First 5 Commission of San Diego County
2005 Family Survey Report

Prepared by Harder+Company Community Research
December 2005
Founded in 1986, Harder+Company Community Research is a comprehensive social research and planning organization located in San Diego, San Francisco, and Davis, California. The focus of the company’s work is in broad-based community development and human services. Its staff conducts needs assessments, program evaluation, planning studies, and trainings for a wide range of clients across the country.
The 2005 Family Survey, along with this report, was guided by the vision of the First 5 Commission of San Diego and brought together many organizations, experts, and families who provided valuable leadership, information and resources. Without these people, this project would not have been possible.

Harder+Company Community Research would like to thank the following people:

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Executive Summary

As part of its ongoing commitment to ensure that every child enters kindergarten "ready to learn," the First 5 Commission of San Diego County spearheaded the 2005 Family Survey to over 1,200 parents and caregivers with children age 0 to 5. This Random Digit Dial (RDD) survey represents the first of its kind to focus on the 0 to 5 population, providing a unique opportunity to collect and present baseline data about child well-being that can be tracked and assessed over time.

Key indicators and findings presented in this report are organized around the four issue areas outlined in the Commission’s strategic plan including:

- Children’s health
- Children’s learning and social-emotional health
- Parent and family development and resources
- Systems improvement and community change.

While the survey was designed to gather information in all four areas, special emphasis was given to issues such as children’s social-emotional health, where little or no baseline data is currently available. The report also includes indicator data from secondary sources in an effort to provide a more comprehensive picture of child well-being. Indicator data and survey findings are presented by population characteristics as well as geographic region throughout the report and, when available, state and national indicators are presented for comparison purposes.

**Issue Area 1: Children’s Health**

Improving child health sets a stronger foundation for a child’s readiness for school. Establishing good health outcomes begins before birth and may include physicals, immunizations and health insurance as well as oral health, vision, safe and healthy environments, and developmental issues. Survey highlights from this issue area include:

- **Majority of respondents have immunization cards for their child.** Approximately 98.0% of respondents reported that their child had an immunization card and 92.6% indicated that they knew where the card was located.

- **Most survey respondents report breastfeeding.** Overall, 83.4% of survey respondents reported that their children were breastfed at six weeks after birth and 60.2% of respondents indicated that their children were breastfed at six months after birth. All regions exceeded the Healthy People 2010 target of 50.0% breastfeeding at six months.

- **Majority of respondents report healthy children.** Overall, 82.6% of respondents indicated that their children’s health was either very good or excellent. The North Central Region reported the highest percentage of children (93.4%) while the Central (72.9%) and South (79.1%) Regions lagged behind.
**Majority of respondents have health insurance however regional disparities exist.** Approximately 91.3% of survey participants had health insurance for their child with the highest rate in the North Central Region (94.9%) and children in the South (88.6%) and Central (86.5%) Regions least likely to be insured.

**Respondents less likely to have a regular source of care compared to national and state figures.** Overall, 91.2% of respondents indicated their children had a primary care provider. Compared to national (97.5%) and state (97.9%) figures from 2003, the participants in the 2005 Family Survey were less likely to have a regular source of medical care.

**Over two-thirds reported their child had received a vision exam.** Nearly 70.0% of respondents with children 3 or older reported that their child had received at least one vision exam in their lifetime.

**Slightly more than half of respondents had taken child for a dental exam.** Approximately 52.8% of respondents reported that their children ages 1 to 5 had received a dental exam in the past 12 months. Over 60.0% of children who did not have health insurance also had not seen a dentist in the past year.

**Majority indicated that child had received developmental check by health care professional.** Parents and caregivers with a child at least one year old were asked if a doctor or another professional had asked their child to perform activities, such as picking up small blocks, stacking blocks, throwing a ball or recognizing colors. The question was designed to determine whether or not some type of developmental assessment had been conducted. The majority (65.0%) of parents and caregivers indicated their child’s development had been checked by a health care professional. Parents in the Central Region reported the least number of developmental checks (55.6%).

### Opportunities for Improvement

While San Diego County fares well compared to state and national health indicators, regional health disparities emerged throughout this report. The Central Region in particular continually lags behind in numerous areas including health insurance enrollment and the percent of children who have received developmental screenings. Notable disparities also exist between English and Spanish-speaking populations, which correlate to regions with higher populations of new immigrants such as the Central, South and North Inland Regions. These areas might benefit most from targeted health services and programs.
Issue Area 2: Children’s Learning and Social-Emotional Health

In the first five years of a child’s life, parents directly affect the course of their child’s social-emotional health and cognitive development. Children’s cognitive and social-emotional development plays a key role in school readiness.\(^1\) Cognitive development refers to how a person perceives, thinks and gains an understanding of his or her world, and includes the acquisition of language, information processing, memory, mental imagery and problem solving.\(^2\) Social-emotional competence is often deemed as a combination of cooperative behavior, initiation and maintenance of relationships, development of self-worth, and emotional regulation.\(^3\) Although the development of these skills is affected by genetic factors, the environment in which a child resides also plays a critical role. Survey highlights from this issue area include:

- **Overall, children watch more television as they age.** According to respondents in the Family Survey, children in the 3 to 6 year old age group watched significantly more television than children 1 to 2 years of age.

- **Children in non-English speaking households watch less television.** Children in English-speaking households were more likely to watch more television compared to children living in households where other languages are spoken.

- **Participation in daily family activities varies by region.** Parents and caregivers participate in the lives of their children on a daily basis however the Family Survey reveals significant differences across the San Diego Region. County-wide, over 65.0% of respondents reported reading stories to their children on a daily basis. However, in the Central Region approximately 52.0% of parents/caregivers read or showed books to their children daily.

\(^1\) There are numerous research findings describing the importance of activities supporting children’s learning and social emotional health. For more a detailed presentation of this subject, see Chapter 2 of the 2003-2004 First 5 San Diego Evaluation Report.


• **The vast majority of County’s children have a bed-time routine.** The Family Survey reveals that almost 80.0% of children have a regular bed-time routine, however differences exist between regions. For example, children living in the Central Region (70.0%) were less likely to have a regular routine, compared to children in the North Central Region (86.0%).

• **Parents of single-child households are more likely to participate in the daily activities.** While children with siblings are more likely to interact with other children, they experience less interaction with their parents than children without siblings. For example, 70.7% of respondents reported reading or showing books to their only child, compared to 62.8% of parents with multiple children.

• **Low-income households tend to be less involved in daily family activities.** The results of the Family Survey suggest that parents with household incomes under $25,000 are less likely to be involved in daily activities with their children.

• **Parents in English-speaking households participate in daily activities at higher rates.** In all childhood activities included in the survey, parents in English-speaking households were more likely to participate in daily activities. For example, 65.3% of English speakers reported singing songs to their child daily compared to 43.3% of Spanish speakers.

• **Parents and caregivers who speak English at home were more likely to identify as their child’s first teacher compared to their counterparts who speak another language in the home:** Similarly, compared to respondents who speak another language at home, respondents who speak English at home were also more likely to report feeling confident in their ability to help their children grow and learn, and to rate themselves as better than average caregivers.

**Issue Area 3: Parent and Family Development Resources**

Through parent education and the development of family resources, the Commission seeks to enhance the skills, comprehensive support and services that parents need to promote their children’s optimal development and school readiness. Survey highlights from this issue area include:

• **Knowledge of where to call for help in dealing with the stress of raising a child varies significantly by region.** For example, 68.2% of respondents in the North Central Region reported knowing where to call for help compared to 46.0% in the Central Region.
The number of respondents who know how to locate a child care center or provider varies by region. Overall, 75.3% of respondents knew where to call for childcare assistance, however only 66.8% of respondents in the Central Region knew how to locate a child care center or provider.

The number of respondents who know how to locate a child care center or provider varies by primary language. Almost half (48.6%) of Spanish-speaking respondents reported not knowing how or where to locate a child care center or provider, compared to just 12.5% of English speakers and 28.4% of those who speak another language.

### Issue Area 4: Systems Improvement and Community Change

The First 5 Commission of San Diego is committed to supporting initiatives and interventions that improve systems, engage communities, increase awareness about local resources, and educate the community about the importance of the first five years of life. Survey highlights from this issue area include:

- **Family Survey reveals a demand for more information about community resources.**
  Two-thirds (65.1%) of survey respondents were interested in more information related to resources for parenting, immunizations, healthcare insurance, child care services, 2-1-1, or First 5 San Diego.

  **Opportunities for Improvement**
  
  As noted above, Family Survey respondents clearly expressed a desire for more information about community resources. Given that less than half of respondents were familiar with First 5 as an organization, more could be done to raise awareness.

  Not surprisingly, parents and caregivers who were less involved in the community were less knowledgeable about available resources and services. Finally, Spanish-speaking respondents expressed less confidence in their role as their child’s first teacher and in their overall ability to help their child learn and grow.
• **Volunteerism enhances knowledge of community resources.** Respondents who reported volunteering in the community were more likely to be aware of existing community resources.

• **First 5 San Diego is recognized by almost half of respondents.** Almost half (45.0%) of parents and caregivers in the Family Survey reported that they had heard of First 5 San Diego.

• **First 5 San Diego promotes parent as child’s most important teacher:** Respondents who have heard of First 5 San Diego strongly agreed that they are their children’s first and most important teachers more often than respondents that did not recognize First 5’s name.

**Conclusion**

The 2005 Family Survey Report marks the beginning of an ongoing effort to track and assess key childhood indicators and trends over time. This valuable information will help inform the strategic decisions of the First 5 Commission of San Diego as well as all those working to improve the health and wellbeing of County’s youngest children.
Introduction

Background

The 2005 First 5 San Diego Family Survey responds to the need for county-wide data related to key well-being indicators for children ages 0 to 5 and their families. The primary purpose for the survey was two-fold: to identify gaps and gather community-level data related to child outcomes based on parent perceptions and attitudes about the social service system. The First 5 Family Survey also provided an opportunity to collect baseline information that speaks to the Community Context Indicators outlined in the Commission’s 2004-2009 Strategic Plan and helps inform Commission decisions. The survey will be repeated every two years to report trends over time about the well-being of children ages 0 to 5 and their families.

Survey Development

The survey instrument was developed in collaboration with First 5 San Diego’s Evaluation Leadership Team (ELT), Commission staff, the Social Science Research Laboratory (SSRL) at San Diego State University, and Harder+Company Community Research (Harder+Company). When possible, the team included questions that could be triangulated with state and national level data (see Appendix B for a copy of the Family Survey).

Using the Community Context Indicators as a starting point, questions were developed to address identified gaps in data. An inventory of available data related to the San Diego 0 to 5 population was conducted, revealing good access to physical health indicators (Issue Area 1: Children’s Health), but a dearth of information related to the Commission’s Strategic Plan for Issue Area 2: Children’s Learning and Social-Emotional Health; Issue Area 3: Parent and Family Development and Resources; and Issue Area 4: Systems Improvement and Community Change. Thus, greater emphasis was given to these areas in the development of the survey questions. However, in an effort to present a comprehensive overview, this report presents secondary data (when available) for important health and well-being indicators, as well as specific findings from the 2005 Family Survey.

Issue Area 1: Children’s Health

- Immunization status (measured by proxy)
- Receipt of well-baby and child checkups by age two
- Breastfeeding status at six weeks and six months of age
- Parent/caregivers’ perception of their children’s health
- Medical insurance coverage
- Access to a regular source of medical care
- Receipt of vision screenings
- Receipt of regular dental care
- Receipt of developmental assessments
**Issue Area 2: Children’s Learning and Social-Emotional Health**

- Provision of early literacy activities
- Exhibition of age-appropriate self-soothing and self-regulation behaviors
- Levels of interaction with parents/caregivers and other children
- Time spent with family members reading, telling stories, or singing
- Time spent watching television
- Parents/caregivers’ discipline techniques
- Parents/caregivers’ levels of confidence in their parental roles
- Parents/caregivers’ perceptions of themselves as child's first and most important teacher

**Issue Area 3: Parent and Family Development and Resources**

- Parents/caregivers’ knowledge of where to access resources to support their children's optimal development and school readiness
- Parents/caregivers’ access to child care

**Issue Area 4: Systems Improvement and Community Change**

- Parents/caregivers’ participation in civic activities to benefit young children and families
- Parents/caregivers’ awareness of First 5

**Household Sampling**

The Family Survey sampling plan was designed to yield an equal representation of households with children ages 0 to 5 in San Diego County and within each Health and Human Services Agency (HHSA) region. The goal was to acquire a sample size of 1,200 with at least 175 interviews in each HHSA region. Thus, the sampling design was not a simple random sample but one where quotas in each region had to be met in order for the study to be complete. The table below presents the response rate estimates based on the actual population of children ages 0 to 4 in the county and the actual sample size of the Family Survey.

Based on the percentage of the actual county total by region, the proposed weighted sample column illustrates that a study with 1,200 cases would result in some regions having fewer than 175 cases. In order to obtain a more stable statistical sample, a quota of 200 interviews was set for each region. The results were not weighted for population by region.

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4 The respondent’s self-reported zip code determined which HHSA region the interviewer was to code.
### Distribution of Children in San Diego County and Sample Size of Family Survey

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Number</th>
<th>Percent of County Total</th>
<th>Proposed Weighted Sample</th>
<th>Family Survey Sample</th>
<th>Percent of Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Coastal</td>
<td>32,752</td>
<td>16.3%</td>
<td>195</td>
<td>202</td>
<td>16.8%</td>
</tr>
<tr>
<td>North Inland</td>
<td>31,718</td>
<td>15.7%</td>
<td>189</td>
<td>202</td>
<td>16.8%</td>
</tr>
<tr>
<td>North Central</td>
<td>40,907</td>
<td>20.3%</td>
<td>243</td>
<td>196</td>
<td>16.3%</td>
</tr>
<tr>
<td>Central</td>
<td>38,249</td>
<td>19.0%</td>
<td>228</td>
<td>201</td>
<td>16.7%</td>
</tr>
<tr>
<td>East</td>
<td>28,639</td>
<td>14.2%</td>
<td>171</td>
<td>200</td>
<td>16.6%</td>
</tr>
<tr>
<td>South</td>
<td>29,228</td>
<td>14.5%</td>
<td>174</td>
<td>201</td>
<td>16.7%</td>
</tr>
<tr>
<td>San Diego County</td>
<td>201,493</td>
<td>100.0%</td>
<td>1200</td>
<td>1202</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Data Collection

Using the Computer Assisted Telephone Interviewing (CATI) system, the SSRL conducted a Random Digit Dial (RDD) telephone survey of 1,202 parents and caregivers in San Diego County. Respondents were selected on the basis of residing in San Diego County and having a child under the age of six living in their households. Interviewers were instructed to request to speak with an adult in the household who was a primary caregiver for any children under age six. If a respondent indicated that there was more than one child under the age of six in the household, the respondent was asked to answer questions referencing the child having the next birthday.

There was a one-week pilot study during which the survey language was adjusted to improve clarity. Data collection began in late January 2005 and concluded at the end of April 2005. Telephone calls were made between 4:00 and 9:00 p.m. on weekdays (with daytime call-backs as needed), 12:00-5:00 p.m. on Saturdays, and 1:00-6:00 p.m. on Sundays. The interviews were conducted in English (n=883) and Spanish (n=319). The average length of the interview was 20 minutes with a response rate of 60.8%.

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Limitations

The purpose of the Family Survey was to explore early childhood issues at the county and regional level. Thus, the sample size was designed for a descriptive study at those levels and not designed to yield a number of responses large enough to run more extensive comparison analyses. In other words, it may have been possible to compare responses by region, but it may not have always been possible to compare responses from English and Spanish-speaking respondents within a region.

Similarly, since children develop in stages, not every survey question was appropriate for all children under the age of six. For example, questions on the number of hours a child watches television was asked for children who were at least one year old. For age-sensitive topics, the number of responses yielded a sample size adequate to generate county-level statistics; however, regional statements were weaker or not possible to infer.

It is also important to note that some households may have been excluded from the sample, such as those without telephone landlines or individuals who only had a cell phone. In generating a random list of telephone sample numbers, some inevitably corresponded to cell phones. However, SSRL operates under the Federal Telephone Consumer Protection Act of 1991, which prohibits calling cell phones if the call is machine-dialed or the person called incurs a charge for receiving the call. Therefore, telephone numbers identified as cell phones were deleted prior to the sample being loaded into the CATI system.

