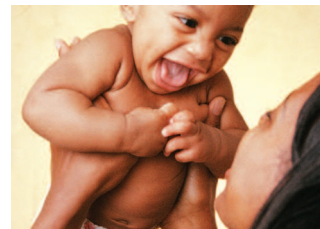


Toronto Perinatal & Child Health Survey 2003



Prepared by Compustat Consultants Inc. for Toronto Public Health



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Preface

This report was prepared by Compustat Consultants Inc. for Toronto Public Health. This report describes the results of the Toronto Perinatal and Child Health Survey.

Note: the original version of this report (as prepared by Compustat Consultants Inc. in September 2003) has been updated by Toronto Public Health to incorporate, where appropriate, the findings of the representativeness assessment conducted by TPH in March 2004 (see Appendix A). The findings reveal that the survey data is representative on a number of important demographic characteristics of the population under study, including the age of Toronto parents with children from birth to age six, as well as the age of their children. The assessment also shows that the survey is not representative with respect to some demographic characteristics. The findings suggest the need for users of the data to assess whether the unrepresentative demographic characteristics might have affected the specific survey results that they are interested in. Nonetheless, the Perinatal and Child Health Survey provides very useful local information for public health policy development and program planning, monitoring and evaluation. Please refer to Appendix A for further details regarding the representativeness assessment results.

1. Executive Summary

The Toronto Perinatal and Child Health Survey project was conducted as part of the Ministry of Health & Long-Term Care Perinatal and Child Health Survey Strategies Initiative. The overall purpose of this telephone survey was to provide representative data on the prevalence of risk and protective factors related to child health and development outcomes of children aged 0-6 years in the City of Toronto. This information was needed to fill data gaps identified by Toronto Public Health in various areas of application. Topics for which information was gathered include childhood injury due to falls, breastfeeding initiation and duration, physical activity participation, smoking restrictions in the home, parenting practices, child food security, parental depression, and dental health.

The telephone survey was initiated on March 1, 2003 and completed on April 7, 2003. Respondents were randomly selected by random-digit-dialing procedures. One thousand parents with children aged 0-6 years residing in the city of Toronto participated in this survey.

Data analysis was primarily descriptive in nature (frequency tables and cross-tabulations). However, where information on statistical significance was required, chi-square and t-test analyses were performed. In addition, correlation analyses were performed to measure the strength of the association between different variables, where appropriate. Data were analyzed using SPSS/PC statistical software.

Data gathered from the survey can be used to inform and support programs that are designed to improve the health of Toronto's children aged 0-6 years. Raw data were provided to Toronto Public Health to facilitate further analysis and reporting.

Highlights of Results and Analysis

- Description of Respondents and Child Health Status
 - The majority of parents who responded to the survey were female (74.2%), over 30 years of age (82.5%), married or living common-law (84.0%), part of a two-parent family (84.1%), and lived in a house (59.7%) or apartment (35.1%). Although less than half of surveyed parents were born in Canada (44.0%), 70.2% of the total sample was comprised of those who were not recent immigrants, having been born in Canada or having immigrated 11 or more years ago. About half of the surveyed parents reported English as a first language (51.6%). In addition, 60.3% of parents reported having a post-secondary certificate, and over two-thirds (69.4%) were in the middle/high income category. However, 23.1% of the sample did not provide information about their annual income.

- Although less than half of parents reported that they were born in Canada, 90.0% of the reference children were born in Canada. Ninety-eight percent of these children were reported to be in excellent, very good, or good health, and 85.6% were reported to have no long-term health conditions. The most frequently reported long-term conditions were asthma (6.8%) and allergies (5.9%).
- Childhood Injury Due to Falls
 - A total of 6.1% of parents who responded to the Toronto Perinatal and Child Health Survey indicated that their child sustained injuries due to a fall within the last year that were serious enough to require medical attention. Most of these children were reported to have fallen only once as a result of a trip or stumble on the same level (31.8%) or a fall from a bed, chair, or other furniture (21.2%).
- Breastfeeding
 - The overall breastfeeding initiation rate was 94.3%. Mothers who were older at the time of their child's birth, mothers with higher levels of education, mothers who were not born in Canada, and those who were recent immigrants (in Canada 10 years or less) at the time of their child's birth were more likely to report that breastfeeding was initiated. Children in two parent families were more likely to be breastfed than children in lone parent families.
 - Almost three-quarters of parents reported that they made a decision about breastfeeding before pregnancy (73.0%). Mothers who were older at the time of their child's birth, parents with higher levels of education, and those who were born in Canada were more likely to report making a decision before pregnancy rather than during or after pregnancy.
 - Almost 90% (89.7%) of parents reported that their baby was breastfed for at least one week, about three-quarters (76.6%) reported breastfeeding for 3 months or more, over half (58.3%) reported breastfeeding for 6 months or more, and about one-quarter (25.6%) reported breastfeeding for 12 months or more.
 - Further analysis revealed that just over three-quarters (78.6%) of all healthy term babies were exclusively breastfed for 2 weeks or more, over two-thirds (68.1%) were exclusively breastfed for 2 months or more, less than half (48.8%) were exclusively breastfed for 4 months or more, and less than 1 in 5 (18.0%) were exclusively breastfed until 6 months.

- Physical Activity
 - The majority of parents (87.4%) reported that one parent and child participated together in some form of physical activity 2 or more times per week, and over half (57.7%) reported participating 4 or more times per week, although there was some variation due to child's age.
 - About three-quarters of parents (76.5%) reported that their children spend 0-2 hours per day on sedentary activities such as watching TV or playing video games.
- Smoking Restrictions in the Home
 - The majority of surveyed parents (92.8%) reported that they do not allow smoking in their homes at any time. However, younger parents (< age 25) were somewhat less likely than older parents to favour rules which prohibit smoking in the home.
- Parenting Practices
 - For children aged 0-23 months, the majority of parents reported engaging in few or no ineffective interactions with their children.
 - For children aged 2-6 years, average Ineffective Parenting Scale scores and Rational Parenting Scale scores indicated that parents reported engaging in few ineffective or aversive interactions with their children. Mothers reported significantly more ineffective interactions than fathers.
 - For parents of children aged 2-6 years, scores for the Ineffective and Rational Parenting Scales were positively associated such that parents who reported more ineffective interactions with their children also reported using more aversive parenting practices.
- Child Food Security
 - Using the criterion of 5 Children's Food Security Scale items affirmed as an indicator of hunger, a very low level of child hunger was identified (0.5%) in the current sample. However, although a substantial proportion of respondents (23%) did not provide information about income, comparisons with 2001 census data suggest the possibility that this survey may have slightly undersampled families in the low income category, which could account for the relatively low observed rate of child hunger.
 - A total of 16.1% of parents did provide responses to affirm 1 to 4 of the food security items, and, of these, 67.5% affirmed one item, 21.0% affirmed two items, 5.7% affirmed three items, and 5.7% affirmed four items.

- Parental Depression

- Although depression scores overall were quite low, mothers, lone parents, and parents in the low household annual income category reported a greater extent of depressive tendencies than fathers, parents in two-parent families, and parents in the higher income categories, respectively.
- Depression scores were significantly related to the two parenting scale scores such that parents who reported more depressive tendencies also tended to report more ineffective and aversive parenting practices.

- Dental Health

- Just over 5% of surveyed parents reported that their children have been diagnosed with early childhood tooth decay. Older children and children not born in Canada were more likely to receive this diagnosis.
- Over half of all children (53.2%) over the age of 9 months were reported to have had a dental visit within the past year, while 42% have never had a dental visit at all. Older children, children from the middle/high income category, and children of lone parents were more likely to have seen a dentist within the past year. For children who had not seen a dentist within the past year, parents most often reported that this was because the child was too young to go or did not need to go.
- The majority of children were reported to have their teeth or gums cleaned one or more times per day (83.6%), with frequency of teeth cleaning increasing with age of the child. Of those children whose teeth were cleaned, over half (59.0%) used toothpaste with fluoride, including a substantial number under the age of three. In addition, almost 1 in 5 (19.0%) children were reported to be using too much toothpaste.

2. Introduction

2.1. Background

The Toronto Perinatal and Child Health Survey project was conducted as part of the Ministry of Health & Long-Term Care Perinatal and Child Health Survey Strategies Initiative. In December, 2001, the provincial government announced the availability of funding to public health units for traditional survey initiatives that address information needs in support of Early Childhood Development. This money is a transfer payment from the federal government resulting from the First Ministers' agreement on key action areas for the early years (ages 0-6). The Survey Strategies Initiative is expected to provide population-based, representative, cross-sectional measures of health status, health outcomes, and factors related to maternal, infant and child health for the local Board of Health's population or selected sub-populations.

As part of this initiative, the Toronto Perinatal and Child Health Survey was designed to address aspects of selected factors relating to child health, growth, and development from birth to 6 years of age. Toronto Public Health (TPH) program needs assessments identified a lack of sufficient, timely, and representative data in these information areas. Further, TPH's 2001 Health Status Report identifies a lack of Toronto-specific population data regarding children's physical activity levels, measures of food security, circumstances of childhood injury, breastfeeding, parenting practices, and child development (1). This project was intended to provide much needed data in these areas.

2.2. Purpose

The Toronto Perinatal and Child Health Survey was conducted by Compustat Consultants Inc. (Compustat) on behalf of TPH. The overall purpose of this telephone survey was to provide representative data on the prevalence of selected risk and protective factors related to child health and development outcomes of children aged 0-6 years in the City of Toronto. This information can be used to inform and support programs that are designed to improve the health of Toronto's children aged 0-6 years.

2.3. Survey Objectives

The specific objectives of the survey were threefold:

1. To fill data gaps identified by TPH staff in order to address and monitor progress of the 1997 and/or (Draft) 2001 Mandatory Health Program and Service Guidelines (MHPSG) related to perinatal and child health that cannot be met by either the Rapid Risk Factor Surveillance System (RRFSS) or by other surveys.

2. To gather local population-based, cross-sectional, representative data on risk and protective factors for perinatal and child health that can be used to assist in planning TPH programs and services.
3. To provide information that may be used as part of a future Toronto Public Health focused reports on Child Health.

3. Methodology

3.1. Survey Instrument

Questions for the Toronto Perinatal and Child Health Survey were provided to Compustat by TPH. In general, the survey was designed to collect data on a variety of topics relevant to child health and development outcomes, including child's health status, breastfeeding, childhood injuries due to falls, child's participation in physical activity, smoking in the home, parenting behaviours and practices, child food security, parental depression, and child's dental health. Demographic information about the parent who responded to the survey was also collected.

Items were included as part of the survey on the basis of their relevance to TPH programs in the following areas: Reproductive Health, Child Health, Dental Health, and Healthy Lifestyles including Nutrition, Physical Activity, Tobacco Use and Prevention and Injury Prevention. Items were also included on the basis of feasibility in gathering valid and reliable estimates over the telephone. In addition, the process in identifying the survey content areas was based on the principles that the data should be consistent with the 1997 and/or (draft) 2001 Mandatory Health Programs and Services Guidelines and should fill data gaps not currently met by other surveys.

Some survey items were taken from existing sources such as the National Longitudinal Survey of Children and Youth (NLSCY), which was used as a source for items pertaining to child health status, birth information, parenting practices, and parental depression. Most items pertaining to breastfeeding were taken from the Canadian Community Health Survey (CCHS) and the Public Health Research, Education and Development Program (PHRED) Benchmarking Support Document: Provincial Breastfeeding Survey. Food security items were obtained from the USDA Food Security Module, and demographic questions were based on those used in the NLSCY, the RRFSS, and the CCHS. In addition, other questions were developed by representatives from the different TPH program areas, staff in the Health Information section, and other staff from the Planning and Policy unit at Toronto Public Health. The initial version of the survey was refined on the basis of pilot testing, as described below. The final survey was comprised of 90 items and took an average of 20 minutes to complete. The survey was approved by Toronto Public Health's Policy for Evaluation and Other Research Endeavours Review Committee.

3.2. Target Population and Sampling

The target population for this survey was City of Toronto families that included at least one child six years of age or younger. Sampling was conducted through random-digit dialing (RDD). Specifically, a RDD sample of locations within the City of Toronto area was obtained from Survey Sampling Inc., a company that

specializes in the RDD method. The particular method involves increasing the last digit in the sampled telephone number by one, ensuring that households with recent listings and unpublished numbers are included in the sampling frame. The RDD method is designed to maximize sample representativeness.

If the survey respondent indicated that he/she was the birth parent, step parent, common-law parent, adoptive parent, or foster parent of the child, and the reference child regularly lived at least part of the time in the potential respondent's home, the survey progressed according to the format shown in Appendix B.* If the respondent indicated that there was more than one child aged 0-6 years old in the home, then a reference child was randomly selected by asking the respondent to answer the survey questions regarding the child who would have the next birthday. In the case of twins, the interviewer instructed the respondent to answer questions with reference to either the youngest or the oldest twin, alternating the request.

3.3. Pilot Testing

The pilot test was conducted from February 18-20, 2003. During this period, six experienced interviewers used a Computer-Assisted Telephone Interview (CATI) system to call City of Toronto RDD telephone numbers between the hours of 9:00 a.m. and 9:00 p.m. A total of 1,658 telephone calls were made to obtain 20 completed surveys.

On the basis of the pilot testing, TPH, in consultation with Computsat, refined the survey instrument in terms of item wording and logic for skip-patterned items. Specifically, alternate wording was added to some parenting and depression scale items for use, if necessary, to increase comprehensibility. In addition, items were added to verify responses including parent's marital status and child's birthweight. The final version of the structured telephone interview is attached as Appendix B.

3.4. Interviewer Training

A standardized procedure was employed to ensure that all telephone interviewers had complete familiarity with the details of the survey and the CATI system of data entry. Each interviewer was trained and periodically monitored throughout the interviewing process. A total of 25 interviewers were trained specifically for this project. In addition, 2 supervisors and a manager were available to oversee the work of 3 to 12 interviewers working simultaneously.

Each interviewer was provided with a detailed Interviewer Protocol package, which details the procedure for telephone interviews (see Appendix C). Training included a review of the survey by the interviewer and a supervisor/manager, as well as

* Note that, because all persons who completed this survey were either a birth parent, step parent, common-law parent, adoptive parent, or foster parent to a child between the ages of 0 to 6 years who was living with them at least part of the time, persons who completed the survey will be referred to as "parents" or "respondents" interchangeably for the remainder of this report.

ample time for the interviewer to become familiar with all aspects of the survey. Interviewers rehearsed the procedure with a minimum of seven different scripted versions of the survey, which varied in terms of skips and flow of the responses. After the paper-based training sessions, it was observed that some interviewers needed to become more familiar with the logic and flow of the survey, and required continued practice reading the proper options. These issues were addressed with interviewers through discussion and further review and practice with the survey both individually and in groups.

During the pilot testing, interviewers demonstrated patience and rapport with respondents including individuals who had English as a second language and those facing distractions such as a small child present. Issues pertaining to correct reading of the survey and not leading respondents based on assumed responses continued to be addressed through additional practice and extensive monitoring with individual feedback from a supervisor/manager through the early implementation of the survey.

3.5. Data Collection

3.5.1. Calling Procedure

The Toronto Perinatal and Child Health Survey was administered during the period of March 1, 2003 through April 7, 2003. Calls were made at various times of the day and week, weekdays between 9:00 a.m. and 9:00 p.m., and weekends between 9:00 a.m. and 4:00 p.m. Up to 10 call attempts were made to each RDD number; if no contact was made after 10 attempts, then the number was deemed “terminated.”

A standard script which explained the nature and purpose of the survey was used. The interviewer introduced the survey by stating that it was being conducted on behalf of TPH and that the purpose was to obtain information to improve understanding of the factors that affect children’s health. Respondents then were asked if there were any children in the home aged 0-6 years. Respondents who affirmed this were asked if they would be willing to complete the survey. At this point in the procedure, potential respondents were told that their decision would in no way affect any of the services they may receive from any health unit, and that they may chose not to answer any question and/or chose to end the interview at any time. For respondents who indicated that they would be willing to complete the survey, the survey progressed according to the format shown in Appendix B. All data for the survey were entered via the customized CATI system, which includes automatic skips and verifications to improve accuracy.

3.5.2. Call Monitoring

Between 5% and 10% of all calls were monitored by Compustat supervisors or management. Interviewers were monitored more intensely during their first several

interviews. Additional periodic monitoring of all interviewers took place throughout the entire survey process.

Monitoring of interviewers consisted of ensuring that there was: (1) proper qualification of respondents (in terms of being a parent to a child aged 0-6 years who was living in their home at least part of the time), (2) correct reading of the survey, (3) lack of bias (not leading respondents), and (4) accurate data entry. Feedback was provided to interviewers to ensure that the survey was being administered as intended and that the Interviewer Protocol was being followed (see Appendix C).

3.5.3. Call Dispositions and Response Rate

During the calling period, a total of 73,775 calls were made in order to obtain 1000 completed surveys. Up to 10 call attempts were made for each of the 23,046 telephone numbers selected from the sampling frame. Table 1 shows the call disposition statistics for the Toronto Perinatal and Child Health Survey.

Table 1: Call Dispositions

<i>Call Type</i>	<i>Abbreviation</i>	<i>Frequency</i>	<i>Percent</i>
Complete	CO	1000	4.3%
Refused	RF	1043	4.5%
Terminate	TE*	2631	11.4%
Hung Up	HU	785	3.4%
Line Busy	LB	7	0%
Language Barrier	LA	822	3.6%
Call Back	CB	55	0.2%
Partial	PT	11	0%
Answering Machine	AM	123	0.5%
No Answer	NA	395	1.7%
Not Eligible – Business	NE/B	4587	19.9%
Not Eligible – No Children	NE/NC	8573	37.2%
Wrong Number	WN	173	0.8%
Not in Service	NS	2862	12.4%

In order to calculate response rate, the eligibility of each call must be taken into account because only a selected sub-population of Toronto was targeted for calling (i.e., households with children aged 0-6). Therefore, ineligible numbers are not included in the calculation of the overall response rate. Of the call dispositions displayed in Table 1, the known ineligible calls are the not eligible/business and the not eligible/no children numbers. Thus, for known ineligible calls:

* The “terminate” call disposition means that no contact was made after 10 call attempts to that number. Call disposition definitions are further detailed in the Interviewer Protocol in Appendix B.

$$\text{INELG} = \text{NE/B} + \text{NE/NC} = 4587 + 8573 = 13160.$$

Of the call dispositions displayed in Table 1, known eligible calls are the completed calls, the partial calls, and the call backs. Thus, for known eligible calls:

$$\text{ELG} = \text{CO} + \text{PT} + \text{CB} = 1000 + 11 + 55 = 1066.$$

Of the call dispositions displayed in Table 1, the call dispositions with unknown eligibility are the refused, terminated, hung up, line busy, language barrier, answering machine, and no answer calls. Thus, for unknown eligibility calls:

$$\begin{aligned}\text{UNKELG} &= \text{RF} + \text{TE} + \text{HU} + \text{LB} + \text{LA} + \text{AM} + \text{NA} \\ &= 1043 + 2631 + 785 + 7 + 822 + 123 + 395 = 5806.\end{aligned}$$

For response rate calculations, it was assumed that the proportion of these 5806 call dispositions that were eligible was the same as it was in the rest of the sample. This proportion, or “eligibility rate” was calculated to be:

$$\begin{aligned}\text{ELG RATE} &= \text{ELG} / (\text{ELG} + \text{INELG}) = 1066 / (1066 + 13160) \\ &= 0.0749 = 7.49\%\end{aligned}$$

The eligibility rate is then applied to the UNKELG call dispositions to obtain an estimated eligibility for the unknowns:

$$\text{ESTELG} = \text{UNKELG} \times \text{ELG RATE} = 5806 \times 0.0749 = 434.87.$$

The response rate (RR) for the survey therefore is calculated according to the following formula:

$$\begin{aligned}\text{RR} &= \text{CO} / (\text{ELG} + \text{ESTELG}) = 1000 / (1066 + 434.87) \\ &= 1000 / 1500.87 = 0.6663\end{aligned}$$

Thus, the overall response rate for the survey is 66.63%.

3.6. Analysis

First-level data analysis for this survey includes presentation of descriptive statistics in tables, text, and figures, as appropriate. Second-level analysis for group comparisons consists of crosstabs with chi-square analysis for categorical data, and t-tests and one-way analysis of variance for continuous variables. For significant F-tests, follow-up multiple pairwise comparisons with a Bonferonni correction were conducted. Pearson correlation coefficients were calculated in

order to measure the strength of association between the parenting practices and depression scales that were included as part of the survey.

For the reporting of chi-square results, the calculated chi-square value is followed by two subscripts which represent the degrees of freedom and the total number of observations (sample size) for the test (e.g., $\chi^2_{(x, y)}$ where x = degrees of freedom, and y = sample size). In the case of 2 x 2 crosstabs with any expected frequencies of < 5, Fisher's Exact Test is reported. For t-tests and F-tests, the test value is reported followed by the subscript of degrees of freedom.

Respondents who did not provide a response to a specific survey item (i.e., refused to respond or responded "don't know") were excluded from the relevant analysis for that item. Furthermore, for the food security scale, the depression scale, and the two parenting practices scales, scores were calculated only for respondents who provided responses that could be coded according to the scoring procedure for each of the relevant items on the scale. Thus, respondents who did not provide a response to one or more scale items (i.e., refused to respond or responded "don't know") are excluded from the relevant analysis for that scale.

The .05 level of significance was observed for all tests of significance and confidence intervals (CI's). Percentages are presented to one decimal place, while measurements for continuous data and test scores are presented to two decimal places (and to three decimal places in the case of some p-values). Data were analyzed using SPSS/PC statistical software, Version 8.

4. Survey Limitations

One limitation of any survey which utilizes telephone interviews to collect data is that those households that do not have telephones cannot be contacted to participate. In Ontario, however, the percentage of households without telephones has been decreasing over time. In 1996, for example, the percentage of households without telephones was only 1.1% (2). The exclusion of this small percentage of households is not likely to have an effect on the outcome of the survey.

Another limitation of this survey is that possible language barriers exist because the interviews were conducted in English only. Therefore, results may not be generalized to the non-English speaking population.

A further limitation of the survey concerns the possibility of social desirability bias. Specifically, some of the topics covered in the survey may be considered sensitive to some respondents. As a result, it is possible that responses may be somewhat biased towards what respondents perceive to be socially desirable answers, thus underestimating the prevalence of risk factors. Administering the survey over the telephone, rather than face-to-face, as well as assuring respondents that the survey is completely confidential, likely minimized the presence of social desirability bias.

As a completely voluntary survey, many more respondents were asked to participate than actually agreed to participate, thus allowing for the possibility of selection biases. However, any selection biases that may exist may be addressed by comparing the demographic characteristics of the sample with the demographic characteristics of the general Toronto population (families with children aged 0-6 years). In this way it should be possible to determine the extent to which the individuals who agreed to participate in the survey are representative of the general population of parents in Toronto.

A substantial percentage (23.1%) of parents did not provide information about their annual income, and comparisons between those who did and those who did not report their income suggest that respondents who did not report their income were less educated, less likely to be employed, more likely to be stay-at-home parents, more likely to be apartment-dwellers, and more likely to be born outside of Canada as compared to respondents who did report their income. The overall net effect of those who did not report their income suggests that if information were obtained from these respondents, the income levels of the entire survey sample may have been lower.

It also should be noted that for the section on breastfeeding, analyses by marital status and parents' educational attainment assume that the parents' marital status and educational levels at the time when the parents make their decisions about breastfeeding are the same as reported by the respondents.

