The Impacts on Health and Education for Children and Families Enrolled in Aboriginal Head Start Urban and Northern Communities in Ontario

by

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A thesis submitted in conformity with the requirements for the degree of Masters of Arts
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Ontario Institute of Studies in Education
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Abstract

Aboriginal Head Start Urban and Northern Communities (AHSUNC) Initiative in Ontario provides an early childhood development program specifically for urban Aboriginal children between 3 and 5 years old. Twenty-nine families from Waabinong Head Start in Sault Ste Marie, Ontario, completed two questionnaires given four months apart covering a range of health and education topics. The completed surveys supported a trend toward healthier lifestyle choices, improved education of the children, upward mobility in employment, increases in self-perceived general and mental health of primary and second caregivers, and decreases in smoking, illegal drug use, and alcohol use. Families reported an increased sense of pride in being Aboriginal shown by their children, plus learning of culture and Ojibwe language, which has lead to improvement in all of the child’s skills and abilities.
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1 Chapter 1 – Why Aboriginal Head Start Urban and Northern Communities Initiative in Ontario?

1.1 Why study Aboriginal Head Start Urban and Northern Communities in Ontario?

This study will provide a much-needed base for future research regarding the Aboriginal Head Start Urban and Northern Communities Initiative in Ontario, and perhaps nationally. This study provides some preliminary findings on the impact that AHSUNC has on the health, education, culture and language, and social support of the children that attend the program and their caregivers. I will also provide evidence of what impact the program can have on a number of health and education related issues. The study was conducted in one AHSUNC project in Ontario, who volunteered to be a part of the study. Twenty-nine families participated in both questionnaires used in the first term of the school year.

I chose to study Aboriginal Head Start Urban and Northern Communities Initiative in Ontario because I have worked with the Ontario Region projects as a Program Consultant for over six years and noticed the lack of research about the impact the program has on the Aboriginal children and their families.

This study shows a positive trend that AHSUNC provides urban Aboriginal children and their families with improved knowledge and skills that can improve their health and education. My study looks at urban Aboriginal families who attend AHSUNC and how the programming, information and knowledge provided helps to improve the health, education, social support and culture and language of the participating families.

Twenty-nine families participated in this research from the Waabinong Head Start in Sault Ste. Marie, Ontario. The results show a positive trend toward improved health, education and social support. Twenty-six percent of parents and caregivers responded that their general and mental health increased over the three months after being a part of the AHSUNC community, but there was a decrease in the parents/caregivers ratings of the child’s health (23% declined). Ten percent of parents and caregivers returned to school, and 33% of parents and caregivers changed their employment status in the period between the two surveys. These two key factors are important to health and the social determinants of health (to be discussed in Section 2.2).
1.2 What is Aboriginal Head Start Urban and Northern Communities Initiative (AHSUNC)?

The Canadian government has taken very small steps to improving the lives of Aboriginal people in Canada after centuries of colonization, assimilation tactics, and neglect. By the 1990’s, the federal government had announced Aboriginal Early Childhood Development programs, intended to improve the lives of urban Aboriginal children (Greenwood, 2001; Palmantier, 2005). In 1994, Health Minister Dianne Marleau announced the Aboriginal Head Start Initiative (Palmantier, 2005). The Aboriginal Head Start Urban and Northern Communities Initiative provides community-based and community driven programming with a specific focus on culture and language, health, education, nutrition, social support, and parental involvement for Aboriginal children between the ages of 3 and 5 years old.

Urban Aboriginal groups developed and planned the initial design of AHSUNC to infuse culture, language and social support into high-risk Aboriginal families through the much-anticipated initiative (personal communication with Ronda Evans, 2000). The first six AHSUNC projects in Ontario recruited children who were living in low-income or single parent families, and those who were at risk for abuse, neglect or child protection. Elders and parents were part of the planning, development and implementation phases of their projects to ensure that they were community-based and driven, but also provided much needed health promotion, nutrition and a building block for further education (Palmantier, 2005; Greenwood, 2001).

AHSUNC consists of six core components: education and school readiness, health promotion, nutrition, parental/family involvement, social support, and culture and language. As mentioned above, Elders, Aboriginal community members, and parents were brought together to review the American Head Start program and how that program could inform and guide the inception of the Canadian Aboriginal Head Start program. All the components work holistically to improve Aboriginal children’s lives from different perspectives. There are values and beliefs that work alongside of the six components. These values and beliefs provide Aboriginal specific meaning to AHSUNC. Some of the values and beliefs are: that children “have a right” to be proud of being Aboriginal, learn an Aboriginal language and worldview, receive guidance in a culturally appropriate manner, have the right to acquire knowledge in an experiential manner, and be loved
by their family and community while living a healthy lifestyle. Each of the core components works toward incorporating the beliefs and values into the curriculum.

AHSUNC is provided to Aboriginal children in urban and northern communities across Canada on a four days per week cycle between September and June. The program is offered free to Aboriginal families with children between 3 and 5 years old and is offered in morning and afternoon sessions similar to kindergarten and other preschool programs. There is no standard curriculum across the country, but each project uses a school readiness curriculum infused with Aboriginal content, which includes culture and language components. All AHSUNC projects in Ontario are licensed as daycare facilities under the Day Nurseries Act (DNA). All teaching staff must have an Early Childhood Educator (ECE) diploma and passed a criminal reference check as per the Day Nurseries Act.

The fourteen AHSUNC projects in Ontario are funded by the Public Health Agency of Canada Ontario Regional office. The projects are located in Sioux Lookout, Kenora, Fort Frances, Thunder Bay, Sault Ste Marie, Moosonee, Hamilton, Fort Erie, one Inuit project in Ottawa, and another First Nations and Métis project in Ottawa, and four locations which represent the four directions of the Aboriginal Medicine Wheel in the Toronto area. The current 2007/08 annual budget for the program in Ontario is $5,548,000 per fiscal year. There is some variability in the levels of funding of the Ontario Region AHSUNC projects, but each project receives money for personnel, transportation, materials including meals, and evaluation. Projects are required to have 10% of their entire budget dedicated to evaluation, which is usually conducted by the Public Health Agency of Canada and used internally. The project funding is renewed based on the federal government’s Treasury Board Secretariat policies and procedures, with the next renewal cycle occurring after April 1, 2009. Future programming is dependent on the level of funding and sustainability of the funding.

While funding does not appear stable, projects still encourage parents and extended family members to be the first teacher the child has. AHSUNC projects, like Waabinong Head Start who participated in this study, provide families with knowledge, experiences, and cultural and linguistic awareness, which affects the health and education of the children and their families as they attend programming. Although AHSUNC’s six core components are established, it appears from my research and Ball and Elliot’s research (2005) that the families’ economic level, their
pride in being Aboriginal, and their connectedness to an Aboriginal community, can affect the parents and family’s decision to transmit culture and language, and to positively reinforce the learning of Western knowledge (Ball & Elliot, 2005; Greenwood & Fiske, 2003).

1.3 Introduction to the Issues

The Aboriginal population is the fastest growing population in Canada at 1.7 times faster than the non-Aboriginal Canadian rate (Cox, 2002; Hanselmann, 2001; Mendelson, 2006). The statistics also show that more than 62 percent of the Aboriginal identity population resides in off reserve areas like cities and rural towns (Mendelson, 2006). The Aboriginal population is younger than the overall Canadian population average. According to Statistics Canada (2006), there is a total of 147,820 self-identified Aboriginal people in Ontario with 17,400 of those being children between 0 and 4 years of age in the off reserve communities in Ontario. AHSUNC projects in Ontario serve approximately 560 children ages 3 to 5 years per fiscal year, which is approximately three percent of the off reserve self-identified Aboriginal children.

The 2001 Census clearly indicates that the Aboriginal identity population is steadily growing, but they are faced with a disproportionate number of historical issues that are now observed as issues in need of programs, services and funding (Newbold, 1998; Richards, 2005). Aboriginal children living off reserve are living in poverty (Campaign2000, 2006). Many of these Aboriginal children live in families with low incomes, have little or no social support or connection to their culture, and may have moved to urban areas to escape poverty on reserve. Poverty increases the number of family and domestic abuse cases, as well as the number of children taken into child welfare and protection agencies as noted by First Nations Child and Family Services (Blackstock, 2006). Children growing up in a single parent household are more likely to suffer from poverty and have less opportunities than a child in a two-parent high functioning family. Therefore it is not surprising that more than 46 percent of urban Aboriginal children are living in lone parent families (Blackstock, 2006).

Health Canada, and later, the Public Health Agency of Canada (PHAC), anticipated that academic and government reports would examine the impact of AHSUNC’s six core components (health promotion, nutrition, social support, education, parental/guardian involvement, and culture and language) to understand the need and value of the program. Since the inception of the program in 1993, there has been one impact evaluation completed nationally, and very few
academic articles or government reports examining the impact AHSUNC has had on any of the six core components it was intended to help address. The national program evaluation has not been released at this time; therefore policies, funding, and programming have not had the opportunity to utilize the information to alter the program in any way. It is now time to begin considering the impact of AHSUNC and the richness in outcomes, cost-effectiveness, and how it provides Aboriginal children with equal footing to move forward in an urban post-modern Canada.

Health Canada (1998) produced a position paper for their Health Promotion and Programs Branch staff that has guided the programs funded through the branch including AHSUNC. The population health approach outlined in the position paper is “to maintain and improve the health of the entire population and to reduce inequalities in health between population groups” (Health Canada, 1998: p. 1). Some scholars and universities have incorporated the population health approach and the twelve social determinants of health into their Public Health programs and courses, but there have been few academic articles or reports about the impact of Health Canada’s programs on these determinants of health (Ball, 2004; Greenwood, 2001).

As a Program Consultant with Health Canada in Ontario Region, I have monitored AHSUNC projects and believe that the social determinants of health are very much intertwined. All of these determinants impact each other in varying degrees while also being impacted by social programs like AHSUNC. Therefore, it is necessary to look at all the social issues surrounding Aboriginal people from birth to death to ensure that appropriate changes are made to revitalize the culture, and improve health by healing the wounds of colonialism and assimilation. Urban Aboriginal children are still more likely than non-Aboriginal children to live in poverty, in a lone parent family, be disconnected from their culture, not have attended a quality childcare facility, and face overt racism and assimilation policies. It is apparent from reviewing Aboriginal history in Canada that many different detrimental government policies (extermination, colonization, assimilation and cultural genocide) need to be reversed and healed. Programs and services have been started over the past fifteen years to begin the healing journey.

1.4 What motivation was there for this study?

I have worked as a Program Consultant at Health Canada and the Public Health Agency of Canada, which allowed me to enter many of the AHSUNC communities on a regular basis. In
this capacity, I spoke with AHSUNC staff, parents, extended families and Elders about what occurs within AHSUNC projects. Unfortunately, there are few reports being written about the successes of the projects as mentioned by participating families and public school staff. *Children Making A Community Whole: A Review of Aboriginal Head Start in Urban and Northern Communities* (2000) and Sones’ (2002) *Parents in Aboriginal Head Start: Building Community* are two reports that provide some information about the impact of the projects. These reports provide some quotes from parents, caregivers, staff, and Elders, but do not provide an Ontario perspective or an in-depth analysis of what impact the program has. After working with projects for a number of years and reading anecdotal quotes in Quarterly Narrative Reports, conversations at project visits, and workshops held in Ontario, I wanted to provide a more critical analysis of the impact AHSUNC has on the entire family.

Many government reports highlighted specific aspects of the program as was needed for internal or external issues, but very few academic studies or reports had been written to assess any aspect of AHSUNC nationally, regionally, or locally (Health Canada, 1998; Baxter and Associates, 1997; Ball, 2004; Sones, 2005; Palmantier, 2005).

From my own knowledge and a literature review about Aboriginal Head Start, Aboriginal Head Start Urban and Northern Communities, and Aboriginal Head Start On Reserve, I noted that more information was necessary to highlight this program and the work that has been and is being done. Many of the fourteen existing AHSUNC projects have anecdotal evidence of success, but without evidence based research, the program will be in constant jeopardy of losing its funding. I decided that studying the health and educational impacts of the children and families would best reflect the work that occurs at many AHSUNC projects not only in Ontario, but nationally, as impacts to health and education are a part of the mandate of the program.

### 1.5 Rationale

Aboriginal Head Start Urban and Northern Communities in Ontario has been operating for 14 years. Little research has documented how the culturally and spiritually sensitive program has impacted any of the social determinants of health, which I will further discuss in Section 2.2.2. Through an initial literature review, it was determined that scholars have reviewed the program to understand the core components and why this program was developed for urban Aboriginal children, but beyond that knowledge, little research exists. My study contributes to the literature
on population health, the social determinants of health, Aboriginal early childhood development, and Aboriginal Head Start Urban and Northern Communities Initiative.

Colonization and assimilation, starting in the 1600s, has created inequalities for Aboriginal people. Currently, First Nations and Inuit Health Branch (FNIHB) of Health Canada has been trying to address issues on reserves across Canada in terms of inadequate clean water, lack of health care professionals, remote schools that take children to continue education, substance abuse issues, and other social issues. Some Aboriginal people leave the reserves for these very reasons and move to large urban centres or continually move between a reserve and an urban community. The federal government has the responsibility for Aboriginal people in Canada, which means that the federal government is responsible for providing treaty rights and adequate living conditions. With this responsibility, there is an increased need for social programs that address Aboriginal-specific issues, like health and education. The Aboriginal Head Start Urban and Northern Communities Initiative started in earnest by 1995 with six core components (health promotion, nutrition, education, parental/caregiver involvement, social support, and culture and language) as the pillars of the programming that would be developed and administered for and by Aboriginal people based on the community’s needs and desires.

Statistics Canada (2007) has shown that Aboriginal people, regardless of where they reside, have poorer health outcomes and lower educational attainment than visible minority immigrants to Canada. While these data are from reserves in Canada, the Aboriginal Peoples Survey, which captures urban and off-reserve Aboriginal people, also suggests that employment opportunities, health outcomes, and educational attainment is lower than the general population, but not as poor as those Aboriginal people living on reserve (Statistics Canada – Aboriginal Peoples Survey, 2001). It is necessary to look at the twelve social determinants of health and apply these to urban Aboriginal people as they are important to understanding the inequalities that have come about because of colonization. Examining a program that utilizes the population health approach by incorporating the social determinants of health in an Indigenous framework will not only provide insight into the issues, but will capture whether such programs help urban Aboriginal children and families.
1.6 Research Questions

This research will provide a base for future research regarding Aboriginal-specific social programs intending to address inequalities in health and education, specifically for early childhood development. In my experiences as a Program Consultant working with AHSUNC projects in Ontario from 2000 to 2006, I heard parents, caregivers, Parent Councils and project staff tell me about the impact that AHSUNC was having as the children entered kindergarten, but I also heard about the impact the program was having on the families. This anecdotal evidence suggested that more was happening when Aboriginal children attended AHSUNC than was originally envisioned. While the federal government wanted to help families reconnect to their culture and language, it is my understanding that increasing social support networks has been an unintended outcome that also helps increase the cultural and linguistic revitalization that urban Aboriginal families are hoping will occur by being a part of AHSUNC.

With my experience and knowledge of the program, I wanted to study AHSUNC in a holistic way. The questions that I will be attempting to answer are:

1) Does AHSUNC provide urban Aboriginal children and their families with knowledge and skills that can improve their health and education in a culturally appropriate manner?

2) What is the perceived change in health and education of AHSUNC children and their families?

In Chapter 3, Section 3.3 below, I will outline the eight hypotheses that will be fully explored in Chapter 5. These eight questions were a way to further direct my study and to bring depth to the research.

It is my intention to promote this information within the Public Health Agency of Canada, who fund the AHSUNC initiative, and within the urban Aboriginal community at conferences, workshops and in reports.

1.7 Study Locations and Participants

There are 14 AHSUNC projects in Ontario as of 2008. These projects all have representation at the Ontario Aboriginal Head Start Association (OAHSA) table, which is a caregiver/parent-
driven body that reviews issues that relate to programming at each of the sites. I attended an OAHSA meeting in January 2007 to provide an overview of the research that I had planned to undertake and the purpose of the research. Two of the fourteen projects contacted me to be a part of the study: Sault Ste. Marie (Waabinong Head Start Family Resource Centre) and Fort Erie (Fort Erie Aboriginal Head Start).

Waabinong Head Start was one of the original six AHSUNC projects in Ontario and has been running since 1994, whereas Fort Erie Aboriginal Head Start was established in 2004 with programming beginning in 2005. I believed that a comparison of an older established project and a newer developing project would also provide insight into how AHSUNC affects the health and education of the families. Waabinong Head Start is located in the middle of the province in northern Ontario, whereas Fort Erie Head Start is located in the extreme south of the province; this difference in location may also have provided some interesting data analysis. Location and length of operation may have provided children and families with different experiences and education, which may have proved important. Future studies should take into consideration that different AHSUNC projects’ location, length of operation, and connection to community may change the AHSUNC experience for participants.

The Program Coordinators for each of the participating projects discussed the questionnaires and recruitment with me and their respective Parent Councils. I felt it was important to collaborate with the communities I was hoping to study with so that the findings were relevant and useful for the projects. Parent Councils determine what occurs within AHSUNC, from programming to financial decisions, therefore, their involvement shows that the parents and caregivers understood and agreed with the need to study the program impacts. The OCAP principles for researching with and in Aboriginal communities guided my decisions to receive input from some of the participants in the study (Schnarch, 2004). Marlene Brant Castellano (2001) argued for the need to collaborate and consult Aboriginal communities to ensure that any research would be relevant, useful, helpful, and sensitive to the issues that the community may be facing.

It was determined that every parent/caregiver with a child enrolled in the 2007/08 school year would be asked to participate in the survey. Additional information pertaining to the study could be addressed through the Project Coordinators. After the questionnaires were returned, it was
determined that there were not enough respondents from the Fort Erie Head Start, and therefore
the project was withdrawn from this study.
2 Chapter 2 –What is the Need for AHSUNC?

2.1 The History of Aboriginal Education in Canada

2.1.1 Introduction to Aboriginal Education in Canada

Traditional Aboriginal education has always been flexible, adaptable, and synergic. The entire community has always been responsible for educating Aboriginal children and youth. It is necessary to involve everyone in the education system to ensure a holistic approach with as much knowledge as can be given to the future generations. The Grandfathers have always said that things that occur now will have impact for seven generations and Aboriginal people in Canada are experiencing impacts from the past three hundred years of change in their education due to European contact. “The current marginalization that Aboriginal people find themselves in today is no recent event, but rather rooted in historical circumstances” (Frideres and Gadacz, 2001; p. 3).

Many changes have occurred in Aboriginal education in Canada over the past three hundred years. Communities have been dispersed, moved, relocated, or been assimilated to a great extent into mainstream society. Faries (1996) stated, “education became the most effective strategy for the resolution of the ‘Indian problem’” (Faries, 1996; p. 38) for the Europeans as they tried to rid themselves of the “savages” on the land.

Longboat (1986) paints the picture of how Aboriginal people came to be at war for their control and power in Canada.

Historically, education controlled by the Canadian government has worked at cross-purposes with the goals and ideals of the Indian nations: politically, by seeking to undermine the authority of traditional governments; economically, by seeking to replace traditional ways of life with others less suitable; and spiritually, by seeking to replace Indian religions and values with Christian ones (p. 23).

Many Aboriginal people believe that their lives need to be balanced in the four directions; mentally, emotionally, spiritually, and physically, therefore Longboat (1986) is suggesting that Aboriginal people have not been in control of their education and it causes some Aboriginal people to be “out of balance” in the four directions. To regain balance and walk in both the post-modern Canadian society as well as follow a traditional Aboriginal cultural and spiritual life,
education became the key to taking control of legal, economical, spiritual, and political ways of life.

“Knowledge includes, among other things, an understanding of human behaviour and human feeling; an insight into nature’s balances and relationships; an ability to create tools for survival; and methods or procedures for promoting growth and awareness in each generation of people – or education” (Beck, 1992; p. 47).

Aboriginal leaders have advocated that education needs to be addressed within communities to ensure vital information and the community’s way of life continues on for future generations. Many scholars (Barman, 1986; Akan, 1992; Frideres and Gadacz, 2001; Battiste, 1995) have echoed this belief that Aboriginal communities must have complete control of their education in order to transmit their culture, language, values and beliefs to another generation, and that everyone in the community is responsible for teaching the youth, especially the Elders.

The Elders that I have spoken with have always said that the medicine wheel represents the circle of life and Calliou (1995) shows how the teachings surrounding the medicine wheel can be used for many other issues and problems. Calliou (1995) states that the “circle symbolizes the continuity and connectedness of events” (Calliou, 1995; p. 51). In this paper, the medicine wheel will be used to show the stages of Aboriginal education in Canada from pre-contact through to the future directions of education.

Different Aboriginal communities teach about the medicine wheel. In these teachings, which can differ from nation to nation, each direction takes on various meanings. In Table 1, the symbolism associated with the medicine wheel and the issue of Aboriginal education in Canada is highlighted using my teachings and knowledge as an urban Algonquian woman. The Eastern door, which traditionally means “new” or “spring” or “birth”, will also represent pre-contact or traditional Aboriginal education. Traditional education or pre-contact education was characterized by its informality, flexibility, and community driven nature (Stonechild, 2006).

The Southern door, which traditionally means “childhood” or “summer” or “growing”, represents contact with Europeans and the educational changes that occurred in this period. While French explorers interacted positively with Aboriginal people in New France in the 1640s, the British explorers and settlers had a more negative approach to dealing with Aboriginal people (Stonechild, 2006).
The Western door, which traditionally means “adulthood” or “autumn” or “maturity”, represents post-contact era from the 1900s to present day. This era saw Aboriginal political organizations develop and begin to advocate for self-determination beginning with control of education (Stonechild, 2006; Adelson, 2005).

Finally, the Northern door, which traditionally means “Elder” or “winter” or “knowledgeable”, represents the future from present day. The future is uncertain, but Aboriginal people have made great strides toward taking control of their education systems at the community level.

**Figure 1  Traditional Medicine Wheel Symbols**

- **NORTH**
  - Traditional: Winter, Elder, & Wisdom
  - Education: Future directions, Use of knowledge & Experience, Appropriate funding, Aboriginal control, AHSUNC

- **WEST**
  - Traditional: Autumn, Adulthood Maturity, Education: Post-Contact
  - Education: Post-contact, Polices Treaty Rights, Change in control Funding issues, Curriculum changes

- **EAST**
  - Traditional: Spring, Infant Inexperienced, Informal Education: Pre-Contact, Family & Community oriented, Oral in nature Rooted in tradition

- **SOUTH**
  - Traditional: Summer, Children & Youth, Growing knowledge & experience
  - Education: Contact era, discontinuity of family life, day & residential schools, Christianity to save the “savages”, Beginning of social problems due to loss of family, culture, language & community connections
2.1.2 Pre-contact

It is widely acknowledged by many scholars that until the end of the 16th century, Aboriginal people educated their children with the oral tradition of reciting myths, legends, morals and songs that were vivid and easy to remember, as well as utilizing other experiential learning experiences that helped Aboriginal children understand the world around them (Atleo, 2004; Battiste, 1995; Barman, 1986; Grant, 1984; Mendelson, 2005; Hull, 2000; Hare, 2004; Bennett, Blackstock and De La Ronde, 2005). Traditional education focused on physical, emotional, spiritual, social and mental factors, thus explaining why “[t]he legends and stories often had highly symbolic meanings and involved intricate relationships… The use of symbolism, anthropomorphism, …animism… and metaphors appears to have been an extremely effective method of teaching very complex concepts” (More, 1989; p. 21).

The family, parents, grandparents, aunts, uncles and others did these teachings in the community to which the child belonged, ensuring that the spirituality of the community was maintained as well as providing behavioural and economic teachings. Traditional Aboriginal education “occurred within cultural settings that were characterized by subsistence economies, in-context learning, personal and kinship relations between teachers and students, and ample opportunities for students to observe adult role models who exemplified the knowledge, skills, and values being taught” (Hampton, 1995; p. 8). Family, community and kinship relationships were especially important in pre-contact survival, but these relationships are still very important for the preservation and re-education of future generations.

Grant (1984) recounts that Aboriginal people in Canada were hunters, and that they needed to follow the game animals, which were found intermittently throughout the forests prior to European contact, as this was their primary food source. Some First Nations were more agricultural, but most First Nations used game animals and fish as primary food sources (Grant, 1984).

“…[T]he winter group consisted of a few nuclear families who stayed together for mutual support and insurance against disaster. Summer conditions allowed larger and somewhat longer gatherings often around fishing stations or near berry fields of a number of such groups that composed a band. At such gatherings, there was time for
games and feasts, matchmaking, and a general cementing of social ties,” (Grant, 1984; p. 17).

Similar summer gatherings still exist today in the modern pow-wows. With these social gatherings, Aboriginal people had the opportunity to pass on education to the young. No formal education or policing existed, but there was a conscious intent to maintain and transmit traditional knowledge, therefore “[e]ducation consisted mainly in the recital of myths, legends, and moral aphorisms of the tribe, normally by a grandfather” (Grant, 1984; p.17). “There is an interdependent relationship among all members of the community” (Faries, 1996; p. 30), which still exists today, especially in traditional families and communities. This relationship helps to pass the knowledge from one generation to the next.

Other scholars (Barman, 1986; Battiste, 1995; More, 1989; Kawagley, 1990) have also stated that education was informal and very dependent on oral narratives that were vivid and easy to remember. Traditional education focused on physical, emotional, spiritual, social and mental factors (McKay and McKay, 1986), thus explaining why oral traditions are high in symbolism and involve many complicated relationships. This is necessary to help with teaching very complex and important concepts (More, 1989; p. 21). Kirkness (1980) states that these teachings were “done by the family, parents, grandparents, aunts and uncles” (p.1) to ensure that the spirituality in Aboriginal communities was maintained as well as providing behavioural and economic learning. Kirkness (1980) continues to state “[e]ach adult was responsible for each child, to see that he learned all that he needed to live a good life” (p. 2).

It has also been noted by scholars (Barman, 1986; Battiste, 1986; Wild, 1983; Hampton, 1995) that Aboriginal education and cultural transmission has occurred mainly by oral communication, but Battiste (1986) has noted that some nations had a form of written communication. Battiste (1986) and Grant (1984) both state that many Aboriginal nations had symbolic written text that the nation could understand.

It has also been acknowledged that Aboriginal people had good health prior to the arrival of Europeans (Atleo, 2004; Moffitt, 2004). There was fresh fish, game and plants to use in foods and medicines. Communities would share food so no one would go hungry, but everyone was responsible for trying to collect enough supplies to last the winter (Atleo, 2004). Without
capitalism, Aboriginal people were moving forward with little need for policing and law making as Kirkness (1984) notes.

To Aboriginal peoples, their informal education system was beyond its infancy and moving toward its western door to changing and adapting before the contact of Europeans. At first contact though, Europeans saw an unkempt and illiterate savage that needed refinement and European education. Barman (1986) relates “[t]he newcomers’ ethnocentricity predetermined an attitude and superiority, reflected in such assumptions as the Micmac being incapable of writing and Aboriginal children benefiting from European-style school” (Barman, 1986; p. 3).

