MANAGING CHALLENGING CONTEXTS: UNDERSTANDING CHILDREN'S HEALTH

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ABSTRACT

We know that the social conditions in which children live exert a strong influence on their health; yet we do not know how children's experience of these conditions of daily life shape their health. This research examined how contexts of daily life influence children's perspectives of health. The children involved in this study all lived in a neighbourhood characterized as having a complex of mid to high range of neighbourhood factors associated with vulnerability. Factors that impede or enhance children's sense of agency in relation to their health were examined, as was the role that parents play in children's perspectives of health.

Ethnographic methods were employed which involved the systematic exploration of the social or cultural setting. Fourteen first grade children (6-7 years old) and their parents participated in this study. The health ideas, beliefs, knowledge, and practices of these young children were examined through in-depth interviews, observations of the children in their after-school care programs, parent questionnaires, and informal conversations with the children, parents, and key informants.

The findings demonstrate that the children were able to articulate the health requirements of physical activity, healthy eating, an awareness of social standards, and the scholastic competencies that support their health. There was a disparity between the children's health knowledge, their perceptions, and their contextual realities in relation to health. Children spoke of concerns for their physical safety within their schools and neighbourhoods; their lack of free range of play, and that they had few opportunities to play with or get to know neighbourhood friends. Most children spoke of a lack of familiarity with neighbours, while parents spoke of not belonging and echoed the

children's concerns regarding safety and lack of neighbourhood cohesion. The children used a variety of resources to support their health and to compensate for their neighbourhood challenges.

The findings of this research have implications for including children in our future research; the findings also support the need for ensuring quality after-school programming, and providing simple solutions for creating safer communities for children. Nurses and other health professionals in contact with children and families who live in challenging social conditions need to be aware of how these contexts shape children's understanding of their own health potential.

TABLE OF CONTENTS

LIST OF TABLES

List of Figures

DEDICATION

In memory
of my father,
William E. Irwin
&
my grandmother,
Doris K. M. Genoe

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CO-AUTHORSHIP STATEMENT

Lori Irwin conceived the study and developed the protocol in collaboration with her supervisory committee. L.I. recruited participants, collected the data, managed the data, carried out the analysis, and drafted the manuscripts. L.I. was responsible for the overall management of the study and is principal author for all the manuscripts. The committee members (J.J., A.H., V.S.D., & C.H.) contributed to the conception, design, analysis, and interpretation of the data as well as provided critical feedback on the drafts of the manuscripts for important intellectual content. The committee members will be acknowledged as co-authors of each manuscript and will have final approval of the version to be published.

CHAPTER 1
INTRODUCTION

> *The social conditions in which people live powerfully influence their chances to be healthy. To improve health for children and promote health equity requires strategies for action, which take into account these social determinants of health.* World Health Organization (2005)

We know that the social conditions of children's lives influence their health potential; yet, we do not know enough about how children make sense of these conditions or how children's perspectives of these conditions ultimately affect their health. This ethnographic research project was conducted to examine how the everyday contexts in which young children live affect their perspectives of health. I had a particular interest in examining the role children play in their own health. While the children experienced differing family and school contexts, they all lived in a neighbourhood with characteristics that have been associated with vulnerability.

Overview of Manuscript-based Format

This thesis follows the University of British Columbia Faculty of Graduate Studies guidelines for a manuscript-based thesis. A manuscript-based thesis must be structured such that Chapter 1 presents a brief review of the literature, sufficient to enable a trained researcher to gain an understanding of the area of study; each separate manuscript also contains a literature review specifically focused towards the individual manuscript's unique content. Chapter 1 also introduces the reader to the research topic and research objectives, and provides a sense of cohesiveness to the manuscript chapters to follow. Due to the nature of ethnography, the methodology employed in this research, and the extent of contact with the child participants, it became clear that readers would

require more detailed information regarding the participants and setting of the study. Chapter 2 contains a detailed description of the data obtained during the one-year period of the study. Although the manuscript-based thesis guidelines suggest placing this type of material in an appendix (Faculty of Graduate Studies, 2005), I break with format here, as the description provides essential information about the participants and setting, yet are more detailed than a traditional manuscript for publication would allow. For optimal comprehension, it is important to record and present the data to the reader *prior* to the manuscript chapters. The three manuscripts each form an individual chapter, Chapters 3-5. Given the nature of qualitative research in which one methodology was employed for the study as a whole, and in the interest of minimizing repetition, the methods sections of the second and third manuscripts (Chapters 4 and 5) are significantly abridged, including only information restricted to the particular nuances of the specific manuscript's methods; the reader is directed to the appropriate chapter or appendix for further details. The final chapter, Chapter 6, contains a general discussion and conclusion, unifying the manuscripts and relating the significance of the work to the field of study with suggestions for future research. Two additional sources of important information for the reader are Appendices A and B. Appendix A is a more detailed methodology section; Appendix B is a published manuscript based on the pilot research for this study.

Field of Research: Children's Health

I approach this research with a long-standing interest in children's health. Prior to my many years as a paediatric nurse in hospitals, educational institutions, and community settings, I was involved in the development and implementation of various community summer programs for children of all ages. My interests in children's health, and issues

related to children as a social group, have framed my clinical work, teaching experience, graduate studies, as well as my emerging program of research, and will continue to frame my career as a child health researcher. The three manuscripts contained in this dissertation focus on the subject of children's perspectives of health: in particular, children who live with challenges associated with their everyday contexts.

Clarification of Terms

During the process of developing the ideas contained in this dissertation, it became clear to me that those writing about children's health have vastly differing definitions of terms. Therefore, at the outset of this dissertation I provide clarification of my use of terms and definitions of commonly used terms or concepts within this dissertation. The category of *children*, the concept of *at risk*, and the concept of *children's health* are central to this dissertation research. As well, terms such as *context* and *environment,* defining children's emotional states and physical spaces, require clarification. I also explain the difference between my use of the terms *neighbourhood* and *community.*

Children as a category

This research is concerned with developing an understanding of children's health and examines how characteristics of their neighbourhoods shape their perspectives of health. When embarking on a qualitative study with young children, it is important to consider each child as an individual, to become aware of the subtle differences that children may attach to their lives that affect their health. Yet, for research purposes, we want to be able to extrapolate, identifying a collective experience of individuals by

attending to the commonalities between children without losing the individual experience. Boyden and Levison (2000) remind us that:

> [w]e must develop more pluralistic concepts of childhood that lead to the understanding that children's experiences are extremely varied, and the paths to their betterment are context-specific to a much greater extent than traditionally assumed. Childhood is not a monolith. There are many different approaches to and experiences of childhood. Different experiences have different meanings, and different child development effects, in different situations (p. 56).

While I do not consider children or childhood a monolith, when one writes about children there is a danger in assuming a wide age range (0-19 years) of referent for the term children. The children who participated in this study were between 5 and 8 years old. When I refer to *children* in this study, I am referring to children of this age group unless otherwise stated. This decision to limit the age range of the referent is especially salient for purposes of specificity regarding the rationale provided for research methods, strengths and weaknesses of the research, implications for future research, practice, and policy, as well as the comparison of this work with other research with young children. Left unspecified, there is a danger that the reader may generalize the findings beyond the age range intended.

The concept of at-risk

This work deals specifically with children and their families who live in a neighbourhood with characteristics associated with risks for children's health. I must, therefore, explain how I refer to these children and families. The phrase *at risk* has been widely used within the literature (e.g., phrasing such as at-risk children/families, or children/families at risk) when describing factors that place children at greater risk for poor health outcomes. While thoughtful use of the phrase at risk provides us with a

language that helps describe a population of children, or states a probability, less considered use of the term may lead us to view the individual child or family in which the child lives as somehow deficient or culpable. I choose, therefore, when referring to such children or families, to use the wording *children who live with vulnerability, adversity, or challenges*. This phrasing locates the source of the potential risk as external to the child or family.

Children's health

The process of defining *children's health*, and the factors contributing to it, proved to be a much more difficult task than expected. While my own clinical practice involved a broad understanding of the important elements of children's health, some of the literature concerning children's health contained many incomplete and somewhat conflicting definitions of children's health. Throughout this research endeavour, I have been exposed to and utilized literature from various disciplines with slightly differing views of what constitutes health: e.g., nursing, medicine, sociology, psychology, geography, political science, engineering, family studies, and genetics. Developing a clear understanding of how *I* define the term children's health within this dissertation was therefore essential.

I use the term *health* in reference to a dynamic process, which extends across the broad domains of social-emotional health, physical health and well-being, language and cognitive abilities and competence. When speaking of health, I am referring to the interconnected dimensions of biological, social, psychological, experiential, and behavioural health across these domains. In addition, I do not consider health as static, but rather as embedded within contexts and fluid, that is, transactionally related to those

contexts. A unique feature involved in defining health in relation to children is that children's growth and development over time must be recognized as a key feature of their health. Although more traditional definitions of each of children's development and children's health have been defined with limited or no explicit consideration of the other, developing and acquiring the necessary social, emotional, behavioural, cognitive, and scholastic ability is considered an integral feature of my definition of children's health.

Context, environment, neighbourhood, and community

If children's health is seen as embedded within specific *contexts*, it is important to establish how those contexts are defined. The child's context is a physical, social, and emotional space; it is the combination of physical environment, familial setting, financial, and social circumstances. The child's context is formulated, in fact, by all those influences surrounding the child that have an effect on the child (especially, for my purposes, on the child's health). While the child's physical environment, for example, exists separate from the child, when I refer to the notion of the child's context, I am making reference to the child's environment that is one of connection, of interaction between the child and his or her surroundings.

I also refer to specific types of environment—*neighbourhood* and *community*—within this dissertation. As much of the focus of this work is on the effects that neighbourhoods impart on children's health, the term requires definition. I use the term *neighbourhood* within this study, at times, in a strictly geographic sense when referring to the area for sampling. The children who participated in this research lived in the selected neighbourhood with boundaries set by The City of Vancouver neighbourhood planning. The children involved in this study were more familiar with the term neighbourhood than

the concept of community. The term neighbourhood is employed within this dissertation as differing from *community*[1] in that community is not necessarily defined by geographic space or place; rather, is considered to be a more fluid concept than neighbourhood within this dissertation. While a child may live within a particular neighbourhood they may feel that they belong to various communities defined for instance by relationships with people and place.

Review of the Literature

This literature review is focused on the elements that influence children's health, with a particular interest in examining how children's neighbourhood characteristics contribute to their health, health knowledge, and behaviours. As each of the three manuscripts in this dissertation contains focused literature reviews, this broader introductory literature review framework briefly outlines what research reveals about individual-level characteristics, family-level characteristics, neighbourhood characteristics, and, finally, the socio-political environments as they relate to children's health. I also argue for the need to include children's voices in our research concerning their health.

Individual-level Characteristics

Children possess individual age, sex, temperament, and hereditary factors that undeniably influence their final health potential. Although is it acknowledged by the research community that individual differences in health outcomes are associated with a child's biological and social characteristics, it is equally important to understand the underlying neural and social mechanisms that contribute to and sustain individual

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[1] In the literature, many authors use the term *community* in reference to what I am calling a *neighbourhood*; therefore, I will make clear their particular use.

differences in ability and competence. Biological characteristics matter for individual children's health. For example, children who are small for gestational age at birth are at increased risk for adult-onset diabetes, heart disease, and high blood pressure (Barker, 1992). The presence of chronic disease processes acquired through genetic inheritance such as cystic fibrosis, asthma, and rheumatoid arthritis in young children can more obviously be understood to shape a child's life trajectory of wellness, illness, and physical activity. Congenital cardiac disease in children can result in chronic health problems such as exercise intolerance, failure to thrive, congestive heart failure and repeat hospitalizations all affecting their long-term health. Congenital heart disease has also been shown to influence functional daily living skills and socialization (Limperopoulos, Shevell, Rosenblatt, Rohlicek, & Tchervenkov, 1999).

Environments, however, do influence individual children's development independent of and in combination with a child's biologic characteristics; there is a growing awareness of specific periods in children's brain development that affect children's health outcomes over time (Barker, 1992; Bronfenbrenner, 1979; Wadsworth, 1997; Willms, 2002). Cynader and Frost (1999) corroborate this position, observing that

> [d]uring development, information from genetic sources, the material environments, and biological and social environments all contribute in complementary ways and at critical times during neural differentiation to forge competencies (p. 154).

Thus, knowledge of the presence or absence of enriched environments during critical periods of development is of utmost importance when considering the relationship between risk factors and health outcomes for individual children. The notion of biological embedding, or neuronal sculpting, has advanced our understanding of the importance of contextual influences upon physiological development, the association between

psychosocial environments and immune responses, as well as bonding or attachment and neuroendocrine responses (Coe, 1999; Suomi, 1999). Thus, this discovery has provided a biological foundation for understanding a sociological process that can create individual differences in how children interpret and respond to their daily lives.

Three separate processes have been proposed to influence children's development—*latency*, *pathways* and *cumulative* processes[2] —and are thought to operate in complex and interrelated manners. *Latency* effects, independent of intervening experience, are the result of events that occur at periods in development when children are particularly vulnerable to conditions of daily living. One such example of a latency effect is poor attachment (social process) in infancy; another example is low birth weight (biologic characteristic). Both of these individual factors are known to have a longstanding impact on health. *Pathways* effects are courses of health trajectories that influence health over time. One such example is lack of school readiness for children. It has been shown that lack of school readiness creates developmental and emotional circumstances for children that are associated with future school failure, criminal behaviour, and poor employability in adulthood (Tremblay et al., 1992). *Cumulative* effects involve the accumulation of multiple stresses and factors that shape a child's health on into adulthood. For example, the multiple stresses and accumulation of stresses as a result of living in chronic poverty would be considered to have cumulative effects.

Each of the processes described—latency, pathways, cumulative—may be expressed simultaneously in one's life, or at various times with a weighting of influence that is individual in nature (Hertzman, Power, Matthews, & Manor, 2001). Consequently,

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[2] For further details about how children, as individuals, are influenced by their environments, see Hertzman, Power, Matthews, and Manor (2001).

risk factors and influences upon a child's health can be experienced as either time limited or ongoing factors in their lives, with individual differences in responses to these factors. At present, research cannot explain the role the individual child plays in these processes. What is required to increase our understanding of how these processes associated with health vulnerability are manifest in the lives of children is a more detailed description of the lived experience of individual children by the children themselves. By examining children's individual perspectives, we expose the role that children play in their own health and can better understand individual differences in responses to environments and risk factors than existing research can provide.

Family-level Characteristics

We have begun to understand many family-level characteristics that influence individual children's health as they grow and develop (Bronfenbrenner, 1986). There is a wealth of research from a variety of disciplines examining the role of family-level characteristics in children's health outcomes. Family-level characteristics have been shown to influence children's health in both a positive and a negative manner, as risk and protective factors, and having direct and indirect effects.

Living in family poverty has long been implicated as influencing children's health (Engle, Castle, & Menon, 1996; Gissler, Rahkonen, & Hemminki, 1998; Wadsworth, 1997). Family poverty in childhood has also been linked to poor health in adulthood (Lundberg, 1993; Rahkonen, Lahelma, & Huuka, 1997; Wadsworth, 1997; West, 1997). Family poverty can affect the extent to which children's basic needs are met, needs such as safe housing, nutritious meals, and high-quality childcare (Brooks-Gunn, 1995). Brooks-Gunn studied the effects of family income (poverty cofactors) on behaviour and

IQ, and found that psychological resources such as family networks of support, high maternal education, and positive maternal mental health mediated children's scores. In addition, Brooks-Gunn, Berlin, and Fuligni (2000) have demonstrated that the home environment mediates about half the effect of low family income on children's cognitive ability. Given that families are embedded in a multitude of contexts, with a mix of positive and negative influences, our ability to understand the exact processes by which family poverty matters for children's health remains limited (Shonkoff & Phillips, 2000).

Family-level factors, such as low maternal education, poor maternal mental health, and lack of family networks, have been demonstrated to pose risks to children's health (Brooks-Gunn, 1995; Hertzman, 2000). In the case of poor parental mental health, in situations of extreme poverty, or high levels of family stress (which could be associated with either of the preceding factors), important parent-child interactions may be impaired, resulting in fewer opportunities for learning experiences in the home (Bornstein, 1995; Willms, 2002). Single parenthood has also been shown to be more highly associated with depression, three times the level found in co-parenting individuals. When socioeconomic factors are considered, the rate of single-parent depression drops to only twice that of co-parenting individuals (Somers & Willms, 2002). As stated earlier, depression and adverse child outcomes are linked. For instance, the severity and chronicity of maternal depression are predictive of disturbances in child development (National Institute of Child Health and Human Development [NICHD] Early Child Care Research Network, 2004).

Parenting behaviours have been implicated as influencing children's health. Behaviours such as positive reinforcement, displays of warmth and affection, and

consistent disciplinary strategies (known as authoritative parenting) result in fewer child behaviour problems and relate positively to academic competence and positive peer relations, which enhance a child's health (Brody & Flor, 1998; Conger, Elder, Lorenz, Simmons, & Whitbeck, 1994). While some literature associates negative parenting strategies with low income, Chao and Willms's (2002) study, using data from the National Longitudinal Survey of Children and Youth (NLSCY), demonstrated that both positive and negative parenting practices were found at all levels of socioeconomic status. Positive parenting strategies have also been shown to provide a buffer for poor child outcomes associated with families experiencing adverse circumstances. For instance, positive parenting has been found to buffer the expected effects of factors such as financial strain and parental divorce, through building children's coping resources (Armistead, Forehand, Brody, & Maguen, 2002; Hertzman, 2000). Individual characteristics of the child can also influence parenting and make consistent, positive, and nurturing parenting difficult to achieve.

Although I have touched on only a few family resource and process issues in this review, existing research does reveal that we need to pay closer attention to how families influence children's health. Most of the studies available have used single-source, parent-reported, quantitative data, and examined the family context in isolation from the larger neighbourhood and social factors that contribute to children's health. What is missing from this extensive body of literature are observations of parent-child interactions, details of how parenting influences children from the young children's perspective, and understanding the emotional and social effect that family contexts have on children's health when children are exposed to the wider environments of school, neighbourhood,

and community (Black & Krishnakumar, 1998; Brooks-Gunn, 1995; Dunn & Hayes, 2000; McCulloch & Joshi, 2001).

Neighbourhood-level Characteristics

Research studies reveal that individual- and family-level characteristics do not completely account for differences in children's health outcomes. Researchers are examining *how* contexts such as neighbourhood conditions shape children's health, and the relative contribution neighbourhood effects have on children's health. As the field is vast, and the debate about effects is ongoing, it is beyond the scope of this review to include all aspects of how neighbourhoods influence health.[3] I therefore provide a very brief outline of some of the salient research with respect to children's health in this area of study.

Neighbourhood characteristics have been shown to influence children's health in a variety of ways. Beauvais and Jenson (2003) provide a summary of theoretical models of neighbourhood influences on children's health. These models include a stresses model (exposure to toxins, and social and psychological conditions such as high crime rates), a social organization model (role models, collective efficacy, and shared values), an institutional model (importance of institutions such as schools, police, neighbourhood services), and an epidemic model (power of peer influences). Neighbourhood composition, social processes, and physical characteristics are thus key elements in the research demonstrating *how* neighbourhoods matter for children's health; *how much* they matter, and *in what ways* they matter, remain somewhat unclear. While there is much debate about the strength of association between neighbourhood effects and children's

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[3] Chapters 4 and 5 do deal with the issue of how neighbourhoods influence children's health and contain further information about this topic.

health, with some researchers suggesting that the influence of neighbourhoods is small compared to the influence of family- and individual-level factors (Tremblay et al., 2001), researchers agree that the effects are not to be ignored.

Neighbourhood safety, cohesion, and crowding are a few of the factors that may influence family practices, family psychological well-being, and thus children's health (Dunn & Hayes, 2000; Hertzman, 2000: Hertzman & Kohen, 2003; Kohen, Hertzman, & Brooks-Gunn, 1998; Sampson, 1991; Sampson, Raudenbush, & Earls, 1997: Shonkoff & Phillips, 2000; Wilson, 1987). For example, concerns regarding safety, for children as well as parents, might affect a child's opportunity to participate in physical activity in venues such as neighbourhood playgrounds; such limitations have a domino effect, inhibiting a child's social experiences. Research also shows that neighbourhood cohesion may act to diminish the effects brought on by safety issues, as social networks may provide supportive enclaves where families and children feel safe (Sampson et al.).

It has been shown that there is variation in the extent of effect neighbourhood-level factors have on children's health outcomes depending on the measures of children's health being used (e.g., mental health, behaviour, academic achievement measures). For example, two recent literature reviews have reported that the socioeconomic status of the neighbourhood demonstrates the most consistently powerful effects on children's health, and that research with school-age children provides the most consistent evidence of neighbourhood-level effects. School-aged children's[4] interaction with their environments increases at a time when they may not have the resources for dealing with challenging

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[4] For instance, Hertzman, Brooks-Gunn, and Kohen (1999) found that family characteristics buffered the neighbourhood effects of school-readiness more for toddlers than for older children. These findings suggest that neighbourhood effects for school readiness measures may be stronger for children who have more interaction with their neighbourhoods.

neighbourhood conditions such as high crime, lack of cohesion, dangerous roadways and more. These reviews showed that neighbourhood effects are stronger for cognitive and academic indicators than for behavioural and mental health measures (Duncan & Raudenbush, 1999; Leventhal & Brooks-Gunn, 2003). Once children enter school, they have an immediate increase in their social networks and *potential* resources from which they can draw, as the influence of teachers and other professional, as well as school dynamics (positive or negative), shape children's lives at this age (Engle et al., 1996). Yet, school-aged children show the strongest detrimental effects of living in adverse neighbourhood conditions and are the least studied group within the literature. Some neighbourhood studies have included school-aged children's perceptions of their neighbourhood conditions in relation to their overall health (Davis, 2001; Davis & Jones, 1996, 1997) however the literature remains inadequate in providing us with essential details of how children experience these conditions of daily life. Studies have yet to observe families and children as they interact in their environments and to examine in detail how the neighbourhood characteristics and dynamics affect children's health. Such an approach would be able to answer questions that researchers pose about the effects of neighbourhoods on children's health, and begin to uncover reasons for the strength of association between neighbourhood effects and children's health. What may be a small effect from a population health perspective may be a significant effect for individual children.

Socio-political Context

Health, for children, is situated within a broader social milieu and is influenced by the political environment (e.g., the rationalization of services and downsizing of health

care), health and social services policy (e.g., welfare policy), community programming, and so on. Broader social, health, and environmental policies (upkeep and presence of playgrounds and green space, presence of neighbourhood policing office, placement of public libraries, availability of enrichment programs and quality preschools) influence neighbourhood conditions, which affects children's health. It has been posited that the social meanings that people attach to their environmental circumstances ultimately effects their health and contributes to the social gradients of health observed in population-health studies (Hertzman & Wiens, 1996; Wadsworth, 1997; Wilkinson, 1994). Many health programs (e.g., Kindergarten readiness programs such as Ready, Set, Learn; parenting programs; public health nursing targeted family visits; and other community and school programs such as Cantonese Mother's Group and Kid Safe) are directed at children and families who live with vulnerability at the family and neighbourhood level; yet, the population-based analyses that support these policies or programs have not included the perspectives or experiences of those who utilize the programs. Policy development has been undertaken without fully understanding this key component to improving health. Dunn and Hayes (2000) suggest that "policy platitudes may remain platitudes" unless improved theoretical and empirical research is developed to better identify pathways accounting for relationships between social and economic environments and risks to children's health (p. 564).

Children's Participation in Research

Children have remained marginalized as sources of knowledge in the research process. Recently, researchers have questioned why children have remained the objects of study in research and have called for children to occupy the position of subject in

knowledge development (Alderson, 1995; Alldred, 1998; James & Prout, 1990; Mayall, 1994). Scholars concerned with knowledge applicable to children have shown growing recognition that children's perspectives of their experiences are a valuable form of knowledge (Docherty & Sandelowski, 1999; Irwin & Johnson, 2005; Morrow & Richards, 1996). It has been shown that children can provide information about their wider social worlds and contribute to knowledge development for understanding children's health needs (Irwin & Johnson). Parents' perspectives of children's health and the factors that affect young children's health flood the literature, while we are only marginally better at gaining insight into factors that affect children's health by accessing the voices of young children. For example, much of the literature that has provided us with a better understanding of children's health in Canada has been provided by studies using data from the NLSCY. This survey includes information about children provided by the person most knowledgeable (PMK) about the children in the household. Older children (aged 10 and 11 years) complete a self-administered questionnaire (about friendships, family relations, and experiences in and out of school) but younger school-aged children's perspectives of their lives remain unexamined (Willms, 2002). There is emerging recognition that population-based research must be augmented by a rich theoretical understanding of the ways in which risk is manifest in the lives of such children and the mechanisms through which risk factors operate (Dunn & Hayes, 2000; Kaplan & Lynch, 1997). This call by researchers for "insight into the mechanisms that might be health promoting" for children, and a richer understanding of "the depth and quality of social relationships" of children (McCulloch & Joshi, 2001, p. 589), could be developed by gaining the perspectives of children on these important matters. It follows

that employing in-depth qualitative research methods exploring what matters in the daily lives of children, with a focus upon the social determinants of health, would add a richness to the current body of research. By including the child's perspective in our research, we could also understand the role the child plays in establishing the connection between living conditions and health outcomes (Davis & Jones, 1997; Irwin & Johnson, 2005).

The idea of children as participants in research is timely, in the light of theoretical perspectives gaining momentum within the sociology of childhood. Sociologists conclude that children are active in the construction and determination of their social lives, the lives around them, and the societies in which they live. To be a child is to be a thinking, acting, individual who shapes and is in turn shaped by social experiences. As such, children influence and are active in the construction of their worlds (Graue & Walsh, 1998; Greig & Taylor, 1999; James, Jenks, & Prout, 1998; Mayall, 1994, 1996). If children were granted greater access to a public voice in venues such as research, they might be able to contribute to the social structures that affect them.

Purpose of the Study

As this brief literature review has established, researchers have been able to identify many individual factors and contextual influences that shape the lives of children and their subsequent health. We know that pathways exist connecting the daily conditions of a child's life to health; we know that these pathways have multiple influences; but we do not know how these pathways or processes are experienced by the child or how a child is an agent within these processes. Producing knowledge that fills this gap will help us to better understand the mechanisms controlling the effects of difficult circumstances, to

increase understanding of the role of the child as agent in the process, to assist researchers in developing more appropriate research related to children's needs, and possibly to develop better policy and programming directed at young children. Addressing these goals, this study proposes to establish how exposure to challenges associated with neighbourhood conditions influences children's perspectives of health, and the role that children play in their own health. To provide detailed answers to these questions, I employ an in-depth, qualitative, ethnographic research method.[5]

Research Objectives

The objectives of this qualitative study, in relation specifically to children who live in neighbourhoods associated with vulnerability, are:

- to examine in detail the perspectives of children regarding their health;
- to examine how children act to enhance or diminish their own health, and the factors that impede and facilitate these actions;
- to describe the ways in which challenging life circumstances (context) influences the health of children, both from the perspective of the child and through detailed observations; and
- to formulate a beginning understanding of the ways parents influence children's health.

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[5] For a review of the ethnographic approach employed in this research, see Appendix A; for a review of the methods employed, see the methods section of Chapter 3.

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CHAPTER 2
SETTING THE STAGE

Traditional dissertation formats are well-suited for documenting the details that ethnographic methods require. However, my choice to undertake a manuscript-based format presented challenges for providing sufficiently suitable detail, given the restrictions that scientific journals place on manuscripts for publication. The purpose of this chapter, then, is to describe more fully some of the characteristics of the neighbourhood, the participants, and the out-of-school (OOS) program involved in this study. I also include salient issues related to this ethnographic research with children that might otherwise be situated in a methods chapter; I discuss these issues here to provide a sense of how my process unfolded while in the research setting. In this dissertation, each of the manuscripts is in preparation for publication; I intend to include abbreviated versions of the information contained in this chapter in each manuscript, as deemed necessary by individual target journals during the final preparation for publication. In the interest of avoiding the pitfall of repetition, I ask that the reader hold in mind the details of this chapter while reading each of the three manuscripts that follow.

The Broader Research Context: The Neighbourhood

This research took place in an urban neighbourhood setting within a larger metropolitan area. This neighbourhood had been previously identified as containing a high proportion of children who had health vulnerabilities, likely due to aggregate level issues. For instance, 25-30% of kindergarten children in this neighbourhood scored in the vulnerable category on the Early Development Instrument, a group level measure of children's readiness for kindergarten measuring performance on physical health and well-

being, social competence, emotional maturity, communication skills, general knowledge, and language and cognitive skills (Hertzman, McLean, Kohen, Dunn, & Evans, 2002).

This neighbourhood can be characterized as having a complex of mid to high range of neighbourhood factors associated with vulnerability[6]. For example, a quarter of the population lives below the low-income cut-off (LICO);[7] a third of the population over 20 years of age have not completed high school; 20% of the families are headed by single parents;[8] in 2000-2001, 16% of the population changed addresses; 30% of the populations' home language is other than English,[9] and 1.5% report aboriginal status (Hertzman, 2005). In addition, 50% of the population (larger geographic area than this neighbourhood) reported low to very low social trust ratings; this neighbourhood also experiences moderately high rates of all crime types, compared to other neighbourhoods in the urban setting, and a greater proportion of violent crimes than other neighbourhoods (Hertzman et al., 2002). These factors together create living conditions that have been shown to exert influence at the neighbourhood level on children's health.

Many items in the list of socio-demographic characteristics that describe the urban neighbourhood in which the study took place are associated with vulnerability for children's health. Observations of the play spaces and streets of the neighbourhood, however, revealed a different sense of vulnerability for children, one that cannot be

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6 Due to more recent gentrification, this neighbourhood is not considered a homogenously disadvantaged neighbourhood.

7 The LICO captures households that spend 55% or more of their income on basic necessities and is regarded by some, including the National Council of Welfare, to be measure of poverty. It is a particularly useful measure of neighbourhood income status, because it is sensitive to local housing and food costs, unlike direct measures of income (Hertzman, 2005).

8 This is relevant because children in single parent families may have access to less adult social support and mentorship, and because work- and home-life conflicts regarding responsibilities to children tend to be greater for single parent families than two parent families. In his analysis of NLSCY data, Willms (2002) found that low-SES children who lived in neighbourhoods with a high proportion of single parents experienced increased vulnerability (although the effects were weak).

9 This frames the ESL challenge for child development and schooling (Hertzman, 2005).

captured by statistics alone. I bring to these observations my history of being a female in the world, which shapes my perspective of safety in ways not unlike some of the fears that children spoke of. As a researcher and a woman alone, I sometimes felt very uncomfortable in this neighbourhood, while I also sometimes felt at home and very safe. I attempted to spend time in many different places in this neighbourhood setting, but also sought to find places that children could be found or spend time. I spent a lot of time visiting play spaces, but I also participated in festivals and family events within this neighbourhood. The OOS programs the children attended were connected to the school grounds, and thus much of my time was spent observing children in the period just after school. As the study continued into the summer holidays, I spent time in the neighbourhood during the summer months.

Play spaces

Few play spaces with well-maintained equipment were found outside of school grounds. Wooden structures showed signs of rot, and metal structures were rusting and dangerous. The grounds of most play spaces were littered with garbage, broken glass, clothing articles, and the leavings of homeless people who had used the parks for shelter. Play spaces seemed to be greatly used by youths loitering on the equipment, and few sites actually had children or families playing. The play spaces belonging to schools were well maintained, clean, and organized such that children were highly visible. In some play spaces located on school grounds, the addition of foliage such as trees provided necessary shade and created an atmosphere of green space in the urban neighbourhood.

Streets

In general, the streets of this neighbourhood were empty; children and families were not visible in my day-to-day encounters. While time spent in the neighbourhood on weekends did expose the more social aspects of neighbourhood life, such as cultural and neighbourhood social events, some streets within the neighbourhood remained barren and lacked the life or essence of a neighbourhood. Upon reflection, the photographs taken of the neighbourhood streets for use in the interviews with children, houses, transit, play spaces, and more, contained few people, a fact reflecting the observations of the lack of *visible* neighbourhood life. There is a mixture of safe, traffic-calmed streets and high-traffic, noisy, and somewhat frightening, four-lane thoroughfares in this neighbourhood.