Finally, it should be noted that for the parenting practices and depression scales that were included as part of the survey, scores were calculated only for parents who provided responses that could be coded according to the scoring procedure for *each* of the relevant items on the scale. As a result, for the Ineffective Parenting Scale (parents of children aged 2-6 years) as well as for the Depression Scale (all respondents), scores were not calculated for a relatively large proportion of respondents (approximately 12% in each case) due to a lack of response to one or more items on the scales.

5. Results

5.1. Description of Respondents

Demographic information about each of the 1000 respondents was collected in order to determine the effects of these variables on risk and protective factors, as well as to assess the representativeness of the sample. City of Toronto 2001 census data on parents with children aged 0-6 years were obtained from Statistics Canada, and were used for the representativeness assessment. Results of the assessment are summarized in Appendix A.

5.1.1. Parent's Age, Gender, Dwelling Type, and Region

Parent's age (at time of survey), parent's age at time of child's birth, parent gender, dwelling type, and region of Toronto are displayed in Table 2.

Table 2: Parent Demographics

<i>Demographic Variable</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
<i>Parent's Age (n=920)</i>			
< 25 years old	33	3.6%	2.4, 4.8
25-29 years old	128	13.9%	11.7, 16.1
30-34 years old	226	24.6%	21.8, 27.3
≥ 35 years old	533	57.9%	54.7, 61.1
<i>Parent's Age at Time of Child's Birth (n=910)</i>			
<20 years old	25	2.7%	1.7, 3.8
20-24 years old	87	9.6%	7.6, 11.5
25-29 years old	203	22.3%	19.6, 25.0
30-34 years old	305	33.5%	30.4, 36.6
35-39 years old	214	23.5%	20.8, 26.3
40 years or older	76	8.4%	6.6, 10.1
<i>Parent Gender (n=1000)</i>			
Male	258	25.8%	23.1, 28.5
Female	742	74.2%	71.5, 76.9
<i>Dwelling Type (n=986)</i>			
House	589	59.7%	56.7, 62.8
Apartment	346	35.1%	32.1, 38.1
Other	51	5.2%	3.8, 6.6
<i>Region of Toronto¹ (n=848)</i>			
East (former cities of Scarborough and East York)	279	32.9%	29.7, 36.1
South (former city of Toronto)	206	24.3%	21.4, 27.2
North (former city of North York)	196	23.1%	20.3, 26.0
West (former cities of Etobicoke and York)	167	19.7%	17.0, 22.4

¹ A total of 59 respondents did not provide postal code information, and postal code information from an additional 93 respondents resulted in failure to code a region.

Parents who responded to the survey ranged in age from 17 to 70, and the average age was 35.76 (SD = 6.62). Table 2 shows that over half of all parents were 35 years of age or older (57.9%) and over three-quarters were aged 25-39 at the time of their child's birth (79.3%). There was a greater proportion of older as compared to younger parents, with almost one-third of parents in the range of 35 years or older when their child was born (31.9%), and only 12.3% less than 25 years old when their child was born.

Approximately three-quarters of the parents who responded to the survey were female (74.2% mothers) and one-quarter were male (25.8% fathers). Well over

half of all parents reported living in a house (59.7%) as compared to an apartment or other dwelling. Residents from all four regions of Toronto were sampled. There was a higher percentage of respondents from the East region, which is consistent with 2001 census data which show that there is a greater number of young children residing in the East region compared to other regions.

5.1.2. Family Profile

Characteristics relating to family profile, including parent's relationship to child, marital status, and family status are displayed in Table 3.

Table 3: Family Profile

Family Profile Variable	Sample		
	Frequency	Percent ¹	95% CI
<i>Parent's Relationship to Child (n=1000)</i>			
Birth parent	980	98.0%	97.1, 98.9
Adoptive parent	11	1.1%	0.5, 1.7
Step parent	<5	--	--
Common-law parent	<5	--	--
Foster parent	<5	--	--
<i>Marital Status (n=990)</i>			
Single, never married	86	8.7%	6.9, 10.4
Married/Common-law	832	84.0%	81.8, 86.3
Other	72	7.3%	5.7, 8.9
<i>Family Status (n=1000)</i>			
Two-parent family	841	84.1%	81.8, 86.4
Lone-parent family	159	15.9%	13.6, 18.2
<i>Lone-Parent Families (n=159)</i>			
Male lone-parent	16	10.1%	5.4, 14.7
Female lone-parent	143	89.9%	85.3, 94.6

¹ Percents based on cells with frequencies of < 5 are suppressed.

The majority of parents who responded to the survey were biological birth parents (98.0%), and the majority reported being married or living common-law (84.0%). In addition, most children were living in a home with two parents (84.1%). Of the lone-parent families in the current sample, most were led by mothers (89.9%), with only 1 in 10 lone-parent families led by a father.

5.1.3. Parent's Education

Parent's education is displayed in Table 4.

Table 4: Parent's Education

<i>Education Category (n=983)</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
Less than secondary certificate	50	5.1%	3.7, 6.5
Secondary certificate (includes those with some post-secondary schooling)	340	34.6%	31.6, 37.6
Post-secondary degree, certificate or diploma	593	60.3%	57.3, 63.4

Over half of all surveyed parents completed some form of post-secondary education (60.3%), and very few reported having less than a secondary certificate (5.1%).

5.1.4. Household Annual Income

Household annual income is displayed in Table 5 in two formats. First, income is displayed in dollar values. Second, household annual income was categorized according to Statistics Canada Year 2000 Low Income Cutoffs (LICO's) for Toronto, which take into account household size. Taking into account household size, household annual income was categorized as low, low/middle, or middle/high.*

* Categories for household family income were as follows: for a 2 or 3 person family, low income was total household income of less than \$20,000, low/middle income was total household income of \$20,000 - \$29,999, and middle/high income was total household income greater than or equal to \$30,000; for a 4 or 5 person family, low income was total household income of less than \$30,000, low/middle income was total household income of \$30,000 - \$39,999, and middle/high income was total household income greater than or equal to \$40,000; for a family of 6 people or more, low income was total household income less than \$40,000, low/middle income was total household income of \$40,000 - \$49,999, and middle/high income was total household income greater than or equal to \$50,000.

Table 5: Household Annual Income

<i>Income Category</i>	<i>Sample</i>		
	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
<i>Annual Income (n=769)¹</i>			
Less than \$20,000	69	9.0%	7.0, 11.0
\$20,000 to < \$40,000	187	24.3%	21.3, 27.3
\$40,000 to < \$60,000	148	19.2%	16.5, 22.0
\$60,000 to < \$80,000	123	16.0%	13.4, 18.6
\$80,000 to < \$90,000	45	5.9%	4.2, 7.5
\$90,000 or more	197	25.6%	22.5, 28.7
<i>Annual Income Category (n=769)¹</i>			
Low	140	18.2%	15.5, 20.9
Low/Middle	95	12.4%	10.0, 14.7
Middle/High	534	69.4%	66.2, 72.7

¹ A total of 101 respondents reported that they “don’t know” their total household annual income before taxes for 2002, and 130 would not provide information about total annual income.

Two-thirds of the survey respondents reported having an annual household income of \$40,000 or more per year (66.7%), while only 9% reported having an income of \$20,000 or less. In addition, just over two-thirds of the surveyed families were categorized as being in the middle/high income range (69.4%).

It must be noted that 23.1% of the current sample did not provide information about their annual income (they reported that they “don’t know” their annual income or they refused to indicate what it was).

Due to the large proportion of respondents who did not report their income (n=231), other demographic characteristics of this group were examined and compared to the demographic characteristics of the group that did report their income (n=769) in order to determine if any differences existed among these groups. From these comparisons, it appears that respondents who did not report their income were less educated, less likely to be employed, more likely to be stay-at-home parents, more likely to be apartment-dwellers, and more likely to be born outside of Canada as compared to respondents who did report their income. Specifically, 55.3% of those who did not report their income completed some form of post-secondary education as compared to 61.7% of those who did report income. In addition, 54.5% of those who did not report their income were employed and 27.9% were stay-at-home parents, as compared to 64.2% and 17.5%, respectively, of those who did report their income. Moreover, of those who did not report their income, 41.5% were apartment-dwellers and 67.7% were not born in Canada, as compared to 33.3% and 52.6%, respectively, of those who did report their income. Overall, 39.9% of those who did not report their income were recent immigrants (\leq 10 years in Canada) as compared to 26.8% of those who did

report their income. Further analysis revealed that when respondents who did not report their income were separated into those who reported that they “don’t know” their income (n = 101) as compared to those who refused to answer (n = 130), the refused group appeared to more closely resemble those who did report their income than those who said they didn’t know their income. Nevertheless, the overall net effect suggests that if information were obtained from those who did not report their income, the income levels of the entire sample may have been lower. Thus, the high non-response rate might help to account for the higher income levels observed in this sample.

5.1.5. Ethnicity

Several items on the survey asked about family ethnicity. Specifically, parents were asked to indicate their first language, and whether or not they were born in Canada. Those parents born outside of Canada were asked to identify the length of time they have lived in Canada as well as their country of origin. These results are displayed in Table 6.

Table 6: Ethnicity

<i>Ethnicity Variable</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI²</i>
<i>First Language (n=1000)</i>			
English	516	51.6%	48.8, 52.3
Other	484	48.4%	45.3, 51.5
<i>Canadian or Foreign-Born (n=991)</i>			
Born in Canada	436	44.0%	40.9, 47.1
Not born in Canada	555	56.0%	52.9, 59.1
<i>Immigration Characteristics (n=991)</i>			
Recent immigrant (Immigrated <= 10 years ago)	295	29.8%	26.9, 32.6
Not recent immigrant (Immigrated 11+ years ago or Born in Canada)	696	70.2%	67.4, 73.1
<i>Length of Time in Canada for Foreign-Born (n=555)</i>			
Immigrated <= 10 years ago	295	53.2%	49.0, 57.3
Immigrated 11+ years ago	260	46.8%	42.7, 51.0
<i>Country of Origin¹ (n=981)</i>			
Canada	436	44.4%	41.3, 47.6
Asia	262	26.7%	23.9, 29.5
Americas minus Canada	141	14.4%	12.2, 16.6
Europe & Central Asia	83	8.5%	6.7, 10.2
Sub-Saharan Africa	28	2.9%	1.8, 3.9
Middle East & North Africa	25	2.5%	1.6, 3.5
Other	6	0.6%	--

¹ Country groupings are based on World Bank Country groupings (see Appendix D).

² CI's based on percents <1 are suppressed.

Parents were asked to indicate the language that they first learned in the home and can still understand. For this item, just over half of parents reported English as a first language (51.6%). Apart from English, over 70 other languages were reported as first languages. The most frequent of these included Tamil (4.0%), Tagalog (Filipino) (3.3%), Urdu (2.9%), Cantonese (2.8%), Mandarin (2.6%), and Portuguese (2.6%).

Over half of all parents were not born in Canada (56.0%). Of the parents who were not born in Canada, just over half have lived in Canada for 10 years or less (53.2%), while the remaining foreign-born parents have lived in Canada for 11 years or more (46.8%). For all respondents, 29.8% reported recent immigration of 10 years ago or less, and 70.2% were not recent immigrants, having been born in Canada or immigrated 11 years ago or more. Thus, although over half of all respondents were not born in Canada, a much higher proportion of the total sample has lived in Canada for 11 years or more (70.2%).

5.2. Description of Children and Child Health Status

5.2.1. Child's Age, Gender, and Country of Birth

Table 7 shows child's demographic information.

Table 7: Child's Age, Gender, and Country of Birth

<i>Demographic Variable</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
<i>Age of Child (n=1000)</i>			
0 to < 1 year old	157	15.7%	13.4, 18.0
1 to < 2 years old	120	12.0%	10.0, 14.0
2 to < 3 years old	128	12.8%	10.7, 14.9
3 to < 4 years old	141	14.1%	11.9, 16.3
4 to < 5 years old	138	13.8%	11.7, 15.9
5 to < 6 years old	147	14.7%	12.5, 16.9
6 to < 7 years old	169	16.9%	14.6, 19.2
<i>Child Gender (n=1000)</i>			
Male	475	47.5%	44.4, 50.6
Female	525	52.5%	49.4, 55.6
<i>Canadian or Foreign-Born (n=1000)</i>			
Born in Canada	900	90.0%	88.1, 91.9
Not born in Canada	100	10.0%	8.1, 11.9

Child's age and gender were roughly equally distributed across the relevant categories. Although only 44.0% of parents were born in Canada (see Table 6), 90% of children were born in Canada.

5.2.2. Child Health Status

As part of the general information collected about Toronto children’s health, parents were asked to indicate their child’s general level of health, as well as whether or not their child had any long-term conditions such as asthma, allergies, or bronchitis. This information is displayed in Table 8.

Table 8: Child Health Status

<i>Child Health</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
<i>Health Status (n=999)</i>			
Excellent/Very Good	869	87.0%	84.9, 89.1
Good	110	11.0%	9.1, 13.0
Fair/Poor	20	2.0%	1.1, 2.9
<i>Long-Term Conditions¹ (n=994)</i>			
Asthma	68	6.8%	5.3, 8.4
Allergies	59	5.9%	4.5, 7.4
Bronchitis	14	1.4%	0.7, 2.1
Other	37	3.7%	2.5, 4.9
None	851	85.6%	83.4, 87.8

¹ Parents were asked to select all that apply.

According to parents’ ratings, 98.0% of children were in good, very good, or excellent health. The majority of children were reported to not have any long-term medical conditions (85.6%). Based on parents’ responses, 6.8% of children have asthma, 5.9% have allergies, 1.4% have bronchitis, and 3.7% have other types of long-term conditions.

5.3. Childhood Injury Due to Falls

5.3.1. Fall Occurrences and Number of Falls

Falls are the leading cause of injury hospitalizations from birth to adulthood, locally, provincially, and nationally (3, 4). According to the economic burden of unintentional injury in Ontario, childhood falls continue to be a significant problem in Ontario with approximately 220 million dollars spent each year. In fact, children aged 0-9 years account for 14% of direct cost associated with falls across all age groups in Ontario (5).

According to the Canadian Hospitals Injury Reporting and Prevention Program (CHIRRP), falls are a major cause of childhood injuries (6). Although CHIRPP collects data on falls, Toronto data reflects only those children seen at the Hospital for Sick Children and does not capture falls which required medical attention at other locations (e.g., other emergency rooms, physician's offices). The Toronto Perinatal and Child Health Survey allowed for examination of the nature of all falls that required attention by a medical professional.

In order to gather information about extent and nature of childhood injuries due to falls, parents were asked several questions regarding falls that occurred within the past 12 months. Of the 997 respondents who provided information about childhood falls, a total of 6.1% (95% CI = 4.6, 7.6) of parents reported that their child sustained injuries that were serious enough to require medical attention due to at least one fall.

Of the parents who indicated that their child had experienced a fall serious enough to require medical attention in the past 12 months, 93.4% (95% CI = 87.2, 99.7) reported that their child fell only once, while a very small proportion reported that their child fell two or more times.

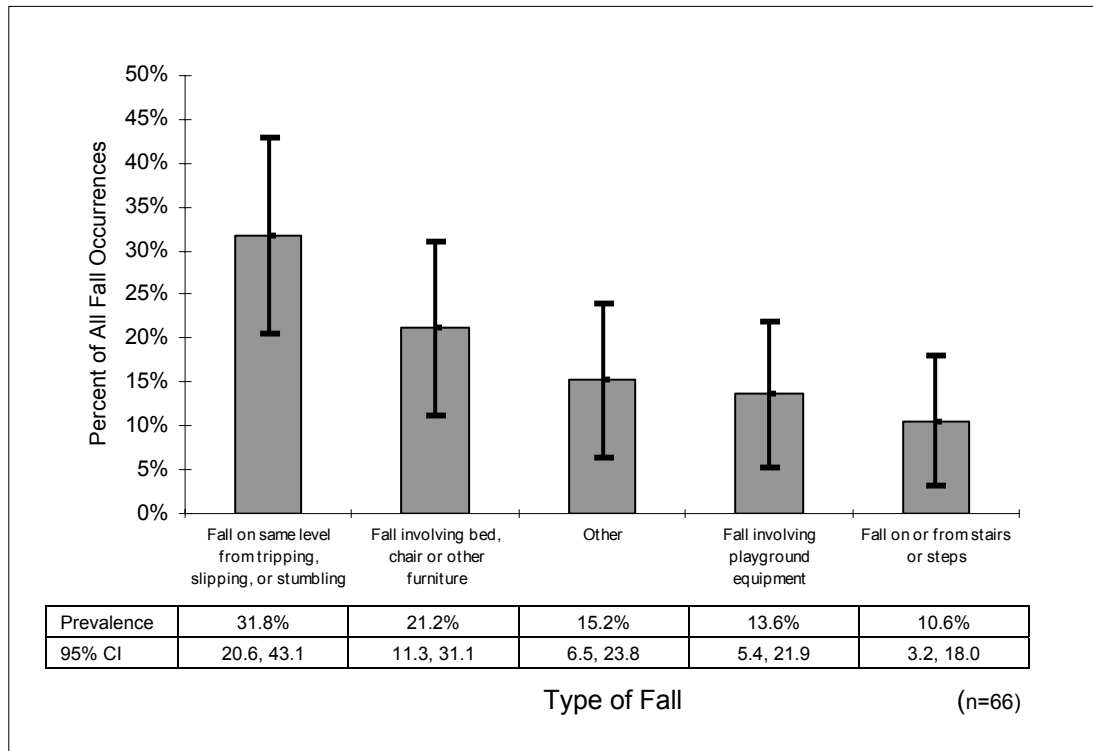
Fall occurrences were also examined according to child's age and household annual income category. Results indicated that fall occurrences were independent of these variables. Thus, occurrence of falls did not appear to vary among children of different ages or families at different levels of income.

5.3.2. Type of Falls

With regard to falls that were serious enough to require medical attention, parents were also asked about the manner in which the child fell. Percentages and 95% CI's for the most frequent types of falls are shown in Figure 1. Estimates are expressed as percentages of all fall occurrences (i.e., percent of total number of falls, n = 66).

* For child's age category $\chi^2_{(2, 997)} = 4.30$, $p = .116$, and for household annual income $\chi^2_{(2, 768)} = 5.17$, $p = .076$.

Figure 1: Type of Falls Serious Enough to Require Medical Attention



The greatest proportion of falls serious enough to require medical attention occurred as a result of “fall on same level from tripping, slipping, or stumbling” (31.8%), followed by “fall involving bed, chair, or other furniture” (21.2%).

5.4. Breastfeeding

The 2001 (Draft) Mandatory Health Programs and Services Guidelines for the Child and Youth Health Program has three Long Term Objectives (2015) related to breastfeeding: (i) the breastfeeding initiation rate will be increased to 92%, (ii) the rate of exclusive breastfeeding, until six months, in healthy term infants will be increased, and (iii) the rate of breastfeeding until 12 months will be increased (7). The most recent baseline breastfeeding initiation rate for Toronto is 86% in 1996 (8). There are no Toronto data related to exclusive breastfeeding at six months or (any) breastfeeding at 12 months.

5.4.1. Breastfeeding Initiation

In order to establish a breastfeeding initiation rate, birth parents were asked to indicate whether they (or their partner) breastfed or tried to breastfeed their child, even if only for a short time. Of the parents who responded to this item, about three-quarters (74.0%) were mothers and one-quarter (26.0%) were fathers.

The overall breastfeeding initiation rate was 94.3% (CI = 92.9%, 95.8%).*

Differences in breastfeeding initiation rates were examined by mother's age at time of child's birth, child's birthweight and gestational age, mother's country of birth (Canada or foreign-born), foreign-born mothers' length of time in Canada, mother's education, and household annual income.† Significant effects were found for mother's age at time of child's birth, mother's country of birth, mother's length of time in Canada for foreign-born, family status, and mother's education. The relevant breastfeeding initiation rates for the categories for each significant variable are summarized in Table 9.

* Items pertaining to breastfeeding were asked only of birth parents. A total of 27 respondents did not provide information about breastfeeding initiation, including those who were not birth parents. Thus, for analysis of breastfeeding initiation, total n = 973.

† Note that, with the exception of mother's age at time of child's birth, all variables apply to the parent who answered the survey questions, whether that was the mother or the father.

Table 9: Breastfeeding Initiation Rates by Parent Demographics

<i>Parent Demographics</i>	<i>Breastfeeding Initiation Rate</i>	<i>Row Count</i>	χ^2	<i>p-value</i>
<i>Mother's Age at Time of Child's Birth</i>				
< 25 years old	88.3%	103	$\chi^2_{(2, 660)} = 9.23$	p < .01
25-29 years old	93.6%	171		
≥ 30 years old	96.1%	386		
<i>Mother's country of birth</i>				
Born in Canada	92.0%	327	$\chi^2_{(1, 716)} = 4.74$	p = 0.03
Not born in Canada	95.9%	389		
<i>Mother's Length of Time in Canada at Time of Child's Birth for Foreign-Born</i>				
10 years or less (Recent immigrants)	97.8%	268	$\chi^2_{(1, 389)} = 7.67$	p = 0.006
11 years or more (Not recent immigrants)	91.7%	121		
<i>Family Status</i>				
Two parent	95.1%	819	$\chi^2_{(1, 973)} = 5.73$	p = .017
Lone parent	90.3%	154		
<i>Mother's Education</i>				
Less than high school completion	83.7%	43	$\chi^2_{(3, 709)} = 19.07$	p < .001
High school completed	89.3%	131		
Some post-secondary (not completed)	93.8%	128		
Post-secondary completed	96.8%	407		
<i>Overall Breastfeeding Initiation Rate¹</i>	94.3%			

¹ Overall breastfeeding initiation rate does not necessarily correspond exactly to marginal totals for each test of significance due to differences in the total number of valid responses for each test.

Table 9 shows that mothers who were older at the time of their child's birth were more likely to initiate breastfeeding than mothers who were younger. Mothers who were not born in Canada were more likely to have reported that breastfeeding was initiated as compared to mothers who were born in Canada. In fact, breastfeeding initiation decreases with the length of time the mother has been in Canada. Mothers who were recent immigrants to Canada at the time of the child's birth were more likely to have reported that they breastfed their child than mothers who

were not recent immigrants.* Children who lived in two parent families were more likely to be breastfed than children who lived in lone parent families. Also, the higher the mother’s level of education, the more likely the mother was to report that breastfeeding was initiated.

No significant effects were found for child’s birthweight, gestational age, or household annual income.†

5.4.2. Decision to Breastfeed

Parents also were asked whether their decision to breastfeed was made before, during, or after pregnancy. These responses are shown in Table 10.‡

Table 10: Timing of Decision to Breastfeed

<i>Timing of Decision (n=948)</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
Before pregnancy	692	73.0%	70.2, 75.8
During first 3 months of pregnancy	100	10.5%	8.6, 12.5
During the last 6 months of pregnancy	64	6.8%	5.2, 8.3
After the baby’s birth	92	9.7%	7.8, 11.6

Almost three-quarters of all parents said they made a decision about breastfeeding even before they became pregnant. About 1 in 10 made the decision early in pregnancy, while a slightly smaller proportion made the decision later during pregnancy. About 1 in 10 parents reported that they did not make a decision about whether or not to breastfeed until after their baby was born.

Timing of decision to breastfeed was also analyzed by several parent demographic variables, and significant effects were found for mother’s age at time of child’s birth, parent’s country of birth (Canada or foreign-born), and parent’s education. There was also a marginally significant effect for household annual income. The relevant frequencies are shown in Table 11.

* This analysis assumes that for mothers who reported that their child was not born in Canada, the length of time in Canada at time of birth was zero. For foreign-born mothers who reported that their child was born in Canada, length of time in Canada at time of child’s birth was assumed to be length of time in Canada minus the child’s age.