Further, individuals who do not speak English or Spanish were excluded from the sample. Resources limited the administration of the Family Survey to the English and Spanish languages. According to data from the U.S. Census 2000, 89.0% of San Diego County residents speak English or Spanish at home. Therefore, monolingual speakers of other languages and Text Telephone users were not able to participate.

Finally, a limitation of this report is that many indicators were measured through the Family Survey, a parent self-report instrument. Inherent to self-report instruments is social desirability bias, which has been defined as “the tendency of individuals to deny socially undesirable actions and behaviors and to admit to socially desirable ones.” Put in the context of responses to the Family Survey, social desirability bias may have affected responses so that respondents reported higher frequencies of actions that are considered positive by societal standards (e.g., inflated ratings of their children’s behaviors) and reported lower frequencies of actions that are considered negative. Therefore, readers of this report should be cautious when drawing conclusions or generalizations.

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How to Read This Report

This report presents findings of the most current information and data on the health and well-being of children ages 0 to 5 in San Diego County. The Family Survey data serves as the primary data source. When available, state and national data were gathered and analyzed for comparison with county level data. The indicators in this report are intended to provide a snapshot of the status of children in the county and are not all-inclusive. Harder+Company selected and presented findings that are most useful to the Commission and that best describe First 5 San Diego’s impact on children and families.

Organization of the Report

The report is divided into five sections:

- Demographics
- Issue Area 1: Children’s Health
- Issue Area 2: Children’s Learning and Social-Emotional Health
- Issue Area 3: Parent and Family Development and Resources
- Issue Area 4: Systems Improvement and Community Change

Throughout each section, indicators include a statement of importance, in reference to their potential impact on children ages 0 to 5 and their families, followed by Family Survey findings and/or secondary data, and graphs or tables illustrating outcomes.

A Note about Statistical Methodology

There were two primary analyses conducted using the Family Survey data: chi-square cross tabulations and independent sample t-tests, both of which compare two or more groups to determine whether or not a relationship exists. Statistical significance is primarily reported within the text of the report or it is located below a table. The following should be considered when interpreting analyses, graphs and tables:

- The “n” that appears in tables, graphs and the text indicates the number of people responding to that particular question. For example, (n=124) means 124 people answered the question.

- Missing data (i.e., when a respondent did not answer a question) was not included in the analysis. Although missing data can sometimes itself be a meaningful statistic, readers are often confused by actual percent (which includes missing data) and valid percent (which leaves missing data out). This report only presents valid percents, or the number of people who gave a given answer divided by the total number of people who answered the question.
• Findings noted as statistically significant are reported using p-values or t-values. This means that the difference between the groups being compared did not occur by chance alone. Significance values of less than or equal to .05 are generally considered to represent an acceptable level of potential error (5%). A value of less than or equal to .01 suggests an even lower level of potential error (1%).

• When reporting ‘means’ tests, the 95% confidence interval is the range within which one would find the true mean, or the average, of the entire population. The true value for the county or region lies somewhere between the upper and lower boundary.

• Harder+Company used the most rigorous statistical tests the data would allow. When selecting the test, the research team accounted for the quality of the data, as well as the readability of the findings for a larger audience.

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8 For example, in some cases a chi-square statistic found significance with a larger sample, but it could not be used to examine sub-samples because the actual number of respondents in the sub-sample was too small.
Demographics

The Family Survey sample consisted of 1,202 interviews of San Diego County parents and caregivers who had at least one child in the household age 0 to 5. The following sections provide additional details about the demographic characteristics of the households who participated in the 2005 Family Survey.

Geographic Distribution

Of the 184 zip codes in San Diego County, 81 were represented in the sample, spanning all six Health and Human Services (HHSA) regions.

<table>
<thead>
<tr>
<th>North Coastal</th>
<th>North Inland</th>
<th>North Central</th>
<th>Central</th>
<th>East</th>
<th>South</th>
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<tbody>
<tr>
<td>(16.8%, n=202)</td>
<td>(16.8%, n=202)</td>
<td>(16.3%, n=196)</td>
<td>(16.7%, n=201)</td>
<td>(16.6%, n=200)</td>
<td>(16.7%, n=201)</td>
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<tr>
<td>Carlsbad</td>
<td>Anza Borrego</td>
<td>Coastal</td>
<td>Central San Diego</td>
<td>Alpine</td>
<td>Chula Vista</td>
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<td>Oceanside</td>
<td>Springs</td>
<td>Elliott Navajo</td>
<td>Mid City</td>
<td>El Cajon</td>
<td>Coronado</td>
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<td>Pendleton</td>
<td>Escondido</td>
<td>Kearny Mesa</td>
<td>Southeast San Diego</td>
<td>Harbison Crest</td>
<td>National City</td>
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<td>San Dieguito</td>
<td>Fallbrook</td>
<td>Mira Mesa</td>
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<td>Jamul</td>
<td>South Bay</td>
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<td>Vista</td>
<td>Julian</td>
<td>Miramar</td>
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<td>La Mesa</td>
<td>Sweetwater</td>
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<td>North San Diego</td>
<td>Peninsula</td>
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<td>Palomar</td>
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<td>Valley Center</td>
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<td>Spring Valley</td>
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Gender and Age

The below graphs illustrate the gender and age of the parents and caregivers who participated in the survey, as well as the referenced child ages 0 to 5.

**Gender of Parent/Caregiver**

Overall, 78.6% (n=945) were female, primary caregivers and 21.4% (n=257) were male, primary caregivers.

**Age of Parent/Caregiver**

- 13.3% (n=159) were 18 to 24 years
- 46.5% (n=558) were 25 to 34 years
- 34.9% (n=419) were 35 to 44 years
- 4.3% (n=52) were 45 to 54 years
- 1.0% (n=12) are 55 years and older

**Gender of Child**

Overall, 52.5% (n=631) were males and 47.5% (n=571) were females.

**Age of Child**

- 13.0% (n=150) were under 1 year
- 16.7% (n=192) were 1 year
- 16.1% (n=185) were 2 years
- 19.9% (n=229) were 3 years
- 15.7% (n=181) were 4 years
- 18.7% (n=215) were 5 years
Race/Ethnicity

Family Survey Findings

The race/ethnicity of parents with children ages 0 to 5 interviewed was:

- 44.7% (n=531) White
- 42.2% (n=502) Hispanic/Latino
- 6.5% (n=77) Asian/Pacific Islander
- 5.2% (n=62) African American/Black
- 1.2% (n=14) American Indian
- 0.3% (n=3) Other

Secondary Data

The California Department of Finance reported the racial/ethnic distribution of all San Diego County residents as 55.7% White, 26.7% Hispanic/Latino, 9.3% Asian/Pacific Islander, 5.6% African American/Black, 0.6% American Indian and 2.2% Multi-ethnic/Other.¹

Comparing households with young children in 2003, county and state figures for race and ethnicity of parents are similar.² The graph below shows the racial/ethnic background of parents with children ages 0-4 at the state and county level.³ The race/ethnic background of the 2005 Family Survey participants are representative of parents in San Diego County.

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³ Racial/Ethnic backgrounds of parents with children ages 0 to 5 are not available with CHIS data.
Language Spoken at Home

The Family Survey was conducted in English and Spanish. There were 883 English language interviews (73.5%) and 319 Spanish language interviews (26.5%). The languages spoken most often at home by Family Survey participants reflect the cultural and linguistic diversity of the county. There were 759 households (63.2%) where English was the language spoken most often and 373 households (31.1%) where Spanish was primarily spoken. There were an additional 69 respondents (5.7%) who indicated speaking a third language most often in the household, and these languages (presented alphabetically, not by prevalence) included: Arabic, Armenian, Chinese, Danish, Finnish, French, German, Gujarati, Hindi, Italian, Japanese, Kannada, Korean, Kurdish, Lao, Marathi, Persian, Portuguese, Punjabi, Russian, Somali, Tagalog, Telugu and Vietnamese.

The map below illustrates the distribution of Spanish-speaking respondent households, as interviewed through the Family Survey, by region. The results are significantly different by region (p ≤ .01).

- More than half (56.7%, n=114) of respondents who lived in the Central Region spoke Spanish most often at home.
- Only 8.2% (n=16) of respondents in the North Central Region and 14.0% (n=28) in the East Region indicated speaking Spanish most often in the home.
Educational Attainment

The educational attainment of Family Survey respondents varied by region (p ≤ .01). The North Central, East and South Regions generally reported higher levels of educational attainment.

<table>
<thead>
<tr>
<th>Region</th>
<th>Not HS Grad</th>
<th>HS or GED</th>
<th>Some College</th>
<th>BA Degree</th>
<th>Graduate Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Coastal</td>
<td>21.9%</td>
<td>14.4%</td>
<td>30.8%</td>
<td>14.4%</td>
<td>18.4%</td>
</tr>
<tr>
<td>North Inland</td>
<td>22.8%</td>
<td>10.9%</td>
<td>26.2%</td>
<td>22.3%</td>
<td>17.8%</td>
</tr>
<tr>
<td>North Central</td>
<td>6.1%</td>
<td>6.1%</td>
<td>30.6%</td>
<td>26.5%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Central</td>
<td>36.3%</td>
<td>16.4%</td>
<td>28.9%</td>
<td>10.9%</td>
<td>7.5%</td>
</tr>
<tr>
<td>East</td>
<td>10.0%</td>
<td>17.0%</td>
<td>44.0%</td>
<td>20.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>South</td>
<td>18.9%</td>
<td>12.9%</td>
<td>40.3%</td>
<td>17.4%</td>
<td>10.4%</td>
</tr>
<tr>
<td>County</td>
<td>19.4%</td>
<td>13.0%</td>
<td>33.5%</td>
<td>18.6%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>


Not a High School Graduate
- 19.4% of county-wide respondents did not have a high school diploma (n=223). The highest percentage (36.3%, n=73) of these respondents resided in the Central Region, followed by the North Inland (22.8%, n= 46) and North Coastal (21.9%, n= 44) Regions.

High School Graduate or GED
- There were 156 county-wide respondents (13.0%) who reported having a high school diploma or GED. With the exception of the North Central Region, the distribution of respondents with a high school diploma or GED was consistent throughout the county.

Some College
- Overall, one-third (33.5%, n=402) of respondents indicated they had some college education but did not complete a bachelor’s degree. The East (44.0%, n=88) and South (40.3%, n=81) Regions showed a higher concentration of these respondents.

Bachelor’s Degree
- 18.7% (n=224) of county-wide respondents had a Bachelor’s degree, with the highest percentage (26.6%, n=52) living in the North Central Region.

Graduate Work
- County-wide, 15.5% (n=186) of respondents had completed at least 1 year of graduate work; the North Central Region had the highest percentage (30.6%, n=60) of these respondents.
Household Size

According to the U.S. Census Bureau, the average household size in 2004 for families with children ages 0 to 18 years old was 3.29 in San Diego County, 3.43 in California and 3.14 in the United States.\(^4\), \(^5\)

Family Survey Findings

The average household size reported in the 2005 Family Survey was 4.51 persons. The table below shows the inverse relationship between the average household size and income category: the more people residing in the household, the lower the annual household income. The average household size is significantly different between each income category.\(^6\)

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Average Household Size</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $25,000</td>
<td>4.97</td>
<td>4.76 - 5.18</td>
</tr>
<tr>
<td>$25,000 to $49,999</td>
<td>4.53</td>
<td>4.36 - 4.70</td>
</tr>
<tr>
<td>$50,000 to $74,999</td>
<td>4.38</td>
<td>4.21 - 4.54</td>
</tr>
<tr>
<td>$75,000 to $99,999</td>
<td>4.09</td>
<td>3.90 - 4.28</td>
</tr>
<tr>
<td>$100,000 or More</td>
<td>4.05</td>
<td>3.91 - 4.20</td>
</tr>
</tbody>
</table>


Household Income

According to the U.S. Census Bureau, the median annual household income in 2004 (inflation-adjusted dollars) was $51,012 in San Diego County, $51,185 in California, and $44,684 in the United States.\(^7\)

Family Survey Findings

In the Family Survey, information about the annual household income was gathered using an income range. Therefore, a median income cannot be reported. The largest percentage (27.5%, n=309) of respondents reported having an annual household income between $25,000 and $49,999. Annual household income by region was statistically significant (p ≤ .01):

\(^4\) The U.S. Census Bureau defines a household as “a household includes all the people who occupy a housing unit as their usual place of residence”.
\(^6\) All categories had significant differences (of at least t ≤ .05) when comparing means through t-tests, except $25,000-$49,999 compared to $50,000-$74,999 and $75,000-$99,999 compared to $100,000+.
Less than $25,000
- 26.2% (n=294) of respondents had annual household incomes of less than $25,000.
- 47.3% (n=87) of respondents who lived in the Central Region earned less than $25,000 annually.

$25,000 to $49,999
- 27.5% (n=309) of respondents had annual household incomes between $25,000 and $49,999.
- 38.2% (n=73) of this group lived in the South Region.

$50,000 to $74,999
- 17.5% (n=197) of respondents reported annual household incomes between $50,000 and $74,999.
- 26.5% (n=49) of these respondents lived in the North Central Region.

$75,000 to $99,999
- 12.3% (n=138) of respondents had annual household incomes between $75,000 and $99,999.
- 18.4% (n=34) of these respondents lived in the North Central Region.

$100,000 or more
- 16.5% (n=185) of respondents reported annual household incomes of $100,000 or more.
- 25.3% (n=46) of respondents living in the North Inland Region earned $100,000 or more.

<table>
<thead>
<tr>
<th>Annual Household Income by Region (n=1,123)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
</tr>
<tr>
<td>North Coastal</td>
</tr>
<tr>
<td>North Inland</td>
</tr>
<tr>
<td>North Central</td>
</tr>
<tr>
<td>Central</td>
</tr>
<tr>
<td>East</td>
</tr>
<tr>
<td>South</td>
</tr>
<tr>
<td>County</td>
</tr>
</tbody>
</table>

Chapter Introduction

Improving child health sets a strong foundation for a child’s readiness for school. Establishing good health outcomes begins before birth with adequate prenatal care. It then extends beyond the narrow confines of what is conventionally thought of as health (e.g., annual physicals, immunizations, and health insurance) to include other elements of child health, such as oral health and hygiene, vision, safe and healthy environments and developmental issues.8

In this section, secondary data collected by other entities related to the San Diego 0 to 5 population is presented on a range of child health and well-being indicators. Whenever available, 2005 Family Survey data is also included.

As outlined in the Commission’s 2004-2009 Strategic Plan, Issue Area 1 pertains to children’s health and focuses on achieving the following:

1. Children are born and stay healthy.
2. Children have access to preventative and comprehensive health care services.
3. Families have the knowledge, skills and resources they need to promote their children’s optimal health.

Chapter Highlights

Survey highlights from this issue area include:

- **Majority of respondents have immunization cards for their child.** Approximately 98.0% of respondents reported that their child had an immunization card and 92.6% indicated that they knew where the card was located.

- **Most survey respondents report breastfeeding.** Overall, 83.4% of survey respondents reported that their children were breastfed at six weeks after birth and 60.2% of respondents indicated that their children were breastfed at six months after birth. All regions exceeded the Healthy People 2010 target of 50.0% breastfeeding at six months.

- **Majority of respondents report healthy children.** Overall, 82.6% of respondents indicated that their children’s health was either very good or excellent. The North Central Region reported the highest percentage of children (93.4%) while the Central (72.9%) and South (79.1%) Regions lagged behind.

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8 Numerous research findings describing the importance of activities supporting children’s physical health were presented in Chapter 1 of the First 5 San Diego 2003-2004 Annual Evaluation Report.
• **Majority of respondents have health insurance however regional disparities exist.** Approximately 91.3% of survey participants had health insurance for their child with the highest rate in the North Central Region (94.9%) and children in the South (88.6%) and Central (86.5%) Regions least likely to be insured.

• **Respondents less likely to have a regular source of care compared to national and state figures.** Overall, 91.2% of respondents indicated their children had a primary care provider. Compared to national (97.5%) and state (97.9%) figures from 2003, the participants in the 2005 Family Survey were less likely to have a regular source of medical care.