Transit

The neighbourhood is home to a rapid transit line, and observations of stations revealed many adults, youths, and children in the area. This rapid transit line is above ground. As this is the first such line in this metropolitan area, the city is still learning how to manage security on this system. Again, this area was at times comforting, due to the large number of people using the transit system, and at times discomforting for the same reason. I chose to include photographs of the rapid transit line in the research, as I assumed it might evoke interest in the children. The children inferred a source of danger from people associated with the line.

Many of the areas visited off the main streets included a mix of clean, well-maintained neighbourhood streets, alleyways with junk and garbage, houses and apartment buildings. These more residential buildings were mixed with non-residential areas, with boarded-up buildings, and graffiti; these areas evoked a sense of desolation.

Whether my own concerns for safety were warranted or not, they were an inescapable aspect of neighbourhood participation for me, and were echoed in the parents' perspectives of living in this neighbourhood.

The Participants

This section contains a table of socio-demographic characteristics of each child and family[10] followed by a brief description of each of the children involved in this study. While more specific details of their lives can be found in each manuscript, I provide details here of children's everyday lives that were obtained through conversations with parents, the parent questionnaire, observations of the children's time spent in the OOS program, and, for some, observations while I was in their homes. So much more could be said about specific examples of children's lives, but in doing so anonymity would be impossible to ensure. The purpose of this section is to introduce the reader to the children through the eyes of an outsider and their parents.

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[10] Of note, the parents who participated in this study had a higher level of education than the median for this neighbourhood, which does not reflect the demographics of the neighbourhood described in the earlier section.

Table 1.1

Sex	Household yearly income from all sources	Single parent	Maternal education	Paternal education	New immigrant	ESL	Parental rated scholastic ability	Moved <1 year	Parental trust of neighbourhood	Parental trust of local adults
M	20-30,000	No	Masters	10th grade	Yes	Yes	BA	Yes	None	None
F	20-30,000	Yes; Maternal	College diploma	College diploma	No	No	BA	No	Yes	Adults in the immediate housing complex
M	20-30,000	No	University	University	Yes	Yes	A	No	None	None
F	10-20,000	Yes; Paternal	N/A	High school	No	No	A	No	Yes (but the child was still not allowed to play in the neighbourhood)	Yes
F	10-20,000	No	University	Masters	Yes	Yes	AA	No	None	Immediate neighbours
M	10-20,000	No	Unniversity	Masters	Yes	Yes	AA	No	None	Immediate neighbours
F	20-30,000	Yes; Maternal	University student	College	No	No	AA	No	None	None
F	>50,000	Yes; Maternal	University	N/A	No	No	AA	Yes	None	None
F	10-20,000	Yes, Maternal	College	College	No	No	A	No	None	None
M	>50,000	No	High school	University	No	No	A→AA	No	None	Immediate neighbours
F	20-30,000	Yes, Maternal	University	High school	No	No	AA	No	Yes	None
M	10-20,000	Yes, Maternal	University	University	Yes	Yes	AA	No	None	None
F	20-30,000	Yes; Maternal	Trade college	High school	No	No	A	Yes	None	None
M	>50,000	Yes	University	University	No	No	A	No	None	None

BA Below average
A Average
AA Above average

Descriptions of Participants

Michelle

Michelle was observed to experience difficulties engaging in relationships with other children during OOS program time. However, she did have one friend whom she played with on occasion. Although I tended to pay less attention to physical appearance during observations of young children, Michelle was unique in that at the age of six had dyed, jet-black hair and at times wore makeup, which set her apart from the other children. The overall outcome of my interactions with Michelle suggested a sadness or a lack of optimism that was difficult to articulate. At first, I thought it might have been a lack of rapport between us, but one visit, while I was talking with a group of older girls, Michelle came up and quietly (without notice) slipped her hand into mine, leaned up against me, and after a few moments left. On a few occasions, I had hoped to connect with either Michelle or her father, and the staff stated they could not contact him and did not know why Michelle was not attending the OOS program. The family had financial difficulties. Her father suggested that they were going to have to leave the OOS program because he could not pay the fees and they were being evicted from their home. When asked about home life, Michelle's father stated that they were company for each other, and that Michelle did not have neighbourhood friends. Her father would not talk about Michelle's mother, and said that she was not an active part of Michelle's life, although he did say that Michelle and her mother talked on the telephone occasionally.

Martin

Martin's mother was very involved with Martin's schooling and his OOS care. He has an older sister and his mother said she was trying to get Martin to see his sister as a

resource, as Martin was too dependent upon her. Martin had multiple challenges associated with school and behaviour. He complained of regular headaches, and his mother stated that he had experienced some emotional difficulties because of bullies at school, although Martin did not mention these difficulties during any of our conversations. He was observed to have trouble focusing during OOS programming time, yet was very happy in general and did have a consistent group of friends. I observed Martin as he became more and more social over time, and his mother was surprised when he would even remember me and know why I came to see and talk to him. His mother also observed that as his scholastic and social difficulties decreased, his headaches decreased.

Fish

Fish's mother described him as someone who "*loves learning*" and "*enjoys friends.*" His mother described his school performance as average. During observations, I detected a difference between how he interacted with peers and adults; he was quite outgoing with peers, yet very shy with adults. Fish was engaged in programming outside school, such as art classes and junior leaders. Fish's mother also described him as liking to succeed or do things well to a fault, in that if he could not do well he would give up. He lived in an apartment and was not allowed to play outside this apartment. Fish had a very narrow sense of neighbourhood, which his mother thought might be due to the restrictions placed on his play.

Kobe Bryant

Although Kobe Bryant was observed to be quite a shy little boy, he also had a cohort of friends that he played with well and regularly. The times he was observed to

have the most difficulty were when he broke rules at the OOS program and was disciplined, not being allowed to play with friends. He did not seem to cope well with being excluded and made numerous attempts to gain the attention of staff members. His attempts at soliciting attention increased his difficulties with the staff. This was uncharacteristic behaviour for Kobe Bryant, and it seemed that he did not know how to deal with this situation, which was, it seemed from his perspective, that the staff did not like him. Religion was important to both him and his family according to his mother. The self-portrait he created at the OOS program included a crucifix around his neck. We discussed the portrait during one of our interviews, and he asked me whether lack of belief in God meant you would go to Hell when you died. His mother suggested that the time they spend together praying in the evenings was family time. Kobe Bryant played various organized sports outside OOS programming and had a very close relationship with his older sister and younger brother.

Dudl

Dudl was a very social little boy whom his mother described as having self-confidence problems. She considered him to give up easily and be self-defeating at times. Dudl's mother commented that Dudl disliked the structure of school, where he is required to sit still for long periods. Dudl's mother did not think they lived in a safe neighbourhood, and, given that they live in an apartment, Dudl was only allowed to play on the sidewalk when an adult was watching. Despite these descriptions of Dudl by his mother, he seemed to be a very happy and gregarious boy, able to manage many challenging situations during OOS program time.

Crystal Gayle

Crystal Gayle's mother parented as a single mother and suggested that they "*lead a lonely existence.*" Crystal Gayle had few friends outside the OOS program and loved the program for this reason. Crystal Gayle spoke of her love of ballet on many occasions, and her mother suggested that her ballet teacher is an important adult in Crystal Gayle's life. While I observed that Crystal Gayle had a positive relationship with many of the staff, I could not truly assess her relationship with the other children, as it seemed to vary quite significantly throughout the months I participated in the program. Conversations with Crystal Gayle were challenging, as she seemed uncomfortable at times with talking about herself. She was a very shy little girl, yet at times she was able to engage in conversations in an easy manner.

Angel

Angel entered this research study near the end of the process of observations. She was observed to engage in regular social interactions with a group of girls her own age and was also observed to play with the older girls. She loves to swim, and spoke about how she liked her new neighbourhood because she lives close to a pool. Angel moved during the course of this study, and although she had agreed to participate in this study while living in the neighbourhood in which the study took place, I interviewed her formally 2 weeks after she had left the neighbourhood. Her mother's perspective of their new neighbourhood was not greatly different from her perspective of the one in which the research took place as "*not a kid friendly place.*" Angel's perspective of moving schools was positive, and she said that she did not have friends in her old neighbourhood (research setting) and hoped to make some in her new neighbourhood.

Sarah

Sarah's mother suggested that Sarah was having difficulties in school. According to her mother, some of Sarah's difficulties are founded on comparison with others who are doing particularly well scholastically. Sarah did not speak until she was four years old, and she has great difficulties with reading. Sarah was observed to be extremely active and had trouble focusing during our conversations. Her mother described her as a very outgoing little girl. During our kinetic conversation in which I interviewed Sarah as she showed me around her neighbourhood, Sarah experienced teasing by neighbourhood girls that resulted in her exiting the play area in tears. Sarah's mother said that the little girl responsible for Sarah's tears was known to have socializing difficulties in their housing complex yet Sarah continued to play with her regularly. She commented that within their housing complex, neighbours have attempted to create an atmosphere of safe spaces and safe adults for children to access if in need. They have regular community dinners, and both Sarah and her mother felt a sense of safety in their complex. This sense of safety did not extend past these narrow physical boundaries.

Seven-up

Seven-up's mother described their family setting as "*close, loving, connected, and gentle.*" Although her mother was a single parent, she expressed that Seven-up had adults in her life who were interested in being a part of her life on a consistent basis. Her mother described their neighbourhood as high-density, high-rental, high-turnover, and expressed that they do not feel connected to the neighbourhood in any fashion. Seven-up finds schoolwork easy and loves to be challenged. Her mother described her as a little girl who loves to learn yet "*hates going to school,*" and spoke of various challenging experiences

that Seven-up had to endure during a period of four months in which she entered a new school in a new neighbourhood. These events were what her mother called "*racist*" in nature; as a result of enduring these difficulties, Seven-up experienced stomach-aches that her mother attributed directly to the challenges. Seven-up had recently moved back to a school within the catchment of this research because of these difficulties.

Merya

Merya's family lifestyle of healthy eating included eating organic foods. Merya was very social, and although he expressed alternate opinions to the other children about the foods they ate, he was not excluded from play. Merya's mother was a single parent, worked full-time, and attended school in the evenings. Merya made reference to his mother's unavailability as she is "*always studying.*" When asked, his mother did not know if Merya was social or shy in his relationships with peers, as she did not see him in social situations. He performed above average in school. His mother restricted his range of play, due to fears of lack of safety and apartment living.

Victor

Victor's father stated that they were having some trouble at school with Victor. The family expected him to do well in school, but he was only average. He had experienced some challenges, getting into trouble for swearing and speaking disrespectfully to teachers. I observed that Victor rarely engaged in play with others unless during activities that the staff organized. His engagements were usually connected to his sister, and he was usually disruptive in those relationships. When I asked his father if Victor liked to succeed in what he did, he suggested that if Victor could not score 10 out of 10, he would give up or not play a game.

Annie

Annie was observed to be a very social, yet shy little girl. I was able to observe Annie through a period of her re-entry into the OOS program after being away for two months. Over a period of 2 weeks, she slowly engaged with two friends on a regular basis. Her father stated that they liked their neighbourhood, but that they would move to provide their children with better schools and safer atmosphere if they could.

Eiley

Eiley's mother suggested that with the recent change in schools they had made that there were too many changes in Eiley's life (two different schools in one year), which was noticeable in Eiley's scholastic life, as she no longer enjoyed school. At the close of this research project, Eiley moved once again. I observed that Eiley loved to engage in quiet, self-directed play and was very creative in her artwork at the OOS program. She was mostly observed either playing with her older sister, who attended the program, or with a staff member. She did not like to play active games; she would start to play, as it was a requirement at times, and would slowly attempt to move quietly to a side of the room to become invisible or sit down. She did not regularly spend time outside; when asked to go outside, she would always request to stay inside. Her mother suggested that after she found a syringe in the area behind her house, she did not let her children play outside. She stated that in her neighbourhood there were "*too many undesirables.*"

Sabrina

Sabrina lived in a home in which two families lived together. Sabrina's mother expressed that her work was very stressful, and that she was underpaid. She was observed to be late most days to pick Sabrina up. Many times during my observations, Sabrina's

mother would call to inform staff that someone other than herself was picking Sabrina up. Sabrina's mother suggested that although Sabrina was an average student, she did not want to go to school and had trouble getting out of bed in the morning. Most days, Sabrina looked tired and ill, with dark circles under her eyes, and was very thin. Sabrina's mother also suggested that she does not have time to do homework with Sabrina. Sabrina was observed to do her homework everyday at the OOS program. Sabrina was observed to be very connected to the OOS staff. At pick up, her mother seemed distant and uninterested in the centre although she usually did speak to the staff. During one walk part-way home, her mother suggested that she tries "*to keep it together*" for Sabrina but finds it difficult to parent at times due to the stresses in her life. Sabrina was not allowed to play in her neighbourhood, and her mother suggested that she played on the porch most days.

While these descriptions provide some details of the children's lives, they in no way capture or are intended to capture the child's life to a full extent. What they do for the reader is give some details, although perhaps not the most salient details, of their lives and relationships. Some of the most important details must remain private.

The Research Setting: The Out-of-School Program

The OOS program setting was the site for accessing children who lived in the sampling neighbourhood. The data gathered during OOS program time (child interviews, observations of social dynamics, parent and staff conversations) were striking in many ways. During my time spent with the children in the OOS program, they organized themselves in small and large groups, ate snacks, played games, engaged in physical activity, kept themselves and friends safe, made friends, lost friends, made friends again,

got into trouble, didn't listen, reaped the rewards of positive behaviours, and learned to be with others in positive ways.

Recruitment

The initial plan for data collection was to enrol children and parents through the OOS program, then observe and speak to children while in their homes and neighbourhoods. However, after spending time getting to know the structure of the OOS settings, I soon realized that the children I sought spent 9-12 hours away from family and in the care of professionals, which constituted a substantial portion of their daily lives. Although the parents seemed very interested in the study, most expressed concern about how much time I was asking of them (2-3 short interviews over 6 months) and suggested that they would be happy to have their child participate in the study if I could carry out my interviews during the time that their child was in the OOS program centre. As a result of these conversations, I became aware of how little time parents had with children at home. Importantly, the opportunity to observe children in the OOS programs presented additional salient information, as the programs were also a place where parents interacted with the system (staff), their own children, and their children's friends, as well as the other neighbourhood parents.

The OOS Programs

The OOS programs involved in this study were all located either within the school setting or on the school grounds. The physical space varied for each program, but each had access to an inside room. Nonetheless, the small size of these interior spaces limited the level of gross motor activity children could engage in. The main rooms usually provided space for both sedentary and active play, a playhouse with a dress-up box full of

clothing, and cupboards for various supplies. In two of the centres, the interior spaces had multiple exits, and children were asked to take a friend with them for safety reasons if they went to the washroom or needed a drink of water.

The walls of the centres told a story in themselves. Children's artwork and poster boards were always on display in the settings. Large notification boards were prominently displayed announcing "Kid of the Week," children who got "Stars" for helping out, and "Junior Leaders in Training." An important aspect of the social milieu of each program was to encourage and acknowledge children who were socially respectful, helpful, played by the rules, waited their turns, and so on. This acknowledgement was performed in a manner that drew attention to the particular children, with large-scaled signs hung in the physical space for all to see.

Each centre had space for active play outside. Each exterior space consisted of climbing equipment, an adventure playground, a field, and some hard surfacing for games such as basketball or hockey. The separation of indoor and outdoor physical space meant that children were required to take buddies with them when moving between spaces. Keeping track of children in the various interior and exterior spaces was essential. The programs each employ one supervisor and 3-4 staff, depending upon the number of children and the special needs of the children (usually a 1:8 ratio). The supervisor had to be aware of staff-to-child ratios at all times, which meant that at times a child might not be able to engage in gross motor play outside because of the need to maintain the appropriate ratios. The children seemed to understand the importance of these rules, even if the rules meant they had limitations placed on their activities.

Pick-up Time

Pick-up times provided much information about a child's world. Parents were required to enter the centre to find their children. In many cases, despite this regulation, the parents would wait in the car, at the playground, or in the field, instead of entering the centre. Children disliked being the last child to be picked up. In some ways, it was difficult to understand if this was because everyone was gone, they had less time to spend with their parent, or they felt like parents were leaving them behind. Parents were usually in a hurry to get their children out of the centre, and so there was a certain sense of urgency imposed upon the children by parents. "*Get your coat on, where are your shoes, what about your pack?*" Although many of the children presented the staff and visitors with examples of their artwork, and talked enthusiastically about their achievements, some were seen to throw their art in the recycling at the end of the day. Very few children brought these same enthusiasms to their interactions with parents during pick up. In addition, most parents did not acknowledge their children's friends or were seen to ask about their child's day during pick up time. While this was the case during observations, this does not exclude the possibility that these interactions took place outside this setting. Parents usually did not make eye contact with staff or other parents, nor did they seem interested in what was happening in the centre. Many just found their child and headed for the cloakroom or exit area. Parents appeared tired and slightly on edge, some verbalized their fatigue, some sat and waited for their child to gather his or her things, others were very withdrawn. The OOS program supervisors commented that many of the parents were under considerable stress in their lives, from financial burden to child behaviour problems, or their own social problems. The exceptions were a few parents

who would linger, talk to the leaders, speak to their children's friends, and ask about what the child did in school that day.

Shaping the Research: OOS Program Participation

The larger research project that provides the foundation for this dissertation was preceded by a pilot research project in which I spent three months getting to know the dynamics of the OOS program.[11] As a result of what I learned during the pilot project, I decided that the children required time and engagement in order to break down barriers of being asked to talk to a stranger (see Appendix B; Irwin & Johnson, 2005).

Despite attempts to engage in programming and play with children, in order to become as invisible as possible as a researcher to the children, it was clear that the staff at each program had developed a relationship with me that warrants description. I found that because the administration of the three programs was centralized, each supervisor had heard about how my presence affected programming prior to my entering the field. To the staff, I was an extra set of hands; I helped out, I cleaned up with the children, I played with the children, freeing the staff for other duties or relaxation. I made it clear that I was not to have full responsibility for children, yet their assumptions about having another adult in the program must be considered. If staff felt greater sense of control or assistance because of my presence, then it follows that this must have also been a factor that had influence on the children. Even though I was playing with the children, they must have been unable to consider me anything other than an authority figure. I did not discipline the children, intervening on only a couple of occasions at each centre when children were being unsafe. Nonetheless, an older child asked me if I was "*a spy from the place that*

[11] This site was an OOS program centre administered by the same governing body yet was not one of the sites selected for the larger project.

makes sure we are doing OK." Trust was an essential component of my presence between the children, the staff, the parents and myself.

Reflexivity

As an adult with cultural, social, and economic differences to the children in this study, and an outsider to the OOS program and neighbourhood, during participation in the program I realized that I carried with me some personal biases that could be difficult to abandon. Instead of attempting to deny my subjective position, I constantly reflected on my biases and assumptions, which necessarily inform the data generated and the subsequent analysis. Time spent in the setting helped me more adequately to understand the social processes I was observing and events I was hearing about during interviews. This time spent also allowed me to develop stronger relationships with the children and the children's parents, and these relationships in turn allowed me to learn more about the children and the adults.

I spent time in each centre prior to recruitment in order for the children to get to know me. On average, I spent 3-4 weeks participating in programming prior to engaging in interviews with any children. While I attempted to take on a role that was different from those of the other adults (staff), by participating in all aspects of programming (Mayall, 1996), I remained open about my presence in the programs and reminded children that I was doing research (a project for school). I remained aware of how my presence may have changed the dynamic of interactions despite my attempts to become less obvious to the children and staff.

Power Dynamics

While I attempted to diminish power hierarchies within this work, I remained aware of the effect of adult-child relations in this research. Alderson and Goodey (1996) suggest that recognizing the dynamics of power in adult-child relationships may assist us in identifying how the worlds of children are constructed and colonized by adults. However, Erica Burman, a sociologist, has challenged the notion of children's *total* lack of power and states that children possess power that is not overtly recognized within adult-child relationships (1994). Burman's challenge reminds us that children do possess power, which requires us to consider *how* children's power operates within relationships. As the power dynamic inherent in the research relationships formed is evident, I maintained reflexivity about my presence when analyzing the data.

Despite some researchers' attempts to equalize power (Alderson, 1995; Harden, Scott, Backett-Milburn, & Jackson, 2000; James & Prout, 1990), I contend that an imbalance of power remains between researcher and participant in any research relationship. This imbalance is exaggerated in adult-child relationships, as a research project cannot erase the context of adult power that children face everyday in their homes, schools, and communities (Alderson & Goodey, 1996; Alldred, 1998; Harden et al., 2000; Hill, Laybourn, & Borland, 1996). My experience of immersion within this research setting increased my awareness about the issue of power in research involving children and assisted me to consider the role it plays in the research, from process to product as a whole.

This chapter has provided the reader with details of the children and the contexts in which they interact on a daily basis that shape the nature of their lives. These details

set the stage for the following three manuscripts that form the foundation of this dissertation research.

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CHAPTER 3
MANAGING CHALLENGING CONTEXTS: CHILDREN'S PERSPECTIVES OF THEIR HEALTH

Introduction

The field of children's health has changed dramatically in recent years, fuelled by the convergence of advancing knowledge about the interrelationship between children's biology and their early experiences and environments (Shonkoff, 2000). In particular, we now understand the importance of the physical, the social/emotional, and the cognitive/language development of a child as integrally connected to the child's life experiences. How a child develops across each of these domains influences each of health, well-being, and competence for the life course (Hertzman, 2004). While all children live with risks to their health, children who experience multiple or ongoing risks in their day-to-day environments are more likely to experience poor health (Willms, 2002). An important question that has emerged in the literature is, given similar challenging circumstances or risks to children's health, why are many children able to develop well, despite adverse circumstances. Theorists have hypothesized that children's perspectives and understanding of their contexts play an integral role in determining their health trajectories (Grotberg, 1995; Werner & Smith, 1982), but we still do not fully understand the role the child's perspectives play in establishing the connection between living conditions and health outcomes.

To date, the most substantial body of research in the area of child health inequalities has been based on longitudinal studies of birth and child cohorts (e.g., National Longitudinal Survey of Children and Youth [NLSCY]–Canada; National Longitudinal Survey of Youth–United States; 1958 British Birth Cohort). The growing

international body of literature emerging from these data has allowed researchers to "identify and quantify the prevalence and importance of risk factors" in children's lives (Willms, 2002, p. 3). By following large populations of children over time longitudinal databases have provided a wealth of data that reveal factors that place some children at higher risk for poor health outcomes. Some established risks to children's health include maternal health problems, low maternal education, negative parenting styles, living in unstimulating or unsafe family environments, living in neighbourhoods with high crime or overcrowding, living in isolation or experiencing language barriers, and living in poverty without human capital resources (Brooks-Gunn, 1995; Feldman, Hancock, Rielly, Minnes, & Cairns, 2000; Kohen, Brooks-Gunn, Leventhal, & Hertzman, 2002; Kotchick & Forehand, 2002). Kohen et al. found that neighbourhood characteristics such as neighbourhood affluence, low rates of unemployment, and neighbourhood safety and cohesion had direct effects on children's competencies over and above family characteristics. As children get older their interactions and experiences within the neighbourhood increase and neighbourhood characteristics exert a more direct impact. There is substantial evidence within the literature to support the claim that particular challenges, or combinations of challenges, categorize children more firmly as *at risk* for poor health (Willms, 2002). What matters most as social determinants of children's health according to NLSCY data analyses in Canada are family characteristics (education, income, parenting style), neighbourhood characteristics (safety, cohesion), and societal factors (access to "quality" care arrangements) (Hertzman, 2000).

The available research concerning risks to health provides only a partial view of the factors that influence children's health. While very useful, these analyses do not shed

light on how particular risk factors may exert influence in the day-to-day lives of children. Indeed, the actual experiences of children have been largely ignored in the current body of research. Brooks-Gunn (1995) points out that the current analyses of children's health outcomes are not contextually rich, as researchers have not included in their research micro-analytical perspectives of the intersection between individuals and their environments. Despite a call for changes to current research methodologies, contextualization of risks has been limited, and researchers have not embedded their inquiry within the lives of families and children who experience the risks. Understanding how risk is manifested in the lives of children is an important feature of understanding more fully how risk factors influence children's health (Popay, Williams, Thomas, & Gatrell, 1998). Children are characterized as being at risk for poor health because of their living conditions, but we do not understand the individual experience of living within adverse conditions from the perspective of those children who are living through it. The child's perspective plays an important role in establishing the connection between living conditions and health. Children are social actors, who shape and are in turn shaped by their environments; as such, our comprehension of their perspectives is an essential component of understanding the process of health.

Much of the available data on children's health indicates that the first six years of life are crucial for health (Hertzman, 2000; Keating & Hertzman, 1999) and various thoughtful and child-centred qualitative research studies examining children's views in these early years have demonstrated that very young children can provide important insights into their health and contextual experiences (e.g., home, homelessness, school, hospital). Young children have provided key perspectives on the experience of living in

violent homes, the experience of homelessness, living with chronic illness, the experience of painful procedures, and children's experiences of cancer (Bluebond-Langner, 1978; Eriksen & Henderson, 1992; Flatman, 2002; Smith Percy, 1995; Woodgate & Kristjanson, 1996). In addition, Elliot and Watson (1997) found that children as young as four years of age were capable of understanding and expressing ideas about their healthcare experiences.

Research findings have also demonstrated that young children are capable storytellers in a variety of differing contexts (Goin & Wahler, 2001; Haden, Haine, and Fivush, 1997; Irwin & Johnson, 2005; Oppenheim, Ayelet, Warren, & Emde, 1997). For instance, in the Goin and Wahler study (2001), children as young as six years of age were asked to talk about the quality of their relationships. Analysis of the children's narratives for coherence, accuracy, and stability revealed that personal narratives were an appropriate mechanism for providing insight into children's relationships at home and at school. Studies involving children have provided accounts of children's emotional and interpersonal relations through utilizing naturalistic methods of interviewing, combined with detailed close observations of children in their everyday lives at home, at play, and at school (Goldman-Segall, 1997; James, 2001; Little & Lopez, 1997; Woodgate, 2001). It is clear from these studies that very young children can participate effectively in the research process (Christensen & James, 2000) and provide important insights into what matters in their lives.

While research concerning children's health has provided an awareness of various factors associated with their health, there remains a scarcity of research focusing on children's perspectives of the contexts (family, school, neighbourhood) in which they live

and grow in combination with in-depth observations of children over time with an analysis of how these contexts shape children's health. Using ethnographic methods, I entered the lives of 14 children (6-7 years of age) during their after-school time who live in a neighbourhood that has been demonstrated to have characteristics associated with moderate to high risks to health. I explored with them and observed how living in these contexts influences their understanding of health. The purpose of this paper is to generate knowledge that illuminates the social contexts of children's lives, and to show how these contexts influence aspects of their lives that are integral to their health.

Methods

The Ethnographic Approach

The setting for this ethnographic research was a children's after-school care group, located in a neighbourhood within a large urban setting. Twenty-five to thirty percent of children in this neighbourhood scored in the vulnerable category on the Early Development Instrument—a group level measure of children's readiness for kindergarten—measuring performance on physical health and well-being, social competence, emotional maturity, communication skills and general knowledge and language and cognitive skills (Hertzman, McLean, Kohen, Dunn, & Evans, 2002). This neighbourhood could be characterized as having a complex of mid to high range of neighbourhood factors associated with vulnerability (see Chapter 2). While these neighbourhood characteristics influence children's health, it must be noted that this neighbourhood is not the most vulnerable within the larger urban setting.

Ethnographic research[12] involves the systematic exploration of a particular social or cultural setting. Ethnographic traditions are grounded in a commitment to the immediate experience (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001). For the purposes of this study, I focus this systematic study on uncovering first-hand shared health ideas, beliefs, knowledge, networks of meaning, and practices of young children. The aim of ethnographic researchers is to produce dense descriptions of contexts, using participant observation (Emerson, Fretz, & Shaw, 1995), which allow the ethnographer to observe not only what people say but also what people do in their everyday health practices. To meet this goal, ethnographic methods require total immersion in the field of study, getting to know the dynamics of the setting and the children involved. Thus, many hours were spent at the children's after-school care program, participating in the daily programming and getting to know the children. This immersion makes ethnography well-suited to research involving children as children are generally wary of unknown adults and therefore require more time to establish rapport with the researcher (Eder & Corsaro, 1999; Irwin & Johnson, 2005; Qvortrup, 2000). Historically, language has been viewed as the primary route of entry into culture (Van Loon, 2001). However, an underlying assumption of participant observation, and rationale for its necessity, especially with children, is that certain knowledge embedded in practice may not be accessible through language. We can gain important insights into this knowledge through observation.

Data Collection

Data collection occurred over a period of 12 months and involved tape-recorded one-on-one interviews with each child; administration of parent questionnaires; notes

[12] What is included here is an overview of ethnographic methods and additional theoretical material is available in Appendix A.

from informal conversations with both children (3-4 informal discussions) and their parents; and 400 hours of participant observation of children.[13]

A semi-structured interview focusing on children's perspectives of home, school, and neighbourhood in relation to their health, guided the one-on-one interviews. The interview questions focused upon issues such as their perspectives on what is health, what makes for healthy families, what neighbourhood spaces (real and imaginary) should be like, resilience markers,[14] as well as the child's school functioning and enjoyment. One way to augment interviews with young children is through the use of visual cues, which allow us to explore what may not be immediately accessible for young children through words; therefore, photographs of the children's neighbourhood (roads, signs, traffic, playgrounds, schools, parks) were used in conjunction with the questions during interviews (MacDonald-Carlson, 2003). Each child was asked to describe what he or she saw in the photographs presented by the researcher. In addition to the interviews, informal conversations were used to clarify previous interview data, talk about immediate social circumstances, or ask the children specific questions about their health. Thus, interviews, informal conversations, and photographs offered the children a range of avenues through which to express themselves.

Parents completed questionnaires and were engaged in multiple conversations about their child's health. These conversations focused on the same home, school, and neighbourhood influences on their children's health. Parents were asked additional questions about family structure, maternal and paternal education, occupation, family

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[13] Observation and participation are characteristic features of ethnography. (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001)

[14] Resilience checklist questions (Grotberg, 1995) were used to gain insight into each child's resilience such as "Do you have someone outside your family that you can tell things to?", "Do you have someone that you want to be like when you grow up? and "do you like to do things well?"

income, adult perspectives of neighbourhood safety, neighbourhood social trust, childcare history, child resilience, child adjustment their child's scholastic abilities, and the time spent with their child (see Chapter 2). While the ethnographic approach would traditionally entail in-depth interviews with parents, I chose to employ questionnaires for gaining additional information about the children and their lives. My rationale for using questionnaires was two-fold. First, I wanted to retain a focus of attention on the children's voices; in consultation with my dissertation committee and other experts, I became aware of the potential for the data from parent interviews to displace the children's voices. Second, given that I was engaged, on a daily basis, in informal conversations with many parents about their children's health, the sheer volume of data generated from additional, formal parental interviews would make the analysis process unproductively challenging. The data gained from parents' perspectives during the questionnaire and informal conversations contributed sufficient depth to the data provided from the other sources, but it is acknowledged that in-depth interviews may have yielded further information.

Children's play and relationship dynamics were observed during participant observations in the after-school care program to establish a better sense of the children's social, emotional, cognitive, and physical health. The collective behaviour patterns, shared ideas, and everyday practices that characterize the children involved in this study were observed over a 12-month period. While limited to one context of children's lives, this observational data became important for describing the contextual influences on children's health that the children were not otherwise able to articulate.