† For child’s birthweight, Fisher’s Exact (1, 906) = 1.03, p = .368; for gestational age, Fisher’s Exact (1, 933) = 1.71, p = .204; and for household annual income category $\chi^2(2, 749) = 1.52, p = .468$.

‡ Of the parents who responded to this item, about three-quarters (74.2%) were mothers and one-quarter were fathers (25.8%). The distribution of responses was similar for mothers and fathers.

Table 11: Timing of Decision to Breastfeed by Parent Demographics

Parent Demographics	Timing of Decision to Breastfeed				Row Count	χ^2	p-value
	Before pregnancy	During 1 st 3 months of pregnancy	During last 6 months of pregnancy	After the baby's birth			
Mother's Age at birth							
< 25 years old	61.4%	13.9%	10.9%	13.9%	101	$\chi^2_{(6, 646)} = 16.77$	p < .01
25-29 years old	69.6%	12.5%	6.0%	11.9%	168		
≥ 30 years	79.0%	8.0%	6.1%	6.9%	377		
Canadian/Foreign-Born							
Born in Canada	77.2%	12.0%	6.3%	4.6%	416	$\chi^2_{(3, 941)} = 23.43$	p < .001
Not born in Canada	69.7%	9.5%	7.0%	13.7%	525		
Parent's Education							
Less than high school	63.0%	8.7%	8.7%	19.6%	46	$\chi^2_{(9, 933)} = 28.21$	p < .001
High school completed	62.7%	13.0%	8.1%	16.1%	161		
Some post-secondary	70.3%	15.2%	5.1%	9.5%	158		
Post-secondary completed	77.6%	8.6%	6.7%	7.0%	568		
Household Annual Income							
Low	63.6%	11.4%	9.8%	15.2%	132	$\chi^2_{(6, 731)} = 12.13$	p = .059
Low/Middle	68.9%	14.4%	6.7%	10.0%	90		
Middle/High	76.0%	9.4%	6.9%	7.7%	509		
Overall¹	73.0%	10.5%	6.8%	9.7%	948		

¹ Overall percentages for timing of decision do not necessarily correspond exactly to marginal totals for each test of significance due to differences in the total number of valid responses for each test.

Mothers who were older at the time of their child's birth were more likely to make a decision about breastfeeding before pregnancy than younger mothers. Parents who were born in Canada were more likely to report making a decision about breastfeeding before pregnancy and less likely to report making a decision about breastfeeding after the baby's birth as compared to foreign-born parents.

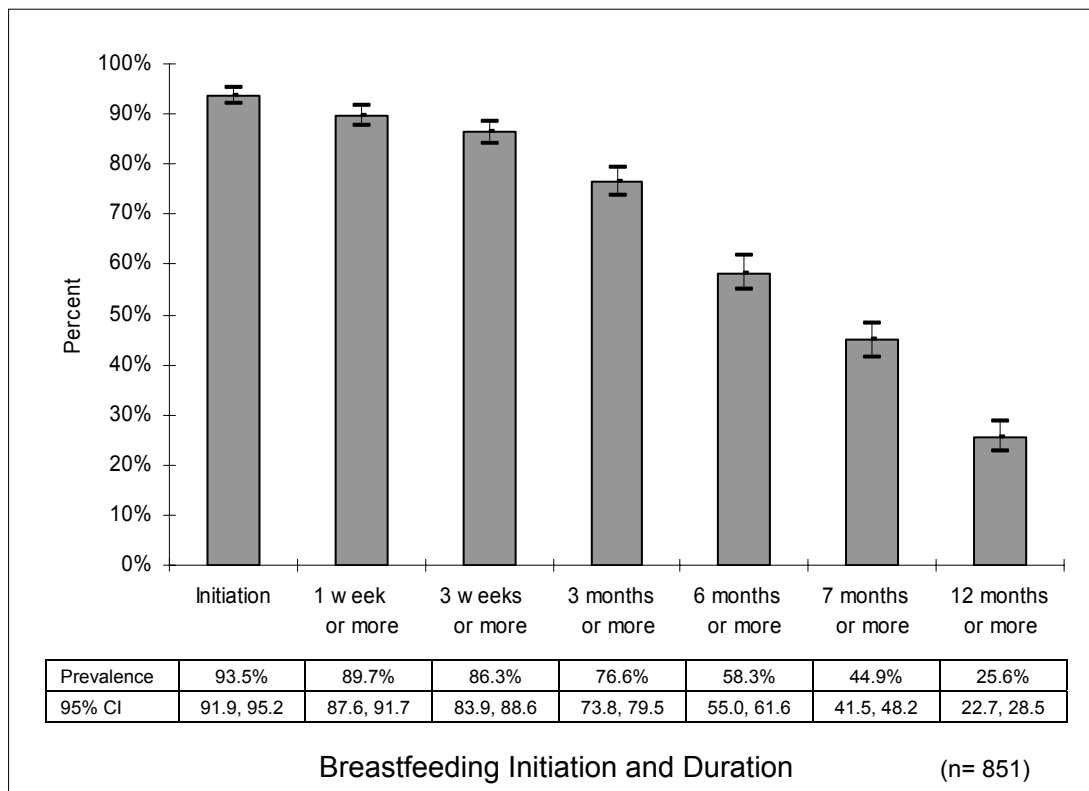
In addition, parents with higher education levels and those with higher income were more likely to report making a decision about breastfeeding before pregnancy and less likely to report making a decision after the baby's birth as compared to parents with lower levels of education and those at lower income levels, respectively.

For timing of decision to breastfeed, no significant effects were found for family status or length of time in Canada for foreign-born.*

5.4.3. Breastfeeding Duration

Parents who reported that their child had been breastfed were asked to indicate the length of time their child was breastfed. Breastfeeding duration rates were calculated for the total number of babies, which include all those who were never breastfed and those who were formerly breastfed. Those who were still being breastfed at the time of the survey were excluded from the analysis (n=115) because the final breastfeeding duration for these children is not known.† Breastfeeding duration rates are shown in Figure 2 with 95% CI's, alongside the overall initiation rate for this group (93.5%).‡

Figure 2: Prevalence of Breastfeeding Initiation and Duration



* For family status, $\chi^2_{(3, 948)} = 2.13$, $p = .545$, and for length of time in Canada at time of child's birth for foreign-born, $\chi^2_{(3, 525)} = 3.59$, $p = .309$.

† It should be noted that although this particular analysis does not include responses from parents of children who were still being breastfed at the time of the survey, further examination involving survival analysis could be conducted to include these censored cases.

‡ For the breastfeeding duration item, parents were not asked to provide a specific time in days, months, or years for breastfeeding duration, but rather responses were coded as falling into one of the following categories: "less than 1 week," "1-2 weeks," "3-4 weeks," "5-8 weeks," "9 to less than 12 weeks," "3-5 months," "6 months," "7-11 months," or "12 months or more." Responses subsequently were collapsed into the categories seen in Figure 2 and are labelled "1 week or more" and so on because parents may have indicated any time within these categories.

As shown in Figure 2, the breastfeeding initiation rate was 93.5%, and almost 90% of parents reported breastfeeding their baby for at least one week. However, only about three-quarters of parents reported breastfeeding for 3 months or more, 58.3% reported breastfeeding for 6 months or more, less than half reported breastfeeding for 7 months or more, and only about one-quarter reported breastfeeding for 12 months or more. Thus, a substantial proportion of parents who initiated breastfeeding stopped by the 6-month mark, and the majority had stopped by 1 year.

5.4.4. Exclusive Breastfeeding Duration

Exclusive breastfeeding is defined as “no food or drink, including water, other than breastmilk, except for medical drops or syrups which may be indicated” (9).

Exclusive breastfeeding duration rates were calculated for healthy term infants. The World Health Organisation (WHO) and the United Nations Children's Emergency Fund (UNICEF) accepted medical reasons for supplementation include: very low birthweight babies (<1500 grams) or those born preterm (\leq 32 weeks gestational age); severely ill babies; babies in need of surgery; and infants with severe dysmaturity or with potentially severe hypoglycaemia who require therapy for hypoglycaemia and who do not improve through increased breastfeeding or by being given breastmilk. Other medical reasons include: infants with inborn errors of metabolism, infants with acute water loss (for example, during phototherapy for jaundice, and whenever increased breastfeeding cannot provide adequate hydration), and infants whose mothers are taking medication which is contraindicated when breastfeeding (10).

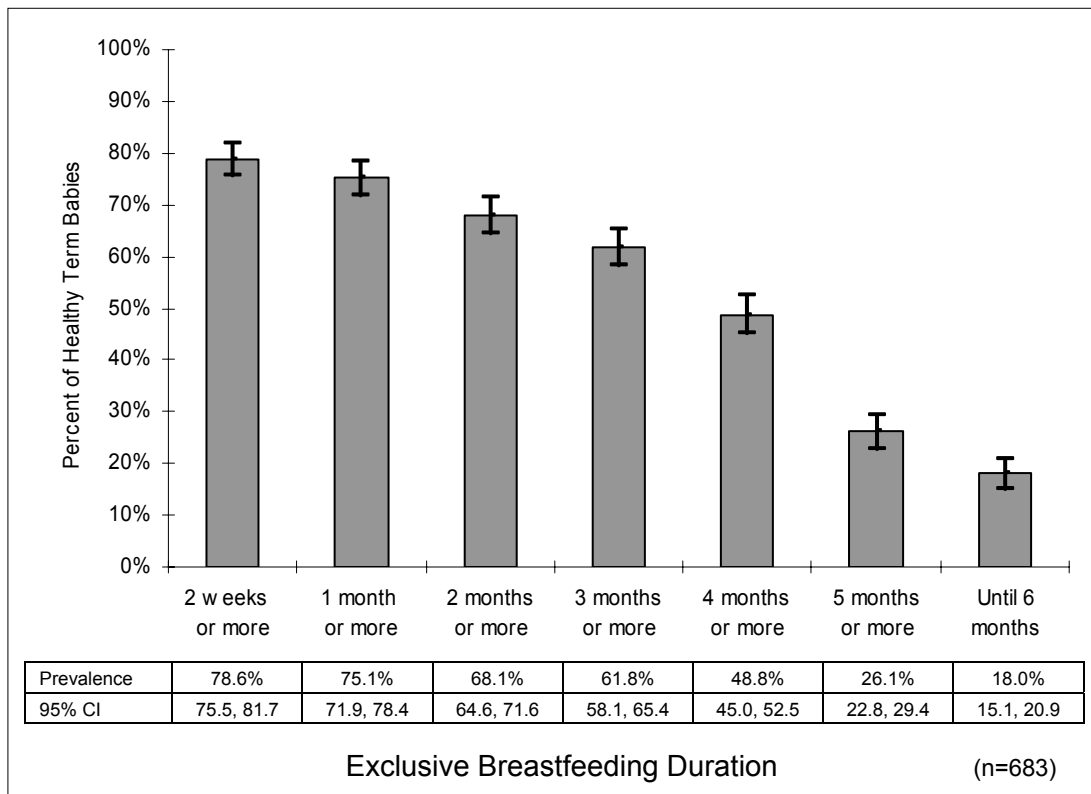
Following the WHO and UNICEF guidelines, babies who were less than 1500 grams and/or 32 weeks gestation or less were excluded from the calculation of exclusive breastfeeding rates. The majority of children (92.1%) in the sample weighed over 1500 grams when they were born. Of the remaining children, 0.4% were excluded from the analysis due to a birthweight of less than 1500 grams, and 7.5% were excluded because birthweight information was not provided. For gestational age, 89.5% of children were born at full-term and 4.2% were born pre-term but not very pre-term (less than 37 but more than 32 weeks gestation). Of the remaining children, 1.1% were excluded from the analysis due to a gestational age of \leq 32 weeks and 5.2% were excluded because this information was not provided.

In addition to providing birthweight and gestational age information, parents were also asked to indicate if their child had any health problems within the first 6 months of life, and if so, what those problems were. For cases in which the parent indicated that the child did have a health problem ($n = 157$), the description of the problem was assessed by two independent child health specialists from TPH and each case was given a rating of “no health problem,” “health problem that was a contraindication to exclusive breastfeeding,” or “insufficient information to

determine infant health in terms of being a contraindication to exclusive breastfeeding.” In total, 87.5% of cases were rated as having no health problem, 2.9% were rated as having a health problem serious enough to interfere with exclusive breastfeeding, and 6.9% were rated as having insufficient information to determine whether or not there was a medical reason to interfere with exclusive breastfeeding.* Any case with missing information regarding birth weight and/or gestational age was excluded from the analysis, as were cases in which the child was still being exclusively breastfed because exclusive breastfeeding duration for these children was not yet known. Based on the birthweight, gestational age, and health ratings criteria, there were 780 healthy term babies. Of these, 70 respondents did not provide information about the age at which the baby first received any food or drink other than breastmilk (they could not remember), and 27 children were still being exclusively breastfed. Thus, 683 records were included in this analysis. Of these records, 81.7% were reported by mothers and 18.3% were reported by fathers.

Exclusive breastfeeding duration rates based on all healthy term babies are shown in Figure 3.

Figure 3: Prevalence of Exclusive Breastfeeding Duration



* Ratings were not made for 27 cases (2.7%) because these children were born under 1500 grams or were born at a gestational age of ≤ 32 weeks which would result in exclusion from the analysis anyway.

As shown in Figure 3, just over three-quarters of all healthy term babies were exclusively breastfed for 2 weeks or more, 68.1% were exclusively breastfed for 2 months or more, less than half were exclusively breastfed for 4 months or more, about one-quarter were exclusively breastfed for 5 months or more, and less than 1 in 5 were exclusively breastfed until 6 months. Of the parents (n = 123) who reported exclusively breastfeeding for 6 months or more, 72.4% reported doing so for 6 months, 7.3% reported exclusively breastfeeding for 7 months, 13.0% reported exclusively breastfeeding for 8 months, 2.4% reported exclusively breastfeeding for 9 months, and 4.1% reported exclusively breastfeeding for 1 year.

Looking at the same results from a different perspective provides even more information about rate of exclusive breastfeeding. Figure 4 shows the percentage of respondents in each of these breastfeeding categories (as opposed to the cumulative percents depicted in Figure 3). Note that “healthy baby not breastfed” and babies exclusively breastfed for “less than 2 weeks” are represented as categories in this analysis because these babies were included as part of the calculations for exclusive breastfeeding rates.

Figure 4: Exclusive Breastfeeding Duration by Category

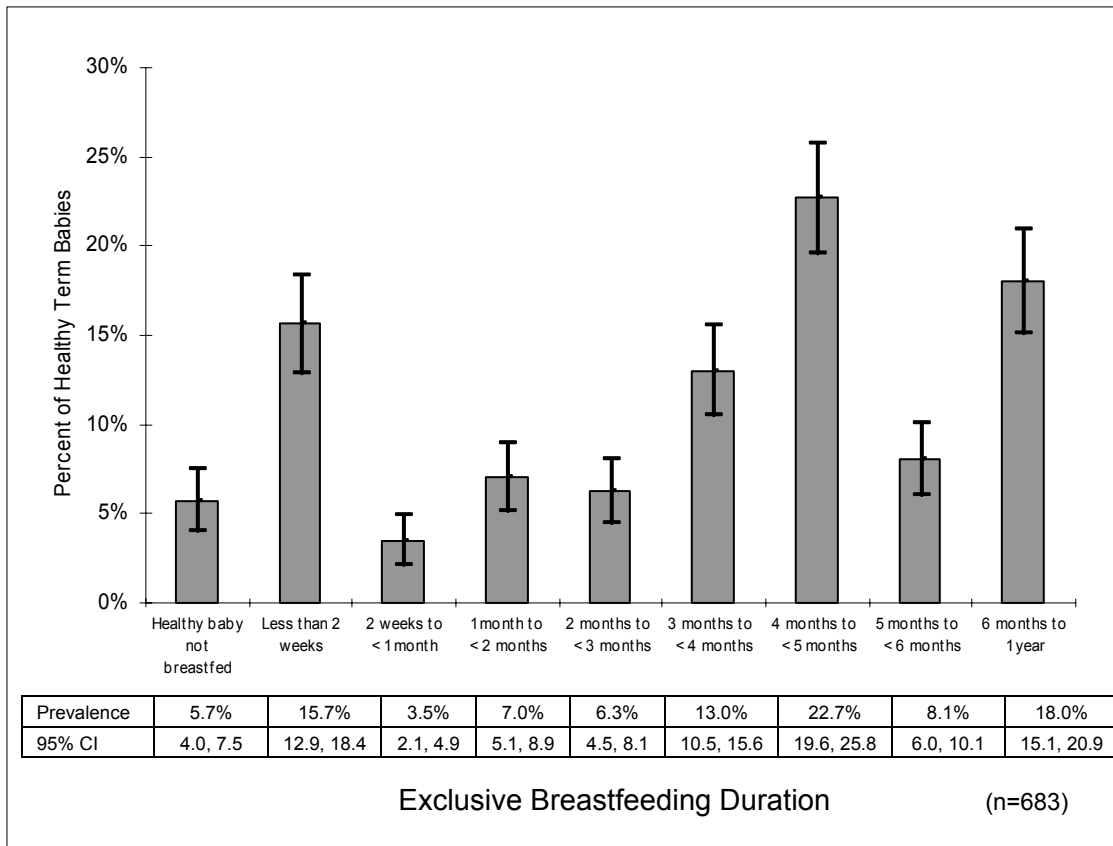


Figure 4 shows that 5.7% of healthy babies were not breastfed at all, 15.7% were exclusively breastfed for less than 2 weeks, 7.0% were exclusively breastfed for 1 month to under 2 months, 13.0% were exclusively breastfed for 3 months to under 4 months, 22.7% were exclusively breastfed for 4 months to under 5 months, 8.1% were exclusively breastfed for 5 months to under 6 months, and 18.0% were exclusively breastfed for 6 months to 18 months. Thus, the greatest proportion of children was exclusively breastfed for between 4 and 5 months followed by 6 months to 18 months. However, this accounts for less than half of all healthy babies. Furthermore, a substantial proportion of babies was exclusively breastfed for less than 2 weeks, and about 1 in 20 healthy babies were never breastfed at all.

Of the parents who exclusively breastfed for less than 2 weeks (n=107), over half (58.9%) reported that their child first received other food besides breastmilk from birth (day 1), and 39.2% reported that their child first received other food sometime between 2 to 7 days of age.

Given the recommendation that children be exclusively breastfed for 6 months after birth, the 6-month rate of exclusive breastfeeding was examined across several parent demographic variables in an effort to try to identify factors that may have an impact on this breastfeeding duration. However, the rate of 6-month exclusive breastfeeding did not vary significantly by mother's age at time of birth, child's birthweight or gestational age, parent's country of birth, parent's length of time in Canada for foreign-born, family status, parent's education, mother's employment status (full-time vs. part-time vs. stay at home vs. other), or household annual income.* Thus, according to the results of this survey, none of these factors can be identified as being specifically related to 6-month exclusive breastfeeding rate.

* For mother's age at time of child's birth, $\chi^2_{(2, 519)} = 1.51$, $p = .469$; for child's birthweight, $\chi^2_{(1, 683)} = 2.33$, $p = .127$; for child's gestational age, Fisher's Exact $_{(1, 683)} = 0.34$, $p = .572$; for parent's country of birth, $\chi^2_{(1, 680)} = 0.41$, $p = .523$; for parent's length of time in Canada at time of child's birth $\chi^2_{(1, 380)} = 1.19$, $p = .276$; for family status, $\chi^2_{(1, 683)} = 1.16$, $p = .282$; for parent's education, $\chi^2_{(3, 675)} = 2.07$, $p = .559$; for mother's employment, $\chi^2_{(3, 549)} = 2.37$, $p = .498$; and for household annual income category $\chi^2_{(2, 535)} = 0.07$, $p = .967$.

5.5. Physical Activity

5.5.1. Family Participation in Physical Activity

Physical activity is an important part of health promotion and disease prevention. TPH Physical Activity programs encourage parents and children to become physically active together. Research suggests that parents' role modelling, support, encouragement, and praise act as positive influences in promoting physical activity (11). In order to obtain information about family participation in physical activity, parents were asked to indicate the number of times in a typical week that at least one parent participates with his/her child in some form of physical activity. Examples of physical activity that were provided include walking, swimming, skating, or playing in the park. Frequencies and percentages for family physical activity participation are displayed in Table 13.*

Table 13: Family Participation in Physical Activity

<i>Typical Week (n=980)</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
0-1 times per week	124	12.7%	10.6, 14.7
2-3 times per week	291	29.7%	26.8, 32.6
4 or more times per week	565	57.7%	54.6, 60.7

Over half of all parents reported that at least one parent participates with the child in physical activity 4 or more times per week. Almost one-third of parents reported participating in physical activity 2-3 times per week, and just over 1 in 10 reported participating only once or not at all in a typical week. However, given that the target age group for children includes those who are newborns to those who are 6 years old, participation in physical activity may vary across these age groups based on the differing physical abilities of the children. Thus, weekly participation in physical activity was examined according to age category of the child. These results are displayed in Table 14.

* It should be noted that, because the survey item asked about participation in physical activities during a typical week and the survey was administered during very cold weather, it is possible that the prevalence of physical activities may be underestimated.

Table 14: Family Participation in Physical Activity by Child's Age Category

<i>Age of Child</i>	<i>Average Number of Times/Week</i>			<i>Row Count</i>	χ^2	<i>p-value</i>
	<i>0-1</i>	<i>2-3</i>	<i>4 or more</i>			
< 1 year old	18.7%	21.3%	60.0%	150	$\chi^2_{(4, 980)} = 25.47$	p < .001
1-4 years old	10.2%	27.2%	62.5%	518		
5-6 years old	13.8%	37.8%	48.4%	312		
<i>Overall</i>	<i>12.7%</i>	<i>29.7%</i>	<i>57.7%</i>	<i>980</i>		

Weekly participation in physical activity was significantly related to age of the child, and the pattern of results suggests that there was a slight tendency for parents with children less than a year old to more often report participating in physical activity 0-1 times per week as compared to parents of older children. However, the majority of parents with children in this young age group reported participating 4 or more times per week. Parents with 5-6 year old children more often reported participating 2-3 times per week as compared to parents with younger children, and less often reported participating 4 or more times per week as compared to parents with younger children. However, it should be noted that the physical activity item specifically asked about participation that includes the child and at least one parent, and, therefore, it is possible that total physical activity participation of older children may have been underestimated. For example, older children may participate in some physical activities that do not directly involve a parent because children at this age require less assistance and supervision. Also, older children may have less time available for these types of activities because of the time they spend in school, which may include participation in gym classes.

5.5.2. Sedentary Activity

To further assess lifestyle behaviours, parents were asked to indicate the number of hours in a typical week that their child spends watching TV or videos, using the computer, or playing video games or hand held computer games. Responses subsequently were recalculated to represent the average number of hours per day that the child spends on these types of sedentary activities. These results are displayed in Table 15.

Table 15: Participation in Sedentary Activity

<i>Hours per Day (n=963)</i>	<i>Frequency</i>	<i>%</i>	<i>95% CI</i>
0 to 2 hours	737	76.5%	73.9, 79.2
>2 to 4 hours	188	19.5%	17.0, 22.0
>4 hours	38	3.9%	2.7, 5.2

Parents most often reported that their child engaged in sedentary activity for between 0 to 2 hours in a typical day, whereas a small proportion reported that their child engaged in 4 or more hours of these kinds of activities per day. Given that sedentary activity may vary among children of different ages based on their different physical and cognitive abilities, average number of hours spent per day on sedentary activity was examined according to age category of the child. These results are displayed in Table 16.