• **Over two-thirds reported their child had received a vision exam.** Nearly 70.0% of respondents with children 3 or older reported that their child had received at least one vision exam in their lifetime.

• **Slightly more than half of respondents had taken child for a dental exam.** Approximately 52.8% of respondents reported that their children ages 1 to 5 had received a dental exam in the past 12 months. Over 60.0% of children who did not have health insurance also had not seen a dentist in the past year.

• **Majority indicated that child had received developmental check by health care professional.** Parents and caregivers with a child at least one year old were asked if a doctor or another professional had asked their child to perform activities, such as picking up small blocks, stacking blocks, throwing a ball or recognizing colors. The question was designed to determine whether or not some type of developmental assessment had been conducted. The majority (65.0%) of parents and caregivers indicated their child’s development had been checked by a health care professional. Parents in the Central Region reported the least number of developmental checks (55.6%).

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**Opportunities for Improvement**

While San Diego County fares well compared to state and national health indicators, regional health disparities emerged throughout this report. The Central Region in particular continually lags behind in numerous areas including health insurance enrollment and the percent of children who have received developmental screenings. Notable disparities also exist between English and Spanish-speaking populations, which correlate to regions with higher populations of new immigrants such as the Central, South and North Inland Regions. These areas might benefit most from targeted health services and programs.
Infant Mortality Rate

High infant mortality rates (deaths per 1,000 live births) can be a sign that pregnant women and newborns are not receiving adequate nutrition and medical care. Healthy People 2010 strives to reduce the 1998 national baseline of 7.5 per 1,000 (infant deaths within 1 year of birth) to 4.5 by the year 2010.

Infant mortality rate by race/ethnicity

While overall, San Diego County is in line with the Healthy People 2010 target (at 4.5 in 2004), a significant disparity is revealed when the data is analyzed by race/ethnicity:

- African Americans experience a dramatically higher infant mortality rate (14.4) compared to other racial/ethnic groups (Hispanics, 3.6; Whites, 4.1; Asians, 2.8).
- No county data is available for Native Americans.

This stark contrast in infant mortality rates by race/ethnicity may be an indicator of inequity in access to care.

Babies Born with Low Birth Weight

When babies are born weighing less than 2,500 grams (5.5 pounds), but more than 1,500 grams (3.3 pounds) they are considered to be low birth weight. Low birth weight is considered an important community health indicator and can be associated with long-term disabilities such as cerebral palsy, autism, mental retardation, vision and hearing impairments and other developmental problems. Although the cause is unknown, low birth weight is known to be associated with tobacco, drug and alcohol use by pregnant women. The Healthy People 2010 target for babies born with low birth weight is 5.0% of live births.

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9 An infant is defined as a child less than 1 year of age.
12 Ibid.
Secondary Data

Nationally, live births with low birth weight have gradually increased since 1998 from 7.6% to 7.8% in 2002,\(^{14}\) and in the State of California there has been an increase from 6.1% in 1999 to 6.4% in 2002.\(^{15}\) In San Diego County, the rates of low birth weight babies decreased from 6.0% in 1998 to 5.9% in 1999, but then increased slightly to 6.1% in 2002.\(^{16}\)

Low birth weight by region

Looking at San Diego County low birth weight data, the 1999-2002 average by region was higher in the Central Region (6.9%), followed by North Central (6.2%), East (6.1%), North Coastal (5.9%), and North Inland and South (both 5.7%) Regions of the county.\(^ {17}\)

Low birth weight by race/ethnicity

- In 2002, San Diego County’s Hispanic women had lower rates of low birth weight babies (5.3%) than did White (5.8%), Native American (6.3%), Asian (7.1%), or African American (11.2%) women.\(^{18}\)

- Similar to County findings, in 2002 Hispanic women in California had lower rates of low birth weight babies (5.8%) than did White (6.0%), Native American (5.9%), Asian (7.5%), or African American (11.7%) women.\(^ {19}\)

- At the national level, in 2002 Hispanic women had lower rates of low birth weight babies (6.5%) than did White (6.8%), Native American (7.2%), Asian (7.8%), or African American (13.3%) women.\(^ {20}\)

\(^{14}\) California Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. 2002.


\(^{17}\) Ibid.


Babies Born with Very Low Birth Weight

Infants who are born weighing less than 1500 grams (3.3 pounds) are considered very low birth weight. According to the University of California San Francisco’s Children Hospital, it is difficult to ascertain whether medical conditions of very low birth weight babies are due to their birth weight, or because of premature birth, since both are related. Some conditions prevalent among very low birth weight babies are hypoglycemia, fluid and electrolyte imbalances, neurological problems such as intraventricular hemorrhage, and increased long-term risks for cerebral palsy and other learning disabilities. There is a direct correlation between survivability and birth weight.

Also tied to birth weight is a mother’s postpartum psychological distress. According to one recent study, mothers of very low birth weight infants suffered more psychological distress than mothers of term infants at one month, at two years, and at three years, with the severity of stress positively related to the child's developmental outcomes. The Healthy People 2010 target for babies born with very low birth weight is 0.9% of live births.

Secondary Data

Recent national rates for very low birth weight babies were higher than the state and county rates. Nationally, the rate remained relatively steady at 1.4% in 2000 and 1.5% in 2003. California has had a lower rate than the nation, and remained steady as well at 1.1% in 2000 and 1.2% in 2003. In San Diego County, the very low birth weight rate decreased from 1.3% in 2000 (a rate higher than the State of California) to 1.1% in 2003.

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Live Births to Mothers Receiving Late or No Prenatal Care

A mother and child’s health are intricately related, and the careful monitoring of both by a healthcare professional helps to ensure a healthy birth, a healthy baby, and a healthy mother. Expectant mothers who do not access prenatal care, or do so late in their pregnancy (in or after their second trimester) are at higher risk for health problems both for themselves and their babies. Late or no prenatal care is associated with premature births and the exacerbation of medical conditions that may be treated if diagnosed. The goal for Healthy People 2010 is that at least 90.0% of pregnant women receive prenatal care during the first trimester.24

Secondary Data

Nationally, the number of live births to mothers receiving late or no prenatal care declined from 3.8% in 1999 to 3.6% in 2002.25 In California, the rate declined from 3.2% in 1999 to 2.5% in 2003.26 Overall, the percent of mothers in San Diego County that received late or no prenatal care during the first trimester declined over a five-year period, decreasing from 4.5% in 1999 to 2.4% in 2003.27

Late or no prenatal care by region

- By region in San Diego County, prenatal care in the first trimester during 2002 was highest in the North Central Region (92.0%),28 reaching the goal for Healthy People 2010.
- The Central Region had the lowest percentage (83.7%)29 of women who received prenatal care in the first trimester.

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27 Ibid.
28 Ibid.
29 Ibid.
Late or no prenatal care by race/ethnicity

- A closer look at the prenatal care data by race/ethnicity in San Diego County during 2002 reveals relatively high proportions of first trimester prenatal care across all groups, with the highest rate among White (92.1% - meets Healthy People 2010 target) and Asian American (88.3%) women.\(^{30}\)

- African American (82.6%), Native American (82.3%) and Hispanic/Latino (82.8%) women all had slightly lower rates.\(^{31}\)

**Live Births to Teen Girls Ages 15 to 17**

There are a range of risk factors associated with births to teen mothers. Pregnant teens are more likely to lack access to healthcare, both for themselves and their babies. They also have a higher risk of delivering low birth weight babies. These complications can then negatively impact school attendance and performance for the mother and eventually the child.\(^{32}\) The Healthy People 2010 target for live births to teen girls ages 15-17 is 43 per 1,000.

**Secondary Data**

Since 1998, the rate of teen pregnancy has been declining at the national, state and local levels. The national rate of babies born to teen mothers has decreased from 30.4 per 1,000 in 1998 to 23.2 per 1,000 in 2002.\(^{33}\) California’s rates have also declined from 32.6 per 1,000 in 1998 to 22.9 per 1,000 in 2002, an even greater decrease than the nation over the same time period.\(^{34}\) Likewise, San Diego County has experienced a decline of 29.0 in 1998 to 20.2 per 1,000 in 2002.\(^{35}\)

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\(^{30}\) California Department of Health Services, Center for Health Statistics.  *Birth Statistical Master Files.*  2002.

\(^{31}\) Ibid.


\(^{34}\) California Department of Health Services, Center for Health Statistics.  *Birth Statistical Master Files.*  2002.

\(^{35}\) Ibid.
Live births to teens by region

Considering the county data by region, a three-year average from 1999 to 2001 reveals the Central Region had a significantly higher rate of teen pregnancies (36.1) followed by the South (25.6), North Coastal (19.0), North Inland (15.7), East (15.1) and North Central (7.9) Regions.\textsuperscript{36}

Live births to teens by race/ethnicity

With regard to race/ethnicity data for teen pregnancy in the county, a three-year average from 2001 to 2003 suggests higher teen pregnancy rates for Hispanic mothers (41.9), followed by African American (19.4), Pacific Islander (19.0), Native American (12.2), Multiracial (10.8), Asian (7.2) and White (5.4) mothers.\textsuperscript{37}

\textsuperscript{37} Ibid.
Cigarette Smoking during Pregnancy

Smoking during pregnancy doubles the chances of placental damage, which may lead to complications during birth and increases the likelihood of a low birth weight baby, as well as the onset of respiratory problems such as asthma. Studies also suggest there is a risk of premature birth, which may lead to chronic lifelong disabilities. The Healthy People 2010 target for mothers abstaining from cigarette smoking in the past month during pregnancy is 99.0%.

Secondary Data

The national percentage of women who smoked during pregnancy (11.4%) in 2002 was slightly higher than that of California (9.0%) and San Diego County (8.0%).

Cigarette smoking during pregnancy by race/ethnicity

In California in 2002, White, non-Hispanic women reported the highest rate (14.0%) of smoking during pregnancy followed by African American women (13.0%), Latino (US-born) women (10.0%), Asian/Pacific Islander women (6.0%), and Latino women (not US-born) (2.0%).

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39 The ChildTrends DataBank defines smoking during pregnancy is as at least one cigarette per day during pregnancy.
42 Ibid.
43 Ibid.
Cigarette smoking during pregnancy by parental educational attainment

By educational attainment levels, in California in 2002, the rate of cigarette smoking during pregnancy for mothers who did not complete high school was 11.0%, those who graduated high school was 10.0% and those who completed some college was 12.0%. However, the rate dropped dramatically to 3.0% among women who graduated college.44

Cigarette smoking during pregnancy by annual household income

The data also indicated that as family income increased, the rate of smoking during pregnancy decreased. Reported as a percentage of the federal poverty level,45 the percent of women in California in 2002 who report smoking during pregnancy are:46

- 14.0% of women with incomes within 100% of the federal poverty level
- 9.0% of women with incomes from 101-200% over the federal poverty level
- 9.0% of women with incomes from 201-300% over the federal poverty level
- 5.0% of women with incomes from 301-400% over the federal poverty level
- 5.0% of women with incomes more than 400% of the federal poverty level

Percent of Households in which Someone Smokes

Inhalation of secondhand smoke increases a child’s risk of developing pneumonia, bronchitis, asthma and ear infections.47 In addition, children who watch adults smoke are more likely to smoke themselves. The Healthy People 2010 target for children who are regularly exposed to tobacco smoke at home is not to exceed 27.0%.

There are no reliable data available for the number of young children exposed to cigarette smoke. Nationally, 43.0% of children 2 months to 11 years of age live with at least one parent who smokes.48 Twenty-seven percent (27%) of children aged 6 years and under live in a household where someone smokes inside the house at least 4 days per week.49 Smoking rates in California are historically lower than national rates.50

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49 Ibid.
50 Ibid.
Alcohol Consumption during Pregnancy

Drinking alcohol during pregnancy increases the risk of miscarriage, low birth weight and still birth, as well as a number of birth defects.\(^{51}\) These include mental retardation; learning, emotional and behavioral problems; and defects involving the heart, face and other organs. In general, alcohol-related birth defects (such as heart and facial defects) are more likely to result from alcohol consumption during the first trimester. Drinking at any stage of pregnancy can affect brain growth and development.

The Healthy People 2010 target for pregnant mothers who report abstaining from alcohol consumption in the past month is 94.0% and 100.0% for mothers abstaining from binge drinking in the past month. Therefore, the goal is that only 6.0% of women would report consuming alcohol in the past month and that no one would report binge drinking in the past month.

Secondary Data

In 2002, the national figure for women who drank alcohol at any time during their pregnancy was 10.1%.\(^{52}\) The percentage of women who reported drinking alcohol was higher in California and in San Diego County than the nation, 19.0% and 17.0% respectively.\(^{53}\) However, these data included drinking alcoholic beverages during the first or third trimesters of pregnancy only. Therefore, data may not truly reflect the prevalence of alcohol consumption during pregnancy.

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Alcohol consumption during pregnancy by race/ethnicity (California)

When considering this data from 2002 by race/ethnicity, the rates of alcohol consumption among pregnant women in California differ:\(^{54}\)

- White women reported the highest rate of alcohol use in both the first (22.0%) and third (13.0%) trimesters.
- 17.0% of Hispanic women (U.S.-born) reported alcohol consumption in the first trimester and 5.0% in the third trimester.
- 13.0% of African American women reported alcohol consumption in the first trimester and 6.0% in the third trimester.
- 13.0% of Asian/Pacific Islander women reported alcohol consumption in the first trimester and 4.0% in the third trimester.
- Hispanics (not U.S.-born) reported the lowest alcohol use, with 7.0% drinking in the first trimester and 2.0% in the third trimester.

Alcohol consumption during pregnancy by parental educational attainment

This data indicated that as the educational attainment level of the mother increased, the prevalence of alcohol use increased in 2002:\(^{55}\)

- Women who had at least a college degree reported the highest rates of drinking alcohol during the first (20.0%) and third trimesters (15.0%).
- Women who had some college reported drinking alcohol at the rate of 17.0% in the first and 6.0% in the third trimester.
- Women who had graduated high school reported drinking alcohol at the rate of 13.0% during the first trimester and 3.0% during the third.
- Women who did not graduate high school reported drinking alcohol at the rate of 9.0% during the first trimester and 3.0% during the third.


\(^{55}\) Ibid.
Alcohol consumption during pregnancy by annual household income

The data also showed that as household income increased, the use of alcohol increased. Reported as a percentage of the federal poverty level, the percent of women in California in 2003 who report consuming alcohol during pregnancy are:

- 11.0% of women with incomes within 0-100% of the federal poverty level reported consuming alcohol during the first trimester and 3.0% during the third trimester of pregnancy.
- 15.0% of women with incomes from 101-200% over the federal poverty level reported consuming alcohol during the first trimester and 4.0% during the third trimester of pregnancy.
- 17.0% of women with incomes from 201-300% over the federal poverty level reported consuming alcohol during the first trimester and 6.0% during the third trimester of pregnancy.
- 16.0% of women with incomes from 301-400% over the federal poverty level reported consuming alcohol during the first trimester and 6.0% during the third trimester of pregnancy.
- 20.0% of women with incomes more than 400% of the federal poverty level reported consuming alcohol during the first trimester and 17% during the third trimester of pregnancy.

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Kindergarteners who Completed Recommended Vaccinations

Children that are properly immunized and vaccinated are protected against preventable diseases like measles or diphtheria, both of which are potentially dangerous to a child’s health. When children are not immunized, it is not just them that are at risk; but they also put other children at risk who are not immunized due to medical or belief exemptions. The Healthy People 2010 target for children (ages 19 to 35 months) to receive their recommended vaccinations is 90.0%.

Family Survey Findings

The 2005 Family Survey respondents were not asked about the status of their child’s vaccinations. However, parents and caregivers were asked if their child had an immunization card and if so, if they knew where the card was located. There were 1,174 respondents (98.0%) who indicated that their child had an immunization card. Of those, 1,083 respondents (92.6%) indicated that they knew where the card was located.

Secondary Data

From 2000 to 2004, the proportion of kindergarteners who received their recommended vaccinations (4:3:1 series) slowly increased in the United States from 75.3% in 2000 to 80.0% in 2004. Overall, the percentage in California also increased from 76.3% to 79.0% for the same period. In San Diego County, the proportion of kindergarteners who received their recommended vaccinations remained constant at approximately 78.0%, fluctuating slightly in 2002.