Analysis

Initial analysis techniques included coding of the interview transcripts, developing and connecting conceptual meanings and categories, and recording theoretical memorandums. Coding of data collected from all sources took place as the data were collected (Hammersley & Atkinson, 1995). Analysis and data collection were carried out in an iterative manner, such that prior insights were refined in light of new data, and concepts were developed through the identification of themes and patterns noted in the data. Relationships were then proposed among concepts and tested or refuted with further data analysis. The iterative process involved moving from a close reading of the data to situating insights in the broader context of the data as a whole, and was informed by insights gained from salient theory. Theoretical perspectives and notes taken during data collection provided the foundation for questioning the data, which was, in turn, aimed at developing theoretically sound explanations of the data (Hammersley & Atkinson).

Sample

Three separate after-school childcare programs in this urban neighbourhood were chosen as sites for sampling. Children were selected for this study by virtue of the fact that they lived in or highly identified with this neighbourhood. Fourteen first-grade, six and seven year olds—six boys and eight girls—participated. None of these children had dealt with a major acute illness or ongoing chronic illness themselves or in their families. As data collection and analysis was underway, I began to question whether the data I was getting would be somehow different if a child lived in a neighbourhood that did not have the same levels of vulnerability associated with it. I then purposefully sought out a negative case child who lived in a neighbourhood with low levels of vulnerability for

comparison purposes. While data from this child is not included in this study, the child's perspectives of health assisted me to gain some understanding on the potential overall range of young children's perspectives of their circumstances in relation to their health. This negative case child's perspective and observations of home life and neighbourhood were used as an analytic tool to pose theoretical questions during data analysis.

Participant recruitment processes were not focused on family characteristics associated with high vulnerability yet many of the children who participated in this study did have family level characteristics associated with vulnerabilities. However, some children also had known protective factors associated with their family characteristics. Of the 14 children, 5 were new immigrants with English as a second language. Seven of the children came from homes in which they were parented by single parents (six single mothers, one single father). Although the parents in this study were well-educated which is associated with children's competencies - especially maternal education, most were either not working in their field of expertise (particularly the new immigrants) or were working in minimum-wage jobs (lack of occupational prestige) requiring long hours away from their children. The median income of the families was $25,000 per annum with a range of 10,000 per annum to greater than 50,000 per annum the wide range reflecting the gentrification occurring in this neighbourhood. All parents and children were proficient in English, thus no interpreters were used. The children involved in this study all had shelter (some less secure), most parents were working, and all the children attended an after-school program.

The consent process for the study entailed both parental consent and child assent.[15] Of note, two children declined participation during assent processes after parents had consented to their participation; thus, were not considered for participation in the study. The study that forms the foundation for this manuscript underwent ethical approval from the author's academic institution, and the children's names used within this manuscript are pseudonyms chosen by the children. The children in this study chose quite unique pseudonyms. At first, I felt compelled to change some of the names for ease of reading and others for their implications but then realized that the influences of children's choices contributed an important layer to this study, which is, after all, about the perspectives of children. The names chosen by the children involved in this study are: Kobe Bryant, Dudl, Crystal Gayle, Victor, Annie, Seven-up, Merya, Sabrina, Angel, Martin, Michelle, Eiley, Sarah, and Fish.

Findings

In order to better understand how everyday contexts influenced perspectives of health, the children in this study were asked questions about their families, schools, and neighbourhoods, related to health. The intent was to focus questioning on these three contexts in order to understand their perspectives on social, emotional, scholastic, and broader influences on health. Each interview began with an open-ended question about health. Children were asked if they could describe what it was like to be healthy, what health meant to them, or to talk about healthy activities. The interviews then moved to focus on health in relation to the three contexts drawing attention to family time, play

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[15] Assent, to concur with the decision of another, differs from consent, to provide permission, in that children under the age of 19 years assent to being involved in the study by agreeing with their parents' decision. The issues of assent and consent are discussed in more detail in Appendix A.

spaces, school settings, school achievement, and neighbourhoods. Children's stories were sometimes confusing to the listener and full of contradictions; yet, at times,[16] children presented very clear ideas about their contexts, which provided insights into their individual perspectives of health. What is at issue in these findings is not the veracity of children's accounts, but how their accounts of living in challenging circumstances provide insight into their perspectives of health. Although the children did not always make direct links between their accounts of everyday life and their health, when the full range of data is considered, we can gain some salient insights into young children's worlds of health, which may, in turn, help determine how best to support their needs. Children's stories about their everyday contexts provided insight both directly and indirectly into their perspectives of health.

Children's Perspectives of Health

The children involved in this study live with challenges every day and although they may not be placed in the highest risk category, still exert influence on their health that would be considered enduring. Accordingly, it is essential that the findings about children's distinctive perspectives of health, whether as a general concept or regarding their own personal health, must not be separated from their daily lives. Children talked about healthy food as a component of physical health, the requirements for physical activity, and being happy as connected to being healthy, and, for many, health included distancing the notion of illness. Children spoke of their perspectives of neighbourhoods and school, the importance of play spaces in their wider contexts, and dealing with the limits that *unsafe* environments construct.

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[16] It is important to note that spending time with the children and engaging in multiple conversations and sources of information during this time was another way in which some of the seemingly fragmented stories developed into a more cohesive whole.

Good Food Makes You Healthy

When asked about being healthy, the children who participated in this study articulated a connection between health and nutritional intake. In fact, a few children required prompting to consider anything beyond foods as connected to health. They understood foods as being "*good for you*" or "*bad for you.*" Although many children had a basic understanding of why different foods were *good* or *bad* for them, some children further understood the rationale for making healthy food choices. Victor stated, "*cause it makes you—like—grow strong and tall.*" Crystal Gayle, who loved ballet, related her rationale to a familiar context and suggested that eating healthy would make your "*muscles strong...*[to] *be able to stand on your toes* [like a ballerina]." A few children had a more complex perspective of nutritional health. For instance, Dudl could differentiate whether sugars were good for you or not. He understood health as connected to "*eating healthy food for you <u>most</u> of the time... not eating food with chocolate and lots of sugar... cause sugar doesn't have vitamins*," but some foods such as "*oranges*" have sugar with vitamins, which were good for you. While Merya also distinguished between good and bad sugars, he called good sugar "*ordinary sugar.*" "*Bad sugar*" was the kind that "*you put on foods*" and was also found "[in] *candy.*" Five of the children involved in this study had visible dental carries (Annie, Martin, Victor, Sabrina, Michelle), and many of the same children provided insight into the importance of oral hygiene in relation to their ideas of good and bad foods. For instance, when Sabrina was asked how she stays healthy she said, "[Don't] *eat so much candy. Brush your teeth. Go to the dentist.*" Later in the interview, when asked what she does with her family to stay healthy, Sabrina stated, "*my family stays healthy by going to the dentist.*"

Some of Merya's perspectives of foods were unlike any of the other children and are worthy of mention. Merya seemed to be influenced by his family context (concern for eating healthy foods such as organic and free range) in a way that set him apart, even socially, from other children. Merya was observed to disagree with many of the children during daycare snack time over the quality of foods and their healthiness. The staff at the program mentioned that he frequently verbalized concern over the naturalness of snacks provided, refused to eat much of the daily snack, and would comment to other children about the chemicals involved in processing foods they were eating. For instance, he said,

> *If you're eating something* [junk food] *and it's not organic ... they put chemicals on it and you're thinking good cause it kills the bugs but it sometimes it kills the people. Cause everyday we eat something that— like— something that's not really organic and you eat a little bit, it's okay, then a little bit everyday then you get very sick cause you've been eating it for twenty years. So then the doctor says, "You've been eating some chemicals for twenty years, I'm sorry I can't fix it."*

When asked what kinds of foods he thought were healthy Merya responded,

> *Apple juice and water from Alberta on the mountains, cause there's some glaciers and they got some ice that is bigger than trees.* [It's healthy] *cause no animals live on it. No animals poop in it. Cause there's not a lot of them* [deer and bears].

Merya's family context seemed to be highly influential in his perspectives of health. While I did not speak to his mother at length about her views of healthy eating, Merya had such distinct and differing views about foods; family was his most likely influential environment. He spoke of how his mother cooks him healthy foods and his father "*buys* [him] *almonds and the stuff that grows from the earth.*"

Surprisingly, given the context of economic strain for most families in this study, children not only spoke of how they made good food choices, they also spoke about

abundance of choice. When the children were asked if they could visualize their cupboard or their fridge at home and make a lunch from what they saw, the children did not see disparity or lack of food choice. Sabrina, whose single-mother expressed having a tough time financially, indicated she made her own lunch which included "*peanut butter and jelly sandwich, carrots, juice box, apples and oranges or bananas... sometimes I put — like— candy in my lunch... just for recess... but I eat all the healthy stuff.*" Sabrina was sick with colds and illness and missed school more frequently than others during this research project. She did not participate in active games or sports and although she had an optimistic emotional outlook had the physical signs of poor health—very thin, lack of energy, and dark circles under her eyes. In Sabrina's case, it is quite possible that she sought to portray herself as eating healthily regardless of her circumstances. In turn, we know that parents will go hungry so that children eat well. In general, children's perspectives of food abundance were puzzling at first; however, breakfast and hot lunch programs offered by school and snack provision in after-school care may have mitigated their awareness of food scarcity at home.

The Requirements of Physical Activity

All the children in this study considered themselves to be physically healthy. While they could articulate the need for physical activity as important to their health, for most of the children, family and neighbourhood physical activity experiences outside their after-school program did not always support their perspectives of their own requirements to stay healthy. All of the children except for Seven-up talked about exercise as an important requirement for being healthy. Victor had to be prompted but, when asked why exercise was healthy, said, "*because it makes you grow up.*" Victor's

perspective mirrored many of the other children's responses, but when asked to explain, Victor, like others, could not provide further rationale for why exercise was healthy. Michelle and Annie both suggested "*it keeps your body healthy.*"

Conversations with Dudl's mother revealed that their family had little opportunity to go to parks on the weekend and, as for many others, living in an apartment severely limited Dudl's opportunities for regular physical activity, although he had an interesting perspective about what happens if you do not meet the requirements of physical activity. Dudl suggested that "*if you watch too much* [TV] *your body doesn't move and your brain starts to melt and you can't go anywhere. And if you turn* [the TV] *off, you can still do stuff when you go somewhere and it starts to unmelt.*" Nevertheless, Dudl spoke of going to the park "*Lots and lots... all weekend*" when asked where he played in his neighbourhood. His mother suggested that his stories of regular park adventures were connected to his out-of-school (OOS) program experiences and not his family. Other children in this study spoke of limitations in their free range of play, yet also spoke of regular family outings where they were engaged in physical activity such as picnics, park adventures, and so on. According to parents, however, these outings did not occur regularly. Dudl's mother wondered if Dudl cognitively readjusted his perspectives of their family time to include experiences he enjoyed while at his OOS program.

Merya who "*loved to play basketball,*" talked about the importance of exercise for staying healthy "*cause your muscles get bigger.*" When asked where he likes to play outside, he said, "*outside, I don't really go outside.*" He commented that he is not allowed outside by himself, stating the reason as "*No, I'm not twenty-five.*" When asked if he had friends to play with in his neighbourhood, he said: "*I used to* [have a friend] *but*

he moved out of my apartment." Lack of friends in the neighbourhood, for many of the children, limited children's free range of play due to the physical and social limitations of their living conditions.

Being Happy

Children offered perspectives on emotional health. Their perspectives of emotional health provided insights into a more global picture of health for some children. Some children mentioned, "*being happy*" as part of being healthy, and understood the idea of caring for one's self as connected to health. Seven-up related, "*Well, because when you're healthy it kind of makes you happy and if you're sick it kind of makes you sad because you don't feel so well... loving makes you happy.*" Dudl was asked directly if you had to be happy to be healthy, and he said being sad was "*still healthy.*" When asked to explain he said, "*Cause you get some happiness and some sadness, so they're both good.*" In Dudl's six-year-old way of explaining the requirements for health, it seemed that he was talking about balance. In conversations with Dudl's mother, she talked about how Dudl "*gets down on himself*" about not being successful at things like scholastics. Dudl's unique perspective on happiness may be the result of positive discussions with his parents, yet demonstrates a young child's ability to formulate a complex perspectives of social and emotional issues.

Many of the school curricula in this neighbourhood include the notion of *caring for self* as part of an anti-bullying program. The general idea of *caring for yourself* entered into children's stories. Children seemed to have varied perspectives of this concept, but, regardless, thought to mention it when speaking about health. Some children connected this concept to their physical health; yet, there was always a

connection in some manner to emotional health. When asked if she was responsible for her health at all, Sarah stated, "*I eat good stuff, that's caring about me.*" A few children said that they are responsible for their own health, and Michelle mentioned being healthy meant that you "*take care of yourself... like you wash yourself... you brush your teeth.*" When asked about the purpose of families, Seven-up stated, "*we need a family to take care of us, to make us healthy and make sure we're okay and help us solve problems.*" Seven-up was a little girl who had experienced many emotional difficulties in her previous school because of "*racism*" according to her mother. Her mother recounted how Seven-up had experienced many troubling social encounters with classmates during recess and Seven-up was then expected to enter class and do group work with these same classmates. Seven-up's perspective on how families help you solve problems may be connected to these emotional upheavals she experienced and how her mother helped her through them. As a result, Seven-up, quite possibly, could not see taking care of self as removed from her family. She revealed,

> *Well, taking care of yourself would be hard work and it's not so easy to take care of yourself, either... Cause without someone taking care of you, it's a bigger job for you to do ...*

Distancing Illness

The children in this study did not consider themselves unhealthy, although they could understand health-related issues and could identify physical illness. *Illness* was mentioned, but usually in reference to someone else. I asked children what their families did together to stay healthy. While the children did not include stories about their own minor illnesses such as colds and flu, they were quick to point out family members who were sick. Four of the children in this study could not call to mind events or experiences

that their family did together to stay healthy possibly because someone was currently sick. Children immediately volunteered when a member of their family was not healthy: Eiley remarked that her sister was "*sick right now with an infected tooth*"; Sarah referred to her father's "*broken leg*"; Helen mentioned a "*sick grandmother*" when I asked what their family does to stay healthy; and Martin mentioned that his mother was "*sick and taking medicine.*"

A few of the children had recently experienced colds, flu and chicken pox just prior to our interviews. When asked directly to talk about these illnesses, they generally did not talk about feeling sick. While some did mention that feeling sick was not fun, instead, their stories focused on how the illness was fun in some way: Fish got to spend time with "*grandma reading stories*"; Sabrina got to "*ride* [her] *bike with mom*"; Kobe Bryant relayed that he "*had fun at [his] house.* [He got] *to do XBox® because* [he] *was sick* [and] *did a lot of fun things.*" Illness, for these children, was a time when extra attention and "treats" were experienced.

Perspectives about Learning

Since relations in school are important for a child's short-term well-being and, also, their long-term life chances, the children were all asked if they liked school, what their favourite thing about school was, about their friends, and their perspectives of how they were doing in school. When asked what she would change about school if she could change anything, Annie revealed, "*Well, I'd change the books I read. Because sometimes when I'm reading one book I would only know only a little bit of those words.*" The notion of working hard and trying at school was important for most of the children. They recognised that teachers will help them but they must do the work. When asked what she

liked about school, Eiley said, "*You have to do a little picture, but if you do it a little bad, that's okay, just try your best,*" referring to taking responsibility for trying to do her letters in school. All of the children were asked what it felt like to learn something in school that they didn't know about before. Fish's response was typical. He said, "*It's good to know things that you didn't know. It makes me feel good about myself.*" Most children felt some sense of accomplishment when it came to learning in school. Michelle, however, did not divulge a sense of accomplishment or, alternatively, may not see these occurrences in her school life as important. When asked about how it felt to do well or learn in school, Michelle's response to every scenario was it made her feel "*normal.*"

Children's Perspectives of their Neighbourhoods

The young children involved in this study were asked to describe their neighbourhood and talk about their favourite places, even create imaginary neighbourhoods. Many of the children could concretely describe a neighbourhood, and some did this in relation to what was familiar. Kobe Bryant's father worked in the hotel industry, and Kobe's definition of a neighbourhood was:

> *It's a place where some people live and other people live. Like, say I was in a hotel the people close to me or even across the hall would be part of my neighbourhood. If far away they're not in my neighbourhood.*

While most children could define what makes up a neighbourhood, they offered competing (or possibly qualified their definitions) information about their own neighbourhoods. Children had the definite idea that, regardless of where their homes were located, if they did not know who lived in a nearby house, townhouse or apartment, those individuals were not neighbours or part of their neighbourhood, which may reflect a low level of neighbourhood cohesive properties. Fish describes a

neighbour as "*somebody that lives beside you.*" Despite Fish's relative family affluence, high maternal and paternal education and prestigious occupation, these protective characteristics (afford him social opportunities) did not seem to influence Fish's perspectives on neighbours differently that the other children living in this neighbourhood associated with challenges to health. When asked to clarify if a neighbour could live around the corner, he said, "*I think you gotta see them.*" And if they live across the road and Fish does not know them "*they are not neighbours.*" The other children from families in which there was relative affluence echoed these perspectives.

Angel is a little girl who moved during the time of this study and although she could define what a neighbourhood was, when asked about her neighbours and whom she likes to play with in her neighbourhood she said, "*I don't have neighbours.*" Angel lived in an apartment complex. What is interesting about Angel's perspective is that she did not think she had neighbours or friends to play with outside the OOS program. Unlike Angel, when Michelle was asked the same question about whom she likes to play with in her neighbourhood, Michelle considered a friend who lived in another city to be "[her] *neighbour*" even though they have to drive to get to her friend's house. Michelle's father was a single parent and stated that "*it's just us*" in their neighbourhood in reference to socializing with friends. The friend that Michelle referred to in our conversations was the daughter of her father's friend that they visit. During our conversations Michelle mentioned having a friend in her immediate neighbourhood but she also mentioned that she does not get to play with her and stated, "*my dad wants me around*" as a rationale. It is possible that a variety of factors

are influencing Michelle's connection to her neighbourhood—her father's need to have company, neighbourhood safety/cohesion factors, availability of playmates and so on. Merya's perspectives of the requirements of a neighbourhood were also quite different from the other children in this study. He said,

> [a neighbourhood] *is somewhere you live and a lot of people are living there. I don't think I live in a neighbourhood... cause there's apartments... lots of* [tall] *buildings...* [the houses] *are somewhere else.*

Merya did not think his apartment complex and the buildings around it constituted a neighbourhood. Quite possibly because he was not allowed to explore and play in his neighbourhood, he did not have a broad view of what a neighbourhood consisted of beyond houses that were *somewhere else.*

Some children struggled with defining a neighbourhood or had very different requirements for their definitions when they spoke of their *own* neighbourhood. Thus, I used visual cues to elicit a more comprehensive picture of children's ideas of neighbourhood. Sarah's second interview occurred while she showed me around her neighbourhood—what we have called a *kinetic conversation* in which the child directs the interview while walking around her environment (Irwin & Johnson, 2005). Points of interest to Sarah were great hiding spots for Hide and Seek, friends' homes within her housing complex, and the playground area. In a matter-of-fact way, she spoke of places that were dangerous to go, such as the alley where "*six guys beat someone up two nights ago.*" When asked about the physical boundaries of her neighbourhood, Sarah pointed out homes adjacent to her housing complex and stated, "*those are not part of my neighbourhood because I do not know those houses.*" During his first interview, Martin had difficulty describing his own neighbourhood or places he liked to play in his

neighbourhood; Martin's mother stated that he is not allowed to play outside without a family member present. When shown the photographs in the second interview, however, he described the houses in the photographs as his friends' homes or homes of his father's friends. He pointed out that everyone in the photographs knew each other as "*friends*," which seemed to be a requirement for being a neighbourhood and that the neighbourhood was a happy place "*because there's no trouble and no robberies, stealing money, and no killing... there's only happy people.*" The photographs seemed to make the neighbourhood come alive for children. Though it was unlikely, many of the children thought they knew someone who lived in the houses in the photographs.

Children's Concerns of Safety

It was clear that children's physical safety figured prominently in stories about their playgrounds, neighbourhoods, neighbours, and schoolyard play. The contribution that feelings of safety has on children's social and emotional health, as well as how a lack of feeling of safety presents limits to physical activity, is well known. Furthermore, all of the parents in this study were asked if they felt they lived in a safe neighbourhood and although some felt their neighbourhood was "*as safe as any other*," none of the parents felt they lived in a safe neighbourhood for children and a few of the parents felt they could trust others to look out for children in their neighbourhood. These factors would reflect the parents' sense of social cohesion in the neighbourhood. Given their parents' concerns and the current pervasive social context of "stranger danger," it was understandable that the children's perspectives about outdoor spaces focused a great deal on issues of safety. Sabrina talked about strangers in a way that mirrored universal stranger danger teaching when asked about keeping herself safe. She said,

> *Like—if there's a stranger...you shouldn't go too close to them. Like—if they're trying to give you candy... don't you shouldn't take it because it—like—when you got closer and closer to them they could grab you.*

In fact, despite having spent a couple of months on a regular basis with Merya, when he was describing his neighbourhood to me he said, emphatically: " *I don't have to tell you my address because you are a stranger.*"

Most of the children talked about their worries about safety and stated that they might be "*lost*" or "*stolen*" if adults did not look out for them in outdoor spaces. Crystal Gayle, like some of the other children, did think that a few of the spaces depicted in the photographs were safe and when asked to explain why she said, "*because there's nobody there outside.*" This requirement was connected to their worries about being stolen or lost and if there were no adults to be wary of in the photographs the children would feel safe playing in the spaces. Fish said he did not play outside without his parents because "*someone could take* [him]." Some children made surprising links to being stolen or lost. For instance, when Merya was asked how he takes care of himself, he responded by saying, "*so no-one steals you and so you don't die before you're supposed to die. You hold your mother's hand and you don't run away.*" At this juncture in the conversation, the idea of safety had not surfaced until I asked about how he takes care of himself.

Children were also able to articulate how they were responsible for their own safety and could differentiate their responsibility from that of parents or significant adults. For instance, Sabrina mentioned that she liked school because "*it's safe.*" When asked why her school was safe, Sabrina suggested that "*I don't play where the— like— where the fences are the open fences... because sometimes it can be dangerous... someone could steal you.*" Although during interviews either the child or I may have

introduced the notion of safety, the children responded in various yet surprising ways to the topic. Like Sabrina, Michelle was not asked directly about safety; rather, the interaction began with questions about her neighbourhood.

INT: Is there anything you don't like about where you live?

M: *A bad person lives there near my house. Cause every time I see him he's—like—wearing all black. And he has a knife.*

INT: How do you know he's got a knife?

M: *Hm hm. Cause he's hiding it, I bet.*

INT: So what do you do when you see this person?

M: *I tell my dad.*

In subsequent conversations with Michelle, the man wearing black came up in her descriptions of her neighbourhood. Interestingly, when Michelle was asked to imagine the best neighbourhood possible for children, she described her imaginary neighbourhood as "*a happy place*." While one might expect that children would create a happy place when given a chance, Michelle's stories about her daily life were somewhat indifferent. Michelle's outlook on many issues was less optimistic than other children and in observations of Michelle she seemed to have less consistent social interactions (adult and peer related) and less consistent network of friends.

Eiley stated that she didn't have any friends in her current neighbourhood, and Eiley's mother said she imposed a very strict range of movement on Eiley due to safety issues. When asked to draw a picture of her neighbourhood, Eiley drew the following picture:

Figure 3.1: Me and Momma

Eiley describes the drawing of her neighbourhood as "*me and momma.*" Although Eiley has an older sister, neither child is allowed to play in their own back yard without adult supervision because of the proximity of a public path. People walk through the backyard and, throughout our conversation Eiley seemed to connect her experience of neighbourhood to her playtime with her mother, possibly because concerns of safety limited her range of experiences. Despite these concerns, when asked directly Eiley indicated she thought her neighbourhood was "*safe*" although her mother suggested that it was not safe.

Perspectives Shaped by Family Mobility

For many of the children in this study, family mobility may have contributed to their particular perspectives of their environments, whether due to feelings of lack of safety or feeling less connected to their places of living. Some children blurred the lines between their old neighbourhoods and where they currently lived. Many of the children

who had relocated would include friends they no longer played with, places they no longer had access to, and historic events in their stories when talking about their current neighbourhoods. For instance, Seven-up talked about playing in a park at the beginning of our interview as if it was in her current neighbourhood. When asked for clarification later on, she eventually identified that the park she had spoken of was near her old school in her old neighbourhood. As Seven-up was drawing the picture of her current neighbourhood, included below, I asked her if the green areas were parks and, although there is a park close that her mother said they had been to, Seven-up said there was "*no green*" in her current neighbourhood but that she wanted to put it in "*because* [she] *liked grass.*" When asked directly if there was park close to her house she replied, "*I don't think so.*" Seven-up lived on a busy four-lane thoroughfare, and her picture quite accurately represents the corner near her home.

Figure 3.2: Seven-up's neighbourhood

Similarly, throughout our interview, Eiley kept referring to her old neighbourhood and school. Even though it was clarified for her that I was interested in where she lived now, it seemed that it was somehow easier for her to talk about her old neighbourhood and school because the questions focused on what she liked and where she played. Her mother stated that Eiley was having a "*difficult time with scholastics and friends*" since the move (she also moved schools after the first four months in her new neighbourhood) and, quite possibly due to her restricted free range of play, could not answer questions about *what she liked* in her current neighbourhood.

Identifying with the Neighbourhood

A child's sense of belonging can develop through various mechanisms regardless of family mobility; however, although parents were not asked questions about whether they identified with their neighbourhoods, many of the parents in this study felt compelled to cast themselves as different from others in their neighbourhoods during our informal conversations. One parent suggested that she did not associate with her neighbours because of their poor parenting practices and described many of the parenting transgressions of her neighbours. Many suggested that they couldn't count on adults in their neighbourhood—a reflection of social trust—to look out for their children, while most did not feel they lived in safe neighbourhoods.

A few parents cast themselves as living in the neighbourhood temporarily. One father's perspective differed; he explained that he did not know his neighbours and said, "*I am not saying that they are bad people but they are not stable.*" Their neighbours on the one side of their house were always changing, so they did not try to get to know them. His daughter Annie's definition of a neighbourhood is, "*It's like somebody who lives*

beside you and you know her or him. I only have one neighbour." Annie, like other children in this study, considered knowing people a requirement of calling them neighbours. One mother moved in order to provide her daughter with a "*better*" neighbourhood, but found the move problematic, and talked of plans to return to her old neighbourhood. Of her new neighbourhood (the one in which they lived during this study), she stated, "*we don't belong here, we are outsiders here not* [of the dominant culture]." She described themselves as "*nomads.*"

It is not surprising that children's perspectives often echoed their parents'. One child participant spoke of how her current house was "*not* [her] *real house*" they just "*borrow it to sleep.*" In subsequent conversations about her neighbourhood, she identified an overseas country that she visits yearly as her "*home.*" Kobe Bryant asked me if he could call his country of origin and his residential country *home.* His lack of clarity on identifying where he belonged may be a function of family perspectives and may reflect a lack of identification with his residential home.

Discussion

> When you are little, you can believe two things at once.
> Ann-Marie MacDonald (2003, p. 25)

The children involved in this study live with multiple challenges to their health as well as protective factors in their everyday lives; yet, for the most part, they maintain positive outlooks about their health. Despite living with characteristics associated with vulnerabilities at the neighbourhood and family levels, the children's perspectives of their health and their healthy outlook about their lives creates a picture of these children as thriving. The enduring nature of these perspectives is of utmost concern to those

interested in affecting children's health trajectories. It was not expected, given their developmental stage that these particular young children could consider the more complex notions associated with being *unhealthy*; in fact, given their reluctance to discuss even minor illnesses, it seemed that children struggled with the idea of being unhealthy. Nonetheless, upon analysis, the children's stories revealed fundamental information about their connection to place, the importance of social connections, and their perspectives of physical health.

Children's social, emotional, and physical connection to place is important to their ongoing health needs, as attachment to place can serve to stabilize memories and create an anchor for the self (Gieryn, 2000; MacDonald-Carlson, 2003; Matthews, 1992; Popay et al., 1998). Analysis of the perspectives of children involved in this study did not reveal a robust connection to or perspectives of their neighbourhoods and places of play. Indeed, research with older children (12-15 years) exploring the implications for well-being of children's views of social networks, neighbourhoods, and levels of community trust, has shown that children did not see their neighbourhoods as a positive resource or a source of identity or belonging (Morrow, 2001a). Finding developmentally appropriate ways of enhancing a child's connection to place can foster positive relationships with a child's environment (people, places, things). The young children involved in this study spoke about a lack of physical safety, had mobile lifestyles, and experienced severe restrictions in free range of play outside their OOS programs. These factors may contribute negatively to the process of developing this important connection. Health care and other professionals interested in supporting the health needs of children need to pay attention to how children define self in relation to their environments, with a view to

improving social and emotional feelings of security and self-efficacy. These efforts, coupled with advocating for real improvements in neighbourhood safety, could enhance children's overall health.

Children require a sense of security about their environments. We know that feelings of lack of safety affect a child's world of active and creative play in venues such as playgrounds and other neighbourhood settings. Wilson (1987) has proposed that living in disadvantaged neighbourhoods is associated with social isolation. These parents' practices tended to be what Shonkoff and Phillips (2000) would classify as the extreme-protection end of the range of strategies for raising children in neighbourhoods associated with vulnerability. The parents involved in this study revealed their lack of feelings of social trust and worries about children's safety, which reflects neighbourhood cohesion. The children and parents involved in this study live in a neighbourhood in which their fears of safety and crime may outweigh the actual moderate to high crime rates. Risk reduction education assists children to be aware of the *potential* dangers in their environments, while the children in this study live in a context in which they recounted stories of men with knives, beatings in places of play, and robberies. Undeniably, the perspectives of children who participated in this study are so heavily focused on their concerns about safety, that it raises the question of where these children *do* feel safe. Possibly because of our social context of living in fear, imagining safe spaces is not possible. People living in privileged neighbourhoods also experience worries about crime and lack of safety and children receive the same risk reduction education. As suggested by Jencks and Mayer (1990), affluent neighbourhoods may differ in that they have adults

that monitor children, serve as role models, or make use of informal social control contributing to children's feelings of relative safety.

Alternatively, when children are presented with hostile environments (or a perception of lack of safety), they may construct an account of neighbourhood that is unlike an adult's version of the confines and boundaries of a neighbourhood: one that may not be fully recognized[17] in this analysis. Children involved in this study may have had a *different* perspective of their contexts than one might expect. It is possible that the inner city children, having limited experience due to concerns about safety, seem to be narrowing their range of vision based upon this lack of neighbourhood engagement experiences, and thus their range of resources and possibilities of describing their neighbourhood. In a national study with older children living in adverse neighbourhood conditions aimed at exploring their experiences of neighbourhood and the connection to health (aged 12-15 years), Morrow (2001b) found that children defined *community*[18] differentially sometimes considering school their community. As researchers, we must consider that children's views may not conform to our adult definitions of community because experiences and opportunities may shape their perspectives in limiting ways. Given what we know about how integral children's sense of self and their sense of belonging in their environment are to their social and emotional health, we need to discover mechanisms through which to help children develop a stronger, more comprehensive connection to place—however they define it.

Many of the children who participated in this study had experienced a high degree of residential transiency, which can shape children's health. If a child experiences

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[17] By this I mean that I have not considered this possibility to its fullest extent through textual analysis.

[18] While Morrow uses the term community in her research she is referring to a physical space.

multiple moves, how do they establish an important sense of connection to place, friends, and a sense of personal security? The literature shows that families who have few financial resources move much more often than other families, and residential turnover decreases social integration in communities (Ross, Reynolds, & Geis, 2000).[19] Exposure to enriched adult-child social experiences, positive parenting strategies related to a sense of belonging to place, and other environmental factors may protect and enhance children's perspectives of place and buoy their sense of self in relation to their environment. In the absence of cohesive communities or enriched adult-child experiences, other mechanisms can be provided to positively shape a child's perspectives of their contexts.