Battiste (1986) states that many Europeans believed themselves to be superior in comparison with the Aboriginal people and believed that “Indians were not capable of writing” (Battiste, 1986; p. 27) as the Europeans could not see evidence of written literacy. Any evidence of written literacy, such as scrolls and codices, were destroyed when they were found. Wilson (1986) also reports that from Champlain’s arrival in 1608 there has been the Europeans’ belief that “they would dominate, oust, or conquer the indigenous population” (Wilson, 1986; p. 65) so they could have the land and all that was within it.

2.1.3 Contact

Many scholars have stated diseases like smallpox, diphtheria and plague, came with the Europeans at the beginning of the 16th century. These diseases caused loss of life and a marked change in communities as the Europeans introduced formal education (Hare, 2004; Bennett, Blackstock & De La Ronde, 2005; Newbold, 2005; Barman, 1986; Barton et al., 2005). Waldram, Herring and Young (2006) argue that many Aboriginal people died when Europeans began to force Aboriginal people into enclosed Western formal education settings. Other scholars have noted that formal education forced Aboriginal people into indoor classrooms, where the learning had been experiential and outdoors (Neegan, 2005; Hesch, 1995). The enclosed spaces provide an easy breeding ground for germs, but the loss of traditional ways of life also killed the spirit (Greenwood, 2005).

The French were primarily interested in major economic activity in New France in the 1600s, not settlement. According to Frideres and Gadacz (2001), the French never intended to colonize the area, but it became common for French men and Aboriginal women to become a family. The
French agricultural lifestyle barely disrupted the Aboriginal way of life and they were totally dependent on the Aboriginal people to survive in the new world (Frideres and Gadacz, 2001). The French men would learn about the land from Aboriginal people and in some instances try to attain Aboriginal family rights by marrying an Aboriginal woman (Frideres and Gadacz, 2001).

Scholars (Barman, 1986; Frideres and Gadacz, 2001; Grant, 1984) have stated that contact and simple interaction with Europeans slowly turned to assimilation and civilization and the French were first to try to assimilate Aboriginal people. They would ask the Aboriginal people to sign treaties to hand over land, without the use of force, but the French had royal assent to use it, if necessary, and there is documentation to say that they had used force (Frideres and Gadacz, 2001).

Between the late 1600s and early 1900s, the Europeans left schooling or “civilizing” to the missionaries to change the Aboriginal lifestyles to be more like the “civilized” Europeans who were settling in the area (Barman, 1986). Faries (1996) argues that education was the most effective strategy for rectifying the ‘Indian problem’ that European settlers found themselves facing; the only other solution would be assimilation strategies to exterminate the offending and repulsive culture and language of the ‘dirty Indians’.

This new paternalistic, one-sided relationship received its legal justification in the British North America Act, which in Section 91 took away Indians’ independent status by making them wards of the federal government. As consolidated in the Indian Acts of 1876 and 1880, Indian self-government was abolished, and finance and all social services, including education, were placed under federal control (Barman, 1986; p. 5).

At this time, day schools similar to those available to poor British and Irish children were established in Canada for Aboriginal children (Barman, 1986). Missionaries from many different Christian denominations established similar schools and began to change the Aboriginal people’s education (Faries, 1996).

In 1879, the new Canadian government commissioned the Davin Report, which reviewed the American system of educating Aboriginal people (Barman, 1986). Barman (1986) explains that in the United States, “…Indian children were best prepared for assimilation into the dominant society if they were removed from the influences of home, family and community” (p.6). The federal government accepted this report and they began to finance large industrial residential
schools located away from the reservations. The missionaries took on this task and set up schools like Blue Quills in Alberta and Shingwauk in Ontario, where they could teach Christianity with a small portion of reading, writing and mathematics blended in for two to three hours a day (Barman, 1986; Persson, 1986; Wilson, 1999; Longboat, 1986).

The federal government relied on missionaries to staff the residential schools, so when Reverend John Strachan and Egerton Ryerson urged laws to ensure all Aboriginal children attend residential schools, the federal government instituted laws that made attendance mandatory (Barman, 1986; Wilson, 1999; Frideres and Gadacz, 2001). The residential schools were located off reserve and away from Aboriginal communities, so children were taken from their families and communities to reduce the influence of their traditional lifestyles and given a Christian education.

Ryerson and Strachan also believed that it was necessary to give Aboriginal people some skills for complete assimilation (Barman, 1986; Wilson, 1986). The Aboriginal children boarding at residential schools were divided by gender into work duties every afternoon. The boys learned skills like farming and the girls learned how to run a home (Wilson, 1986; Persson, 1986). The federal government enacted the 1910 education policy that helped “to fit the Indian for civilized life in his own environment” (Barman, 1986; p. 9), which made academic education very minimal and skills more apparent. There were many Aboriginal families who chose not to send their children to the residential schools and would hide them when the Department of Indian Affairs staff and missionaries came to see who should be at school (Barman, 1986; Battiste, 1995; Faries, 1996). Those Aboriginal children attending industrial and residential schools were away from their families and communities and forced to use English or French and not use their native language, which was detrimental to the survival of the culture, language, values and beliefs of Aboriginal people (Persson, 1986). “The sad thing is that most of us, in our lifetimes, will witness the end of a tradition which has existed for millennia in this country now known as Canada: the last of the monolingual speakers of aboriginal languages” (Faries, 1996; p. 71).

The Indian Acts of 1876 and 1880 abolished Indian self-government and placed finances and all social services, including education, under federal control (Barman, 1986). Longboat (1986) also argued that education has been one of the issues that has continually forced the federal government and Aboriginal people to be at odds on numerous occasions because the purpose of
education means something different to both parties and education replaces traditional spirituality to Christianity.

Aboriginal families and communities were torn apart, and this created social problems that continue into present day Aboriginal communities. Some Aboriginal parents felt less like parents and began to drink and abuse their children when they were home (Barman, 1986; Persson, 1986; Wilson, 1986). “…[M]any residential school survivors suffer from low self-respect, and long-term emotional and psychological effects” (Barton et al., 2005, p. 296), which the Aboriginal Healing Foundation (2005) states is shown through alcoholism, family violence, systemic unemployment, and poor educational results.

2.1.4 1960s to Present Day

In the 1960s, there was political unrest in Canada and the United States. People were demonstrating against war, poverty and other social ills in the United States and that had an effect on Aboriginal people here in Canada. The Federation of Saskatchewan Indians was established, as was the National Indian Brotherhood (Faries, 1996). The federal government was starting to shut down some residential schools as attendance dropped and the schools were deemed to cost more than assimilation should (Persson, 1986). The federal government commissioned the Hawthorne Report, which advocated for social programs and policies that would have Aboriginal peoples’ input (Richards, 2006). Shortly after the release of the Hawthorne Report, the federal government’s 1969 White Paper was revealed proposing that the Indian Act be abolished and phase out reservations so that Aboriginal people could be integrated into mainstream Canadian society (Richards, 2006; Hull, 2000). The Aboriginal people were outraged and the National Indian Brotherhood responded to this paper through protests (Barman, 1986).

In 1972, the National Indian Brotherhood responded with the “Indian Control of Indian Education” paper, also known as the ‘Red Paper’. In this paper, there were two main principles, parental responsibility and local control of education (National Indian Brotherhood, 1972). The Trudeau government agreed in principle to the paper immediately and it was agreed that educational control would transfer to Aboriginal people (Barman, 1986). The Department of Indian Affairs believed that they could not implement such a policy and the federal government has continued to find legal ways around allowing Aboriginal communities (on and off reserve) to
take control of education (Barman, 1986; Longboat, 1986). AHSUNC provides some control over early childhood education through the Parent Councils’ ability to decide such things as curriculum and financial expenditures.

Blue Quills residential school in Alberta was the site for a sit-in to take control of the school and after many negotiations; they became the first school in Canada to be officially administered by Aboriginal people in September 1970 (Persson, 1986). Many Aboriginal groups have taken control of their education since Blue Quills (Barman, 1986).

With growing tensions and Aboriginal support toward the government dwindling, the federal government introduced the Child Care Initiatives Fund (CCIF) in the mid 1980s. The federal government also began releasing some control of education to Aboriginal communities, based solely on the fiscal need of the government. In 1982, the federal government released a position paper that stated the federal government had failed to set up “guiding principles and develop operational guidelines”, which had slowed the development of Aboriginal education and almost stopped implementation (Barman, 1986; p.16). By the early 1980s, regardless of the poor funding from the federal government, 450 of 577 Indian bands in Canada had taken control of their education either partially or fully. Taking control allowed Aboriginal people to develop and implement an Aboriginal specific curriculum, as well as determine where funds would be spent and when. For many years, Aboriginal communities were forced to send their children to provincially run schools that were likely a great distance from the community and the federal government transferred funds to the provincial government for the education services that did not meet the needs of the Aboriginal community (Barman, 1986; Faries, 1996). By taking back control of education, Aboriginal communities could decide extra-curricular curriculum, beyond the provincial requirements for curriculum, while using whatever funds were left to determine future priorities and funding allocations (Barman, 1986). Faries (1996) also argues that Aboriginal people have not taken control in a meaningful way yet and that much more work needs to be done to accomplish true control of education.

One hundred and eighty-seven bands operated their own schools by the late 1980s, with at least 20% of Aboriginal children attending band schools in Canada (Barman, 1986; Greenwood, 2001). By having Aboriginal children attend band schools, the Aboriginal communities have the
ability to provide culturally relevant curriculum, and in some cases language courses (Faries, 1996).

In 1985, the Indian Act was revised to restore status to thousands of Aboriginal people who had previously lost it through marriage or leaving the reserves (Pal mantier, 2005; Greenwood, 2001). This change has increased the number of Ontarians who are identified as First Nations, and many of these individuals had left the reserves, but did not receive any programs and services because of the loss of their status. Bill C-31 provided the federal government with some knowledge of the number of Aboriginal people living in urban centres like Toronto.

The 1990s was a flurry of activity surrounding early childhood development and childcare. Politically, Aboriginal people had come to be a focus of various federal government programs, services, and reports. The provincial government in Ontario was still taking a stand-off approach to Aboriginal people, even though a large number of Aboriginal people were migrating to urban centres like Toronto. The Ontario government continued to see Aboriginal people and their issues as a federal government responsibility and that there was no need for the provincial government to become involved in any way, although education policy is clearly a provincial responsibility as is health and health care.

The Canadian government hosted the 1990 World Summit for Children and by 1991, the Royal Commission on Aboriginal Peoples had begun its investigation into the social issues surrounding Aboriginal people in Canada (Cox, 2002). By 1994, a discussion paper on Aboriginal childcare was released to the public and federal government, and by the end of the year, Minister Axworthy’s Social Security Discussion Paper reaffirmed the federal government’s commitment to First Nations and Inuit communities (Bennett et al, 2005; Cox, 2002). As part of the federal government’s commitment, they announced the Aboriginal Head Start Urban and Northern Communities Initiative and the First Nations and Inuit Child Care Initiative to provide Aboriginal early childhood development that was directed and controlled by Aboriginal people in a holistic way (Palmantier, 2005; Greenwood, 2001; Ball, 2005; Cox, 2002; Health Canada, 1994).

In 1996, the Royal Commission on Aboriginal Peoples (RCAP) released their final report. Many of the recommendations state that social problems pertaining to Aboriginal people can be rectified in a timely manner, if appropriate funding levels are provided and if
provincial/territorial and federal governments work together to provide the services needed to heal the Aboriginal communities in Canada. Many scholars have discussed the inappropriate funding levels that are controlled by political whim under contribution agreements that are inflexible and always being reviewed (Barman, 1986; Wilson, 1986; Diamond, 1986; Charters-Voght, 1991).

Aboriginal communities or organizations that choose to establish AHSUNC or AHSOR programs should be recognized both by the provincial ministries, the Public Health Agency of Canada and Indian and Northern Affairs Canada. The amount of funding necessary to provide the ongoing programming has increased through inflation, and the necessity for more funds to expand the program has also been documented (Palmantier, 2005). Not even 10 percent of the Aboriginal children in Ontario receive the program, but urban Aboriginal children in Canada have been identified as the “at-risk” population through the population health and public health literature (Palmantier, 2005).

Aboriginal education has always been flexible while adapting to the changing environment with the most changes occurring in the past three hundred years. Aboriginal communities have been dispersed, moved, relocated, or been assimilated to some extent into mainstream society (Barman, 1986). Many scholars and Aboriginal communities agree that it is necessary to learn mainstream education, but it is also necessary to continue to use traditional methods of teaching to pass on cultural knowledge to future generations (Stonechild, 2006; Greenwood, 2001; Ball, 2004). Akan (1992; p. 205) sees “literacy is the universal western mode of communication and thought” and therefore the Elders have believed there is a need for all Aboriginal people to learn Western teachings without forgetting traditional teachings.

“For hundreds of years, Algonquian nations of the Northeastern sub artic area (James Bay Cree, Ojibway, Algonquians, Attikamiks, Montagnais and Napkasi people) have shared a common technology, a common set of languages, a common type of environment, and a common way of life. Within the last 40 years they have all shared a common experience of massive economically motivated acculturation to the ‘white’ universe” (Larose, 1991; p. 81).

The future of Aboriginal education in Canada will rely on using the knowledge and experience that we as a people have gained over the past three hundred years since contact with European peoples. Barman (1986) argues that control of education is the key to self-determination, but that control can’t be transferred because “the lack of a direct legal basis for transfer in the
agreement reached in 1973 between the federal government and the National Indian Brotherhood” (Barman, 1986; p. 16). This has slowed down progress to complete control, but it has not dampened the spirit of Aboriginal people gaining control of their education. AHSUNC is one piece of the education puzzle; therefore it needs to provide young Aboriginal children with a sense of identity, heritage, and bi-culturedness that will reduce the gaps in health and education that so many Aboriginal people experience in Canada.

Providing evidence that Aboriginal control of education is a key to improving educational outcomes is one reason that I have chosen AHSUNC to study. The federal government requires evidence based research and cost-benefit analysis before decisions can be made, this includes on Aboriginal education, therefore knowing the history of Aboriginal people and their educational path is necessary to look at how to move forward.

Many scholars have noted that social problems like alcoholism, family violence, and chronic unemployment all stem from the lack of control of the education system for Aboriginal people (Mackay and Myles, 1990; Frideres and Gadacz, 2001), therefore it is necessary to establish research that proves that Aboriginal controlled education works the best for Aboriginal people and that many social problems can be resolved if Aboriginal people feel a sense of pride in their identity. A sense of pride in identity is clearly one key component of AHSUNC. The AHSUNC projects in Ontario hope that by instilling a sense of pride in being Aboriginal in the children will move with these children throughout their lives, and help to improve their lives.

2.2 Literature related to AHSUNC and the Social Determinants of Health

2.2.1 History of Aboriginal Health in Canada

Historical events in North America have had an accumulated effect on the health of Aboriginal people. There are significant historical and political decisions that have impacted Aboriginal health for centuries as well as altering the relationship with “mainstream” populations. From the arrival of Europeans, to colonizing and assimilating policies, to exclusionary laws, all have had significant repercussions on health, social, mental, physical, spiritual and emotional well-being.

Population estimates for North America prior to the arrival of Europeans are estimated from a few million to over 112 million Indigenous peoples (Jones, 2006). These population estimates
are important as some scholars (Jones, 2006; Anderson et al, 2005; Kramer & Weller, 1989; Waldram, Herring, Young, 2006) argue that illness and disease were a part of pre-contact life, but in a much more manageable way. Since time immemorial, “First Nations Peoples had health systems founded on holistic and ecologic understandings of health and wellness that strove for balance” (Anderson et al, 2006) in all aspects of life with balance being in oneself, family, community, nature and in the Creator’s laws. Traditional healers used traditional medicines found within the environment to heal illness in the four directions (emotional, mental, physical and spiritual). Traditional healers or medicine men were guided by tradition and culture based on the Creator’s laws and ways of knowing (Anderson et al, 2006).

The Aboriginal population was decimated after European contact through illnesses like smallpox, tuberculosis, and pneumonia (Jones, 2006; Waldram et al, 2006. Jones (2006) argues that the disparities in health status began in the contact era and “eventually contributed to the formation of modern ideas of racial difference” (p. 2124). Many Aboriginal people suffered from tuberculosis while the Europeans stayed well, therefore “Indians” were seen as a weaker race. Kramer & Weller (1989) argue that Aboriginal people became more vulnerable to disease and illness as land and culture were broken down.

With the arrival of the missionaries and European settlers, biomedical health care also arrived, but it was very rudimentary and inconsistent (Adelson, 2005). Health care services were provided by a wide variety of individuals from the Hudson’s Bay Company, missionaries, RCMP and military personnel (Anderson et al, 2006). The British North America Act of 1867 allowed the new Canadian government to take responsibility for “Indians.” As a result, Canada legally prohibited the use of cultural and healing practices, which further placed “Indians” in a position of oppression by having to use biomedical health care services instead of traditional and cultural healing practices (Anderson et al, 2006). Although the Department of Indian Affairs was created in 1880 to deal with the growing issues surrounding Indians, medical services weren’t included (Adelson, 2005).

Aboriginal children and adolescents were being forced to attend residential schools since the 1870s (Stonechild, 2006), thus halting cultural practices and intergenerational traditional teaching. This had a significant impact on the mental, physical, spiritual and emotional well-being of generations of Aboriginal people. The forced separation, inadequate and negligible
living conditions at the residential schools, when paired with punishment for speaking their mother tongue, created Aboriginal adults that could do menial tasks, but did not know how to raise children or live in either an Aboriginal or “mainstream” community (Adelson, 2005).

Nurse-visitors to First Nations communities began in 1922 and the first nursing station was established in 1930 (Anderson et al, 2006). A branch of the Department of Indian Affairs began in 1927 to deal with Indian health and healthcare. This branch moved to the National Health and Welfare Department in the early 1940s and was renamed the Medical Services Branch in the 1960s, and again renamed First Nations and Inuit Health Branch in 2000. In all these inceptions, Aboriginal people who did not live on reserve or Inuit territories were all but forgotten until the 1990s.

Universal healthcare services were not being provided systematically to everyone until after 1945 (Adelson, 2005). Tremendous loss of population through long periods of infectious disease, and social upheaval was devastating, and left the Aboriginal population even more susceptible to further illnesses and diseases (Kramer & Weller, 1989) as well as being further colonized and oppressed.

In 1973, the American Indian Movement began to fight for tribal sovereignty (Jones, 2006), which was the impetus for the National Indian Brotherhood (NIB) in Canada to also fight for First Nations sovereignty. The NIB began in this era to advocate on a number of pressing issues relating to Aboriginal people. The NIB began lobbying the federal government to view the Aboriginal peoples as sovereign and self-governing, and to end colonialist policies controlled by the nation state in the areas of education, employment, and health. All these efforts were in vain as the federal government continued to make decisions for and about Aboriginal people (Adelson, 2005). By 1974, the Indian Health Policy was created to integrate Aboriginal health care into the larger national and provincial health care systems (Adelson, 2005). A Health Transfer Policy began in 1979 with First Nations fighting for autonomy and control of health care funds to work on the health issues that were rampant in First Nations communities like diabetes, cancer, mental health, obesity, and early childhood development (Adelson, 2005).

In 1987, the Canadian government signed the Meech Lake Accord giving Quebec ‘distinct society’ status, but did not acknowledge Aboriginal people or treaty rights, but later some provincial governments would not sign it (Greenwood, 2001). The Meech Lake Accord would
have provided funding for health care services for Aboriginal people regardless of where they resided.

By 1996, all residential schools were closed in Canada, but the Assembly of First Nations (AFN formerly known as NIB) argued that the effects of these schools would be felt for generations to come, as skills and abilities that the general population takes for granted were not taught within those walls.

FNIHB has a mandate of providing health care services to First Nations and Inuit peoples in Canada. Unfortunately, the primary focus of the branch remains on reserve, but over 50% of Aboriginal people live beyond the jurisdictions of reserves or Inuit territories (Anderson et al, 2006). Anderson et al (2006) argue that health data collected by FNIHB and Statistics Canada do not adequately reflect the Aboriginal population, as there are many First Nations communities and Aboriginal people who do not participate in the surveys.

The provinces provide universal health care to all residents at no cost, but have not provided any unique or culturally sensitive programming to Aboriginal people because they comprise a very small portion of the overall provincial population (Statistics Canada, 2006). It is believed that urban Aboriginal people will receive their health care and related services from the “mainstream” programs, services and health care in the province (Health Council of Canada, 2006; Anderson et al, 2005). With urban Aboriginal people comprising only a small portion of the population, many provinces do not look at the unique needs of this community (Health Council of Canada, 2006). Métis and non-status Aboriginal people receive some services and programs through urban Aboriginal organizations, but the funding levels are unstable and insufficient for the populations they serve (Anderson et al, 2005).

It is also not surprising that the meaning of health means something different to Aboriginal people in comparison to Euro-Canadians, because they place health within a cultural context that sees a holistic meaning and not just the absence of disease (Adelson, 2005). The World Health Organization proposed a definition of Indigenous health in 1999 under the Declaration on the Health and Survival of Indigenous Peoples, in which, health from an Indigenous perspective is not only individual, but also considers the community and family. This definition is also based on the four directions or aspects known by most Indigenous groups as spiritual, intellectual,
physical and emotional and the link of these four directions to the past, present and future (Durie, 2003). This holistic approach to health will be discussed in the following sections.

Smylie (2003) further states the differences between Indigenous knowledge and Western science. Indigenous knowledge has been described as “ecologic, holistic, relational, pluralistic, experiential, timeless, infinite, communal, oral and narrative-based” (Smylie, 2003; p.141), whereas Western science is “described as reductionist, linear, objective, hierarchical, empirical, static, temporal, singular, specialized, and written” (Smylie, 2003; p. 141). AHSUNC tries to meld the two perspectives by providing families with health promotion, nutrition, and education information in a culturally sensitive manner, but the information is derived from Euro-Canadian Western science, but in some AHSUNC projects, Traditional healers and medicine people provide an Indigenous perspective on this information.

2.2.2 Population Health Approach and AHSUNC

The legacy of colonization in Canada has lead to multiple social and health issues for Aboriginal people further increasing the disparities between Aboriginal people and other Canadians. Smylie and Anderson (2006) argue that current statistics only show a portion of Aboriginal people’s health, but the gap in health status has grown to epidemic proportions. Social programs and services for Aboriginal people have not consistently looked at unique population groups, but with the commissioned position paper, “Taking the Population Health Approach”, Health Canada (1998) identified the need to view Canadians’ health in a more holistic way.

The population health approach outlined in the position paper is “to maintain and improve the health of the entire population and to reduce inequalities in health between population groups” (Health Canada, 1998; p. 1). Figure 2 lists the twelve social determinants of health currently used by the federal health portfolio.
Determinants of health is the collective label given to the factors and conditions that research has shown to influence health status. These are currently identified as income and social status, social support networks, education, employment and working conditions, social environments, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture. ... The determinants do not exist in isolation from each other, but rather function in an intricate web. A population health approach considers the interconnectiveness of determinants and mediating factors and their influences on health,” (Health Canada, 1998; p. 8).

Through monitoring the AHSUNC projects in Ontario, it is my belief that the social determinants of health are very much intertwined and all of these determinants overlap each other in varying degrees. Therefore, it is necessary to look at many social issues surrounding Aboriginal people to ensure that appropriate changes are made to revitalize the culture and heal the wounds of colonialism and assimilation.

Blackstock (1999) noted that urban Aboriginal children are still more likely to live in poverty, in a lone parent family, be disconnected from their culture, not have attended a quality childcare, and face overt racism and assimilation policies than mainstream or immigrant children. A strong sense of identity, clear understanding of physical environment, adequate health services, employment opportunities, steady income, educational opportunities, and strong social support
networks would help urban Aboriginal families to raise their children holistically and in a “good way” as traditional teachings often say (Blackstock, 1999; Smylie and Anderson, 2006; Adelson, 2005). AHSUNC provides a holistic approach to improving health, nutrition, education, culture and language, parental involvement, and social support.

After beginning the Ontario AHSUNC projects in 1994, the Ottawa Aboriginal Head Start project conducted an evaluation in 1998. The 1998 evaluation examined only the first seven months of operation for the Ottawa project and reviewed the socio-economic demographics of the families attending, how parents and caregivers perceived the program’s impact, and the staff’s experiences. The evaluation did not examine the impact of the six core components (health promotion, education, social support, culture and language, parental involvement, and nutrition) on school success or health disparities (Baxter & Associates, 1999). It was recommended at the end of the report to invest in further research including a longitudinal study of how the Ottawa Aboriginal Head Start may impact the educational attainment of the children attending in 1997 (Baxter & Associates, 1999).

Jessica Ball has written several articles about various British Columbia AHS programs both on and off reserve (2003, 2004, 2005). One article, written by Ball & Elliot (2005), “Measuring Social Support in Aboriginal Early Childhood Programs”, examines social support parents perceive they receive after their children are in the program on reserve. Ball & Elliot (2005) provide previous literature showing how social support and the perception of social support can help parents feel positive about their parenting and can help with reducing stress, which will improve parents’ reports of their health. A similar study conducted by Greenwood and Fiske (2003) also shows parents who feel they have increased their social support networks by being a part of the AHSUNC community, also rate their parenting and health more positively.

Similarly, Greenwood and Blackstock have written about Aboriginal children’s welfare and child care, but

“[t]here is a challenge, however, with regard both to the lack of knowledge about what research is currently taking place concerning Aboriginal Early Childhood Development and with regard to how contemporary Aboriginal Early Childhood Development research might be effectively linked to and employed by the Aboriginal Head Start program” (Palmantier, 2005; p.11).
The Public Health Agency of Canada’s National Office is currently completing an impact evaluation of the AHSUNC program that was due to be released in 2007 (Lynne Robertson, personal communication, November 2006), but was unavailable at the time of this writing.

In December 2004, the National Roundtable on Aboriginal Early Childhood Development was hosted by AHSUNC with the Centre of Excellence for Children and Adolescents with Special Needs. The one-day event provided a forum for researchers, academics, policy makers, and government staff to look at the unique needs of the AHSUNC program (Palmantier, 2005). Palmantier (2005) noted that few articles had examined AHSUNC or its impact on Aboriginal children and their families. Health Canada and the Public Health Agency of Canada also have some governmental reports (Sones, 2002; Health Canada, 2000), but none of these reports have looked at the impact to the social determinants of health or how the use of the population health approach has impacted Aboriginal health status.