![Completion of Recommended Vaccinations at 24 Months of Age](chart)


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58 This immunization series includes four or more DTP, three or more poliovirus and one or more MMR by the age of two at the time of data collection.
60 Ibid.
61 Ibid.
Children who Received Well-Child Checkups by Age 2

Well-child checkups reduce the incidence of illness and general health problems. Medicaid recommends well-child checkups include a health history; physical examination; assessment of development, nutrition, dental status and immunizations; screening of vision and hearing; blood work; and discussion of health issues and provision of preventive health recommendations. Additional prevention measures, such as immunizations; screenings for anemia, lead, or tuberculosis; dental and nutrition assessment and referrals; and health education for parents, are also part of well-child care. These prevention efforts lead to a reduction in health care costs as the need for treatment of avoidable illness is reduced.

Family Survey Findings

For the 2005 San Diego Family Survey, parents and caregivers were asked how many times in the past 12 months their children had received a well-child checkup. The average number of well-child visits in the past year for children 0-2 in San Diego was 2.66.

Secondary Data

Data from 2002 indicated that the national and state average for the number of well-child visits in the past year for children 0 to 2 years was higher than reported for the County in the 2005 Family Survey. Nationally, the average number of visits was 3.05 visits in the past year. Similarly, in California the average was 3.02 visits.

<table>
<thead>
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<th>Region</th>
<th>Average Visits</th>
<th>95% Confidence Interval</th>
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<tr>
<td>Central</td>
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<td>2.90</td>
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<tr>
<td>East</td>
<td>2.48</td>
<td>2.87</td>
</tr>
<tr>
<td>South</td>
<td>2.46</td>
<td>2.89</td>
</tr>
<tr>
<td>San Diego County</td>
<td>2.66</td>
<td>2.83</td>
</tr>
</tbody>
</table>


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65 Ibid.
67 There was a statistical difference between the North Central and Central regions (t ≤ .05), the North Central and East regions (t ≤ .05), as well as the North Central and South regions (t ≤ .05).
Children Breastfeeding at Six Weeks and Six Months

Given the nutritional, health, immunological and developmental benefits that breast milk provides for infants and children, rates of breastfeeding are an important indicator of child health and well-being. Mother-child bonding during breastfeeding also benefits the psychological well-being of children. Research reveals that infants who are breastfed are less likely to suffer from a variety of health-related ailments and may also experience cognitive and developmental benefits. Further, research has shown a positive association between longer breastfeeding and improved school performance in children and adolescents. Exclusive breastfeeding for the first six months of life provides the most complete form of nutrition, supports optimal growth and development and reduces the incidence of infant illnesses. The Healthy People 2010 target for children breastfeeding at six weeks is 75.0% and at six months is 50.0%.

Family Survey Findings

Parents and caregivers who participated in the Family Survey were asked if their child was breastfed at all (not necessarily exclusively) when the child was 6 weeks and 6 months of age.

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Breastfeeding at six weeks

Overall, 83.4% (n=985) of respondents reported that their children were breastfed at six weeks after birth. By region, there were no statistically significant differences; however, all regions exceeded the Healthy People 2010 goal.

Breastfeeding at six months

Overall, 60.2% (n=668) of respondents indicated that their children were breastfed at six months after birth. All regions exceeded the Healthy People 2010 target of 50.0% breastfeeding at six months of age. However, regional findings were not statistically significant.

Secondary Data

Breastfeeding at six weeks

State and national comparison data on breastfeeding at six weeks are scarce. Data are primarily collected at hospital discharge or at six months. Thus, the 2005 Family Survey data for children breastfeeding at 6 weeks will prove invaluable when comparison analyses are conducted after the next survey administration.

Breastfeeding at six months

The proportion of children who were breastfeeding at six months at the county, state and national levels as reported in 2004 were lower than the rates found in the 2005 Family Survey (48.1%, 45.1% and 36.2%, respectively).72

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Child’s Overall Health Rating by Parents and Caregivers

Studies show that children’s observed health is closely related to how their health is rated by their parents. Children whose parents report them to be in fair to poor health are likely to have significant health problems that limit their daily activities and require a significant amount of medical attention.73, 74, 75 Children who are healthy are better able to focus in school, engage in learning and are less likely to miss school due to health or medical problems.76

Family Survey Findings

Overall, 82.6% (n=990) of respondents indicated that their children’s health was either very good or excellent.

Parental rating of overall child health by region

The North Central Region reported the highest percentage of children (93.4%, n=183) who were in excellent or very good health, followed by East (87.5%, n=175), North Coastal (82.1%, n=165), and North Inland (81.1%, n=163) Regions. The Central (72.9%, n=145) and South (79.1%, n=159) Regions lagged behind (p ≤ .01).

Secondary Data

Parent and caregiver respondents of the 2005 Family Survey rated their child’s health slightly less favorably than a 2003 national sample (85.9%), yet better than a 2003 state sample 73.8%).77, 78

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Children with Health Insurance

Health insurance is an important indicator of access to healthcare. Families without health insurance are more likely to either delay care for their children or obtain care through hospital emergency departments or other expensive locations. The Healthy People 2010 target for people (all ages) with health insurance is 100.0%.

Family Survey Findings

According to the 2005 Family Survey findings, approximately 91.3% (n=1,095) of survey participants had health insurance for their child. There were statistically significant differences by region (p ≤ .05).

![Child has Health Insurance by Region](chart)

The North Central Region reported the highest percentage of children (94.9%, n=185) who had health insurance, followed by North Coastal (93.6%, n=189), East (92.5%, n=185), and North Inland (92.0%, n=185) Regions. Children in the South (88.6%, n=178) and Central (86.5%, n=173) Regions were the least likely to have health insurance.

Secondary Data

The 2005 Family Survey health insurance findings were consistent with the national rate (91.3%, as reported in 2000) but slightly lower than the rate for California (95.7%, as reported in 2003). In 2002, it was estimated that 85.0% of San Diego County’s households with children 0 to 18 had health insurance. Additionally, the Central (75.0%) and South (81.0%) Regions experienced the lowest rates of health insurance.

Children with a Primary Healthcare Provider

Women and children who have a medical home are less likely to use the emergency room and are more likely to obtain appropriate care for chronic conditions and have their immunizations up-to-date. \(^ {83, 84, 85}\) Having an ongoing relationship with a health provider can help improve health outcomes for women and children who may have chronic illnesses or risk behaviors. The Healthy People 2010 target for children under the age of 18 with a specific source of ongoing care is 97.0%.

Family Survey Findings

Overall, 91.2% (n=1,093) of respondents indicated their children had a primary care provider. Compared to national (97.5%) and state (97.9%) figures from 2003, the participants in the 2005 Family Survey were less likely to have a regular source of medical care. \(^ {86, 87}\) The findings were not statistically significant by region; however they are noteworthy in comparison to secondary data, as seen below.

Secondary Data

In 2002, 86.0% of San Diego County households with children 0 to 18 reported having primary healthcare providers. Additionally, the Central (77.0%) and South (82.0%) Regions reported the lowest percentages at that time. \(^ {88}\)

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Children who Received a Vision Exam

Many vision problems begin before children start school. Healthy Vision 2010 recommends that children receive a vision screening exam before they are five years old. Early recognition of a vision-related disease results in more effective treatment that can be sight-saving and even life-saving.\(^{89}\) The Healthy People 2010 target for children that have had a vision screening is 52.0%.

Family Survey Findings

In the 2005 Family Survey, parents or caregivers of children ages 3 or older were asked if their child had ever had a vision exam. Over two-thirds (69.1%) of respondents with children 3 or older (n=427) reported that their child had had their vision checked at least once in their lifetime, thus exceeding the Healthy People 2010 goal.

By region, the findings were not significantly different.

The North Central Region had the highest rate (74.4%, n=67), while the North Inland Region had the lowest (59.4%, n=63).

Vision exam by age of child

The percentage of children that received a vision screening increased with age (p ≤ .01):

- 52.8% (n=105) of 3-year olds
- 76.6% (n=134) of 4-year olds
- 77.3% (n=160) of 5-year olds

Vision exam by language spoken in the home

Over three-fourths (76.0%, n=291) of English-speaking respondents reported their children had received a vision exam, compared to more than half (57.7%, n=112) of Spanish-speaking respondents and respondents who spoke other languages (58.5%, n=24) (p ≤ .01).

Vision exam by parental educational attainment

As the educational attainment of respondents increased, the percentage of children who had received vision exams also increased (p ≤ .01):

- 56.5% of parents or caregivers (n=74) that did not graduate high school or receive a GED reported that their child had received a vision exam.
- 78.6% of parents or caregivers (n=66) that completed some graduate school work reported that their child had received a vision exam.

Vision exam by annual household income

The percentage of children who received a vision exam categorized by annual household income had statistically significant differences (p ≤ .01):

- 56.8% (n=79) of those with annual household income of less than $25,000
- 69.5% (n=121) of those with annual household income of $25,000 to $49,999
- 81.4% (n=83) of those with annual household income of $50,000 to $74,999
- 68.1% (n=49) of those with annual household income of $75,000 or more.
- 74.5% (n=73) of those with annual household income of $100,000 or more.

Average months since last vision exam

The 2005 Family Survey also asked parents and caregivers the amount of time that had passed since their child’s last vision exam. Those who reported their child had not had a vision screening were not included in this analysis. The average number of months since the last vision screening for children ages 3 to 5 was 7.13.

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<thead>
<tr>
<th>Region</th>
<th>Average Months</th>
<th>95% Confidence Interval</th>
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<tr>
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<td>East</td>
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<tr>
<td>South</td>
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<tr>
<td>San Diego County</td>
<td>7.13</td>
<td>6.48</td>
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</table>


Average months by other variables

There were no statistically significant differences in the average number of months since the last vision exam between different racial/ethnic backgrounds, educational attainment level, annual household income, gender of child, or age groups.

Secondary Data

A search for comparison data on vision screenings did not yield secondary sources. Therefore, collection of vision screening data at a county level serves as a critical baseline and should prove invaluable for anticipating the vision needs of children ages 3 to 5.
Children who Received a Dental Exam

The American Academy of Pediatrics recommends dental screenings for children beginning at 12 months of age. Annual dental exams provide children with preventive care and facilitate early diagnosis and treatment of oral problems.\(^{90}\) In combination with good dental health practices, regular professional preventive care can reduce the chance of dental caries and their consequences. Untreated dental problems can interfere with diet, nutrition and sleep. In addition, children’s self-image, concentration, as well as school attendance and performance, can be adversely affected by chronic dental problems.\(^{91}\) The Healthy People 2010 target for children ages 2 and older that use the oral health care system each year is 56.0%.

Family Survey Findings

For the 2005 San Diego Family Survey, 52.8% (n=537) of respondents’ children ages 1 to 5 years old had received a dental exam in the past 12 months. By region, the findings were not significantly different. One significant finding, however, was that 60.2% of children (n=56) who did not have health insurance also had not seen a dentist in the past year (p ≤ .01).

Secondary Data

The national and state data were computed using the National Survey of America’s Families (NSAF) online statistical analysis tool.\(^{92}\) The percentage of children ages 1 to 5 who received a dental exam in the past year was about the same for the nation in 2002 (52.2%) as reported for San Diego County (52.8%) in the 2005 Family Survey; while California’s 2002 rate was slightly lower (49.8%).

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Children who Received a Developmental Assessment

Early identification of and intervention for children with special needs is important for enhancing development. 93 Several studies document the positive effects of special early interventions for infants, toddlers, and preschoolers with disabilities or at risk of disabilities. In addition, research indicates that it is cost-effective to initiate interventions for children with special needs as early as possible. 94

Family Survey Findings

Parents and caregivers with a child at least one year old were asked in the Family Survey if a doctor or another professional had asked their child to perform activities, such as picking up small blocks, stacking blocks, throwing a ball or recognizing colors. The question was designed to determine whether or not some type of developmental assessment had been conducted. The majority (65.0%, n=643) of parents and caregivers indicated their child’s development had been checked by a health care professional.

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Developmental assessment by region

Parents in the Central Region reported the least number of developmental checks (55.6%, n=95) compared to 76.7% (n=132) in the North Coastal Region (the highest in the county) (p ≤ .01). All other regions were around the county average of 65%.

Developmental assessment by age of child

The percentage of children who received a developmental check increased until age four, then dropped at age five (p ≤ .01):

- 42.8% (n=71) of 1-year olds
- 55.8% (n=101) of 2-year olds
- 66.5% (n=145) of 3-year olds
- 81.5% (n=141) of 4-year olds
- 74.9% (n=152) of 5-year olds

Developmental assessment by language spoken in the home

The proportion of Spanish-speaking respondents who reported that their child had received a development check (58.5%, n=186) was significantly lower than English-speaking respondents (68.2%, n=418) and those who spoke languages other than English or Spanish (68.4%, n=39) (p ≤ .01).

Developmental assessment by parental educational attainment

The relationship between children’s developmental checks and the educational attainment of respondents was significant (p ≤ .05). The proportion of respondents whose children had received developmental checks generally increased with the respondent’s education level:

- 58.7% (n=122) of respondents who did not complete high school stated their child had received a developmental assessment
- 64.8% (n=81) of those who completed high school or GED
- 63.1% (n=205) of those who completed some college
- 72.6% (n=135) of those who completed a 4-year college degree
- 68.8% (n=99) of those who completed some graduate work

Developmental assessment by annual household income

The relationship between annual household income and respondents who stated their child had received a development check was significant (p ≤ .01):

- 57.7% (n=139) of respondents who earned less than $25,000 reported that their child had received a developmental assessment
- 60.9% (n=159) of those who earned $25,000 to $49,999
- 70.3% (n=111) of those who earned $50,000 to $74,999
- 64.5% (n=71) of those who earned $75,000 to $99,999
- 74.5% (n=117) of those who earned $100,000 and more
Length of time since last developmental check

Parents and caregivers were asked how many months it had been since their child had had their last developmental check (n=630). Overall, 85.1% (n=536) of parents indicated the length of time was within the last 12 months. Of the 14.9% (n=94) of children who had checks more than 12 months ago, approximately 69.1% (n=65) had received a developmental check in the past 24 months, 19.1% (n=18) were in the past 36 months and the remaining 11.7% (n=11) were more than 37 months ago. The average length of time since the most recent development check was 8.24 months. There were no significant differences in the length of time by region.

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Months</th>
<th>95% Confidence Interval</th>
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</tr>
<tr>
<td>San Diego County</td>
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<td>7.51</td>
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Length of time by age of child

As the child aged, a longer amount of time had elapsed since the last development check, as follows:95

- 3.87 months (n=68) for 1-year olds since the last assessment
- 6.77 (n=100) for 2-year olds
- 8.13 (n=142) for 3-year olds
- 9.30 (n=138) for 4-year olds
- 10.45 (n=149) for 5-year olds

Length of time by race/ethnicity

The average length of time since the last developmental check was 8.94 months (n=296) for White/Caucasian children and 7.24 months (n=248) for Hispanic/Latino children (t ≤ .05). No other significant differences were found between racial/ethnic groups.

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95 T test findings were statistically significant (t ≤ .05) by age, except between 2-year and 3-year olds, 3-year and 4-year olds, 3-year and 5-year olds and 4-year and 5-year olds.
Length of time by language spoken in the home

There were significant differences between the length of time since the last developmental check and those who spoke English and Spanish most often at home ($t \leq .01$). For those who spoke other languages, there was no significance difference.

- English-speaking households (n=410) averaged 8.87 months.
- Spanish-speaking households (n=181) averaged 6.71 months.
- Households with other languages spoken in the home (n=39) averaged 8.72 months.

Length of time by parental educational attainment

There was a significant difference ($t \leq .05$) in the average length of time since the developmental check for children whose parents did not finish high school (6.74 months, n=118) and those who obtained a 4-year college degree (9.38 months, n=133). No other significant differences between educational attainment levels were found.
Chapter Introduction

In the first five years of a child’s life, parents establish the foundation for their child’s potential and directly impact the course of their social-emotional health and cognitive development. Children’s cognitive and social-emotional development plays a key role in school readiness.96

Issue Area 2 of the First 5 San Diego strategic plan articulates the Commission’s goals, objectives and strategies for supporting children’s social-emotional health and development. The key indicators for this Issue Area include:

1. Children have access to quality services that promote their early learning
2. Children are socially and emotionally healthy
3. Children are cognitively developing appropriately
4. Families have the knowledge and skills they need to support their children’s learning and social-emotional health

This section of the report summarizes a variety of learning, parent involvement and social-emotional indicators gathered through the 2005 Family Survey.