The children in this study spoke of lives in which they experienced restricted range of play: restrictions that not only severely curtailed their opportunity for physical activity, but also put limits on their socializing within their neighbourhoods. Research findings have revealed that children who live in neighbourhoods with crime, crowding, and lack of cohesion experience a more restricted range of play (Matthews, 1992). When an historical perspective is taken on children's range of play in their environments the tables have turned; whereas children from less affluent neighbourhoods enjoyed free range of play 30 years ago, they now are severely restricted in their movements. Conversely, children from affluent neighbourhoods now enjoy less physical restrictions on their range of play. Furstenberg, Cook, Eccles, Elder, & Sameroff (1998) suggest that families formulate different strategies for raising children in neighbourhoods with characteristics associated with adversity which can range from extreme protection to

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[19] We must keep in mind that Ross et al. (2000) also point out that residential stability does not necessarily translate into social control.

becoming actively involved in developing social networks to enhance children's safety. Most children involved in this study either did not have friends in their neighbourhood or were unable to bring to mind their playtime or friends' names. Play provides an important socializing function, beyond the merits of being physically active, in which children learn about and negotiate identity and the social subtleties of relationships (James, 1993).

The children involved in this study could articulate the requirements for physical health: regular exercise, healthy eating, and freedom from illness. In fact, when asked about illness, the children seemed to distance illness as happening to someone else or chose only to talk about the positive aspects of their own acute illnesses. These findings mirror, to a certain extent, other research with children about their perspectives of health (Backett & Alexander, 1991; Eiser, Patterson, & Eiser, 1983). Backett and Alexander asked children to talk about their own health and the health of others. Their findings show that younger children think of their parents as being healthy, despite poor health behaviours. They suggest that this may be related to a lack of awareness of parents' unhealthy behaviours such as smoking or drinking. Eiser, Patterson and Eiser spoke to children about their perspectives of health and the limitations they discovered in the six-year-old children's knowledge were explained by age-related cognitive development. The children involved in this study demonstrated a more comprehensive overall perspective of health and illness than the children in these previous studies. Children's health education has changed over the 10-20 years since these studies were published and I would suggest that the children in the current study quite possibly sought to cast themselves and their families as healthy by distancing the idea of illness. The nature of children's worlds is complex and their acquisition of knowledge is not straightforward

yet we must still support children to develop the necessary knowledge for healthy living while managing their need to define their lives in their own way.

Despite their positive outlooks, children's descriptions of their lives did not correspond to their articulated needs for physical activity. Parents spoke of being unavailable to monitor children due to long work hours, and the parents' activities of choice during family time were focused indoors. Many of the children in this study seemed to adjust their accounts, or alter the circumstances around their physical health opportunities, when recounting their stories. When faced with a disconnect between what children understand is essential for physical activity and lives in which many restrictions are placed on their activity, it is understandable that children might adjust or remember their active times to fit their own perspectives of the requirements of health. While these alterations may help children cope emotionally with their realities, we need to support children's real need for physical activity despite their contextual realities. The children who participated in this study, like many children with parents who work long hours, require neighbourhood programming focused on health opportunities that support their need to run, jump, and engage in social connections with friends during play in the after-school hours. Since the children considered themselves physically healthy, it is possible that opportunities for physical activity did occur during the school and after-school hours to bridge the chasm between their social circumstances and their perspective of the requirements of healthy living.

During the course of data collection, the financial constraint that families experienced became apparent, as parents spoke of being unable to pay rent, or pay the fees for their child's daycare, as well as other stresses of living without economic

resources. The tone of abundance in the children's accounts of food sources required further investigation. In order to probe these ideas further, the children were asked to talk about what they saw in their own fridges and cupboards. Children still spoke of abundance of choice at home. It is possible that children might experience a tension between what they are taught about health and healthy eating and their social realities. Health education messages for children such as *if you eat healthy, you will be healthy* may affect children in ways that are not readily apparent to educators. For instance, when faced with daily poverty a child may have no means for making sense of the lack of availability of healthy food. It is quite possible that children sought to portray their lives as different from their realities, and this in and of itself is an interesting finding. Health educators (nurses, teachers) must be aware of how "cookie cutter" versions of health education might affect some children who live with adversity. We need to look to the broader social context within which these children live, to understand why children might present a different picture to an interviewer, and consider the implications of working with children who might be quite skilled in representing a reality unlike their own. Alternatively, the children involved in this study may not perceive a lack of resources due to buffers present in their lives that should be explored further. One such buffer is the possibility that parents went without food sources in order for their children to eat well. The school programs within this neighbourhood involve providing children with breakfast and a hot lunch. It may also be possible that these programs buffer a child's reality of healthy food availability. These programs may also assist parents by reducing the financial constraints of providing meals and snacks to children while at home.

Early childhood health specialists are proposing frameworks for intervention that support children's health which include: civil society, universal, targeted and clinical interventions. These various levels of intervention will to help communities who are interested take responsibility for and support children's health needs. Hertzman and Kohen (2003) suggest that "creating the conditions for healthy child development calls for a profound degree of inter-sectoral collaboration" (p. 5), and Kingsley (2003) talks of a "community building approach" and giving communities a voice in planning their early childhood development strategies (p. 6). The findings of this research add a voice to these existing perspectives: the youngest voice. What would it take to create cohesive communities by mobilizing neighbourhood resources to create broader agendas for children's health? Our research, policies, and practices need to focus not only on good quality programming within targeted areas of vulnerability to support children's health needs and universal programming for all but also on creating safer social environments that support children's health.

The perspectives offered by the children in this study point to the need for health programming to include both universal and targeted physical activity for children who live in unsafe neighbourhoods, food provision for healthy eating, initiatives for creating safer communities, and programming whether in schools or after-school time that includes social and cultural events to help children create enduring relationships with their neighbourhoods or communities. While these recommendations focus on contextual influences outside of the family,[20] health programming must also consider supporting

[20] I recognise the important relationships that families hold for children. However, given the practicalities of parents who work long hours, the focus of this paper has deliberately been upon the outside influences in children's lives that professionals can affect.

families to best meet their children's needs to play, make friends, and feel connected to their place of living, through participation in their home environments.

Limitations

These findings have some limitations. Although interviewing children of various ages, and with various contextual influences would have provided rich data, the age-limits in this study were imposed in order to maintain a focus upon younger children's experiences. This study was also limited by access to participants. Although I made all attempts to gain access to children who are more vulnerable by virtue of their neighbourhood of residence, it is acknowledged that targeting research participants who are most vulnerable is fraught with obstacles. The research then is focused on a less vulnerable population in general as it includes children from a diverse socioeconomic background, some children have protective factors associated with family, and some children also have increased vulnerability because of family factors. The range and mix of protective and vulnerability factors were not explored further.

Summary

This study has generated valuable knowledge that illuminates the social contexts of children's lives, and how these contexts influence aspects of their lives that are fundamental to their health. The contexts of home, school, and neighbourhoods are the primary environments for supporting children's health potential, and children's perspectives of these environments form an integral part of their health. If we describe the children in this study, we find young children who are optimistic about their health despite their day-to-day challenges. These findings provide rich insights to what we, as a community, should address in order to improve the life chances of our youngest citizens.

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CHAPTER 4
MANAGING CHALLENGING CONTEXTS: OUT-OF-SCHOOL CARE PROGRAM'S INFLUENCE ON CHILDREN'S HEALTH

Introduction

The state of knowledge regarding the health outcomes for children living in social and economic deprivation is particularly robust (Chase-Lansdale & Gordon, 1996; Levanthal & Brooks-Gunn, 2000). Neighbourhood characteristics associated with disadvantage have a host of negative impacts on the educational, recreational, and social environments for health. Children who live with multiple or ongoing challenges associated with their day-to-day environments are more likely to experience health deficits (Willms, 2002). Some of the recognized neighbourhood characteristics associated with vulnerability for children's health include living in neighbourhoods with high crime or overcrowding; living in isolation; living in areas with high economic deprivation (Hertzman, 2000). For many families, the neighbourhood-level disadvantage is layered on top of family-level characteristics that pose particular risks to children's health such as maternal health problems; a low level of maternal education; living in unstimulating or unsafe family environments; negative parenting styles; experiencing language barriers; and living without human capital resources (Brooks-Gunn, 1995; Feldman, Hancock, Rielly, Minnes, & Cairns, 2000; Kotchick & Forehand, 2002; To et al., 2004). Despite the many challenges identified in the research literature, one resource has been proven to mediate children's well-being: access to and participation in good quality childcare (Eccles, 1999). Given what we currently know about health outcomes, scholars have encouraged innovative ecological examination of the mechanisms that produce and foster particular positive health outcomes (Earls & Carlson, 2001). Taking up this challenge, in

a study examining children's perceptions of their health, I explored whether or not out-of-school (OOS) care shapes the lives of these children who live in a neighbourhood with characteristics associated with vulnerability—if the OOS program shapes their lives in positive ways. A sound understanding of the processes that predict positive health for young children, despite their exposure to challenges from neighbourhood and social conditions, has significant implications for prevention, intervention, and policy.

The early school years (ages 6-9) are marked by important biological and cognitive changes that occur concomitant with movement into the wider social context as young children's interactions with neighbourhoods, peers and institutions outside their family increases. We know children's health can be influenced by appropriate intervention as children move from home into these wider social contexts (Erikson, 1968; Morrow, 2001). The early school years have also been identified as a critical timeframe for intervention to mediate the effects of living with health challenges (Doherty & Stuart, 1997), and an emerging body of research has uncovered the benefits of institutionalized care settings in the out-of-school hours for school-aged children (Eccles, 1999; NICHD Early Child Care Research Network, 2004). Cognitively, children in this stage develop the ability to reason, take the perspective of others, and develop learning and problem-solving strategies that they will carry with them throughout their lives (Eccles, 1999). Children form their personal identities in relation to others and forge their orientation toward learning and challenges in life during this period. It is during the early school years that children begin to recognise themselves as successful or not in their daily endeavours. School is a key setting in which children's experiences can be properly supported; however, OOS programs provide an equally important alternative setting that

can further shape a child's health and, also, their perspectives of health outside of the structured setting of school.

Out-of-school childcare programming is typically offered to schoolchildren 5-12 years of age, and the demands for programming have been steadily increasing in many communities. Changing demographic patterns, single-parent households, and changes in social programs (e.g., work for welfare) have resulted in a significant shift in childcare arrangements for hundreds of thousands of school-aged children during the out-of-school hours (British Columbia, 2003; Hofferth, Brayfield, Deich, & Holcomb, 1991).[21] In British Columbia (BC) alone, there are an estimated 27,000 children in OOS care; 20,000 of those children are between the ages of 6 and 9 years (British Columbia). While program types may vary, they share common activity structures such as organized games, free time, quiet play, physical activities, snack provision, arts and crafts, cultural awareness activities, homework help, fieldtrips, and opportunities for interaction with adult caregivers (Halpern, 1999).

The benefits of participation in OOS programming have been noted in all domains of health: physical, social-emotional, and language/cognitive. Out-of-school programs that support children's health across the health domains have also been shown to buffer the effects of living in challenging life circumstances (Eccles, 1999). Studies have shown that children who experience the greatest disadvantage or risks to their health benefit the most from quality OOS programming. Out-of-school programs can perform many positive functions, including protecting children who face daily life challenges from neighbourhood conditions; providing significant adult figures to model positive social

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[21] The definition of out-of-school hours varies with each individual situation, but for the purpose of this paper it is generally considered to include before-school care (0600-0900) and after-school care (1500-1800) hours.

and emotional behaviours; providing safe play spaces for activity; and providing much-needed nutritional intake for children. Research involving children from low-income families living in neighbourhoods characteristic of high crime, who participate in OOS childcare arrangements, have shown developmental benefits such as decreased behaviour and social competence problems (Pettit, Laird, Bates, & Dodge, 1997; Vandell & Shumow, 1999). Furthermore, programs that seek to foster self-esteem and encourage strong cultural identities have helped children overcome academic deficits (Kerrebrock & Lewitt, 1999). Programs that have proven most beneficial to children, in general, include those that offer a balance of structure and child autonomy or choice, and provide a positive emotional climate (Smith & Barker, 2000; Vandell & Shumow).

Financial constraints can create situations in which families with few social resources have little choice for young children to gain care. As an alternative to institutionalized OOS childcare, some children spend the out-of-school hours in *self-care* situations (Vandell & Shumow, 1999). Difficulties have arisen for researchers in defining self-care due to the multitude of types and combinations of self-care arrangements for children. For instance, children in self-care situations may be completely homebound or allowed free range in safe neighbourhoods. Children may also participate in heavily scheduled, adult-supervised activities: piano lessons, soccer practice, Scouts, and so on. Regardless of definition, studies consistently demonstrate that children's age, gender, and maturity influence self-care choices by families; however other factors, such as higher incomes and the perception of relative neighbourhood safety, also increase the instances of children in self-care (Pettit et al., 1997). Evidence would suggest that children who spend time in self-care do not have sufficient opportunities for play, exercise, and social

interaction. Children in self-care are at higher risk for physical injuries, social and behavioural problems, and for academic and school adjustment problems (Kerrebrock & Lewitt, 1999; Pettit et al.). Regardless of socio-demographic characteristics, overall, young children involved in self-care demonstrate poorer developmental outcomes. Even when social class and prior adjustment factors were considered; children in self-care are less socially competent and received lower academic scores (Pettit et al.).

In the current study exploring children's perspectives of their health, the OOS program they attended was found to be supportive for their growth and development, and an influence on the children's own perspectives of their health. We have evidence to suggest that quality OOS programming can benefit children by providing safe play situations, adult supervision, and opportunities for learning and growth, yet we do not know how participation in programs can alter or shape a young child's perspective of his or her health and well-being. While there is an emerging body of literature exploring the contribution OOS programs make to health (ages 5-12 years), the current study focuses on 6-7 year olds who are exposed to challenges from neighbourhood conditions. The purpose of this manuscript, therefore, is to examine the ways in which participation in OOS programs may buffer the contextual challenges faced by children and the influence the program has on their attitudes. Because we know that children play a significant role in their own health, it is imperative that we have a richer understanding of the ways in which we could better instil and support children's positive ideals of health.

Background

This paper is the second in a series of papers examining how neighbourhoods with characteristics associated with vulnerability influence young children's (ages 6-7

years) perspectives of health. As described in Chapter 3, the children who participated in this study lived with multiple challenges to their health; yet, for the most part they maintained positive attitudes about their health. In relation to their health, the children spoke of the necessity for eating healthy foods, and described the existence of an abundance of choice despite family economic deprivation, for many of the children. While children were able to articulate the requirements of physical activity to support their health, they also spoke of real and pervasive concerns about threats to their safety,[22] lack of free range of play, and few opportunities to play with neighbourhood friends. Most children spoke of a lack of familiarity with neighbours, while parents spoke of not belonging in their neighbourhoods and echoed the children's concerns of lack of safety in their neighbourhoods. For the children in this study, the school and the OOS program were places in which both the parents and children placed their trust. The findings presented in Chapter 3 called into question the strength of the children's connection to place; demonstrated a disparity between children's knowledge, perceptions and their contextual realities in relation to health; and revealed a disconnect between a child's social and emotional needs and the social opportunities available within this urban setting. However, the children nonetheless maintained positive attitudes about their health, which required further exploration. During the many hours of participant observation, it became evident that the OOS program provided a buffering of the effects of living with challenging neighbourhood conditions and possibly helped children to maintain positive attitudes towards health in the face of a challenging reality.

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[22] While all children live in a time in which parents warn them of the dangers in their environments, we must consider that the children in this study spoke of robberies, men with knives, men being beaten in their alleyways and more as actual occurrences in their neighbourhood contexts.

Methods

The methodology employed by this research was ethnography. Ethnographic research methods involve the systematic study of cultures and subcultures; for the purposes of this study, these methods are focused upon the shared health ideas, beliefs, knowledge, networks of meaning, and practices of children situated within this urban neighbourhood OOS program. I remind the reader that the neighbourhood chosen was known to have characteristics associated with vulnerabilities for children's health. I spent one year visiting three separate OOS programs in their after-school hours to observe and interview children. I participated in all aspects of programming. For a more detailed description of the recruitment process, the participants and their families, the neighbourhood characteristics and descriptions, data collection techniques, analysis and ethical considerations see Chapter 2, the Methods section of Chapter 3, and Appendix A.

Findings

In order to contextualize the analyses of the multiple sources of data for this research, I point the reader to specific sections in Chapter 2—*The Research Setting: The Out-of-School Program* and *Shaping the research: OOS program participation.* The analyses of data revealed that the OOS program shaped the children's lives in four distinct ways. The OOS program is: their "neighbourhood"; a supportive social context, a safe place for physical activity, and a site for essential nutritional intake. These four elements function in combination, providing a distinct influence on children's perspectives of health, despite their contexts associated with vulnerability.

The OOS Program is *my Neighbourhood*

As described in Chapter 3, the children did not have a strong connection to their neighbourhoods outside of the OOS program, and various reasons were posited for specific children's lack of connection to place; however, the children's perspectives also provided insight into the possibility that the OOS program was the place they most saliently connected to their neighbourhoods: the OOS program *is* my neighbourhood. Children imparted very little information about family time spent in their neighbourhoods. According to some parents, children seemed mistakenly to connect physical activity opportunities with family that were actually offered during OOS program time.

Given the amount of time and the variety of neighbourhood experiences offered by the OOS program, it was not surprising that children seemed to have a unique identification with the OOS program, so much so that they would speak of friends from the OOS program as *neighbours*. For example, Martin spoke of four of the boys in the OOS program as his neighbours. These boys were not his neighbours, nor his school classmates, but the friends that he was observed to play with in the program on a daily basis. Kobe Bryant also spoke of A, one of the OOS program boys that he played with regularly, as one of his neighbourhood friends, yet they do not live close. Most children in this study mentioned "*friends*" as an important part of their neighbourhoods. Still, it was not uncommon for the children to experience lapses in their memories about these same friends' names. Fish and Sabrina both mentioned a neighbour who was a friend, but when asked to talk about their friend said, "*I forget his* [her] *name.*" Sabrina even carried on to say that she doesn't really get to play with this friend. Annie and Victor, in separate

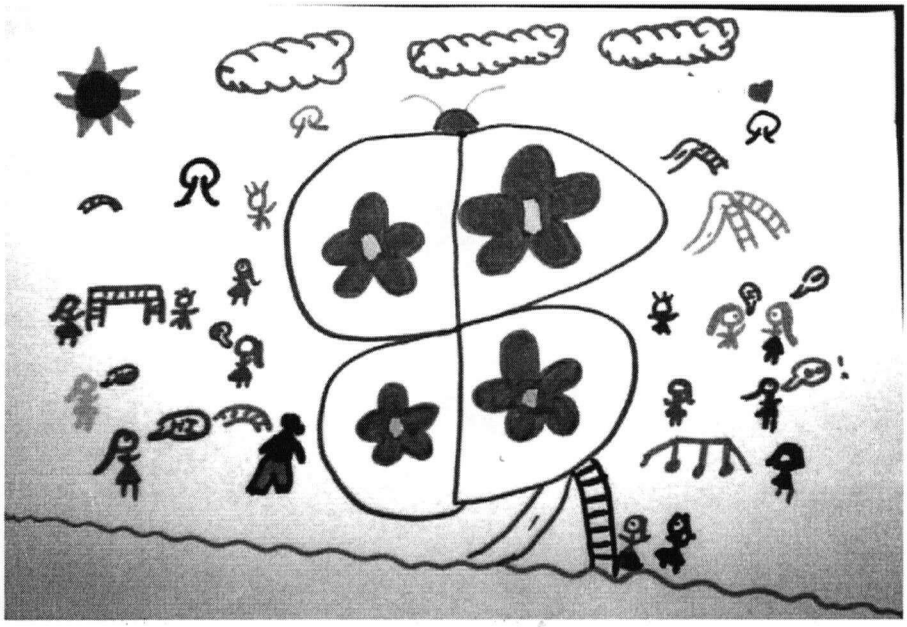
interviews, did not even suggest that they knew their next-door neighbours' names, although they both said they played with them. While not knowing the names of neighbourhood friends may not seem particularly significant, when placed against these same children knowing all of the children's names in their OOS programs (regardless of age group), as well as the fact that many of the children involved in this study suggested they did not have any friends to play with in their neighbourhoods, forgetting a friend's name may be an indication of lack of connection to place for these children.

When viewing photographs of familiar, yet not immediate, neighbourhood streets, children would identify houses in photographs as belonging to friends from the OOS program, although the photos were not of these friends' homes. For instance, Merya, who said he did not have friends where he lived, said, "*see that's T's* [house] *there*" when viewing photographs. T was a friend from the OOS program. The findings of Chapter 3 demonstrated that children articulated many fears associated with their neighbourhood contexts. It is understandable that children identified their OOS program friends as their neighbours, given that their perspectives of their actual neighbourhoods contained unanimous statements regarding places they do not go for reasons of safety such as "c*ause there might be a robber, like in alleys.*" Merya made this observation about an open street corner he viewed in the research photographs.

The children in this study were also asked to draw pictures of their neighbourhoods. Annie drew a picture of a park and, according to her father; there were two parks "*steps*" from their house; yet when asked, Annie stated that there were "*no parks*" in her neighbourhood quite possibly because her range of play was restricted by her family limiting her intimate knowledge of adjacent parks. Interestingly, Annie's

drawing of her favourite place in her neighbourhood contained many children playing in "*a park talking to each other having fun.*" Annie was observed to be a very social little girl who loved to play at the OOS playground. She was physically very active and loved to play games such as tag and to climb on the Monkey Bars. The drawing below includes all the equipment that Annie was observed to enjoy during OOS playground time.

Figure 4.1: Annie's playground



Children's understanding of the requirements of any neighbourhood, while accurate in description, were less than accurate when they were asked to talk about their *own* experiences of neighbourhood. Of significance, children would use their OOS program site as a familiar marker in their accounts of neighbourhoods. Children would confuse distant neighbourhood sites as those near their OOS program. They would consider play spaces safe that they thought were connected to their OOS program. When asked to create an imaginary neighbourhood, children were told that their imaginary neighbourhood could have anything in it and they could bring anyone to visit. For many

of the children, the games (e.g., Foosball), toys, and friends from the OOS program were included in their imagination of the best neighbourhood possible.

A Place of Safety

In contrast to the children's notions of the dangers of playing in open spaces such as parks and neighbourhoods identified in Chapter 3, the OOS program sites were observed as providing a safe and stable environment for children. While the safety of OOS program spaces was not an issue raised with the children in this study, the children did not refer to any perceptions of lack of safety when speaking of their time in the OOS program, although the staff's ongoing vigilance in keeping track of children's comings and goings may have contributed to children's perception of their personal safety. For some of the children, the program was their favourite thing about school and their neighbourhood. When shown photographs of the neighbourhood, the children unanimously asserted that the spaces resembling their OOS program playgrounds were safe, and stated that they would like to play in these places.

The children invariably stated that the playgrounds in the photos "*looked safe*" if they thought the playgrounds in the photos were familiar. Martin stated that the playground was safe "*because it is the one at the OOS program.*" The children in this study consistently attributed positive connotations (safe, fun, and so on) to the play spaces in the photographs if they connected the play spaces to known school or OOS settings. For instance, Angel thought that she would not like to play in some of the playgrounds depicted in the photographs; her rationale was because "*it's not* [her] *school.*" Familiarity was an important component of children's understanding of neighbourhood safety. In addition, the children were observed to participate in helping

themselves and others stay safe during OOS program time by taking buddies with them if they moved out of sight of staff and monitoring peers for boundary violations that would be seen as unsafe. Free-play times occurred at all centres, and during these times, although children collectively monitored others, their play was spontaneous and did not seem to involve worries about others.

A Supportive Social Context

The importance of friends

The OOS program offered opportunities for social connection with other children, staff, and neighbourhood parents. Friends provided socializing and were used as multiple resources beyond direct play opportunities. The importance of friends, while not always articulated by the children beyond their desire for friends, could be observed in interaction. During times of stress at the OOS program, such as when a child was being unsafe (acting out, throwing objects, yelling and crying), the other children looked to their friends for support. When a child was being disruptive, the other children in the centre would first move to their friends, then move away from the physical event together.

The children in this study spoke often of their friends. Friends entered into almost every story told, whether it was a child's way of imbuing a setting with meaning or of relating their favourite elements of their schools or neighbourhoods. In one OOS program, the children drew self-portraits; when asked to talk about their portraits, they were quick to mention which pictures were their friends', and made note of whose portrait was beside theirs, as this was perceived as essential information for me to know. While some of the children also attended school together, many of the children were not

in the same class during school hours. It also became clear through interviews and parental questionnaires that many of the children in this study did not have opportunities for social interaction at home with school or OOS program friends. During summer programming, centres were combined, and children such as Dudl said that he loved it because "*you get to do neat things and I have new friends here.*" The programs provided children with many opportunities for socializing with friends of various ages and, during summer programming, with children from adjacent neighbourhoods. Quite possibly, the 15 to 25 hours a week that children attended the programs was more time than most non-program children would spend in social settings with peers outside of school. Children were observed to play games and participate in sports on a daily basis that were not otherwise available in school or home settings.

The role of the OOS program boundaries

While the children in this study were not observed in social settings at home, the OOS program seemed to provide some necessary boundaries for children's socializing. Children were aware of the rules in each centre, and the rules helped maintain the social order. These boundaries seemed to give the children a sense of control during activities. Boundaries also seemed to provide a sense of comfort for children. If a child's behaviour was inappropriate, the other children would have a tool for identifying the inappropriate behaviour and would be better equipped to solve the social problems resulting from this behaviour. Rules such as sharing or playing fair were of particular importance. Rules were not just important boundaries for children when they were broken; they also provided social opportunities for children. The rules served, at times, as opportunities for positive social behaviour. Children were observed quite often to help a friend clean up in

order to move more quickly onto the next activity, and behaviour such as this supported children in their endeavours to socialize.

Respect was a concept that transcended all areas of play and all relationships at each OOS program. Children were asked to respect others, and the articles that belonged to the program. In some sense, this created a social milieu of belonging, a sense of "everything is ours" and "these are my friends so we must take care." For example, during observations, when two older boys were playing roughly with a ball, one young girl stated, "*if you break it no one will be able to play with it.*" The boys easily understood the girl's concern for the collective needs of the group, and they stopped their actions.

Interestingly, some children most saliently understood concepts such as respect and being responsible for items specifically through the OOS program. Eiley said she knew what respect was because " *it's one of the rules in the daycare...* [it] *means helping people and being nice to people.*" Eiley then took this concept and applied it more broadly, such as, when caring for her cat, she commented "*when somebody picks him up he does not like it...so you have to respect that he doesn't like it.*" In one centre, children were initially publicly rewarded for showing respect for others, helping or playing with someone that they did not know, or helping someone who was hurt or sad. These initial rewards were put in place to help children socialize, to promote emotional understanding, and to help children emulate respectful behaviours. Respectful behaviour became such a part of their daily activity that children eventually forgot about the rewards. Boundaries, such as showing respect and following rules, created a social environment that maintained a sense of order in the children's daily environment.

The contribution of OOS-program social opportunities

Each centre had unique processes for acknowledging children and built upon opportunities in their program throughout the year. These acknowledgements were socially sanctioned and coveted ways of gaining recognition. For example, in one centre during science class, Wise Old Owl was considered the science expert and the first grade children got to take turns wearing the Wise Old Owl mask, which meant that, while they wore the mask during science class, anyone in the group could ask them questions about anything. Being Wise Old Owl was a coveted position, a type of social status for the children. The children learned the importance of listening and respecting Wise Old Owl, and understood that if they played well during experiments they might be chosen for the position next. Wise Old Owl's insights were not to be doubted; thus, a child could be an expert on a subject regardless of "real" knowledge, and all participants knew the activity was only for fun.

The staff of the program identified many of the individual needs of children within their programs as well as the broader needs of the group. For instance, in one program the staff would attempt to engage particular children in physical activity, if they were known to require movement to control their behaviour, in order to facilitate their getting along with others. In another program, the staff were aware of a few children who lacked positive social skills. In order to engage these children in groups, they changed their program to an age-based program so that these particular children could interact with children of their own ages, without having to seek friendships on their own. The staff of the program observed that over time many children who lacked positive social abilities engaged in friendships that assisted them to blossom in social settings, related

well to their first best friends, and were better able to interact with adult caregivers and others.

As with any social environment, not all encounters were positive; yet, when they witnessed altercations or set-backs, staff were extremely forthcoming in helping children choose their language and express their feelings appropriately, and in supporting the children's needs. In one encounter, an older boy was calling Martin names while they played together. The staff member took the children aside and quietly talked to both boys about their actions; after apologies were made, each boy was required to tell the other something about him that he liked. Both boys smiled as the other suggested compliments like "*You're good at Beyblades, Martin.*" Whether another approach to the situation may have been more effective is immaterial; both boys were able to return to their game together with integrity intact and with visibly good feelings about themselves. Beyond providing children with good role modelling and a positive social environment, the staff also provided adult company, which the children were observed to appreciate. Interactions were usually respectful, and most children seemed to enjoy the fun atmosphere created by the staff. Sabrina stated said she liked being picked up last by her mother because "[she got] *the leaders all to herself.*"

Given the nature of the context, the staff were understandably unaware of many unpleasant encounters between children. During one arts and crafts session, a "White" boy was sitting at a table with an Indo-Canadian boy and two African-Canadian boys, and when the "White" boy was not getting what he wanted (more PlayDoh™), he started calling the others "*Brownies*" and laughing. The three boys did not acknowledge the "White" boy with eye contact and physically moved away from him. I spoke with the

three boys about what had transpired, and they said the "White" boy was "*name-calling*" and that wasn't nice or respectful. To call someone names "*broke the rules*" of the program. Somehow, being able to identify the social norms being broken provided the offended boys with a positive resource for dealing with the situation.

Physical Activity

The children in this study were observed to participate in physical activity on a regular basis. All children would participate freely in gross motor activities, although the males were far more likely to play more physically active gross motor games, while the younger girls tended to play at the playground. The staff would encourage all children to play outdoors for at least part of their day. For some, this was the best part of the program, and for others the worst. When speaking of his enjoyment of the physical play, Kobe Bryant, blurred the lines between the school program and the OOS program. When asked what his favourite thing about school was, Kobe Bryant stated, "*...we go to parks and play games.*" While we cannot assume Kobe Bryant was talking about the OOS program, his answers were set in a context of referring to the OOS program as *school.* Kobe Bryant was observed to play sports at the OOS program, but verbalized that soccer was "*his favourite sport.*" Although children were observed to engage in physical activity during the OOS program on a regular basis through sports or games, not all children enjoyed participating. Girls were much more likely to demonstrate the signs of not enjoying the more vigorous physical games they played at the OOS program. Eiley participated in games, but was observed to enjoy the less physical games. When asked what her least favourite thing about school was, Eiley said, "*I don't like Duck Duck Goose...cause you have to run everywhere.*" Again, Duck, Duck, Goose may have been a

game she also played in school, but it certainly was a game she was asked to play regularly at the OOS program. Eiley and Sabrina were observed to ask quite often if they could draw instead of play sports or do gymnastics. Regardless, many of these same children played outside regularly at games such as Hide and Seek, Monkey Bars, Tag, and other physical games that were less structured.

Nutritional Intake

Children attending the OOS programs had most of their daily meals provided. Children's awareness of scarcity at home may be tempered by their environmental opportunities, such as meal provision outside the home environment. Although breakfast and lunch times were not observed in the period of data collection, snack time occurred at the OOS program approximately 30 minutes after the children's arrival. This time was a social time, as all age groups sat together and ate the snack provided. The snack was usually a nutritious meal consisting of some protein, carbohydrate, and fruits. Additional fruits or other snacks were provided for those children who required more during the later program hours. When questioned about the meals provided, Seven-up said, "*In my school... they help grownups there cause they don't have to force you to make lunches cause...we have free lunch...and they make sure you eat it, too.*" Seven-up's understanding of why she got lunch at school was focused on how it makes things easier for her mother. While children were not questioned directly about their OOS program snacks, it became clear that the program was providing a significant contribution to the children's nutritional intake.