Table 16: Participation in Sedentary Activity by Child's Age Category

<i>Age of Child</i>	<i>Average Number of Hours/Day</i>			<i>Row Count</i>	χ^2	<i>p-value</i>
	<i>0 to 2</i>	<i>>2 to 4</i>	<i>>4</i>			
<1 year old	96.6%	2.0%	1.4%	148	$\chi^2_{(4, 963)} = 40.53$	p < .001
1-4 years old	72.3%	22.8%	4.9%	509		
5-6 years old	73.9%	22.5%	3.6%	306		
<i>Overall</i>	<i>76.5%</i>	<i>19.5%</i>	<i>3.9%</i>	<i>963</i>		

Daily participation in sedentary activity was significantly related to age of the child, and, as may be expected, children aged less than 1 year old were reported to spend less time on sedentary activities such as watching television or playing video games than older children. Specifically, over 96% of children aged less than 1 year were reported to spend 2 hours or less per day on these kinds of sedentary activities, whereas just under three-quarters of older children were reported to spend 2 hours or less per day on these activities. Almost one-quarter of those over the age of one year were reported to spend more than 2 and up to 4 hours per day on sedentary activity (22.8% of 1-4 year olds and 22.5% of 5-6 years olds). Additional analysis that excluded children aged less than 1 year revealed that the reported sedentary activity of 1-4 year olds did not differ significantly from that of 5-6 year olds.*

* For participation in sedentary activity by child's age category with <1 year olds excluded, $\chi^2_{(2, 815)} = 0.82$, p = .664.

5.6. Smoking Restrictions in the Home

TPH is committed to gathering information to monitor and track the prevalence of smoking in the home. This information may be used to help modify the existing Breathing Space Campaign, and to provide input for further research. The Toronto Perinatal and Child Health Survey gathered information on the percent of Toronto households with children aged 0-6 that (i) allow smoking anywhere in the home, (ii) allow smoking in some places or at some times, and (iii) do not allow smoking anywhere inside the home. These results are displayed in Table 17.

Table 17: Smoking Rules in the Home

<i>Rule (n=999)</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
Smoking not allowed in the home	927	92.8%	91.2, 94.4
Smoking allowed some times, some places	59	5.9%	4.4, 7.4
Smoking allowed anywhere in home	13	1.3%	0.6, 2.0

Of all surveyed parents, 92.8% reported that smoking is not allowed anywhere inside the home at any time, while a total of 7.2% do allow smoking at least some of the time. Smoking rules (smoking not allowed vs. smoking allowed) also were examined according to parent's age, child's age, dwelling type, and household annual income category. A marginally significant effect was found only for parent's age category.* The relevant descriptive statistics are presented in Table 18.

Table 18: Smoking Rules by Parent's Age Category

<i>Parent's Age</i>	<i>Smoking Rule</i>		<i>Row Count</i>	χ^2	<i>p-value</i>
	<i>Smoking not allowed</i>	<i>Smoking allowed¹</i>			
< 25 years old	81.3%	18.8%	32	$\chi^2_{(2, 919)} = 5.85$	p = .054
25 to 29 years old	93.0%	7.0%	128		
30+ years old	92.8%	7.2%	759		
Overall²	92.4%	7.6%	919		

¹ This category combines the responses "Smoking allowed some times, some places" and "Smoking allowed anywhere in the home."

² Overall percentages do not correspond exactly those in Table 17 due to differences in the total number of valid responses.

* For child's age category, $\chi^2_{(2, 999)} = 0.24$, p = .889; for dwelling type $\chi^2_{(2, 985)} = 1.00$, p = .607; and for household annual income category $\chi^2_{(2, 768)} = 2.37$, p = .306.

These results suggest that parents who are less than 25 years of age may be somewhat less likely than those in the older age groups to favour rules which prohibit smoking in the home. This observation must be treated with appropriate caution, however, given the small total number of parents in the younger age group. Nevertheless, given the importance of reducing children's exposure to any form of second-hand smoke, further education of younger parents about the dangers associated with smoking in the home is an area worthy of further investigation.

5.7. Parenting Practices

The two most critical aspects of parenting are parental warmth, as opposed to hostility or harshness, and consistency (12). Hostility and power assertion in the parent-child relationship have been associated with the onset of externalizing behavioural disorders (13). Harsh parenting has also been found to be associated with increases in externalizing behaviours and aggression (14) as well as internalizing disorders such as depression (15).

Data from the Cycle 1 of the NLSCY (1994/95) suggest that there is a relationship between parenting practices and children's developmental outcomes (16). For 2-3 year old children, (hostile) ineffective parenting practices were associated with a higher likelihood of emotional problems and aggressive behaviour, whereas consistent parenting reduced the likelihood of aggressive behaviour and hyperactivity by over 50%. Positive parenting was not particularly effective in reducing the likelihood of having problems. Data on 4-11 year old children suggested that positive parenting practices reduced the likelihood of having relationship problems, an emotional disorder, conduct disorder or repeating a grade in school whereas (hostile) ineffective parenting practices increased the occurrence of these problem behaviours as well as hyperactivity (16).

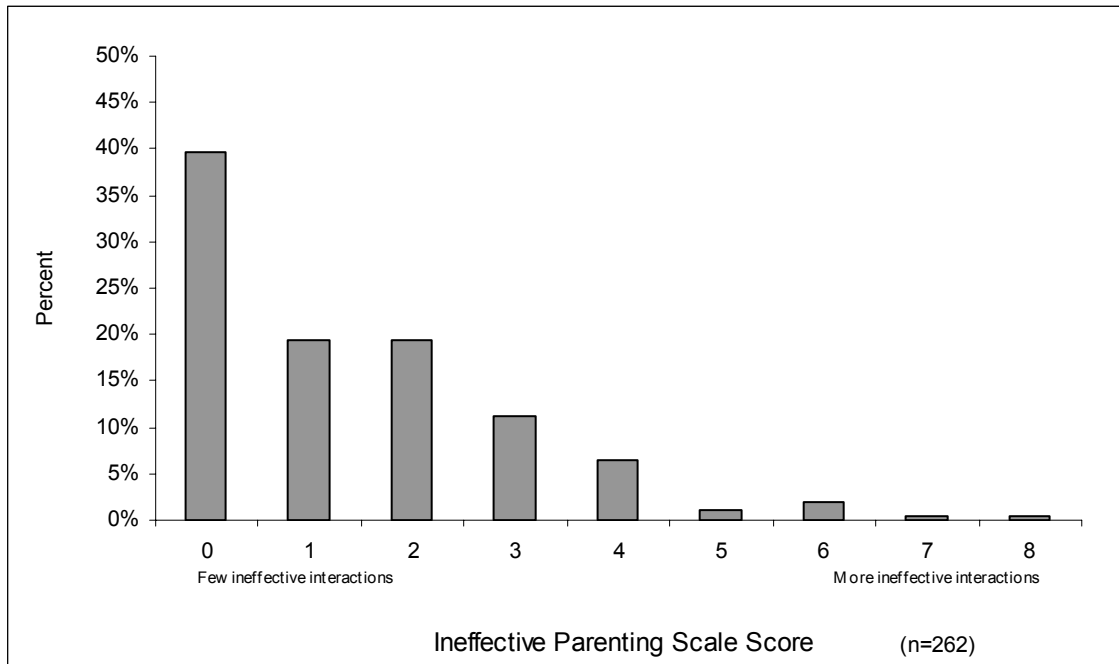
The NLSCY Ineffective Parenting Scale and the NLSCY Rational Parenting Scale were included in the Toronto Perinatal and Child Health Survey. Scores for the Ineffective Parenting Scale are calculated differently for cases in which the child is 0-23 months old as compared to cases in which the child is 2 years or older. Therefore, analyses for this scale are presented separately for these two age groups. The Rational Parenting Scale applies only to children aged 2 years or older. For all of these scales, parents were included in the scoring only if they provided responses that could be coded according to the scoring procedure for each of the relevant items on the scale.

5.7.1. Ineffective Parenting Scale, 0-23 Months

The Ineffective Parenting Scale (previously known as the Hostile/Ineffective Parenting Scale) is designed to provide scores that reflect the extent to which parents engage in ineffective interactions with their children. Scores for cases in which the child is 0-23 months old ($n = 262$)* are based on the parent's response to two items (see Appendix B – questions 33 and 34). Responses for each item were coded from 0 to 4, resulting in a minimum possible scale score of 0 and a maximum possible scale score of 8. Higher scores indicate a higher level of ineffective interactions. The frequency distribution of Ineffective Parenting Scale scores for children aged 0-23 months is shown in Figure 5.

* A total of 15 parents did not provide a response to one or more items on this scale. For this analysis, total $n = 262$, which represents 94.6% of all surveyed parents with children aged 0-23 months.

Figure 5: Ineffective Parenting Scale Scores, 0-23 Months



As illustrated in Figure 5, scores ranged from 0-8, with the distribution skewed toward the positive side; in other words, most parents reported engaging in few ineffective interactions with their children. The most common score was 0, which indicates a very low or absent level of reported ineffective interactions between parent and child. Specifically, 39.7% of parents reported that they never engage in ineffective interactions with their children. Moreover, another 50.1% of parents scored at the low scale values of 1, 2, or 3, and the overall mean score was 1.40 (SD = 1.56). Ineffective Parenting scores did not vary across family status, household annual income category, dwelling (rent vs. own), parent's education, or parent gender.*

5.7.2. Ineffective Parenting Scale, 2-6 Years

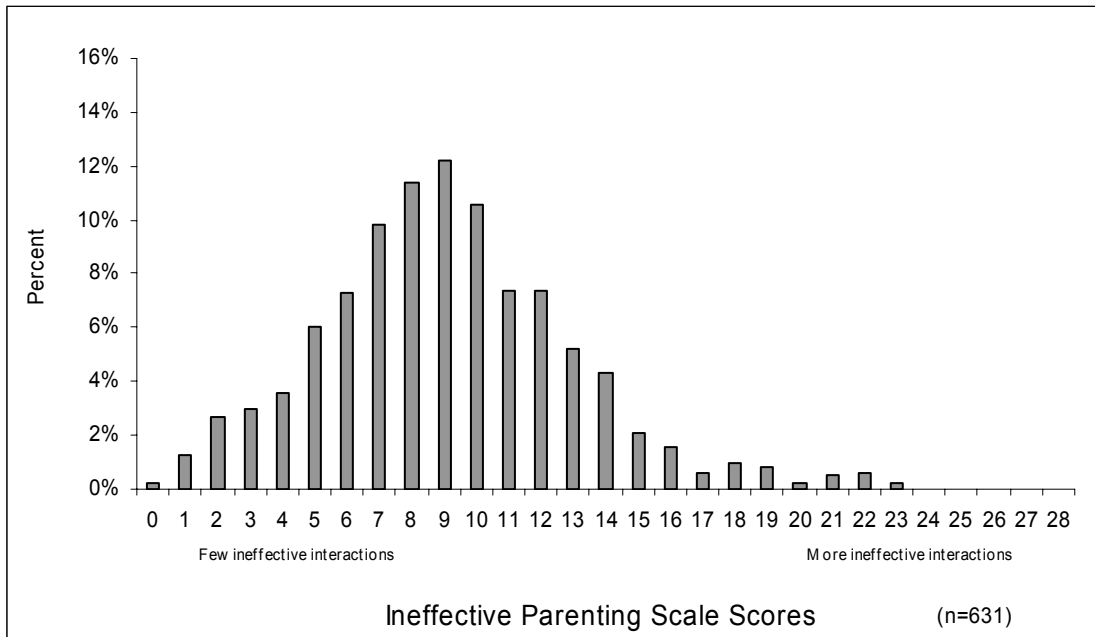
Ineffective Parenting Scale scores for cases in which the child is 2 years or older are based on parents' responses to seven items (see Appendix B – questions 33, and 35-40). Responses to each item were coded from 0 to 4, resulting in a minimum possible score of 0 and a maximum possible score of 28, with higher scores indicating a higher level of ineffective interactions (note that question 35 was reverse coded). Scores were calculated only for parents who provided responses that could be coded according to the scoring procedure for each of the relevant items on the scale. A total of 92 parents did not provide a response to one

* For family status, $t_{(260)} = 1.04$, $p = .299$.; for household annual income, $F_{(2, 211)} = 0.96$, $p = .385$.; for dwelling (rent vs. own), $t_{(257)} = 1.82$, $p = .070$; for parent's education $F_{(3, 254)} = 0.20$, $p = .898$.; and for parent gender $t_{(260)} = 0.61$, $p = .540$.

or more items on this scale. For this analysis, total n = 631, which represents 87.3% of the total sample.*

The frequency distribution of Ineffective Parenting Scale scores for children aged 2-6 years is shown in Figure 6.

Figure 6: Ineffective Parenting Scale Scores, 2-6 Years

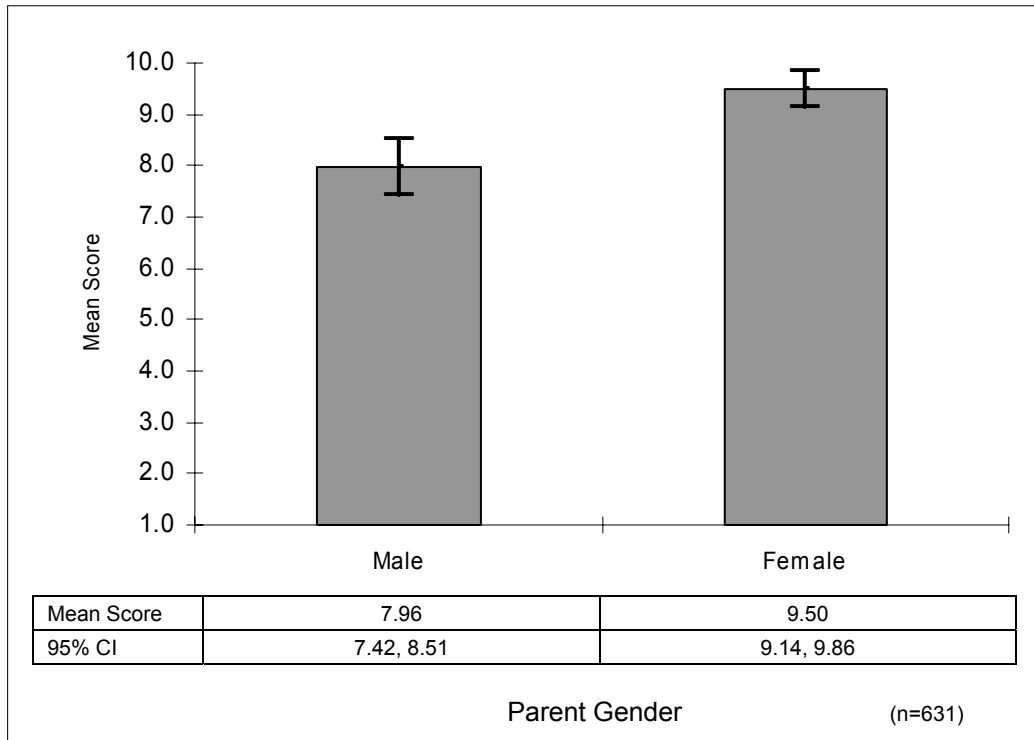


As illustrated in Figure 6, Ineffective Parenting scores ranged from 0 to 23, with the distribution skewed toward the positive side (i.e., most parents practised few ineffective interactions). The modal score was 9, and over three-quarters of parents scored between the values of 5 and 13 on the scale (77.3%, n = 489). The mean score was 9.09 (SD = 3.89).

In order to further explore the nature of parenting practices, Ineffective Parenting scores were examined across several demographic variables. A significant effect was found for parent gender ($t_{(629)} = 4.44, p < .001$). Mean scores for gender with 95% CI's are displayed in Figure 7.

* When a comparison was made between those who completed each item for this scale (n = 631) and those who did not (n = 92), non-responders appeared to be more likely to have lower income and lower education, to live in an apartment, to be born outside of Canada, and to be a recent immigrant (in Canada 10 years or less) as compared to those who did respond to every item on the scale. Given the relatively large non-response rate for this scale and the possible differences between responders and non-responders, analysis involving this scale should be interpreted with caution.

Figure 7: Ineffective Parenting Scale Scores by Parent Gender



Ineffective Parenting Scale scores for females (Mean Score = 9.50) were significantly higher than those for males (Mean Score = 7.96). However, parenting scores were independent of family status, household annual income, dwelling (rent vs. own), and parent's education.

5.7.3. Rational Parenting Scale, 2-6 Years

The Rational Parenting Scale is designed to measure the extent to which the parent has punitive or aversive interactions with the child. This scale is computed only for parents with children aged 2 years and older ($n = 685$)[†] and is comprised of seven questions (see Appendix B – questions 41 to 47). However, only four items contribute to the Rational Parenting Scale score (questions 43 to 46), and are coded with values of 1 to 5, resulting in a minimum possible score of 4 and a maximum possible score of 20 (questions 44 and 46 are reverse-coded). Higher scores indicate a higher level of punitive or aversive interaction between parent and child. The frequency distribution of Rational Parenting Scale scores is shown in Figure 8.

* For family status, $t_{(629)} = 0.64$, $p = .526$; for household annual income, $F_{(2, 487)} = 0.79$, $p = .453$; for dwelling (rent vs. own), $t_{(617)} = 1.64$, $p = .102$; and for parent's education $F_{(3, 618)} = 0.76$, $p = .515$.

[†] A total of 38 parents did not provide a response to one or more items on this scale. For this analysis, total $n = 685$, which represents 94.7% of all surveyed parents with children aged 2-6 years.

Figure 8: Rational Parenting Scale Scores

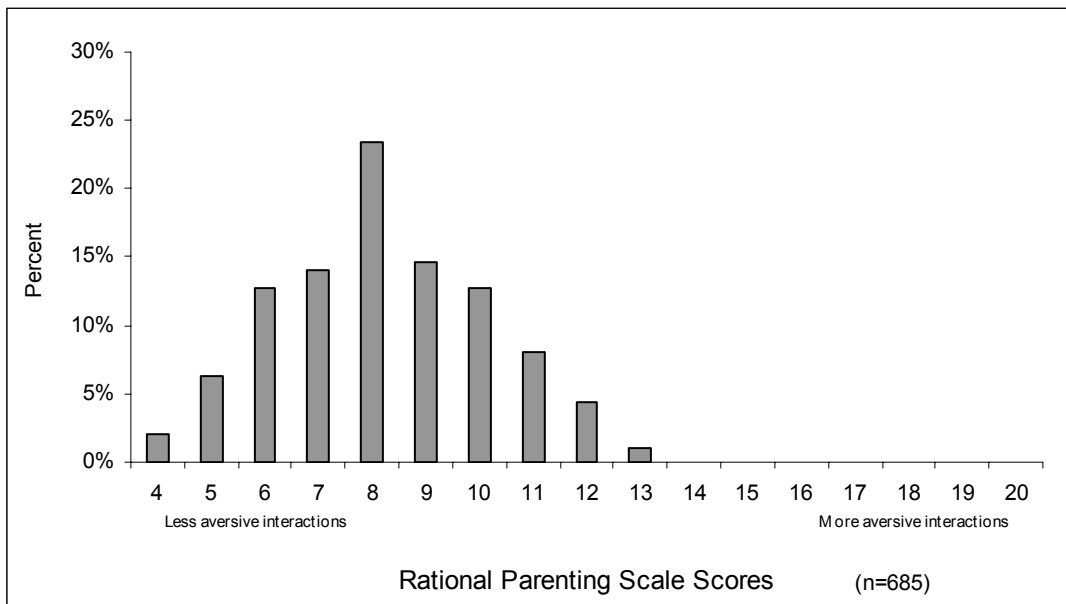


Figure 8 shows that Rational Parenting Scale scores ranged from 4 (the minimum possible score) to 14. Similar to the distribution of the Ineffective Parenting scores, the distribution of the Rational Parenting Scores was skewed toward the positive side (i.e. most parents practised less aversive interactions with their children). The most common score was 8, with almost one-quarter (23.4%) of parents scoring at this level. Over three-quarters (77.6%) of all parents scored between the values of 6 and 10, and the mean Rational Parenting Scale score was 8.24 (SD = 2.01). Rational Parenting Scale scores did not vary significantly across family status, household annual income, dwelling (rent vs. own), parent’s education, or parent gender.*

5.7.4. Ineffective and Rational Parenting Scales, 2-6 Years

For parents of children aged 2-6 years, Rational Parenting Scale scores were positively associated with Ineffective Parenting Scale scores to a moderate degree ($r = .35$, $p < .001$). Thus, parents who reported a greater number of ineffective interactions with their children also tended to report having more aversive interactions with their children.

* For family status, $t_{(683)} = 1.54$, $p = .123$; for household annual income, $F_{(2, 522)} = 1.44$, $p = .238$.; for dwelling (rent vs. own), $t_{(671)} = 0.15$, $p = .885$; for parent’s education $F_{(3, 672)} = 0.76$, $p = .516$.; and for parent gender, $t_{(683)} = 1.00$, $p = .316$.

5.8. Food Security

To inform efforts to ensure that Toronto families have adequate access to appropriate sources of food, the Toronto Perinatal and Child Health Survey included 8 items from the 18-item USDA Food Security Module that are specifically designed to assess the extent of child hunger in the home (17). These 8 items form the children’s food security scale, which is a graduated, continuous measure of the severity of food insecurity among children in a household (see Appendix B – questions 48-55). The items on the children’s food security scale vary across a wide range of severity of food insecurity, and flow from less to more severe indicators of food insecurity. The items that comprise the children’s food security scale are strongly ordered such that a household that affirms a particular item also will typically have affirmed items that are less severe. Conversely, a household that denies a particular item also typically deny all items that are more severe. The percentage of the total respondents who affirmed each of the child food security items is shown in Table 19.

Table 19: Food Security Items

<i>Item</i>	<i>Item Affirmed (n=1000)¹</i>		
	<i>Frequency</i>	<i>Percent²</i>	<i>95% CI³</i>
Relied on only a few kinds of low-cost food to feed child	156	15.6%	13.4, 17.8
Couldn’t feed child a balanced meal	68	6.8%	5.2, 8.4
Child was not eating enough	31	3.1%	2.0, 4.2
Cut the size of child’s meals	15	1.5%	0.7, 2.3
Child skipped meals in the past year	6	0.6%	--
Child skipped meals 3 or more months	<5	--	--
Child hungry but couldn’t afford more food	5	0.5%	--
Child did not eat for a whole day	<5	--	--

¹ Percent of items affirmed are calculated for the total number of households with children, without regard to any “don’t know” or “refused” responses for any particular item.

² Percents based on cells with frequencies of <5 are suppressed.

³ CI’s based on percents <1 are suppressed.

Table 19 shows that 15.6% of all respondents reported relying on low-cost food to feed their child(ren), and 6.8% could not afford to feed their child(ren) a balanced

meal. In addition, 3.1% of sampled parents reported that their child had not eaten enough within the past year.

The food security scale allows calculation of food security scores with each item on the scale being scored as “affirmed” or “not affirmed.” With a value of 1 assigned to each affirmed item, food security scores can range from 0 to 8. The threshold for identifying children’s hunger in the home is set at a raw score of 5 items affirmed. Food security scores are shown in Table 20.*

Table 20: Food Security Scores

<i>Score (n=973)¹</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI²</i>
0 items affirmed (no child hunger)	811	83.4%	81.0, 85.7
1 item affirmed	106	10.9%	8.9, 12.9
2 items affirmed	33	3.4%	2.3, 4.5
3 items affirmed	9	0.9%	--
4 items affirmed	9	0.9%	--
5-8 items affirmed (child hunger identified)	5	0.5%	--

¹ A total of 27 respondents did not provide responses to one or more Food Security items.