2.2.3 Other Factors that Influence Health Status

It must not be forgotten that self-esteem, social support and coping skills are very important to the overall health and well-being of everyone. Ball and Elliot (2005) argue that social support can help people from the negative effects of stress and protect a person if their social support network is good, which comes from Emile Durkheim’s work on suicide. Durkheim had argued that factory workers who left their homes had higher suicide rates (quoted in Ball and Elliot, 2005). Perception of support and caring by individuals is believed to also have an effect on health (Greenwood and Fiske, 2003; Ball and Elliot, 2005). AHSUNC provides social support as one of the six core components; therefore by building the social support network of the families, it is likely that AHSUNC affects a person’s perceived health status. Tjepkema (2003) argued that self-reported health status was based on the interrelated determinants of health, and Ball and Elliot (2005) further argue that AHSUNC and Aboriginal Head Start On Reserve (AHSOR) help to improve health by improving social support networks. “Social support has several functions: emotional, support, tangible support, informational support, companionship support, and validation” (Ball and Elliot, 2005; p. 44). It is important to understand how AHSUNC Ontario projects assist families in creating, improving, or further developing their social support networks, which would be beneficial to the health of the parents and caregivers as well as for the children.
Self-esteem is intrinsically linked to the way a person is identified, as Dawson (1988) argues that if children are proud to be identified as “Indian”, then they will have higher self-esteem than the Aboriginal children who do not want to identify as “Indian” or “Aboriginal”. Therefore it is important to look at how Aboriginal people in Canada have been defined by a paternalistic federal bureaucracy, which has excluded many Aboriginal people through policies and legislation. The federal government has defined who is considered “Indian” through birth rights and blood quantum, not through connection to community, traditional practices, or maternal lineage, which is the traditional way of identifying for some First Nations communities. Even how Aboriginal people are defined and “labeled” are colonizing and paternalistic, which also contributes to poor health status as it affects self-esteem and consequently can start the cycle of believing/being hopeless within an industrialized society. Corenblum (1996) and Mishibinijima (2004) argue that being defined as a specific ethnic group can be detrimental if the ethnic group in question does not have preferential status in society.

The Canadian government determines who can be registered as a “status” Indian through the Indian Act, with all others being considered non-Indian, which does not provide eligibility for registration as an “Indian”, or the rights that registration provides in terms of programs, services and funding. The act of registration is another part of colonialism and assimilation by excluding people who follow and believe themselves to be Indigenous by birth and culture from registering for the rights of being Indigenous.

The term, Aboriginal people, has been used since 1987 to denote those Aboriginal people in Canada that are of Indigenous decent, but further divides the three main categories, First Nations, Métis and Inuit, and then again divides First Nations into “status” and “non-status” groups. Indian and Northern Affairs Canada (previously known as Department of Indian and Northern Development) and First Nations and Inuit Health Branch of Health Canada do not share the moniker of Aboriginal, although the Canadian government has chosen this title to represent all Indigenous groups. Recently, the Federal Interlocutor of First Nations, Métis and Inuit Affairs Office were assigned to Indian and Northern Affairs Canada, but no changes have occurred to the label of any of these federal government entities.

The federal government is responsible for most aspects of Aboriginal life. Through legislation, it determines who qualifies as an Indian based upon blood quantum or paternal lineage. These
definitions of who can be considered “Indian” also reduce health status in a variety of ways. First, individuals who consider themselves to be Indigenous, but are not legally recognized as such through the Indian Act, may feel less like they belong, and therefore it will lower self-esteem, and in turn, that will affect their education, employment, social and physical environments because their sense of being is not in balance. Secondly, the federal government has provided health care and programs for reimbursement of prescription drugs and medical devices as per treaty rights. Therefore if a person is not considered to be registered or “status” by the government, they will not be eligible for these payments for services as defined in treaty rights, and this will directly affect health status and quality of life.

Many scholars state that education affects employability, health status, poverty, culture, and social support, specifically for Aboriginal people (Cox, 2002; Greenwood, 2001; Palmantier, 2005; Benoit et al., 2003; Newbold, 1998; Barton et al., 2005; Health Canada, 1998). Because education is a key to improving many other determinants of health, it is necessary to improve education for Aboriginal people from an early age. One of AHSUNC’s core components is education, which is intended to increase the motor skills and school readiness skills of the children attending the program. Greenwood and Fiske (2003) and Ball and Elliot (2005) argue that the parents and caregivers also benefit from improved informal education. Greenwood and Fiske (2003) argue that parents learn health promotion, culture, and language from their children as they return from AHSUNC and that this learning can sometimes encourage parents to return to formal education or change their employment. Greenwood (2001) argues that parents need to feel that their children are in the care of trusted caregivers and that they are receiving quality child care that will improve their skills; otherwise, parents feel the need to stay with their children.

It is necessary to research and show evidence to the federal government that AHSUNC works best with Aboriginal people in control as well as the impacts that this program has on health disparities and other social problems. This research will provide evidence that will help to ensure the continued funding of AHSUNC, and will provide more than the anecdotal success provided by parents is accurate. Funding for any federal government program is precarious (Palmantier, 2005; Cox, 2001), and AHSUNC is no exception. It is therefore necessary to show what impact the program has on the lives of the children who attend and their families, as the federal government provides funding based on evidence-based decision-making strategies.
Many scholars have noted that social problems like alcoholism, family violence, and chronic unemployment all stem from the lack of education, which is intrinsically tied to health status (Mackay and Myles, 1990; Frideres and Gadacz, 2001; Health Canada, 1998). Therefore it is necessary to establish evidence based research to establish if programs like AHSUNC are working toward changing the determinants of health in an upstream manner. The holistic manner of the population health approach recommends that programs be implemented at the earliest possible stage in life to provide the biggest impact, but without studying how community-based programs work, it is unlikely to prove that an upstream approach is being used to improve the health of all Canadians.

There is a need to have evidence based research about Aboriginal health and education to move forward for the next seven generations and this research will be one piece of a much larger evidence base to present to Aboriginal people, policy makers, politicians, decision-makers, bureaucrats, and the Canadian public. AHSUNC is one program that contributes to changing Aboriginal health and education, so it is important to establish a base of literature about the effects the program is providing in urban Aboriginal communities.
3 Chapter 3 – Methods and Methodology

3.1 Methodologies

3.1.1 Population Health Approach and Marxism

In light of my thesis topic, I began to see the synergy between the population health approach/theory used by Health Canada (1998) and the Marxist theory (Wotherspoon, 2004). The population health approach looks at the connectedness of the twelve social determinants of health (SDOH) and mediating factors that influence health (Health Canada, 1998). Health Canada (1998) defines the twelve social determinants of health as “the collective label given to the factors and conditions that research has shown to influence health status” (p.8) and these determinants are

(a) income and social status,
(b) social support networks,
(c) education,
(d) employment and working conditions,
(e) social environments,
(f) physical environments,
(g) biology and genetic endowment,
(h) personal health practices and coping skills,
(i) healthy child development,
(j) health services, and finally
(k) gender and
(l) culture.

The population health approach provides insight into inequalities felt by different groups and individuals in society, because each of the determinants interacts or can affect other determinants, which will affect the individual and/or society in negative ways. Similarly, Marxism could be translated to many different aspects of people’s lives by showing capitalism
and materialism creates inequalities for most of the social determinants of health in individuals
and groups. Using the social determinants of health from a Marxist perspective, I will be able to
look at the interactions of health, education, parental roles, culture and language, and a program
that was created to empower an oppressed group to aspire to transformative change.

Jeffery et al (2006) argued that no frameworks or templates currently exist which incorporate
Aboriginal community concerns, but that the population health approach and the social
determinants of health are the most appropriate way to develop an Aboriginal specific
framework to look at health. The social determinants of health provide a general overview of
health status and Tjepkema (2002) reveals that the most commonly used measure for measuring
health status is using a population health survey with questions about self-perceived health.
Building upon Tjepkema (2002) and Jeffery et al (2006), I have tried to use the population health
approach from an Aboriginal perspective to determine if there were any changes in health and
education for the entire family.

3.1.2 Indigenous Methodology

Tuhiwai Smith (1999) and Wotherspoon (2004) agree that schools and schooling further
reproduce social inequalities. Tuhiwai Smith (1999) argues that the western educational
paradigm is contradictory in nature, and continually perpetuates the inequalities in social class
relations by preventing the majority of indigenous people from obtaining the education required
to be a part of the larger society. The public education system provides basic education to all
residents of the society, but those children with parents who can afford better education, or can
supplement their children’s education with events, trips, and other learning experiences, will
exceed those children that cannot afford such experiences. Therefore, lower income families
will receive just a basic education and those families with higher incomes will be able to ensure
that their children learn beyond the classroom, which will serve to enhance their learning
experience and increase grade levels (Tuhiwai Smith, 1999). Wotherspoon (2004) further states
that education is a key to economic, political, and social well-being, so if Aboriginal people
cannot obtain a western education, it will bar them from being able to argue the reasons for and
about Aboriginal education or the integration of Aboriginal education into the western
educational paradigm.
Barsh (1988) argues that even if materialism did not exist, and indigenous people were represented in comparable numbers in post-secondary education, Aboriginal people would still face oppression and that oppression in some form likely existed prior to contact as well. Barsh (1988) explained that it is likely oppression occurred between different nations, families and communities, and that some individuals were outcast and oppressed because of acts committed against individuals and/or the community. Barsh (1988) argues that capitalism is not the root of Aboriginal problems, but oppression in a variety of other forms is. Essentially, Aboriginal people are oppressed in education, health services, politics, and legal venues, and for Aboriginal people to rise beyond this oppression and at least take a comparable place in Canadian society, much work is needed by society as a whole, but the government needs to assist in reducing the inequalities. Barsh (1988) argues that if Aboriginal people confronted oppression in education, health and knowledge venues, they would likely be able to rise above their current place in society. Smith (1999) and Grande (2004) agree that capitalism alone is not the root of Aboriginal issues, but they argue that Indigenous methodology must be used to understand any Aboriginal issues as Aboriginal people view the world from a different perspective than others in society.

Marxism suggests that capitalism is one root of social inequalities (Wotherspoon, 2004), but that oppression in any form can create inequalities where one group wishes to change their position in life with that of another group. Stonechild (2006) has argued that the only way to reduce inequalities, and by extension oppression, would be to increase the number of Aboriginal peoples with post-secondary education. In a Marxist paradigm, post-secondary education would be one avenue to reduce oppression and hegemony, thus creating Aboriginal people who were more comparable to the general Canadian society.

Schools are an extension of society and its values; therefore imperialism and materialism (by extension) will continue to be perpetuated in education as it is in the rest of the social structures in modern society (Tuhiwai Smith, 1999). Lattas (1993) similarly finds the Aboriginal worldview(s), language(s) and culture(s) are not recognized by white scholars in the academy and this perpetuates hegemony and colonialism. Neegan (2005) also argues that Aboriginal worldview is extremely important to education and to decolonization. From a Marxist paradigm, it could be stated that formal Western education will only help reduce inequalities if an
Aboriginal worldview is imposed on the teachings, thus helping with decolonization and the reduction of oppression.

Only an “indigenist theory” will stop the social inequality, oppression, and racism that currently occur in any society with indigenous people (Rigney, 1999). Aboriginal worldview must play an important part in any theory and research for and about indigenous people, so theories like Marxism and feminism can help to build a decolonizing framework and theory dedicated for indigenous scholars to work from, but none will be the ‘perfect’ theory (Rigney, 1999).

Grande (2004) spoke of ‘Red Pedagogy’, which looks at social artifacts from an Aboriginal worldview perspective with knowledge of what indigenous people have survived and a vision of where indigenous people need to go, but this theory is still developing with indigenous scholars. Because of the deep and lasting problems that residential schools have had on educating Aboriginal people in Canada, this type of historical knowledge continually needs to be addressed (Neegan, 2005), but the use of red pedagogy by indigenous scholars would not need to revisit this issue and could move forward without having to justify why change is needed (Grande, 2004). It would be preferential to speak about topics like residential schools, or the need for programs like AHSUNC, without having to provide a detailed history each and every time we would like to discuss an issue. Grande (2004) argued that all those who were going to read about an Aboriginal issue would need to come from the same understanding, knowledge and experience to forego the historical details, but Grande felt that a time would come when Indigenous scholars could write about issues without providing detailed reasons why a topic needed to be covered. I have decided to provide a detailed background on Aboriginal health and education in Canada as I do not feel that we have come to a point where everyone would have the knowledge of the history and why programs like AHSUNC are needed, or why these programs address a variety of issues that come from the history I have provided.

Marxism from an Indigenous perspective provides the Aboriginal worldview, while explaining that Aboriginal people are the “proletariat”, who constantly has to push and rebel against the “bourgeoisie”, the Canadian society. Many scholars have discussed the inequalities that exist between Aboriginal people and the general population in Canada (Smylie & Anderson, 2006). Inequalities, whether in health, education or other aspects of life, force Aboriginal people to look at ways to reduce the inequalities gap by using Aboriginal specific methods provided through
traditional teachings, experiential learning, and a holistic approach to life. The population health approach also tries to use a holistic framework to reduce social inequalities through individuals, families, groups, organizations, and communities working toward a healthier life, which is not just the absence of disease or illness, but rather the feeling that one’s life is meaningful and they belong to a family, group, community, organization and society (Smylie & Anderson, 2006).

I am certain that the Indigenous Marxist theory combined with the population health approach has guided my research. The Marxist theory shows that the education system can continue to oppress certain groups of people and the population health approach shows how oppression in any of the social determinants of health can affect other determinants. In unison, the synergies of these two approaches/theories guide my thesis to provide a social justice perspective of the research I have carried out with Aboriginal Head Start parents and children.

3.2 Participants and Data Collection

The questionnaires were developed in collaboration with the Project Coordinators at Waabinong and Fort Erie Head Start projects, as well as input from the Fort Erie Head Start Parent Council. The questionnaire produced for September (Appendix A) asks participants demographic data as well as health, education, social support, culture and language questions. The second questionnaire for December (Appendix B) is similar to the first questionnaire without the demographic data being collected and some additional questions regarding changes in education, employment, culture and language. These questionnaires were developed to meet the needs of this study and to provide information to the projects about their program and its’ effectiveness. A slight variation in the questionnaires was required to ensure that comparison data would be easily attained. Building upon Ball and Elliot’s (2004) social support questionnaire and information about the National Aboriginal Head Start Urban and Northern Communities Impact Evaluation questionnaire, I created a draft questionnaire. The population health approach and the Marxist theory provided some of the variables that were inserted into the questionnaires.

The empirical data of this study was composed of primary qualitative and quantitative data derived from an entry and exit questionnaire completed by AHSUNC parents or caregivers in September and December 2007 at Waabinong Head Start in Sault Ste. Marie. Fort Erie Aboriginal Head Start was originally a part of the study, but due to low returns, was omitted from the study. Waabinong Head Start had a completion rate of 95%.
With the assistance of the Project Coordinators, Parent Councils and teachers, the entry questionnaire was numbered with no personal identifying information and provided to participants as they started the program in September.

For the exit questionnaire, to facilitate comparison, the identifiers were printed on the questionnaires and the appropriate families were given the questionnaire to complete and mail directly to me. Staff at Waabinong Head Start did not know who did or did not complete the questionnaires and all answers provided will be used in an anonymous fashion, as the Informed Consent Form assured participants that no part of their responses would be directly quoted.

It must be noted that Waabinong Head Start and the Sault Ste Marie area is populated by First Nations “status” and “non-status” people as well as Métis peoples. It was important to Waabinong Head Start to continue to refer to both First Nations and Métis people as they feel they are distinct and unique, but a part of their community.

### 3.3 Research Questions

As described in Section 1.6: Research Questions, above, there are two overarching questions:

1) Does AHUSUNC provide urban Aboriginal children and their families with improved knowledge and/or skills that can improve their health and education in a culturally appropriate manner?

2) What is the perceived change in health and education of AHSUNC children and their families?

While reviewing the data from the two questionnaires, I also wanted to know if any, some or all of these statements could be proven. In Chapter 5, I will discuss these at greater length.

A. The children attending AHSUNC pass information learned at the program on to their parents/caregivers informally, especially in the areas of health, culture, language and education.

B. Parents/caregivers of AHSUNC learn new skills, through events and workshops, in a number of areas (i.e. parenting, employment skills, continuing education, nutrition,
hygiene, etc) that can be applied to their own health and education as well as for their children.

C. The perception of new/improved educational skills in the AHSUNC children will be multiplied in self-reports of the parents/caregivers.

D. Nutrition skills will have moved toward a healthier way of life.

E. AHSUNC children will gain a sense of pride in being Aboriginal and identifying with what it means to be Aboriginal.

F. Parents/caregivers will gain a sense of pride in being Aboriginal and will be able to improve their skills and employability as a member of the AHSUNC community.

G. Access to knowledge of health, employment and education issues will be improved for the children and their families.

There are many more questions that could have been reviewed, but I decided not to pursue these avenues because of time and data constraints. For example, building upon Palmantier’s (2005) suggestions, I could have run standardized tests on the children, which would have shown the impact the project had on the children’s social, motor, and school readiness skills. It was apparent to me that while this information would be highly useful, AHSUNC provided a much broader program, with social support and education as only components of a greater whole. Therefore I chose to look at some of the social determinants of health as they correlate to the six core components in the program.

3.4 Ethics

The Ethics Review Board at the University of Toronto reviewed the Research Protocol for Supervised and Sponsored Researchers and signed the Protocol on May 18, 2007. In the Informed Consent letter, I assured participants that I would not use any direct quotes from their responses. In Chapters 4 and 5, I discuss the results from the open-ended responses, but do not quote from the questionnaires as promised.

The Informed Consent form was used for both questionnaires and is attached in Appendix C.
3.5 Data analysis

The completed questionnaires were sent directly to me via Canada Post with postage prepaid. The completed questionnaires were then coded for entry into SPSS software. Coding was based on nature of the responses. Data analysis was conducted for all quantitative questions in SPSS and qualitative open-ended responses were collated in Word 2007. Analysis was done on the initial questionnaire, then on the second questionnaire, then as a comparison of the two answered questionnaires. Responses outside of the mean were further examined as was any additional data provided by participants or the project. Looking at the mean and correlation percentages, I checked for statistical significance with Chi square and through t-tests. I found that the number of participants was low, and therefore I was unable to make concrete statements about the statistical significance of the data. General trends in the data were further analyzed and compared to qualitative answers, if applicable. By looking at frequency tables, cross-tabulations, and the means, I revealed the trends for (a) the September questionnaires, (b) the December questionnaires, and (c) the comparison of the two questionnaires.

Questions regarding social support, parental involvement, education, health, culture and language were cross tabulated to determine if any trends existed. For example, questions about regular check ups at a family doctor or other health professionals were cross tabulated with self-reported health status to determine if there were any correlations. Limitations are discussed in the next section, 3.6, but I must stress that the number of respondents was relatively high for the population size (n=45 with a response of 29 completed questionnaires for both times). Using Chi square and t-tests, I determined that while there were trends in the data, the data could not show statistical significance.

While I could not generalize the data to the AHSUNC population in Ontario, I did compare the data to the Aboriginal Peoples Survey conducted by Statistics Canada and to Ball and Elliot’s (2004) data. By comparing the results of this study with other studies, I was able to show that the trends I found were similar to those found by others.

Qualitative responses were entered by question into Word. I looked for similarities in responses and ascertained the percentage of respondents that used similar wording on a particular question.
For many of the open-ended questions, respondents were similar in their responses, which made collating answers easier to see trends. After determining how many respondents answered a particular open-ended question, I determined the percentage of respondents with similar answers for use in Section 4, Findings.

In support of the quantitative data analysis, I used qualitative data to determine if there were trends amongst respondents. The Informed Consent Form and discussions at the Parent Orientation Sessions determined that I would not use any direct quotes from the open-ended questions. Many respondents provided lengthy qualitative answers with a high number of details, which added to a greater understanding of how the respondents felt and understood the questions.

3.6 Limitations

Due to the short time frame for the study, it is acknowledged that further research and analysis may be needed to show long term effects of AHSUNC such as employment and education changes. The initial questionnaire was sent in September 2007 and the follow up questionnaire was sent at the end of December 2007, which does not provide AHSUNC much opportunity to provide information, programming, and services that may lead to change.

Another limitation was the number of projects that intended to be a part of the study. With only two of fourteen Ontario AHSUNC projects participating, it is difficult to compare projects, regional differences, or assess if more established projects have different or more influence on behaviour change. A larger sample size that reflects a majority of the projects and participants is required to elaborate on the results. This study is limited by number of responses, and because no control or comparison groups were used. Future studies should include a control group and have large enough sample sizes so that the analysis can be descriptive of more than trends in the data.

Because I did not have a control group to compare the data to, I chose to compare the data to the Aboriginal Peoples Survey conducted by Statistics Canada to show the comparison in the demographic data for Ontario urban Aboriginal people with that of Waabinong Head Start’s participating families. Ball & Elliot (2004) compared their social support data to Greenwood & Fiske (as quoted by Ball & Elliot). I decided that I would review their data and try to compare
qualitative findings to their research, but since no statistics were made available in their article, this comparison is limited to comparing qualitative responses to their findings.

Another limitation was how the questionnaires were answered. Both the primary caregiver and the second caregiver were asked to fill in a single questionnaire; therefore caregivers could be influenced by each other’s responses. This may have some weight on the findings of certain questions, were there is a perceived “correct” answer.

Finally, I chose not to use any standardized tests with the children, which would have provided insight into the changes in preschool readiness and skill development. Most of the existing standardized tests have been designed for non-Aboriginal middle-class children, which would not necessarily show any changes for AHSUNC children (Ball & Elliot, 2004; Pertusati, 1988). Greenwood & Shawana (2002) recommend that an Aboriginal specific tool be created and utilized when determining changes in skills and behaviours of Aboriginal children in Aboriginal child care, otherwise a colonial bias may be present and cause the results to be skewed to a lower attainment.

3.7 Conclusions and Revelations

Throughout this endeavor, I have used an Indigenous and Marxist perspective of conducting the study. I have also embraced the Population Health Approach that Health Canada and the Public Health Agency of Canada use to further understand the holistic nature of the AHSUNC projects and the changes that occur for AHSUNC children and families.

In future, research should look at a longitudinal data collection that can be assessed at predetermined times to reflect on changes in which the project and program may have been influential. Some of the trends were interesting and did indicate that a larger and longer analysis may show more of the positive impact that AHSUNC has on the children and families.
Chapter 4 – Findings / Data Presentation

4.1 Initial Assessment – September 2007

In September 2007, a questionnaire was given to every parent or caregiver at Waabinong Head Start in Sault Ste Marie, Ontario. The questionnaire used is attached as Appendix A. In total, 44 completed questionnaires were returned from a possible 45. Fort Erie Aboriginal Head Start provided 38 parents or caregivers with the survey and had a completion rate of 6.

All parents or caregivers were given the opportunity to withdraw at any time or not complete the questionnaire. Only one respondent returned a blank questionnaire from Waabinong Head Start. The completed questionnaires were coded and entered into SPSS and the open-ended responses were entered into a Word document for analysis.

The September responses provide an initial assessment of the parents/caregivers and children who attend Waabinong Head Start. From the completed questionnaires, I determined that 86% of respondents were female and 90% identified themselves as the mother of the child enrolled in the program. Only 30% of completed questionnaires had responses from a second caregiver, and 75% of those respondents identified themselves as being the father of the child enrolled in the program. From the Aboriginal Peoples Survey (Statistics Canada, 2001) identified that there were 14,450 lone parent families in Ontario in 2001, which is approximately 7% of the Ontario Aboriginal population. This would indicate that lone parent families are overrepresented at Waabinong Head Start, but this can be attributed to the recruitment process by the project.

Of the completed questionnaires, 63.6% of primary caregivers or parents identified themselves as “status” Indian, 16% listed non-status, 9.1% as Métis, 9.1% as non-Aboriginal and 2.2% did not respond. Second caregivers or fathers represented 62.5% “status” Indians, 25% non-status Indians, and 12.5% non-Aboriginal. The mean age of respondents was 26.9 years old for primary caregivers and 23.2 years old for second caregivers. Statistics Canada (2006) reported from the Aboriginal Peoples Survey 2001 for Ontario, “45% of Aboriginal people were under the age of 25”, which means that Waabinong parents and caregivers are similar to the Statistics Canada data.
The average education was high school for both caregiver groups. According to the Statistics Canada (2006), 34% of Aboriginal people in Ontario had less than high school and 42% of Aboriginal people over 25 years old had post-secondary qualifications. This indicates that Waabinong parents and caregivers fall below the provincial average attained by Statistics Canada.

In the Aboriginal Peoples Survey (Statistics Canada, 2001), there was approximately 57% of the Aboriginal population who were “status” Indians, which shows that parents and caregivers at Waabinong Head Start are a slightly higher percentage, but similar to the general Aboriginal population in Ontario.

Figure 3 Aboriginal Identification Compared to Aboriginal Peoples Survey

These statistics provide insight into “who” the attending families are. AHSUNC is intended to reach Aboriginal families living in urban and northern communities, with the goal to reach at-risk families. At risk families are defined by Health Canada and the Public Health Agency of Canada as those headed by a single caregiver, low income, teen or young parents, and those who may be in contact with children’s welfare agencies. Based on the demographic data, it is apparent that many respondents are young, and that there are a high number of single parent families. AHSUNC is doing well to reach their target population as most of the families would be within the definitions provided by the Public Health Agency of Canada.
4.1.1 Culture and Language

Waabinong Head Start provides Ojibwa language in the curriculum as well as providing teachings from local Elders from Garden River and the Indian Friendship Centre of Sault Ste Marie. Respondents were clearly interested in having their children learn an Aboriginal language and more about their Aboriginal culture, which is likely to occur with Waabinong’s current curriculum and Resource staff.

As one of the core components of AHSUNC, culture and language is an extremely important issue to Aboriginal people. Faries (1996) and Chesire (2001) argue that language and culture provide Aboriginal people with a sense of pride in themselves. Bramley et al (2004) describe Maori language nests in New Zealand, in which schools are created with the specific design to revitalize the Maori language for all ages. The Maori language is the primary language of educational instruction, which helps to revitalize its usage in the community, and therefore keeps it from extinction (Bramley et al, 2004). While AHSUNC provides a place where children learn an Aboriginal language and culture specific to the location of the project, it is not the intent of the program to provide an immersion for the entire family, but in fact is a starting point for the journey of learning an Aboriginal language.

The questionnaire included questions about cultural practices and language use. One historic issue that has been found to affect the use of cultural practices and mother tongue is residential school. Amongst the primary caregivers or mothers, 53.6% had a relative that had experienced residential school, with aunts and uncles being taken to residential school for 25% of respondents, mother or father at 10.7%, grandfather at 14.3% and grandmother at 32.1%. It is interesting to note that no primary caregivers attended residential school, but 3.6% of second caregivers or parents had attended. Some scholars have argued that residential school experience reduces parenting and social skills, which leads to many other social problems like alcoholism, family violence, and distrust of the education system (Hampton, 1999; Mendelsohn, 2006; Blackstock, 2006). Second caregivers or parents also had grandmothers or grandfathers taken away to residential school (3.6% each), which could also reduce the likelihood that culture and language are transmitted (Cooke-Dallin, 2001).