Discussion

Within current health inequalities research, there is little dispute regarding the health effects of living in socially and economically deprived environments. Longitudinal research has consistently shown that a socioeconomic gradient in health exists across all populations, with children from poorer families experiencing poorer health outcomes (Hertzman, 2000). The findings of this research add a unique perspective to the current literature. Children in this study spoke of their lives, and in the telling of the stories a broader picture developed, giving us insight into health from the world of a six or seven year old. The findings also provide insight into the complex mechanisms that shape health for young children. Earls and Carlson (2001) remind us of the importance of finding appropriate means to support children's health for those who live with daily challenges:

> The consequence of increased density of poor families is that all aspects of the human ecology suffer. The quality of housing, school, parks and recreational areas, businesses, and transportation facilities all are diminished, and the safety and security of such neighbourhoods are systematically undermined. To grow up in a neighbourhood in which a high proportion of families live in poverty is to experience a context in which demeaning and threatening encounters are qualitatively different from those experienced by a child raised in neighbourhoods in which the great majority of families are economically secure (p 146).

The intention of this research was to begin to understand the qualitative difference that Earls and Carlson speak of, and to understand how this difference affects children's perspectives of health. The OOS program that the children attended may have provided a buffer to their adverse conditions of daily life by providing important opportunities and experiences to aid children in navigating their challenging circumstances thus enabling the maintenance of positive attitudes in the face of a challenging reality. While the

quality of OOS programming is not addressed here, the outcome of analyses of children's perspectives on health reveals that OOS programs may shape children's social, emotional, physical, and behavioural health in ways that cannot be ignored. The findings suggest that the OOS program is developmentally enriching, in that it provides children with a unique connection to their neighbourhood, support for positive social skills, a link to friends, and a site for essential physical activity and nutritional intake.

The children imbued neighbourhoods (read OOS program) with meaning because of the connections they establish with friends and family, and because they hold memories of the places where they spend most of their time living, learning, and playing. The children involved in this study spent 15 to 30 hours weekly in the OOS program. In addition, day-to-day concerns of lack of safety limited their neighbourhood experiences outside of the OOS program, and the lack of parental availability for these same types of neighbourhood experiences may be significant barriers to establishing and maintaining children's connection to place. The OOS program may be the physical and social space to which the children involved in this study most saliently ascribe their memories of neighbourhood, and the implications of this must be taken into consideration.

Neighbourhoods can provide members with a sense of collective efficacy that can affect their health and well-being (Coley, Morris, & Hernandez, 2004; Sampson, Raudenbush, & Earls, 1997). Neighbourhoods that provide a sense of collective efficacy are experienced as protective, involving social cohesion, control, and shared values between members. The children involved in this study could describe *a* neighbourhood, but when asked to talk about their *own* neighbourhoods, the children immediately associated their neighbourhood experiences and friends with that of the OOS program.

What is important to consider here is not whether the children were accurate in their descriptions of their *own* neighbourhoods, but that they chose to speak of what was of most significance for them. In the absence of a wider neighbourhood demonstrating the principles of cohesion for children, perhaps "belonging" in an OOS program provided a microcosm of collective efficacy for the children, shaping perspective of personal well-being in a positive way. This sense of belonging must be partially explained by the identification the children established with friends and staff in the OOS program.

Given the importance of friends and adult figures in children's lives, it may also be useful to consider the implications that the theoretical work of Earls and Carlson (2001) has for this research. Earls and Carlson suggest that, "from the child's perspective, [a sense of neighbourhood] may be best represented in terms of the quality of relationships with teachers, police, neighbours, parents and peers" (p. 145). Children live and learn in relationships with peers and adult figures (Hart, 1997; Heymann, 2000). Adult engagement with youth within neighbourhood settings has been shown to provide a protective role against social and behavioural problems (Coley et al., 2004). Finding ways to foster and support these day-to-day relationships earlier in a child's life may be a first step to providing children with positive role-models that could buoy a children's sense of self and provide a connection to their neighbourhood.

The OOS program did provide the children with unique experiences within their neighbourhood and helped some children make important connections with their wider social context; however, for most children this connection seemed to be limited to the experience of the OOS program. MacDonald-Carlson (2003) has carried out research with young children involving mapping activities as a means to understanding a child's

developing sense of place, and suggests that "[children] need a greater variety of outdoor and cultural events with local meaning that will enrich their memories of community and place [neighbourhood]" (p. 12). While the occasions suggested by MacDonald-Carlson may indeed assist children in making important connections to their neighbourhoods and develop a sense of community, parents who work long hours have little opportunity to satisfy these needs. Other significant adult figures could, however, provide such opportunities to support children's connection to place. The OOS programs are usually located within the boundaries of a child's neighbourhood and provide a stable, enriching environment for children; thus, the OOS staff are well positioned for creating connections to a wider understanding of community for children. Building upon the children's identification with their OOS programs may be one strategy for supporting this important connection to community. For instance, one particular OOS program attempted to foster the children's sense of community by having the children participate in creating a community quilt. Out-of-school program staff used the making of the quilt to help children explore the concept of community (more than physical space) as different to that of neighbourhood and encouraged children's interest in their surroundings, identifying important relationships, experiences and more within their communities. Projects such as this could become part of regular OOS programming curricula, without affecting the programs' essential component of play-based education; in order to begin building the necessary foundations for helping children connect to their communities.

The findings of this research indicate a necessity for exploring the OOS program's importance as a significant socializing agent. The program is unlike the school setting in that it offers children the opportunity to socialize with children from various

age groups; it is less formal; and children in the OOS program experience a greater degree of autonomy with respect to their activities. OOS programs can support children by scaffolding their developing sense of self and assisting them to learn to participate effectively in their social worlds (Hart, 1997; Larner, Zippiroli, & Behrman, 1999). Satisfying children's "basic psychological needs—to achieve competence, autonomy, and relatedness" (Eccles, 1999, p. 31)—is important to overall health. Although the children involved in this study did not make direct links between the importance of a social connection and their health, their stories of health were imbued with connections between health, social opportunities, and friendships. Notwithstanding the dynamic and fluid nature of friendships (James, 1993), children's family availability and concerns for neighbourhood safety precluded much opportunity for socializing. Friendships have an important effect on a child's personhood or social identity, how children define themselves in relation to those around them (Hart, 1997; Hartup, 1996). Friendships facilitate social competence and adjustment in children (Dunn, Cutting, & Fisher, 2002). Hartup suggests that when children have friends, "they use them as cognitive and social resources on an everyday basis" (p. 10). Children seem to understand the subtle social regulations of getting along, and this has profound implications for development of the sense of self (Dunn, 1988).

Children's positive perspectives on friendships within their OOS programs could possibly be attributed partially to the staff's positive modelling, both creating a positive emotional atmosphere and fostering the value of friendships for the children (Hartup, 1996; Pierce, Hamm, & Vandell, 1999). The OOS program provided regular access to, and enabled children to explore, creative and educational play socially with friends and

adult caregivers. Morrow (2001) suggests that children's health and well-being may depend on the degree to which they are integrated into their neighbourhoods in a manner that endorses self-efficacy. The OOS program professionals would be members of a collection of adults within children's spheres of influence who could help buoy their sense of self. Out-of-school program professionals should be aware of the need for them to support a child's sense of self-efficacy, especially as regards techniques for managing within their daily challenges. The OOS program creates social settings that support children's socializing needs and provides an alternative to the school setting for enhancing children's social success. For the children involved in this study, the OOS program provided a means for augmenting their social resources by increasing their networks of friends, providing a place in which they could participate in shared identity, and enhance their sociability (Morrow). When children perceive themselves as successful in their daily interactions, or gain important life skills of problem solving, they are creating the competence necessary for healthy social and emotional development (Hart, 1997).

While the OOS programs may be beneficial to some children, the logistics of keeping the programs running smoothly may diminish some children's developing sense of autonomy. The control the program requires, such as monitoring children's movements, careful timing of games, and so on, may affect each child's perspective differently. A balance between structure and free time during programming is important (Pettit et al., 1997). In research in which children were asked their perspectives on their OOS programs in England, the children stated that they were happiest when they had

some control over the program (Smith & Barker, 2000). In Smith and Barker's study, children experienced OOS programs as spaces of empowerment.

Given parents' employment hours, the children in this study understandably spent very little time in the care of their parents. One hour per day was typical, and this "inability of parents to supervise their children's outdoor play activity may impair their social and cognitive development" (Matthews, 2001, p. 42). Indeed, when parents mentioned spending time with their children, the activities involved walking to and from the OOS program, reading, making dinner together, or watching television; very few mentioned outdoor or social activities with other friends as part of their time spent with their child. Yet children who have restricted opportunities for interaction with positive adult figures (mainly parents) in their lives have been shown to benefit from the involvement of other significant adults in their environmental spheres of influence (Heymann, 2000). The OOS program can provide an alternative to the home and school settings for supporting children's social success.

The OOS program provided children with opportunities for physical activity and high-quality nutritional intake. The OOS program provides children living in unsafe neighbourhoods a protected environment for engagement in physical, social, and educational events. Since the children consider themselves physically healthy, is it possible that the opportunities for physical activity during the OOS program alleviate the discrepancy between their social circumstances and their perspective of the requirements of healthy living. In addition, given the recent concern over the rising incidence of childhood obesity (Campbell, Waters, O'Meara, Kelly, & Summerbell, 2004), the OOS program could be utilized as an alternative institution to school that provides the

necessary physical activity and nutritional intake for children living with risk to their physical health. The OOS program provided regular and play-based exercise for the children, children who otherwise are not allowed to play in their neighbourhoods, have few friends outside the program, and have parents who work long hours and cannot supervise the physical activities necessary for healthy development.

Many of the children in this study live in a context of poverty; yet, most children spoke of healthy foods as readily available. Knowledge of their contexts may lead one to question whether this is *true* to their experience of nutritional intake. However, it is quite possible that for some children the opportunity to eat fresh fruits and vegetables daily in the OOS program transformed their perceptions of food availability. An alternative to institutionalized care for many families living in poverty is some form of self-care for children, as self-care arrangements are an established feature of social life. One fifth of school children spend some time alone at home. Almost 30% of these children are between 6 and 9 years of age (Gillis, 1995), and these findings are more dramatic for children from low-income families. We know that children who spend out-of-school time in self-care situations are more inclined to eat poorly and make poor food choices, such as convenience foods. Further, working parents may be more comfortable knowing their children in self-care are entertaining themselves indoors after school, rather than in a potentially unsafe outdoor space. The restrictions this situation imposes limit opportunities for gross motor activity and contribute to the shaping of these children's overall physical health.

The findings of this research suggest that the OOS program was strikingly connected to children's health. Halpern (1999) has pointed out, however, that key

institutions in children's lives are experiencing more pressure to meet obligations to families, while families are increasing their expectations of their children's places of play; the combination creates a burden difficult for existing OOS programs to shoulder. Halpern points out that it is dangerous to assume that participation in OOS programs should nurture the basic skills of sense of worth, competence, and so on. Mayall (1994), a sociologist who has completed extensive research with young children concerning negotiating health at home and school, points out the contradictions children face within school structures with respect to health maintenance. She states that health education within many schools promotes eating well, pacing one's day, and getting exercise. Yet these same schools do not allow children choices about when or what to eat, or times and places for resting or brushing teeth. We must consider the observations of these researchers and find ways to support children's health outside the structured school setting in a fun yet purposeful manner. OOS programs can offer consistent, trusted adult figures to support children's ongoing understanding of neighbourhood and the possibility of a safe atmosphere for creative endeavours and the sites for physical activity within their communities, while providing necessary adult-child and child-child relationships for fostering a positive social atmosphere within a play-based curriculum. We need to recognize, as well, that quality programming that supports children's health does not take place in a vacuum and requires a supportive community.

Limitations

Concern has been raised about the current body of research regarding OOS care, as the significant matter of *quality* with respect to programming has been largely ignored in some of the research praising its merits (Rosenthal & Vandell, 1996). The quality of the

chosen OOS programs has not been systematically assessed in this research, because the focus of this study was to elicit the views of children about their health. Analyses of children's perspectives revealed that children identified with their programs for various reasons that support their health. These insights contribute a unique point of view to the literature concerning the quality of OOS programming and point to our need to include the perspectives of children in evaluations of programs. While this research may appear to focus on idiosyncratic perspectives of contextual influences on health, during analyses I maintained that children's views are embedded in families, schools, and neighbourhoods in a relational manner that may not be immediately evident through this work. Parents, school staff, and program supervisors were consulted, in order that their input might add to, clarify, and provide insight into findings. However, the purpose of this research was to highlight the perspectives of the individual children, while paying attention to their collective experience.

It is recognised that some families and children will self-select out of institutionalized care settings regardless of financial constraints. This research did not include the perspectives of children outside of institutional programs, and did not include the perspectives of children who might not view their daily encounters as positive within the OOS program. It is quite possible that these overlooked children might be considered to be in a higher risk category. These children must exist and are considered theoretical outliers that could be sought for further research (McPherson & Thorne, in review).

It has been suggested that the children involved in this study may have had a weak connection to place due to factors such as unavailability of family members, lack of safety and cohesion in their neighbourhood, and lack of opportunities to foster this

connection. Derr (2002) suggests that children's sense of place occurs on differing scales that we need to pay attention to in our research. For example, Derr suggests that there is a child-scale, a family-scale and an historical, cultural and community-scale for experiences that can connect a child to place. These types of connection can determine the extent of connection a child will have to place. These ideas were not incorporated into the analysis of this study and could provide this work with an alternative perspective on the children's sense of place in future research.

Summary

This research study has moved beyond the customary approaches to investigating children's health and, as such, provides insight into how children's contexts influence aspects of their lives that are integral to their health. If we describe the children in this study, we find young children living in neighbourhoods with characteristics associated with vulnerability, and yet we find children who—other than speaking about issues of safety—are optimistic about their health and the neighbourhoods in which they live. The OOS program provided many opportunities for physical, neighbourhood, artistic, and community cohesion experiences, as well as social engagement, yet the findings of this research suggest that still more could be done. The OOS programs and activities were the physical locations and social experiences that were invested with meaning and value for the children, the contexts in which they learned to be a functioning part of a unique community. Experience of these early relationships and social settings helps set children on paths for their future health. While we can only begin to consider the importance of the connections to the OOS programs, the children's perspectives nevertheless provide an

important link to the potential social and environmental buffer that the programs may provide.

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CHAPTER 5
MANAGING CHALLENGING CONTEXTS: UNDERSTANDING HOW CHILDREN USE RESOURCES IN THEIR EVERYDAY CONTEXTS TO SUPPORT THEIR HEALTH

Introduction

Children's health is influenced by personal, social, and environmental factors, factors that frame the lives of children in the circumstances in which children live, learn, and grow. Ecological studies have begun to illuminate the complex interplay of various environments, such as family, school, neighbourhood/community, and broader society as they shape children's health. For children who live with vulnerability stemming from their neighbourhood characteristics, we can now describe factors that influence[23] their health (Brooks-Gunn, 1995, Brooks-Gunn, Berlin, & Fuligni, 2000; Duncan & Raudenbush, 1999; Kohen, Brooks-Gunn, Leventhal & Hertzman, 2002; Kohen, Hertzman, & Brooks-Gunn, 1998; Shonkoff & Phillips, 2000; Willms, 2002), and evidence indicates that not all children are equally susceptible to the negative influences of neighbourhood disadvantage (Tremblay et al., 2001; Werner & Smith, 1982).

Researchers and practitioners have developed an understanding of how young children acquire knowledge about health (Tinsley, 2003), yet there remain limitations in our understanding of how acquisition and enactment of knowledge about health is affected by living in neighbourhoods with characteristics associated with challenges for children's health. For children who live in neighbourhoods that present challenges, we are limited in our ability to fully explain exactly why neighbourhood conditions matter,

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[23] While neighbourhood characteristics such as lack of cohesion and safety, socioeconomic differences (social distance), and poor access to quality care arrangements can have negative effects on children's health, family characteristics such as high maternal education, high family income, positive parenting styles, and development of attached and nurturing relationships have been shown to mediate the neighbourhood effects associated with vulnerability.

and why they have a stronger effect on some children's health than others. It is therefore critical that we begin to examine *how* children use the resources available to them to support their health in their everyday lives, in order to better describe children's contribution to shaping their own health. In effect, this knowledge will advance our understanding of the role children play in their own health.

An increase in knowledge concerning what has traditionally been considered the field of children's health (physical health, illness, and well-being) has developed along a parallel yet separate trajectory to that of children's development (social, psychological, behavioural development, and competence). However, the child health and child development fields have overlapping interests, which have implications for not only how we can best support children's health in general but also for understanding how children develop knowledge about the concept of health that might be enduring, all of which have relevance for this study. For example, despite a history of individualistic and linearly conceptualized paths of development for children (Erikson, Piaget, Kolberg), an increasing number of developmental psychologists have discarded the premise that the social world is external to individual children; rather, some have adopted a more dynamic *child-in-context* conceptualization of how children acquire knowledge and skills, including their understanding of health. Unlike Piaget's controlled clinical laboratory experiments with children, Vygotsky (1978) observed the behaviour of children and listened to their conversations and social interaction with others in their homes, schools, and playgrounds. Thus, we now better understand that children acquire knowledge and skills through participation in their environments and within social interactions (Vygotsky, 1978; Wertsch, 1985). Cultural psychologists would suggest further that the

relationship between a child and their context is dynamic, reciprocal, and mutually constituted (Fiske, Kitayama, Markus, & Nisbett, 1998; Rogoff, Baker-Sennett, Lacasa, & Goldsmith, 1995). In particular, children incorporate meanings and practices embedded in their social worlds into their psychological processes, and these processes in turn transform the social environment. Similarly, there is a parallel body of sociological research involving children as participants in research that has shown that children are not passive social beings (Graue & Walsh, 1998; Greig & Taylor, 1999; James, Jenks, & Prout, 1998; Mayall, 1994, 1996). Accordingly, the common link between emerging theories from the fields of developmental psychology, cultural psychology, and sociology—that is, recognizing the importance of studying children in relation to their daily environments—has obvious implications for the current research. Research about how children learn to be healthy, and how they understand their health, must take into consideration the influence of the immediate and broader environments in which children live.

The broad fields of sociology and psychology have undergone some reconsideration of what constitutes child development. New insights have emerged into how biological conditions of wellness and illness contribute to the process of children's development; in turn, new developmental models now incorporate both biological and experiential components (Tinsley, 2003). Neuroscience research into early brain development is a fitting example of the emerging, intersecting relationship between biology, environment, and childhood development. At a time when the nervous system is developing, physical and social environment interactions contribute to neural differentiation. If these social and emotional experiences are inadequate (unstimulating)

or inappropriate (chronic stresses), children's higher brain functions can be compromised (Cynader & Frost, 1999). We know that the foundations for children's health are laid down early and persist throughout life. Certainly, neuroscience research has provided evidence that the first years of a child's life are important for brain development, and we know that a child spending his/her first years in an unstimulating or stressful environment can lead to cognitive, social, and behavioural delays that will affect school readiness and subsequent learning (Kohen et al., 2002; Hertzman, 2000). This knowledge highlights the importance of a complex interplay of environmental factors that influence children's health, and through developmental processes, their ability and skills for knowledge acquisition.

We understand a great deal about the processes for children's acquisition of knowledge about their health, their subsequent behaviours, and attitudes (for a review, see Tinsley, 2003). Yet, if exposure to a range of circumstances matter in these processes, then *how* does it matter for children who live in neighbourhoods associated with challenges? It has been theorized that children who have the ability to draw upon personal resources[24] are less affected by adversity, have better coping skills, have higher social competence, and a well-developed sense of self, despite their environmentally based vulnerabilities (Garmezy, 1991; Werner & Smith, 1982). In particular, it has been theorized that when children experience vulnerability associated with one or more of their everyday contexts, (e.g., school, home, neighbourhood, peer relations) they draw on

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[24] I refer to the personal resources that children may utilize to construct and respond to their life circumstances within this paper. A personal resource might be familial teachings, experiential knowledge, negotiating with others, coping mechanisms, or garnering peer support to meet one's needs. I suggest that attempting to uncover children's capacities—where, when, and how—to draw on personal resources may provide nuanced insight into understanding children's contribution to their health.

resources from other contexts to support their health needs (Bernard, 1991; Garmezy; Werner & Smith). The intent of this paper is to focus on children's contribution to their health by examining *whether* children recognize the resources available to them to support their health, to better understand *how* children use the resources available to them, and *how* these resources may fall short of supporting children's health within the various contexts of their daily lives.

Background[25]

This paper is the third of three in a series of papers examining how neighbourhood characteristics associated with challenges to children's health influence young children's (ages 6-7 years) perspectives of health. The findings from the first manuscript (Chapter 3) revealed that the children who participated in this study lived with multiple challenges, yet also experienced some protective factors associated with their health; for the most part they maintained positive attitudes about their health. The second manuscript (Chapter 4) examined how the out-of-school (OOS) care program that the children attended contributed to children's positive health perspectives. This final manuscript will endeavour to illuminate the children's role in their health, with a particular interest in examining how children draw on resources (personal knowledge, experiential knowledge, contextual factors) to develop these positive attitudes towards health in the face of daily challenges.

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[25] For a detailed description of the children and their families that participated in this research, the neighbourhood vulnerabiltiy factors, a rich decription of the neighbourhood setting and the OOS setting in which this research took place, see Chapter 2 of this dissertation.

Methods[26]

Ethnography was the qualitative research approach employed in this study. Ethnographic methods are grounded in the assumption that the members of a group under examination have a learned and shared set of beliefs and practices, which can be described and understood in context (Boyle, 1994). Ethnographic methods are well suited to exploring children's perspectives about their health. Indeed, some scholars argue that employment of ethnographic methods with children has demonstrated that children can be "competent interpreters of their social worlds" (James, 2001, p. 246). I conducted this inquiry with 14 children (6-7 years old) who attended an OOS care program (OOS) in a neighbourhood with socio-demographic characteristics associated with vulnerability for children's health. The data collection involved asking children to discuss their experiences and perspectives of health, detailed observations of children's interactions in their OOS care, and the perspectives of the children's parents on issues related to health.

Findings

In order to engage children in conversations regarding their perspectives of the role they play in their health, and its relationship to their everyday life settings, I asked children questions pertaining to health and made observations of their social interactions during out-of-school time across the domains of social/emotional, physical health and well-being, and early learning and cognitive skills. I pursued a line of questioning aimed at discovering if, and how, the children could change their circumstances, and how they managed within these settings. These findings show that children utilized resources

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[26] For a more detailed description of the methods, data collection, sample, consent and recruitment processes and analysis involved in this paper see Chapter 2, Appendix A, and Chapter 3 methods section.

within their families, schools, and OOS programs to support their understanding of health. The findings also suggest that there were times when children were unable to garner support for their health needs.

The analysis revealed details about how children incorporate family health socialization into their lives and use family teaching as a resource; how children function within their daily social environments, and identify and use resources for social problems; and how they draw on resources to keep safe. It became evident that personal experience shaped how children learned to incorporate these ideas into their lives.

The Family as a Resource

The family is the first environment where children learn about, observe, and enact health-maintenance behaviours. The analysis revealed that children's understanding of health and health maintenance was deeply rooted in family knowledge and values. The children spoke about incorporating personal experience with illness into their health knowledge, which has its origins in family teaching. Despite the ubiquity of the media, most children did not acknowledge a media influence in their understanding of health; however, for one child, we can see the role family can play in children's knowledge development about health.

Incorporating family teaching

While some children's perspectives and actions echoed that of family teachings, we see that others' perspectives were an emergent property of supportive parent-child interactions. Many children also demonstrated their development of independent ideas about being healthy *despite* family teaching.

Fish's perspectives about health provided insight into the relationship between family teaching and children's development of personal knowledge about health. During our conversation, Fish's perspectives seemed to reveal that he deferred to his family members, especially his mother, as the agent or decision-maker with respect to health issues in his life. For instance, when asked if he was responsible for keeping himself healthy he replied, he would, "*do what* [his family says]." When subsequently asked what he would do if his family members were not around when he was eating and had to make choices about healthy or unhealthy foods, he said, "*Well, do the things they say when they were around me.*" While this could be interpreted in many ways, it seemed that for Fish, like many of the other children, this demonstrates how children incorporate family teaching into their attempts to stay healthy. Fish understood that he could utilize his family teaching as a resource when making decisions about eating properly.

Eiley spoke about the things she did to keep herself healthy by taking care of herself. In the following excerpt we can see how, in the parent-child interaction, her mother supported or scaffolded her beginning understanding of health maintenance behaviours. Eiley was speaking about how she is becoming independent in her ability to make choices in her life:

E: *...I can't get myself a cup.*

MOM: *So, but what do you do? Do you get your food?*

E: *Mommy helps me.*

MOM: *I help you, yeah. But you do some of it, don't you?*

E: *I poured my milk on my cereal in my cup.*

MOM: *Yeah, you do a lot of things for yourself, don't you?*

E: *I wash my hair.*

At this point in the conversation, Eiley's older sister interjected with "*she needs help, a little bit.*" Eiley was quick to respond with an emphatic "*No, I don't,*" and Eiley's mother supported her perspective of her independence by saying to Eiley, "*No, you're doing a good job.*" In this exchange, we can see how Eiley might find the confidence to disagree with her older sister and buoy her sense of competence through family teaching and a supportive relationship. Many of the parents spoke of times in which they actively discussed health issues with their children, although most did not identify interactions such as this one focused on supporting independence as related to health.

Sarah and her mother spoke about their joint attempts to stay healthy, and Sarah spoke of how her mother was trying really hard to lose weight to become healthier. Sarah's mother's teaching and support was evident throughout my conversations with Sarah about health, as Sarah's mother very actively participated in our conversations; yet, in the midst of talking about how she ate good food to stay healthy, Sarah, like most children in this study, revealed, *"Sometimes, I sneak and eat some of the candy."* Sarah may have been demonstrating that children can make choices even though they do not conform to parental teaching about being healthy, or she may have been testing her mother for a response to saying she *cheats.* It was common for children to confess their love of junk food, candies, and so on, in our conversations about health, but most of the children understood the importance for balance between eating healthy and eating junk food.

The transformative nature of personal experience

Some children described their personal experience as a contributing factor in their understanding of health. This experience seemed to transform their knowledge and

become a personal resource in subtle ways, through a physical embodiment of family teachings. For example, Annie had a few visible dental carries and had recently started to get her second teeth. Annie, who had just turned seven, stated, *"I ate too much candy when I was young. I don't eat them anymore, since when I was six years old."* When I asked why she didn't eat candy anymore, she answered, "*Because my mom told me that it would make my new teeth blacker."* Annie, like the other children, related her mother's teaching to her previous experience of dental carries and understood that her new teeth should be cared for as part of maintaining her health.

Martin also discussed his understanding of being healthy by relating his knowledge to an illness experience he had during school hours. Martin experienced behaviourally based difficulties in school, and his mother thought that some of his difficulties in school might have been a result of poor eating choices at school, such as high sugar intake. For example, his mother stated that Martin had difficulty sitting in class and complained of feeling sick quite often after school. She even observed times when he was shaky after school and when asked Martin seemed to have eaten little food other than highly processed, sugary foods, such as ice cream and chocolate. Martin's mother spoke of trying to encourage and teach Martin to eat properly, as he had dental carries and did not have a balanced diet. Martin appeared to incorporate his experience of illness into his understanding of health; when referring to ice cream he stated, *"I can't buy it again at school, ... because it will make me sick."* Although we would not hold Martin to his claim to not buy ice cream at school, we can see how experiences of children can become part of their consciousness of how to take care of themselves.

During snack time at the OOS program, Martin ate nutritious snacks and appeared to enact some of his family teachings.

Contextual influences

While the influence of media has been highly researched and shown to be important to children's health attitudes and behaviours (Tinsley, 2003), for the most part the children in this study did not speak directly about media influences. Regardless, we cannot assume that some aspect of the media's (television, internet, advertising, and so on) impact does not enter into family teachings. Merya's family context gives us an example of how media influences may be tempered or enhanced by family teaching. Merya spoke at length during our interviews and conversations of a movie that exposed the negative side of fast food restaurants as influential in his understanding of how to stay healthy. He expressed that he had learned that, "*...there's so much fat in their food that it makes you feel full when you didn't even eat a lot.*" According to Merya's mother, this theory was supported by Merya's father and provided a strong influence in the life of this little boy. Despite the potential for social isolation, Merya shared his theory about junk food with other children and told them that what they were eating during OOS program snack time was not healthy (mainly because it was not organic). He would talk about the chemicals that they were eating and complain to the staff that the snacks were not good for you, calling them *junk food.* The staff mentioned that Merya frequently refused to eat the prepared snack. Although Merya's perspective on foods was unique, and he seemed to follow his family teaching, he also revealed that he liked to eat at fast food restaurants sometimes, and did not consider it too unhealthy, occasionally. While Merya understood the foundations of eating well in relation to family teachings, and was observed to hold to

his own standards by not eating processed foods during snack time, during our informal conversations he still revealed his enjoyment of fast foods.

Resources for Social Problems

All of the children were asked about the school context in an attempt to understand how they managed in school scholastically (school performance), socially (friendships), and emotionally (anything they would change or didn't like about school). Children were given scenarios which included the process of the child learning to read, do their letters, and so on, in an attempt to get them to consider their own competence in school, how much responsibility they took for their own learning, and how it made them feel to achieve. On more than one occasion, Michelle mentioned that she liked math, while other subjects in school did not seem to excite her. It seemed that she liked solving problems. Our conversation began,

INT: If your teacher asks you to do something and you find it difficult to do, how does that make you feel?

M: *Dumb.*

INT: Really? And if the teacher gave you something really, really hard to do and you were able to do, how does that make you feel?

M: *Normal.*

INT: And one day, you were doing all your letters and the teacher gave you three stars cause you did your letters so well, how does that make you feel.

M: *Normal.*

INT: Okay, can you tell me what makes you feel really, really happy about what you do at school?

M: *Math. Cause they give you more and more* [math questions].

I asked Michelle what she meant by her final comment and she said she liked doing math questions. Perhaps math gave her an important sense of accomplishment that other aspects of school did not. In conversations and observations of Michelle over time, it seemed that she did not have many resources for buoying her sense of competence; hence, it was interesting to hear about the significance she placed on math, and its place in her daily life (see Chapter 3).

The questions directed at scholastic learning and achievements were purposefully aimed at divulging a situation in which each child personally overcame a problem without assistance. Martin's response to the same line of questioning as Michelle revealed a slightly different response but was more typical of the other children than Michelle's perspectives. Most children stated that they would feel good about learning and achieving in school during any scenario presented and seemed to draw on this achievement for their sense of competence. I asked Martin,

INT: Okay, tell me, if your teacher gave you a problem to do, and you had to think really hard, and you were able to solve the problem...

M: *And I think so hard, and I think and I got it, it was not wrong?... it was right?* [I nod yes]

INT: And so how did that make you feel?

M: *Happy. All done. And I said, "Whew."*

INT: So, how do you know if you're doing well in school or not?

M: *Because, I'd be happy* [with] *my own self...*

Despite the similarities to the other children's in Martin's response about being pleased with himself, there was a unique sense of relief in the tone of his voice. Martin had immigrated to Canada within the last three years, and his mother had been concerned because Martin was requiring special assistance in school and was being "worked up" for

Attention Deficit Hyperactivity Disorder (ADHD). Martin's mother thought that he needed to be interested in the topic in order to focus on learning. She did not believe that Martin was fully understood by his schoolteachers. Martin may not have had a truly typical response to this line of questioning, since he had many scholastic challenges that overlapped into social difficulties that may have affected his sense of scholastic ability. It is quite possible that Martin felt a pressure in school to achieve that might have affected his ability to feel "*happy*" with himself and his ability to succeed. During OOS program time, Martin was observed to have friends, but he quite often experienced difficulties in his peer relationships and had difficulty focusing on staff instructions and games. These observed social difficulties mirrored his mother's concerns regarding his classroom troubles. This research project occurred over a period of time, and eventually Martin was 'Kid of the Week' at the OOS program; staff suggested that they were surprised by his social improvements and assumed incorrectly that Martin had been put on medication, which accounted for changes in his social behaviour. We can hope that this change in behaviour was also reflected in changes in his scholastic abilities.