² CI's based on percents <1 are suppressed.

Using the criterion of 5 items affirmed, child hunger was not identified for 99.5% of surveyed families. However, a total of 16.1% of parents did provide responses to affirm 1 to 4 of the food security items. Of those who affirmed 1 to 4 items, 67.5% affirmed one item, 21.0% affirmed two items, 5.7% affirmed three items, and 5.7% affirmed four items.

* Food Security scores were calculated only for parents who provided responses that could be coded according to the scoring procedure for each of the relevant items on the scale. A total of 27 parents did not provide a response to one or more items on this scale. For this analysis, total n = 973.

5.9. Parental Depression

5.9.1. Depression Scale

Children's development is influenced by their parents' mental health status in various ways. For example, maternal depression can increase children's vulnerability to anxiety and behavioural disorders (18). The impact of parental depression on children's development is related to factors such as the nature and severity of the illness, and the presence of other caregiver(s) in the home who buffer the effects of the illness (19). Analysis of Cycle 1 (1994/95) data from the NLSCY revealed that parental depression was associated with one or more problem outcomes for children aged 2-3, 4-8 and 9-11 (18). Using NLSCY data from Cycle 1 (1994/95) and adjusting for all family background variables, children of depressed mothers were about 1.5 times as likely to be vulnerable as those of mothers who were not depressed, providing strong evidence that maternal depression has an effect on children's early cognitive development that is independent of socioeconomic status. Controlling for family background factors, children of depressed mothers were more than twice as likely to exhibit behaviour problems as perceived by the mother (20).

Twelve items on the Toronto Perinatal and Child Health Survey were included to assess the extent of parental depression (see Appendix B – questions 56 to 67). These 12 items form the abbreviated version of the Centre for Epidemiological Studies-Depression Scale (CES-D Scale) (21). For each item, parents indicated how often they experienced the specified depressive tendencies (or non-depressive tendencies in the case of reverse-coded items) within the past week. Responses were coded from 0 to 3, resulting in a minimum possible total score of 0 and a maximum possible total score of 36. Lower scores indicate fewer depressive tendencies, whereas higher scores indicate more extensive depressive tendencies, with scores of 13 or more indicating moderate to severe depression (22). It should be noted that Depression Scale scores were calculated only for parents who provided responses that could be coded according to the scoring procedure for each of the relevant items on the scale. A total of 119 parents did not provide a response to one or more items on this scale. For this analysis, total n = 881, which represents 88.1% of the total sample.*

The frequency distribution of depression scores is shown in Figure 9.

* When a comparison was made between those who completed each item for this scale (n = 881) and those who did not (n = 119), non-responders appeared to be more likely to have lower income and lower education, to live in an apartment, and to be a recent immigrant (in Canada 10 years or less) as compared to those who did respond to every item on the scale. Non-responders were also slightly more likely to be male. Given the relatively large non-response rate for this scale and the possible differences between responders and non-responders, analysis involving this scale should be interpreted with caution.

Figure 9: Parental Depression Scores

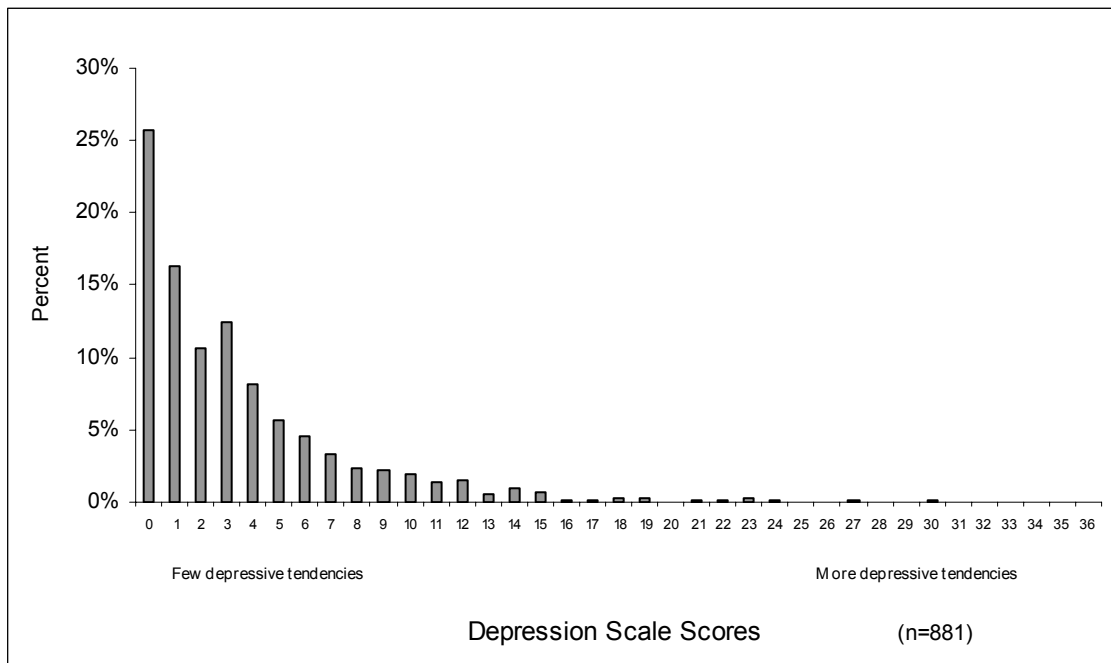
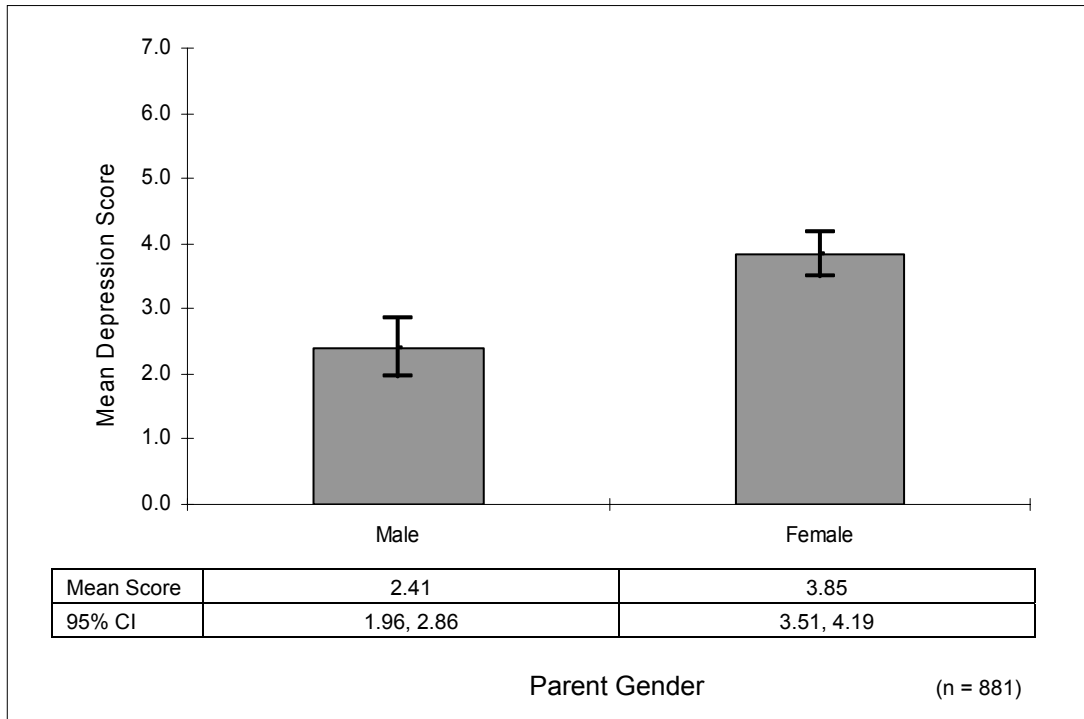


Figure 9 shows that depression scores ranged from 0 to 30. The predominant leftward bias of the distribution strongly indicates that the majority of children were living with parents with few depressive tendencies. The most common score was 0 (25.7%, n = 226), which indicates very few or no depressive tendencies during the past week. Scores for over three-quarters of all respondents ranged between 0 and 5. The mean depression score was 3.49 (SD = 4.27). A total of 3.9% of respondents (n = 36) had depression scores of 13 or more.

Depression scores also were examined across several variables and significant effects were found for parent gender, family status, and household annual income.* Mean scores for gender with 95% CI's are shown in Figure 10.

* Depression scores also were analyzed by the variable of immigrant status which included “recent immigrants,” defined as those respondents who were not born in Canada and have lived in Canada for 10 years or less, and “not recent immigrants,” defined as those respondents who were born in Canada or who were not born in Canada but have lived in Canada for 11 years or more. Depression scores were not found to vary significantly by immigrant status, $t_{(873)} = 0.92$, $p = .358$.

Figure 10: Mean Depression Scores by Parent Gender

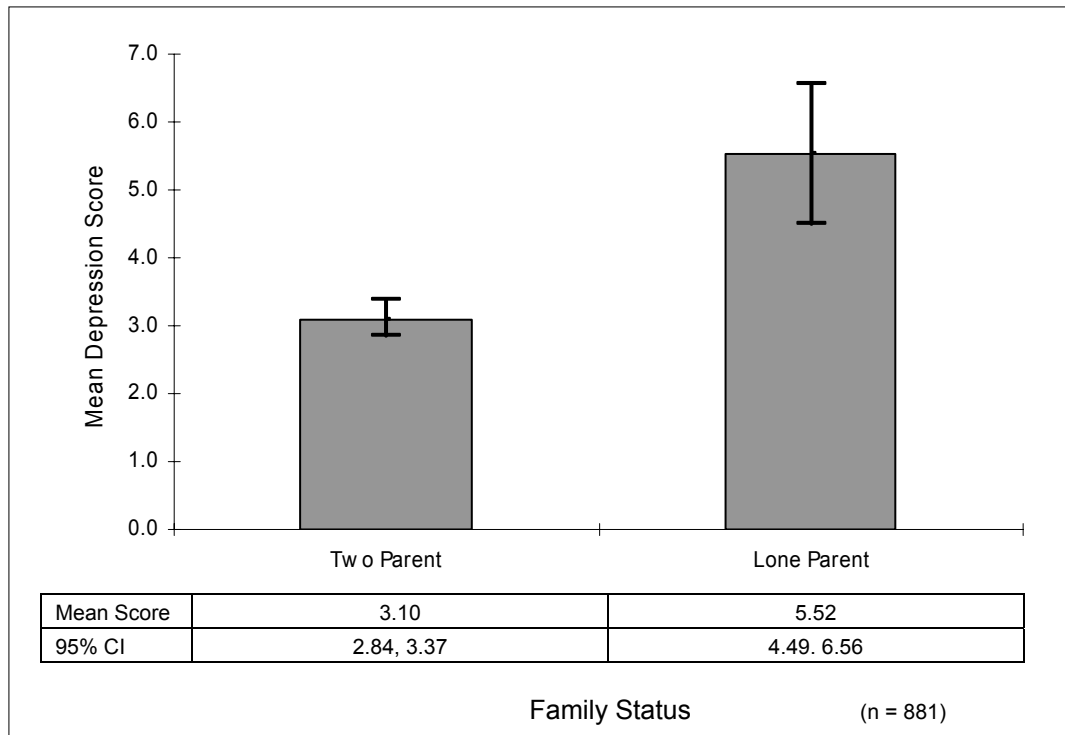


Male and female survey respondents differed significantly in their depression scores ($t_{(879)} = 4.40, p < .001$), with males reporting fewer depressive tendencies than females. However, the average depression score for both males and females was less than 4 on a scale that can range between 0 and 36.

The descriptive statistics for depression scores by family status are shown in Figure 11.*

* Note that, despite the significant effect for parent gender, the additional analyses for depression scores are presented with data from males and females combined. Analyses that were conducted separately by parent gender revealed a similar pattern of findings for males and females.

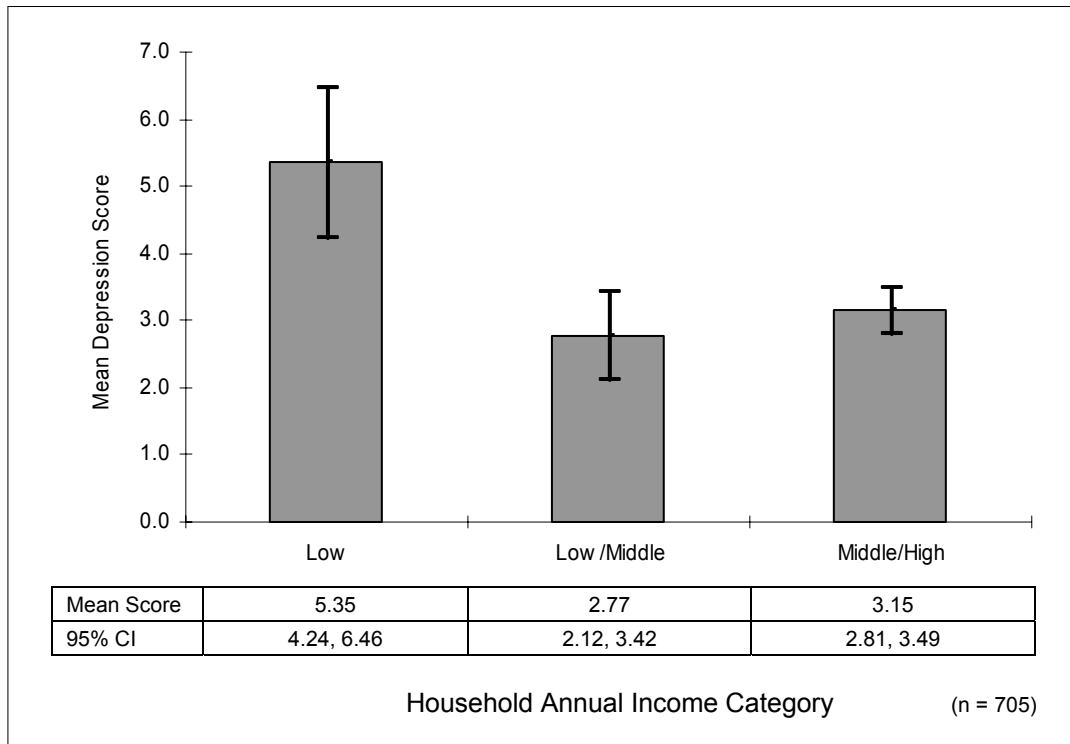
Figure 11: Mean Depression Scores by Family Status



A significant effect for family status was found ($t_{(879)} = 6.29, p < .001$), such that parents who did not have another parenting partner living in the home with them reported more depressive tendencies than those who did have another parenting partner living with them. Recall, however, that the overwhelming majority of lone-parent families were female-led lone-parent families (89.9%), and females already have been shown to have higher depression scores than males. Thus, further analyses that control for gender of respondents may be required to assess the extent to which the greater depressive tendencies of lone parents are associated with lone parenting, independent of gender.

The descriptive statistics for depression scores by household annual income are shown in Figure 12.

Figure 12: Mean Depression Scores by Household Annual Income



A significant effect for income categories was found ($F_{(2, 702)} = 14.33, p < .001$), indicating that depression scores differed among the three income levels. Follow-up pairwise comparisons revealed that respondents in the low income group had higher depression scores as compared to both those in the low/middle income group and the middle/high income group ($p < .01$ in each case). It is of note that 40.2% of all lone-parent families, who are mostly females, are in the low income group, as compared to only 14.3% of two-parent families. Further analyses are required to assess the interaction of family structure and income with depressive tendencies.

5.9.2. Depression and Parenting Practices

The relationship between depression scores and parenting practices for the current sample also was assessed.

For parents of children aged 0-23 months, the correlation between Depression scores and Ineffective Parenting scores was not significant ($r = .08, p = .223$). However, for parents of children aged 2-6 years, there was a significant correlation between Depression scores and Ineffective Parenting scores ($r = .22, p < .001$). Depression scores were also related to Rational Parenting scores to a lesser but still significant degree ($r = .134, p < .001$). Thus, parents of 2-6 year old children who reported more depressive tendencies also tended to have more ineffective

interactions with their children as well as somewhat more aversive or punitive parenting practices.

5.10. Dental Health

5.10.1. Early Childhood Tooth Decay

Early childhood tooth decay (ECTD), which is a preventable form of tooth decay among young children, is responsible for significant pain and suffering among children as well as the need for hospitalization and highly-specialized care (23). Poor oral health also affects socialization and the capacity to eat healthy foods. Given the importance of oral health to the overall health of young children and the lack of representative local data on this topic, several questions on the Toronto Perinatal and Child Health Survey were designed to address the issue of child dental health.

Parents were asked if they have ever been told by a physician or dentist that their child has the condition known as early childhood tooth decay (ECTD), and 5.6% (CI = 4.1, 7.0) of respondents said that this was the case. Frequency of ECTD diagnosis was found to vary significantly by child's age and country of birth, as shown in Table 21.

Table 21: ECTD Diagnosis by Age and Country of Birth

Variable	Received Diagnosis of ECTD	Row Count	χ^2	p-value
<i>Child's age¹</i>				
0-2	1.3%	372	$\chi^2_{(2, 954)} = 23.20$	p < .001
3-4	6.6%	272		
5-6	9.7%	310		
<i>Child Born in Canada</i>				
Yes	4.6%	857	$\chi^2_{(1, 954)} = 16.22$	p < .001
No	14.4%	97		
<i>Overall²</i>	5.6%			

¹ For this and all dental health analyses, the age category of "0-2" includes all children aged 0 to <3 years, the age category of "3-4" includes all children aged 3 to <5 years, and the age category "5-6" includes all children aged 5 to <7 years.

² Overall percentages for all children do not necessarily correspond exactly to marginal totals for tests of significance due to differences in the number of valid responses.

Parents of older children were more likely to report a diagnosis of ECTD than parents of younger children. The odd's ratio (OR) = 5.20 (95% CI = 1.91, 14.19) for the 3-4 year old age group using the youngest group as a reference, and the OR = 7.86 (95% CI = 3.01, 20.53) for the 5-6 year old age group using the youngest group as a reference. Thus, the odds of being diagnosed with ECTD

were 5.20 times higher for 3-4 year olds than for 0-2 year olds, and the odds for 5-6 year olds were 7.86 times higher than those for 0-2 year olds.

In addition, parents of children who were not born in Canada were more likely to report a diagnosis of ECTD than parents of children who were born in Canada. The OR = 3.54 (95% CI = 1.85, 6.78) using born in Canada as a reference, which indicates that the odds of being diagnosed with ECTD were 3.54 times higher for children born outside of Canada than for children born in Canada. No significant effects were found for family status, household annual income category, or parent's education.*

5.10.2. Most Recent Dental Visit

Parents of children older than 9 months of age also were asked about when the child last saw a dentist or dental hygienist (not including visits at school). These responses are shown in Table 22.

Table 22: Most Recent Dental Visit

<i>Most Recent Visit (n=872)</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
Within the last year	464	53.2%	49.9, 56.5
Between 1 to 2 years ago	31	3.6%	2.3, 4.8
More than 2 years ago	10	1.1%	0.4, 1.9
Never	367	42.1%	38.8, 45.4

Over half of the children (53.2%) were reported to have seen a dentist or dental hygienist within the last year, while 42.1% have never had a dental visit.

Dental visits were also examined according to several demographic variables, and significant effects were found for child's age, household annual income, and family status.† In addition, a marginally significant effect was found for child's country of birth (Canada or other). Category percentages for each of these variables are shown in Table 23.

* For family status, $\chi^2_{(1, 954)} = 0.33$, $p = .563$; for household annual income category, $\chi^2_{(2, 741)} = 4.36$, $p = .113$, and for parent's education, $\chi^2_{(3, 938)} = 2.05$, $p = .562$.

† No significant effect was found for parent's education $\chi^2_{(6, 857)} = 6.81$, $p = .339$.

Table 23: Dental Visits by Age, Income, and Family Status

Variable	When child last saw dentist.			Row Count	χ^2	p-value
	Within the last year	More than 1 year ago ¹	Never			
Child's age						
0-2	16.1%	0.7%	83.2%	286	$\chi^2_{(4, 872)} = 310.58$	p < .001
3-4	64.2%	5.5%	30.3%	274		
5-6	77.6%	7.7%	14.7%	312		
Income						
Low	47.2%	7.2%	45.6%	125	$\chi^2_{(4, 665)} = 17.49$	p < .002
Low/Middle	42.1%	6.6%	51.3%	76		
Middle/High	59.3%	2.2%	38.6%	464		
Family Status						
Two Parent	52.0%	4.1%	43.9%	731	$\chi^2_{(2, 872)} = 8.30$	p < .017
Lone Parent	59.6%	7.8%	32.6%	141		
Child Born in Canada						
Yes	53.0%	4.1%	42.9%	774	$\chi^2_{(2, 872)} = 5.86$	p = .053
No	55.1%	9.2%	35.7%	98		
Overall²	53.2%	4.7%	42.1%			

¹ This category combines the responses "Between 1 and 2 years ago" and "More than 2 years ago."

² Overall percentages for all children do not necessarily correspond exactly to marginal totals for tests of significance due to differences in the number of valid responses.

Examination of Table 23 reveals that older children, children from the middle/high income category, and children from lone-parent families were more likely to have seen a dentist within the past year. Specifically, over three-quarters of all children aged 5-6 years were reported to have had a dental visit within the past year, whereas just under two-thirds of 3-4 year olds and 16.1% of those under the age of 3 have had a recent dental visit.

Children from the middle/high income category were more likely to have seen a dentist within the past year as compared to children in the lower income categories. Children from the low/middle income category were least likely to have seen a dentist in the past year and most likely to have never seen a dentist, as compared to the other income categories. In addition, children from lone-parent families were more likely to have seen a dentist recently as compared to children from two-parent families, and children who were born in Canada were somewhat

more likely to have never seen a dentist as compared to those who were not born in Canada.

For cases in which the child had not seen a dentist within the last year, parents were asked to indicate all reasons why the child did not go more recently. These results are shown in Table 24.

Table 24: Reasons for Not Seeing a Dentist More Recently

<i>Reason (n=408)</i>	<i>Frequency</i>	<i>Percent of Total Responses (n=445)¹</i>	<i>95% CI</i>
He/she is too young to go	192	43.1%	38.5, 47.7
No need to go, he/she has no problems	145	32.6%	28.2, 36.9
Other	36	8.1%	5.6, 10.6
Our family dentist won't see children that young	15	3.4%	1.7, 5.0
We don't have dental insurance	15	3.4%	1.7, 5.0
We can't afford to take him/her	11	2.5%	1.0, 3.9
Don't know	11	2.5%	1.0, 3.9
He/she is afraid to go	8	1.8%	0.6, 3.0
We don't have or don't know a dentist	8	1.8%	0.6, 3.0
We would have to lose too much time from work	<5	--	--
Our dentist is too busy – booked way ahead	<5	--	--

¹ More than one response allowed. Percents based on cells with frequencies of <5 are suppressed.

Of all the reasons that were given for why children did not see a dentist more recently, the majority fell into the categories of “he/she is too young to go” and “no need to go, he/she has no problems.”

5.10.3. Frequency of Teeth Cleaning

Parents also were asked questions about how often their child's teeth or gums are cleaned and how they are cleaned. These responses are shown in Table 25.

