages or dissuades someone from using the centre, what I'm referring to is everything under the sun *except* "They do/don't use it because they do/don't want to".**

2. **You may choose to stop this interview at any point in time. You may choose not to answer any question that you do not want to answer. There are NO right answers; I am here to learn about your experiences.**

3. **When I started this project, I spoke to a lot of different people involved with the Ontario Early Years Centre in Hamilton and they all have their own hypotheses of what encourages use and what stops use of the Early Years Centre by carers. What I'd like to know from you is what *you* think allows people to use the centre; not what you have *heard* from other staff members, or any other people involved with *providing* this program in Hamilton, rather, I'm interested in learning about *your own experiences* at this centre with parents and carers. From what *you* have heard, and what *you* have seen, and what *you* have experienced, what brings people to the centre?**

4. **What keeps families coming back again and again?**

5. **We've talked about things that encourage or allow carers to visit and use the centre. What do you think prevents families from even showing up?**

6. **Based on your experience with carers, what have you found are some of the reasons that families stop using the centre?**

7. **The Early Years Centre welcomes every child and his or her family, but for my next question, what I'm interested in knowing about is who *you* envisage using the centre when you're planning activities, events, workshops, etc… *(pause)* Who is the Early Years Centre designed for?**
8. **Probe for: demographic characteristics**

9. **Is there anything else you think I need to know about…?**

END

Interview Questions for Users

FACTORS THAT INFLUENCE THE USE OF THE [ORGANIZATION'S NAME] EARLY YEARS CENTRE

You may choose to stop this interview at any point in time. You may choose not to answer any question that you do not want to answer. There are NO right answers; I am here to learn about your experiences.

1) **Tell me about the first time you visited the Early Years Centre.**
    a. **Probe for: how they found out about the centre; what attracted them to the centre**

2) **What do you like about the centre?**

3) **What don't you like about the centre?**

4) **We've talked a bit about the Early Years Centre itself, and now I would like to shift gears and talk about the act of going to the centre. In other words, I'm interested in knowing your thought process before you physically go to the Early Years Centre. *(pause)* Thinking back to times when you have gone to the centre, what is it about *those days* that makes it possible for you to visit Early Years?**
    a. **Probe for structural issues (e.g., time, location, etc).**
    b. **Probe for personal issues (e.g., relationship between structure/design/provision of the centre and their own circumstances).**

5) **Now, thinking back on times when you wanted to visit the centre but couldn't; how were those days different from the ones you have just described?**

6) **We've talked about what you like and don't like about the centre, and what makes it possible for you to visit the centre, and what stops you from visiting the centre… If you could change anything about the centre, what would you make different?**

7) **Shifting gears again, the next question is purposefully vague so you can answer it in any way that it makes sense to you: How has the centre helped you?**

8) **Is there anything else you think I need to know about that we didn't discuss?**

END

Interview Questions for Non-Users

FACTORS THAT INFLUENCE THE USE OF THE [ORGANIZATION'S NAME] EARLY YEARS CENTRE

You may choose to stop this interview at any point in time. You may choose not to answer any question that you do not want to answer. There are NO right answers; I am here to learn about your experiences.

1) **What programs do you and your child(ren) use in the community right now?**

2) **What do you like about the programs that you use?**

    a. **Probe for personal preferences.**
    b. **Probe for structural characteristics about the program (i.e., time, location, activities available).**

3) **What do you not like about the programs that you use?**

    a. **Probe for personal preferences.**
    b. **Probe for structural characteristics about the program (i.e., time, location, activities available).**

4) **Do these programs meet your current needs?**
    a. **If yes, how so?**
    b. **If not, how so?**

5) **I'm interested in learning more about you as a person and your personal experience using programs and services for your child(ren). What is it about you – your situation, your past experiences your personality, your desires, whatever, - what informs your decision to use a program?**

6) **Imagine a children's centre designed specifically for you and your child(ren) to use. It looks like however you want it to look; it would be located wherever you wanted it to be; it would be open whenever you wanted; it would have whatever you needed inside; provided in a way that will fit into your daily life. What would it look like?**

7) **Have you ever heard of the Early Years Centre at [location]?**

    a. **If yes, have you ever considered using the Early Years Centre at [location]? Why or why not?**

8) **Is there anything else you think I need to know about that we didn't discuss?**

END

APPENDIX D

Demographic Questionnaires

Questionnaire for Service Providers

Gender (please circle): Female / Male

How many years have you been working as an early childhood educator? _____

How long have you been working at the Early Years Centre? _____

Questionnaire for Users

Age: _____

Gender (please circle): Female / Male

What is the highest level of education you have completed?

___ Elementary school
___ High School or equivalent
___ College
___ Bachelor's degree
___ Master's degree
___ Doctoral degree
___ Professional degree
___ Other (please specify: _____)

What is your employment status?
___ Full time employed
___ Part time employed
___ Self-employed
___ Housewife/husband
___ Unemployed
___ Retired

How many children between the ages of 0 and 6 do you care for? _____

How many children above the age of 6 do you care for? _____

What is your relationship to her/him/them? _____

How long have you been coming to the Early Years Centre? _____

How often do you use the centre in one month? _____

Questionnaire for Non-Users

Age: _____

Gender (please circle): Female / Male

What is the highest level of education you have completed?