Sarah attended a special assistance class for reading twice a week and evoked unique strategies for coping with her scholastic difficulties. When I asked her about learning to read in her class she said, "*I cheat on that.*" Sarah does not like the repetition of writing letters and when asked about it she said, "*it's kind of weird. There is a big black book. I put E, E, E, E,* [over and] *over again.*" And when asked if she was getting better she replied, "*I'll say it's weird. Yeah. It's weird.*" Her perspective on the learning process was that she was getting better, but her tone of voice suggested that it was not an

interesting way to learn. Quite possibly, as a way of managing her difficulties, Sarah minimized or found fault in the whole process of having to do special education classes.

Managing problematic relationships

The social organization of school and the OOS program provided children with opportunities for socialization, but with these opportunities came relationships that the children found challenging. For instance, while many of the children spoke of their love of recess, recess was also the most common source of stories about bullying and children's concerns over physical safety. Some of the children had developed tools or resources for managing these problematic relationships. The concept of *caring for self* is part of anti-bullying programs in many of the neighbourhood schools. When Dudl was asked if there was anything about school that he did not like, at first he said no, then his expression changed to one of concern as he reconsidered and said,

D: *But the bullies I don't like... They wreck stuff that I make.*

INT: Oh, and how does that make you feel?

D: *Sad.*

INT: What do you tell them?

D: *That I feel sad but they keep on doing it.*

While in this conversation Dudl was prompted to explore resources for his problem, and he suggested he could tell the teachers, it seemed that the issue of bullies remained unresolved for him.

Crystal Gayle also spoke of children being mean to her during class time. In response to asking if there was anything she didn't like about school, she said,

CG: *Well, I don't like it when people bother me when I'm trying to do my work? Some people sit in my group that are sometimes really mean to*

me, sometimes they bang their feet against my desk or go under my desk and pull my shoe off.

INT: And do you know what's that called when kids are mean to you?

CG: *No?*

INT: And when kids are mean to you whose responsibility is it [to get them to stop]?

CG: *Yours? Ask them to please stop.*

INT: Okay you ask them to stop. And say they don't stop, what is it that you can do next?

CG: *You can call a teacher or your mom and dad.*

Although Crystal Gayle immediately identified the resources available in her daily context, later in the interview, when I asked her if she could change anything, what would she change about school, she replied, "*to stop the people who are being mean to me and they can be nice to me.*" The importance of other children being mean to her surfaced again; despite the fact that she appeared to have some tools for solving her problem; she just wanted it to stop. During OOS program time, Crystal Gayle was observed to experience isolation by her peer group for reasons that were not readily apparent to the outside observer. For instance, one Friday, Crystal Gayle was engaged in planning her birthday party on Sunday with all the girls her age at the OOS program. On Monday, I approached her, as she had been sitting alone for most of the OOS programming time. She revealed that only one friend came to her birthday party, and that she was very disappointed. No rationale was given for why the girls did not attend. There were several occasions when she was systematically excluded from peer social relationships, and in response to these occasions she would turn to staff, possibly as a means of coping. For example, she would ask staff if she could help or clean up, possibly utilizing the staff as a

resource during stressful times with peers. On several occasions, the different staff members described Crystal Gayle as "a lovely little girl," "helpful," and "easy to have around."

One child, Seven-up, chose not to talk during our interviews about the bullying she had recently endured at school. Her mother's perspective on why Seven-up chose not to talk about the incidents with me in particular was that she had learned not to trust others with important emotional events in her life ("*especially white folks in a place of power*" [Excerpt from a telephone conversation with Seven-up's mother]). Seven-up had experienced many incidents in her previous school, events that caused her mother to move back to her old neighbourhood, the one in which this research took place. When asked about these incidents, her mother relayed that Seven-up was teased on many occasions during school hours and the most jarring for her was when she was teased that her "*gums were the colour of 'poo'*" by classmates during recess. Seven-up was then required to engage in group activities with these same children during class time, and this affected her ability to function scholastically. According to Seven-up's mother, the school did not acknowledge the bullying Seven-up experienced, and in response she decided to change schools. We can imagine the effect that Seven-up's experiences may have had on her when the social establishment beyond her family did not recognize and support her difficulties. Seven-up's experience with her new school, which she attended during the period of this research study, did not involve these types of challenging relationships, according to her mother.

Although many of the events children spoke about in relation to bullying were recent, Sabrina called to mind experiences of bullying from kindergarten that must have

had a long lasting impact on her. When asked about playing with the big kids at recess, she said, "*once in kindergarten I got teased.... It made me feel really sad.... I told them to stop it because they were hurting my feelings.*" I asked Sabrina what happened after she told them to stop. Despite her being able to articulate her feelings, she said, "*they kept doing it.*" From Sabrina's story, we can appreciate the enduring effect that problematic relationships have on children.

Invoking social rules

The children involved in this study spoke openly about taking personal responsibility for their own health, yet the children did not always articulate the nuances of actively and consciously managing within the various social environments they encountered on a day-to-day basis. However, observations of children in their environments engaging in relationships with peers, parents, and other adults revealed that the social rules and standards of the multiple environments in children's lives were important resources for their health. Children were observed to utilize social rules of playing fair and taking turns as resources for social competence, opportunities for physical activity, and positive emotional health. Engagement in social activities such as games was important for children to foster friendships. In the following scenario, two girls drew upon the rules of the OOS program, potential support from staff, their experience of what happens if you do not play fair, and the support of friends working in alliance, to strengthen and develop their ability to face the social world.

> When three of the children were playing a game of mini pool at the OOS program, Victor was using the pool cue to physically stop the others (two smaller girls) from taking their turns. He would put the cue between himself and the girls and then use his body to push them away. The girls verbalized that he was not playing fair, and raised their voices. When Victor did not stop, the girls eventually

> looked around the OOS program for support, and although they saw that a staff member was close, the girls did not attempt to gain the staff member's assistance. In this situation, the offended children's complaints of not playing fair were enough to eventually change Victor's behaviour. He was reminded that they could go to a staff member and he would not be allowed to play, and the game continued to the satisfaction of all (Fieldnote, March, 2004).

While the results of this interaction may differ in less-structured settings, the girls made an active choice to use the rules, buoyed by peer support, to enlist Victor's cooperation to meet their intended goals.

Social standards seemed to be embodied by the children within the structured environment of OOS care, although not all children adhered to the known standards, and some children attempted to disregard them, recognizing that it would result in social isolation. For instance, Michelle refused to share the new markers during one craft session and was asked to leave the table by a staff member when the other children enlisted the staff member's support. Occasionally, after exiting the group, the child who was asked to leave would use strategies to try to get others to leave the group with her/him, sometimes being successful. Michelle did attempt to get a friend to leave the craft table by offering to play another *fun* game, without success (Fieldnote, January, 2004). Scenarios such as the ones described were commonplace in the OOS program; whether during sedentary or physically active games, utilizing the rules helped children to get along and extend play encounters.

Resources to Keep Safe

Issues of safety pervade the lives of young children in modern society. Despite diminishing crime rates, as a society we are teaching our children to fear strangers, being alone, and being out of our view. But everyday life for children is not lived in a state of

alarm, even within neighbourhoods associated with adversity. The children in this study found ways to incorporate their understanding of personal safety into their lives and used learned rules about safety and strangers as tools for keeping themselves safe.

The family as protector

As reported in Chapter 3, children articulated fears of being lost or stolen, and many children spoke of their responsibility and strategies for keeping themselves safe. Most children internalized their parents' teachings and recalled them to use as tools to protect themselves even when the parents were not around. For instance, Dudl was asked if there was anytime that he was responsible for keeping himself safe. He said, *"Yeah, when I'm at home. And when my parents are at work, at school, that's my responsibility. I don't talk to strangers."* When family was present, the children deferred to them for protection from dangers. Michelle spoke about going to the park with her family and, when asked if she felt safe while at the park, replied, "*Yes, 'cause my family's all around me. One person goes to get some food and some people stay to take care of us so we don't get stolen."* The parents involved in this study suggested that they do not allow their children to play outside their range of view, and although children can hold their parents' teachings about being safe in mind, the children in this study seemed to be highly protected while out in their neighbourhoods.

Merya spoke of being out with his father and related a scenario in which his father fell asleep while playing at one of the playgrounds he viewed in the research photographs. He said he wouldn't feel safe playing in the playground, "'*cause someone might be there ... I'm all by myself and I'm like six and he steals me and if my dad's there and he's looking at a newspaper and he's falling asleep and he doesn't get awake as he's*

usually a sleepy cat..." Children may internalize the discourse of "stranger danger" and experience vigilant protection by family to the extent that it limits their ability to draw on their personal resources for self-protection.

Knowing the supports

School is another primary socializing context for children in which there are many rules intended to keep them safe. For instance, the findings in Chapter 3 demonstrated how children scan areas of play and understand the unwritten safety rules, as children spoke of areas that were not safe to play in their schoolyards. Sabrina had mentioned the open fencing around her schoolyard as a place that she should avoid to stay safe. Other children spoke of places that they could play safely, and still others spoke about "*recess monitors*" who keep the children safe. Another resource that many of the children spoke of during interviews was the Grade 7 buddies. Some of the schools "buddy" the young children with an older child, fostering a relationship that is intended help younger children adjust to school and to help them during various events inside and outside class time. Annie spoke about recess at school and seemed to rely on her buddies for assistance. She said, *"Well, sometimes when I play ... Grade 7 buddies are the ones I know. They always help me."* The children were not observed in situations in which they used these resources, and knowing the resources may be quite different from using them when children feel unsafe. In addition, children did not mention utilizing other peer group members for support during school time.

Taking buddies with me

During OOS program time, the staff were entrusted with keeping children safe, which entailed keeping track of children in the various interior and exterior spaces. The

separation of indoor and outdoor physical space meant children were required to take buddies with them when moving between spaces. Children could not go to the washroom, get a drink, or go to the playground area by themselves, thus limiting their sense of independence, yet they did not seem affected by this rule. One centre that was having difficulty keeping track of the children between the playing field, the playground, and the centre, due to spatial logistics, acquired a walkie-talkie system so that the staff could communicate regarding children's movements. The program staff were constantly counting and monitoring children being picked up by parents at each centre due to the multiple areas of indoor and outdoor activity that were separated from view of the staff. Despite the occasional attempt by children to move between spaces by themselves, the children seemed to internalize the need to take buddies with them using other children as supports for safety. Children helped each other to stay safe by reminding others when they needed to take a buddy with them.

Learning to Manage within the Neighbourhood

Many processes and relationships in children's lives foster the internalization of a wariness of the environment. The children involved in this study provided information about their concerns for their own personal safety while out in their neighbourhood. Some children indicated that their parents would keep them safe, but others, such as Crystal Gayle, seemed to have formulated plans for keeping themselves safe, although most of the children were not allowed to play in parks by themselves. Below is a photograph of a park that many of the children mentioned that they liked to visit with their families (Figure 5.1). This is a local playground in a larger park that holds appeal for adults as well as children as it offers green space and a children's playground. Crystal

Gayle said, "*whenever I go to the park I* [would] *look for bad guys and stuff. So, I can stay away from them. Cause they could hurt you. …*" Children could also keep themselves safe while out in their environments by making choices to hold their mothers' hands, to listen to their parents, or not to "*run off.*" Fish suggested that because someone could take him "*anytime*," he needed to be vigilant. The photo in Figure 5.1 includes children and their families playing on the playground equipment, and during the course of this research this park was observed to be enjoyed by many families. This is also the place that some of the children who participated in this study may feel they need to look for bad guys.

Figure 5.1: Neighbourhood park

The children revealed features of neighbourhood safety when viewing the research photographs of the neighbourhood. The original intent of showing children photographs was to give the children visual cues for talking about their neighbourhoods,

but, unexpectedly, these photographs elicited responses about safety. If a child chose to speak about safety, this line of questioning was pursued. Each child was shown photographs of parks (e.g. Figure 5.1), neighbourhood streets, high traffic streets, alleyways, big open areas, and transit locations. High traffic streets and street corners were considered to be unsafe. Traffic-calmed areas were thought to be safe, but only by some children. Some children thought that photographs without people in them meant they were safe areas, and some thought that if there were people in the photographs that the area was safe. Many children expressed concerns about the playground areas they viewed. While the playgrounds associated with the school grounds were considered safe, other playgrounds had people in the photographs, garbage and clothing on the ground, and equipment that children did not think looked safe. The children who recognized their play spaces at school may have related their personal experiences of feeling safe in formulating their responses to my questioning. Fish expressed that many of the areas in the photographs were not safe. During this exchange, Fish looked at a few of the photographs and observed,

F: *It's too dirty.* (See Figure 5.2.)

INT: And what's wrong with dirty?

F: *It's not healthy.*

INT: Do you think it looks like it would be fun if we cleaned that up?

F: *Yeah.*

INT: Do you think that one [playground at a school] looks like it's fun to play at?

F: *Yes.* (See Figure 5.3.)

INT: Why is that, why do you think?

F: *Because it's not dirty.*

INT: Do you think you'd like to play in that field? [open grass field]

F: *Yes. Of course, you check around and see if it's safe or not.*

INT: What would you look for to see if it's safe?

F: *No glass or no stuff like that. Maybe like no garbage.*

Martin expressed similar sentiments when viewing the neighbourhood photographs of a playground he was somewhat familiar with, by saying,

M: *Oh* [someone's] *throwing garbage* [there].

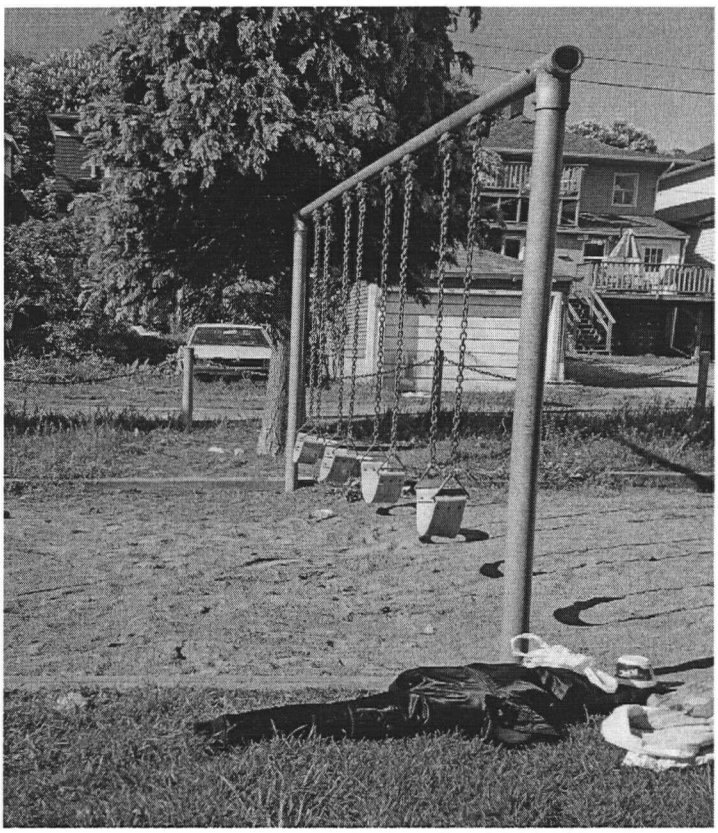
INT: Would it be fun to play there? (See Figure 5.4.)

M: *No! Last time I went to this* [playground], *it was all dirty with people's stuff like shoes and boots and stuff* [everywhere] *in the playground.*

Figure 5.2: Rusted blue slide

Figure 5.3: School playground

Figure 5.4: Playground garbage



While we cannot know what these children will enact (given the choice, would they play in these spaces), we can begin to see how children formulate an understanding of what matters in their environments. We see vigilance in children's perspectives of safety in their neighbourhoods, and what they know to look for, and how they make judgements before they play. While we may interpret some situations as stress provoking, children may find comfort in these same situations, in knowing how to manage their environments by scanning for strangers and assessing the safety of play spaces.

Discussion

I want to be like who I am...
Merya

The children involved in this study demonstrated and spoke about a variety of resources that they drew upon to support their health and compensate for neighbourhood challenges: family teaching, personal experiences, anti-bullying programs, adult caregivers, OOS program rules, peer relationships at school and in OOS care, and stranger danger teaching, among others. As the family is the primary socializing context for children's understanding of health (Tinsley, 2003), it is not surprising that the children spoke about how their parents' teachings were influential in their daily decisions and understandings about health. The children utilized family teaching, embodied it, and transformed it through paying attention to their own experience of health and illness. As children spoke and were observed in their daily environments, it was evident that their schools, OOS programming, and the physical state of the neighbourhood not only influenced their health but also created barriers to enjoying a healthy lifestyle, free of stress and worries about safety. The findings of this study raise questions such as: How

do we best support children's attempts to draw on positive resources for supporting their own health? How do we find resources for children who lack the ability to access them? And how do we find creative ways to enhance the contextual resources in children's lives, when they live with daily vulnerability that acts to diminish their agency with respect to health?

In the longitudinal study of infants born in 1955 on the island of Kauai, Werner and Smith (1982) found that personal resilience characteristics of children affect their ability to "to draw on their own resources to meet their physical and emotional needs" (p. 77). While the current research project did not investigate the notion of resilience in children to its fullest extent,[27] the resilience literature has proven instructive for considering how children's health can be appropriately supported. Children in the Kauai study drew upon informal sources of support such as peers, siblings, parents, and teachers more than their less-resilient counterparts. The importance of resources that children could learn to *depend on* to support their needs are significant for children (Garmezy, 1991), and it has been suggested that peer counsellors might be a source of support for children (Werner & Smith, 1982). The findings of this study further the work of Werner and Smith by providing details of how children access these sources of support in their daily lives. Although the children were not asked directly about the Grade 7 buddies, it seemed that these buddies were an important source of support for some children, whether direct or indirect, in the school environment.

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[27] Questions were asked of both the parents and children related to the children's characteristics that might demonstrate resilience, in order to gain a greater understanding of each child's contextual influences and personal traits. This data is not comprehensive, as only selected items from resiliency checklists (Grotberg, 1995) were used; the data nonetheless provided the researcher with more insight into the children's perspectives on self.

The OOS program provided children with another less-articulated source of support in their daily contexts, providing rules and social groupings that facilitated their ability to socialize, participate in physical activity, and sedentary games. In addition, the OOS program was lead by consistent caregivers who managed children's social environment interaction in supportive manners. What we can learn from these findings is that providing children with resources to depend on in their lives may, as Gramezy (1991) suggests, shift the balance from vulnerability to resilience. Supportive relationships and experiences are key for enhancing children's health within neighbourhoods associated with vulnerabilities, but more action needs to be taken, as these families, programs, and schools are set in neighbourhoods that require systematic change. If our families, programs, and schools were more closely linked with neighbourhoods, such that services were integrated and collaboration were more prominent, we may be able to build models of care that have been proven to be successful for all children (e.g. Sweden).

Anti-bullying programs have demonstrated that, given the tools or resources for managing difficult relationships, young children can identify and articulate experiences about challenging social situations. Some children also demonstrate the ability to solve important day-to-day social problems for themselves. Olweus's (1993) longitudinal study demonstrated that prevention programs successfully reduced bullying in schools by 50%. As evidenced by their stories, the children in this study demonstrated the ability to articulate their problems, but lack the skill or know-how to "*make it stop.*" While we may consider it our moral and social obligation to give children tools for dealing with these

challenging relationships, it remains unclear *how* to best do this, and it raises the question of whether our efforts are addressing the source of the problem.

Those interested in improving or supporting children's health, like the children themselves, recognize the various external dangers that may threaten children's health, but are also aware that the principal threats to health have their roots in psychosocial stresses. Psychosocial stresses for children still remain somewhat less-legitimate or less-identified sources of threat to children's health. It is not surprising that the children in this study easily identified external dangers in their lives (garbage, strangers, poorly maintained play spaces), and that these dangers seemed undifferentiated from other content in their lives with respect to health: you brush your teeth, do your homework, eat well, and make sure there are no bad people in your play spaces. The fact that the children in this study used cues such as garbage in their play spaces as indication of the quality of their environments validates the research on collective efficacy (Sampson, Raudenbush, & Earls, 1997), as well as the approach of the National Longitudinal Survey of Children and Youth (NLSCY) in Canada, which examines the implications of neighbourhood conditions for children's health. In the case of children's physical environments, it is of value to concentrate our efforts on what we can tangibly improve (garbage removal), which may go a long way to improving children's psychosocial health. Decreasing the "visible signs of social disorder," such as graffiti, garbage, and people loitering in public spaces, can decrease crime through informal mechanisms of social cohesion in neighbourhoods (Sampson et al., p. 919). Indeed, Sampson et al.'s research into the relationship between neighbourhood crime and collective efficacy—social cohesion among neighbours, in which neighbours are willing to act on behalf of

the common good—suggest that informal mechanisms such as a willingness of neighbours to monitor children's play areas or minimize the physical signs of social disorder is strongly related to reduction in neighbourhood violence.

One of the most prominent external dangers children discussed was the notion of *stranger danger.* The findings of this study correspond with research in which children were asked about their environments in relation to their health. For instance, in Davis and Jones' (1996) research on children's (9-11 years) views of adults' restrictions placed on them because of the adults' perceptions of risk in their environments, the findings revealed that although parks and open spaces were intended to keep urban children off the roads and safe in designated play areas, children thought of these play spaces as unsafe because of the presence of strangers and youths. Stranger danger teaching for children has become so ingrained in society that it has become a discourse of childhood, a discourse that adults perpetuate, schools reinforce, social forces exaggerate, and children internalize to point of creating barriers to keeping healthy and active (Davis, 2001). Parental and societal teachings of a wariness of strangers is fraught with faulty assumptions and misplaced trust, such as that strangers are the most prevalent source of danger in children's lives, whereas statistics show that children are much more likely to know the perpetrators of abuse and abduction (Cheit, 2003; Corby, 2000; Gallagher, Bradford, & Pease, 2002).

Uncritical interpretation of risks obscures the insidious threats to well-being in children's lives. It raises the question of the implications for children of creating in them a sense of wariness, and the affect of this wariness on children's sense of well-being and mental health (Scott, Jackson, & Backett-Milburn, 1998). Risk anxiety, engendered by

the desire to keep children safe, comes with costs for children and serves, potentially, to curtail children's activities in ways that may constrain their autonomy, and limit the development of social skills and skills to cope with their daily environments (Furstenberg, 1993). Vigilance for safety may be an internalized part of the lives of the children lives that participated in this study, yet we know from research that these internalizations of daily stresses have consequences for children's health and well-being. It is possible that parents feel more secure knowing that their children have some tools for keeping themselves safe, especially parents who work long hours and live within neighbourhoods associated with crime or dangers. While the children in this study seemed to draw on these standardized (what to do about strangers) and gendered notions (what strangers look like [males]) of dangerous strangers, these ideas are reinforced as we continue to hear about stereotypical cases in which men with intent to harm children are able to convince them to make choices contrary to family or society teachings.[28] We also hear about young children who have fought off perpetrators possibly because they have developed some skills from being taught to fight and get away. So where does the balance lie for children and families? The individual project approach to children's safety in which children bear the weight of responsibility for their safety seems flawed. Again, the notion of collective efficacy, in which members of a neighbourhood are willing to intervene on behalf of the collective good against violence, may decrease the burden on children, yet strategies do not occur in a vacuum. Sampson et al. (1997) suggest that self-help strategies enacted by residents can be enhanced by partnerships with more formal sources such as community policing.

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[28] At the time this paper was written, a known sex offender convinced two 10-year-old girls sitting on the school grounds of their elementary school to help him look for his dog for money. It was only when he took the hand of one girl and kissed her on the neck that the girls fled (Chu, 2005).

Although the children involved in this study may enjoy somewhat protective family environments that support their understanding of health, their lives remain embedded in neighbourhoods with characteristics associated with vulnerability, and they spend many hours away from their parents and in the care of professionals. If one were to envision the ideal neighbourhood for supporting children's health and promoting healthy living, one would envision a neighbourhood with safe, clean, and well-maintained play spaces, a socially cohesive community with access to programs and social networks. The children involved in this study, like many others, do not live in such conditions, so it is not surprising that these were not the resources children drew upon for keeping themselves healthy. The children also spoke of home and school life situations in which they drew upon resources and enacted their understanding of health, yet these contexts were for the most part not observed and important adults in these contexts were not interviewed. Many questions were raised during the course of this research, the answering of which necessitates in-depth immersion in these contexts, yet would provide further important insights that would add to this analysis.

Summary

The children involved in this study spoke about a variety of resources that they drew upon to support their health and to compensate for their neighbourhood challenges. Despite their ability to identify supportive resources within their lives, the children's accounts of daily life remained focused on dangers such as strangers, garbage, traffic, and endemic bullying. The children's perspectives provide us with important insight into what matters in children's environments so that health professionals can advocate for the necessary changes within children's environments to support their health.

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CHAPTER 6
DISCUSSION AND CONCLUSION

Summary of Findings

The objectives of this research focused on gaining a more detailed understanding of how contexts of daily life (family, school, after-school setting, neighbourhood) influence children's perspectives of health and the role children play in their own health. The children involved in this study were chosen because of the neighbourhood in which they lived, as I was particularly interested in examining how living in neighbourhoods with characteristics associated with vulnerability for children's health influences their perceptions of health. I was interested in understanding the factors that impede or enhance children's sense of agency in relation to their health and in understanding the role that parents play in children's perspectives of health for those who live with neighbourhood adversity.

This research adds an essential and unique perspective—that of young children—to a growing body of research investigating the effects of neighbourhood challenges on children's health. The children involved in this research were able to articulate the requirements of physical activity, and healthy eating, an awareness of social standards, and scholastic competencies to support their overall health. However, the findings demonstrate a disparity between children's health knowledge, their perceptions of the requirements for good health, and their contextual realities in relation to health. Their perspectives reveal a disparity between their voiced social and emotional needs and the social opportunities available to them within this urban setting. Nonetheless, the out-of-school (OOS) programs that the children attended provided many opportunities to bridge

the chasm between children's needs and their ability to satisfy those needs; the OOS programs helped to support children's need for physical activity, proper nutritional intake, and, for some, confidence in food security, neighbourhood engagement, artistic endeavours, and community experiences. The OOS programs also provided social experiences with friends and adult caregivers in a safe and supportive atmosphere. It was clear that the OOS sites were invested with meaning and value for the children, and the findings of this research provide insight into the physical, social, and environmental influence that the programs provide.

Children spoke of concerns for their physical safety within their schools and neighbourhoods; they revealed their lack of free range of play, and that they had few opportunities to play with or get to know neighbourhood peers. Most children spoke of a lack of familiarity with neighbours, while parents spoke of not belonging and echoed the children's concerns regarding safety and lack of cohesion in their neighbourhoods. These findings call into question the strength of these children's connection to place, which is an important component of a child's sense of self and overall health (Gieryn, 2000; MacDonald-Carlson, 2003; Matthews, 1992; Popay, Williams, Thomas, & Gatrell, 1998). The OOS programs that the children attended were observed to be the settings in which children learned to be functioning members of a unique and protected social microcosm within their neighbourhoods. However, the findings of this research suggest that still more could be done to improve children's sense of belonging *within* their neighbourhoods, and that OOS programs could provide enhanced curricula to facilitate this connection.

The children involved in this study demonstrated and spoke about a variety of resources that they drew upon to support their health and to compensate for their neighbourhood challenges: family teaching, personal experiences, anti-bullying programs, OOS program rules, peer relationships at school and in OOS care, adult caregivers, and stranger-danger teaching among others. Despite their ability to identify supportive resources within their daily lives, the children's accounts of daily life nonetheless focused on external dangers (strangers, garbage, traffic) and endemic bullying. In the face of recognized daily neighbourhood challenges, however, the children involved in this study remained positive about their health.

Implications and Recommendations for Future Research

The three manuscripts included in this work are thematically linked in a number of important ways. The key issues that establish the manuscripts as a cohesive body of research, contributing significantly to the field of children's health, include what we have learned about: the importance of listening to the voices of children; the limits of family; the importance of the OOS programs; some simple solutions to complex problems; and the insidious nature of psychosocial stresses in children's lives. After establishing these important connections, in this section I will discuss the implications and significance of this research to the field of study and present recommendations for future research.

The Voices of Children

By listening to the voices of children, I have produced evidence about young children's experiences that has implications for conducting future research with children, for improving children's health education, and for increasing our understanding of how the social determinants of health are manifest in the lives of children.

Children have not had adequate opportunity to participate in the research process (Alderson, 1995; Alldred, 1998; James & Prout, 1990; Mayall, 1994). Yet we know from the available literature that children's perspectives about their life experiences provide important knowledge (Docherty & Sandelowski, 1999; Irwin & Johnson, 2005; Morrow & Richards, 1996). The current research has shown that putting children's voices in a central position as research participants and including various sources of knowledge such as observations, parents' perspectives, key informants, and policy learning, can produce distinct knowledge; however, researchers must remain aware of the complexity that working with young children presents to the research process.

Although the children demonstrated a wide range of knowledge about health issues, we learned that the children involved in this study, as a group, had a more complex understanding of issues related to health in general than the previous research has demonstrated (Backett & Alexander, 1991; Eiser, Patterson, & Eiser, 1983). This difference may be a result of refining our health education; children may have increased exposure to health-related knowledge because of computers and video; or it could also be attributed to changing dynamics in family teaching. Regardless, these results inform nursing and other health professionals interested in doing research with young children about their health that given the appropriate research methods, young children can express ideas related to complex health issues, which provide important learning.

Within the field of health education, despite health promotion curricula focusing on healthy lifestyle behaviours, children have had been shown to lack opportunities to express themselves concerning contextual factors that contribute to health (Kalnins et al., 2002). The current research demonstrated that, for children who live with contextual

challenges such as economic and neighbourhood disadvantage, we possibly fall short in our health education, in that children experience a disconnect between what they are taught about health and healthy lifestyles, and what they live with everyday. When developing health programming, health educators, nurses, and teachers must be aware of the range of social circumstances that children live in. The current research creates a nuanced understanding of children's needs, which can assist nursing and other health practitioners who facilitate and develop programs that support children and families.

The current research has captured some important knowledge about the social determinants of health through uncovering the details of children's experiences. Living in adverse neighbourhood conditions has long been shown to affect health from birth to old age (Kohen, Brooks-Gunn, Leventhal, & Hertzman, 2002; Ross, Reynolds, & Geis, 2000; Sampson, 1991; Sampson, Raudenbush, & Earls, 1997; Shonkoff and Phillips, 2000; Wilson, 1987). Some of the children involved in this study lived in this neighbourhood because of economic restrictions, others because of the unique feature within this urban setting of affordable housing for middle-income earners. We now know more about how issues such as safety, lack of cohesion, the signs of social disorder, and more, can effectively enter the consciousness of children, regardless of family level characteristics. The children in this study were adept at expressing their concerns about their communities and readily identified physical dangers. Despite the opportunities that children of more affluent families may be afforded, living in this neighbourhood may have limited these children's potential range of knowledge of their neighbourhood (e.g., who are their neighbours, and what defines their neighbourhood). None of the children talked about their neighbourhoods as resources for their health. Nursing and other health

professionals connected to community programming must hold in mind the limits that issues of lack of safety can have on children's connection to their neighbourhoods and find creative ways to help children make meaningful connections through programs such as the OOS program. Nursing professionals could develop programs related to health and healthy living that incorporate children's understanding of neighbourhood as an important aspect of overall health. These programs could then be delivered within settings such as OOS programs—the sites in which they interact with their neighbourhoods.