Table 25: Teeth Cleaning

<i>Teeth Cleaning Variable</i>	<i>Frequency</i>	<i>Percent</i>	<i>95% CI</i>
<i>How often are teeth/gums cleaned (n=989)</i>			
1 or more times per day	827	83.6%	81.3, 85.9
2-6 times per week	59	6.0%	4.5, 7.4
Once or less per week	12	1.2%	0.5, 1.9
Never	91	9.2%	7.4, 11.0
<i>Is toothpaste with fluoride used (n=909)¹</i>			
Yes	536	59.0%	55.8, 62.2
No	246	27.1%	24.2, 30.0
Don't know	108	11.9%	9.8, 14.0
Not Applicable (no teeth yet)	19	2.1%	1.2, 3.0
<i>How much toothpaste put on brush (n=528)²</i>			
A light smear	156	29.5%	25.7, 33.4
The size of 1 small pea	272	51.5%	47.3, 55.8
The size of 2 small peas	69	13.1%	10.2, 15.9
The size of 3 or more small peas	31	5.9%	3.9, 7.9

¹ Item applied to all respondents except those who said child's teeth were "never" cleaned.

² Item applied only to those who said that toothpaste with fluoride is used, and excludes those who said they don't know how much toothpaste is used.

The majority of parents reported that their child's teeth or gums are cleaned one or more times per day (83.6%). Of the children whose teeth are cleaned, over half use toothpaste with fluoride (59.0%). Furthermore, of those who use toothpaste with fluoride, about half use the amount of toothpaste equal to the size of one small pea (51.5%).

Frequency of teeth cleaning was examined according to child's age, family status, household annual income, parent's education, and child's country of birth. Of these, significant effects occurred only for child's age and family status.* The relevant frequencies are shown in Table 26.

* For household annual income category, $\chi^2_{(4, 762)} = 1.65$, $p = .799$; for parent's education, $\chi^2_{(6, 974)} = 2.60$, $p = .857$; and for child's country of birth, $\chi^2_{(2, 989)} = 3.41$, $p = .182$.

Table 26: Frequency of Teeth Cleaning by Age and Family Status

Variable	How often child's teeth/gums are cleaned.			Row Count	χ^2	p-value
	1 or more times per day	2-6 times per week	Once or less per week or never ¹			
<i>Child's age</i>						
0-2	64.8%	9.9%	25.3%	395	$\chi^2_{(4, 989)} = 186.56$	p < .001
3-4	94.6%	4.7%	0.7%	278		
5-6	97.5%	2.2%	0.3%	316		
<i>Family Status</i>						
Two-parent	82.2%	6.4%	11.4%	831	$\chi^2_{(2, 989)} = 7.92$	p < .02
Lone-parent	91.1%	3.8%	5.1%	158		
<i>Overall²</i>	83.6	6.0	10.4			

¹ This category combines the responses "Once or less per week" and "Never."

² Overall percentages for all children do not necessarily correspond exactly to marginal totals for tests of significance due to differences in the number of valid responses.

Parents of younger children reported less frequent teeth/gum cleaning than parents of older children. Just under two-thirds of children aged 0-2 years have their teeth or gums cleaned one or more times per day, and one-quarter have their teeth or gums cleaned once per week or less or never. In contrast, approximately 95% or more of children aged 3 and older have their teeth cleaned one or more times per day. In addition, children in lone-parent families are reported to have their teeth cleaned more often than children in two-parent families.

Toothpaste use was also examined according to child's age category, and a significant effect was found. The relevant frequencies are shown in Table 27.

Table 27: Toothpaste use by Child's Age

Age Category	Is toothpaste with fluoride used ¹ (n=909)				Row Count	χ^2	p-value
	Yes	No	Don't Know	Not Applicable			
<i>Child's age</i>							
0-2 years	28.3%	54.9%	10.8%	6.0%	315	$\chi^2_{(3, 909)} = 251.65$	p < .001
3 years and older	75.3%	12.3%	12.5%	0%	594		
<i>Total</i>	59.0%	27.1%	11.9%	2.1%	909		

¹ Item applied to all respondents except those who said child's teeth were "never" cleaned.

This analysis reveals that a greater proportion of children in the older age category were reported to be using toothpaste with fluoride than those in the younger age category. Nevertheless, over one-quarter of parents with children under the age of three years reported the use of toothpaste with fluoride for their children’s teeth. In addition, over 1 in 10 parents reported that they did not know what kind of toothpaste is used to clean their child’s teeth.

The amount of toothpaste with fluoride that was used also was examined by child’s age category and again a significant effect was found. The relevant frequencies are shown in Table 28.

Table 28: Amount of Toothpaste by Child’s Age

Age Category	How much toothpaste is put on brush ¹ (n=528)			Row Count	χ^2	p-value
	A light smear	The size of 1 small pea	The size of 2 or more small peas ²			
<i>Child’s age</i>						
0-2	41.7%	51.2%	7.1%	84	$\chi^2_{(4, 528)} = 27.28$	p < .001
3-4	36.1%	48.2%	15.7%	191		
5-6	20.6%	54.2%	25.3%	253		
<i>Total</i>	<i>29.5%</i>	<i>51.5%</i>	<i>18.9%</i>	<i>528</i>		

¹ Item applied only to those who said that toothpaste with fluoride is used.

² This category combines the responses “The size of 2 small peas” and “The size of 3 or more small peas.”

Overall, parents with younger children reported using the smallest amount of toothpaste, while parents with older children reported using larger amounts of toothpaste. However, of all children who use toothpaste with fluoride, 28.3% are under the age of 3 years (see Table 27), and a total of 18.9% of children are using toothpaste more than the size of one small pea (see Table 28).

6. Summary of Findings

In this section of the report, results from the survey are briefly summarized and implications for relevant TPH programs are discussed. Note that the analyses presented in this report did not use multi-variable methods, so the independent effects of age, education, income, and other variables may be overstated.

6.1. Childhood Injuries Due to Falls

Information regarding childhood injuries due to falls obtained through the Toronto Perinatal and Child Health Survey may be used to inform the Early Child Development Injury Prevention Project, as well as the Injury Prevention/Substance Abuse Prevention programs. Long- and short-term objectives concerning injury prevention include decreasing the rates of unintentional child and youth injuries and injury fatalities, increasing the safety of children's external environments, and increasing the proportion of children and their caregivers who practice injury prevention and risk management. Based on hospitalization data, between 1998-2000, total hospitalizations for childhood falls (ICD9 E880-888) in Toronto were as follows: for children under 1 year, rate = 159.3/100,000; for children 1 to 4 years of age, rate = 140.0/100,000; and for children 5 to 6 years of age, rate = 169.5/100,000 (24). Rates for falls-related hospitalizations in Toronto were significantly less than the rates for the rest of Ontario (24).

The rate of injuries due to falls that was identified in the Toronto Perinatal and Child Health Survey was higher than the hospitalization rates most likely because the survey specifically asked about all falls that required any kind of medical attention, not just hospitalizations. For the current survey, 6.1% of all parents reported that their child required medical attention due to injuries from a fall. Of those who indicated that their child did sustain injuries due to a fall, the vast majority reported that this happened only once. Fall occurrences did not appear to vary among children of different ages or families at different levels of income. The two most frequent types of falls were falls from tripping, slipping or stumbling on the same level, and falls involving a bed, chair, or other furniture. Falls involving playground equipment, stairs or steps, and other types of falls were reported to a lesser extent. Overall, the current results suggest that many more children seek medical treatment as a result of falls than are actually hospitalized for these kinds of injuries. Hospitalization rate was not assessed in the current survey, however, so there is a limitation on the kinds of direct comparisons that can be made.

6.2. Breastfeeding

The MHPSG 2001 (Draft) Child & Youth Health Program Long Term Objectives (by 2015) include the following: (i) to increase the breastfeeding initiation rate to 92%, (ii) to increase the rate of exclusive breastfeeding until 6 months in healthy term infants, and (iii) to increase the rate of breastfeeding until 12 months. According to the 1996/97 Ontario Health Survey, 86% of mothers breastfed their

children or tried to breastfeed their children (8). This figure is below the 2015 provincial target of 92%. However, the breastfeeding initiation rate of 94.3% (CI = 92.8, 95.8) found in the current survey seems to indicate that the provincial 2015 target is now being met in the City of Toronto. Thus, according to parental reports, the overwhelming majority of mothers are initiating breastfeeding. However, mothers who were younger at the time of their child's birth, mother's with lower levels of education, and immigrants who have been in Canada for 11 years or more were less likely to initiate breastfeeding than older mothers, mothers with higher levels of education, and immigrants who have lived in Canada for 10 years or less, respectively. Specifically, women less than 25 years of age, those with less than high school education or high school completion only, and immigrants who have lived in Canada for 11 years or more had rates of less than 92% (88.3%, 83.7%, 89.3%, and 91.7%, respectively). Also, children in two parent families were more likely to be breastfed than children in lone parent families. Thus, these factors must be taken into consideration when planning programming for breastfeeding initiation.

Almost three-quarters of parents surveyed for the Toronto Perinatal and Child Health Survey indicated that they made a decision about breastfeeding before pregnancy. Nevertheless, over one-quarter of parents indicated that they made this decision at some point during pregnancy or after their baby was born, so these time periods are critically important in the decision-making process for some parents.

Mothers who were older at the time of their child's birth, parents who were born in Canada, parents with higher levels of education, and parents with higher income were more likely to report making a decision about breastfeeding before pregnancy and less likely to report making a decision about breastfeeding after their baby's birth as compared to younger mothers, parents who were not born in Canada, parents with lower levels of education, and parents in the lower income categories, respectively. Younger mothers, parents who were not born in Canada, parents with lower levels of education, and parents in the lower income categories may have more of a tendency to delay their decision to breastfeed. Thus strategies to promote earlier decision-making among these mothers are warranted.

Despite the high rate of breastfeeding initiation (94.3%), only 58.3% of parents reported breastfeeding for 6 months or more and one-quarter (25.6%) reported breastfeeding for 12 months or more. This is of concern in light of the objectives set in the draft 2001 Mandatory Health Programs and Services Guidelines.

Rates of exclusive breastfeeding for healthy term babies were even lower. Over three-quarters (78.6%) of healthy term babies were exclusively breastfed for 1 month or more, less than half (48.8%) were exclusively breastfed for 4 months or more, about one-quarter (26.1%) were exclusively breastfed for 5 months or more, and less than 20% were exclusively breastfed until 6 months.

Further exploration of factors associated with premature cessation of breastfeeding and early introduction of other liquids and solids is warranted.

6.3. Physical Activity

One of the goals of the 1997 MHPSPG Chronic Disease Prevention is to increase the proportion of children who are physically active. TPH program planners can utilize data from the Toronto Perinatal and Child Health Survey to target programs that influence parents and children to become active together for at least 2-3 times per week. Other research has indicated that 43% of parents report playing active games or sports either often or very often with their 1-4 year old children (25), and that two-thirds of families are not active enough to benefit their health (26).

Over 85% of parents surveyed for the Toronto Perinatal and Child Health Survey reported that at least one parent and child participate together in some form of physical activity 2 times per week or more. Moreover, over half of all parents reported participating 4 or more times per week. Thus, the vast majority of parents reported that their children's physical activity participation meets or exceeds the goal of 2-3 times per week. Nevertheless, some parents and children are getting less than the target amount of physical activity. Also, the nature of the physical activity participation (either its duration or intensity) was not assessed, and, therefore, it is difficult to comment on the quality of the physical activity that was reported.

Physical activity participation varied by age, with parents of children aged 5-6 years being less likely than parents of younger children to report participating in physical activity 4 or more times per week. It appears, then, that this is an age at which physical activity participation involving both parent and child begins to drop off, perhaps because children in this age group have the independence to be physically active on their own or because they actually are less physically active at this age. Parents of this age group were, however, more likely to report participating 2-3 times per week as compared to parents of the younger and older age groups.

Although the majority of parents with children aged less than one year reported physical activity participation of 4 or more times per week, parents in this group were slightly more likely than those with older children to report participation of once per week or none at all. Thus, this may be a group to target with a goal of starting positive parent-child physical activity practices at a young age.

With regard to sedentary activity, which may interfere with participation in physical activity, over three-quarters of all parents reported that their children engage in sedentary activity such as watching TV or playing video games for an average of 0 to 2 hours per day. Only 4% of parents reported that their children spend 4 hours per day or more on these kinds of activities.

6.4. Smoking Restrictions in the Home

According to the Canadian Tobacco Use Monitoring Survey, in 2001, 20% of Ontario households had family members or regular visitors who smoked in the home every day or almost every day (27). Information from the Toronto Perinatal and Child Health Survey can be used for monitoring and tracking progress toward TPH's Comprehensive Tobacco Control Program, one objective of which is to increase the percentage of households that are 100% smoke-free.

Over 90% of parents surveyed for the Toronto Perinatal and Child Health Survey reported that they do not allow smoking inside the home at any time. About 6% allow smoking at some times in some places, and 1% allow smoking anywhere in the home. These results were independent of child's age, household annual income, and dwelling type. There was a marginally significant effect for parent's age, however, with parents in the youngest age category (less than 25 years old) being the least likely to favour rules that prohibit smoking in the home. Although this result must be interpreted with caution, it points to an area in need of further investigation. If younger parents are, in fact, less stringent in terms of smoking rules for the home, they may be identified as a target group for provision of information on the risks of second-hand smoke and strategies for attaining smoke-free homes.

6.5. Parenting Practices

The majority of parents with children aged 0-23 months reported engaging in relatively few ineffective interactions with their children. Scores did not vary significantly across family status, household annual income category, dwelling (rent vs. own), parent's education, or parent gender.

Parents of children aged 2-6 years indicated a low to moderate level of ineffective interactions between parent and child. However, a small proportion of parents engaged in more ineffective interactions. Mothers reported significantly more ineffective interactions than fathers, although both mothers' and fathers' mean scores were relatively low. However, it must be noted that scores could not be calculated for over 12% of respondents with children aged 2-6 years due to non-responses to one or more items on the Ineffective Parenting scale. Given this relatively high rate of non-response and the possible differences between those who responded to each item on the scale and those who did not, conclusions regarding the level of ineffective interactions for parents of children aged 2-6 years must be interpreted with caution.

Rational Parenting Scale scores indicated that the majority of parents engaged in few aversive parenting practices. However, a small proportion of parents did engage in more aversive interactions. Rational Parenting Scale scores did not vary by any demographic variables under consideration. For parents of children aged 2-6, Ineffective Parenting Scale scores were positively associated with Rational

Parenting Scale scores to a moderate degree, suggesting that parents who interact ineffectively with their children also tend to have a more punitive parenting practices.

6.6. Food Security

One of the requirements of the 1997 MHPSPG Chronic Disease Prevention is to promote access to sufficient, safe, nutritious and personally acceptable food for people of all ages. Thus, information about child hunger can be used to inform efforts to ensure that families have adequate access to appropriate sources of food. The Toronto Perinatal and Child Health Survey identified a low incidence of child hunger as defined by a criterion of 5 items affirmed on the USDA Food Security Module's 8-item scale. The vast majority of parents reported no child hunger at all, and of those who affirmed less than the critical number of child hunger indicators, most affirmed only the least severe items. In 1994, the NLSCY found that 1.2% of the 13,000 randomly selected Canadian families with children 11 years old or less experienced hunger (28). Rate of child hunger identified in the current survey (0.5%) was less than half the national rate. Recall, however, that when compared to the 2001 census data, the current sample was found to have slightly under-sampled households with low income, which would have important implications for assessment of food security. This under-sampling of households with low income might account for the lower rate of hunger identified in the Toronto Perinatal and Child Health Survey, although income is not known for a substantial proportion of respondents (23%) who did not report this information. Further research is necessary in the continuing efforts to identify, describe, and assist those families in which child hunger exists.

6.7. Parental Depression

Parents who responded to the Toronto Perinatal and Child Health Survey reported few depressive tendencies, with scores for over three-quarters of all respondents ranging between 0 and 5 on a scale that has a maximum value of 36. Mothers had significantly higher depression scores than fathers, lone-parents had higher depression scores than those in two-parent families, and parents with low household annual incomes had higher depression scores than parents with higher incomes. Analysis of NLSCY data (Cycle 1, 1994/95) reveal that income, mother's education, and father's occupation were the most important predictors of maternal depression (16). The likelihood of being depressed was reduced by an average of 9% per \$10,000 increase in family income. This decrease was comparable to that associated with each additional year of the mother's education, and with an increase of one standard deviation in the father's occupation. Single mothers were twice as likely to be depressed as mothers in married relationships.

However, given that the overwhelming majority of lone parents in this survey were female and a greater proportion of lone parents were in the low income category,

further analysis is required to disentangle the effects of gender, family status, and income on depressive tendencies.

Also of importance is the finding that depression scores were significantly related to both Ineffective Parenting Scale scores and Rational Parenting Scale scores for parents with children aged 2-6 years. Thus, parents who reported more depressive tendencies also tended to have a more ineffective and aversive parenting practices.

A total of 3.9% of respondents had depression scores of 13 or more, indicating moderate to severe depression. Previous analysis of NLSCY data (Cycle 1, 1994/95) has suggested that children were about twice as likely to display behavioural problems if their mothers were depressed. Over half of this effect could be accounted for by measures of family functioning and parenting style (20).

Scores were not calculated for almost 12% of respondents due to non-responses to one or more items on the depression scale. Given this relatively high rate of non-response and the possible differences between those who responded to each item on the scale and those who did not, conclusions regarding depression must be interpreted with caution.

6.8. Dental Health

The Consolidated Mandatory Health Programs and Service Guidelines (MHPSG) Objectives for Child Health include estimating the prevalence city-wide of early childhood tooth decay (ECTD), as well as identifying young children's sources of care and reasons for not obtaining care (31). Prevalence of ECTD, frequency of dental visits, and reasons for not obtaining care were assessed as part of the Toronto Perinatal and Child Health Survey. Information about extent of teeth/gum cleaning and use of toothpaste with fluoride was also collected. This information can be used by Dental and Oral Health Services programs to guide information provided to the public and guide advocacy programs on behalf of young children's oral component of health, as well as to provide public information on the proper use of fluoride dentifrice and other topical fluoride sources.

Just over 5% of parents who responded to the Toronto Perinatal and Child Health Survey indicated that they have been told by a dentist or physician that their child has ECTD. Older children and children who were not born in Canada were more likely to be diagnosed with ECTD than younger children and children who were born in Canada. The odds of being diagnosed with ECTD were 5.20 times higher for 3-4 year olds than for 0-2 year olds, and the odds for 5-6 year olds were 7.86 times higher than those for 0-2 year olds. The odds of being diagnosed with ECTD were 3.54 times higher for children born outside of Canada than for children born in Canada.

Over half of all children older than 9 months were reported to have seen a dentist or dental hygienist within the past year, while 42% never had a dental visit at all. Further analysis revealed that older children, children from the middle/high income category, and children from lone-parent families were more likely to have seen a dentist within the past year. For cases in which the child did not have a dental visit within the past year, parents most often indicated that it was because “he/she is too young to go” or “no need to go, he/she has no problems,” rather than citing time, economical, or other scheduling constraints. It may be necessary to increase public information about when it is necessary for young children to begin having dental visits and the recommended frequency of those visits.

The vast majority children have their teeth or gums cleaned once per day or more. Older children and children in lone-parent families were reported to have their teeth cleaned more often than younger children and children in two-parent families.

Of the children who clean their teeth, over half use toothpaste with fluoride, and, of those who use toothpaste with fluoride, about half use the amount of toothpaste equal to the size of one small pea. Older children use toothpaste with fluoride more often than younger children, although over one-quarter of children less than 3 years of age were reported to use toothpaste with fluoride. This is contrary to the Ministry of Health and Long-Term Care guidelines which recommend that toothpaste with fluoride not be used for children under the age of 3 years. In addition, about 1 in 10 parents did not know what kind of toothpaste their child uses.

Almost 1 in 5 children use the amount of toothpaste equal to the size of two small peas or more, which is more than the appropriate amount of one small pea that is recommended by the Ministry of Health and Long-term Care. Thus, although rate of teeth and gum cleaning was reported to be quite high, many children are not having their teeth cleaned appropriately. In view of these findings, one of the most important areas for dental health education appears to be in the area of proper use of dental care products.

7. References

- (1) Day, N, Fleischer, P, Basrur, S. Toronto's Health Status: A Profile of Public Health in 2001. Toronto Public Health. May 2001.
- (2) Statistics Canada (1997) Household Facilities and Equipment Survey.
- (3) Hospital Inpatient Data 1998-2000, Provincial Health Planning Database (PHPDB) V13.10, Health Planning Branch, Ontario MOHLTC.
- (4) Health Canada, (1999). Canadian Injury Data: Mortality - 1997 and Hospitalizations - 1996-97. Child Injury Division, Bureau of Reproductive and Child Health, Laboratory Centre for Disease Control, Health Protection Branch, Health Canada. <http://www.hc-sc.gc.ca>.
- (5) SmartRisk, (1999). The Economic Burden of Unintentional Injury in Ontario. Hygeia Group. http://www.smartrisk.ca/burden_ont.html.
- (6) Canadian Hospitals Injury Reporting and Prevention System. For the Safety of Canadian Children and Youth, Chapter 7, Falls. Available at URL: <http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/fscopy-psjc/ch7/index.html>.
- (7) Ontario Ministry of Health (2001 draft). Child and Youth Mandatory Program.
- (8) Ontario Health Survey, 1996/1997.
- (9) Williams, AF (1997). Hypoglycemia of the newborn. Review of the literature. Geneva: World Health Organisation.
- (10) World Health Organization. Fifty-fourth world health assembly. April 9, 2001. Provisional agenda item 13.1. Global strategy for infant and young child feeding.
- (11) Kremarik, F. (2000) A family affair: Children's participation in sports. 2000 Canadian Social Trends. Autumn: 20-24. Statistics Canada - Catalogue No. 11-008.
- (12) Deater-Deckard, et al., 1996; Olweus, 1980; Patterson, 1982; Petit & Bates, 1989; Lefkowitz, Eron, Walder, & Huesmann, 1977; West & Farrington, 1973, as cited in Miller, F, Jenkins, J, and Keating, D. (2002) Parenting and children's behaviour problems (pp. 167-181). In Willms, JD (Ed). Vulnerable Children. Findings from the National Longitudinal Survey of Children and Youth. Edmonton, Alta: The University of Alberta Press and Human Resources Development Canada, Applied Research Branch.
- (13) Olweus , 1980; Patterson, 1982 as cited in Miller, F, Jenkins, J, and Keating, D. (2002) Parenting and children's behaviour problems (pp. 167-181). In

Willms, JD (Ed). *Vulnerable Children. Findings from the National Longitudinal Survey of Children and Youth*. Edmonton, Alta: The University of Alberta Press and Human Resources Development Canada, Applied Research Branch.