Primary caregivers or mothers experienced racism at school (37%) more than second caregivers or fathers (28.6%), but almost an equal number in both caregivers experienced racism sometimes
(25.9 and 28.6% respectively). Racism reduces a person’s self-esteem and can cause shame in who they are (Smith, 1999). Bramley et al (2005) and Smylie & Anderson (2006) argue that if a person is ashamed of their identity or feels the need to hide their identity, it will reduce their mental and physical health through stress. Taylor et al (1993) argued that racism can cause some groups to hide their traditions, spirituality, or beliefs because the racism defeats their mental health. It is not surprising that many Aboriginal people have hid their culture and language or stopped trying to transmit it to their children, and when this occurs, a gap in learning occurs. One third of primary caregivers at Waabinong have experienced racism, which could affect their mental and physical health, or it may be a factor in why culture and language revitalization is required.

Having an Aboriginal Social Support Worker or Family Support Worker provides caregivers or parents with a knowledgeable individual who is sensitive to cultural and linguistic practices of the area as well as the needs of families. Just under half (46.2%) of primary caregiver respondents answered that they had contact with an Aboriginal Social Support Worker, while 37.5% of second caregivers had. Ball and Elliot (2004) note that social support provides several functions including emotional, informational, companion, and tangible support as well as validation. Ball and Elliot (2004) examined peer social support and how the AHSOR project provided social support, which could be through a social support worker, teacher-parent interactions, or events within the community. Aboriginal Social Support Workers are not funded by AHSUNC, but work closely with the families that attend AHSUNC to provide access to health professionals and traditional healers, introduction to social support networks, provides contacts within the Aboriginal community including Elders, and helps families negotiate programs and services that they may require or encounter. Almost half of respondents from Waabinong reported having contact with an Aboriginal Social Support Worker in September, which may explain why half of respondents had also visited a Traditional Healer and almost all caregivers, wanted their children to learn an Aboriginal language and culture.

More than 66% of second caregivers and 48% of primary caregivers had visited a Traditional Healer. A traditional smudge or Aboriginal ceremony had not been attended by 41.9% of the children entering the program in September. A traditional smudge is a cultural practice which varies in its teachings based on where an Aboriginal person is from or what Aboriginal culture they belong to. For Inuit people, a smudge does not exist as it does for more southern Aboriginal
cultures. In fact, Inuit people burn whale oil for their connection to the Creator, whereas southern Aboriginal cultures like Ojibwa, Odawa, Mohawk, and Cayuga use sage, sweet grass, tobacco, and cedar to smudge and cleanse themselves, as well as connecting to the Creator. There are a number of websites and articles that provide more information about the purpose and ways of smudging.

Almost all the respondents, 97%, wanted to use the language and culture learned in the program at home. This higher than the results found in the Aboriginal Peoples Survey 2001, which showed 88% of Aboriginal people rated learning, relearning or keeping an Aboriginal language as very important or somewhat important (Statistics Canada, 2003). Only 44.2% of Waabinong parents smudged or practiced Aboriginal ceremonies at home in September. The Canadian Health Network (2007) provided information about how Aboriginal people who reconnected with their culture and language were likely to have children who were healthy and had a positive self-identity as an Aboriginal person. Waabinong respondents were overwhelmingly in favour of revitalizing culture and language for their children, but approximately half of the parents and caregivers were not practicing Aboriginal ceremonies or using Aboriginal language when they entered Waabinong.

It is likely if the primary caregiver or mother has seen a traditional healer, the child has also had the opportunity to smudge or be a part of an Aboriginal ceremony prior to entering Waabinong. Primary caregivers that have identified as Status and Non-status and have seen a Traditional Healer, also have children who have participated in a smudge or Aboriginal ceremony (94%). As stated above, it is likely that cultural and linguistic revitalization is a factor in why this number is high. Revitalization of culture can help to promote positive self-esteem and increase the perception of health (Cheshire, 2001).

Respondents were given an area to explore the benefits that Aboriginal Head Start would provide to them in the coming year as parents or caregivers, and 41.9% believed that they and their children would learn more about Aboriginal culture and language through the program. More than 52% believed that their child would gain a sense of pride in being Aboriginal and knowing what that means. Chesire (2001), Cox (2002) and Greenwood and Shawana (2000) all argued that culture and language revitalization provides a positive sense of identity and could help children perform better in school skills as well as in motor skill activities. Chesire (2001) and
Cox (2002) further argued that school readiness could be increased if Aboriginal children felt positively about their identity and if they felt support by parents. Waabinong respondents clearly wish for their children to obtain Aboriginal culture and language, which would indicate that these children will be connected to an Aboriginal community (likely Waabinong), and continue to increase their pride in being Aboriginal.

### 4.1.2 Education

Many Aboriginal people were required to attend residential schools were they suffered from physical and sexual abuse, forced to not speak their Aboriginal language, did not learn what being in or with family meant, and had poor living conditions (Aboriginal Healing Foundation, 2007). More than half of primary caregivers had a relative in residential school (25% of aunts and uncles, 10.7% of mothers and fathers, 14.3% of grandfathers and 32.1% of grandmothers). Just over 7% of second caregivers or fathers had a relative that attended residential school with 3.6% of second caregivers also experiencing residential school themselves. The Aboriginal Healing Foundation’s website (2007) suggests that residential school survivors and their families are likely to have more social issues as these Aboriginal people did not have the opportunity to experience what parents do, and likely feel distrustful of the Western education system. The fact that so many caregivers and parents had family attend residential school is alarming because education is considered the key to reducing social inequalities for Aboriginal people in Canada (Stonechild, 2006).

Table 1 below shows that primary caregivers had varying education levels with 36.8% having less than Grade 12, 13.6% a high school diploma, and 22.7% having some college. Only 9.1% of primary caregivers had completed college or university, whereas 25% of second caregivers or fathers had this level of education. Primary caregivers were double the number of urban Aboriginal people with some college that Tjepkema (2002) found in the Canadian Community Health Survey, but were almost six times less likely to have obtained a college or university credential compared to the CCHS findings. Three quarters (75%) of second caregivers had a high school diploma or less. Overwhelmingly, 82% of primary caregivers and 37.5% of second caregivers wanted to return to school at some point in the future, and only 3.4% did not want to return to school for both groups.
Table 1  
Caregiver/Parent’s Highest Level of Education in September 2007

<table>
<thead>
<tr>
<th></th>
<th>Less than Grade 12</th>
<th>High School Diploma</th>
<th>Some college</th>
<th>Completed College or university</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Caregiver/Mother</td>
<td>36.8%</td>
<td>13.6%</td>
<td>22.7%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Second Caregiver/Father</td>
<td>10%</td>
<td>65%</td>
<td>0%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Primary caregivers (36.8%) with less than Grade 12 education have not seen a Traditional Healer and self-identified as Status or Non-status. Some scholars (Restoule & Smillie, 2007; Brown & Smirles, 2003) have shown that the higher the education level, the more likely people are to turn to culture and spirituality. Restoule and Smillie (2007) highlight that attendance at post-secondary education institutes may be correlated to how spiritually-connected an Aboriginal person finds one’s self. It may be likely that families that have children attending Waabinong and other AHSUNC projects will become more culturally and spiritually aware and connected to their Aboriginal heritage and this new connection may help them with their choices for education.

With education a key to employability, it is interesting to note that 70.5% of primary caregivers or mothers identified being stay at home parents, and 25% of second caregivers or fathers were stay-at-home parents. More than 50% of second caregivers or fathers were full-time employees and 88.9% of those wanted to continue being employed in the future. Smylie & Anderson (2006), and Jones (2006) argue that having secure employment leads to improved health and that health, employment and education are intrinsically linked in a cyclical pattern, which is also found in the population health approach. Waabinong families are represented in a variety of education levels, but a large percentage of caregivers/parents identify as stay-at-home parents, which may cause stress. This will be further discussed in Chapter 5, Section 5.1.4.

In open-ended questions, primary caregivers responded that they had issues within the school system when they attended and hoped that Aboriginal Head Start would provide a place where their children could get a sense of pride in themselves before moving into a larger diverse
classroom. Over 60% of respondents provided information about issues they had in school, but felt that their children would learn and be able to negotiate the greater society better than they had themselves. Neegan (2005) suggests that residential schools and distrust of the education system have left deep and lasting issues with education and that persistence and knowledge development amongst the Aboriginal community will be necessary to move forward.

Waabinong families are interested in their children being at ease when they enter kindergarten, and believe that developing the necessary skills (i.e. counting, etc), would assist in their child’s confidence and abilities in school. Respondents also indicated that they knew that education would help them and their children in the future.

4.1.3 Social Support

Social support networks can be attained in a number of ways and through a number of different mechanisms like the workplace, school, children’s social network, and programs offered in community. Waabinong Aboriginal Head Start offers all parents and caregivers an hour’s orientation session prior to the beginning of the school year. Parents and caregivers are provided an opportunity to ask questions, receive answers, meet other parents, and discern what will occur in the program. All 44 parents or caregivers had a family member attend the orientation session at Waabinong. The questionnaire did not ask who attended the orientation session.

Fifteen percent of primary caregivers and more than 50% of second caregivers are employed or attend school. These caregivers and parents were not asked to identify other social support networks that they may have developed outside of the Aboriginal Head Start program.

As mentioned in 4.1.1 Culture and Language section, just under half (46.2%) of primary caregivers and 37.5% of second caregivers answered that they had had contact with an Aboriginal Social Support Worker. Aboriginal Social Support Workers or Aboriginal Family Support Workers not only provide information and linkages to health professionals, they provide an informal network for parents or caregivers to access each other. The questionnaires did not ask any specific questions about if the Aboriginal Social Support Worker assisted caregivers or parents in meeting other Aboriginal people or other Aboriginal parents and caregivers.

Aboriginal Social Support Workers or Aboriginal Family Workers provide families with knowledge and assistance in obtaining programs or services, including those from health professionals.
Many social programs are offered in the Sault Ste Marie area including the Ontario Early Years Centre programs, the Community Action Program for Children, the Aboriginal Community Action Program for Children, the Canada Prenatal Nutrition Program, and other independent or government sponsored early childhood programs for zero to six year-old children. Primary caregivers responded that they had attended the Ontario Early Years Centre (OEYC) programs (65.9%) and 2.3% had attended a Community Action Program for Children (CAPC). Primary caregivers also indicated that they had used daycare facilities (34.1%). While primary caregivers responded about use of these programs and services, they did not consistently provide the length of usage; therefore it could not be determined what the duration of usage was. Programs like OEYC, CAPC and daycare centre attendance has been shown to have a positive effect on early childhood development and school readiness skills (Mustard, 1999; Mustard, 2002; Mustard, 2006), therefore any attendance to these types of programs may be a confounding factor in the improvement that children attending AHSUNC show.

Waabinong Aboriginal Head Start provides workshops for parents and caregivers at various times throughout the school year. These workshops are about a variety of issues, concerns, or knowledge that would be useful for parents and families. More than 90% of parents anticipated attending workshops. Many of the caregivers and parents wanted to attend provided workshops regarding parenting skills, Aboriginal culture, Aboriginal language, and social events. These workshops provide parents and families with another way of connecting with other Aboriginal families, and could possibly lead to long-term relationships that would improve the social support networks of the participating families.

4.1.4 Health and Healthy Living

Of the 43 primary caregivers or mothers who responded in September, 55.5% rate their health as “very good” or “excellent”, with only 14.8% rating their health as “fair”, whereas 37.5% of second caregivers or fathers rate their health as “very good” or “excellent” and 12.5% rate their health as “fair”. A negative relationship exists between primary caregiver general health and the child’s rated health (Kendall’s tau-b = -0.134). No significant responses are seen, but as the child’s health moves toward “excellent”, the primary caregiver rates their own health less (i.e. good = 23.3%, and very good = 20.9%).
Primary caregivers who are stay-at-home parents rate their own and child’s health better than other employment categories. Being a stay-at-home parent might be less stressful because the parent does not need to rush through daily activities to attend a job, which could lead the parent or caregiver to feel better because they are not under stress. This will be further discussed in Section 5.1.4. Another possible reason for this finding could be that these parents or caregivers have a social support network that provides them opportunities to leave the home with their children, again reducing the stress of leaving a child at daycare facilities or with strangers, which many parents find extremely stressful.

Second caregivers who rate their health high (“excellent” or “very good”) also had a child’s health rate high. As many of the second caregivers were fathers of the child in the program, it could be that they rate their health higher when the child’s health is higher because the stress of disease and/or illness is not present. I would believe that when a child has a disease, or is ill often, there would be stress, lack of sleep, and possibly loss of some of the social support networks the person needs because the child needs the parent more than a healthy child. Ball (2004) has worked with the Public Health Agency of Canada and other scholars to research father involvement and the impact that having a father present may have on children. Fernand Lozier, Program Consultant at the Public Health Agency of Canada Ontario Region, has consulted with many community organizations, academic researchers, community members and fathers. In this work, it has been determined that having a father or father figure can affect many of the social determinants of health for the child, so it would also be logical to believe that the child’s health status was rated high because of the presence of the father or father figure in their life.

Many other factors could be attributed to this interesting finding. One other possibility could be that the second caregiver feels satisfied with AHSUNC programming and other child care arrangements that are in place, and therefore has less stress, which would increase their health or self-perceived health. Many scholars attribute stress to lower self-reported health status (Tjepkema, 2002), so the second caregiver may have reduced stress because the child’s health status is perceived as high.

Mental health for primary caregivers was rated as 59% “very good” or “excellent”, 22% “fair” or “troubled”, and for second caregivers, they rated 75% as “very good” or “excellent” and 25% as
“good”. Primary caregivers’ responses showed that 6.8% were reporting trouble in mental health. If self-reported mental health is rated lower, it would be reasonable to believe that general health status would be perceived lower, but this is not what the findings showed. For those that reported “troubled” or “fair” mental health, were either “good” or “very good” in their general health self-report. This finding could suggest that while the caregiver is suffering from some form of mental health concern, it is not sufficient enough to reduce their overall health, which is contrary to Tjepkema (2002). From my knowledge of AHSUNC, it may be that a strong social support network is helping to alleviate other concerns (i.e. child care, transportation, etc), and therefore the caregiver has more resources to deal with the mental health concerns and not affect their general health.

It must be noted that articles that express the structure and functions of Indigenous families were not found when conducting the literature review. My personal knowledge of my Aboriginal family and how they interact compared to my non-Aboriginal family has provided me with a view that Aboriginal families function and relate differently than non-Aboriginal families. If an Aboriginal family lives in close proximity to each other, there is a lot of social, mental and physical assistance provided and given between family members, which could increase both general and mental health. This assistance and interaction could also improve the child’s general and mental health. For some urban Aboriginal families, AHSUNC provides a surrogate family, much like other Aboriginal people experience, so the social support networks that are created through AHSUNC may also work to provide social, mental and physical support that improves general and mental health.

More than 75% of primary caregivers had seen the doctor or other health professional for regular check ups in September, which is slightly below the rate of 76.8% that was found in the 2001 Canadian Community Health Survey (Tjepkema, 2002). Primary caregivers may not feel a need to schedule or have regular health check ups with a doctor. Smylie & Anderson (2006) suggest that many Aboriginal people do not feel comfortable in discussing concerns with a physician. It has been noted by other researchers that some Aboriginal people visit doctors or health professionals when it is necessary, otherwise they do not feel that the health professional understands their culture, language, or traditional practices (Burhansstipanov, 2000).
More than 81% of primary caregivers had regular dental visits, and 52.3% had visited a traditional healer. Tjepkema (2002) argued that off-reserve Aboriginal people visited dentists or dental professionals more when there were no fees associated with the service (i.e. public health dental days, free clinics, etc). The use of traditional healers is approximately half of the respondents, which could indicate that some families are still in the process of cultural revitalization and do not have an awareness of what a traditional healer does, or it can indicate that some families are not comfortable with using traditional methods of healing and are learning culture, traditional practices, and (re) defining their identity to incorporate their Aboriginal identity.

When looking at the social determinants of health, employment is a key determinant in a person’s health status, therefore it is interesting to note that 72.7% of primary caregivers wanted to have a job in the future. Almost all of the primary caregivers had responded that their employment status was stay-at-home parent. While this is a worthy job and should receive recognition and compensation, it is likely that the caregiver would like to be able to increase (a) their career opportunities, (b) the household income, and (c) their social support networks. Employment provides adults with a sense of belonging, pride in their work, and most importantly, income. Many scholars (Greenwood & Shawana, 2000; Waldram et al, 2006; Stephens et al, 2005; Adelson, 2005) have argued that education is the key to health, insofar as education provides more employment opportunities with higher income, which in turn can assist people in eating and living healthier.

Urban Aboriginal people have more employment opportunities than Aboriginal people living on reserve (Tjepkema, 2002), but still face many barriers to accessing these opportunities. AHSUNC staff provides workshops and informal advice to parents and families about how to attain employment and/or education. It is likely that Waabinong respondents would like to have a job in the future after their children have started school, or they have more skills and knowledge to obtain higher paying employment, as 72% indicated an interest in future employment.

While the number of tobacco smokers has been steadily declining for the past decade, it should be noted that Aboriginal people smoke at close to 10 times the general population rates (Murray Kaiserman, Director of the Office of Research, Evaluation and Surveillance, Tobacco Control
Program, personal conversation). The overwhelming majority of primary caregivers who answered the questionnaire smoke (70.5%), and 61.4% of those smoke daily with 47.7% outside the car and home. More than half (53%) of the children were exposed to cigarette smoke occasionally or on a regular basis. Seventy-five percent of second caregivers smoked with 20.5% smoking daily. Physicians for a Smoke-Free Canada (2008), Health Canada and the Ministry of Health Promotion in Ontario all have statistics that show the Aboriginal population smoking in far greater numbers than the general population. Through conversations with individuals in all three organizations, it is apparent that Waabinong respondents are very similar to the general Aboriginal population in Ontario and Canada. In Ontario, there have not been any targeted education and awareness campaigns geared toward Aboriginal smokers, which could also account for the high number of smokers. Recent media campaigns by Health Canada’s Tobacco Control Programme do not depict Aboriginal people smoking, nor do they specifically address how and why second-hand smoke is more toxic in the home and car than outside. Health promotion practices at Waabinong Head Start would provide respondents with much more information about smoking and the effects of smoking on children.

Another lifestyle choice that affects all Canadians is the use of illegal drugs like crystal meth. The Parent Council and Project Coordinator at Waabinong Head Start have identified that there is a high use of crystal meth in the Sault Ste Marie area. Therefore, Waabinong provides information about the effects of crystal meth and other illegal drugs to parents and caregivers during the school year. Prior to starting the Aboriginal Head Start programming, 63.6 % of primary caregivers reported knowing the effects of crystal meth and other illegal drugs. With a growing concern about crystal meth usage, Waabinong Head Start and their Parent Council have decided to provide workshops and information about the effects of a variety of illegal drugs. Alcoholism and drug use are concerns in all Aboriginal communities regardless of location, therefore having a large percentage of primary caregivers with knowledge about the effects of drug and alcohol use may benefit them and their children. Primary caregivers responded that 27.3% of them had drank alcohol or taken illegal drugs prior to their children starting the program. While this is still one quarter of Waabinong’s respondents, this number is below that found by Tjepkema (2002) in the Canadian Community Health Survey 2000/01. Primary caregivers could have knowledge or experience with drug and alcohol use from their own
families, or they may have been educated on the issues that come from drinking or taking drugs, or they may not have been honest when disclosing information about these issues.

Only 20.5% of primary caregivers reported knowing what the Aboriginal Food Guide was, and almost 39% had missed a meal in the past month. Health Canada issued the first Aboriginal Food Guide in 2003 and has produced a revised version in 2007. The Aboriginal Food Guide inserts Aboriginal specific foods into the Canada Food Guide food groups to help Aboriginal people to determine what category it belongs in and the health value. It is likely that many Aboriginal people do not know about the Aboriginal Food Guide as the announcement for the guide was not widely publicized in the media.

As a Program Consultant visiting AHSUNC projects across Ontario, I would hear that children would come to AHSUNC and have only one fruit or vegetable that they would eat. After watching other children and through encouragement from AHSUNC staff, many projects conveyed to me that children would expand their eating repertoire. Parents and caregivers were asked about their child’s favourite fruit and vegetable to see if there were any changes in the food choices. The children had a wide variety of favourite fruits and vegetables, and all respondents provided an answer for these questions. Carrots (28.6%) and corn (23.8%) were most chosen of the favourite vegetables in September with apples (29.7%) and strawberries (23.8%) the favourite fruits. AHSUNC projects, including Waabinong Head Start provide the children with a variety of different fruits and vegetables throughout the year to improve the variety that the children will eat without creating a fuss. If the children will eat a variety of fruits and vegetables, they will receive a wider variety of vitamins and nutrients, which likely improve their general health.

Primary caregivers responded that 68.2% of them had other children not entering the Waabinong program this year, but 36.4% had used AHS prior to this September. Approximately 9% of respondents had an older child that had been to Waabinong prior to this September. This prior awareness and knowledge of the program could have an impact on why some questions were answered in a positive manner. All children receive health promotion, nutrition, and education components in the curriculum. Parents and caregivers also have access to a variety of educational materials about health promotion, nutrition and education including workshop
discussions, booklets, and pamphlets. This prior knowledge may have also affected the caregivers and child’s self-reported health.

Almost half of the children entering Waabinong’s program in September had attended the program the previous year (45.5%). Again, attendance at the program will have had an impact on the answers provided to the questionnaire. It is likely that the parents and caregivers had received knowledge and educational materials about health and healthy lifestyles as well as encouragement for the parents/caregivers to return to the education system or workforce.

Parents and caregivers were asked to rate their child’s health and mental health. It is likely that many parents and caregivers answered based on the absence of disease and the child’s holistic health. More than 56% of caregivers or parents thought their child’s health was “excellent” and 42% felt their child’s health was “good” or “very good”. For almost all of the children, their general health was rated high as perceived by the parents/caregivers.

Parents and caregivers see their children’s disposition and emotions on a regular basis, thus parents and caregivers will likely rate their child’s mental health based on these factors. The ratings for the child’s mental health were more varied than that for their general health, with 61.9% rating “excellent”, 29% “very good”, 7% as “good”, and 3% rating “fair”. Many caregivers and parents perceive their child’s mental health as “excellent” or “very good”, which could be attributed to the disposition and emotions the children show at home. If the parents and caregivers have more children at home, they may determine the AHSUNC child’s mental and general health in comparison to their other children.

Attending visits with a doctor or health professional is essential to preventing serious illness. Also visiting a dentist or dental hygienist can help prevent serious dental and medical issues. It is interesting that all but one child had regular visits with a doctor or health professional, and 70% had seen a dentist or hygienist. Every child brushed their teeth, but only 58% did it twice a day or more. It is likely that after the birth of the child, the parents/caregivers were provided with a schedule of visits the child needed to attend for the first few years of their lives. In Ontario, there is a recommended guideline for regular check ups and vaccinations, therefore as a requirement to enter the public school system, parents and caregivers likely ensure that the child attends regular doctor or health professionals to ensure that the child will be able to attend kindergarten when they are of age. Specific vaccinations are required before entry into
kindergarten or a signed letter from a religious leader specifying why these vaccines have not been received.

As noted by the Aboriginal Healing Foundation (2007) and the Canadian Health Network (2007), Aboriginal children are more likely to be exposed to adults who consume drugs and/or alcohol because of colonization, residential schools, and oppression that Aboriginal people have faced. The Aboriginal Healing Foundation (2007) argues that residential school survivors suffered greatly from their educational experiences in those institutions, and they have translated across generations with alcoholism, drug abuse, depression, and poverty being grave issues that stem from residential schools and the colonial policies of the government. It is not surprising then that children in the survey had been exposed to adults consuming alcohol and/or illegal drugs over 12% of the time. Tjepkema (2002) found that off-reserve Aboriginal peoples “were less likely than the rest of the Canadian population to be weekly drinkers”, but there were geographical differences for heavy drinking. In the Canadian Community Health Survey 2000/01, 29.4% of urban Aboriginal people were weekly drinkers, which indicate that Waabinong parents and caregivers are significantly less likely to drink than other urban Aboriginal people. Many factors may contribute to alcohol and drug consumption. For those parents and caregivers who have been a part of the program in years prior to 2007, they may have received education and awareness about the effects of drug and alcohol use and the impact that has on children. With that knowledge, parents and caregivers who have had contact with the program in the past may have altered their consumption patterns to benefit themselves and their children.

The second caregivers, who were likely the father of the child in attendance at AHSUNC, also self-reported their general and mental health as well as how often they visited health professionals like doctors, dental professionals, and family support workers. Second caregivers rated their health as “good” at 50%, and 8.3% as “fair”, with the other 42% rated their general health “excellent” or “very good”. This could be attributed to regular visits to the doctor or health professional, strong social support networks and family relationships, knowledge and awareness of healthy lifestyles, and the impact that AHSUNC has had if their child or children had attended AHSUNC prior to the 2007 school year. Sixty-six percent of second caregivers rated their mental health as “excellent” or “good”, while 8.3 % rated it as troubled. If the second
caregivers felt that they had a strong social support system and or familial support, as well as a reduced amount of stress, they may be more likely to report their mental health higher.

Connection to the Aboriginal culture provides Aboriginal people a way to connect spiritually to the Creator as well. It was found that a majority of second caregivers had attended a traditional healer (66.7%), which could indicate that second caregivers had embraced their Aboriginality and culture. Since the majority of second caregivers were also status Aboriginal people, it is likely that they had a connection to Aboriginal culture and/or knew what a traditional healer could provide to them and the difference to a western physician or health professional.

As all the families lived in an urban centre and likely lived a bi-cultured lifestyle, it is not surprising that more than 65% of second caregivers had visited a doctor or health professional on a regular basis. Similar to the issues for the primary caregivers, it is likely that access could be an issue, or the distrust or the feeling of not being able to discuss personal issues with the physician or health professional caused some of the second caregivers to not attend regular check ups. Another factor for both primary and second caregivers or parents could be time to attend a visit with a health professional without their child(ren) present, which could impede the reason for the visit.

Missing a meal is deemed a sign of poverty (Campaign2000, 2006) and is seen more frequently in Aboriginal families living in urban centres. The survey asked parents and caregivers if they had missed a meal in the past month prior to completing the survey. About half of second caregivers reported missing a meal in August according to the findings. Some of these caregivers could have forgone a meal to ensure their children had enough to eat, or there may have been a lack of money. This will be explored further in Chapter 5.

4.2 Second Assessment – December 2007

In late December 2007, Waabinong Head Start told me that 9 families had withdrawn from the program for various reasons. This phenomenon happens every year and is part of the nature of the population being served (i.e. moving between on and off reserve; moving for jobs; returning to family, etc). By December 31, 2007, 29 completed questionnaires were returned along with the 9 withdrawn surveys. Ten families withdrew from the study at this time. Over 90% of the respondents were women this time with only 7 second caregivers completing the questionnaire.
Fort Erie Aboriginal Head Start had returned 6 completed questionnaires in September and only 2 of the original families chose to complete the second questionnaire, and the project was asked to withdraw from the study as no statistical significance could be obtained from their responses.

The December questionnaire was a slightly different assessment questionnaire than September, and is attached as Appendix B. In the December questionnaire, additional questions regarding changes in education, employment, tobacco consumption, culture and language use, and social support were added. These new questions allowed parents and caregivers to give more open-ended responses as well as providing questions regarding if the parent or caregiver perceived change in education, employment, tobacco consumption, culture and language. Two additional questions about social support were supported by Ball and Elliot’s (2005) questionnaires. These additional questions provided further insight into the changes between responses by allowing parents or caregivers to give more detail.