Chapter Highlights

Survey highlights from this issue area include:

- **Overall, children watch more television as they age.** According to respondents in the Family Survey, children in the 3 to 6 year old age group watched significantly more television than children 1 to 2 years of age.

- **Children in non-English speaking households watch less television.** Children in English-speaking households were more likely to watch more television compared to children living in households where other languages are spoken.

- **Participation in daily family activities varies by region.** Parents and caregivers participate in the lives of their children on a daily basis however the Family Survey reveals significant differences across the San Diego Region. County-wide, over 65% of respondents reported reading stories to their children on a daily basis. However, in the Central Region approximately 52.0% of parents/caregivers read or showed books to their children daily.

96 Numerous research findings describing the importance of activities supporting children’s learning and social-emotional health were presented in Chapter 2 of the First 5 San Diego 2003-2004 annual Evaluation Report.
- **The vast majority of County’s children have a bed-time routine.** The Family Survey reveals that almost 80.0% of children have a regular bed-time routine, however differences exist between regions. For example, children living in the Central Region (70.0%) were less likely to have a regular routine, compared to children in the North Central Region (86.0%).

- **Parents of single-child households are more likely to participate in the daily activities.** While children with siblings are more likely to interact with other children, they experience less interaction with their parents than children without siblings. For example, 70.7% of respondents reported reading or showing books to their only child, compared to 62.8% of parents with multiple children.

- **Low-income households tend to be less involved in daily family activities.** The results of the Family Survey suggest that parents with household incomes under $25,000 are less likely to be involved in daily activities with their children.

- **Parents in English-speaking households participate in daily activities at higher rates.** In all childhood activities included in the survey, parents in English-speaking households were more likely to participate in daily activities. For example, 65.3% of English speakers reported singing songs to their child daily compared to 43.3% of Spanish speakers.

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**Opportunities for Improvement**

As previously mentioned, limited population-based data is currently available for indicators related to children’s learning and social-emotional health. Thus, the 2005 Family Survey provides an opportunity to pilot questions and collect baseline data.

Similar to the Children’s Health Issue Area, differences were noted between English and non-English speaking populations as well as geographic regions. For example, parents and caregivers in the Central Region and lower-income households were less likely to participate in daily activities with their children and less likely to impose bed-time routines.
Children who have Access to Resources that Promote Early Learning

Reading to children enhances language, literacy and interpersonal skills, all of which are critical to a child’s preparation for school.\(^{97}\) Taking time to read with a child can also encourage positive parent-child interactions, an essential component of social-emotional development.\(^{98}\)

**Family Survey Findings**

Overall, 65.1\% of parents and caregivers (n=781) indicated reading stories daily to their children.

**Parents who Read to Their Child Daily by Region**

There was a significant difference in the number of parents and caregivers who reported reading to their child daily by region (p ≤ .01):

- Respondents in the North Central Region reported the highest percentage of reading to children daily (75.0\%, n=147)
- The Central Region had the lowest percentage of daily reading to children (51.7\%, n=104)

**Secondary Data**

In comparison, 52.0\% of parents nationwide reported reading to their children daily in 2000.\(^{99}\) In 2003, 52.5\% of California parents reported reading to their children daily.\(^{100}\)

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Children who Exhibit Age-Appropriate, Self-Soothing and Self-Regulation Behaviors

Self-regulation skills form the basis of many of the behaviors that are related to a successful transition to school.\textsuperscript{101} Furthermore, kindergarten teachers consider a child’s ability to self-regulate as essential and very important to school readiness.\textsuperscript{102}

Family Survey Findings

In order to assess the child’s self-soothing and self-regulation abilities, parents and caregivers were asked a series of questions regarding their child’s behavior. Because children develop certain behavioral skills at specific ages, only respondents with children 12 months or older were asked these questions. Respondents that stated they did not witness their children with others also skipped these questions. Below are the questions from the Family Survey:

\begin{itemize}
  \item \textbf{Throw temper tantrums when (he/she) doesn’t get (his/her) way?}
  \item \textbf{Hit, kick or bite others when (he/she) is angry?}
  \item \textbf{Use words to say how (he/she) is feeling?}
  \item \textbf{Calm himself/herself down when (he/she) is angry or sad?}
  \item \textbf{Use words to say what (he/she) wants?}
\end{itemize}

For each question, the majority of parents stated their children were on equal footing or ahead of other children of the same age in regard to their self-soothing and self-regulation behaviors. However, due to the nature of the questions, many parents may have felt uncomfortable stating their children displayed unfavorable behaviors.

\begin{figure}
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\includegraphics[width=\textwidth]{chart}
\caption{Child Actions Compared to Other Children of the Same Age - Children 1 to 5}
\end{figure}


Children who Exhibit Social Competence with their Parents and Other Children

A young child’s ability to get along with other children and adults is of great importance to his or her future success in school and beyond. Some experts cite how well a child gets along with other children as "the single best childhood predictor of adult adaptation." The benefits of practicing social skills extend to children’s interactions with adults as well. The child who plays, talks, resolves disagreements, and collaborates with peers and adults strengthens his or her social competence and is therefore more likely to have better mental health, stronger relationships, and more success in school and work.

Family Survey Findings

If the child was at least one year old, parents and caregivers were asked how well their child got along with other children and adults compared to other children the same age. As with self-soothing and self-regulation behaviors, the majority of parents and caregivers stated that their children behaved better than, or the same as the average child. However, also as mentioned earlier, the reader should consider that social desirability might constitute an inherent factor within the responses.

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107 Ibid.
**Daily Family Activity Participation**

Parents have a direct impact on the progress of their child’s cognitive development, because children learn about language through speech they hear and the activities they engage in at home. The development of language and reading skills is fundamental to a child's academic success, as well as success throughout life. Children need to have reached a certain level of cognitive development prior to entering kindergarten, as research has shown increasingly stringent expectations for academic excellence from children at a younger age.108

**Family Survey Findings**

Parents were asked to indicate the frequency with which they engaged in five different activities with their children. Overall, most parents (79.1%, n=945) stated that they participated in a daily bedtime routine with their child. Another two-thirds of parents (65.1%, n=781) reported reading or showing books to their child daily.

![Daily Family Participation Chart](chart.png)


**Daily family activities by region**

In looking at each childhood activity where results were statistically significant, the Central Region had the lowest level of daily parental participation. In most cases, the North Central Region had the greatest amount of daily parental participation. However, not all activities yielded statistically significant differences. In some instances, there were too few cases to be statistically reliable.

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Parents sing songs to their children

With the exception of the Central Region, the majority of parents and caregivers indicated singing songs to their child on a daily basis. These findings are statistically significant (p ≤ .01).

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<thead>
<tr>
<th>Parents Sing Songs to Their Children by Region (n=1,200)</th>
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<td>Region</td>
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<tr>
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<td>San Diego County</td>
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Differences between regions are statistically significant (p ≤ .01).  

Parents read or show books to their children

The majority of parents and caregivers indicated reading books to their children. Respondents in the Central Region indicated reading or showing books to their children less often (51.7%, n=104) than those living in other regions. The North Central Region had the largest percentage (75.0%, n=147) of respondents who read daily to their child. The findings are statistically significant (p ≤ .01).

<table>
<thead>
<tr>
<th>Parents Read or Show Books to Their Children by Region (n=1,199)</th>
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<tr>
<td>San Diego County</td>
</tr>
</tbody>
</table>

Differences between regions are statistically significant (p ≤ .01).  
Parents tell stories to their children

The distribution of responses by parents who tell stories to their children was more consistent across regions than that of singing songs and reading. However, the disparity in responses between the Central and North Central Regions remained constant. There were more parents and caregivers (52.6%, n=102) who indicated telling stories to their children daily in the North Central Region than in the Central Region (29.3%, n=58). The findings were statistically significant (p ≤ .01).

<table>
<thead>
<tr>
<th>Parents Tell Stories to Their Children by Region (n=1,191)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>North Coastal</td>
</tr>
<tr>
<td>North Inland</td>
</tr>
<tr>
<td>North Central</td>
</tr>
<tr>
<td>Central</td>
</tr>
<tr>
<td>East</td>
</tr>
<tr>
<td>South</td>
</tr>
<tr>
<td>San Diego County</td>
</tr>
</tbody>
</table>

Differences between regions are statistically significant (p ≤ .01).


Parents who take their children outside to walk or play

The table below illustrates the frequency in which parents walked or played with their children outside by region, with the North Coastal and North Central Regions reporting the highest levels of daily outside activity with their children. There were significant differences by region (p ≤ .01).

<table>
<thead>
<tr>
<th>Parents who Take Their Children Outside to Walk or Play by Region (n=1,200)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>North Coastal</td>
</tr>
<tr>
<td>North Inland</td>
</tr>
<tr>
<td>North Central</td>
</tr>
<tr>
<td>Central</td>
</tr>
<tr>
<td>East</td>
</tr>
<tr>
<td>South</td>
</tr>
<tr>
<td>San Diego County</td>
</tr>
</tbody>
</table>

Differences between regions are statistically significant (p ≤ .01), with 6 cells with counts less than expected.

Children follow a regular bedtime routine

Although 79.1% (n=945) of the county’s children follow a daily bed-time routine, statistically significant differences (p ≤ .01) exist between regions as illustrated below.

<table>
<thead>
<tr>
<th>Region</th>
<th>Not At All</th>
<th>1-2 Times a Week</th>
<th>3-6 Times a Week</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Coastal</td>
<td>4.0%</td>
<td>4.5%</td>
<td>12.9%</td>
<td>78.7%</td>
</tr>
<tr>
<td>North Inland</td>
<td>3.0%</td>
<td>2.0%</td>
<td>12.0%</td>
<td>83.0%</td>
</tr>
<tr>
<td>North Central</td>
<td>4.1%</td>
<td>1.6%</td>
<td>8.3%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Central</td>
<td>7.5%</td>
<td>9.5%</td>
<td>13.0%</td>
<td>70.0%</td>
</tr>
<tr>
<td>East</td>
<td>3.5%</td>
<td>3.5%</td>
<td>14.6%</td>
<td>78.4%</td>
</tr>
<tr>
<td>South</td>
<td>5.5%</td>
<td>4.5%</td>
<td>11.4%</td>
<td>78.6%</td>
</tr>
<tr>
<td>San Diego County</td>
<td>4.6%</td>
<td>4.3%</td>
<td>12.1%</td>
<td>79.1%</td>
</tr>
</tbody>
</table>

Differences between regions are statistically significant (p ≤ .01).


Daily family activities by race/ethnicity

Looking at parental involvement and frequencies in childhood activities with regard to racial and ethnic background provided significant differences. However, due to small sample size of certain racial/ethnic groups, these data must be viewed with caution.

Sing Songs

- Almost three-fourths (74.2%, n=46) of African Americans reported singing songs to their child daily, compared to only half of American Indians (50.0%, n=7)\(^{109}\) and Hispanic/Latinos (50.4%, n=253)\(^{110}\).

Read or Show Books

- Just over half (52.6%, n=263) of Hispanic/Latinos reported reading or showing books to their child daily, compared to over three-fourths of White/Caucasians (77.4%, n=410)\(^{111}\).

Tell Stories

- Over half of White/Caucasians (55.8%, n=294) and African Americans (52.5%, n=32) reported telling stories to their child daily, compared to only about one-quarter (26.3%, n=131) of Hispanic/Latinos\(^{112}\).

Walk or Play Outside

- Almost 60% of White/Caucasian (59.8%, n=317) and American Indian (57.1%, n=8)\(^{113}\) respondents reported taking their children outside daily to walk or play, compared to only 35.1% (n=27) of Asian/Pacific Islanders\(^{114}\).

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\(^{109}\) Statistically significant at (p ≤ .01), with 9 cells with counts less than expected

\(^{110}\) Statistically significant at (p ≤ .01), with 9 cells with counts less than expected

\(^{111}\) Statistically significant at (p ≤ .01), with 7 cells with counts less than expected

\(^{112}\) Statistically significant at (p ≤ .01), with 9 cells with counts less than expected

\(^{113}\) Due to sample size, caution should be taken when considering the validity of the data on American Indians.

\(^{114}\) Statistically significant at (p ≤ .01), with 9 cells with counts less than expected
Regular Bedtime Routine

- About 70% of Hispanic/Latinos (71.2%, n=356) reported that their children followed a regular bed-time routine, compared to about 90% of American Indians (92.9%, n=13)115 and White/Caucasians (86.8%, n=459).116

Daily family activities by language of interview

When family activities were considered by the language in which the interview was conducted (i.e., English or Spanish), significant differences emerged in the analyses.117

Sing Songs

- 65.3% (n=575) of those who spoke English during the interview reported singing songs to their child daily, compared to 43.3% (n=138) of those who spoke Spanish (p ≤ .01).
- 8.8% (n=28) of Spanish speakers reported they never sang to their child.

Read or Show Books

- 71.9% (n=633) of those who spoke English during the interview reported reading or showing books to their child daily, compared to 46.4% (n=148) of those who spoke Spanish (p ≤ .01).

Tell Stories

- Only 18.0% (n=57) of those whose survey was conducted in Spanish reported telling stories to their children daily, compared to 51.0% (n=446) of those who responded to the survey in English (p ≤ .01).
- 20.8% (n=66) of Spanish speakers reported that they never tell stories to their children.

Walk or Play Outdoors

- One-third (n=106) of those who spoke Spanish during the interview reported taking their children outside to walk or play daily, compared to over half (54.4%, n=480) of the English speakers (p ≤ .01).

Regular Bedtime Routine

- Over two-thirds (69.9%, n=223) of those whose survey was conducted in Spanish reported their children follow a regular bed-time routine every night, compared to 82.4% (n=722) of those who were interviewed in English (p ≤ .01).

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115 Due to sample size, caution should be taken when considering the validity of the data on American Indians.
116 Statistically significant at (p ≤ .01), with 11 cells with counts less than expected
117 Analysis of daily family activities by language spoken at home was conducted. However, the sample sizes for those who speak another language were too small to generate valid results. Therefore, the language of the interview was used in the analysis.
**Daily family activities by number of children in household**

Over one-quarter (29.4%, n=353) of Family Survey respondents had only one child in the household, while the remaining respondents indicated multiple children.

There were significant differences in regard to childhood activities between children that have siblings and those that do not (p ≤ .01):

- Single children were more likely to have their parents participate in activities compared to children with siblings.

Below are the childhood activities, along with the percent of parents who participated in such activities:

**Sing songs daily**
- 71.9% (n=253) of single children, compared to 54.2% (n=460) of children with siblings (p ≤ .01).

**Read or show books daily**
- 70.7% (n=249) of single children, compared to 62.8% (n=531) of children with siblings (p ≤ .05).

**Tell stories daily**
- 51.9% (n=180) of single children, compared to 38.2% (n=322) of children with siblings (p ≤ .01).

Some childhood activities were not significantly different depending on the number of children in the household.

**Walk or Play Outdoors**
- 49.1% (n=173) of single children and 48.6% (n=412) of children with siblings went outside to walk or play with their parents on a daily basis.

**Regular Bedtime Routine**
- 82.1% (n=288) of single children and 77.8% (n=656) of children with siblings followed a daily regular bedtime routine.
Daily family activities by annual household income

When household income was taken into account, several childhood activities yielded statistically significant differences. With larger sample sizes, findings based on income are more reliable than those based on racial/ethnic background. For activities that were significantly different, those in the income category of under $25,000 were least likely to report daily participation.

Sing Songs
- 9.9% (n=29) of respondents who reported less than $25,000 in annual household income indicated they never sing songs to their children (p ≤ .01).
- Half (50.7%, n=149) of respondents who reported less than $25,000 in annual household income reported singing songs daily, compared to 70.3% (n=137) of those in the range of $50,000 to $74,999.