- (14) Simons, Whitbeck, Conger, & Chyi-in, 1991 as cited in Miller, F, Jenkins, J, and Keating, D. (2002) Parenting and children's behaviour problems (pp. 167-181). In Willms, JD (Ed). *Vulnerable Children. Findings from the National Longitudinal Survey of Children and Youth*. Edmonton, Alta: The University of Alberta Press and Human Resources Development Canada, Applied Research Branch.
- (15) Sternberg et al, 1993 as cited in Miller, F, Jenkins, J, and Keating, D. (2002) Parenting and children's behaviour problems (pp. 167-181). In Willms, JD (Ed). *Vulnerable Children. Findings from the National Longitudinal Survey of Children and Youth*. Edmonton, Alta: The University of Alberta Press and Human Resources Development Canada, Applied Research Branch.
- (16) Landy, S., Tam, K.K. *Understanding the Contribution of Multiple Risk Factors on Child Development at Various Ages*. 1998. W-98-322E. Applied Research Branch, Strategic Policy, Human Resources Development Canada.
- (17) Nord, M. Bickel, G. *Measuring children's food security in U.S. Households, 1995-99*. 2002. *Food Assistance and Nutrition Research Report, Number 25*, USA Department of Agriculture, Economic Research Service.
- (18) Beardslee, Bemporad, Keller, & Klerman, 1993; Carro, Grant, Gotlib, & Compas, 1993; Pape, Byrne, & Ivask, 1996, as cited in Landy, S., Tam, K.K. *Understanding the Contribution of Multiple Risk Factors on Child Development at Various Ages*. 1998. W-98-322E. Applied Research Branch, Strategic Policy, Human Resources Development Canada.
- (19) Anthony, 1982; Bell & Pearl, 1982; Phares & Compas, 1983; Wieder Jasnow, Greenspan, & Strauss, 1983 as cited in Landy, S., Tam, K.K. *Understanding the Contribution of Multiple Risk Factors on Child Development at Various Ages*. 1998. W-98-322E. Applied Research Branch, Strategic Policy, Human Resources Development Canada.
- (20) Somers, MA, & Willms, JD (2002). *Maternal depression and childhood vulnerability*. (pp. 211-228). In Willms, JD (Ed). *Vulnerable Children. Findings from the National Longitudinal Survey of Children and Youth*. Edmonton, Alta: The University of Alberta Press and Human Resources Development Canada, Applied Research Branch.

- (21) Strayhorn, J.M., and Weidman, C.S. (1988). A parent practices scale and its relation to parent and child mental health. *Journal of Academy of Child and Adolescent Psychiatry*, 27: 613-618.
- (22) Landy, S., Tam, K.K. (1996). Yes, Parenting does make a difference to the Development of Children in Canada. *Growing up in Canada. National Longitudinal Survey of Children and Youth. Human Resources Development Canada, Statistics Canada.*
- (23) Mouradian, W.E., Wehr, E., Crall, J.J. Disparities in Children's Oral Health and Access to Dental Care. *Journal of the American Medical Association* 2000; 284 (20): 2625-2631.
- (24) Hospital Inpatient Data 1998-2000, Provincial Health Planning Database (PHPDB) V13.10, Health Planning Branch, Ontario MOHLTC.
- (25) Canadian Fitness and Lifestyle Research Institute. 2000 Physical Activity Monitor. At URL: <http://www.cflri/pa/surveys/2000survey/2000survey.html>.
- (26) Good, Margaret. Active Families. redaysetgo.org. Available at URL: www.readysetgo.org/ophea/RadySetGo/articale.8.cfm.
- (27) Health Canada, 2001. Canadian Tobacco Use Monitoring Survey. Available at URL: <http://www.hc-sc.gc/hecs-sesc/tobacco/research/ctums>.
- (28) Human Resources Development Canada. A Glimpse of Child Hunger in Canada. Available at URL: <http://www.hrdc.gc.ca/sp-ps/arb-dgra/nlscy-elnej/w-98-26es-e.pdf>.
- (29) Consolidated Mandatory Health Programs and Service Guidelines. Issued February 3, 1998 to Chairs of Boards and Medical Officers of Health, page 30.

Appendix A – Representativeness Assessment of the Toronto Perinatal & Child Health Survey, 2003

The Toronto Perinatal & Child Health (PCH) Survey was completed by Compustat Consultants Inc. for Toronto Public Health (TPH) in September 2003. Although respondents were randomly selected, participation in the survey was completely voluntary. This may have introduced selection biases which in turn, may have affected the generalizability of the survey results.

The first issue to consider in order to assess generalizability is the potential bias arising from the level of non-response to the survey.* The PCH Survey achieved a response rate of 67%, suggesting that this potential bias should receive greater scrutiny.† Thus, a representativeness assessment of the survey was completed in March 2004.‡

The assessment compared demographic characteristics of the survey sample (respondents with at least one child from birth to 6 years of age) to 2001 Census data on Toronto households of parents with at least one child in the same age range. The demographic variables that were compared included: parent's age, parent's gender, dwelling type, region of Toronto in which respondents live, family status (lone vs. two parent), parent's education, household income, parent's first language, parent's place of birth, immigrant characteristics, and the child's age. Below is a summary of the results. This summary should be viewed in conjunction with the survey limitations (section 4) as noted in the full PCH Survey results report.

SUMMARY OF REPRESENTATIVENESS ASSESSMENT RESULTS

The assessment showed that the 2003 Toronto PCH Survey sample appears **representative** of the general population of families in Toronto with children from birth to age 6, with respect to:

- the age of parents,
- the age of children,
- the region of Toronto in which the respondents live, and
- the gender distribution of lone-parent families.

The findings suggest that the survey sample is **not representative** of the corresponding Toronto population with respect to all other characteristics analyzed. Significant differences were found for the following variables:

* 'Non respondents' are those eligible members of the population who do not take part in the survey for whatever reason.

† Diamond, S. S. 1994. "Reference guide on survey research." In the Federal Judicial Center's Reference manual on scientific evidence. Washington, DC: Federal Judicial Center.

‡ A full report of the representativeness results is available on request. See contact information at end of this Appendix.

- parent's gender
The survey sample had a greater proportion of mothers with young children compared to that found in the corresponding Toronto population (74% vs. 54%).
- parent's education
The survey sample had a greater proportion of parents who were post-secondary graduates compared to the corresponding Toronto population (60% vs. 39%). The survey sample also had fewer parents who had less than a high school certificate (5% vs. 27%).
- immigration characteristics
The survey sample had a greater proportion of parents who were not recent immigrants (immigrated 11+ years ago or were born in Canada) compared to the corresponding Toronto population (70% vs. 55%).

The differences between the survey sample and the 2001 Census data for these three demographic characteristics were statistically significant (p-value < 0.05) and the absolute differences between the percentages were greater than 15 points. **These three characteristics were deemed to have an impact on public health relevance** due to the statistical significance and the magnitude of differences noted.

Other demographic variables were found to have percentages that were statistically different between the survey sample and the Census, but the magnitude of the **differences was considered 'notable'** (i.e. 5 – 6 percentage point difference). These include:

- Dwelling type
The survey sample a greater proportion of respondents living in houses compared to the corresponding Toronto population (60% vs. 54%)
- Canadian or Foreign Born
The survey sample had a greater proportion of respondents who were born in Canada compared to the corresponding Toronto population (44% vs. 39%). This finding confirms and correlates with the finding for the 'immigrant characteristics' variable as noted above.

Three demographic variables (family status, annual household income category, parent's first language) were found to have percentages that were also significantly different between the survey sample and the Census data, but these differences were fairly small (<5% difference). For example, results of the assessment on the 'annual household income category' variable showed that the proportion of survey respondents whose household annual income category was 'low' was statistically lower than the 2001 Census (p = .01). However, the absolute difference between the survey and 2001 Census results was fairly small (3.9%) for this particular income category. The proportion of survey

* Categories for annual household family income were adjusted for household size. See full Perinatal & Child Health Survey report for details.

respondents whose household annual income category was either low/medium or medium/high was representative compared to the 2001 Census.*

PUBLIC HEALTH IMPLICATIONS OF REPRESENTATIVENESS ASSESSMENT FINDINGS

Despite the limitations discussed above, the PCH Survey provides very useful local information for public health policy development and program planning, monitoring and evaluation. **Users of the PCH Survey data should assess whether the unrepresentative demographic characteristics listed above might have affected the specific survey results that they are interested in.** Some demographic characteristics may have a greater potential to bias the results than others. For example, since the survey slightly under-represents those with low income, the incidence of food insecurity among Toronto parents with young children may be underestimated, as there is a positive relationship between low income and food insecurity.

When reporting results, survey users must state relevant limitations. For example, when reporting on health indicators that are strongly influenced by parental education, it should be stated that “*the survey sampled fewer parents with low levels of education (less than high school) than the general population of Toronto parents with children from birth to 6 years of age.*” When reporting on indicators that are strongly associated with household income, it should be stated that “*the survey sampled a slightly lower percentage of low income households than the general population of Toronto parents with children from birth to 6 years of age.*”

For further explanation or clarification of the implications arising from the representativeness assessment, please contact: Wil Ng, Epidemiologist, Health Information & Planning, Toronto Public Health at: 416-338-8077 or e-mail wng2@toronto.ca.

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* Note that this result should be interpreted with caution as there was a very high non-response rate to the household income item (23.1% of respondents did not provide income information).

Appendix B – Toronto Perinatal and Child Health Survey

INTRODUCTION

Hello, my name is _____ and I am calling on behalf of Toronto Public Health. We are conducting an important survey with Toronto residents to obtain information to improve our understanding of the factors that affect children's health. Are there children in your home under 7?

No – There are no children under 7 in the home – Thank you for your time. (Not Eligible)

Yes – This information will help the health unit to plan programs and services for children under seven years of age, as well as their parents. This survey is confidential and voluntary. Whether you participate or not will not affect the services you may receive from the health unit. You may choose not to answer any question, or to end the survey at any time. Would you be willing complete this survey with me now?

Yes – go to I1

No – I2 Would it be possible to do this at another time?

Yes – I3 Thank you. When should I call back? (record Callback information)

No – I4 Thank you for your time. (Refused)

I1. How many children under 7 years regularly live at least part of the time in your home?

_____ child(ren)

If 1 child go to q1

1. Are you the: (READ LIST)

- Birth parent
- Step parent
- Common-law parent
- Adoptive parent
- Foster parent
- None of the above
- Don't know
- Refused

If none of the above – May I speak with the child's parent?

Yes – repeat intro

No – Would there be a better time to call back?

Yes – take call back information

No – Thank you for your time, terminate interview – Refused)

Go to q2 or terminate if DK, R

2. Does this child have another parent also living in your home? This could be a birth, step, common-law, adoptive, or foster parent.

Yes
No
Don't know
Refused

3. Could you tell me this child's date of birth?

Yes – mm/dd/yyyy (go to q4) (please only allow year of 1997 or later)

If No,

3b. Could you please provide us with the age of this child? ____ years
and/or ____ months old

4. In the next questions we want to talk to you about this child who is XX year(s)/month(s) of age (from q3). To make it easy to ask these questions could you tell me his/her first name?

Yes (take name & go to q5)

If No,

4b. That's okay, we will refer to your child as your XX year/month old.
(from q3)

5. If unknown: Is this a boy or a girl?, If known: Fill in the sex of the child (go to q11)

If greater > 1 child go to q6 else go to q7

6. Because I want to ask questions about only one of these children, please answer only for the child under age 7 who will have the next birthday. [If twins, ask for the older child & younger child alternately (see board). If same birthday/ year(s) apart, ask for the older child & younger child alternately (see board).]

Are you the: (READ LIST)

Birth parent
Step parent
Common law parent
Adoptive parent
Foster parent
None of the above
Don't know
Refused

If none of the above - May I speak with the child's parent?

Yes – repeat intro

No – Would there be a better time to call back?

Yes – take call back information

No – Thank you for your time, terminate interview – Refused)

Go to q7 or terminate if DK, R

7. Does this child have another parent also living in your home? This could be a birth, step, common-law, adoptive, or foster parent.
Yes
No
Don't know
Refused
8. Could you tell me this child's date of birth?
Yes (go to q9) (calculate button to give accurate age based on the date called)
If No,
8b. Could you please provide us with the age of this child? _____ year(s) and/or _____ month(s) old
9. In the next questions we want to talk to you about this child who is XX year(s)/month(s) of age (from q13). To make it easy to ask these questions could you tell me his/her first name?
Yes (take name & go to q10)
If no,
9b. That's okay, we will refer to your child as your XX year/month old. (from q8)
10. If unknown: Is this a boy or a girl?, If known: Fill in the sex of the child
11. Was (child) or (your XX year old) born in Canada?
Yes (go to q13)
No (go to q12)
Don't know (go to q12)
Refused (go to q12)
12. How long has (child) or (your XX year old) lived in Canada?
_____ years _____ months (if child's age=6, allow year range <1 yr – 6 yrs, 5, range is <1-5, etc) *** LOGIC OPTIONS ARE BASED ON AGE
Refused

Now we are going to ask some questions about your child's general health.

13. In general, would you say that (child)'s or (your XX year/month old) health is
Excellent
Very good
Good
Fair
Poor
Don't know
Refused

14. In the following questions long-term conditions refer to conditions that have lasted or are expected to last 6 months or more and have been diagnosed by a health professional. Does (child) or (your XX year/month old) have any of the following long-term conditions? (READ LIST) SELECT ALL THAT APPLY (ESL – Does your child have any health problems that will last for a long time, like asthma, allergies, or bronchitis?)

Asthma

Allergies

Bronchitis

Any other long-term conditions (does not include chicken pox, measles, or anything not lasting six months or an acute illness)

14d_comm) Yes _____ (specify) (e.g. down's syndrome, diabetes, muscular dystrophy)

None or No conditions

Don't know

Refused

The next few questions refer to falls that occurred in the past 12 months.

15. In the past 12 months, did (child) or (your XX year/month old) sustain any injuries due to a fall that were serious enough to require medical attention?

Yes (go to q16)

No (go to q19)

Don't know (go to q19)

Refused (go to q19)

16. How many times did he/she fall?

_____ times (1 go to q17, >1 go to q18 & repeat accordingly)

Don't know (go to q17)

Refused (go to q17)

For 1 fall only

17. Thinking of this fall that required medical attention, how did (child) or (your XX year/month old) fall? (gives probes – e.g. fall from stairs, fall from chair, slipped on flat surface, etc. but DO NOT READ RESPONSE LIST)

Fall while being carried or supported by other persons

Fall on or from stairs or steps

Fall on same level from slipping, tripping, or stumbling

Fall involving a child product (e.g. crib, playpen, walker, highchair, stroller, etc.)

Fall involving bed, chair, or other furniture

Fall involving playground equipment (backyard or public)

Fall involving tricycle, bicycle, bike carrier or other recreational "vehicle"

Fall from or out of building or other structure (e.g. window, balcony)

Other fall _____ (specify) (includes all sports injuries, wagon, bath tub, etc.)
Don't know
Refused

Go to q25

For > 1 fall (repeat up to 5)

18. Thinking of the first (second, third, fourth, fifth) fall that required medical attention, how did (child) or (your XX year/month old) fall? (from q19) (gives probes – e.g. fall from stairs, fall from chair, slipped on flat surface, etc. but DO NOT READ RESPONSE LIST)

Fall while being carried or supported by other persons
Fall on or from stairs or steps
Fall on same level from slipping, tripping, or stumbling
Fall involving a child product (e.g. crib, playpen, walker, highchair, stroller, etc.)
Fall involving bed, chair, or other furniture
Fall involving playground equipment (backyard or public)
Fall involving tricycle, bicycle, or other recreational "vehicle"
Fall from or out of building or other structure (e.g. window, balcony)
Other fall _____ (specify) (includes all sports injuries, wagon, bath tub, etc.)
Don't know
Refused

The following questions concern (child)'s birth.

19. What was (child) or (your XX year/month old)'s birth weight (in kilograms and grams or pounds and ounces)?

Kg/g
Lbs/oz
Don't know
Refused

LOGIC: ANYTHING OVER 15 LBS OR 6.82 KG CAN LEAD TO ANOTHER QUESTION:

20b) Is this the birth weight or the current weight of the child?

Yes (continue)

No (go back and correct)

20. Was (child) or (your XX year/month old) born before or after the due date?

- Before (go to q21)
- After (go to q22)
- On due date (go to q22)
- Don't know (go to q22)
- Refused (go to q22)

21. How many days or weeks before the due date was (child) or (your XX year/month old) born?

- _____ days
- _____ weeks
- Don't remember
- Refused
- (go to q22)

22. Was this a single birth, twins, or triplets?

- Single birth
- Twins
- Triplets
- More than triplets
- Don't know
- Refused

If Child >6 months old:

23-A. You may have already given us this information, but during the FIRST 6 months of (child) or (your XX year/month old)'s life, including the time around his/her birth, did (child) or (your year/month old) have any health problems? (If required: like surgery, or baby was in intensive care after birth)

- Yes
- No
- Don't know
- Refused

If yes → (Please specify) And what was the health problem? _____

If Child \leq 6 months old:

23-B. You may have already given us this information, but can you please tell me if (child) or (your XX month old) has had any other health problems during the XX months of his/her life, including the time around his/her birth?

- Yes
- No
- Don't know
- Refused

If yes → (Please specify) And what was the health problem? _____

The following are a few questions on breastfeeding. (only if birth parent or q1, q6=1)

24. Did you (or your partner) breastfeed or try to breastfeed (child) or (your XX year/month old) even if only for a short time?

- Yes (go to q25)
- No (go to q25)
- Don't know (go to q29)
- Refused (go to q29)

25. When was the decision made on whether or not to breastfeed your child?

- Before pregnancy
- During the first three months of pregnancy
- During the last six months of pregnancy
- After the baby's birth
- Don't know
- Refused

(If Yes to q24 go to q26, if else skip to q29)

Some mothers breastfeed for a very short time, or not at all, while others breastfeed for much longer periods of time.

26. Is (child) or (your XX year/month old) still being breastfed?

- Yes (go to q28)
- No (go to q27)
- Don't know (go to q28)
- Refused (go to q28)

27. How long was (child) or (your XX year/month old) breastfed?

Less than 1 week

1 to 2 weeks

3 to 4 weeks

5 to 8 weeks

9 to less than 12 weeks

3 to 5 months

6 months

7 to 11 months

12 months or more

Don't know

Refused

28. At what age did your child first receive any food or drink besides breast milk? This would include giving the child some water or a taste of **any** food even one time, but not drops or syrups consisting of vitamins, mineral supplements, or medicines. (If under 6 months, very important specifics. Please ask for best guess. Logic: cannot exceed child's age)

_____ years _____ months _____ weeks _____ days (e.g., if 2
month & 1 week, enter "0" for years, "2" for months, and "1" for weeks)

Never, exclusively breastfed

From birth

Don't remember

Refused

The next few questions ask about family lifestyle.

29. In a typical WEEK, how many times do (child) or (your XX year/month old) and at least one parent participate together, in some form of physical activity such as walking, swimming, skating, playing in the park, etc?

_____ times per week

_____ Don't know

_____ Refused

30. How many hours in a typical WEEK, including the weekend, does (child) or (your XX year/month old) spend watching TV or videos, using the computer, playing video games or hand held computer games? (Be specific or ask to give best guess)

_____ hours per week

_____ Don't know

_____ Refused

31. Which best describes the rules about smoking inside your home? (Do not include decks, garages, or porches)?

- Smoking is not allowed anywhere inside your home
- Smoking is allowed in some places or at some times inside your home
- Smoking is allowed anywhere inside your home
- Don't know
- Refused

The following questions have to do with things that (child) or (your XX year/month old) does and ways that you react to him/her.

Please indicate:

- Never
- About once a week or less
- A few times a week
- One or two times a day
- Many times each day
- Don't know
- Refused

32. How often do you and (child) or (your XX year/month old) talk or play together, focusing attention on each other for five minutes or more, just for fun? (READ SCALE) (**Logic: children of all ages**) (ESL – How often do you and (child) talk or play together for even 5 minutes just for fun? REPEAT SCALE)

33. How often do you get annoyed with (child) or (your XX year/month old) for saying or doing something he/she is not supposed to? (READ SCALE) (**Logic: children of all ages**) (ESL – How often do you get upset or irritated with (child) for saying or doing something he/she is not supposed to? REPEAT SCALE) (If respondent states that child is too young, or seems confused by relevance of question, repeat question as “How often do you get upset or irritated with (child) for doing something he/she is not supposed to?”)

34. How often do you tell (child) or (your XX year/month old) that he/she is bad or not as good as others? (READ SCALE) (**Logic: children 0-<2 only**) (ESL – How often do you tell (child) that he/she is bad or not good like others? REPEAT SCALE) (If respondent states that child is too young, or seems confused by relevance of question, repeat question as “How often do you tell (child) that he/she is bad?”)

Now, we know that when parents spend time together with their children, some of the time things go well and some of the time they don't go well. For the following questions, I would like you to tell me what proportion of the time things turn out in different ways. (ESL – Now we know that when you are with your kids, sometimes things are good and sometimes things are not so good. I would like you to tell me how much of the time the following things may happen)

Please indicate:

- Never
- Less than half the time
- About half the time
- More than half the time
- All the time
- Don't know
- Refused

35. Of all the times that you talk to (child) or (your XX year/month old) about his/her behaviour, what proportion is praise? (**Logic: children 2-6 only**) (ESL – When you talk to (child) about the way he/she is acting, how much of the time do you praise or say good things about what he/she is doing?)
36. Of all the times that you talk to (child) or (your XX year/month old) about his/her behaviour, what proportion is disapproval? (**Logic: children 2-6 only**) (ESL – When you talk to (child) about the way he/she is acting, how much of the time do you tell him/her you don't like what he/she is doing?)
37. How often do you get angry when you punish (child) or (your XX year/month old)? (**Logic: children 2-6 only**) (ESL –When you punish (child), how much of the time do you get angry?)
38. How often do you think that the kind of punishment you give (child) or (your XX year/month old) depends on your mood? (**Logic: children 2-6 only**) (ESL – How much of the time do you think that the way you punish (child) depends on how you feel at that time? For example, if you are in a good mood, you may just talk about it with him/her, but if you are in a bad mood, you may raise your voice or yell at him/her)
39. How often do you feel you are having problems managing (child) or (your XX year/month old) in general? (**Logic: children 2-6 only**) (ESL – How much of the time do you think you have problems dealing with (child)?)
40. How often do you have to discipline (child) or (your XX year/month old) repeatedly for the same thing? (**Logic: children 2-6 only**) (ESL – How much of the time do you need to tell (child) to stop doing the same thing over and over again?)

Just about all children break the rules or do things that they are not supposed to. Also, parents react in different ways. Please tell me how often you do each of the following when (child) or (your XX year/month old) breaks the rules or does things that he/she is not supposed to do.

Please indicate:

- Never
- Rarely
- Sometimes
- Often
- Always
- Don't know
- Refused

41. Tell him/her to stop? (**Logic: children 2-6 only**)
42. Ignore it, do nothing? (**Logic: children 2-6 only**)
43. Raise your voice, scold or yell at him/her? (**Logic: children 2-6 only**)
44. Calmly discuss the problem? (**Logic: children 2-6 only**)
45. Use physical punishment? (**Logic: children 2-6 only**)
46. Describe alternative ways of behaving that are acceptable? (**Logic: children 2-6 only**) (ESL – Explain to (child) other ways of behaving that are okay?)
47. Take away privileges or put him/her in his/her room? (**Logic: children 2-6 only**) (ESL – Take away things that he/she likes to do, like watching television?)

Sometimes different situations arise which may affect family life. Now I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether they were Often true, Sometimes true, or Never true for your household in the last 12 months.

Scale:

- Often true
- Sometimes true
- Never true
- Don't know
- Refused

48. I relied on only a few kinds of low-cost food to feed my child(ren) because I was running out of money to buy food in the past year. (REPEAT SCALE IF NECESSARY)
49. I couldn't feed my child(ren) a balanced meal because I couldn't afford that in the past year. (REPEAT SCALE IF NECESSARY)

If true (1 or 2) to either of the above 2 ques., then continue, or if 3, 4, or 5 skip to q56

50. My child(ren) was/were not eating enough because I just couldn't afford enough food in the past year. (REPEAT SCALE IF NECESSARY)

If true (1 or 2) then continue or if 3, 4, or 5 skip to 56

51. In the past year, did you ever cut the size of your child(ren)'s meals because there wasn't enough money for food?
 - Yes
 - No
 - Don't know
 - Refused

52. In the past year, did your child(ren) ever skip meals because there wasn't enough money for food?

Yes

No (go to q54)

Don't know (go to q54)

Refused (go to q54)

53. How often did this happen?

Almost every month

Some months but not every month

Only 1 or 2 months

Don't know

Refused

54. In the past year, was/were your child(ren) ever hungry but you just couldn't afford more food?

Yes

No

Don't know

Refused

55. In the past year, did your child(ren) ever not eat for a whole day because there wasn't enough money for food?

Yes

No

Don't know

Refused

The next set of statements describe feelings or behaviours. For each one, please tell me how often you felt or behaved this way during the past week.