4.3 Comparison between September and December Results

There were a total of 29 respondents to both questionnaires from Waabinong Head Start in Sault Ste Marie, Ontario. Discussions with the Project Coordinator provided additional information about workshops provided, language offered, and reasons for withdrawing from this study. With an understanding of the families and the programming that had occurred between September and December 2007, I began the analysis of the data to determine if there were any trends in the data. It is important to note that due to the number of respondents, generalizing the results from Waabinong Head Start respondents will be limited to possibilities that could occur at the other thirteen AHSUNC projects in Ontario.

There were 44 responses from the September questionnaire, of those families who had responded to the September questionnaire, only 29 families remained. All 29 families provided responses in both September and December.

The demographic data did not change between September and December with 90% of primary caregivers identifying as the mother of the child in the program, and 90% of second caregivers identified as fathers or stepparent. One family did not have two caregivers in September, but did in December. There were 23 single parent or caregiver families and 6 two caregiver families by December 2007, whereas there were 32 single parent or caregiver families and 12 two caregiver
families in September 2007. The changes in family dynamics may also have an impact on health and education of both the parent/caregiver and the child(ren). As noted earlier, Fernand Lozier of the Public Health Agency of Canada, and other researchers in the Father Involvement Research Alliance (FIRA) and Father Involvement Initiative Ontario (FII-ON), have found that having a father or father figure involved in the family changes income, education, additional learning opportunities, and interaction between family members (parent-child, child-child, parent-parent). Therefore, the decrease of two caregiver families may have an effect on how health and education is perceived because the family has changed.

4.3.1 Culture and Language Comparison

As a core component of AHSUNC, culture and language is incorporated into the curriculum provided to the Aboriginal children attending the program, and in workshops provided to parents and caregivers. Waabinong Head Start provides Ojibwa language and culture in their project, but the culture and language changes depending on where the AHSUNC project is in Ontario.

There was no change in the percentage of primary caregivers who visited a Traditional healer. Approximately 15% of primary caregivers had visited a Traditional healer, and only 20% of second caregivers had visited a Traditional Healer, which also remained unchanged between questionnaires. With the time between questionnaires being short, it is likely that many caregivers were still learning or revitalizing their knowledge and use of Aboriginal culture and therefore did not choose to visit a Traditional Healer in greater numbers. It is also likely that if there were no concerns that required a Traditional healer’s expertise that caregivers did not need to visit a Traditional healer.

Table 2 shows the cross tabulation of the caregivers and parents responses in September and December about smudging at home. It is interesting to note that 7.7% of caregivers began smudging at home, while another 7.7% stopped smudging at home between September and December, therefore the net change was nil. One factor could be that these caregivers who stopped smudging at home believed that their children were being allowed to smudge and practice other cultural activities at AHSUNC and it was not necessary to also provide smudging in their homes. About 5% of caregivers and parents had also responded that their child(ren) had asthma and allergies, and AHSUNC could have provided educational materials that explained
how smoke, regardless of what it comes from, is carcinogenic, and then decided to not have smudging smoke in the home.

Table 2 Caregivers Smudge At Home – Comparison September to December

<table>
<thead>
<tr>
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</tr>
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<td></td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
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<tr>
<td></td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>65.4 %</td>
</tr>
</tbody>
</table>

Another interesting finding was that more than 15% of primary caregivers who smudged in their homes also visited a Traditional Healer in December, compared to 26% in September. Of second caregivers, 25% (or one person) stopped attending a Traditional Healer. One possible reason for the decline in the number of parents and caregivers that smudge and visit a Traditional healer may be that there was no need to visit with a Traditional healer between September and December, and the parents and caregivers could have been provided information about the harmful effects of any smoke and asthma. The questionnaire did not ask if parents and caregivers about their journey to reclaim their Aboriginal culture and language, or if there was any concerns with revitalizing their culture and language. Without any specific questions about if parents and caregivers wanted to revitalize Aboriginal culture and language, there could be a number of factors contributing to the decline in Aboriginal cultural practices.

There was no change in the number of parents or caregivers that want to use culture and/or language in homes. Almost 90 percent of families intend to use culture and language in their
homes as their children learn it at AHSUNC. This is shown in Figure 4 below. AHSUNC provides workshops and information about where and when the parents and caregivers can access Aboriginal language classes or workshops and cultural events and teachings. It is likely that the majority of families see the need to revitalize Aboriginal culture and language and that without using the newly acquired knowledge, their children will not retain the Aboriginal language.

**Figure 4** Caregivers Incorporation of Aboriginal/Métis Culture at Home Comparison

Table 3 provides the cross tabulation of primary caregivers that visited an Aboriginal Social Support Worker between September and December. There was a slight increase (12%) with another 28% who continued their visits with an Aboriginal Social Support Worker. Waabinong Head Start encourages families to connect with an Aboriginal Social Support Worker as it benefits the parents and caregivers by helping to connect them with programs and services that their family may need, as well as connecting families with the public school system, health professionals, and other professionals that children or their families may require.
Table 3  Primary Caregiver visited Aboriginal Social Support Worker Comparison

<table>
<thead>
<tr>
<th>Primary Caregiver visits ASSW December</th>
<th>Primary Caregiver visit ASSW September</th>
<th>No</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Count</td>
<td>11</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>44.0%</td>
<td>16.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>Count</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>12.0%</td>
<td>28.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>14</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>56.0%</td>
<td>44.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Only 4% of those primary caregivers visiting an Aboriginal Social Support Worker also visited a Traditional healer. There was no change for second caregivers’ visitation with Aboriginal Social Support Workers. As discussed above, parents and caregivers may not have had a need to visit a Traditional healer between the two questionnaires, which could be why the number of parents and caregivers that visited a Traditional healer and an Aboriginal Social Support Worker is low. Aboriginal Social Support Workers have lists of Aboriginal programs, services, and professionals, who are Aboriginal or sensitive to the needs of the Aboriginal community. Parents and caregivers who visited an Aboriginal Social Support Worker may have been connected to a Traditional healer after their visit with the Support Worker, which may also explain why the finding is low.

In the open-ended responses, caregivers and parents have consistently voiced that they want their children to learn their Aboriginal culture and language. More than 90% of families not only wanted their children to learn the Aboriginal culture and language, but also wanted to use this new knowledge at home. This finding is supported by many scholars (Bramley et al, 2004; Bramley et al, 2005; Greenwood, 2000; Adelson, 2005; Canadian Health Network, 2007; Chesire, 2001), who also argue that positive self-identity in being Aboriginal and being able to
practice and use Aboriginal culture and language will assist in revitalization and transmission into the future.

In the December questionnaire, parents and caregivers were excited, interested and amazed at the amount of Aboriginal culture and language that their children had learned. Approximately 50% of parents and caregivers attempted to bring culture and language into their home. Chesire (2001) argued that cultural transmission occurs in different forms, but that transmission amongst Indigenous populations is unique and has survived in the face of adversity and oppression for more than 300 years. The interest in utilizing the culture and language by families will likely help with revitalizing language and the continuation of learning culture and language. The Canadian Health Network (2007) argued that cultural identity is very important to early childhood development and that parents/caregivers, community and social networks are all key players in the development of a strong Aboriginal identity in early childhood and beyond. Further discussion about culture and language will occur in Chapter 5, Section 5.1.1.

4.3.2 Education Comparison

Residential school has made an impact on Aboriginal people in western Eurocentric schooling. Residential schools took Aboriginal children from their families and forced them to learn English and Eurocentric education, which was quite different than education had been prior to contact. Many Elders and residential school survivors saw the impact that residential schools and Eurocentric education had on their children and advocated for many years that Aboriginal children should not attend English Eurocentric schools (Battiste, 1986). The Royal Commission on Aboriginal People (1996) found that many Aboriginal people suffered physical and mental abuses in residential schools as well as losing their Aboriginal culture and language. Some of the parents and caregivers at Waabinong Head Start had indicated that they or a close relative had attend a residential school, which could influence their feelings about mainstream Eurocentric schooling and its impact on their child(ren). It is very interesting that primary caregivers show no significant change in education based on their experience or familial experience with residential schools. This would contradict the literature, and shows a trend toward what Stonechild (2006) believed would help Aboriginal people reduce the inequalities that Aboriginal people face: formal education in the general education system.
Approximately 33% of primary and second caregivers changed their employment status. In the current Canadian economy, employment opportunities require a certain amount of schooling. Tjepkema (2002) found that 53% of urban Aboriginal people in Canada had a high school diploma or less, and that 28% of urban Aboriginal people in Canada have a “low” household income equivalent to the low-income-cut-off (LICO). Tjepkema (2002) also reviewed work or employment status from the 2000/01 Canadian Community Health Survey, which showed that only 5.9% of urban Aboriginal people did not work and looked for work, and 12.4% had worked part of the year and looked for work, which is significantly lower than how many parents and caregivers who changed their employment status from Waabinong Head Start.

In Table 4, 10% of primary caregivers changed their plans to return to school, with just over 10% returning to school between September and December. This is a significant amount of caregivers or parents at Waabinong that had decided to change their educational credentials. Stonechild (2006) argues that education will assist Aboriginal people in reducing social inequalities, and lead Aboriginal people to self-governance.
Table 4  Primary Caregiver Wanting to Return to School Comparison by Self-Report Education Change

<table>
<thead>
<tr>
<th>Primary Caregiver Schooling Changed</th>
<th>Primary Caregiver Return to School December</th>
<th>Primary Caregiver Return to School September</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Maybe Count</td>
<td>Primary Caregiver Return to School September</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>% of Total</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>No</td>
<td>Count</td>
<td>0</td>
</tr>
<tr>
<td>% of Total</td>
<td>0.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>% of Total</td>
<td>5.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>2</td>
</tr>
<tr>
<td>% of Total</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not at this time</th>
<th>Yes Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Total</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
<tr>
<td>% of Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>Maybe Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Total</td>
<td>33.3%</td>
</tr>
<tr>
<td>Yes</td>
<td>Count</td>
</tr>
<tr>
<td>% of Total</td>
<td>66.7%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
</tr>
<tr>
<td>% of Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Fifty percent of second caregivers went from possibly returning to school to wanting to return to school. While this is a high percentage, due to the small number of second caregiver respondents, this is not a significant finding, but interesting to note that after being exposed to AHSUNC,
many second caregivers or fathers could recognize the need to further their education. Waabinong staff does encourage parents and caregivers that want to return to school and help to provide them with adequate information for their potential return.

Figure 5 shows the highest level of education attained by the primary caregiver in September and December. It is interesting that primary caregivers with “some college” education decreased in December and that the number of those with a “college diploma” increased by the same amount. More discussion about this change will occur in 5.1.2. This change in educational attainment could be attributed to primary caregivers having a safe and nurturing environment for their child while they attended college. Far more second caregivers improved their education level, with 40% increasing their highest level of education. It is possible that these second caregivers were encouraged by their children’s educational progress at AHSUNC, or the staff at AHSUNC provided information and encouragement for their return to school.

**Figure 5** Primary Caregiver’s Highest Level of Education Comparison
Those primary caregivers with the highest levels of schooling (graduate degree, college diploma or some university) did not change their employment or education status between September and December, but those primary caregivers with a high school diploma or less changed their employment status (12%). Based on Stonechild’s (2006) argument that education would be the “new buffalo” and provide Aboriginal people for many generations with help to reverse the social problems created by colonialism, it is not surprising that caregivers with the lowest level of education were more likely to change their education and/or employment status. Waabinong parents and caregivers showed a change in educational attainment and employment, which will further help their children to want to further their education and obtain employment of equal or greater “value” to that of their parents (Mustard, 2002).

In the open-ended responses, 42% of caregivers and parents wrote that they were encouraged to return to school by the progress their children have made and the impact that their education would have on their children’s education. These parents and caregivers believed that by role modeling the behaviour they wanted to have their children to have, they could help themselves (increasing educational attainment and thus employment opportunities), and ensure that their children could see why education was necessary.

Twelve percent of parents and caregivers also responded that they intended to make changes for their education in the near future because of their relationship with Waabinong Head Start. Education is important to employment and health as it contributes to materialism, consumerism, and healthy lifestyles. Through the Marxist perspective, materialism and consumerism would create more inequalities by oppressing the working class, but in Canadian society it is important to have education that will increase the likelihood of employment, and allow Canadians to obtain better quality foods and health services, which will decrease the inequalities between classes in the future.

Some scholars have shown that if a person has higher educational attainment, they can obtain employment with higher income, which in turn allows them to buy healthier foods, pay for enrolment in recreational physical activities, and improve their general health, which in turn can improve mental health. Higher education is also associated with increased knowledge of health promotional practices, which also improves health, and can lead to an individual wanting to
increase their education further (Canadian Health Network, 2007; National Aboriginal Health Organization, 2006).

Parents and caregivers report in the open-ended questions that 65% of children were potty-trained between September and December, and more than 90% reported an improvement in their child’s language, reading, and math skills. Sones (2002) compiled similar parental reports and found that parents and caregivers were appreciative of the curriculum and Aboriginal-specific teachings that AHSUNC projects in Canada provide.

Many parents and caregivers wrote a note to the Waabinong staff thanking them for their hard work with their child and how excited they were with the progress of their child’s learning (socially, emotionally, physically, and spiritually). Sones (2002) and Ball (2004) found that parents and caregivers were extremely happy with their decision to send their children to AHSUNC because of the increase in skills and abilities that their children showed after entering the program, which is consistent with the responses from Waabinong Head Start parents and caregivers.

4.3.3 Social Support Comparison

With approximately 33% of primary and second caregivers changing their employment status, Waabinong respondents far exceed the findings from the Canadian Community Health Survey 2000/01 that Tjepkema (2002) reported. Twenty-two percent of primary caregivers employed outside the home became stay-at-home parents, while 22% of primary caregivers that were stay-at-home parents in September returned to the workforce. Waabinong staff and Aboriginal Social Support Workers provide AHSUNC parents and caregivers with information and encouragement to return to school and employment, so this finding could be a result of the encouragement and positive support that parents and caregivers receive after their children start in the program.

Eleven percent of second caregivers moved from part-time jobs to full-time employment and 3.6% moved from outside employment to stay-at-home parent status. These employment changes can have an effect on social support networks and health as these caregivers meet new people and can afford to live a healthier lifestyle with more income.

Twelve percent of primary caregivers began seeing an Aboriginal Social Support Worker between September and December. There was no change for second caregivers.
Table 5 shows attendance at Ontario Early Years Centres (OEYC) programs in September and December. Almost 22 percent of all caregivers began attending OEYC by December. OEYCs were created by the province of Ontario to provide universal programs and services for families with children aged 0 to 6 years old. Workshops designed for parents and caregivers provide information about parenting skills, managing on a shoe-string budget, healthy foods and snacks, as well as how to help your child and advocate for their needs. Because OEYC programs are universal, Aboriginal families may not feel as welcome in these programs as they would in an Aboriginal specific program like AHSUNC or Aboriginal Community Action Program for Children (CAPC), but OEYC programs are available to any Ontario family with young children. The OEYC programs are more widely advertised and referred to by health professionals because of their universal access.

<table>
<thead>
<tr>
<th>Attend OEYC December</th>
<th>Attend OEYC September</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>39.1%</td>
</tr>
<tr>
<td>Yes</td>
<td>Count</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>21.7%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>60.9%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>39.1%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Four percent also began attending the Community Action Program for Children (CAPC) between September and December with 12.5% beginning to use daycare facilities in that time. The question posed to respondents did not ask if they attended specific workshops or programs at CAPC, or if they attend the Aboriginal-specific CAPC. Many AHSUNC projects in Ontario refer their families to the nearest Aboriginal CAPC programs. Many participants in CAPC programming are not aware that the project is named CAPC because it is not mandatory for
CAPC projects to put a logo at the location where programming is occurring. It has been noted in the 2003 Ontario CAPC/CPNP Renewal Report (Mashford-Pringle, 2003) that many participants attend CAPC programs like “Moms and Tots” or “Toy Lending Library” without realizing what the program is named or who funds the program. It is likely that Waabinong families also attend Aboriginal CAPC in Sault Ste Marie, but do not realize they are attending workshops or events that are linked to that project.

Nine workshops were provided at Waabinong Head Start between the administering of the September and December questionnaires. Fifty-four percent of caregivers and parents that intended to go to workshops did in fact attend a workshop. Just over four percent of parents and caregivers that did not intend to attend a workshop did, but 33% that intended to attend did not. This turnout of parents and caregivers at workshops shows that AHSUNC families are interested in connecting with other Aboriginal families while acquiring new skills and knowledge.

4.3.4 Health and Healthy Living Comparison

4.3.4.1 Caregiver or Parent Health Comparison

Table 6 represents a cross tabulation of the primary caregivers self-reported health comparison. Just over twenty-six percent of primary caregivers rated their health improved between September and December, but fifteen percent rated their health declined. It is interesting to note that Tjepkema (2002) noted that 23.1% of Aboriginal people living off reserve in 2000/01 rated their health as either “fair” or “poor”, which is not consistent with the findings from Waabinong respondents.
### Table 6 Primary Caregiver Self-Reported Health Status Cross Tabulation

<table>
<thead>
<tr>
<th>General Health Rating in September</th>
<th>General Health in December</th>
<th>Count</th>
<th>Excellent</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td></td>
<td></td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>11.5%</td>
<td>.0%</td>
<td>3.8%</td>
<td>.0%</td>
<td>15.4%</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>.0%</td>
<td>3.8%</td>
<td>7.7%</td>
<td>.0%</td>
<td>11.5%</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>3.8%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>11.5%</td>
<td>30.8%</td>
<td></td>
</tr>
<tr>
<td>Very Good</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>3.8%</td>
<td>7.7%</td>
<td>.0%</td>
<td>30.8%</td>
<td>42.3%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>19.2%</td>
<td>19.2%</td>
<td>19.2%</td>
<td>42.3%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6 below provides a visual glimpse of the changes in the primary caregivers’ general health. Tjepkema (2002) wrote that self-reported questions are standard when conducting population health surveys and best represent what respondents believe their health status is, and this has been proven reliable and consistent in other research.

#### Figure 6 Primary Caregiver’s Self-Reported General Health Comparison Graph

![Graph showing percentage of respondents by general health rating for September and December](image-url)
Figure 7 shows the differences in self-reported general health of the second caregivers. The increase in reported general health could be attributed to reduction in stress, less concern about their child’s health and educational abilities, or increased social support networks by attending events and workshops at AHSUNC.

Tjepkema (2002) reported statistics from the 2000/01 Canadian Community Health Survey (CCHS), which showed that 43.2% of Aboriginal people living in urban areas in provinces reported their health as “very good” or “excellent”, and 34.8% reported their health as “good”, which is slightly lower than the results for Waabinong respondents.

Figure 7 Second Caregiver’s Self-Reported General Health Comparison

The cross tabulation for the primary caregivers self-reported mental health is represented in Table 7. The results indicate that 26% of primary caregivers rated their mental health as improved between September and December and more than 30% remained excellent. Primary caregivers and mothers worry about a child’s development, learning opportunities, and ability to fit in to school (Chesire, 2001). This increase in mental health status could be attributed to the reduced stress as their child(ren) acquire new skills and these caregivers are provided with reassurance and encouragement that the child is “on track” for developmental milestones, or if the parent/caregiver recognizes a concern with the child’s development, it is possible that AHSUNC staff alleviate the concern or confirm the problem, which can also lead to reduced
stress. Many parents and caregivers who believe there is an issue with a child’s development feel that no one will understand and that the medical community may not be able to diagnose or treat the condition (Greenwood, 2000), but children attending AHSUNC are screened for a number of developmental concerns. With a confirmation of either a problem or that there is no problem; many primary caregivers may feel a reduction in stress.

Another reason there may be an increase in mental health for the primary caregivers could be that their child(ren) are in a safe, welcoming, and cultural sensitive environment when they are not with the caregiver/parent. Blackstock (2006) argued that when children are away from their parents, parents are concerned that the environment is welcoming, safe, and provides a similar set of values as the child(ren) would receive at home. AHSUNC provides this environment; therefore parents and caregivers may reduce their stress about their child’s well-being, and increase their social support networks which will provide positive differences in the families’ lives (Light & Martin, 1996).

Table 7 Primary Caregiver Self-Reported Mental Health Status Cross Tabulation

<table>
<thead>
<tr>
<th>Mental Health in December</th>
<th>Mental Health in September</th>
<th>Count</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Troubled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Count</td>
<td>8</td>
<td>2</td>
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<td>0</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>30.8%</td>
<td>7.7%</td>
<td>3.8%</td>
<td>0%</td>
<td>0%</td>
<td>42.3%</td>
<td></td>
</tr>
<tr>
<td>Very Good</td>
<td>Count</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>7.7%</td>
<td>7.7%</td>
<td>3.8%</td>
<td>7.7%</td>
<td>3.8%</td>
<td>30.8%</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>Count</td>
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<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td>0%</td>
<td>3.8%</td>
<td>11.5%</td>
<td>3.8%</td>
<td>0%</td>
<td>19.2%</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>Count</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
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<td>0%</td>
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<td>0%</td>
<td>0%</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>Troubled</td>
<td>Count</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>3.8%</td>
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<td>Total</td>
<td>Count</td>
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<tr>
<td>% of Total</td>
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<td>38.5%</td>
<td>23.1%</td>
<td>19.2%</td>
<td>11.5%</td>
<td>7.7%</td>
<td>100.0%</td>
<td></td>
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</tbody>
</table>
Below, Figure 8 provides a visual comparison of the data shown in Table 7 for the primary caregiver’s self-reported mental health. It is apparent from reviewing Figure 8 that primary caregivers show a trend toward improved mental health after their children begin attending AHSUNC. Sones (2002) provided similar stories from parents who believed that AHSUNC had a positive impact on their family’s well-being.

**Figure 8   Primary Caregiver’s Self-Reported Mental Health Comparison Graph**

Second caregivers rated their general health improved with 60% moving up from “good” to “very good” or “excellent”, and as shown below in Figure 9, 40% of second caregivers also rated their mental health improved from “fair” to “good”. These improvements are strong and can be an effect of their child’s improved social, physical, and mental abilities. As their child improves, it is likely that stress regarding the child’s well-being decreases, which increases general and mental health for the second caregiver. While the Canadian Community Health Survey 2000/01 does ask about major depressive episodes, it does not ask respondents to rate their mental health (Tjepkema, 2002); therefore I could not locate comparable statistics for these findings.
Primary caregivers that rated their general and mental health either “excellent” or “very good” also rated their child’s mental health “excellent” were 36.9% of the total group. This suggests that parents and caregivers who reported their general and mental health high also perceived their child’s mental health high. This finding could be attributed to increased social support networks, improved skills and knowledge in education and health, and a sense of pride in being Aboriginal, which was attained from attending AHSUNC programming. Approximately half of all primary caregivers who rated their general and mental health “excellent” or “very good” also rated their child’s general health “excellent”. Similarly, parents and caregivers perceive their own health and their child’s health improved because of the changes in their social and physical environments as everyone’s social and physical environment has changed as they enter AHSUNC. The parents/caregivers and their children that attend AHSUNC change their social environment by expanding and including AHSUNC staff in their daily activities, and for many participating families, they will include other AHSUNC families and Aboriginal or Métis community members in their social events. AHSUNC is a new physical environment for the children who attend, but many parents and/or caregivers also attend the site on a regular basis, therefore they change and expand their physical environment to include the AHSUNC project.
Children and their families have the opportunity to meet more Aboriginal people who may share similar interests and concerns, which could expand their social support network and provide encouragement and support. By having a nurturing and safe environment for attaining school readiness skills, parents and caregivers will have provided a positive physical environment, which could also increase the perception of increased health status for the parents/caregivers and their children.

AHSUNC projects provide children and families with health promotion and healthy living information that can lead to increased usage of health professionals and other services that will continue to improve health and education. In this study, the number of primary caregivers that visited a doctor or health professional for a regular check-up increased by 20% and 11.1% for regular dental visits. Second caregivers also visited a doctor or health professional for regular check-ups more frequently with a 60% increase, but there was a 20% decrease in the number of second caregivers who visited a dental hygienist or dentist between September and December.

Figure 10 below shows the comparison of smoking habits between September and December. Ten percent of primary caregivers quit smoking between September and December and almost 20% decreased the frequency of smoking and more than 22% changed where they smoked. These changes in smoking behaviour could be attributed to the health promotional materials provided to the children and their families through AHSUNC. Since tobacco smoke has been proven to be cancerous, caregivers and parents may not have been aware of the harmful effects prior to receiving information from the AHSUNC program.
In Figure 11, there is evidence the number of primary caregivers that smoked daily decreased and there is an increase in occasional smoking instead. This finding could help to increase the primary caregivers’ perception of their general and/or mental health, but likely played a factor in the rating of the child’s health.
Figure 12 provides the finding that 12% of smokers moved their smoking from the house and car to alternative places. Second caregivers did not change their smoking habits between September and December.

**Figure 12       Where Primary Caregivers Smoke Comparison Data Graph**

There was an increased knowledge of the effects of illegal drugs as 16% of primary caregivers and 20% of second caregivers believed they knew the effects of crystal meth and other illegal drugs more in December than they had in September. Figure 13 shows the primary caregivers change in their knowledge of the effects of illegal drugs.

**Figure 13       Primary Caregiver Knowledge of Effects of Illegal Drugs Comparison Graph**
Furthermore, 20% of primary caregivers stopped drinking alcohol or taking illegal drugs, but there was no change for second caregivers, although the percentage was low at 3%. In AHSUNC programming, children are given information, in the curriculum and to take home, about the use of alcohol and illegal drugs. Waabinong Head Start has been a leader in providing information about the effects of using illegal drugs and alcohol and how it will affect children. Waabinong Head Start recognized a concern within the community, crystal meth use, and took the initiative to educate the families that attend AHSUNC through literature, information sessions, and health care professionals visiting the project site. This could be why there was a change in alcohol and illegal drug consumption.

Figure 14 provides a visual representation of primary caregivers’ knowledge of the Aboriginal Food Guide in September and December. Twenty-three percent of primary caregivers had begun to use the Aboriginal Food Guide or the recipes provided by Waabinong Head Start, but 40% of second caregivers felt that they had not used the Aboriginal Food Guide or recipes. As every meal is important, it is important to note that 23.1% of primary caregivers and 40% of second caregivers missed a meal in the past month, therefore there is a decline in primary caregivers missing meals since it was 33.6% in September, but no change for second caregivers.

**Figure 14  Primary Caregiver Knowledge of Aboriginal Food Guide Comparison Graph**
Health Canada’s (1998) *Taking the Population Health Approach* discusses the interconnectivity of missing meals with reduced health status. Missing meals can disrupt learning, job duties, and can cause stress. Figure 15 below shows that primary caregivers missed a meal more in September than December. AHSUNC projects provide parents and caregivers with workshops and/or information about how to buy food and other necessities on a shoe-string budget, which could have helped to reduce the number of primary caregivers that had to miss a meal because of economic conditions in the household. Some AHSUNC projects provide leftover food to families on a rotational basis, or create community gardens that help to provide free food to families with low income. It is possible that the reduction of primary caregivers who missed a meal was due to AHSUNC information and/or workshops about spreading food and money further.