Read or Show Books
- Over 80% of those with annual household incomes of $75,000 to $99,999 (83.9%, n=115) reported reading or showing books to their children daily, compared to only 50.0% (n=147) of those with under $25,000 in annual household income.118

Tell Stories
- 61.3% (n=84) of respondents with an income of $75,000 to $99,999 reported telling stories to their children daily, compared to only 26.1% (n=76) of those with less than $25,000 (p ≤ .01).
- 16.8% (n=49) of those with less than $25,000 and 12.0% (n=37) of those with $25,000 to $49,999 reported they never tell stories to their children.

Walk or Play Outdoors
- Half of each income category group over $50,000 reported taking their children outside to walk or play daily ($50,000-$49,000 = 57.1%, n=112; $75,000-$99,000 = 58.7%, n=81; and $100,000+ = 57.8%, n=107).
- Only 38.8% (n=114) of those with annual incomes of less than $25,000 reported participating in this activity daily.119

Regular Bedtime Routine
- Almost three-quarters of respondents in all income categories reported that their children have a regular bedtime routine (p ≤ .01).
- 74.1% (n=217) of respondents in the lowest income category (under $25,000) reported that their children have a regular bedtime routine.
- 87.0% (n=161) of those in the highest income category ($100,000 or more) reported that their children have a regular bedtime routine.

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118 Statistically significant at (p ≤ .01), with 1 cell with a count less than expected
119 Statistically significant at (p ≤ .01), with 3 cells with counts less than expected
Daily Opportunities for Children to Play, Write or Draw

Parents and caregivers with a child at least one year old were asked how often their child had the opportunity to play with other children. Parents and caregivers with a child at least three years old were asked how often their child had opportunities to draw or write. More than half (52.2%, n=535) of parents indicated their child had opportunities to play with other children on a daily basis. Nearly three-fourths (73.8%, n=470) of parents indicated that their child had daily opportunities to write or draw. Findings were not significant due to the reduced number of responses based on the age of the child.

Children have opportunities to play with other children by region

Regardless of the region, about half of the respondents indicated their children have opportunities to play with others on a daily basis.

<table>
<thead>
<tr>
<th>Region</th>
<th>Not At All</th>
<th>1-2 Times a Week</th>
<th>3-6 Times a Week</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Coastal</td>
<td>2.2%</td>
<td>15.6%</td>
<td>29.6%</td>
<td>52.5%</td>
</tr>
<tr>
<td>North Inland</td>
<td>1.2%</td>
<td>17.9%</td>
<td>31.2%</td>
<td>49.7%</td>
</tr>
<tr>
<td>North Central</td>
<td>3.2%</td>
<td>18.4%</td>
<td>29.1%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Central</td>
<td>2.9%</td>
<td>19.4%</td>
<td>25.7%</td>
<td>52.0%</td>
</tr>
<tr>
<td>East</td>
<td>2.9%</td>
<td>16.4%</td>
<td>29.8%</td>
<td>50.9%</td>
</tr>
<tr>
<td>South</td>
<td>1.8%</td>
<td>17.8%</td>
<td>21.9%</td>
<td>58.6%</td>
</tr>
<tr>
<td>San Diego County</td>
<td>2.3%</td>
<td>17.6%</td>
<td>27.9%</td>
<td>52.2%</td>
</tr>
</tbody>
</table>

Differences between regions are not statistically significant.

**Children have opportunities to write or draw by region**

Most respondents with children over age 3 in all regions indicated that their children have opportunities to write or draw on a daily basis.

<table>
<thead>
<tr>
<th>Region</th>
<th>Not At All</th>
<th>1-2 Times a Week</th>
<th>3-6 Times a Week</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Coastal</td>
<td>0.0%</td>
<td>3.4%</td>
<td>22.2%</td>
<td>74.4%</td>
</tr>
<tr>
<td>North Inland</td>
<td>0.0%</td>
<td>4.6%</td>
<td>21.1%</td>
<td>74.3%</td>
</tr>
<tr>
<td>North Central</td>
<td>1.1%</td>
<td>8.6%</td>
<td>15.1%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Central</td>
<td>0.9%</td>
<td>7.4%</td>
<td>19.4%</td>
<td>72.2%</td>
</tr>
<tr>
<td>East</td>
<td>0.0%</td>
<td>3.8%</td>
<td>19.8%</td>
<td>76.4%</td>
</tr>
<tr>
<td>South</td>
<td>1.0%</td>
<td>4.8%</td>
<td>24.0%</td>
<td>70.2%</td>
</tr>
<tr>
<td>San Diego County</td>
<td>0.5%</td>
<td>5.3%</td>
<td>20.4%</td>
<td>73.8%</td>
</tr>
</tbody>
</table>

Differences between regions are not statistically significant.


**Opportunities to play, write/draw by race/ethnicity**

42.2% (n=27) of Asian/Pacific Islanders reported that their children had opportunities to play with others, compared to over 50% of all other racial/ethnic groups. 120

**Opportunities to play, write/draw by language of interview** 121

- Although significantly different, about half of Spanish-speaking (48.7%, n=135) and English-speaking (53.5%, n=400) respondents reported their children have opportunities to play with others on a daily basis (p ≤ .01).

- 77.6% (n=367) of English-speaking respondents reported their children have opportunities to write or draw, compared to 62.8% (n=103) of Spanish-speaking respondents. 122

**Opportunities to play, write/draw by families with one child**

- 57.9% (n=438) of respondents that had multiple children stated their child has opportunities to play with others daily, compared to only 35.8% (n=96) of those with only one child (p ≤ .01).

- 78.0% (n=99) of parents with one child and 72.7% (n=370) of those with multiple children stated their child has opportunities to write or draw.

120 Statistically significant at (p ≤ .01), with 9 cells with counts less than expected
121 Analysis of daily family activities by language spoken at home was conducted. However, the sample sizes for those who speak another language were too small to generate valid results. Therefore, the language of the interview was used in the analysis.
122 Statistically significant at (p ≤ .01), with 2 cells with counts less than expected
Television Watching by Children

Although appropriate television (TV) programming can be both entertaining and beneficial to children’s learning, there is growing concern that children spend too much time watching TV. Research has shown correlations between viewing television and childhood obesity, high-risk behaviors, poor school performance and even Attention-Deficit/Hyperactivity Disorder (ADHD).\textsuperscript{123, 124} Currently, the American Academy of Pediatrics (AAP) recommends no television viewing for children under 2 years old, and less than 2 hours of television per day for children 2 years and older.\textsuperscript{125}

*Television watching by age*

Parents and caregivers of children over the age of one were asked on average how many hours of television and videos their child watches on weekdays and weekends. If respondents asked, interviewers explained that the number of hours should include any time the television is on and within earshot of the child. In other words, the child did not have to be intently watching something on television for it to be included in the estimate.

The number of hours was averaged by weekday and by weekend. The table below shows the average number of hours watched per day by the age of the child. Overall, as children aged, they watched more TV.

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Average Hours</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Weekdays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Year</td>
<td>1.29</td>
<td>1.57</td>
</tr>
<tr>
<td>2 Years</td>
<td>2.28</td>
<td>2.64</td>
</tr>
<tr>
<td>3 Years</td>
<td>2.24</td>
<td>2.47</td>
</tr>
<tr>
<td>4 Years</td>
<td>2.20</td>
<td>2.41</td>
</tr>
<tr>
<td>5+ Years</td>
<td>2.04</td>
<td>2.26</td>
</tr>
<tr>
<td>Weekends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Year</td>
<td>1.17</td>
<td>1.41</td>
</tr>
<tr>
<td>2 Years</td>
<td>2.02</td>
<td>2.29</td>
</tr>
<tr>
<td>3 Years</td>
<td>2.32</td>
<td>2.58</td>
</tr>
<tr>
<td>4 Years</td>
<td>2.46</td>
<td>2.70</td>
</tr>
<tr>
<td>5+ Years</td>
<td>2.73</td>
<td>2.98</td>
</tr>
</tbody>
</table>


**Television watching on weekdays and weekends**

To compare the television watching habits of younger and older children, dichotomous categories were created. One category included children 1 and 2 years old; the other included children ages 3, 4, and 5 years of age. There was a significant difference in the amount of television watching between children ages 1 to 2 and 3 to 5. As children get older, they spend more hours watching TV. Children ages 1 to 2 watched similar amounts of TV on weekdays and weekends; however, children ages 3 to 5 watched more TV on weekdays than weekends.

![Graph: Hours Watching TV on Weekdays by Age - Children 1 to 5 (n=1,008)](chart.png)

**Weekday Television Watching (p ≤ .01):**

- 32.3% (n=123) of children ages 1 to 2 watched TV for 30 minutes or less; however, only 12.1% (n=76) of children ages 3-6 watched TV for 30 minutes or less.

- 40.9% (n=156) of children ages 1-2 watched TV for 2 hours or more; but, 56.3% (n=353) of children ages 3-6 watched TV for more than 2 hours.

**Weekend Television Watching (p ≤ .01):**

- 34.5% (n=132) of children ages 1-2 watched TV for 30 minutes or less; however, only 12.8% (n=80) of children ages 3-6 watched TV for 30 minutes or less.

- 40.5% (n=155) of children ages 1-2 watched TV for 2 hours or more; but, 65.3% (n=408) of children ages 3-6 watched TV for more than 2 hours.
**Television watching by language spoken at home**

English-speaking respondents tended to report that their children watched more television. There was also a significant difference (p ≤ .01) in hours spent watching TV on the weekends depending on the language spoken in the home:

- When English was spoken in the household, 60.3% (n=382) of children watched two or more hours of television on the weekends.
- Less than half (47.8%, n=150) of children in Spanish-speaking households watched two or more hours of television on the weekends.
- Just over half (52.5%, n=31) of children in households that spoke other languages watched two or more hours of weekend television.

![Hours Watching TV on Weekends by Language - Children 1 to 5 (n=1,007)](image)

**Television watching by annual household income**

Examining television watching by household income, the findings suggest that children of families with lower incomes tended to watch the most television. More children in the lower income categories watched two or more hours of television than in other income categories. The data showed a trend wherein the higher the annual household income, the lower the percentage of children who watched television for two or more hours.

**Weekday Television Watching (p ≤ .01):**

- 56.8% (n=133) of children in households with annual household income of less than $25,000
- 58.4% (n=157) in homes with income of $25,000 to $49,999
- 50.0% (n=81) in homes with income of $50,000 to $74,999
- 40.4% (n=46) in homes with income of $75,000 to $99,999
- 37.0% (n=61) in homes with income of $100,000 or more
Weekend Television Watching (p ≤ .01):

- Households with annual incomes of less than $25,000 was the category with the lowest percentage of children who watched 2 or more hours of television on the weekends (49.4%, n=116).

- After a slight increase (65.2%, n=174, for those with $25,000-$49,999), the percentage of children who watched 2 or more hours of television on weekends remained relatively consistent through the higher income categories:
  - 57.0% (n=94) of children in homes with income of $50,000 to $74,999
  - 54.9% (n=62) in homes with income of $75,000 to $99,999
  - 52.1% (n=86) in homes with income of $100,000 or more

![Chart 1](chart1.png)

Parents and Caregivers who Practice Positive Discipline Techniques

Just as every child is unique, so is every parent. There is great variation in how parents and caregivers approach the important task of childrearing. The normal variations in parents’ attempts to control and socialize their children are known as parenting style.126

Of the four generally recognized parenting styles (Indulgent, Authoritative, Authoritarian, and Uninvolved), research reveals that the authoritative parent consistently produces children that have high levels of social competence and low levels of problem behavior.127 Authoritative parents are both demanding and responsive, balancing these two important elements of parenting style, and these parents use discipline techniques that are supportive, rather than punitive.128 129

In addition to variations in parenting styles, individual parents may adjust their discipline techniques based on different situations; there is “no one size fits all when it comes to promoting positive behavior and self-responsibility and responding to unacceptable behaviors.”130 Child Welfare League of America asserts that positive discipline techniques:

- Are proactive
- Promote positive behavior and self-control
- Encourage self-responsibility
- Respond to unacceptable behavior and a lack of self-control
- Protect and strengthen the child’s self-esteem
- Strengthen the parent-child relationship
- Advance development

Family Survey Findings

Parents and caregivers with a child at least one year old were asked what they found to be the most effective way to get their child to behave well. This was the only open-ended question in the 2005 Family Survey. There were two levels of coding open-ended responses.131 First,

131 Responses were coded by two researchers. Inter-rater reliability analysis was conducted to ensure consistency and validity of coding processes. There was a 74.5% agreement in coding parenting strategies, and 71.5% agreement in coding assessment of parenting strategies.
responses were categorized into one of 10 parenting strategies: observation, redirection, modify environment, discussion, isolation, consistent expectations, modeling, incentives, consequences, and physical reaction. Once coded into a strategy, open-ended responses were coded as positive, negative or unable to be determined. Of the 1,015 responses, 90.2% (n=916) were coded as positive parenting strategies (see Examples of Reported Positive Action table below).133

The following represent the findings for each parenting strategy, highlighting responses that reflected positive techniques.

**Discussion strategies**

Parents named discussion strategies most often (39.5%, n=401):

- The majority of discipline strategies in this category involved positive action (95.5%, n=383). For example, many parents reported explaining why the child was misbehaving and making suggestions for better behavior.
- Parents also talked about strategies such as getting down to child’s level, making eye contact, speaking in a calm voice, and having patience. For example, one parent explained, “I make him look me in the eye and explain to him what he needs to do and give him choices to pick from: stop doing something, take away a toy, and send him to his room.”
- Positively reinforcing good behavior seemed to be an effective technique for many parents.
- The few parents who reported utilizing negative discussion or verbal action (3.7%, n=15) reported yelling, getting into the child’s face, or threatening punishment.

**Isolation techniques**

Isolation techniques were also commonly used (19.9% of respondents, n=202):

- These responses were overwhelmingly positive; only one parent described a negative action that involved sending the child to the closet for a five-minute time out.
- Most parents reported using appropriate time-out strategies. For example, one parent described, “I give her a warning and if she does it again I have her sit on a time-out rug for two minutes and afterwards I have her tell me what she did wrong and apologize.”

**Consequences**

Ten percent (10.4%, n=106) of parents reported using consequences to discipline their child:

- Positive action involved taking away privileges for bad behavior and rewarding good behavior.

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132 A list of parenting strategies was compiled by the First 5 San Diego’s Evaluation Leadership Team from the Child Welfare League of America (CWLA), Children’s Care Connection (C3) and Developmental Screening & Enhancement Project (DSEP).
133 The content validity of this indicator is limited given the subjective nature of open-ended questions; therefore, analysis to examine differences within independent variables was not conducted.
While most parents reported positive action in this category, a few parents (7.5%, n=8) reported negative action. For example, a few parents reported threatening an action the child did not like, such as turning on the shower or giving the child medicine to get them to behave. Other parents stated they simply give the child what they want so they will stop crying or misbehaving.

Redirecting techniques

Redirecting techniques (reported by 8.0% of parents, n=81) involved distracting the child with a new activity or engaging in calming techniques (such as giving the child a bath, singing, or playing) to calm the child down.

Incentives

Almost six percent of parents (5.6%, n=57) reported using incentives; half of which used positive action including rewarding good behavior, setting weekly goals and giving prizes for achievement.

Consistent expectations

Five percent (5.0%, n=51) of parents reported using consistent expectations; all but one parent used positive action. Use of this technique involved being firm, sticking to a pattern or routine, and letting the child know what is expected. For instance, one parent described their three-step program, “we acknowledge his feelings, tell him what he’s going to do, and divert his attention to something completely different or tell him he can’t act that way.”

Modifying child’s environment

Three percent (3.0%, n=30) of parents reported modifying their child’s environment in order to change their behavior. Positive action for this technique involved removing the child from the situation that was causing the unwanted behavior.

Observation

Two percent (2.1%, n=21) of parents reported using observation; most of these parents used negative action such as ignoring the child when they misbehave.

Physical reaction

Very few parents (4.9%, n=50) reported using physical reaction as a discipline technique:

- Of these, some parents described holding, hugging, and carrying their child to calm them down when they were angry or upset.
- There were some parents (30.0%, n=15) who described using physical reaction in a negative manner; using spanking or other physical punishment when the child misbehaved.
The technique that was least reported was modeling, with only seven respondents (0.7%):

- One parent described their use of this technique as, “verbal and visual corrections; we stop and then show him what we want him to do.”