Please indicate:

Never

Less than 1 day

1-2 days

3-4 days

5-7 days

Don't know

Refused

56. I did not feel like eating; my appetite was poor.

57. I felt that I could not shake off the blues even with help from my family or friends.
(ESL – I felt that I could not stop feeling sad even with help from my family or friends.)

58. I had trouble keeping my mind on what I was doing.

59. I felt depressed. (ESL – I felt very sad.)

60. I felt that everything I did was an effort. (ESL – I felt everything I did was hard to do.)

61. I felt hopeful about the future. (ESL – I look forward to the future.)

62. My sleep was restless. (ESL – I couldn't sleep well.)

63. I was happy.

64. I felt lonely.

65. I enjoyed life.

66. I had crying spells. (ESL – I cried.)

67. I felt that people disliked me. (ESL – I felt that people didn't like me.)

68. Now, changing topics, we have a few questions about dental health. Have you ever been told by a physician or dentist that (child) or (your XX year/month old) had the condition known as early childhood tooth decay – also known as baby bottle tooth decay, or early childhood caries? (ECTD refers to children who have multiple cavities especially on the front baby teeth. Young children with ECTD often have to see a specialist and receive treatment under general anaesthesia. A child who has had one or two cavities on the back teeth does not have ECTD)

Yes

No

Don't know

Refused

Not applicable (no teeth yet)

If yes, interviewer should be prompted to clarify: Were these cavities in the front teeth or the back teeth?

69. Can you tell me when (child) or (your XX year/month old) has been to see a dentist or dental hygienist (not at school)? (**only for children > 9 months old**) (**Logic: cannot exceed child's age**)

Within the last year (go to q71)

Between one and two years ago (go to q70)

More that 2 years ago (go to q70)

Never (go to q70)

Don't know (go to q71)

Refused (go to q71)

Logic: If child is < one year and option 2 or 3 is selected,
Interviewer should say: You stated your child age was XX months old, do you mean within the last year?

70. Why did (child) or (your XX year/month old) not go more recently? (DO NOT READ - SELECT ALL THAT APPLY) (*only for children > 9 months old and q69=2, 3, or 4*)

- He/she is too young to go
- No need to go, he/she has no problems
- He/she is too afraid to go
- We don't have or don't know a dentist
- Our family dentist won't see children that young
- Our dentist is too busy – booked way ahead
- We don't have dental insurance
- We can't afford to take him/her
- Would have to lose too much time from work
- Other _____ (specify)
- Don't know
- Refused

71. How often are (child) or (your XX year/month old)'s teeth/gums brushed or cleaned?

- One or more times per day
- 2-6 times per week
- Once or less per week
- Never (go to q74)
- Don't know
- Refused

72. Is toothpaste with fluoride used to clean this child's teeth? (*only if q71=1, 2, 3, 5, or 6*)

- Yes (go to q73)
- No (toothpaste is not used at all, or non-fluoride toothpaste is used) (go to q74)
- Don't know (go to q74)
- Refused (go to q74)
- Not applicable (child has no teeth) (go to q74)

73. About how much is put on the brush? (Read List)

- A light smear
- The size of one small pea
- The size of two small peas
- The size of three or more small peas
- Don't know
- Refused

Finally, I would like to ask you some questions about yourself.

74. What is your date of birth?

- Mm/dd/yyyy (allow possibility of only receiving month and year)
- Refused

75. What is your current marital status? (READ LIST)

Single, never married
Legally Married (and not separated)
Living common-law
Separated (but still legally married)
Divorced
Widowed
Refused

LOGIC: IF Q75=2 OR 3 AND Q2 OR Q7=2 (NO OTHER PARENT), THEN ASK,
75B. So, does this mean that your partner doesn't live in the house?
Yes
No
Don't know
Refused

NOTE TO INTERVIEWER: IF THEY HAVE CORRECTED THEIR ANSWER, PLEASE
RECORD IN ERROR LOG BOOK TO HAVE DATA CORRECTED TO SHOW THAT
THERE IS ANOTHER PARENT LIVING IN THE HOME

76. How many people are living in your home? _____ (add Refused option)

77. How many people are between the ages of 7 and 18? _____

78. What is the highest level of education that you have ever completed?

Less than grade 9
Some high school (not completed)
High school
Some trade school, technical or vocational school, business college, community
college, or non-university nursing school
Some university
Diploma or certificate from trade, technical or vocational school, business college,
community college, nursing school or university
Bachelor or undergraduate degree or teacher's college
Post-graduate or professional degree
Other _____ (specify)
Don't know
Refused

79. Can you tell me what type of home you live in? (For example, a single-detached house, or high rise apartment)

- Single detached house
- Semi-detached or double (side-by-side)
- Garden house, town house or row house
- Duplex (one above the other)
- Low-rise apartment (less than 5 stories)
- High-rise apartment (5 or more stories)
- Institution
- Collective dwelling (hotel/motel, rooming or boarding house)
- Mobile home
- Other _____ (specify) (e.g. condo)
- Don't know
- Refused

80. Is this home owned by a member of this household, even if being paid for (e.g. mortgage)? (If required: "Is this apartment/house/condo owned by a member of this household?")

- Yes (go to q82)
- No (go to q81)
- Don't know (go to q81)
- Refused (go to q81)

Note: questions 81 and 82 were removed from the final interview procedure.

83. Could you please tell me which best describes your total household income before taxes for 2002? Please include income FROM ALL SOURCES such as savings, pensions, rent, as well as wages. Please stop me when I reach your category. Was it:

- less than \$20,000
- \$20,000 to less than \$30,000 (29,999)
- \$30,000 to less than \$40,000 (39,999)
- \$40,000 to less than \$50,000 (49,999)
- \$50,000 to less than \$60,000 (59,999)
- \$60,000 to less than \$70, 000 (69,999)
- \$70,000 to less than \$80,000 (79,999)
- \$80,000 to less than \$ 90,000 (89,999)
- \$90,000 to less than \$100,000 (99,999)
- \$100,000 to less than \$120,000 (119,999)
- \$120,000 to less than \$150,000 (149,999)
- \$150,000 or more?
- Don't know
- Refused

People living in Canada come from many different ethnic or cultural backgrounds.
 84. To what ethnic or cultural group did your ancestors belong? (SELECT UP TO 2) (ESL:
 What is your ethnic or cultural background?)

Canadian	ENGLISH	Italian	Norwegian	Sri Lanka
Australian	El Salvador	Indian	Pakistani	Swedish
Austrian	Ethiopian	Israeli	Philipino	Tamil
Bahamian	French	Jamaican	Polish	Trinidadian
Bangladeshi	Finnish	Japanese	Portuguese	Ukrainian
BLACK/African	German	Jewish	Russian	Vietnamese
British	Greek	Korean	SCOTTISH	Yugoslavian
Chinese	Guyanese	Labanese	Serbia	Welsh
Croatian	Haitian	Macedonian	Sikh	
Czech	Holland	New Zealand	Netherlands	Inuit, Metis
Danish	Hungarian	Netherlands	Slovakian	Aboriginal
Dutch	Irish	Nigerian	Spanish	Native
Other (specify)	Don't know	Refused		

85. Were you born in Canada?

- Yes (go to q88)
- No (go to q86)
- Don't know (go to q88)
- Refused (go to q88)

86. How many years have you lived in Canada? _____ years (go to q87) (add a less than 1 year option)

87. In what country were you born? (DO NOT READ, SELECT ONLY ONE)

Canada	Ireland	Sri Lanka
China	Italy	United Kingdom(England, Scotland, Northern, Ireland, Wales)
France	Jamaica	
Germany	Korea	United States
Greece	Netherlands (Holland)	Vietnam
Guyana	Phillipines	Other _____ (specify)
Hong Kong	Poland	Don't Know
Hungary	Portugal	Refused
India		

88. What is the language that you first learned at home and can still understand? (If respondent can no longer understand the first language learned, choose the second language learned) (SELECT UP TO 2)

English	Polish
Arabic	Portuguese
Cantonese	Punjabi
Cree	Spanish
French	Tagalog (Filipino)
German	Tamil
Greek	Ukrainian
Hungarian	Vietnamese
Italian	Other _____ (specify)
Korean	Don't know
Mandarin	Refused
Persian (Farsi)	

Note: question 89 was removed from the final interview procedure.

90. Can you tell me your current employment status?

- Employed full-time
- Employed part-time
- Self-employed
- Out of work for up to 1 year
- Out of work for 1 year or more
- Stay at home parent, guardian, etc.
- Retired
- Unable to work
- Student
- Other _____ (specify (e.g. maternity leave))
- Don't know
- Refused

91. What are the first three digits of your postal code?

If postal codes = M6M, M9N, M3C, M4G, M4C, M4K, M4J, M4N, M4P, M5M, M6E, M6N, M6S, M5P, M6B, ask What are the last three digits of your postal code?

92. Are you male or female? (may be completed by interviewer)

Those are all the questions that I have for you. Thank you very much for your time. If you have any questions or concerns about child health, or your health or family circumstances as they relate to your child, please feel free to call The Toronto Health Connection line at (416)338-7600.

(Note to interviewer: if the respondent expresses interest in survey results, or has questions about the survey itself, offer the following contact information: Wil Ng, Toronto Public Health Epidemiologist, (416) 338-8077).

Appendix C – Interviewer Protocol

Training

- Your Manager or your supervisor will go through the survey with you explaining each question, the flow of the survey, and advise you of any particular logic.
- Any uncertainty with respect to the clarity of any of the questions or options should be addressed.
- Familiarize yourself with the survey.
- Pick a partner and go through the survey with one another verbally. This is only done with smaller surveys that do not involve any complex logic.
- For more complex surveys, scripted interviews will be provided by your Manager for training.
- Once you are comfortable with the wording of the survey, phone one another & do the survey, timing yourselves.
- Vary your answers to test each question, the skips and the flow of the survey. In the case of scripted interviews, please adhere to the scripted answers provided.
- Using your hard copy, double check that the computer program always goes to the next appropriate question.
- If you find that the computer does not lead you to the proper question, notify your supervisor immediately.

Things to Remember

- Read each question COMPLETELY.
- Do not read OPTIONS when you are not supposed to.
- Depending on the survey, you may be provided with examples to give without reading out the options, in which case, you may provide those examples to assist the respondent. However, resist the temptation to read the options when it clearly states “DO NOT READ”. If you attempt to reword the question and the respondent is still unable to answer, please select the “DON’T KNOW” option.
- If the question has multiple answers or a scale, be prepared to read or re-read the options as often as necessary.
- Do not re-arrange options or scales, read or repeat them as they appear.
- If the client requests options rotated, the program will do so for you.
- If a respondent doesn’t understand the question(s), offer a simple re-wording or explanation. If it is still not understood, select the “DON’T KNOW” option.
- Please make sure that if a question includes “Why” that you ask “Why?” as these answers in some cases provides very crucial information for the client. Do not rush through these & type your answers in immediately, even if in point form using ALL CAPS.

- Never comment on your opinion regarding the survey. If the interviewee has any concern, advise them of the contact name that will be provided by the client.
- Remember that the interviewee may refuse to answer any question(s). If an interviewee refuses to answer a question, click on the “Refused” option.
- If an interviewee says “I don’t know” or “Not sure” select the “Not sure” option.
- The specific telephone numbers and name are usually not kept or reported in any form.
- The value of the survey depends on people being as accurate as they can with their answers, so be sure to record them properly.
- If the survey makes any reference to a promotion, campaign, specific materials, etc., please make sure that this information is provided to you by your Manager or Supervisor. If an interviewee needs to be prompted in any way, we will be prepared.

Call Monitoring

Between 5 and 10% of the calls will be monitored unless the contract stipulates differently. You will be checked for:

- Proper qualification of respondents
- Proper data entry of answers
- Proper reading of the survey (not changing the context of a question)
- **Unbias – do not lead an answer out of a respondent by the way you ask the question, do not assume what the answer will be**

On the first day of surveying, all interviewers will be monitored for their first 5 completes

Once all interviewers have completed a number of calls, a meeting will be held to recap any potential problems that have been found.

Standard Protocols

Times for calling

9 a.m. to 9 p.m. Monday to Thursday
9 a.m. to 4:30 p.m. Friday
10 a.m. to 4 p.m. Saturday
12 p.m. to 4 p.m. Sunday

Refusals

If the interviewee refuses to do the survey, simply respond, “Thank you for your time” and terminate the survey using the “Refused” option.

Refusals from any interviewee on any particular question(s) in the survey are to be accepted graciously, without pressure or request for the reason why. If the reason is given, record it. Please tell them that if they want to ask questions about the survey, they are welcome to call the appropriate contact and number provided by the client.

Death

If the interviewee reports that there has been a death in the family, respond, “I am very sorry for your loss. We will not disturb you again.” Record that there has been a death in the callback information and then click “Refuse” to terminate the survey. Double check to ensure that the number is removed from the working list so that it is not called again.

Unease/Skeptical/Defensive

If the interviewee seems uneasy, skeptical or suspicious about the survey or its purpose, state: “I have a contact and phone number provided by the client. Would you like that number?”(provide contact name and/or number provided by client). If the number is provided, ask: “Can I call you back in a few days after you have had a chance to call?” Based on the interviewee response, either record callback information, or terminate the call.

Unlisted Numbers (from RDD sample)

If a person asks you how you got the number, simply respond: “These are randomly computer generated numbers. They are not purchased from the telephone company. If you are not interested in completing the survey, I will have your number removed from the list so that you are not called again. Sorry for the inconvenience. Have a nice day/afternoon/weekend.

Using *67

When conducting a public opinion or similar survey, please dial *67 first to block the company name. This step would not be used for any samples provided by a client which will generally be consented surveys.

Attempts

Up to 10 attempts are to be made on each number (depending on the survey contract), at various times of the day & days of the week.

Tracking calls

Keep a notepad handy to record any callbacks, change of phone numbers, etc. **YOU ARE RESPONSIBLE FOR THE APPOINTMENTS THAT YOU MAKE ON YOUR SHIFT.** If you have callbacks that are outside your shift, please give the supervisor all the information, and they will schedule another interviewer to do them.

On the first 5 completes, take note of the following:

- Any hesitation or reactions of the respondents to words, phrases, or questions
- Record the time it takes from the beginning of the call to the completion of the survey
- Any questions that needed to be repeated more than once
- Anything unusual? Any problems?

Handling a Callback Inquiry

If you get a person who calls back stating that our number was on their phone:

- Ask what area they are calling from & then explain whom we were calling on behalf of
- If they are interested in doing the survey, take down their number and pass the message on to a Supervisor for a callback at the specified time
- If they do not wish to do the survey, ask them what their phone number is, and reassure them that their number will be removed from the list. Give the phone number to the Manager/Supervisor. This will be coded as “Refused”.

Interrupted Calls

Keep a hard copy of the survey by your phone in case of a computer glitch for whatever reason and complete it on paper (the survey data can be input later by Manager).

If the interviewee is unable to complete the survey, offer to call back at another time. These surveys can be completed at whatever time is suitable for the interviewee. The program is designed to continue from where you left off.

Health advice/questions

Depending on the survey, if the interviewee asks for health advice or has questions, please respond, “I am not a health specialist, but I can provide you with a number for someone who you could call to help answer any questions you may have.” (provide contact name and/or number provided by the client)

Confidentiality

All information that an interviewer obtains during an interview, however seemingly unimportant, is CONFIDENTIAL, and interviewers are strictly prohibited from sharing any information regarding interviewees surveyed or their responses. Please be sure to always log off your terminal when not in use. If you are going on break, please close the program.

Potential Abuse/Children's Aid Society Referral

There is only ONE exception to breaking our confidentiality rule: bona fide indication of child abuse. It is extremely unlikely that an interviewer will be told by the interviewee about child abuse or that they will hear something in the background during the call that is a bona fide indicator of abuse. However, if during the survey, the caller hears evidence of abuse, the interviewer will:

- Say nothing about this to the interviewee
- Complete the interview

After completion, the interviewer will discuss the call with the Manager/Supervisor. If it is agreed upon that there is evidence of abuse, the interviewer will call the local CAS number for the relevant survey area.

Call Dispositions

CB – Callback

If you get a time from the interviewee to call back, type in the appropriate details (e.g. 11/09 c/b tomorrow 8:30pm). Remember, if an interviewee has given you a specific time; call back at that time.

NS – Not in Service

If you dial a number and it is not in service, simply click the "Terminate" button and select the "Not in Service" option and this will eliminate that number from the working list.

WN – Wrong Number

If the number you dialed gives you a forwarding number, click "Wrong Number" option and record the number in the space provided. If this number is called & the person you are trying to reach is not at that number or has moved, click "Wrong Number" option again. This option will be used for any number that is dialed and connects to a fax line.

AM, LB or NA – Answering Machine, Line Busy or No Answer

If you dial a number and you get the answering machine, a busy signal, or no answer, click the terminate button, select the appropriate option, and the date and time of the call will be recorded automatically for you. No messages will be left on the answering machine.

In case of a busy signal, try again in 15 minutes.

LA – Comprehension/Language Barrier/Mental Ability

If the interviewee states that they don't understand English, asks questions to be repeated, responds inappropriately to questions (lack of understanding), or becomes frustrated with the questions, end the survey with "Thank you for your time" and use the "LA" code for Language Barrier.

HU – Hang Ups

If you are able to connect with a potential interviewee, but you are hung up on after you introduce yourself and the purpose of your call, click the "Hung Up" option.

NE – Not Eligible

If the interviewee you are trying to reach is now out of the specified surveying area, click the Not Eligible option and the number will be eliminated from your working list. Depending on the contract, this code should also be used for business number or if an interviewee does not qualify to do the survey.

PT – Partial

This is used if the interviewee terminates an interview part way and has requested not to finish the survey. Also used if the interviewee has specified a call back time and could not be reached after the proper number of attempts have been made.

TE - Terminate

This is used if the proper call attempts have been made and no contact was made at that number. (e.g. 10 attempts)

RF – Refused

This is used if the interviewee has refused to participate in the survey.

CO – Complete

The proper completion of any interview.

Appendix D – World Bank Country Groupings

World Bank Country Groupings

This table groups all world member economies as well as other economies with populations of more than 30,000.

Sub-Saharan Africa		Asia		Europe & Central Asia		Middle East & North Africa		Americas
East & Southern Africa	West Africa	East Asia & Pacific	South Asia	Eastern Europe & Central Asia	Rest of Europe	Middle East	North Africa	Americas
ANGOLA	BENIN	AMERICAN SAMOA	AFGHANISTAN	ALBANIA	ANDORRA	BAHRAIN	ALGERIA	ANTIGUA AND BARBUDA
BOTSWANA	BURKINA FASO	AUSTRALIA	BANGLADESH	ARMENIA	AUSTRIA	IRAN	DJIBOUTI	ARGENTINA
BURUNDI	CAMEROON	BRUNEI	BHUTAN	AZERBAIJAN	BELGIUM	IRAQ	EGYPT	ARUBA
COMOROS	CAPE VERDE	CAMBODIA	INDIA	BELARUS	CHANNEL ISLANDS	ISRAEL	LIBYA	BAHAMAS
CONGO DEM. REPUBLIC	CENTRAL AFRICAN REP	CHINA PEOPLES REP	MALDIVES	BOSNIA & HERZEGOVINA	CYPRUS	JORDAN	MALTA	BARBADOS
ERITREA	CHAD	FIJI	NEPAL	BULGARIA	DENMARK	KUWAIT	MOROCCO	BELIZE
ETHIOPIA	CONGO, REP.	FRENCH POLYNESIA	PAKISTAN	CROATIA	FAEROE ISLANDS	LEBANON	TUNISIA	BERMUDA
KENYA	COTE D'IVOIRE	GUAM	SRI LANKA	CZECH REPUBLIC	FINLAND	OMARI		BOLIVIA
LESOTHO	EQUATORIAL GUINEA	HONG KONG, CHINA		ESTONIA	FRANCE	QATAR		BRAZIL
MADAGASCAR	GABON	INDONESIA		GEORGIA	FRENCH GUIANA	SAUDI ARABIA		CANADA
MALAWI	GAMBIA	JAPAN		HUNGARY	GERMANY	SYRIAN ARAB REPUBLIC		CAYMAN ISLANDS
MAURITIUS	GHANA	KIRIBATI		KAZAKSTAN	GREECE	UNITED ARAB EMIRATES		CHILE
MAYOTTE	GUINEA	KOREA DEM PEOPLES REP		KYRGYZ, REP	GREENLAND	WEST BANK AND GAZA		COLOMBIA
MOZAMBIQUE	GUINEA-BISSAU	KOREA, REP		LATVIA	GUADELOUPE	YEMEN, REP		COSTA RICA
NAMIBIA	LIBERIA	LAO PEOPLES DEM REP		LITHUANIA	ICELAND			CUBA
RWANDA	MALI	MACAO, CHINA		MACEDONIA, FYR	IRELAND			DOMINICA
SEYCHELLES	MAURITANIA	MALAYSIA		MOLDOVA, REP	ISLE OF MAN			DOMINICAN REPUBLIC
SOMALIA	NIGER	MARSHALL ISLANDS		POLAND	ITALY			ECUADOR
SOUTH AFRICA	NIGERIA	MICRONESIA		ROMANIA	LIECHTENSTEIN			EL SALVADOR

Continued

Sub-Saharan Africa		Asia		Europe & Central Asia		Middle East & North Africa		Americas
East & Southern Africa	West Africa	East Asia & Pacific	South Asia	Eastern Europe & Central Asia	Rest of Europe	Middle East	North Africa	Americas
SUDAN	SAO TOME & PRINCIPE	MONGOLIA		RUSSIAN FEDERATION	LUXEMBOURG			GRENADA
SWAZILAND	SENEGAL	MYANMAR		SLOVAK REP	MARTINIQUE			GUATEMALA
TANZANIA, REP	SIERRA LEONE	N. MARIANA ISLANDS		SLOVENIA	MONACO			GUYANA
UGANDA	TOGO	NEW CALEDONIA		TAJIKSTAN	NETHERLANDS			HAITI
ZAMBIA		NEW ZEALAND		TURKMENISTAN	NORWAY			HONDURAS
ZIMBABWE		PALAU		UKRAINE	PORTUGAL			JAMAICA
		PAPUA NEW GUINEA		UZBEKISTAN	REUNION			MEXICO
		PHILIPPINES		YUGOSLAVIA, FED REP	SPAIN			NETHERLANDS ANTILLES
		SAMOA			SWEDEN			NICARAGUA
		SINGAPORE			SWITZERLAND			PANAMA
		SOLOMAN ISLANDS			TURKEY			PARAGUAY
		TAIWAN, CHINA			UNITED KINGDOM			PERU
		THAILAND						PUERTO RICO
		TONGA						SAINT KITTS AND NEVIS
		VANUATU						SAINT LUCIA
		VIETNAM						SAINT VINCENT & GRENADINES
								SURINAME
								TRINIDAD AND TOBAGO
								UNITED STATES
								URUGUAY
								VENEZUELA
								VIRGIN ISLANDS, U.S.