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 MHPSG 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 MHPSG 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 underesampled households with low income, which would have important implications for assessment of food security. This undersampling 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 Guildelines (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.