### Examples of Reported Positive Discipline Techniques and Actions

<table>
<thead>
<tr>
<th>Discipline Technique</th>
<th>Examples of Reported Positive Action</th>
</tr>
</thead>
</table>
| Discussion           | • Acknowledge his frustration; give him choices and talk to him about it and console him.  
                        | • Explain things by using a low voice to her; I sometimes tell her what to do, sometimes I use toys to get her attention and make what I tell her interesting. |
| Isolation            | • I give her a time-out: she goes into her room, no TV, no toys for 3-5 minutes.  
                        | • Naughty chair; he gets one chance, if he is doing something wrong and does it again; he gets to stay in the chair. He hates to sit and watch his toys, so he doesn’t do it again. |
| Consequences         | • Get her attention or try to punish her lightly. She loves books and recent movies, if she doesn’t do something we won’t buy her things or we prohibit her from doing what she wants.  
                        | • He has a warning first, and then has to lose a game or book for the rest of the day if he doesn’t improve his behavior. It’s a loss-of-privilege system. |
| Redirection          | • Acknowledge frustration and try to channel the feelings in a different way; suggest something else the child may be interested in to distract.  
                        | • Guide him into doing something else; like if he is playing with a hammer, I’ll pick up a ball and he’ll start to play with it. |
| Incentives           | • Reinforcement: we have many problems with behaviors and we work through it by having sort of a step ladder, for every good thing he does, we give him a prize, such as candy.  
                        | • Reward him with praise; set weekly goals for him, rewards from a prize box for achieving goals. |
| Consistent Expectations | • Consistency so he knows what to expect. When he is acting up, count from five and do a time-out if needed. Routine for daily life helps too.  
                        | • Keep a consistent routine. He has a schedule; he knows when play time is, and when it’s time for a nap. This way he doesn’t really misbehave. |
| Modify the Environment | • He is so young that if he is messing with something he is not supposed to, I just move him to another area.  
                        | • We lay her on her bed, turn the fan on with the wind chime on the fan and the constant noise with calm her down. |
| Observation          | • I wait until she calms down.  
                        | • Let him carry on until he’s ready and then calming time. |
| Physical Reaction    | • I let her cry a little bit and then pick her up and she forgets what she is crying about.  
                        | • When we go to the store and my child doesn’t get what she wants, she cries. I calm her down by giving her hugs and tell her jokes to make her smile. |
| Modeling             | • Be patient and calm with gentle discipline.  
                        | • Talking and teaching him through my example. |
Parents and Caregivers who Report High Levels of Confidence in Their Parental Roles

Policymakers have widely lauded parents as a child’s first and most important teachers. However it is not policymakers’ but parents’ endorsement of this statement that determines whether or not the home truly is a child’s first classroom. Parental beliefs such as this shape a young child’s social-emotional well-being. For example, it has been shown that a mother’s confidence in her parenting ability, partnered with her knowledge of child development, is related to how she interacts with her child.

Respondent is the First and Most Important Teacher of Child

In the 2005 Family Survey, respondents were asked how strongly they felt about being their child’s first and most important teacher. The vast majority of respondents rated themselves favorably. Almost all (96.9%, n=1,162) parents and caregivers strongly or somewhat agreed with the statement, “I am this child’s first and most important teacher.”

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Most important teacher by gender

Female caregivers were more likely to strongly agree (82.4%, n=776) with this statement than male caregivers (72.0%, n=185).\(^{138}\)

Most important teacher by language spoken at home

English-speaking (87.5%, n=662) respondents and respondents that spoke a language other than English or Spanish (82.4%, n=56) strongly agreed that they are their child’s first and most important teacher more often than Spanish-speaking respondents (65.1%, n=243).\(^{139}\)

Most important teacher by annual household income

The percentage of respondents that strongly agreed with this statement increased steadily from those with annual household incomes of less than $25,000 per year to those with incomes of $50,000 to $74,999, and then it slightly declined for those with $100,000 or more:\(^{140}\)

- 71.1% (n=209) with under $25,000 strongly agreed
- 80.1% (n=246) with $25,000 to $49,999
- 90.4% (n=178) with $50,000 to $74,999
- 89.9% (n=124) with $75,000 to $99,999
- 80.5% (n=149) with $100,000 or more

Most important teacher by knowledge of where to call for social support

Respondents that reported knowing where to call for support with raising a child strongly agreed with this statement at a higher rate (84.7%, n=560) than to those that said they did not know where to call (74.4%, n=392) (p \(\leq .01\)).

Most important teacher by volunteerism

Respondents who said they had volunteered in the past 12 months reported a higher percentage (84.1%, n=329) of strongly agree than those who had not volunteered (78.3%, n=630).\(^{141}\)

Most important teacher by awareness of First 5 San Diego

Approximately 84.5% (n=451) of respondents that had heard of First 5 San Diego strongly agreed that they are their child’s first and most important teachers, compared to 76.7% (n=501) of respondents that said they had never heard of First 5 San Diego (p \(\leq .01\)).

\(^{138}\) Statistically significant at (p \(\leq .01\)), with 2 cells with counts less than expected
\(^{139}\) Statistically significant at (p \(\leq .01\)), with 3 cells with counts less than expected
\(^{140}\) Statistically significant at (p \(\leq .01\)), with 8 cells with counts less than expected
\(^{141}\) Statistically significant at (p \(\leq .05\)), with 1 cell with a count less than expected
**Respondent is Confident as a Caregiver to Help the Child Grow and Learn to the Best of His/Her Ability**

Almost all (98.6%, n=1,184) parents and caregivers somewhat agreed or strongly agreed with the statement, “I feel confident as a caregiver about how to help this child grow and learn to the best of their ability”.

**Caregiver confidence by gender**

Male caregivers were more likely to agree with this statement than female caregivers (85.2%, n=219 and 79.2%, n=748, respectively).\(^{142}\)

**Caregiver confidence by language spoken at home**

Parents and caregivers whom primarily spoke English (85.0%, n=645) agreed with this statement more often than Spanish-speaking respondents (72.4%, n=270) and those who spoke another language (75.0%, n=51).\(^{143}\)

**Caregiver confidence by other variables**

There were no significant differences seen with this survey item between annual household incomes, respondents that had volunteered, respondents who had knowledge of where to call for support with raising a child, or those who reported knowledge of First 5 San Diego.

**Respondent’s Feelings of Themselves as Caregivers**

The majority (81.7%, n=979) of parents and caregivers, regardless of their gender, rated themselves as better than average or a very good caregiver.

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\(^{142}\) Statistically significant at (p ≤ .05), with 2 cells with counts less than expected

\(^{143}\) Statistically significant at (p ≤ .01), with 4 cells with counts less than expected
Caregiver rating by age

As the age of caregivers increased, the percentage that rated themselves at least better than average also increased (from 76.6% (n=121) of those 18-24 to 90.4% (n=47) of those 45-54), but declined dramatically for those 55 and older (41.7%, n=5).\(^{144}\)

Caregiver rating by language spoken at home

A higher proportion of English-speaking respondents rated themselves above average (89.0%, n=674) than did those that spoke Spanish (69.9%, n=260) or another language (65.2%, n=45).\(^{145}\)

Caregiver rating by household income

As the annual household income level increased, the percentage that considered themselves at least better than average also increased (from 73.1% (n=215) for those with incomes less than $25,000 to 91.4% (n=169) for those with $100,000 or more).\(^{146}\)

Caregiver rating by knowledge of where to call for social support

Respondents that reported knowing where to call for help with the stresses of raising a child rated themselves as better than average (86.1%, n=569) compared to those who reported not knowing where to call (76.1%, n=401) (p ≤ .01).

Caregiver rating by volunteerism

Respondents that had volunteered in the past year were more likely to rate themselves as a better than average caregiver (86.2%, n=337) compared to those who had not volunteered (79.5%, n=640) (p ≤ .05).

\(^{144}\) Statistically significant at (p ≤ .01), with 4 cells with counts less than expected

\(^{145}\) Statistically significant at (p ≤ .01), with 1 cell with a count less than expected

\(^{146}\) Statistically significant at (p ≤ .01), with 3 cells with counts less than expected
Chapter Introduction

As articulated in its strategic plan, First 5 San Diego seeks to support parent and family development in a variety of ways. Specifically, the desired result for Issue Area 3 is that families have the skills, comprehensive support and the resources they need to promote their children’s optimal development and school readiness. To measure this outcome, three questions were asked in the 2005 Family Survey about how families access services including health insurance, social support and child care.

Chapter Highlights

Survey highlights from this issue area include:

- **Knowledge of where to call for help in dealing with the stress of raising a child varies significantly by region.** For example, 68.2% of respondents in the North Central Region reported knowing where to call for help compared to 46.0% in the Central Region.

- **The number of respondents who know how to locate a child care center or provider varies significantly by region.** Overall 75.3% of respondents knew where to call for childcare assistance, however only 33.2% of respondents in the Central Region, 27.0% in the South and 25.6% in the North Inland Region knew how to locate a child care center or provider.

- **The number of respondents who know how to locate a child care center or provider varies by primary language.** Almost half (48.6%) of Spanish-speaking respondents reported not knowing how or where to locate a child care center or provider, compared to just 12.5% of English speakers and 28.4% of those who speak another language.

Opportunities for Improvement

Levels of educational attainment, English-language proficiency, and household income all appear to be differentiating factors in parental awareness about community resources, where to call for help and how to locate a childcare provider. Once again, responses to these questions varied by geographic region. Spanish-speaking respondents were less likely to know how to locate a childcare provider or where to call for help than their English-speaking counterparts.
Knowledge of Where to Find Health Insurance

As mentioned earlier in this report, 91.3% of Family Survey respondents indicated they had health insurance for their child. Of the 8.7% (n=104) who did not have health insurance, 84.6% (n=88) stated that they knew where to find health insurance. The percentage of respondents without health insurance was too small for further comparative analyses.

Knowledge of Where to Call for Social Support

Poverty, health problems, and other economic and parental concerns can pose significant challenges to parents.\textsuperscript{147} When parents are preoccupied with the stresses of raising a child, they may be less able to provide optimal home environments for their children and, when overwhelmed, may even become harsh or coercive toward their children.\textsuperscript{148} Children living in stressful environments are more likely than other children to exhibit low levels of school engagement and have high levels of behavioral and emotional problems.\textsuperscript{149} Connecting parents to the resources they need to reduce the stress involved in raising a child can help ensure that children and families are secure.

Family Survey Findings

There were significant differences between regions regarding knowledge of where to call for help in dealing with the stress of raising children. While over half of the county overall reported affirmatively (55.7%, n=663), there was a vast disparity between the highest and lowest reporting regions (p ≤ .01):

\begin{figure}
\centering
\includegraphics[width=\textwidth]{map.png}
\caption{Percent Knowing Where to Call for Help with Stress}
\end{figure}

\begin{itemize}
\item North Coastal: 58.0%
\item North Inland: 53.5%
\item East: 59.3%
\item Central: 46.0%
\item South: 49.2%
\end{itemize}

\begin{footnotes}
\end{footnotes}
Knowledge of where to call for social support by region

- The Central Region had the lowest percentage of respondents (46.0%, n=92) that reported they knew where to call for help in dealing with childrearing stress.
- In comparison, 68.2% (n=133) of respondents in the North Central Region reported knowing where to call for help.

Knowledge of where to call for social support by age-appropriate, self-soothing and self-regulation behaviors

Parents and caregivers were asked the frequency with which their children were able to express themselves appropriately compared to other children the same age. Parents were asked to compare their child’s behavior with other children in five areas: throwing temper tantrums, hitting, kicking or biting others when angry; describing their feelings; calming themselves when angry; and using words to express wants. Response categories included more often, as often, or less often. An examination of parents’ ability to find social support for childrearing and their perception of the level of development of their children’s age-appropriate behaviors yielded significant findings.\(^{150}\)

Children describe their feelings

- For parents who reported they knew how to find social support, 51.3% (n=263) stated their children used words to describe feelings more often than other children of the same age, compared to 42.1% (n=175) of children whose parents said they did not know where to call for help (p ≤ .05).

Children calm themselves when angry

- Over half of parents (58.3%, n=301) who reported knowing how to find social support stated their children can calm themselves down when angry or sad as often as other children of the same age, compared to 51.5% (n=220) of parents who did not know where to call for help (p ≤ .05).

Children use words to express their wants

- Of parents who said they knew how to find social support, 60.5% (n=314) of them stated their children used words more often to express their wants than other children of the same age, compared to 56.4% (n=238) of children whose parents did not know where to call for help (p ≤ .01).

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\(^{150}\) 90.0% of children were rated positively in regard to throwing temper tantrums and hitting, kicking or biting when angry. Therefore, the cross tabulations yielded cell sizes that were too small for analysis with regard to social support.
Parents and caregivers were asked how well their children got along with children and adults compared to other children the same age. The response categories were better than average, about the same, or not as well as other children. Similarly, an analysis of children’s interaction with social support yielded significant results.

**Children get along with other children better than average child**

- For parents who knew how to find social support, 46.3% (n=241) of their children were reported to get along with other children better than average than other children the same age, compared to 40.7% (n=175) of children whose parents did not know where to call for help (p ≤ .05).

**Children get along with adults better than average child**

- For parents who reported knowing how to find social support, 60.2% (n=314) of their children were reported to get along with adults better than average than other children the same age, compared to 51.0% (n=219) of children whose parents did not know where to call for help (p ≤ .05).

**Knowledge of How to Locate a Child Care Center or Provider**

The demand for quality child care is growing as maternal employment rates increase, in part due to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which requires mothers receiving public assistance to fulfill work requirements.\(^{151}\) However, the availability of quality center-based care varies throughout California.\(^{152}\) Parents who can locate a child care provider have access to reliable care for their child during the day, before and after school, or in the evening when the parent is at work or school.

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Family Survey Findings

Throughout the county, three-quarters (75.3%, n=896) of respondents indicated that they knew how to locate a child care center or provider if they needed someone to care for their child.

Knowledge of child care provider by region

Over one-quarter of respondents in the Central (33.2%, n=66), South (27.0%, n=54) and North Inland (25.6%, n=51) Regions reported they did not know how to locate a child care center or provider (p ≤ .05).

Knowledge of child care provider by race/ethnicity

More than one third of Hispanic/Latino respondents (39.7%, n=197) reported not knowing how to locate a child care provider, a higher rate than all other racial/ethnic groups (e.g., compared to 11.8% (n=62) of White/Caucasian respondents). 153

Knowledge of child care provider by language spoken at home

Almost half (48.6%, n=180) of Spanish-speaking respondents reported they did not know how to locate a child care center or provider, compared to 12.5% (n=94) of English-speaking respondents and 28.4% (n=19) of those who spoke another language (p ≤ .01).

Knowledge of child care provider by parental educational attainment

Similarly, the lower the educational attainment, the less likely parents and caregivers were to know how to locate a child care center or provider; ranging from 47.0% (n=109) of non-high school graduates to 93.4% (n=171) of those who had completed some graduate work (p ≤ .01).

Knowledge of child care provider by annual household income

The lower the household income, the less likely a respondent was to know how to locate a child care center or provider; ranging from 57.2% (n=166) of households with less than $25,000 to 91.4% (n=169) for those with $100,000 or more (p ≤ .01).

Knowledge of child care provider by families with one child

More parents and caregivers that have only one child (80.2%, n=280) reported knowledge of how to locate a child care center or provider than parents and caregivers with multiple children (73.2%, n=615) (p ≤ .01).

Knowledge of child care provider by knowledge of where to call for social support

Almost half (42.5%, n=221) of respondents that did not know where to call for help with the stresses of raising a child also did not know how to locate a child care center or provider (p ≤ .01).

153 Statistically significant at (p ≤ .01), with 3 cells with counts less than expected
Knowledge of child care provider by volunteerism

Parents and caregivers that had volunteered in the past year stated they knew how to locate a child care center or provider more frequently (83.5%, n=324) than parents and caregivers that had not volunteered in the past year (71.3%, n=570) (p ≤ .01).