___ Elementary school
___ High School or equivalent
___ College
___ Bachelor's degree
___ Master's degree
___ Doctoral degree
___ Professional degree
___ Other (please specify: _____)

What is your employment status?

___ Full time employed
___ Part time employed
___ Self-employed
___ Housewife/husband
___ Unemployed
___ Retired

How many children between the ages of 0 and 6 do you care for? _____

How many children 7 years of age and older do you care for? _____

What is your relationship to her/him/them? _____

APPENDIX E

Initial Codebook for analysis with directed content analysis.

Codes – AAA Framework	**Codes**	Definition
Availability	Av	Discussion or comments that refer to the relationship between the services and the population of interest.
• Location of the drop-in centre	Av-Loc	Discussion or reference to the relationship between the location of the service, the population in need, and the transportation opportunities of that population.
• Times & Hours	Av-Tim	Discussion or reference to the degree of fit between service provider hours and the times that individuals need services to be provided.
• Willingness or Ability of service provider to provide care	Av-Pro	Discussion or reference to the willingness and ability of providers to service the population based on the type and severity of their condition.
• Type, quantity, and quality of programming	Av-Ty	Discussion or reference to the characteristics of the service provided and the nature and extent of the needs of the population.
Affordability	Af	Discussion or reference to the full costs to the individual of using the service and the individual's ability to pay in the context of the household budget and other demands on that budget.
Acceptability	Ac	Discussion or reference to the fit between providers and patient attitudes towards and expectations of each other. Included in acceptability are the factors related to the expectations of both carers and providers and the beliefs, perceptions, and past experiences of the carers.

APPENDIX F

Table categorizing all carers (N=9) by location and use of the ELDC

	Used the ELDC within the last year	Did not use the ELDC within the last year
Currently lives in the neighbourhood where the ELDC is located.	2	1
Currently does not live in the neighbourhood where the ELDC is located.	0	6

Table categorizing carers who have lived in the area (N=6) by location and use of the ELDC.

	Have used the ELDC	Have not used the ELDC
Currently live in the area	2	1
Currently does not live in the area	1	1

All carers (N=9)

	Have use the ELDC	Have not used the ELDC
Self-identify as Aboriginal/ Aboriginal heritage	3	3
Do not identify as Aboriginal	1	2

Table of languages spoken by users of the ELDC and affiliated programs between April 1, 2010 and September 15, 2011.

Language	**Unique users**	**No. of visits**	**No. of visits/user**
English	600	2620	4.4
Asiatic	32	415	14.1
Aboriginal	22	253	11.5
Other languages	12	79	6.6
Total	**666**	**3369**	**NA**

Aboriginal languages are Mohawk and Ojibwe
Asiatic languages include Mandarin, Chinese n.o.s., Korean, & Vietnamese
Other languages include Russian, Polish, French, Spanish & Arabic

Table of the number of participants and visits across the seasons between April 1, 2010 and April 1, 2011.

Season	No. of users	No. of visits
Winter	178	541
Fall	148	459
Spring	105	341
Summer	144	305
Total	**575**	**1646**

No. of users: the number of children between the ages of zero and six and parents/carers counted separately

Table of organized activities that were hosted or affiliated with the ELDC between April 1, 2010 and September 15, 2011

Activity	**No. of activities at the drop-in centre**	**No. of activities outside of the drop-in centre**	**TOTAL**
Aboriginal-themed	21	35	**56**
Child-minding	22	32	**54**
Public Health Professional	33	3	**36**
Physical Activity and Outdoors	23	2	**25**
Parenting	9	0	**9**
Male Carer-oriented	0	7	**7**
Songs and Stories	6	0	**6**
Check It Out Clinic	4	0	**4**
Cooking/Diet/Nutrition	4	0	**4**

Carer Personal Development	3	0	**3**
Parent/carer and child bonding	3	0	**3**
Arts and Crafts	2	0	**2**
School Readiness	1	0	**1**
Interactive activities	2	0	**2**
Other	0	1	**1**
TOTAL	**134**	**80**	**214**

Table of geographical origins of users of the ELDC between April 1, 2011 and September 15, 2011 that are organized by electoral districts.

District	No. of children (%)	No. of carers (%)	**TOTAL (%)**
Hamilton Centre	165 (54.3)	141 (47.0)	**306 (50.7)**
Unspecified	91 (29.9)	85 (28.3)	**176 (29.1)**
Hamilton East – Stoney Creek	33 (10.9)	49 (16.3)	**82 (13.6)**
Hamilton Mountain	4 (1.3)	13 (4.3)	**17 (2.8)**
Ancaster-Dundas-Flamborough-Westdale	7 (2.3)	4 (1.4)	**11 (1.8)**
Niagara West – Glanbrook	3 (1.0)	7 (2.4)	**10 (1.7)**
Burlington	1 (0.3)	1 (0.3)	**2 (0.3)**
TOTAL	**304 (50.3)**	**300 (49.7)**	**604 (100)**