The Limits of Family

We can see that the children involved in this study relied heavily on their families to support their ongoing understanding of health. Family teaching was an important component of how children learn to be healthy and make judgements about their lives. The findings of this research support previous research in the field of children's development of cognitive understanding of concepts related to health, which has demonstrated that these concepts are learned, modelled, and reinforced first through family socialization processes (Tinsley, 2003). Many children of school age are not in the presence of their families for large portions of their day, the findings of this study show that the non-familial environments in which they spend their time *also* shape children's knowledge about health in particular ways. The findings show that, in their daily lives, children face many known and less-easily recognized challenges, that may be enduring regardless of family support, such as: bullying, worrying about strangers, noticing visible signs of disorder. Family can support, nurture, and enhance a child's understanding of health, but family may not be able to control the nature of how children respond to their

environments and how they internalize the challenges in their lives. Nurses in contact with families (public health, clinic nurses, school nurses) can educate families about these types of psychosocial stresses in children's lives as children may not be forthcoming with identifying these sources of stress.

Listening to the voices of children discussing the stresses in their lives, and the responsibilities they assume due to their challenging environments, causes one to question whether children of contemporary society are burdened with too much individual responsibility. In fact, this study has demonstrated how parents—with the best of intentions—can add to their children's daily stresses through concerns for their general safety, a worrying possibility. Finding a balance for how much responsibility we place on children is important in the short term, yet our longer-term solutions need to address the societal problems that foster our fears.

Out-of-School Programming

This work contributes to a growing body of research indicating that quality childcare matters for children (Vandell & Shumow, 1999; Garmezy, 1991a, 1991b). We now understand better just how *quality* is manifest in the consciousness of young school-aged children, children who may not be afforded opportunities for exploration outside these programs. In effect, participation in the OOS childcare programs became an essential component of these children's health, and through this research we understand more fully possible mechanisms by which the connection between children's understanding of health and OOS program is established. The mechanisms that support the connection could be the microcosm of collective efficacy found in the OOS program; it could be that OOS programs set in neighbourhoods help buoy children's sense of place;

it could be that OOS programs are also the sites of access to consistent adult supervision that goes beyond cursory to caring; it may be that this is the place children find comfort in rules and social etiquette, fostering empowerment outside the structure of school; it could be simply that children find friends in OOS programs who are otherwise unavailable due to neighbourhood conditions. The findings of this research cannot answer definitively whether all of these factors are important for all children, or that some are important for only some children; what it can do is begin to build a foundation for developing future research models. There is an emerging body of research examining children's perspectives of their OOS programs (Smith & Barker, 2000) with older school-aged children—what they like, don't like, and how to change after school programs; we now need to turn our research efforts towards examining younger children's perspectives of how to improve the quality of OOS programming and help young children feel empowered to affect change.

The findings of this research impart support for stability of funding in our policy regarding programs for school-aged children. Given that within this urban setting many such programs have had various cuts to their funding sources in recent years,[29] in both operating budgets and family subsidies, the lack of funding stability has made it difficult to ensure quality programming. Programs must piece together funds from various fund raising efforts, city and municipal grants,[30] and private and corporate donations in order to provide quality care. For instance, a centre may plan for enhanced program initiatives,

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[29] In 2002, programs for school-aged children were impacted by changes in provincial childcare funding, policy affecting subsidies for families, and operating budgets for programs (Child Care Advocacy Forum, 2003; Kershaw, 2004).

[30] E.g., Inner City Bursary Grant, Program Enhancement Grant, Inner City Childcare Grant, Childcare Operating Grant, Supported Childcare Inclusion Contracts and Child Specific Contracts, Minor Capitol Funding - Equipment, Repair and Replacement Grants.

but if not successful in their application process, may be left to access funds from other, less-reliable resources such as fundraisers.

Maintenance of quality in OOS programming comes at a high cost. Quality includes upgrading staff education, staff retention initiatives, providing resources for follow-through with recommendations suggested by evaluation of programs, creating plans for enhanced programming, and more. For instance, enhanced programming may include better quality snacks and hot lunches for summer programs, library and community centre visiting programs, or community connections programs. The children and families involved in this study did not talk about participation in these types of community events, and OOS care may be the only place that many of these children will gain access to important activities. If OOS programs could count on a stable funding source for enhanced programs such as described above, they could focus more strongly on the essential task of ensuring program quality through the evaluation of programming and staff education.

Simple Solutions to Complex Problems

We still do not know enough about how children internalize what happens in their environments; however, because of this research we now know more about how adversity is manifested in the lives of children. At the risk of moving beyond the learning that this research imparts, there are some very simple solutions we could begin to initiate that may produce significant effects. The experience of living within a neighbourhood associated with challenges can create a domino effect of limiting a child's resources for health. Many of the contextual factors that influence children's health are modifiable. The children in this study did not talk about *how* they would change their environments, but

children should be asked these types of questions. Younger children are largely excluded from discussions about their environments (Davis, 2001; Davis & Jones, 1996, 1997). In their study, Davis and Jones asked 9-11 year olds and 13-14 year olds about growing pressure to adopt healthy lifestyles while living in high-density neighbourhoods with restricted range of independence and opportunities for health and well-being. The children in the Davis and Jones study live with neighbourhood characteristics similar to the neighbourhood in this study. The children in the Davis and Jones study demonstrated that they are active in assessing their environments for risks and have developed strategies for dealing with their environments, similar to the children in the current research. As in the Davis and Jones study, the younger children in this study experienced incongruence between what they are taught and what their neighbourhoods support. Health professionals and city planners should work together and take views of children into consideration when planning initiatives for safer communities.

Other simple solutions to the problems children identified would be for those responsible for neighbourhood upkeep to decrease the signs of social disorder, by strategies such as ensuring garbage removal on an ongoing basis. If parks cannot be maintained due to financial restrictions, remove them. It seems simple to suggest that playground equipment that are dangerous and offer opportunity for accidents should just be dismantled; it would seem much more important to have a few well-maintained places of play in a neighbourhood (which this neighbourhood did have) than sites that are not used and not maintained. When viewing research photographs, the children in this study suggested that they would like to play in green space that is unstructured. This finding adds to current research in the province of British Columbia suggesting that children are

not the major users of the designated play spaces (Mayfield, Chen, Harwood, Rennie, & Tannock, 2005). If parks invite disorder and create a source of stress for young children, we need to rethink these spaces, reconstructing them as green space, which is always difficult to find in inner-city urban neighbourhoods may be a viable solution.

Insidiousness of Social and Emotional Stressors

Throughout this research we see how children are forthcoming with their emotional experiences of peer relationships that may be challenging and have become adept at identifying external physical dangers in their lives. We can also see that children utilize available resources for their health. While I was interested in finding out how children draw on resources as a reflection of their sense of personal agency with respect to health, I discovered unexpectedly that children focused primarily on physical dangers and the resources they use to minimize these dangers. I also learned that the principal threats to their sense of agency are not easily counteracted. This research has provided insight into our need to increase our awareness of the important mental health stresses of daily living for children. However, in many ways children's perspectives mirror societal thinking that does not easily recognize the principal threats to health as coming from social and emotional stresses in children's lives. Identifying external sources of danger—strangers, crime rates, poor housing, and so on—has acquired societal legitimacy, but it should be equally legitimate to recognize and respond to the less-apparent stresses that the children identified in this research. Yet questions remain regarding how best to validate these psychosocial sources of danger for children.

How do all of these sources of stress become embedded in the way children feel about themselves in the world? This research cannot answer the question of whether there

is a connection between, for example, the experience of being told that your "*gums are the colour of poo*," being unable to make bullying stop, and noting that there is garbage in your play spaces—all social cueing that contributes to feeling that this situation is a reflection of who I am, and the perception that others do not care about me.

This research does, however, substantiate Sampson et al.'s (1997) collective efficacy theory about "visible signs of social disorder," as we now know that children *do* recognize these visible signs in their neighbourhoods and *do* experience psychosocial stresses because of this disorder (p. 919). Future research could focus upon answering the direct question of how these visible signs of social disorder influence children's agency with respect to health, because through the current research we now know that such effects are potentially enduring.

Strengths and Limitations

This research project provided insight into young children's perspectives of health, has advanced our understanding of children's needs from the perspective of children themselves, and contributes important knowledge to the growing body of research about children's health. Given that some young children may not have well-developed language skills and are less adept at recall than adults, this research demonstrated that by providing multiple venues for children to express themselves children can make a significant contribution to our understanding of their health needs. Based on the insights gained from research with children in the literature and the findings of the pilot study, my decision to allow each child the necessary time to feel comfortable with me prior to interviews proved to create a stronger rapport between the child and myself. This rapport enhanced the level of detail that children were willing to share with

me and how much time they were willing to give to the project. Time spent in the setting also allowed me to piece together shorter conversations and have conversations at salient junctures in their program time (e.g., when interactions occurred, we could talk about them). In addition, time spent in the centres meant that parents were involved in the research on a daily basis (for some children this involved both parents) over a matter of months. Another strength of this research is that the program staff (4-5 staff), as key informants at each centre, had intimate knowledge outside the family setting and provided details of their experiences with the children in general, and specifically about the children involved in this study. Field notes from four hundred hours of observations of the children also provided an essential informational component regarding the children's daily lives that children may not have been able to articulate. I also spent time outside the centre with four children in their homes and had one kinetic conversation walking around the neighbourhood. Two other kinetic conversations were planned and would have added a unique knowledge to this work; however, both families moved near the end of the study and locating them was not possible.

The limitations of this study were predominantly related to data sources. Fourteen children and their families is a small sample size, and although ethnographic research entails hours of immersion and time spent with participants, the implications of the knowledge that this study imparts must be interpreted with caution.

The nature of this sample presented some additional limitations worthy of mention. This sample was a convenience sample and some children may not have been included because I did not have the opportunity to meet their parents; because the parents were dealing with stressful life circumstances; because they were not willing to give up

time with their child; or because they did not place trust in a researcher asking to speak to their child outside of their presence. The study included children from families who wanted to participate at this time, and such a selection may have resulted in a sample of children with interested and engaged parents that are more homogenous than a random sampling would be. In addition, insights were not gained from children outside this OOS program or children who live in self-care or other care situations within this neighbourhood.

Many of the children's stories were retrospective, and thus some of the detail may have been lost. Detail may also have been lost because of the nature of conversations: some occurred with many distractions; others occurred during home time and children were possibly tired; during at least two of the interviews children seemed to want to go and play at the centres; still others did not have the capacity to focus for long enough at times. Despite these shortcomings, the children and families who participated were willing to talk to me over a period of a year, which contributed to a rich data source.

Researchers have cautioned us to consider that our interpretations of children's views can be adult-centric (Fine & Sandstrom, 1988). In order to ensure that interpretations were as close to what children intended as possible, during analysis I spoke to the children about my insights to gain clarification or to broaden my interpretations. In addition, I spoke to parents to clarify any questions about the data. Interestingly, this process would reveal that on occasion parent's interpretation of their child's daily events differed. However, parents were also able to provide important connections in children's stories that advanced the analysis of the data. I can only claim

to have created an interpretation of the children's lives and what is important to their health; however, the credibility of the findings is enhanced by the multiple data sources.

Conclusion

By examining how the contexts in which children live affects their perspectives of health, this research revealed multiple and various factors that may place children at higher risk for immediate and future health problems. The findings of this study provide a foundation for developing theories regarding the ways in which context shapes children's health, and will assist in making policy recommendations related to improving service provision at multiple levels, aimed at supporting children. Not only is this research important for health professionals, but it confirms that the notion that health transcends the boundaries of health professionals. It points to a community of professionals (public health nurses, teachers, community centre programmers, policy makers) and families in contact with children who can affect and alter the trajectories of children's lives. The research has shown that broader neighbourhood conditions and practices generate an environment that is fundamental in raising happy, healthy children. If we can provide a more global picture of children's health needs and experiences, we can come closer to supporting children's needs effectively. Most notably, this study shows that young children can contribute to providing a more comprehensive picture of what matters for their health.

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APPENDIX A
OVERVIEW OF METHODS

The purpose of this overview of methods is to provide supplementary information to the reader concerning ethnographic methods utilized in this study. In the interest of avoiding repetition, the contents of this section include only those important aspects of ethnographic methods that are not otherwise captured in Chapter 2 and the Methods section of Chapter 3.

Rationale for Ethnographic Methods

In order to adequately answer the research questions posed in this inquiry, I required a method that would generate a rich description of the perspectives, experiences, activities, behaviours, and social functioning of children in their everyday lives. The research design also had to be suitable for working with young children. The design that best met these requirements was ethnography. Ethnographic research is commonly employed with adult participants; however, one of the characteristic features of ethnography that made it well-suited to work with children is that it typically involves both participant observation and interviews (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001). Through participant observation methods, ethnographers gain first-hand knowledge about what people do, and how they react to, and manage, their day-to-day lives. Essentially, ethnographers uncover many of the aspects of participants' daily lives that may not be assessed through traditional, qualitative methods such as interviews alone. By participating in everyday life through immersion in the participants' contexts, ethnographers can note the nuances of daily life that become invisible to participants.

Through ethnographic methods, research has been able to demonstrate that children can be the primary participants or voices in research concerning their lives (Eder & Corsaro,

1999; Irwin & Johnson, 2005; James, 2001; Qvortrup, 2000). By entering the worlds of children, ethnographers can document crucial changes and transitions over a period of time in the child's life. In addition, many children of similar ages may not have similar language skills and may not have the capacity to, for instance, articulate their emotions or needs. Thus, participation in children's daily lives can help the ethnographer document salient junctures in their lives that may not be otherwise recorded. In addition, as mentioned in Chapter 2, during the pilot study for this research I discovered the implications of being perceived as a stranger to young children. Getting to know all of the children, so that they would be comfortable enough to speak with me one-on-one, took time and consistent immersion in the field. This preparation became a critical feature of this strategy of inquiry. While participant observation allows researchers to observe *people in context*, it performed the alternative yet no less important function of assisting children in becoming familiar with me, the researcher.

Sampling

Ethnographic research methods typically employ *purposive sampling* techniques. Purposive sampling in qualitative research is used to ensure the selection of participants who can best provide in-depth descriptions of their experiences; this technique guided the selection of child participants for in-depth interviews for this study. All parents of children who attended the three out-of-school (OOS) programs were given a summary of the research project by the researcher to inform them of the intent to perform participant observations during OOS programming time. If parents had questions about the research at this time, I explained the research project and process. The notice of ongoing research was posted on parent information boards within each centre. The program supervisors then approached parents of children who attended the first grade in school and also

participated in the OOS program, to ask if they would be interested in speaking to me about further details of the study. I had also been approached by some parents to ask about my presence at the OOS programs, as some thought I was a new staff member. This confusion occurred because initial explanation of my presence may have been provided to the other parent, or the caregiver for the family. For the most part, each parent who was approached had prior knowledge of the project because of these processes. Not all parents were approached for inclusion in this study; for example, a few children were excluded from this study because of behavioural or verbal challenges that would render them inappropriate for interviews and focused topics. While these children's perspectives would provide information that could contribute significantly to the data, utilization of different techniques may be warranted, such as therapeutic play, focus groups, extensive visual cues, behaviour management techniques, video, and so on. These types of techniques were not planned for this research project but could be utilized in future research. While the children involved in this study all attended the first grade in one of three different schools, upon reflection I acknowledge that there was a wide range of ability[31] exhibited by the children in engaging in the interview process; however, the children selected for this study primarily shared a particular social (neighbourhood, OOS program, and school), rather than developmental experience (James, Jenks, & Prout, 1998).

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[31] By this I mean that some children could sustain attention to the topic over longer periods of time and do this verbally. Other children could do this in very limited timeframes (i.e. less than 10 minutes). Still other children could engage in conversations while playing, or drawing, or while talking about the photographs. The child who participated in the kinetic conversation walking through her neighbourhood could participate in formal interviews, but was much more focused while walking and pointing out important places, people, and things in her neighbourhood.

In addition to the fourteen children and their parents who participated in this study, *theoretical sampling* was also utilized to clarify or broaden findings through seeking out alternative sources of data. Theoretical sampling was utilized for selection of a "negative case" mentioned in Chapter 3, sampling of policy documents (funding policy, healthy schools document), interviews with institutional stakeholders (neighbourhood school principal, vice-principal, two first grade teachers), and other key informants (OOS program staff and administrators). This line of selective sampling followed a parallel path to the primary source data collection in order to broaden the findings and provide a rich context to the child and parent interviews.

Data Collection

The ethnographic data collection methods for this study involved detailed participant observations, in-depth interviews with primary participants and key informants, as well as information obtained through administration of a parent questionnaire.

Participant Observation

Ethnographic researchers aim to produce dense descriptions of settings using participant observation (Emerson, Fretz, & Shaw, 1995), as certain knowledge embedded in practice may not be accessible through language. As a result of insights from his research with children, Bloch (1991) argues that children's knowledge is often conveyed in a non-linguistic manner. Further, it is assumed that the relationship between experience and language, regardless of age, is not straightforward, and that experience does not exist independently of the socio-political context (Willig, 2000). Therefore, observations of everyday experiences of children offered valuable insights into how life is organized for

the children who attended the OOS program. Participant observations provide opportunities to observe everyday life events, to begin to establish relationships with children over time, and to examine the relations and interactions between the children and their environments.

The boundaries of the participant observation settings, however, are "constituted and maintained through cultural definition and social strategies" (Hammersley & Atkinson, 1995, p 41). Ethnographic methods do not produce an exhaustive description of a setting; however, the researcher engages in a process of criteria selection and inference, guided by a theoretical perspective that directs the researcher towards relevant questions, insights, and a subsequent refining of the process of description. As time is an important component of any ethnography, and it is impossible to observe or participate in all aspects of the field of study, the ethnographer must use a selective approach to data collection. Sampling of salient periods and junctures in the lives of the participants is therefore necessary. For instance, snack time provided a great deal of information about children's nutritional intake, socialization, and health beliefs. Age-grouping interactions provided unique information, but were coupled with equally important observations of free time in which children mixed ages. Parent pick up times were also an essential aspect of observed daily interactions; therefore, if I had to select particular times to visit programs, I would ensure pick up time was included. Not only did my selected observations broaden my understanding of the everyday lives of the children who participated in this study, they also provided insights into how the environment influences children's health.

I used a consistent approach to documenting fieldnotes, guided by questions provided in the participant observations guide. For instance, I observed and documented interactions between OOS staff and children, children and children, parents and children, as well as conversation patterns, and patterns of movement in the setting. Questions were also posed during observations, such as what are children doing? What are they trying to accomplish? How are children responding to their interactions? Why do children make particular choices during play? and so on. I also documented the physical set up of the OOS program, the nature of the play spaces, and, as presented in Chapter 2, observations of the neighbourhood in which the children live. Initially, the content of my fieldnotes provided a broad picture of the setting in which they took place; however, as I spent time in each setting, the notes became much more focused. For example, I observed who started and stopped interactions, how adult-child interactions were managed with respect to power, non-verbal communication, verbal content, and interruptions. I also observed particular children's interactions to help broaden my understanding of our conversations and fill in gaps in social function for some children. In my fieldnotes, I would document insights and challenges I was experiencing during analysis, so that I could keep in mind salient information during time spent in the settings. This served as an imperative process, because I was moving between three centres and four homes within the neighbourhood over a 1-year time period.

In-depth Interviews

The research literature to date involving qualitative interviews with children spans many disciplines. Many of the research studies involving children cited in this dissertation, including the dissertation pilot project, have provide a great amount of

practical knowledge with respect to how best to approach interviews with young children, how much time was necessary, how many interviews were necessary, and how to best enter the worlds of children in a non-threatening manner. For the most part, theory provided the foundation for decisions about interviews; however, the children involved in this study were equally influential in driving this process. Some days, some children were particularly enthusiastic and provided robust and detailed insights; other days, these same children may have been worried about missing important games or events, and thus the research was not a priority. To accommodate such varying situations, I had to remain extremely flexible in my daily interview plan.

Interviews with children that involve forms of play or creative techniques using the child's imagination have elicited much of the necessary data within studies involving children's health experiences. Play therapy has long been known to assist children in various contexts (e.g., hospitalized children, children with mental illness, children who have been abused) to talk about their experiences (Christensen & James, 2000). As I was aware that one-time interviews with children may yield a limited amount of information and only provide a snapshot of a child's health concerns, I engaged in multiple, short interviews over a period of a year with children as necessary. Deatrick and Ledlie (2000) suggest 30 minutes may be the most time a child six years of age can sustain focused attention to the research topic. It has also been suggested that children may not be willing or able to talk about the subject that the researcher is interested in, without the researcher having spent time with the child or the child and family prior to the interviews. I enlisted the assistance of parents, included parents in the interviews when the children requested, and also talked to the program staff about how best to approach particular children. One

mother was concerned that her child would be uncomfortable with missing any special event at the program, and the staff provided the necessary gap in programming for our interview to take place. Listening to the suggestions of parents was an essential component of success for the research interviews.

Ethical Considerations

There has been much debate over the effects of the *researcher as authority figure* in the process of data collection, as the power imbalance between adults and children is thought to influence the data collected. Although I believe that the issue of power imbalance can be overlooked in research involving adults, I established a relationship with each child prior to interviews that was not based upon evaluation, authority, or a position in which my assumed power could affect the child in their day-to-day activities. I am aware that for some children this process was much more seamless than for others. I kept detailed fieldnotes of the process of getting to know each child and attempted to find the "right" time to interview or speak to each child.

Informed consent was obtained from each adult-participant for their participation in answering the parent questionnaire, to agree to be observed in parent-child interactions during OOS program time as well as at home (if necessary), and to consent to their child's participation in the study.[32] Parents were made aware that a child assent process would also be completed prior to commencement of the study. The University of British Columbia Behavioural Ethical Review Board (BREB) guidelines state that children under the age of 19 are unable to give consent, and, therefore, although not required by the ethical review board, I chose to ask children for their assent to participate in the study,

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[32] Of note is that in any interview in which a researcher enters into a child's world, the researcher must always be prepared for uncovering experiences of an abusive nature. I therefore informed each parent during consent procedures of my duty to report ongoing child abuse disclosures.

agreeing to their parents decision to allow them to participate. Before children were approached for assent by the researcher, initial screening was performed on two levels: first, once the study was described in full detail to the parent, the parent was questioned about whether they still felt their child had the ability to understand what was involved for participation in the study; second, during my assent procedure with the child, I explained the study in full (see Appendices C and D), and I ensured that the child was acting as a willing participant. Two children were not considered for participation in this study because it was determined during assent processes that they did not truly wish to participate. Assent was gained from each child-participant prior to commencing the interviews. I remained child-centred in my approach to the research, with attention to the needs of each child as paramount to the research process; if I perceived that a child was uncomfortable in any way within the research process, the interview or observations would be suspended until I could ascertain the child's comfort level. As the study took place over a timeframe of months, I kept an ongoing *checking in* with children, to make sure that their assent to participate remained active, as it cannot be assumed that assent would be maintained through the entire project.

As I was asking the parent and child to give of their time over a 6 to 8 month period, I offered parents a one-time honourarium of twenty dollars to cover their time, childcare costs, transportation, and so on. I also gave the child-participants a small gift that was pre-approved by their parent to thank them for their participation. I did this purposefully after the second interview took place, so that the children would not feel compelled to give second interviews because they had received gifts.

I drew upon my extensive experience talking with children who are hospitalized, who live with chronic illness, and who participate in community programming. I drew upon this experience during interviews with children, attempting to remain informal in conversations by allowing children to ask questions, to establish a relationship at their pace, and by offering each child-participant the choice of a parent to be present in the one-on-one interviews. Four of the children involved in this study were interviewed in their homes with their parents present. Eleven of the children's interviews took place at the OOS program. A parent was present during one interview at the centre. Otherwise, the interviews included a staff member's presence, as a rule for this OOS program was that any non-staff member was not allowed to be alone with any child. Interviews took place in a room in which the children and I were in full view of staff but somewhat private, or were performed out in the open in a corner of the larger room when necessary. Therefore, when the OOS program setting was used, it was impossible to maintain anonymity. While every effort was made to ensure as much privacy as possible, the reality of interviewing children outside their homes, and even inside their homes, makes this requirement difficult to meet (Irwin & Johnson, 2005).

Data Analysis

Data collection in ethnographic research is obtained through a variety of sources, and thus requires differing, yet consistent, approaches to data analysis. Data analysis for this study followed the established techniques of ethnographic research (Hammersley & Atkinson, 1995) and was guided by insights into interpreting sources of data obtained from children (Fine & Sandstrom, 1988; James, 2001). While a brief review of the steps

of analysis are provided in Chapter 3, this section provides details of nuances of the process.

Analysis techniques included initial coding, developing and connecting conceptual meanings and categories, and theoretical memo taking. Initial coding of data collected from data sources took place as the data were collected (Hammersley & Atkinson, 1995). Initial coding proceeded in a line-by-line manner, in which I identified sections of the transcripts and fieldnotes that were significant to the research questions. At an early stage in the process, identification of these sections remained open to all concepts or core ideas that the data may have contained. This stage of data analysis was also guided by questions concerned with the theoretical perspectives found in the literature. For instance, questions[33] were asked of the data during initial analysis such as

1. What is going on here? (I.e., Problems child faces: How does he or she try to manage? What are the barriers?)
2. What are this child's concerns and what is he or she trying to do to change or alter these concerns?
3. How does this child describe his or her relationships with parents, OOS staff, and others?
4. How does the child's perception of family and neighbourhood environment affect his or her beliefs or actions?
5. Is this child demonstrating signs of resilience or vulnerability?
6. How has my or the parents' presence influenced what the child is saying?

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[33] These are just sample questions and not intended to be exhaustive.

As I progressed with an iterative process of analysis and data collection, I refined earlier insights and developed concepts through the identification of themes and patterns noted in the data, proposed relationships among concepts, and tested or refuted those relationships with further data analysis. I moved back and forth from close reading of the data to situating my insights in the broader context of the data as a whole, as well as the theory and other significant data available. Analytic notes and memos were generated throughout the entire research project and intensified during the more formal phases of analysis. Notes and theoretical perspectives provided the foundations for posing questions of the data, toward developing theoretically sound descriptions of the data. When data collection and initial coding and categorization were completed, I provided my committee with a draft of these insights and discussed these with my committee members prior to commencing more intensive analysis aimed at gaining alternative perspectives on analysis. As I focused on children's perspectives and the particular contextual influences important in the lives of children, my aim was to develop theoretically explanatory answers to the research questions (Hammersley & Atkinson, 1995). Artful selectivity pervaded this research analysis in order to exemplify the most salient aspects of the data collected. To this end, the analysis simultaneously exemplified commonality and complexity in the findings

Analysis of the observations of children, interviews of children, and other sources of data, were approached according to theoretical insights provided by the literature in each field, the insights of the dissertation committee, and by emerging insights that evolved during data collection. Data analysis in ethnography is not a distinct stage, but rather occurs simultaneously with data collection. The iterative process between analysis

and data collection during analysis served to identify areas for theoretical sampling as data collection proceeded. The iterative process also allowed for follow up on insights with alternative children. For example, a few children mentioned challenges that recess with the "*big kids*" held for them, and during analysis it became clear that other children were referring to interactions that were important to understand more fully concerning the dynamics of recess within school. The idea of recess with the big kids was then incorporated into formal and informal conversations with children. This line of questioning then tapped into a child's world of play during school hours that had not otherwise been considered.

Interpretation of data concerning children is a complex task and has been widely critiqued (Alldred, 1998; Mayall 1994, 1996; Morrow & Richards, 1996). Of note, researchers warn those interested in engaging in ethnographic research with children not to assume they "understand children" just because they have once been children themselves (Fine & Sandstrom, 1988, p. 7). Their perspective on the danger in the interpretation or analysis stage of research with children is that analysis occurs through or from an adult perspective. I suggest that all unreflexive researchers, not just those working with children, are in danger of imposing artificial interpretations on data of any source. In addition, attending to the multiple philosophic problems within research with children is important, but if taken to an extreme may result in paralyzing the practical application of research. For instance, during analysis I asked myself how do I "practically" step out of my adult perspective? I recognized that I could not; I could only be aware of how my adulthood influenced the analysis. I did not discount the views of these researchers concerned with analysis of children's data and saw it as important to

consider for the integrity of this study. I managed the challenges inherent in conducting analysis with children by remaining reflexive through journaling and consultation with committee members about my insights and my perspective.

Rigour

The hallmarks of rigour in ethnography differ from traditional reliability and validity in quantitative work. Many different positions exist concerning the exact requirements for rigour in ethnographic research; unaligned with a specific side in this theoretical debate, I developed and applied a comprehensive framework for ensuring the quality of this ethnographic research. A synthesis of the arguments suggested that rigour in ethnographic research is measured in terms of the extent to which one can be convinced that the researcher has sampled extensively throughout relevant situations by *immersion in the field* and in terms of the *wealth of details* that can be assembled. Additionally, the quality of ethnographic research is enhanced by producing a detailed depth of description, which can be accomplished by incorporating *multiple sources of knowledge*, not only in data sources, but also in data analysis within a team context. To achieve the required depth of description, I remained reflexive regarding the possible data collection situations, my presence in the research process and its affect on the data, and remained curious and open to alternative ideas for and explanations of information. I enlisted the expertise of my dissertation committee and a group of child health experts (Human Early Learning Partnership Analysis Team) by providing early drafts of initial analyses for feedback. I had regular meetings with the dissertation supervisor concerning analytic challenges and consulted the dissertation committee and specific outside experts,

such as an expert on children's social and emotional health, on particular challenges during this process.

Ethnographic researchers who aim to develop theory must use caution in their claims about knowledge production; however, prolonged immersion in the field can produce in-depth descriptions and insights that move the researcher closer to this goal. The value of ethnography lies in a researcher's ability to make interesting connections and bring new perspectives to our understanding of important matters, such as children's perspectives of health and the influence challenging contexts have in their lives.

Summary

The methods employed in this ethnographic approach provided the necessary tools for answering the research questions in relation to children's perspectives and role in their own process of staying healthy. Indeed, I was asking children to talk to me about difficult concepts such as health, safety, neighbourhood cohesion, feelings of belonging, scholastic challenges, and so on. While I do not claim to have uncovered all there is to know about the factors that influence children's health, bringing to light the social worlds of children from the unique perspective of the children themselves has shed new light on our understanding of factors that contribute to children's health.

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APPENDIX B
INTERVIEWING YOUNG CHILDREN: EXPLICATING OUR PRACTICES AND DILEMMAS[34]

Introduction

Children are active in the construction and determination of their social lives. As such, they are not the mere recipients of contextual influences but, rather, are active in the construction of their worlds (Coles, 1986; Greig & Taylor, 1999; James, Jenks, & Prout, 1998; Mayall, 1994, 1996). Because the voices of children have traditionally not been included in child-related research, our understanding of child health is incomplete (Woodgate, 2001). Coles has suggested that children formulate important opinions about their social, political, and cultural contexts that are not simply reflective of their parents' ideas. Indeed, child health researchers concerned with hearing the voices of children need to reconsider the value of including the perspectives of children within our research venues. If children had greater access to a public voice through vehicles such as research, they would be able to contribute to the social structures that concern them.

To date, the majority of knowledge available from research related to the health needs and experiences of young[35] children has been based on the perspectives of parents or pediatric health professionals. These perspectives have provided data that have allowed health professionals to understand more fully the needs of their young clients. In recent years, a growing number of researchers in the health care field have begun to capture the perspectives of children through qualitative interviews.

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[34] A version of this appendix has been published: Irwin, L. G. & Johnson, J. L. (2005). Interviewing young children: Explicating our practices and dilemmas. *Qualitative Health Research, 15*(6), 821-831.

[35] Throughout this manuscript we make reference to many ideas that apply to young children, however, these ideas are by no means intended to be monolithic and it is recognized that the developmental capabilities of individual children will vary.

Qualitative research studies have demonstrated that children as young as 4 years can provide important insights into their daily lives and health experiences. For example, children have provided insights into their experience of living in violent homes, homelessness, living with chronic illness, cancer pain, and their understanding of consent to surgery (Alderson, 1993; Bluebond-Langner, 1978; Eriksen & Henderson, 1992; Smith Percy, 1995; Woodgate & Kristjanson, 1996).

There is an emerging literature concerning the theoretical basis for the conduct of qualitative research with children. For example, Docherty and Sandelowski (1999) have provided a good review of the social, emotional, and cognitive developmental requirements for participation in qualitative interviews. They have discussed the appropriate content, timing, number, and overall structure of interviews and have offered principles for ensuring that children's experiences are faithfully represented.