**Figure 15  Primary Caregivers Response to Missed Meals Comparison Data Graph**

![Primary Caregivers Response to Missed Meals Comparison Data Graph](image)

### 4.3.4.2 Child’s Health Comparison

It is interesting that parents and caregivers rated their child’s general health less well in December (23% decline overall), but in cross tabulation, 15.3% of children’s general health ratings were increased to “good” or “very good”. Figure 16 shows that the general trend that caregivers and parents reported was a decline in general health of the child. This could have occurred because the parents and caregivers were provided with information and resources about

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health, nutrition, and healthy lifestyles. As the parents and caregivers learned through AHSUNC and additional referrals to other professionals about healthy living and lifestyles, the parents and caregivers would be able to revise their perception of health. This revised perception would influence the parents/caregivers reporting of their child’s general health. The more knowledge parents and caregivers obtain about developmental milestones, healthy living and eating habits, and overall health, it is possible that the parents and caregivers changed their view of the child’s health.

Figure 16  Child’s General Health Status Comparison Graph

A similar finding to the child’s general health occurs when reviewing children’s mental health ratings. Figure 17 shows that 16% of children were rated lower in December than in September while 12% were rated higher. This finding is interesting because the child’s general health is perceived lower after being in AHSUNC than prior to entering the program. This could have occurred because of increased knowledge on the parents/caregivers behalf. AHSUNC sends information about health issues home with the children on a regular basis, as well, some projects provide information sessions with health professionals, and most AHSUNC projects provide one-on-one information through a Parent Coordinator. The Parent Coordinator can help with referrals to health professionals, traditional healers, Elders, or other needs that the family has. Through the different mechanisms to provide information, parents and caregivers can improve
their knowledge and understanding of health. Tjepkema (2002) found that Aboriginal people define health differently than non-Aboriginal Canadians, and that the self-perceived health status of the respondent and their family may be lower if no examples are provided as to what each category means. This will be further discussed in Section 5.1.5.
The cross tabulations showed a 3.8% increase in regular check-ups with a doctor or health professionals when comparing families against themselves from September to December. Figure 18 shows a decrease overall in the number of children visiting doctors or health professionals for regular check-ups. Waabinong Head Start’s Project Coordinator, Cathy Alisch, has explained that in Sault Ste Marie, many families cannot find family doctors because of the shortage of physicians in the area. This finding is quite interesting and could be attributed to the lack of primary care physicians in the area, or it could be that many children completed their regular check-up prior to the September questionnaire and have not had another scheduled check-up before the December questionnaire. Another possibility is that these children may have seen a Traditional Healer in the intervening three months, and therefore did not need to see a primary care physician.
Figure 18  Child’s Visits Doctor for Regular Check ups Comparison Graph

There was a decline in the number of children visiting a dentist or dental hygienist for a regular check-up between September and December (16%), which is shown in Figure 19 below. Based on the wording of the question; “Has your child seen a dentist, dental hygienist, nurse practitioner or other dental health professional on a regular basis since September 2007?”. It is likely that parents and caregivers had taken their child(ren) to visit the dentist prior to September, but would not have had another regular dental visit until after the completion of the December questionnaire. This decrease in dental professional visits could be fully attributed to the inaccurate wording of the question as dental care amongst the AHSUNC children improved in the same time frame.
There was no change in the number of children that brush their teeth, but 12% of the children increased the number of times they brushed their teeth according to their parents/caregivers questionnaire responses as seen in Figure 20. In the “Other” category, parents and caregivers could provide further information and for all 15% who had checked that category in December, reported that the children were brushing two times a day with flossing, or three times a day. After completing cross tabulations on individual families, there was an increase in brushing for 38% of the children when they were compared in September to the December responses. The comparison of individual families from September to December showed positive dental health improvements, but there was an overall trend toward less brushing. The questions about dental care may not have taken into consideration that the children at AHSUNC projects are asked to brush their teeth while in attendance at the program. Therefore, if a parent/caregiver answered that the child(ren) brushed their teeth only once or twice a day, it may be likely that they did not know or forgot to add in that the child(ren) were also brushing their teeth at AHSUNC programming at least once.
Parents and caregivers were asked for the approximate weight and height of the children both in September and December. Just fewer than 50% responded in September, but over 85% responded in December, which highlights that parents and caregivers were becoming more familiar with the health of their children after entering AHSUNC. All the children were increasing in weight and height where the parents/caregivers provided information in September and December.

It is not surprising that 19.2% of children were no longer in the presence of cigarette smoke since it has been noted that a number of primary caregivers have reduced or quit smoking and have moved their smoking outside. Although the children are not in the presence of tobacco smoke, there was an increase of 11.5% of children in the presence of someone drinking alcohol. Almost 75% of children had developed a new favorite fruit and/or vegetable between September and December.

The open-ended responses from the parents and caregivers showed excitement about the new language, activities, and learning that the children were presenting at home. Just over half of the open-ended answers spoke about new health practices that the child was now exhibiting at home and about twenty percent spoke about English language and math skills.

It should be noted that there was an overrepresentation of single parent Aboriginal families amongst Waabinong Head Start participants, but these respondents were similar to the 2001
Canadian Community Health Survey and the 2001 Aboriginal Peoples Survey with an average age of 26.9 years and with 57% having “status”.

Some of the interesting findings were that there was only about one quarter visiting a Traditional Healer and/or smudging at home, but that 88% had begun to incorporate culture and language from AHSUNC into their homes; there was a 12% increase in visits with an Aboriginal Social Support Worker; 10% of caregivers returned to school with another 12% intending to return to school in the future, while 22% of stay-at-home primary caregivers returned to the workforce and 11% of second caregivers moved from part-time to full-time employment; approximately 26% of caregivers rated their health and mental health improved, but 23% rated their child’s health decreased; there was also a 20% decrease in the frequency of smoking with 22% changing where they smoked; and finally there was increase in attendance at OEYC programming. This shows that AHSUNC has had a positive effect on AHSUNC children and families by increasing health, education, employment, and social support networks. Of the 29 families that completed both the September and December questionnaires, there was a trend toward healthier lifestyle choices, improved education of the children, upward mobility in employment, increases in self-perceived general and mental health of primary and second caregivers, and decreases in bad habits like smoking, illegal drug use, and alcohol use.
5 Chapter 5 – Discussion

5.1 Summary

The health and education of the parents and caregivers was improved as they showed a 26% increase in health and mental health reports, and 10% returned to school. These improvements are significant and can show that a positive environment and social support can improve health and education. These changes cannot be fully attributed to AHSUNC, but it is likely that AHSUNC has played an important role in the changes made to both the children and their families.

This study shows that there is an improvement in the knowledge and/or skills of the children who attend AHSUNC based on parents and caregivers observations. Parents and caregivers provided qualitative responses about their child’s new skills and knowledge. Sixty-five percent of children are potty-trained in the first three months of attendance at AHSUNC and more than 90% of children had shown improvements in language, reading and math skills. Parents and caregivers also perceived that their children’s health had declined (23%) over the study, but there was an increase in regular check-ups with a primary care physician and an increase in dental health care. These changes will be discussed in Section 5.1.5.

AHSUNC also provided the children and families with a cultural sensitive curriculum and learning environment, which was acknowledged overwhelmingly by a number of families that expressed their gratitude for giving their children a sense of pride in being Aboriginal, and (re)learning their culture and language, which has lead to a vast improvement in the child’s skills and abilities. The AHSUNC environment has likely lead these parents and caregivers to make changes in their own health and education, but again, it cannot be fully attributed to AHSUNC.

The quantitative statistics show gains in a number of areas, but the qualitative responses from parents and caregivers in this study and past government reports like Parents in Aboriginal Head Start: Building Community, (2002) clearly voicing their opinions about how AHSUNC’s help gave them a sense of pride in being Aboriginal, which in turn improved other aspects of their lives including helping them to teach and advocate for their children. These improvements are
indefinable, and have affected entire families, not just the children who attend AHSUNC on a regular basis.

The impacts of AHSUNC go beyond the six core components of the program and are defined, captured, and reported on in this study. My research provides a glimpse of the impacts that affected the children and their families with regards to their education and health, but much more needs to be studied and addressed (refer to Section 5.2 Recommendations). In the first three months of attending the program, it is apparent that Aboriginal children show an improvement in their school readiness and early learning skills as well as improved health routines (i.e. teeth brushing and regular doctor and dental visits). Parents and caregivers also show improvements in educational attainment, employment, social supports, self-perceived health and mental health status, and health behaviours (i.e. reduced tobacco consumption, increased dental and doctor visits, improved knowledge of illegal drug effects, etc). Future research may be able to build upon the findings of this study and look at clear indicators in an indigenous way. The discussion that follows is a melding of the results, literature and conjecture on my part.

AHSUNC provides parents and caregivers with learning opportunities beyond parenting skills, but these opportunities need to be culturally sensitive and open to all parents and caregivers with children in the urban Aboriginal community. Unfortunately the current 5.5 million dollar budget in Ontario is not adequate to support the over 17,400 Aboriginal children who require a program like AHSUNC. With 14 AHSUNC sites in Ontario, it is not likely that all Aboriginal children will be able to attend this valuable program and have the opportunity to increase their skills, knowledge and pride in being Aboriginal. As mentioned in Chapter 1, the AHSUNC sites in Ontario vary in their locations, but many parts of the province are still without a Head Start site as the funding for the program has not increased sufficiently to allow the current projects to grow and to expand the program to more areas of the province.

AHSUNC projects in Ontario are required to be licensed by the Day Nurseries Act, which governs all daycare facilities, although the program was not intended to be a daycare facility but a school readiness and early learning centre. The licensing requirements determine how many children can attend based on space and number of ECE (early childhood educator) staff employed. The younger the children, the more ECE staff are required, which increases the budget of the project and can reduce the number of children that can potentially attend the
project. The fourteen AHSUNC projects in Ontario are widely dispersed in urban and northern communities. Waabinong Head Start was among the first six projects to be funded in Ontario and has established partnerships and referrals with a variety of organizations, health professionals, and community members. The established nature of Waabinong could contribute to the positive trends seen in this study.

Of the 29 families that completed both the September and December questionnaires, there was a trend toward healthier lifestyle choices, improved education of the children, upward mobility in employment, increases in self-perceived general and mental health of primary and second caregivers, and decreases in bad habits like smoking, illegal drug use, and alcohol use. The results support that AHSUNC projects do provide urban and northern First Nations and Métis children and their families with knowledge, experiences, social support, and culture and language that increase the positive sense of pride in being Aboriginal and help to revitalize the Aboriginal culture and language. Many Head Starts have a large number of both First Nations and Métis in their population, but it must be noted that the largest population of Inuit people in Ontario are in the Ottawa area, where there is an Inuit Head Start.

From the findings, there is a positive trend toward healthier lifestyles that could be attributed to the health promotion and nutrition components of AHSUNC. There are also positive trends toward increased education of the children and their parents/caregivers, which would acknowledge the work that AHSUNC project staff do with and for the children and families. The open-ended responses and positive trends in the culture and language questions also could be attributed to the workshops and curriculum AHSUNC provides to the families and children. The overall findings indicate a positive trend toward improved general and mental health with increased knowledge of positive lifestyle choices for AHSUNC families. A larger scale study over a longer period of time may find that all AHSUNC projects in Ontario and across Canada impact health and education of Aboriginal children and their families, as I have found from this study.

Waabinong Head Start, through the Parent Coordinator and teaching staff, ensure that all parents and caregivers are aware of opportunities to volunteer, build skills, and receive training and education, and Aboriginal cultural opportunities that can enhance or improve their lives. While no data was collected regarding the impact that individual workshops had, or the relationships
parents and caregivers have/had with staff, it is apparent from the questionnaires and discussions with Waabinong staff that everyone belongs to the Waabinong family and community. Even after graduation, families continue to be a part of the Waabinong Head Start community in a variety of ways. It has been my experience that other AHSUNC projects also operate in this way, which ensures that there is a passing of corporate, as well as, traditional knowledge between parents and caregivers as new families come and older families leave.

AHSUNC projects in Ontario truly provide children and their families with knowledge, experience, culture, language, social supports, nutrition, healthy living practices, and much more. This study provided positive general trends, but much more extensive research would be needed beyond this study to show if these trends discussed in the next sections of this chapter occur beyond Waabinong Head Start.

Waabinong Head Start clearly offers more than school readiness to 3 to 5 year old First Nations and Métis children. The results of the study show that parents and caregivers also benefit from their children attending AHSUNC. Waabinong Head Start is an established project and has many ties to the Sault Ste Marie Aboriginal community and to Garden River First Nation located just outside of the city. These factors may also have had an impact on the positive trends witnessed in this study. From this research and my experience with AHSUNC, it is clear that funding such social programs for Aboriginal people with Aboriginal people involved in the planning, implementation, and continued functioning is important to the overall success of the program. First Nations and Métis families in Sault Ste Marie, Ontario have created a very supportive community that also assists other First Nations and Métis families with raising their children and learning traditional knowledge, culture and language.

5.1.1 AHSUNC, Culture and Language, and the Pride of Being Aboriginal

The health and education of families involved with AHSUNC is affected by their economic level, their pride in being Aboriginal, and their connectedness to an Aboriginal community, whereas their child(ren) are affected by the parents and family’s decision to transmit culture and language, and to positively reinforce the learning of Western knowledge so that the children will be bi-cultured (Palmantier, 2005; Sones, 2002). First Nations and Métis families are recruited to AHSUNC projects in Ontario based on having a child between 3 and 5 years old, and need for
the program. The findings in this study suggest that many of the families are headed by a lone female parent, with a high percentage being stay-at-home parents. The income level of these families was not revealed in the questionnaires, but from other research, single parent families generally have lower household incomes than two parent families (Tjepkema, 2002). Mishibinijima (2004) explained that some Aboriginal people in urban areas do not feel connected to their identity because they have not had support or linkages to an Aboriginal community. Light & Martin (1996) argued that traditionally, Aboriginal families would help raise children, provide food and shelter, and offer positive support and encouragement to other members of the extended family, but Sones (2002) and Greenwood (2000) have found that a number of families with children in AHSUNC programs in Canada do not have extended family or community near their current residence and therefore these families need to create their own social support networks.

Mishibinijima (2004) further explains that identity in modern Canada is difficult for everyone, but that Aboriginal peoples must determine who they are without relying on legislation like the Indian Act or their home community supporting and guiding them. It is necessary for Aboriginal people in Canada to be cognizant of the political and legal issues that separate their perceived identity from the “acknowledged” identity, but to decolonize and connect with traditional teachings like the Seven Grandfather teachings that many Ontario First Nations believe in, it is necessary to have an identity that blends their Aboriginal and non-Aboriginal identities together in a bi-cultured way (Mishibinijima, 2004).

Children who learn their own culture and that of the majority culture become bi-cultured as they grow to understand the traditions, celebrations, religion(s), rights, and beliefs for both the mainstream and family cultures. Brown and Smirles (2003) argue that urban Aboriginal children and youth learn about their “biculureness” from their parents and extended family as they provide the children with knowledge about how to negotiate the oppressive society outside their front door. Other scholars (Friedel, 1999; Ball, 2004) further argue that dedicated culturally-specific programs are only effective if families become involved in the education used by Euro-Canadians, otherwise the program goals and achievements will be lost or have little or no effect over time. This study found that there was no net increase in cultural or linguistic use by caregivers, but the majority of caregivers’ open-ended responses showed excitement and interest in the Aboriginal culture and language skills their children had acquired and were using at home.
Over half of caregivers had attempted to bring culture and language into their home after their children had spent time in AHSUNC, therefore these children would likely exhibit the biculturedness noted by Brown and Smirles (2003).

The results clearly indicate that AHSUNC provides children with a chance to learn Aboriginal culture and language. More than half of the parents and caregivers provided examples of how the children were learning Aboriginal culture and language at Waabinong, and that these children were able to use the language at home and teach their families. About twenty percent of qualitative responses suggest that parents and caregivers not only enjoyed children using the new culture and language skills, this prompted these adults to try to incorporate these new practices at home. Since all these families would already have some aspects of the dominant culture and language (Euro-Canadian and English) in their homes, these children and their families were clearly learning to be proud of being Aboriginal and how to incorporate this new knowledge into their identities, just as Brown and Smirles (2003) suggest.

By incorporating the culture and language aspects into their own identity, parents, caregivers and their children begin to have a sense of belonging that Adelson (2005) suggests will improve health. It is, therefore, not surprising that 14% of primary caregivers rated their health and mental health as “excellent”. A sense of belonging to a group and a social support network, similar to traditional social networks, provided these caregivers with assistance, advice, and self-esteem. Ball & Elliot (2004) and Greenwood & Fiske (2003) found similar findings in AHS projects in British Columbia. Ball & Elliot (2004) conducted their research at Aboriginal Head Start projects on reserve and found that the social networks were established along familial lines with a clear sense of culture, whereas Greenwood & Fiske (2003) found that AHSUNC projects in British Columbia had families from different communities and cultures, so there was less interconnectedness, but the culture and language brought these Aboriginal families in AHSUNC together and increased these parents and caregivers sense of belonging. Parents and caregivers were asked to provide their Aboriginal identity and were also asked about their use of an Aboriginal language and some cultural practices known to be used amongst Waabinong’s families. An open-ended question about what parents and caregivers expected to receive from AHSUNC was also provided. The results found that while there was a decrease in smudging at home, many parents and caregivers responded that they hoped to learn more about their Aboriginal or Métis culture and hoped that their child(ren) would learn about their culture and be
proud to be Aboriginal. By December, some parents and caregivers felt that they had gained more knowledge about their culture and the Ojibwa language, and they felt that this new knowledge helped them be proud of being Aboriginal.

Bob Thomas (as quoted by Lobo and Peters, 2001) wrote that a pan-Indian identity would see Aboriginal languages lost and eventually a new Aboriginal culture would be created because people would lose so much of the individual local cultures, that they would have to subscribe to the pan-Indian culture. Lobo and Peters (2001) argue that Aboriginal languages and cultures are being revitalized, while a pan-Indian identity is used to educate society about why Aboriginal cultures and languages are important. Waabinong Head Start provides participating families and children with a way to gain their local culture and language. The project provides the Oji-Cree language and the Algoma area culture through their programming. The responses suggest that the children attending Waabinong are indeed learning the cultural teachings and language, but are willing to use these teachings and language at home. After reviewing the data, it became apparent that while AHSUNC could provide some culture and language to the children, and possibly their families, there was no guarantee that these individuals would retain or build upon the knowledge gained in the program. The culture and language component needs to be studied in a longitudinal study to determine best practices for retention of language and culture over the long term. Based on Bramley et al (2004), language nests, which are programs developed to immerse Maori people in the Maori language, particularly the children, have been proven the most effective way of maintaining and revitalizing the Maori language, therefore AHSUNC may need to advocate to Aboriginal organizations and the federal government to pilot-test some language nests in Canada.

Caregivers and parents responded that 7.7% began smudging in their homes after starting AHSUNC, but interestingly, another 7.7% stopped smudging. While this creates a net effect of zero, the change could be reflective of: (i) asthma or other breathing related problems starting, (ii) receiving traditional teachings or knowledge about the parent/caregiver’s cultural background that may not be congruent to Waabinong’s Aboriginal cultural teachings, or (iii) deciding that the children are smudging at Waabinong and there is not a need to do so in the home. There are many more reasons why some caregivers/parents chose to change their cultural practices, but after reviewing the open-ended responses, it was noted that approximately fifteen percent of the children had asthma or allergies listed in December (many of these were not noted in the
September questionnaire), and that at least ten percent of parents/caregivers also had breathing ailments that may prevent them from having the smoke from a smudge present in the home. Asthma is usually not diagnosed in children until after their 5th birthday (Asthma Society of Canada, 2008). The Asthma Society of Canada (2004) provides that some of the strongest risk factors for developing asthma are “exposure, especially in infancy, to indoor allergens”, or tobacco smoke or other chemical irritants, with the number of people diagnosed with asthma increasing 50% each decade. Smudging, cigarette/cigar smoking, and wood burning stoves and fireplaces can be a trigger for asthma and other breathing ailments that Waabinong participants noted in their December questionnaires.

May & Aikman (2003) and Friedel (1999) argue that parents and families play a vital role in advocacy at school and ensuring that the child learns about their cultural identity and language early, therefore, having some parents/caregivers who have decided to begin smudging increases the likelihood that those children will continue to learn about their culture beyond AHSUNC. The Canadian Health Network (2007) also posted on their website an article about the importance of children being proud of their Aboriginal heritage and how that can affect their learning, awareness, and involvement in school. The Canadian Health Network (2007) provides some cultural traditions that help Aboriginal children have a positive sense of identity in being Aboriginal, with an emphasis on AHSUNC and AHSOR. Smudging is only one way to participate in traditional or cultural practices, so it is important to note that learning how to be a part of a smokeless smudge, or attending a pow-wow, or learning from an Elder are all a part of learning First Nations or Métis cultural practices, which children and parents can be a part of at Waabinong Head Start, and at many other AHSUNC projects in Ontario.

Most of the parents and caregivers acknowledged wanting their children to learn Aboriginal culture and language in the September questionnaires, but more than 90% of parents and caregivers acknowledged that the child(ren) learned phrases and words in Oji-Cree and began teaching them when they returned home. Approximately 20 percent of parents and caregivers expressed that the child was interested in learning more about Aboriginal culture and language in the December questionnaires. These findings are supported by Beaulieu (2006) who stated that “...learning is a social activity” (p. 51) that requires immersion in a culture-based education to help with revitalization and transmission of the culture and language. Waabinong Aboriginal
Head Start provides a culture and language immersion program that also has the hallmarks of early childhood education and school readiness.

5.1.2 Education – The New Buffalo?

In September, questions were asked about whether anyone in the caregivers’ families had attended residential school. Residential school has had many implications for today’s Aboriginal people because the children were taken away from their families and communities, where they did not learn their culture, language, or how to parent. Residential schools were intended to create assimilated “Westernized” Indians that could fit into the larger Canadian society (Blackstock, 2006). Scholars (Blackstock, 2006; Battiste, 1986; Stonechild, 2006) argue how residential schools have created a gap in social learning because those Aboriginal children who attended the schools did not see how to parent or be a community member. In fact, Aboriginal children attending residential schools had little contact with members of their own family because it was a source of punishment (Stonechild, 2006).

Without learning how to be a parent or role model for their children and the younger generations, including siblings, many Aboriginal people begin to have low self-esteem, distrust in the education system, a feeling of rebellion, and inadequate social skills (Adelson, 2005; Blackstock, 200?; Stonechild, 2006). Fifty-three percent of primary caregivers and 13.8% of second caregivers responded that they had a close relative with residential school experience. None of the primary caregivers had been to residential school, but one second caregiver, or 3.6%, had attended residential school. AHSUNC provides workshops and cultural events for parents and families to attend throughout the year. Waabinong Head Start provided some parenting workshops, and the Parent Coordinator also attempts to provide parents and caregivers with information regarding other programs, services and supports available in the community. Each Waabinong family has a meeting with the Parent Coordinator early in the school year, and attempts are made to connect families with Aboriginal Social Support Workers or Aboriginal Family Support Workers at that time. These Support Workers help parents, caregivers and families, in a culturally appropriate way, to determine what services or programs they may need.

There was an increase in the number of caregivers/parents that visited with an Aboriginal Social Support Worker. An increase of 12% of primary caregivers/parents was noted in the comparison data. It was very interesting to note that 4% of those primary caregivers/parents that visited with
an Aboriginal Social Support Worker also visited a Traditional Healer. As parents and caregivers become more confident and have a positive Aboriginal identity, they can create and sustain strong connections to an Aboriginal community, which will also reduce the impact of external negative factors like racism, oppression, and ill health (Cochrane, 1992; Brown & Smirles, 2003). Being surrounded by and working with other Aboriginal people with a positive sense of identity, could be one reason why a small number of primary caregivers/parents began to see both an Aboriginal Social Support Worker and Traditional Healer; these caregivers/parents gained a positive sense of being Aboriginal, therefore they were comfortable with asking for and receiving help from other Aboriginal people in the community.

Brown & Smirles (2003) argue that as any person gains a positive sense of identity, they are more likely to contribute to the greater community and society. Approximately one third of all caregivers and parents changed their employment status between September and December, and of those primary caregivers/parents with an education of a high school diploma or less, twelve percent changed their employment status. Many AHSUNC projects have workshops and other cultural events occur throughout the school year, which allow parents and caregivers to meet each other and other community members. It is likely that those parents and caregivers who changed their employment status had done so because of the social networks they had created at Waabinong. In the open-ended responses, at least eight percent of respondents felt that the workshops had provided them with information and contacts that allowed them to “dream of a better life with a job” they would enjoy and could still maintain time with their child(ren).

It was interesting to note that 10% of primary caregivers had returned to school between September and December. Two primary caregivers/parents revealed in their open ended responses that they enjoyed attending school and had returned after they knew their children were in a safe environment (meaning Waabinong Head Start). At least 3.6% of these caregivers acknowledged that Waabinong had played a role in their return to the education system. Many scholars (Cox, 2002; Greenwood, 2001; Palmantier, 2005; Benoit et al, 2003; Newbold, 1998; Barton et al, 2005) argue that education influences employability, health status, poverty, culture, social support, and physical environments, especially for a disadvantaged group like Aboriginal people. Therefore, those caregivers/parents that returned to school may actually have a greater impact on their children’s lives because education is the key to a number of other social determinants of health.
It is also interesting to note that between September and December, 40% of second caregivers/parents had improved their education level. These second caregivers went from not having a high school diploma to having at least a high school diploma, and at least one parent/caregiver had begun to attend college after completing their high school equivalency. In the open ended responses, approximately 10% of the respondents revealed that Waabinong staff had provided insight into employment opportunities and pointed out that they would require more education, therefore they returned to school. The other respondents did not provide any response as to their reasons for returning to school. Tjepkema (2002) noted that the lower the household income, it was more likely that urban Aboriginal people would have lower educational attainment based on the 2000/01 CCHS. Waabinong respondents were similar, except on the rate of university or college completion, which was far below the findings in the CCHS.

Just under half of all parents and caregivers wrote that they were encouraged by their children’s progress and hoped to return to school themselves in the future. About ten percent of caregivers believed that they would return to school to better themselves and to show their children that education improved their opportunities in life.

When discussing their children’s progress, 65% of children had been potty-trained in the short time between questionnaires, and more than 90% commented on the improvements in their child’s language, reading and math skills. Some parents and caregivers wrote encouraging notes to Waabinong staff about the progress their children were making. Unfortunately, Waabinong staff did not see the completed questionnaires, and only received the encouragement through me. All the parents and caregivers were excited by the progress their children were making. This was interesting because the first questionnaire was completed in the first week of school and the second questionnaire was completed the final week before Christmas holidays. While the timeframe was short, apparently AHSUNC programming is geared to make the most amount of impact in the shortest timeframes.

No standardized testing was used on the children, therefore no quantitative data is available regarding the change in educational skills, but based on parental reports, changes in educational skills were visibly and audibly noticeable. As Brown & Smirles (2003) have stated, when parents become involved in their children’s education, it will become apparent in the skills
learned. Clearly, not only were parents and caregivers encouraging their children, AHSUNC was addressing a number of different educational skill sets that were highly visible to parents.

Finally, parents and caregivers provided some qualitative responses about how their children were also learning social skills. This will be further discussed in the Social Support section below.

5.1.3 Social Support, Connections and Networks – AHSUNC Helps

Faiman-Silva (1993) stated that economic development helps Aboriginal communities to sustain culture and language, but also social support networks, like community. This argument is supported by the number of parents and caregivers that returned to paid employment. Just over 10% had moved from part-time to full-time employment while another 3.6% re-entered the workforce. By having employment, these families could provide larger social support networks, greater opportunities to the children and improve their self-esteem.

Employment was only one aspect of increasing the social support network that parents and caregivers improved upon. As noted in Section 5.1.2, Education – The New Buffalo, 10% of primary caregivers/parents returned to school. This will also expand the social support network that AHSUNC families have.

Twelve percent of primary caregivers began visiting with an Aboriginal Social Support Worker between September and December, but there was no change for second caregivers/parents. By having a social support worker that understands the culture, language and needs of the AHSUNC families, parents and caregivers will feel more welcome, accepted, and assured that they are receiving the best advice and counseling. An Aboriginal Social Support Worker could also provide parents and caregivers with ways to connect with others in the community, in health professions, and point out opportunities for improving education, employment, and social skills. All of these connections are intertwined with other social determinants of health and support AHSUNC families outside of the project setting.

Almost 22% of all caregivers began attending Ontario Early Years Centre’s (OEYC) programming. The Ontario Early Years Centres provide universal access programs to help families with children aged zero to six. These programs can be directed at the children or the parents/caregivers. The questionnaires did not ask what programs had been accessed; therefore I
am unable to provide insight into whether these programs provided any parenting skills, social skills, early childhood education, or family relations. The increased use of the provincial family centres suggests that parents and caregivers felt confident enough to attend universal programs that may not be sensitive to the needs of Aboriginal people. These programs are open to all Ontarians with children under six years of age; therefore the AHSUNC families who attended programs at OEYCs have had opportunities to expand their social support networks by meeting new people. Through these new people, some parents and caregivers may have also been able to find educational and employment opportunities. Faiman-Silva (1993) and Adelson (2005) recommend that Aboriginal people network beyond the reserves and find economic and educational opportunities through this networking that will help Aboriginal people move forward.

The Community Action Program for Children (CAPC) and the Aboriginal Community Action Program for Children operate in a numerous towns and cities throughout Ontario. PHAC Ontario Region decided to dedicate 30% of the overall budget to Aboriginal CAPC and CPNP (Canada Prenatal Nutrition Program). These programs are funded through the PHAC and are intended for families with children aged zero to six whose health is at risk. These programs are targeted to families who are lone parent, low income, teen parent, have children who experience developmental delays and/or social, emotional and behavioural problems, those at risk of abuse or neglect, and special considerations are made for those of Aboriginal descent, or are recent immigrants to Canada, or live in isolated or remote areas of the country (Public Health Agency of Canada, 2008). CAPC and the Aboriginal CAPC programs offer parenting skills, parent/tot programs, toy lending libraries, prenatal and postnatal classes, home visiting, School’s Cool early childhood development classes, and a variety of other activities. The Aboriginal CAPC projects also provide specific workshops and classes on culture, with some projects providing some aspects of language and traditional healing as well. Only 4% of parents/caregivers began attending CAPC programs between September and December. The Aboriginal Social Support Worker or Waabinong Head Start staff may have provided information about this program to parents and caregivers between September and December. It is likely that the parents and caregivers were unaware of the program prior to beginning AHSUNC as the CAPC program receives many of its participants by referral from other social agencies.
Waabinong Head Start provided nine workshops between September and December for parents and caregivers to attend. With 54% of parents/caregivers intending to and actually attending a workshop (or more), it is likely that these parents and caregivers created new social support networks with other parents and caregivers who share a similar experience (AHSUNC). Some of the open-ended responses suggest that the workshops were highly informative and allowed the parent/caregiver to meet other people similar to them. Brown & Smirles (2003) argued that when parents have a strong and positive sense of identity, they can advocate and teach positive identity development with their children. By creating social support networks, AHSUNC parents and caregivers improve their own sense of identity in being Aboriginal, which they can then teach to their children, as well, these parents and caregivers develop friends and community by attending the workshops, which further helps their children see and learn about being Aboriginal as the other parents and caregivers are likely of Aboriginal descent as well.

As AHSUNC parents and caregivers become more comfortable at the project and with other parents and caregivers in the program, it is likely that the number of parents and caregivers that attend workshops would increase. Unfortunately, due to the tight timeframe for the study, this could not be ascertained.

Jeffery et al (2006) argue that improved health and education can only be brought about if local communities build capacity and use an Aboriginal model to understanding health, which encompasses social networks. From discussions with the Project Coordinator at Waabinong Head Start, it was revealed that parents and caregivers are encouraged to attend and become members of the Parent Council, which provide skills as a board member, and how board meetings are run. These are valuable experiences and skills that can assist parents and caregivers when they apply for employment opportunities as I have been told by many Parent Council members over the years. Waabinong Head Start and other AHSUNC projects in Ontario encourage parents and caregivers to volunteer in classroom activities (after a criminal reference check has been completed as per the Day Nurseries Act requires) or assist with developing and planning cultural events for the AHSUNC community. Again, these experiences provide parents and caregivers with employable skills, and build the capacity of the Aboriginal community in the town or city where the AHS project is located.
5.1.4 Health and Healthy Living for Parents and Caregivers

Without employment or educational opportunities, many people become unhealthy with alcoholism, hopelessness, depression, abuse and other ailments attributable to the social environment (Faiman-Silva, 1993). As was noted in earlier sections, there was an increase in employment and education for parents and caregivers at Waabinong Head Start. AHSUNC projects encourage, and sometimes motivate, parents and caregivers to improve their life situation by increasing their education level or attaining skills relevant to the current job market in the area. Increasing employment or education has been shown to have an effect on how people perceive their health (Garroute, 2001; Adelson, 2005). Tjepkema (2002) used the Canadian Community Health Survey (CCHS) 2000/01 in his analysis of off-reserve Aboriginal health. Tjepkema (2002) argued that educational attainment, income level, employment status, geographic region, and marital status were influencing socio-demographics that need to be considered when ascertaining health status or when reviewing self-reported health status.

Kramer and Weller (1989) argued that if Aboriginal people have steady and meaningful employment, their perceived health status was better than those who felt that their employment was in jeopardy. The findings from the questionnaires may support this argument. Twenty-six percent of primary caregivers/parents rated their health as improved, and over 14% rated both their general and mental health as “excellent” compared to 11% in September. Since one third of all caregivers/parents changed their employment status between September and December, it is likely that some of these people did perceive their health as improved because they had meaningful employment that they did not have when completing the first questionnaire. Another argument to this improved perception of health was stated in Section 5.1.1. As AHSUNC parents and caregivers began to have a positive sense of identity in being Aboriginal, it is likely that it improved their self-esteem, which in turn could have led to employment and educational opportunities. Clearly, more research is necessary around this confounding finding.

Second caregivers also improved their health, with 60% moving from “good” to “very good” or “excellent”. They also rated their mental health improved from “fair” to “good” (40%), which could be for the very same reasons as the primary caregivers. An additional theory could be that the children were safe, happy, and learning at AHSUNC, therefore the parents and caregivers felt confident and comfortable, so their perception of their health improved. Again, by using self-
reported health status on the questionnaires, there is no quantitative data to suggest that health improved physically, mentally, emotionally, or spiritually, but the respondent perceived that their health improved.

AHSUNC projects encourage children and families to see health professionals as necessary; this includes Traditional Healers or Medicine Men. Primary and second caregivers/parents did increase visits with doctors or health professionals for regular check ups, with 26.3% for primary caregivers/parents, and 60% for second caregivers/parents between September and December. As primary caregivers/parents visit health professionals for regular check-ups, it is likely that some of these caregivers/parents translate this into improved health. It must be noted that in Ontario, there is a lack of family physicians and public health professionals, especially in rural and remote areas. While Sault Ste Marie, Ontario is not remote, it is the northern part of the province and may not attract as many family physicians as southern Ontario (Toronto area). Some of the parents/caregivers may not have had a family physician or regular health professional to visit before attending AHSUNC; therefore they did not seek medical attention unless a problem arose (crisis management versus preventive medicine). AHSUNC provides information about why regular medical check-ups are good, and through the Aboriginal Social Support Worker and Parent Coordinator at the project, parents and caregivers are provided with ways of finding a family doctor to start preventive medicine. This indicator may only show that by being an AHSUNC family, these caregivers/parents learn about health services available and how to access them that they were unaware of before attending AHSUNC. Tjepkema (2002) provides statistics from CCHS 2000/01 that indicated that off-reserve Aboriginal people are less likely to have contact with dentists than the Canadian population, and regular visits with a doctor were slightly less likely than the Canadian population.

Smoking in Canada has been declining for the past ten years, but in the Aboriginal communities, there is still far more people that smoke than in the general population (Henriette Dery, personal communication, 2008). The Federal Tobacco Control Strategy (FTCS) has been operating since 1992, with an Aboriginal FTCS on-reserve strategy that ended in September 2006. The FTCS provides funding to community-based and non-governmental organizations to provide education, awareness, mass media and cessation programming across Canada. Resources from the Ontario Region FTCS have been provided to AHSUNC, CAPC, and the Canada Prenatal Nutrition Program in Ontario. Ontario has implemented a number of smoke-free by-laws including no
smoking in workplaces and public spaces. These by-laws may have had some effect on the
smoking habits of AHSUNC parents and caregivers. Ten percent of primary caregivers quit
smoking between September and December with another 20% reducing the frequency of their
tobacco use, and more than 22% changed the location of where they smoked (from inside the
home or car to outside). AHSUNC projects provide information to the children about the
dangers of smoking tobacco, as well as providing parents and caregivers with information on
how to quit. This study did not ask what motivated parents/caregivers to quit or reduce their use
of tobacco, but some of these parents/caregivers could have been motivated to quit or change
their tobacco habits because of information provided by Waabinong Head Start staff. As has
been noted by the Tobacco Control Programme at Health Canada (2008), smoking cigarettes is
an addiction that is as powerful as using some illegal drugs like heroin. Because of the addiction
to the nicotine in cigarettes, many adults have difficulty quitting smoking, and that makes it even
more important to provide current and culturally relevant literature on cigarette smoking and
addiction.

Traditional use of tobacco is quite different than the current addiction to smoking cigarettes and
other tobacco products. AHSUNC projects including Waabinong Head Start provide parents and
caregivers with the knowledge of the traditional use of tobacco and how to obtain traditional
tobacco, which differs from the tobacco used in cigarettes, cigars, and cigarellos.

There are 4000 chemicals in second hand smoke with 40 known cancer-causing chemicals
(Physicians for a Smoke-Free Canada, 2008). The smoke will cling to fabrics and stay in the air
for up to 18 hours after a person has smoked a cigarette. Waabinong Head Start provided
caregivers and parents with information about quitting smoking and the harmful effects of
second hand smoke through literature. Twelve percent of smokers in the study moved their
smoking from in the house and/or the car to outside between September and December. The
move to outdoor smoking may have been a result of legislation, mass media campaigns, or
information provided by AHSUNC. Further research would be required to understand what
motivated parents and caregivers to change their smoking behaviour.

Waabinong Head Start also provides information and resources to parents and caregivers about
the effects of crystal meth and other illegal drugs as there have been issues with the use of such
drugs in the community. There was a 16% increase in knowledge amongst primary caregivers
and 20% increase for second caregivers, but 8% of primary caregivers believed that their knowledge about illegal drugs had decreased between September and December. By increasing parents and caregivers knowledge about smoking and illegal drugs, this would increase their health status. Many scholars (Ball, 2004; Adelson, 2005; Smylie and Anderson, 2006) argue that health promotion and awareness information is powerful and can help to reduce health disparities for Aboriginal people.

Finally, 23% of primary caregivers had begun to use the Aboriginal Food Guide from Health Canada and/or the recipes provided by Waabinong Head Start, but 40% of second caregivers felt that they had not used the Aboriginal Food Guide or recipes provided. It is apparent that if parents and caregivers understand what healthy eating is and what foods are best for the children and themselves, they are likely to change their eating behaviours. The Aboriginal Food Guide incorporates traditional foods like venison, wild rice, and berries into the food groups and estimates how large a serving is appropriate. The Guide also provides information about other foods; therefore parents and caregivers can make choices based on their knowledge and income, since some foods are more expensive in northern communities.

Every meal is important, and planning to incorporate the four food groups into meals can be an arduous task, but Waabinong Head Start provides recipes that families can afford and easily make. This may have had an effect on why almost a quarter of primary caregivers/parents believed that they had increased their use of the Aboriginal Food Guide and/or recipes provided.

5.1.5 Child Health – A New Generation of Healthy Aboriginal People

As parents and caregivers begin to gain knowledge about health and mental health, they can perceive issues that may be of concern with their children. When parents and caregivers rated their children’s general health, they rated it less well in December with 23% rating the child’s general health lower than they had previously. Interestingly, 15.3% of the ratings showed an improvement in general health to “good” or “very good”. Similar results occurred in the child’s mental health ratings. Since 22% of parents and caregivers changed the location of the smoking, and 23% of primary caregivers/parents had begun to use the Aboriginal Food Guide, it would seem that the perception of the child’s general health should improve, yet there was a decrease in the ratings. Further research needs to be conducted on why these changes occurred.
As parents and caregivers gain knowledge about health promotion, healthy living, and healthy eating practices, it can be assumed using the population health approach that the children would increase their healthy behaviours, and parents and caregivers would notice changes in the health and appearance of their children. This theory is supported with the findings as 3.8% of children increased their visits to a doctor or health professional for regular check-ups and the number of times children brushed their teeth each day also showed a marked increase at 38%. Fewer than half of parents and caregivers could give the height and weight of their child in September, but after only three months of AHSUNC programming, over 85% of parents and caregivers could provide the height and weight of their child. This implies that parents became more aware of their child’s appearance and statistics.

Almost 75% of the children developed new favorite fruits and/or vegetables, which shows their openness to try new foods. Some parents and caregivers (9%) provided information about the changes in their child’s eating habits at home. More research and better indicators could provide more insight into whether AHSUNC programming had any correlation with the changes in eating habits for the children as AHSUNC provides one hot meal and one nutritious snack every day for the children who attend a half day program.

As discussed in other Findings sections, parents and caregivers were excited by the skill development and knowledge that the children learned in the three months between questionnaires. Adelson (2005) argues that as families learn more about healthy living and health, they are more likely to educate their children about healthy living and ensure that the child is in good health. In the open ended responses, some parents and caregivers provided health issues relating to their children, with many having asthma and allergies. Parents and caregivers of children with health concerns have to learn about the diagnosis and what changes need to be made in and around the home for the child not to struggle with the illness. This knowledge will ultimately ensure that the family will work toward a healthier lifestyle than they had previously had, even if the lifestyle was relatively healthy to begin with.

More research is needed about the perceptions of health status and why these differences exist for the children and families of AHSUNC. It appears that issues not asked in the questionnaires may be affecting the perception of health and mental health for all respondents.
5.2 Recommendations

Based on the findings from this study and knowledge of the AHSUNC initiative, I am recommending the following actions be initiated.

Recommendation 1: Clear indicators must be defined with and by the community prior to developing any tools for assessment of health, education, culture, language, health promotion, social support, or parental involvement as they correspond to AHSUNC. Health indicators can be hard to develop if the study is asking for self-reported data instead of using medical records or standardized medical information. Standardized educational assessments may provide insight into changes in skills, but may not be appropriate with Aboriginal children. It is therefore recommended that the indicators and tools for assessment of the AHSUNC program be developed in collaboration with AHSUNC parents, caregivers, staff, and community members as their combined knowledge.

Recommendation 2: With such a small amount of research conducted on the impact of AHSUNC participants (children and their families), it is recommended that a database be created that will hold information about the educational attainment of AHSUNC graduates, as well as data on all six of the core components to encourage further research to be conducted. A longitudinal study should be conducted to determine if AHSUNC has long term effects on education, and what effects they may be. The database and longitudinal study could be modeled after the National Childhood and Youth Longitudinal Survey (NCYLS) conducted by Statistics Canada. AHSUNC could then develop curriculum and make policy recommendations based on the evidence collected through the study. The Public Health Agency of Canada should fund this research as it is clearly a gap in knowledge development.

Recommendation 3: Health is defined differently by Aboriginal people (Tjepkema, 2005). It is not just the absence of disease, but how someone perceives their overall health, which includes spiritual, physical, mental and emotional mental health. There were questions about different aspects of health in my study, but it is clear from the literature and my findings that a definition of health should be provided to participants prior to answering questions about perceived health. Therefore, it is recommended that future research that looks at AHSUNC families and their health provide a definition of health and then verify the perception of health with measurements of health.
Recommendation 4: It is recommended that the Federal Tobacco Control Strategy (FTCS) in Ontario collaborate with AHSUNC projects to conduct surveys about Aboriginal parent/caregiver smoking habits and then provide literature and information about quitting and second hand smoke, and then return to discuss changes in smoking habits after a lapse in time. Since smoking and second hand smoke can reduce health status, it is important to partner with other programs and services to improve any health issues as they relate to Aboriginal people.

Recommendation 5: This study found that AHSUNC provides valuable changes in education, employment status, health, and nutrition of both the children and families that attend. An increase in funding will help to provide more spaces in the limited number of AHS projects that currently exist. Based on the statistics for Aboriginal children 0 to 4 years old in the Aboriginal Peoples Survey 2001 (Tjepkema, 2002), it is apparent that there are over 17,000 First Nations and Métis children who live in urban and northern communities in Ontario, but it is estimated that only 560 children can attend AHSUNC each school year. Therefore, it is sensible to expand the current AHSUNC program to reach more of the Aboriginal children who live off reserve as this study shows that there are improvements in health and education for the entire family. It is recommended that funding of current AHSUNC projects and the expansion to more locations increase the number of urban and northern Aboriginal children attending AHSUNC to at least 5% from the current amount of less than 1% in Ontario.

Recommendation 6: This study found that the culture and language component of AHSUNC is highly regarded and provides urban Aboriginal families with a way to revitalize, reconnect, and learn Aboriginal languages and culture. Therefore, it is recommended that the federal government, in consultation with Aboriginal people and organizations, review the possibility of creating language nests across the country and begin with AHS projects both on and off reserve. Consultations will be necessary in a variety of regions and areas to ensure that the various Aboriginal languages be represented and acknowledged. After consultations, it is further recommended that a joint task force be developed to work with Maori educators, who have successfully, created and maintained language nests across New Zealand. AHSUNC projects can only provide an initial learning of the Aboriginal language of their community; therefore this recommendation will help to ensure that Aboriginal languages are revived and continue for many years to come. In this study, 90% of parents and caregivers hoped that their children would learn their culture and language, which is similar to the 88% of Aboriginal people who thought that
learning or relearning culture and language were very or somewhat important in the Aboriginal Peoples Survey 2001 (Statistics Canada, 2006).

Recommendation 7: After completing the literature review and discussing the issue of Aboriginal health and education in a population health approach, it was apparent more research was required. It is recommended that more policy research for and about urban Aboriginal people’s health and education be conducted outside of the sphere of the federal government. AHSUNC provides one window as does the Aboriginal Peoples Survey, but it is necessary for Aboriginal people themselves, to become involved in the policies and research for and about them. Therefore, I am recommending that Aboriginal organizations and individuals work toward expanding the knowledge about and for urban Aboriginal people to help move government policies for the benefit of urban Aboriginal people.

5.3 Conclusions & Future Research

This study has shown that AHSUNC in Ontario does have an impact on the health and education of the children and families attending the program, although the correlations are not strong enough to be statistically significant. This may be due to the low number of respondents. Without a control group, it is hard to measure just how strong the impact was. Nevertheless, health and education status improved for parents, caregivers and children who attended AHSUNC in Waabinong. It is likely that similar results would be found across the 14 AHSUNC projects in Ontario.

This study provides a snapshot of how participating families increased their knowledge and behaviours in regards to health, education, Aboriginal culture and language. However, the study is limited by the number of participants and is non-parametric. This is not important in terms of the study, but is significant to (a) the ability to generalize the study to larger populations, and (b) the participants have decided that they require assistance or knowledge and have enrolled their children in AHSUNC. The parents and caregivers who enroll their children in AHSUNC are compelled to attend such a program to add knowledge for them or their children, therefore the participants would not be a random sample as they have selected to attend the program.

The qualitative data is rich in illustrations, but as part of the informed consent, participants were told that their responses would not be quoted in the study. The qualitative data provides a full
picture of how AHSUNC improves the health and education of the children and their families, even in the short time frame that this study was conducted. Most of the parents and caregivers that responded to the questionnaires gave their gratitude for the program and the help they had received from the staff at Waabinong Head Start.

While there is a change in the self-reported health and some change in the self-reported education of parents and caregivers, it is the qualitative answers that provide insight into the real changes in the lives of the AHSUNC families. The questionnaires provided parents and caregivers a way of relaying their thoughts about their children’s health and educational skill development. It was apparent in the responses that the children’s health and educational skills improved after they attended Waabinong Head Start, therefore AHSUNC in Ontario does have an effect on the health and education of children and likely has an effect on their families. It was recommended that future research studies provide clear indicators or use standardized tests for the children to determine the change in educational skills. It was also recommended that a database be created and a longitudinal study be undertaken to determine the impact AHSUNC has over the long term on the children’s educational attainment.

This study has been an extensive journey. The findings from the study shed some light on the impact of AHSUNC in Ontario, but more importantly, it provides insight into policy issues that need to be addressed. Clearly, parents and caregivers are impacted by AHSUNC and the programming that is provided to their children and the workshops they attend through AHSUNC. Therefore policies and procedures created in and for AHSUNC projects in Ontario must be from parents and caregivers. Parent Councils provide one mechanism for families to have input into curriculum, workshops, cultural events, languages, and future directions of the project. Parents need to continue to be involved in their child’s life beyond AHSUNC.

As stated in the Recommendations Section, there are many different avenues for researching Aboriginal Head Start Urban and Northern Communities. Each of the six core components is closely correlated to each other, and could warrant research on each. The more research undertaken about this successful Aboriginal-specific program can only help with its future funding and development, therefore I highly recommend that AHSUNC communities in Canada collaborate with researchers to develop local, regional, and national research about this program.
Aboriginal education for Aboriginal people by Aboriginal people creates healthier communities. My research suggests that Aboriginal-specific programming does change and influence the behaviours of Aboriginal people in a positive way. AHSUNC provides Aboriginal children and their families a supportive and culturally sensitive environment to learn and explore issues like health promotion, nutrition, parental skills, social support networks, traditional and cultural knowledge, Aboriginal language, and education. Through health promotional materials and curriculum, Waabinong Head Start provided the children and families with an increased awareness and knowledge of some of these issues that may have influenced parents and caregivers in their education, health, social support networks, and culture and language.

There was evidence that AHSUNC improved parents and caregivers health and mental health (26%), as well as increasing healthy lifestyle choices (20% decrease in frequency of tobacco consumption; 16% increase in knowledge of the effects of illegal drug use; and 12% increase in visits with an Aboriginal Social Support Worker). While the parents and caregivers perceived that their children’s health was not as high in December (23% decline), this can be seen as an increase in knowledge and education about child health.

AHSUNC also provided Aboriginal children with a culturally sensitive environment to learn school readiness skills with 90% of children improving their reading, math and language skills. Children’s health behaviours also changed with more children brushing their teeth daily and visiting a primary care health professional.

AHSUNC families also increased their educational attainment, with 10% of parents and caregivers returning to school and another 12% intending to return to school in the near future. Education is a key determinant of health and is closely correlated to employment and income as was highlighted in Section 2.2.2. Thirty-three percent of caregivers and parents changed their employment status after their children began attending AHSUNC. AHSUNC projects link families to educational and employment opportunities whenever possible. Therefore, it is interesting to see such a change in education and employment as AHSUNC believes in supporting parents and caregivers in their goals for themselves and their children.

This study has provided some evidence of positive trends that may be attributed to attendance in Aboriginal Head Start Urban and Northern Communities Initiative. AHSUNC does have some effects on health and education of the children and their families that attend. There are positive
changes in health, mental health, education, culture, language, and social support. Therefore, I hope that projects like Waabinong Head Start have the opportunity to continue providing programming for many more years. More research will be needed, but at least some Aboriginal families in Canada have a head start in education and healthy lifestyles. Of the 29 families that completed both the September and December questionnaires, there was a trend toward healthier lifestyle choices, improved education of the children, upward mobility in employment, increases in self-perceived general and mental health of primary and second caregivers, and decreases in bad habits like smoking, illegal drug use, and alcohol use.
References


Appendix A
September 2007    Family Number _________________________

Survey regarding the Impact of Aboriginal Head Start Urban and Northern Communities (AHSUNC) on the Health and Education of the Children and Their Families in the Program

An information letter has been attached. Please read the information letter before beginning this questionnaire. By completing this questionnaire, you are giving consent to participate. As the researcher, I will NOT have access to your name, your child’s name, or contact information. This is a voluntary survey that will be a part of my Masters thesis about the impact of the Aboriginal Head Start program on you and your child. Any written answers you provide will be used in a general way and not be provided to Head Start staff or any other person. This will be totally confidential!

If you need help or have a question about the survey or the questions in it, please contact Crystal LaForme in Fort Erie, or Cathy Alisch in Sault Ste Marie and they will either help you or contact me for more information.

Please return the questionnaire sealed in the envelope provided with a mark across the seal either directly to me or to your AHS office. Meegwetch! I appreciate your help in my research study!