Despite the shift to include children's perspectives in research and document principles related to good data collection with children, however, there has not been a parallel move within the scholarly community to lay bare the practical challenges inherent in conducting interviews with children. Admittedly, there is little opportunity within the context of research articles to discuss the complex challenges faced during data collection. Our "sanitized" descriptions of data collection mask the unique situations, dilemmas, and practical sticking points involved in collecting data from children. As researchers embarking on a study involving eliciting young children's understanding of how their everyday contexts (home, school, community) influences their health, we found ourselves wondering about the interviews that lay behind other published qualitative studies involving children: What was the structure of the

interviews? How did researchers manage the practical challenges? and How did the researchers ensure the interviews were of good quality?

Established principles of quality data collection:

The challenges of working with children

In the context of an ethnographic research study that incorporated the perspectives of 6-year-old children, we faced numerous practical challenges as we engaged in the process of conducting qualitative interviews asking children to talk about health. As we listened to the tapes of these interviews, we found ourselves wondering if our data were rich enough, complete enough, and coherent enough. If not, how could we improve the quality of these interviews? Experts on qualitative methods have articulated standards and principles for conducting "good" qualitative interviews (Miller & Glassner, 1997; Morse & Field, 1995; Rubin & Rubin, 1995). These standards and principles are taught widely in methods courses and have been passed on to research trainees. As researchers, we have internalized these standards and have come to expect that our interviews will have particular qualities. However, in our interviews with children, we found that our experiences sometimes fell short of capturing these qualities. Given that in most cases, the well-known standards we are speaking of were not intended explicitly for children, we found ourselves questioning their applicability for research with children. Furthermore, when we attempted to access literature for guidance, we found limited information (e.g., Deatrick & Ledlie, 2000; Docherty & Sandelowski, 1999; Woodgate, 2001). Similarly, Greig and Taylor (1999) claimed that there remains very little practical guidance on the conduct of qualitative interviews with children, especially the 5- to 12-year-old group. Therefore, our purpose is to consider the degree to which well-known

standards for qualitative research are applicable to research interviews with young children. The study that forms the foundation for this article underwent ethical approval from the authors' academic institution, and the children's names used within this manuscript are pseudonyms chosen by the children. Based on our experience, we would like to make practical recommendations that build on the theoretical work of Docherty and Sandelowski about the conduct of qualitative interviews with young children.

Stranger Danger: How Do We Build Rapport?

One commonly held standard for conducting qualitative research is the notion that prior to beginning an interview, one needs to develop rapport with the participant (e.g., Greig & Taylor, 1999; Miller & Glassner, 1997; Morse & Field, 1995; Rubin & Rubin, 1995; Wilson & Powell, 2001). This is accomplished by taking time before the interview begins for the interviewer and participant to get to know each other. It is thought that with the appropriate rapport, the interview becomes a "personal sharing with a trusted friend" (Morse & Field, p. 90), because it leads to fuller and less constrained disclosure. Building rapport might also be enhanced through techniques such as letting the participant choose the location of the interview and ensuring the setting is private. In light of these principles, consider the following scenario in which we attempted to build rapport with Brett.

> Brett chose his front yard as the location for his interview. Brett's sister and friend played in the yard while the research relationship was fostered. As we knew that it is important to build rapport with Brett and that children might take longer to establish this trust with an unknown adult, we sat and chatted for a while before

> approaching the topic of the interview. We played with the tape recorder so that he might feel less uncomfortable about being recorded and had fun with our voices on the machine. Brett was constantly distracted by the play of the others, and it seemed that he would much rather have been with them than doing the interview. Throughout the interview, Brett's body language indicated that he seemed uncomfortable at times He gathered up his little legs into his arms and gave one-word answers to open-ended questions, yet, at times, he would seem totally engaged, tell a short story, and then return to his previous demeanour. In the end, Brett asked to stop the interview. On leaving, there was a distinct feeling that we had little data because of the brevity of some of Brett's answers, and we questioned the quality of the interview.

When we listened to and transcribed the interview with Brett, however, we realized that although there were some rich data to analyze, the interview did not conform to our expectations. Building rapport with young children takes time, and we cannot expect that a first-time meeting with a child is going to see the establishment of suitable rapport, particularly in our current social context, in which children are encouraged to be wary of unknown adults. Adults understand the social interaction of building rapport and the niceties involved in getting to know one another, whereas many young children are less savvy. In addition, young children might not fully understand the purpose of a research interview and the relationship that this context requires. Nevertheless, it is the responsibility of researchers to establish a working relationship with the child. In doing

so, the researcher must also establish a working relationship with the parent. Wilson and Powell (2001) have cautioned that the research relationship does not involve trying to be best friends with the child.

In our work with children, we employed several forms of play (drawing, role-playing, and using props) to enhance their level of comfort. Although these techniques might provide a natural context for some children, we agree with Harden, Scott, Backett-Milburn, and Jackson (2000), who suggested that we should not assume that all forms of play are appealing to children. "While for adults, children's involvement in drawing may be associated with 'fun,' we cannot assume that this is the case for children...not all children are comfortable with it" (p. 2.11). In our interviews with children, we found that if the form of play did not match the needs of the child, barriers to rapport building were created. For example, some children found it taxing to draw pictures and answer questions at the same time. Separating these activities, however, created a time-consuming interview process that further taxed the child. Strategies that can facilitate the development of a working relationship, enhance rapport, and, possibly, improve the quality of the data collected include (a) working with parents to learn about how the child prefers to interact and what might facilitate his or her comfort in an interview context; (b) using one or several pre-meetings to get to know the child before the research study begins; and (c) incorporating the use of multiple interviews, so that the needs of the child can be respected, as some children might find a long interview more challenging than two or three shorter ones (Deatrick & Ledlie, 2000).

Consider the Individual Child: How do We Structure the Interview?

When rapport is established, it has also been suggested that the researcher has only to start with "Tell me a story about..." and the adult participant will be able to lead the interview. Morse and Field (1995) suggested that an unstructured qualitative interview, wherein the participant is allowed to tell his or her story with few interruptions and in which the interviewer assumes an "active listening stance," should elicit good-quality data. Megan's first interview, described below, did not generate much initial spontaneous conversation and resulted in our reconsidering the timing and appropriate use of open-ended questions.

> Megan's interview took place in her home with her parents watching television in the same room. We wanted to know about her health and what she did to stay healthy. Even though we incorporated play strategies, such as drawing pictures, there was much silence in our conversation as we waited for Megan to formulate her responses. It became apparent that Megan was either unable or, possibly, too uncomfortable to answer many of the open-ended questions. It was not until some closed-ended questions were used that Megan began to smile and, seemingly, to relax.

Megan's situation illustrates that researchers must be aware of the linguistic needs of the children they interview. Like some children this age, Megan was unable to deal with the complexities of open-ended questions in the absence of other verbal prompts or cues, particularly at the beginning of an interview. As some children of this age might find the verbal ability necessary to engage in a quality qualitative interview challenging,

Wilson and Powell (2001) suggested that closed-ended questions put less weight on the child's verbal ability. Rather than opening the interview with the traditional open-ended question, we have found that a series of direct questions can help a child to begin to engage in the interview process. Although these types of closed-ended questions might not initially tap into the full experiences of children, when used at the beginning of an interview, they forge a path to developing a better understanding of the child's experiences and assist in identifying openings for additional questions.

Although we have come to expect that a good qualitative interview, when transcribed, typically has solid blocks of text representing the voice of the participant and limited lines from the research interviewer, clearly, as our experience with Megan's and other interviews suggests, this standard is not easily met when interviewing children. As researchers, we might have to reconsider notions such as blocks of text as an ideal when working with children, who might require more prompts and direct questions to engage in the topic at hand. In addition, when considering the verbal and cognitive load that interviews can require, we must be prepared with an alternate structure to our interviews to meet the needs of each individual child as well as being open to moving completely off topic (to one of interest of the child) to facilitate conversation and comfort.

Thinking Outside the Box: What does the Setting for the Interview Require?

In addition to building a strong rapport and developing an appropriate interview structure, the setting for the interview must also be considered carefully. In interviews with adults, it is suggested that a small yet private space can create a feeling of intimacy, ensure confidentiality, and enhance the engagement of the dyad. Our experience suggests that some children, however, are unable to confine themselves to one small space. In

addition, researchers who are working with young children might need to accommodate "space" for parents and guardians. The natural world of many children involves movement and activity, and to attempt to have them sit and focus can create unnecessary strain. Consider the following scenario.

> Emerald's interview took place in her home and started with tea and cookies. Her mother was present throughout the entire interview, and her home was an open-concept main floor in which our interview took place. You could not have predicted just how much space Emerald would need. Emerald was a kinetic chatterer. During our interview, Emerald tumbled on the sofa without missing a beat answering or telling her stories. She ran around the room, hid behind the curtains, and left the room to get props such as hats and pictures on many occasions, never leaving the context of her present story. She would keep talking in a louder voice when she left the room to let us know she was still with us, just getting something from her room.

The issue of using an intimate space in which privacy can be ensured would certainly have curtailed Emerald's creativity and expressiveness. In contrast, other children we have interviewed have seemed to be comfortable sitting on their parents' lap at a table. They have remained engaged in the interview and have used their parents to scaffold[36] their stories. Wilson and Powell (2001) contended that some children might feel overcrowded in a small interview room; yet, how do we reconcile that there needs to be enough space for some children, whereas others might offer more quality data and feel

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[36] Parents provide support or scaffolding of children's conversations through identifying characters or offering words or concepts to their children but do not direct the topic.

less intimidated in an enclosed and intimate space? We need to tailor the interview space to the expressional style of the child, and in so doing; we need to think beyond the traditional spaces that are often associated with high-quality interviews. Some children might best be interviewed as they walk, play, or are enjoying outdoor spaces, in what we refer to as kinetic conversations. Although kinetic conversations can be technically challenging, our experiences to date have been successful; these interview contexts yield more complete and more naturalistic expressions of children's experiences for some children.

Everyday Interactions: How do We Minimize Leading the Child?

In daily life, it is common for adults to help children find words and for children to look to adults for cues that what is said is appropriate. As such, it follows that children will look to adults for cues and assistance in conversation. Within the context of a research interview, however, it has been suggested that assisting a participant to find words or concepts might compromise the integrity of the data.

The way in which a child presents his or her experiences or tells a story during an interview might not make sense to an interviewer initially; the meaning systems of children are different from those of adults (Miller & Glassner, 1997). In an attempt to forge common ground, the interviewer might try to introduce words or concepts to help make sense of what is being said. This is more likely to be the case when a child is having difficulty finding the appropriate words or descriptions for his or her thoughts or the interviewer is having difficulty grasping what is being said. In these situations, it is very tempting to interject and offer the child words or suggest descriptors that the child is struggling with expressing. As is evident in the following scenario, children might be

more inclined to agree with the researcher's selection of concepts or words to complete their stories than adults would be, and the researcher must consider the effect on the integrity of data collected.

Alex was describing his version of a healthy neighbourhood, and he kept referring to the concept of comfort. As the interviewer attempted to get a clearer idea of exactly what he meant, the following dialogue ensued:

A: *Where we're really comfortable places. That's what my best neighbourhood would be like.*

INT: *What do you mean, "where we're really comfortable" at places...can you give me an example like...*

A: *Like if we went to someplace and we weren't really comfortable going before and then we figured out and I was really comfortable...*

INT: *Do you mean like you feel safe when you're there?*

A: *Ya.*

INT: *So, being safe when you are out in your neighbourhood is important to you?*

A: *Ya, there's always somebody out watching at recess if there's people and sometimes we go outside and there's nobody watching but I still feel safe.*

When Alex mentioned being comfortable, did he mean being safe? Alex might have come up with the concept of safety himself, but it was tempting to make immediate sense of his ideas about having a healthy neighbourhood. If we had not offered the concept of safety to Alex, we might have discovered through analysis that this was his intention or that we had somehow altered his version of comfort in our attempt to make sense of his experience. Yet, in some situations, we might need to help children find words to express themselves. When we do this, we need to ensure that the words we offer fit the ideas of the child and not our preconceived ideas.

Although we cannot avoid placing an adult interpretation on the expressions of children, we need to try to ensure that their voices are expressed as "authentically" as possible.[37] For example, in the case of Alex, we could have offered a "shopping list" of terms for him to select from when he was struggling with the concept of comfort, offering options such as "happy," "safe," or "fun." Alternatively, we could have asked him to describe a comfortable place. When a term or phrase is offered by an interviewer and taken up by a child, the researcher should be reflexive about the possibility of having led the child, and be prepared to explore the authenticity of the expressions during analysis and validate meaning in subsequent interviews. With Alex, we could see if he spontaneously uses the term *safety* by re-exploring the notion of comfort in subsequent interviews. Finally, it should be recognized that language is only one route to understanding a child's idea of comfort; others are observational data, drawing and play-acting.

Sitting on Mom's Lap: Does a Parent's Presence Compromise or Enhance the Integrity of a Study?

Our experience of interviewing young children involved choice for the children (and parents) of parents' being present throughout the interviews. Some parents sat with their child, whereas others were present (somewhere close by) but not actively involved in the interview. When parents are present during interviews with young children, they might also contribute to the interview in ways that could be seen as leading the child in a complementary way. Although at first, we were concerned that some parents directed the children in leading ways, we came to realize that parents' scaffolding of stories added a

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[37] Alldred (1998) reminds us that we cannot fully access the authentic voice of the child. The child's voice is not independent of the interview context. When adults engage children in conversation the children have to render themselves meaningful in adult-centred terms.

richness and completeness that might not have been accessible on first or even subsequent meetings. For example, parents would insert phrases to prompt the child, such as "Remember when..." "How about..." and "What did you tell me the other day about..." Other parents explained terms or the significance of people involved in the child's story as an aside to the researcher. The data these cues evoked provided important insights about the child's world and their shared memories of events as well as further data from which to develop appropriate interview probes.

Children develop and learn the skills of storytelling most often in parent-child interactions. Children's development of these skills might differ vastly depending on their personal parenting contexts, emotional organization, and cognitive abilities (Oppenheim, Ayelet, Warren, & Emde, 1997). The question of whether a parent's interjections into an interview primarily focused on the child will compromise the integrity of the research must be considered. Again, we turn to the natural context of a child's interactions. Children of this age are likely to be supported by a parent in many, but not all, of their interactions; therefore, it would seem reasonable that contributions to a child's stories should be expected in an interview with a child when a parent is present.

The Question of Dross: How do We Assess and Recognize the Value of our Data?

Although it has been suggested that good informants who are allowed to tell their stories uninterrupted will "invariably tell stories sequentially" (Morse & Field, 1995, p. 92), rarely do adults tell a story in full with all parts of the story in sequence. Our extensive experience in interviewing adults about their health has revealed that adults are, for the most part, able to talk to us about their experiences but that their stories are usually full of tangents that might not appear to be part of the interview topic. It has been

suggested that interviews should ideally contain a minimum of dross, or talk that is not relevant to the study (Morse & Field, 1995). The interviewer is responsible for keeping the participant on track. In the case of the young children in this study, rarely was a story, however short, told with a beginning, a middle, and an end. In reviewing transcripts, researchers are unlikely to find text in which the child "tells a story" that conforms to researchers' expectations of completeness. Janna's ideas about health are one example of allowing a child to follow their own storytelling path.

Janna sat on her mother's knee during our interview and consulted her mother to clarify or support her stories. These contextual factors need to be considered in the analysis. When Janna was asked what it meant to be healthy she replied, "It means by eating good healthy foods and that you stay healthy." Her reply also involved talking about running and playing, and getting exercise with her friends. She also said she liked to organize food with her mother.

> *We dump the whole closet out, well we dump one of the drawers out and put all in and all around it and there's this big space in the middle of the drawer and then in the closet we put like we put all the can there and all the health foods that are canned there and we put all sweets up high so no one could get to them.*

She continued,

> *In the summer we go, we have a cabin...there's no electricity so we have to bring some marshmallows to eat but we usually eat hot dogs or something like that.*

Her story then carried on to talk about her cabin, who goes there, how you have to sit on logs to eat, how they swim and a long story about how her father fell into the lake.

As Janna told her stories, we were tempted to try to redirect her back to the topic of interest. We did not understand initially how the stories she told were ultimately related to her ideas of being healthy. Similar to the experience of other researchers (see Mauthner, 1997), on analysis, it became apparent that what we might have interpreted initially as dross was a part of a larger picture of her experience of health. Wilson and Powell (2001), whose expertise involves interviewing children for information of legal matters, advised that a "young child does not tend to say much at any one time" and is less likely to give a detailed account of events (p. 52). In many of the interviews, the children described stories and experiences that seemed tangential and confusing to the first-time reader. Children's stories often included seemingly conflicting data that on first blush could be interpreted as irrelevant to the logistics of the story. Yet, for the children, they were part of their 6-year-old way of telling a story.

For Janna and for other children in this study, the skill of responding to open-ended interview questions might be challenging, and we propose that if the interviewer attempts to redirect the child, it might result in the loss of valuable data. As a researcher, you might have to be willing to let interviews take their natural course rather than controlling its direction. During analysis of our interviews, we have found that "tangents"

have provided valuable perspectives about the experiences of the children we interviewed. By not hastily redirecting the children, we believe, we come closer to their authentic voices about the issue of health.

Expect the Unexpected: Go with the Flow?

Our interviews with children were eventful. Rarely did a child sit quietly and answer the questions that we posed. The events that unfolded during the process of interviewing young children might not be surprising; however, these incidents are rarely addressed in scholarly articles and make up an important aspect of the life world of children. The "events" that took place in the context of our interviews included having a child vomit at the beginning of the interview because of excitement. Another child climbed up on a chair and entered the house through a window six feet up, one girl had a friend "pop" in to her house in the middle of the interview and sit down at the table with us, and still another had friends making faces on the door of the interview room at her daycare and was talking to them during our interview. One child even received three phone calls from friends during our interview. No matter how we try to control our interview settings with children to gain the most accurate or true to life experiences, it has come to light for us as researchers that these occurrences are important and necessary parts of the child's context. When working with children, we must consider whether altering or attempting to control these occurrences might not be our best route to finding a child's authentic voice in research venues.

Summary

We have described many of the challenges that we faced during our research study involving interviews with young children about their perspectives on health, and

although researchers doing similar studies might have different experiences, we suggest that researchers who embark on work with young children need to forge a new understanding of the standards for quality in qualitative research with children. Researchers have been criticized for obscuring the processes of our work and excluding discussion of our methodological dilemmas in our study reports (Alldred, 1998). Through revelation of some of the practical challenges that working with young children might present, we have attempted to begin the conversation with other researchers about this challenge. In doing so, we have attempted to respond to Alldred's challenge to researchers to make "explicit our practices and dilemmas" (p. 164).

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APPENDIX C: PARENT CONSENT FORM

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

PARENT CONSENT FORM

Study: Growing up healthy, Phase I

Principal Investigator: Dr. Joy Johnson, Professor, School of Nursing, 604-XXX-XXXX.

Student Investigator: Lori Irwin, School of Nursing, Doctorate of Philosophy in Nursing Student, 604-XXX-XXXX.

Purpose:
The purpose of this study is to describe children's experiences of health in relation to their daily life circumstances. In particular, the researcher will explore children's perspectives of (a) their healthy development, (b) how children act to enhance/diminish their healthy development and the factors that impede and facilitate these actions, (c) the ways in which life circumstances/context influence their healthy development, and (d) to describe how parents influence the child's understanding of healthy development.

Study Procedure:
I understand that I am being asked to participate in this study by answering a parent questionnaire, and to talk to the researcher about my child's health and environment. The researcher plans to take notes about these informal conversations, which will become confidential information used within this study. I am aware that I will be offered a one-time honorarium of twenty dollars to cover my expenses for travel or childcare over the duration of this research project. I understand that my child will also be asked to participate in this study. To begin, the researcher will have a casual conversation with my child lasting about 30-60 minutes to establish familiarity with or "get to know" my child with me present. My child's participation will then involve 2-3 short interviews lasting approximately 30-60 minutes, and that the researcher will takes notes on observations that she makes about my child during 2-3 visits to the Out-of-school program over a six month time period. I am aware that my child will be offered a one-time developmentally appropriate gift for participation after the first formal interview. I am also aware that this gift will be pre-approved by myself. All meetings will be conducted at a time and location convenient to my child and me and that only the interviews with my child will be audiotape recorded. I am aware that my child can request my presence at any or all of the meetings. I am also aware that my child can ask questions of the researcher during the interview process.

Confidentiality:
I know that my child's identity will be protected by code numbering of the tapes and that the only person having access to the code numbering is Lori Irwin. The tapes will be kept in a locked filing cabinet. I am aware that the only people who have access to the audiotapes or transcripts will be four professors who are members of Lori's dissertation committee, a professional transcriptionist, and the researcher, Lori Irwin. I understand that all names and identifying information will be removed from the transcripts of the interviews and will be destroyed after five years. I understand that no names or identifying information will be used in any written reports of this study. At any time during the research process, my child can refuse to answer questions, and/or request that the tape be turned off or erased. I am aware that the researcher has a legal obligation to report any disclosures of child abuse that may occur during conversations with my child. I have also been informed that my child is free to withdraw his/her participation from this study at any time, for any reason, without jeopardy to his/her current or future health care or social services.

Contact:
If I have any questions or desire further information with respect to this study, I may contact Lori Irwin at 604-XXX-XXXX or her supervisor, Dr. Joy Johnson at 604-XXX-XXXX.

If I have any concerns about my child's treatment or rights as a research subject, I may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent:
I understand that my participation, and my child's participation in this study are entirely voluntary and that I may refuse participation or withdraw from the study at any time. I understand that by accepting the honorarium and/or gift for my child that my child and I are in no way obligated to continue participation in this study. I am aware that I may be asked to consent to participate in a second phase of this research involving observation of my child in the home/neighbourhood setting.

My signature indicates that I am aware that ideas obtained from this research may be used in research dissertation towards a Doctorate degree, in future scholarly publications and/or presentations and may be used for secondary analysis in future research by the author in this field.

I consent to participate in this study by answering questions from the parent questionnaire, to have the researcher take notes on informal conversations with me about my child's health and environment, and to have my child participate in this study. I have received a copy of this consent form for my own records.

_____

Signature of parent Date

_____

Print name

_____

Signature of witness Date

_____

Print name

APPENDIX D: CHILD ASSENT FORM

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School of Nursing
T201- 2211 Wesbrook Mall
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Tel: (604) 822-7417
Fax: (604) 822-7466

ASSENT FORM

Study: Growing up healthy

Principal Investigator: Dr. Joy Johnson, Professor, School of Nursing, 604-XXX-XXXX.

Student Investigator: Lori Irwin, School of Nursing, Doctorate of Philosophy in Nursing Student, 604-XXX-XXXX.

The Project:
I understand that Lori Irwin is doing a project for school about children's health. She will ask me about how my family, my school, and where I live affect my health. There are lots of things that nurses would like to know about how I keep healthy and happy that will help them do their jobs better. By talking to Lori, I might be able to help other children because this project will be reported to people like school nurses, teachers, doctors and other nurses in the hospital.

What will happen in the project?
My mom/dad has said it is OK for me to be a part of Lori's project. It would mean that Lori and I would talk to each other a few times, maybe 3-4 times over the next few months for about 30-60 minutes each time. It will be up to me how long we talk each time. Lori will ask me about how my daily life at home, school, and within my neighbourhood affects my health. Our first talk will just be about getting to know each other and will not be tape-recorded. Our next talks will be about my health and will be tape-recorded each time so that Lori can remember exactly what I said. I know that I can ask Lori any questions I like during our talk or I can play or draw if I like. I also understand that I will spend some time with my parent or playing while Lori is around and that Lori will take notes about what we are doing. If I decide at any time during our talks that I don't want to answer questions or I want to stop talking that is OK. If I decide I don't want to help with Lori's project anymore that's OK too, I can just tell Lori because its important that I want to do this each time we meet.

My name will not be used:
I know that I will pick a secret code name so that anyone reading Lori's project will not know that I spoke to Lori. I also know that Lori will be talking to other kids and that when she talks about her project no one will know which kid she is talking about. Lori will put code numbering on the

tapes and that she is only person who will know the codes. The tapes and computer read outs will be kept in a locked filing cabinet at Lori's school for five years. I know that the only people who can hear the tapes or read the computer print out of my conversations with Lori will be four teachers who are members of Lori's project committee, a professional typist, and the researcher, Lori Irwin.

Who to call:
If I have any questions about Lori's project, I can talk to my parent or I can call Lori Irwin at 604-XXX-XXXX or her University teacher, Dr. Joy Johnson at 604-XXX-XXXX.

Assent:
I understand that I am participating in Lori's project because I want to and that I can change my mind about being part of her project at any time without getting into trouble.

My printed or written name shows that I agree with my mom/dad's decision to allow me to be a part of Lori's project.

_____

Signature of child-participant Date

_____

Print Name

_____

Signature of a Witness Date

_____

Print Name

APPENDIX E: CHILD INTERVIEW GUIDE

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

CHILD INTERVIEW GUIDE

Study: Growing up healthy

Will start each session with introductions and some casual conversation prior to starting preamble to attempt to establish comfort level with.

Introduction

Hello _____, my name is Lori and I go to school at the University of British Columbia. Have you heard of my school? Etc…

Preamble

I am a children's nurse and I have asked you to come here and talk to me today about your health. Is it OK if I use a tape recorder to make sure I don't miss anything that you say? Do you know how to work the tape recorder? I have brought some paper and markers if you would like to draw and some toys to play with while we talk. Maybe you could draw me a picture of something and we could talk about it?

Interview Questions:

(Note: the following questions indicate content area for the interviews)

Health Questions

Do you know what being healthy means?

Who do you think is in charge of (responsible for) your health?

I want to talk to you about families. What do you think a family is? Can you tell me who is in your family?

We're going to use our imagination. I would like you to imagine the best family possible now. Can you tell me about that family?

How is it like your family, not like your family?

Can you tell me a story about how you and your family stay healthy?

What is one of your favourite things to do with your family? Anything else?

Neighbourhood Questions

Do you know what a neighbourhood is? Can you tell me about neighbourhoods?

_____, I want you to imagine the best neighbourhood for children, can you do that? OK, can you tell me what it is like?

How is it the same/different from your own neighbourhood? Why?

What is it you like about where you live, don't like?

If you could bring anyone to your imaginary neighbourhood, who would you bring to this neighbourhood? Why?

Where do you like to play in your neighbourhood? What do you like about it?

Do you know your neighbours? Do you visit/play with your neighbours?

Can you tell me about someone who lives in your neighbourhood?

Do you feel safe in your neighbourhood? Why?

Resilience Questions

Do you have someone outside your home that you can tell things to?

Is there someone that you would like to be like? (prompt if necessary: e.g., could be in your family, a superhero, a friend)

Do you like to do well when you do something? (prompt if necessary: e.g., like in school, sports, drawing)

How many friends do you have? Do you have a best friend?

School Questions

Now, I want you to pretend that you are sitting in your classroom at school, can you do that? OK, now can you look around and tell me what you see and who you see? What is your teacher's name?

Can you tell me what it is that you like about school?

How do you think you are doing in school? How do you know how are doing? (teacher, other children, parents)

If you could change anything about school, what would it be? Why?

Can you tell me a story about something that happened this week at school? It could be something funny or even something you didn't like.

When I was your age I liked to play with my friends at recess, I liked learning to read, and I loved my gym class. Is there anything special that you like about school.

Is there anything you want to ask me?

APPENDIX F: PARENT QUESTIONNAIRE

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
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Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
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PARENT QUESTIONNAIRE

Study: Growing up healthy

(Note: To be administered by researcher)

Family Questions

1. Number of children younger than 19 years who are living in your home?

---

2. Ages/sex of children? Are these children siblings?

---

3. Number of people living in the home including yourself

---

4. How would you *describe* the family living in the home, e.g., blended family, extended family, one or two-parent family?

---

5. What is the MAIN language you speak in your home?

---

6. Do you speak any other languages?

Neighbourhood Questions

7. How long have you lived in this home?

If answer to #7 under a year go to #7a.

7a. How long have you lived in your previous home?

8. Was your previous home in the same neighbourhood?

9. Can you count on adults in this neighbourhood to watch out that children are safe and don't get into trouble? (circle one) Yes No

10. Do you feel you live in a safe neighbourhood for children? (circle one) Yes No

11. If not/so, can you tell me why? (crime, safety, programs, crowding)

Childcare Question

12. Has someone other than yourself ever cared for your child? (e.g. daycare, relative, nanny) If yes, could you tell me about the different childcare arrangements you have used?

School Questions

13. How would you rate your child's school achievement? (circle one)

Below average
Average
Above average

14. Does your child like school?

15. Can you tell me why your child likes or dislikes school?

16. Are you involved in your child's school in any way? (Volunteering, school outings, PAC)

17. How much time would you say you spend on average one on one with your child per day?
(interviewee)_____
(your partner)_____

e.g., focusing attention on each other just for fun?, doing something special with your child that he or she enjoys? reading aloud to him/her or listening to him/her

18. What kinds of activities do you do in this time? (read books, play games, go for walks)

19. Where does your child like to play outside your home?

20. Is your child involved in any organized programs outside the home? (Sports, Swimming lessons, Community health centre, Community neighbourhood house, Community Centre programs for child)

Resilience Questions

21. Does your child have someone other outside your home that he/she can tell his/her about problems and feelings?

22. Does your child have someone that he/she wants to be like? Who?

23. Does your child like to achieve in what he/she does?

---

24. About how many days a week does he/she do things with friends? (circle one)

Never
1 day/week
2-3 days/week
3-5 days/week
6 or more days/week

25. When it comes to meeting new children and making new friends is he/she: (circle one)

Somewhat shy?
About average
Very outgoing, makes friends easily?

Parent Questions

26a. What do you consider to be your main activity currently? (circle appropriate)

Caring for family
Working for pay or profit
Caring for family and working for pay or profit
Going to school recovering from illness/on disability
Looking for work
Other (specify)

26b. What does your partner consider to be the main activity currently? (circle appropriate)

Caring for family
Working for pay or profit
Caring for family and working for pay or profit
Going to school recovering from illness/on disability
Looking for work
Other (specify)

If answer: work for pay go to #27a & b

27a. What is your occupation?_____

27b. Partner?_____

28. What is the highest level of education you have ever attained?

Maternal Education (complete/incomplete)

Grade school _____
High school _____
Trade, technical, or vocational school or business college_____
Diploma/Certificate in profession _____
College _____
University _____
Other _____

Paternal Education (complete/incomplete)

Grade school _____
High school _____
Trade, technical, or vocational school or business college_____
Diploma/Certificate in profession _____
College _____
University _____
Other _____

29. What is the income of your household from all sources before taxes and deductions?

Under $10,000 _____
$10,000-20,000_____
$20,000-30,000 _____
$30,000-40,000_____
$50,000 and up_____

30. Is there anything about your child's health that you deal with on a day-to-day basis that you would like to tell me about? (e.g., asthma, food allergies)

_____
_____
_____
_____
_____
_____
_____

Notes:
Language of questionnaire _____
Questions asked
_____
_____

APPENDIX G: GENERAL INFORMATION LETTER

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417

STUDY INFORMATION LETTER

Study: Growing up healthy

My name is Lori Irwin and I am a registered nurse who is studying toward her Doctorate of Philosophy in Nursing degree. This letter is to inform you that I am conducting a study to learn about how children's experience of health is influenced by their families, schools and neighbourhood in the XXXX area. Children that are participants in this study attend the Out-of-School programs in the neighbourhood.

- I will be making notes on observations of each child-participant in the study, 2-3 visits, over a six-month period
- Confidentiality of child-participants will be maintained; no one will be able to identify you or your child.

If you have any questions or concerns, please call me at 604-XXX-XXXX or my dissertation chairperson, Dr. Joy Johnson, at 604-XXX-XXXX.

Sincerely,

_____ _____

Lori Irwin, RN. XXXX, XXXX Program Director