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<tr>
<th>Questions</th>
<th>Parent or Caregiver completing the survey</th>
<th>Parent/Caregiver or other adult living with the child</th>
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<td>1) Please provide gender.</td>
<td>Inuit</td>
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<td>2) What is your relationship to the child?</td>
<td>Métis</td>
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<td>3) What is your age?</td>
<td>Non-Status</td>
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<td>4) Please choose one of the following groups to identify yourself.</td>
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<td>Status</td>
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<tr>
<td></td>
<td>Non-Aboriginal</td>
<td>Non-Aboriginal</td>
</tr>
<tr>
<td>5) What is the highest level of education that you have completed right now? Please check only one.</td>
<td>Less than Grade 9</td>
<td>Less than Grade 9</td>
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<tr>
<td></td>
<td>Less than Grade 12</td>
<td>Less than Grade 12</td>
</tr>
<tr>
<td></td>
<td>High school diploma</td>
<td>High school diploma</td>
</tr>
<tr>
<td></td>
<td>Some college</td>
<td>Some college</td>
</tr>
<tr>
<td></td>
<td>Some university</td>
<td>Some university</td>
</tr>
<tr>
<td></td>
<td>Trade certificate</td>
<td>Trade certificate</td>
</tr>
<tr>
<td></td>
<td>College diploma</td>
<td>College diploma</td>
</tr>
<tr>
<td></td>
<td>Undergrad degree</td>
<td>Undergrad degree</td>
</tr>
<tr>
<td></td>
<td>Graduate studies</td>
<td>Graduate studies</td>
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<tr>
<td></td>
<td>Graduate degree</td>
<td>Graduate degree</td>
</tr>
<tr>
<td></td>
<td>Other?</td>
<td>Other?</td>
</tr>
<tr>
<td>Questions</td>
<td>Parent or Caregiver completing the survey</td>
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</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>6) Would you like to return to school?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>Maybe</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Not at this time</td>
<td>Not at this time</td>
</tr>
<tr>
<td>7) Did you, your parents, grandparents, aunts or uncles attend residential school or were taken away from their family to be raised in a non-Aboriginal place? Please circle everyone on the list who has experienced it.</td>
<td>Yes.</td>
<td>Yes.</td>
</tr>
<tr>
<td></td>
<td>Me</td>
<td>Me</td>
</tr>
<tr>
<td></td>
<td>Mom</td>
<td>Mom</td>
</tr>
<tr>
<td></td>
<td>Dad</td>
<td>Dad</td>
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<tr>
<td></td>
<td>Grandmother</td>
<td>Grandmother</td>
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<td></td>
<td>Grandfather</td>
<td>Grandfather</td>
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<tr>
<td></td>
<td>Aunt</td>
<td>Aunt</td>
</tr>
<tr>
<td></td>
<td>Uncle</td>
<td>Uncle</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8) Did you face racism in school?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9) What is your current employment situation?</td>
<td>Full-time job</td>
<td>Full-time job</td>
</tr>
<tr>
<td></td>
<td>Part-time job</td>
<td>Part-time job</td>
</tr>
<tr>
<td></td>
<td>More than one job</td>
<td>More than one job</td>
</tr>
<tr>
<td></td>
<td>Full-time student</td>
<td>Full-time student</td>
</tr>
<tr>
<td></td>
<td>Part-time student</td>
<td>Part-time student</td>
</tr>
<tr>
<td></td>
<td>Not working</td>
<td>Not working</td>
</tr>
<tr>
<td></td>
<td>Stay-at-home parent</td>
<td>Stay-at-home parent</td>
</tr>
<tr>
<td></td>
<td>Other?</td>
<td>Other?</td>
</tr>
<tr>
<td>10) Would you like to be employed now or the near future?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Not sure/Not right now</td>
<td>Not sure/Not right now</td>
</tr>
<tr>
<td>11) How would you rate your general health? Please check the one that best describes the way you feel about your health now.</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td></td>
<td>Very Good</td>
<td>Very Good</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Troubled</td>
<td>Troubled</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>Questions</td>
<td>Parent or Caregiver completing the survey</td>
<td>Parent/Caregiver or other adult living with the child</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>12) How would you rate your mental health right now? For example, if you feel sad a lot of the time, check Troubled.</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td></td>
<td>Very good</td>
<td>Very good</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Troubled</td>
<td>Troubled</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>13) Have you had any long-term illnesses? Like diabetes, heart disease, high blood pressure, hearing, etc. Please list all that you know of in the box.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14) Do you visit a doctor, walk-in clinic, nurse practitioner, emergency room, or other health care professional on a regular basis for check ups?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>15) Do you go to the dentist or hygienist, nurse practitioner or other dental professional on a regular basis?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>16) Do you have an Aboriginal Social Support Worker or Family Support Worker?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>17) Have you ever visited a Traditional Healer?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>18) Do you smoke cigarettes?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>19) If ‘yes’, how often do you smoke?</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td>Occasionally</td>
<td>Occasionally</td>
</tr>
<tr>
<td></td>
<td>In certain situations</td>
<td>In certain situations</td>
</tr>
<tr>
<td></td>
<td>Other (please explain):</td>
<td>Other (please explain):</td>
</tr>
<tr>
<td>20) Do you smoke in your home or car?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Yes, in the house</td>
<td>Yes, in the house</td>
</tr>
<tr>
<td></td>
<td>Yes, in the car</td>
<td>Yes, in the car</td>
</tr>
<tr>
<td></td>
<td>Yes, in the car and house</td>
<td>Yes, in the car and house</td>
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<td>Questions</td>
<td>Parent or Caregiver completing the survey</td>
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<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>21) Do you know the effects of cocaine or crystal meth?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>Maybe</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>22) Do you drink alcohol or take non-prescription drugs?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>23) Have you heard of or used the Aboriginal Food Guide from Health Canada?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>I think so</td>
<td>I think so</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>24) Have you gone without a meal in the past month?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>25) Are there any other health concerns or issues at home that you would like to describe here? Please use the other side of the page if you have more to add.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26) Would you be willing to describe your own school experience here? How do you expect Aboriginal Head Start to help your child have a different learning experience? Please use the other side of the page if you have more to add.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27) Do you have other children living in your home?</td>
<td>Yes _____ No ____</td>
<td></td>
</tr>
<tr>
<td>28) What are the ages of the other children living in your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29) Did any of these children attend Aboriginal Head Start?</td>
<td>Yes _____ No ____</td>
<td></td>
</tr>
<tr>
<td>30) What is the age of your child that is in/entering Aboriginal Head Start?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31) What gender is your child in/entering Aboriginal Head Start? Female Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32) Has the child ever attended Aboriginal Head Start before? No ____ Yes ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33) Has the child ever attended Ontario Early Years Centre programs? Yes _____ How long? ____ No ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34) Has the child ever attended the Community Action Program for Children (CAPC)? Yes _____ How long? __________ No ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35) Has the child ever attended any other early childhood development programs or a daycare centre? Yes _____ How long? __________ No ____</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
36) How would you rate your child’s health?
   Excellent _____ Very Good _____ Good _____ Fair _____ Troubled _____ Poor _____

37) How would you rate your child’s mental health?
   Excellent _____ Very Good _____ Good _____ Fair _____ Troubled _____ Poor _____

38) Does your child have any long-term illnesses? For example: diabetes, asthma, heart problems, fetal alcohol spectrum disorder, autism, attention deficit disorder, speech, language, etc. Please specify.

____________________________________________________________________________
____________________________________________________________________________

39) Does your child see a doctor, walk-in clinic, nurse practitioner, or other health care professional for regular check ups? Yes ____ No ____

40) Does your child see a dentist, dental hygienist, nurse practitioner or other dental health professional on a regular basis? Yes ____ No ____

41) Does your child brush their teeth? Yes ____ No ____ Sometimes ____

42) How often does your child brush their teeth? Once a day__Twice a day___ Other _______

43) What is your child’s current weight roughly? _________________LBS / KGS

44) What is your child’s current height roughly? _________________Inches / Centimetres

45) Is your child in the presence of tobacco smoke? Yes ____ No ____ Sometimes ____

46) Is this exposure to tobacco smoke from Aboriginal/Métis ceremonies? Yes ____ No ____

47) Is this exposure from someone smoking tobacco near the child? Yes ____ No ____

48) Is your child exposed to drugs or adults taking drugs? Yes ____ No ____ Sometimes ____

49) Is your child exposed to alcohol or adults consuming alcohol? Yes ____ No ____ Sometimes ____

50) Has your child smudged or been a part of any Aboriginal ceremonies prior to coming to Aboriginal Head Start? Yes ____ No ____ Not sure ____

51) Will you attempt to include Aboriginal/Métis language learned at Aboriginal Head Start at your home? Yes ____ No ____

52) Will you attempt to include Aboriginal/Métis culture learned at Aboriginal Head Start at your home? Yes ____ No ____

53) What is your child’s favourite vegetable? ______________________________________

54) What is your child’s favourite fruit? __________________________________________

55) Is there any other information that you would like to share about your child’s learning prior to starting Aboriginal Head Start this year?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

56) When and how did you learn about Aboriginal Head Start? ___________________________
36) Why did you decide to enrol your child in Aboriginal Head Start? _____________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

37) What do you expect your child to learn at the program? Please be very detailed. ____________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

38) Do you think you will attend any workshops or events already advertised for this year?  
   Yes ___ No ___

39) Do you smudge or practice other Aboriginal/Métis ceremonies at home now? Yes ___ No ___

40) What other benefits do you believe that Aboriginal Head Start will provide for you as a  
    parent?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

41) What other benefits do you believe that Aboriginal Head Start will provide your child?  
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Meegwetch! Please return the complete survey in the envelope provided or drop it by the AHS  
office to Crystal LaForme in Fort Erie or Cathy Alisch in Sault Ste Marie. I appreciate your help  
and thank you for all your answers!
Appendix B
Survey regarding the Impact of Aboriginal Head Start Urban and Northern Communities (AHSUNC) on the Health and Education of the Children and Their Families in the Program

This is the second and final questionnaire for my research project. By completing this questionnaire, you are giving consent to participate. As the researcher, I will NOT have access to your name, your child’s name, or contact information. This is a voluntary survey that will be a part of my Masters thesis about the impact of the Aboriginal Head Start program on you and your child. Any written answers you provide will be used in a general way and not be provided to Head Start staff or any other person. This will be totally confidential!

If you need help or have a question about the survey or the questions in it, please contact Cathy Alisch and she will either help you or contact me for more information. You can return the completed questionnaire to your AHS office, or send it in the envelope provided. Meegwetch! I appreciate your help in my research study!

<table>
<thead>
<tr>
<th>Questions</th>
<th>Parent or Caregiver completing the survey</th>
<th>Parent/Caregiver or other adult living with the child</th>
</tr>
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<tbody>
<tr>
<td>1) Please provide gender.</td>
<td></td>
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</tr>
<tr>
<td>2) What is the highest level of education that you have completed right now? Please check only one.</td>
<td>Less than Grade 9</td>
<td>Less than Grade 9</td>
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<tr>
<td></td>
<td>Less than Grade 12</td>
<td>Less than Grade 12</td>
</tr>
<tr>
<td></td>
<td>High school diploma</td>
<td>High school diploma</td>
</tr>
<tr>
<td></td>
<td>Some college</td>
<td>Some college</td>
</tr>
<tr>
<td></td>
<td>Some university</td>
<td>Some university</td>
</tr>
<tr>
<td></td>
<td>Trade certificate</td>
<td>Trade certificate</td>
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<tr>
<td></td>
<td>College diploma</td>
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<tr>
<td></td>
<td>Undergrad degree</td>
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<tr>
<td></td>
<td>Graduate studies</td>
<td>Graduate studies</td>
</tr>
<tr>
<td></td>
<td>Graduate degree</td>
<td>Graduate degree</td>
</tr>
<tr>
<td></td>
<td>Other?</td>
<td>Other?</td>
</tr>
</tbody>
</table>

3) Would you like to return to school? Yes Maybe No Not at this time

4) Have you returned to school since September 2007? Yes No Not at this time

5) Has your employment situation changed? Yes No Not at this time
<table>
<thead>
<tr>
<th>Questions</th>
<th>Parent or Caregiver completing the survey</th>
<th>Parent/Caregiver or other adult living with the child</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) Has the Aboriginal Head Start project been helpful in changing your education and/or employment level?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>Maybe</td>
</tr>
<tr>
<td>7) What is your current employment situation?</td>
<td>Full-time job</td>
<td>Full-time job</td>
</tr>
<tr>
<td></td>
<td>Part-time job</td>
<td>Part-time job</td>
</tr>
<tr>
<td></td>
<td>More than one job</td>
<td>More than one job</td>
</tr>
<tr>
<td></td>
<td>Full-time student</td>
<td>Full-time student</td>
</tr>
<tr>
<td></td>
<td>Part-time student</td>
<td>Part-time student</td>
</tr>
<tr>
<td></td>
<td>Not working</td>
<td>Not working</td>
</tr>
<tr>
<td></td>
<td>Stay-at-home parent</td>
<td>Stay-at-home parent</td>
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<tr>
<td></td>
<td>Other?</td>
<td>Other?</td>
</tr>
<tr>
<td>8) Would you like to be employed now or the near future?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Not sure/Not right now</td>
<td>Not sure/Not right now</td>
</tr>
<tr>
<td>9) How would you rate your general health? Please check the one that best describes the way you feel about your health now.</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td></td>
<td>Very Good</td>
<td>Very Good</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Troubled</td>
<td>Troubled</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>10) How would you rate your mental health right now? For example, if you feel sad a lot of the time, check “Troubled”.</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td></td>
<td>Very good</td>
<td>Very good</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Troubled</td>
<td>Troubled</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>11) Have you had any long-term illnesses? Like diabetes, heart disease, high blood pressure, hearing, etc. Please list all that you know of in the box.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>12) Have you visited a doctor, walk-in clinic, nurse practitioner, emergency room, or other health care professional on a regular basis for check ups since September 2007?</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>13) Have you gone to the dentist, hygienist, or nurse practitioner on a regular basis since September 2007?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Questions</td>
<td>Parent or Caregiver completing the survey</td>
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</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>14) Do you have an Aboriginal Social Support Worker or Family Support Worker?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>15) When was your first visit with the Aboriginal Support Worker or Family Support Worker?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>16) Have you visited a Traditional Healer since September 2007?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>17) Do you smoke cigarettes?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>18) If ‘yes’, how often do you smoke?</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td>Occasionally</td>
<td>Occasionally</td>
</tr>
<tr>
<td></td>
<td>In certain situations</td>
<td>In certain situations</td>
</tr>
<tr>
<td></td>
<td>Other (please explain):</td>
<td>Other (please explain):</td>
</tr>
<tr>
<td>19) Do you smoke in your home or car?</td>
<td>No</td>
<td>No</td>
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<td></td>
<td>Sometimes</td>
<td>Sometimes</td>
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<tr>
<td></td>
<td>Yes, in the house</td>
<td>Yes, in the house</td>
</tr>
<tr>
<td></td>
<td>Yes, in the car</td>
<td>Yes, in the car</td>
</tr>
<tr>
<td></td>
<td>Yes, in the car and house</td>
<td>Yes, in the car and house</td>
</tr>
<tr>
<td>20) Has your cigarette smoking changed since September 2007?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>21) Do you know the effects of cocaine or crystal meth?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Maybe</td>
<td>Maybe</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>22) Do you drink alcohol or take non-prescription drugs?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>23) Have you started to use the Aboriginal Food Guide or the recipes from the Aboriginal Head Start project?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>I think so</td>
<td>I think so</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>24) Have you gone without a meal in the past month?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>25) What gender is your child in/entering Aboriginal Head Start? Female _____ Male _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26) Has the child attended junior or senior kindergarten since September 2007? Yes ___ No ____</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
27) Are there any other health concerns or issues at home that you would like to describe here? Please use the other side of the page if you have more to add.

_______________________________________________________________________________
_____________________________________________________________________________
28) Has the child attended Ontario Early Years Centre programs since September 2007? 
   Yes _____ How long? _______     No ____

29) Has the child attended the Community Action Program for Children (CAPC) since September 2007? 
   Yes ____ How long? ___________     No _____

30) Has the child attended any other early childhood development programs or a daycare centre since September 2007? Yes ____ How long? _____________    No _____

31) How would you rate your child’s health now? 
   Excellent ____ Very Good ____ Good____ Fair____ Troubled___ Poor ____

32) How would you rate your child’s mental health now? 
   Excellent____ Very Good ____ Good____ Fair____ Troubled____ Poor ____

33) Does your child have any long-term illnesses? For example: diabetes, asthma, heart problems, fetal alcohol spectrum disorder, autism, attention deficit disorder, speech, language, etc. Please specify.
_______________________________________________________________________________
_____________________________________________________________________________

34) Has your child seen a doctor, walk-in clinic, nurse practitioner, or other health care professional for regular check ups since September 2007? Yes ____ No ___

35) Has your child seen a dentist, dental hygienist, nurse practitioner or other dental health professional on a regular basis since September 2007? Yes ___ No ___

36) Does your child brush their teeth? Yes ___ No ___ Sometimes ____

37) How often does your child brush their teeth? Once a day__ Twice a day___ Other ________

38) What is your child’s current weight roughly? _________________LBS / KGS

39) What is your child’s current height roughly? _________________Inches / Centimetres

40) Is your child in the presence of tobacco smoke? Yes _____ No ____ Sometimes ___

41) Is this exposure to tobacco smoke from Aboriginal/Métis ceremonies? Yes ___ No ___
42) Is your child exposed to drugs or adults taking drugs?  Yes ___  No ___  Sometimes ___

43) Is your child exposed to alcohol or adults consuming alcohol?  Yes___  No ___  Sometimes ___

44) Have you attempted to include Aboriginal/Métis language learned at Aboriginal Head Start at your home?  Yes ___  No ___

45) Have you attempted to include Aboriginal/Métis culture learned at Aboriginal Head Start at your home?  Yes ____  No ____

46) What is your child’s favourite vegetable? _________________________________

47) What is your child’s favourite fruit? _________________________________

48) Is there any other information that you would like to share about your child’s learning since starting Aboriginal Head Start this year?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

49) Has your child been learning what you had expected they would at the program? Please be very detailed. Please use the other side of the page or add pages.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

50) Have you attended any workshops or events at your Aboriginal Head Start since September 2007?  Yes _____  No _____

Do you smudge or practice other Aboriginal/Métis ceremonies at home now?  Yes ___  No ___
52) What other benefits have you experienced from the Aboriginal Head Start for you as a parent or guardian?

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________


53) What other benefits do you believe that your child has received from the Aboriginal Head Start?

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Meegwetch! Please return the complete questionnaire in the stamped envelope provided or drop it by the AHS office to Cathy Alisch in Sault Ste Marie. I appreciate your help and thank you for all your answers!
Appendix C
Informed Consent Form for September 2007

Informed Consent /Information Letter – Sault Ste Marie

Research Project Title: Aboriginal Head Start: Impact on Health and Education

Researcher: Angela Mashford-Pringle, Sociology and Equity Studies in Education, Ontario Institute of Studies in Education, University of Toronto/Collaborative Program in Aboriginal Health

Aboriginal Head Start: Impact on Health and Education consists of two separate questionnaires. Using the data from the questionnaires, I will compare parents or caregivers initial self-assessment of the families and children enrolled in Aboriginal Head Start in September 2007 with questionnaires completed later in the school year to see if there are changes in health, education, or employment after experiencing Aboriginal Head Start programming. I will be able to understand what impact the program has on the children as well as their parents/caregivers through their attendance at social, cultural and learning events that occur at the Head Start. You are about to complete the first one now, and another questionnaire will be given out in early December 2007 as a follow up regarding changes in health, education, and employment of AHS children and their families.

The final draft of my thesis will be shared at a Parent Council meeting in February 2008 to discuss the findings and allow you to provide your input into the final paper. There will be no compensation for you as a participant, but this research could benefit your Aboriginal Head Start project by showing if there are any areas of the program that are not working well.

The Project Coordinator and I have determined that these questionnaires will take about 30 minutes to complete. These questionnaires will focus on the health and education of children attending Aboriginal Head Start Urban and Northern Communities program in Ontario, and their parents or caregivers’ health and education and the changes between the two questionnaires will help to place the impact of AHS programming on your children and yourselves.

Your participation is completely voluntary and your decision either to participate or not to participate will be kept completely confidential. You can withdraw from the study at any time without explanation and without negative consequences to you or your child’s attendance in the Head Start program. No Aboriginal Head Start staff or community members will know your answers to the questionnaires as they will not be shared and I will not have your names. At the end of my thesis, I will destroy the questionnaires and database. I intended to publish and make public presentations based on the research, but

OVER……..
I will not be able to identify you through your participation and I will be presenting and publishing the overall results for the two projects that are participating in the study.

Should you wish to not answer any questions or take part in the study, please feel free to put this questionnaire back in the envelope provided and mail back to me or give it to the Head Start staff in the attached stamped envelope, as they are numbered and this will prevent anyone from knowing which families are participating. You do not have to answer any questions that you do not feel comfortable answering, and you can stop the questionnaire at any time and return an incomplete questionnaire. You also do not have to complete the Exit Questionnaire if you are uncomfortable.

There is a stamped and addressed envelope for you to return your questionnaire to me. I encourage you to mail it to me directly as the postage is paid. If you choose to return it to your Head Start, please put the questionnaire in the envelope, seal it and put a mark across the seal. Please return the questionnaire by October 19, 2007.

This consent form is your copy for your records and reference, and is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please take the time to read this consent form carefully. Please feel free to ask if you require any additional information about anything mentioned here. You may contact Cathy Alisch at Waabinong Head Start, or my supervisor, Dr. Jean-Paul Restoule by email at jrestoule@oise.utoronto.ca. You may also contact the University of Toronto Ethics Review Office (http://www.research.utoronto.ca/ethics/index.html) at (416) 946-3273 or ethics.review@utoronto.ca

By completing the survey, you are giving your informed consent to participate in this study.

Meegwetch!

Angela Mashford- Pringle, M.A. Candidate
Informed Consent Form for September Fort Erie

Informed Consent / Information Letter – Fort Erie – September 2007

Research Project Title: Aboriginal Head Start: Impact on Health and Education
Researcher: Angela Mashford-Pringle, Sociology and Equity Studies in Education, Ontario Institute of Studies in Education, University of Toronto/Collaborative Program in Aboriginal Health

Aboriginal Head Start: Impact on Health and Education consists of three separate questionnaires. Using the data from the questionnaires, I will compare parents or caregivers initial self-assessment of the families and children enrolled in Aboriginal Head Start in September 2007 with questionnaires completed later in the school year to see if there are changes in health, education, or employment after experiencing Aboriginal Head Start programming. I will be able to understand what impact the program has on the children as well as their parents/caregivers through their attendance at social, cultural and learning events that occur at the Head Start. You are about to complete the second one now, and a final questionnaire in June 2008 as a follow up regarding changes in health, education, and employment of AHS children and their families.

The Fort Erie Parent Council has asked that I go beyond my thesis to provide the project with a report that studies the project from September 2007 to June 2008. The final draft of my thesis will be shared at a Parent Council meeting in February 2008, and a final draft report for Fort Erie Aboriginal Head Start will be available in July 2008. You can be a part of the meetings regarding these reports and provide any input to the final papers at those meetings. There will be no compensation for you as a participant, but this research could benefit your Aboriginal Head Start project by showing if there are any areas of the program that are working well or need changes.

The Fort Erie Parent Council determined that the questionnaires will take about 30 minutes to complete. These questionnaires will focus on the health and education of children attending Aboriginal Head Start Urban and Northern Communities program in Ontario, and their parents or caregivers’ health and education and the changes between the three questionnaires will help to place the impact of AHS programming on your children and yourselves.

Your participation is completely voluntary and your decision either to participate or not to participate will be kept completely confidential. You can withdraw from the study at any time without explanation and without negative consequences to you or your child’s attendance in the Head Start program. No Aboriginal Head Start staff or community members will know your answers to the questionnaires as they will not be shared and I will not have your names. At the end of my thesis, I will destroy the questionnaires and database. I intended to publish and make public presentations based on the research, but...
I will not be able to identify you through your participation and I will be presenting and publishing the overall results for the two projects that are participating in the study.

Please return by mail, the questionnaire in the self-addressed stamped envelope provided or give it to the Head Start staff in the attached stamped envelope and this will prevent anyone from knowing which families are participating. You do not have to answer any questions that you do not feel comfortable answering, and you can stop the questionnaire at any time and return an incomplete questionnaire.

This consent form is your copy for your records and reference, and is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please take the time to read this consent form carefully. Please feel free to ask if you require any additional information about anything mentioned here. You may contact Crystal LaForme at the Fort Erie Head Start, or my supervisor, Dr. Jean-Paul Restoule by email at jrestoule@oise.utoronto.ca. You may also contact the University of Toronto Ethics Review Office (http://www.research.utoronto.ca/ethics/index.html) at (416) 946-3273 or ethics.review@utoronto.ca

By completing the survey, you are giving your informed consent to participate in this study.

Meegwetch!

Angela Mashford-Pringle, M.A. Candidate

**Research Project Title:** Aboriginal Head Start: Impact on Health and Education

**Researcher:** Angela Mashford-Pringle, Sociology and Equity Studies in Education, Ontario Institute of Studies in Education, University of Toronto/Collaborative Program in Aboriginal Health

Aboriginal Head Start: Impact on Health and Education consists of two separate questionnaires. Using the data from the questionnaires, I will compare parents or caregivers initial self-assessment of the families and children enrolled in Aboriginal Head Start in September 2007 with questionnaires completed later in the school year to see if there are changes in health, education, or employment after experiencing Aboriginal Head Start programming. I will be able to understand what impact the program has on the children as well as their parents/caregivers through their attendance at social, cultural and learning events that occur at the Head Start. You are about to complete the final one now to follow up regarding changes in health, education, and employment of AHS children and their families.

The final draft of my thesis will be shared at a Parent Council meeting in February 2008 to discuss the findings and allow you to provide your input into the final paper. There will be no compensation for you as a participant, but this research could benefit your Aboriginal Head Start project by showing if there are any areas of the program that are not working well.

The Project Coordinator and I have determined that these questionnaires will take about 30 minutes to complete. These questionnaires will focus on the health and education of children attending Aboriginal Head Start Urban and Northern Communities program in Ontario, and their parents or caregivers’ health and education and the changes between the two questionnaires will help to place the impact of AHS programming on your children and yourselves.

Your participation is completely voluntary and your decision either to participate or not to participate will be kept completely confidential. You can withdraw from the study at any time without explanation and without negative consequences to you or your child’s attendance in the Head Start program. No Aboriginal Head Start staff or community members will know your answers to the questionnaires as they will not be shared and I will not have your names. At the end of my thesis, I will destroy the questionnaires and database. I intended to publish and make public presentations based on the research, but will not use your words in my thesis or other works.

Should you wish to not answer any questions or take part in the study, please feel free to put this questionnaire back in the envelope provided and mail back to me or give it to the Head Start staff in the attached stamped envelope, as they are numbered and this will prevent anyone from knowing which families are participating. You do not have to answer any questions that you do not feel comfortable answering, and you can stop the questionnaire at any time and return an incomplete questionnaire.
There is a stamped and addressed envelope for you to return your questionnaire to me. I encourage you to mail it to me directly as the postage is paid. If you choose to return it to your Head Start, please put the questionnaire in the envelope, seal it and put a mark across the seal. Please return the questionnaire by **December 31, 2007**.

This consent form is your copy for your records and reference, and is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please take the time to read this consent form carefully. Please feel free to ask if you require any additional information about anything mentioned here. You may Cathy Alisch at Waabinong Head Start, or my supervisor, Dr. Jean-Paul Restoule by email at jrestoule@oise.utoronto.ca. You may also contact the University of Toronto Ethics Review Office ([http://www.research.utoronto.ca/ethics/index.html](http://www.research.utoronto.ca/ethics/index.html)) at (416) 946-3273 or ethics.review@utoronto.ca

By completing the survey, you are giving your informed consent to participate in this study.

Meegwetch!

Angela Mashford-Pringle, M.A. Candidate
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