Knowledge of child care provider by information requests

56.8% (n=167) of parents and caregivers that reported they did not know how to locate a child care center or provider requested more information on child care services in the county. 30.0% (n=359) of all 2005 Family Survey respondents requested information about child care services.
Chapter Introduction

This section of the report relates to Issue Area 4 of the Commission’s strategic plan, which describes First 5 San Diego’s commitment to impacting systems of care, engaging communities, promoting integration of services, and maximizing the potential for long-term impact on children ages 0 to 5 and their families. The 2005 Family Survey included a number of questions designed to examine perceptions about, as well as awareness and access to, services and community resources; and which addressed the following Issue Area 4 desired results:

1. Communities have adequate service capacity that is effective, coordinated, integrated, and sustainable.

2. Families have access to culturally and linguistically responsive services.

Chapter Highlights

Survey highlights from this issue area include:

- **Family Survey reveals a demand for more information about community resources.** Two-thirds (65.1%) of survey respondents were interested in more information related to resources for parenting, immunizations, healthcare insurance, child care services, 2-1-1, or First 5 San Diego.

- **Volunteerism enhances knowledge of community resources.** Respondents who reported volunteering in the community were more likely to be aware of existing community resources.

- **First 5 San Diego is recognized by almost half of respondents.** Almost half (45.0%) of parents and caregivers in the Family Survey reported that they had heard of First 5 San Diego.

- **First 5 San Diego promotes parent as child’s most important teacher:** Respondents who have heard of First 5 San Diego strongly agreed that they are their children’s first and most important teachers more often than respondents that did not recognize First 5’s name.

- **Parents and caregivers who speak English at home were more likely to identify as their child’s first teacher compared to their counterparts who speak another language in the home.** Similarly, compared to respondents who speak another language at home, respondents who speak English at home were also more likely to report feeling confident in their ability to help their children grow and learn, and to rate themselves as better than average caregivers.
Opportunities for Improvement

As noted above, Family Survey respondents clearly expressed a desire for more information about community resources. Given that less than half of respondents were familiar with First 5 as an organization, more could be done to raise awareness.

Not surprisingly, parents and caregivers who were less involved in the community were less knowledgeable about available resources and services. Finally, Spanish-speaking respondents expressed less confidence in their role as their child’s first teacher and in their overall ability to help their child learn and grow.

Parents and Caregivers Requested Information for Resources

First 5 San Diego has worked diligently to increase families’ access to resources by partnering with 2-1-1 San Diego (previously INFO LINE of San Diego County, Inc.), which provides assistance to all residents of the county with linkages to health and social services. In the 2005 Family Survey, respondents were asked if they were interested in finding out more about 2-1-1, parenting information, immunization services, healthcare insurance, child care services, First 5 San Diego and the 2005 Family Survey itself. Overall, two-thirds (65.1%, n=778) of respondents requested more information on at least one of the above resources. County-wide results for individual resources are as follows:

- 47.7% (n=571) of caregivers in the county requested information about 2-1-1 San Diego.
- 44.7% (n=535) of county-wide caregivers requested information on parenting.
- 13.7% (n=164) of caregivers in the county requested information on immunizations services.
- Overall, 16.5% (n=198) of caregivers requested information on health insurance.
- 30.0% (n=359) of county-wide caregivers requested information on child care services.
- 34.9% (n=418) of caregivers in the county requested information on First 5 San Diego or the 2005 Family Survey.

Information requests by region

Information about First 5 San Diego (and the 2005 Family Survey itself) was the only resource that did not yield a statistically significant difference between regions. Each of the remaining information sources yielded significant differences by region, with respondents in the Central Region requesting information at a higher rate than all other regions.

154 Since the time of data collection for the Family Survey, INFO LINE of San Diego County has transitioned to 2-1-1 San Diego. For brevity's sake, the organization is referred to as 2-1-1 in this report.
## Requests for Information by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>2-1-1 San Diego</th>
<th>Parenting Information</th>
<th>Immunization Services</th>
<th>Health Insurance</th>
<th>Child Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>North Coastal</td>
<td>93</td>
<td>46.3%</td>
<td>94</td>
<td>46.5%</td>
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<tr>
<td>North Inland</td>
<td>102</td>
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<td>97</td>
<td>48.3%</td>
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<td>North Central</td>
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<td>30.3%</td>
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<tr>
<td>Central</td>
<td>122</td>
<td>61.0%</td>
<td>113</td>
<td>56.5%</td>
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<tr>
<td>East</td>
<td>76</td>
<td>38.2%</td>
<td>68</td>
<td>34.2%</td>
<td>18</td>
</tr>
<tr>
<td>South</td>
<td>111</td>
<td>55.5%</td>
<td>104</td>
<td>52.0%</td>
<td>28</td>
</tr>
<tr>
<td>San Diego County</td>
<td>571</td>
<td>47.7%</td>
<td>535</td>
<td>44.7%</td>
<td>164</td>
</tr>
</tbody>
</table>

Differences between regions are statistically significant for each resource ($p \leq .01$).


## Average Number of Information Requests by Region

A scale was constructed to examine differences among the regions with regard to the total number of information requests. Ranging from 0 (no information requested) to 6 (information was requested for every service), the scale yielded the following distribution:

- The countywide average for information requested was 1.87.
- The lowest average for requests by parents and caregivers was seen in the North Central Region (1.27 requests), while the highest occurred in the Central Region with an average of 2.47 requests.\(^{155}\)

### Average Number of Information Requests by Region (n=1,195)

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Requests</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>North Coastal</td>
<td>1.94</td>
<td>1.67</td>
</tr>
<tr>
<td>North Inland</td>
<td>2.02</td>
<td>1.75</td>
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<tr>
<td>North Central</td>
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<td>1.05</td>
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<tr>
<td>Central</td>
<td>2.47</td>
<td>2.19</td>
</tr>
<tr>
<td>East</td>
<td>1.45</td>
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<tr>
<td>South</td>
<td>2.09</td>
<td>1.83</td>
</tr>
<tr>
<td>San Diego County</td>
<td>1.87</td>
<td>1.77</td>
</tr>
</tbody>
</table>


\(^{155}\) T test findings were statistically significant ($t \leq .05$) by regions, except between North Coastal and North Inland regions, North Coastal and South regions, North Inland and South regions, and North Central and East regions.
Information requests by language spoken at home

Comparing the information requests by the language spoken in the household resulted in statistically significant outcomes (p ≤ .01):

- 52.7% (n=397) of English-speaking respondents requested at least one type of information.
- 89.2% (n=332) of Spanish-speaking respondents requested at least one type of information.
- 71.0% (n=49) of those who spoke other languages requested at least one type of information.

Average number of information requests by language spoken in the household

Using the same 0 to 6 scale for the number of information requests, the average number of requests by language spoken in the home was significantly different (t ≤ .01):

- The average number of requests for Spanish-speaking respondents was 3.25 (n=372).
- The average number of requests for English-speaking respondents was 1.19 (n=753).
- The average number of requests for those who spoke other languages was 1.94 (n=69).

Information requests by parental educational attainment

Comparing the number of information requests by educational attainment yielded statistically significant results (p ≤ .01). Of the 11.6% (n=139) of respondents who requested information for at least 5 of 6 services:

- 48.9% (n=68) did not have a high school diploma.
- 12.2% (n=17) were high school graduates or GED recipients.
- 26.6% (n=37) had some college education.
- 8.6% (n=12) had Bachelor degrees.
- 3.6% (n=5) had completed some graduate-level work.

Average number of information requests by parental educational attainment

When considering the average number of requests and educational attainment level, it was found that the higher the educational attainment of the respondents, the lower the average number of information requests:

- The lowest average for requests was by those who had obtained a Bachelor’s degree or had completed some graduate work (1.41 requests, n=224), while the highest average was 3.33 (n=232) by those who reported not completing high school.156

156 T test findings were statistically significant (t ≤ .05) by educational attainment, except between those who completed some college and those who had obtained a Bachelor’s degree.
Parents and Caregivers who Volunteered in the Past Twelve Months

First 5 San Diego actively supports community capacity building, education, and engagement, with the belief that these activities benefit individuals, neighborhoods and society in general. The amount of volunteerism among parents and caregivers of children ages 0 to 5 is a useful indicator of involvement in community activities throughout San Diego County.

Family Survey Findings

About one-third (32.7%, n=392) of the survey respondents had volunteered in the community in the past 12 months. There was a statistically significant difference in volunteering rates among the six regions in San Diego County (p ≤ .05).

Volunteerism by region

- 37.8% (n=74) in the North Central Region
- 36.3% (n=69) in the North Coastal Region
- 35.0% (n=70) in the East Region
- 34.5% (n=69) in the North Inland Region
- 28.9% (n=58) in the South Region
- 23.9% (n=48) in the Central Region

Volunteerism by gender

34.4% (n=324) of women had volunteered compared to 26.6% (n=68) of men (p ≤ .05).

Volunteerism by race/ethnicity

- 43.1% (n=228) of White/Caucasians
- 39.0% (n=30) of Asian/Pacific Islanders
- 35.5% (n=22) of African Americans
- 20.5% (n=103) of Hispanic/Latinos
- 21.4% (n=3) of American Indians\(^\text{157, 158}\)

\(^{157}\) Due to sample size, caution should be taken when considering the validity of the data on American Indians.

\(^{158}\) Statistically significant at (p ≤ .01), with 3 cells with counts less than expected
Volunteerism by language spoken at home

More English-speaking respondents report participation in volunteer work than speakers of other languages (p ≤ .01):

- 41.0% (n=310) of English-speaking respondents
- 36.2% (n=25) of respondents that spoke other languages
- 15.3% (n=57) of Spanish-speaking respondents

Volunteerism by parental educational attainment

As the education attainment level increased, volunteer participation level increased (p ≤ .01):

- 13.7% (n=32) of those who did not have a high school diploma
- 25.6% (n=40) of high school graduates
- 33.4% (n=134) of those who had some college experience
- 42.8% (n=95) of 4-year college graduates
- 48.9% (n=91) of those who had completed some graduate work

Volunteerism by annual household income

Respondents in higher annual household income categories reported higher percentages of volunteering (p ≤ .01):

- 18.0% (n=53) of those who reported annual household incomes of less than $25,000
- 27.0% (n=83) of those with annual household incomes between $25,000 and $49,999
- 43.9% (n=86) of those reporting annual household incomes between $50,000 and $74,999
- 48.6% (n=67) of those with annual household incomes between $75,000 and $99,999
- 44.9% (n=83) of those who reported annual household incomes of $100,000 or more

Volunteerism by information requests

- Parents and caregivers who did not volunteer in the past 12 months requested information for resources more often than those who did volunteer (t ≤ .01).
  - An average of 2.09 requests for information were made by those who reported they had not volunteered (n=802) compared to 1.44 (n=390) for those who had.

- Respondents who did not volunteer in the past 12 months:
  - 52.1% (n=419) requested information about 2-1-1 (p ≤ .01).
  - 49.2% (n=395) requested parenting information (p ≤ .01).
  - 16.2% (n=130) requested information on immunization services (p ≤ .01).
  - 19.2% (n=154) requested information on healthcare insurance (p ≤ .01).
  - 35.6% (n=286) requested child care service information (p ≤ .01)
Parents and Caregivers Received the Kit for New Parents

First 5 California provides the Kit for New Parents to all new families in the state. The Kit is intended to universally provide first-time parents with information and resources to help them during the first five years of their child’s life. Since January 2002, there have been 147,157 Kits for New Parents distributed through 663 partnering agencies in San Diego County. In the 2005 Family Survey, parents and caregivers were asked if they had received the Kit. The table below shows the Kit distribution by region (reported by San Diego Welcome Baby Program), along with the distribution reported by respondents to the 2005 Family Survey.\(^{159}\)

<table>
<thead>
<tr>
<th>Region</th>
<th>Distributed in San Diego County</th>
<th>Reported in Family Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent of Total</td>
</tr>
<tr>
<td>North Coastal</td>
<td>20,616</td>
<td>14.0%</td>
</tr>
<tr>
<td>North Inland</td>
<td>23,561</td>
<td>16.0%</td>
</tr>
<tr>
<td>North Central</td>
<td>30,924</td>
<td>21.0%</td>
</tr>
<tr>
<td>Central</td>
<td>32,397</td>
<td>22.0%</td>
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<tr>
<td>East</td>
<td>16,198</td>
<td>11.0%</td>
</tr>
<tr>
<td>South</td>
<td>23,561</td>
<td>16.0%</td>
</tr>
<tr>
<td>San Diego County</td>
<td>147,257</td>
<td>100.0%</td>
</tr>
</tbody>
</table>


Family Survey Findings

Overall, 41.9% (n=495) of parents and caregivers stated they received the Kit for New Parents.

\(^{159}\)While percentages of Kits distributed by region are similar to percentages of Kits received by Family Survey respondents, there was no statistical analysis conducted.
Received Kit for New Parents by region

A statistically significant difference ($p \leq .01$) was seen by region, with the North Central Region reporting the highest, and the North Coastal the lowest:

- 49.0% (n=95) in the North Central Region
- 45.4% (n=89) in the South Region
- 44.9% (n=89) in the North Inland Region
- 44.1% (n=86) in the East Region
- 35.9% (n=71) in the Central Region
- 32.7% (n=65) in the North Coastal Region

Received Kit for New Parents by race/ethnicity

- 44.2% (n=230) of White/Caucasians
- 37.6% (n=185) of Hispanic/Latinos
- 50.0% (n=31) of African Americans
- 40.8% (n=31) of Asian/Pacific Islanders
- 64.3% (n=9) of American Indians

Received Kit for New Parents by language spoken at home ($p \leq .01$)

- 45.6% (n=340) of English-speaking respondents reported receiving a Kit for New Parents
- 43.5% (n=30) of those who spoke another language at home reported receiving a Kit for New Parents
- 34.3% (n=125) of Spanish-speaking respondents reported receiving a Kit for New Parents

Received Kit for New Parents by parental educational attainment

Receiving a Kit for New Parents had a positive relationship with educational attainment level. The higher the education level of the respondent, the more likely that person was to have stated receiving the Kit ($p \leq .01$):

- 32.0% (n=73) of those who reported no high school diploma
- 33.6% (n=51) of high school graduates
- 45.3% (n=180) of those who had some college experience
- 44.6% (n=99) of those reporting a 4-year college degree
- 51.1% (n=92) of those who had completed some graduate work

Received Kit for New Parents by first time parents

First time parents were more likely to report receiving the Kit for New Parents (45.5%, n=240) than parents that had at least one other child (39.1%, n=255) ($p \leq .05$).

---

160 Statistically significant at ($p \leq .05$), with 2 cells with counts less than expected
Received Kit for New Parents by children with a primary healthcare provider

Approximately 11.2% (n=76) of parents and caregivers who did not receive the Kit also reported that their child does not have a primary healthcare provider. By contrast, only 5.5% (n=27) of parents and caregivers who reported having a primary healthcare provider did not receive a Kit (p ≤ .01).

Received Kit for New Parents by children with excellent or good overall health

Of those respondents who said they received the Kit for New Parents, 87.3% (n=432) also rated their child’s overall health as either excellent or good, compared to only 79.6% (n=542) of those who did not receive the Kit (p ≤ .01).

Received Kit for New Parents by dental exam in the past 12 months

Children of respondents that reported receiving the Kit (52.6%, n=215) were more likely to have visited a dentist in the past year than children of respondents that did not receive one (44.0%, n=260) (p ≤ .01).

Received Kit for New Parents by knowledge of child care provider

More parents and caregivers that received the Kit (78.3%, n=385) reported that they also knew how to locate a child care center or provider than those who did not receive the Kit (72.8%, n=492) (p ≤ .05).

Received Kit for New Parents by awareness of First 5 San Diego

Just over half (56.2%, n=276) of respondents who received the Kit for New Parents had heard of First 5 San Diego.
Parents and Caregivers are Aware of First 5 San Diego

In addition to supporting many direct services for children ages 0 to 5 and their families, First 5 San Diego strives to raise community awareness about the importance of children’s physical and social emotional health and its relationship to school readiness and future success in life. One measure of whether the community has taken note of these social marketing messages is by gauging community awareness of First 5 itself. In the 2005 Family Survey, respondents were asked whether they had heard of First 5 San Diego.

Family Survey Findings

Overall, 45.0% (n=535) of parents and caregivers reported that they had heard of First 5 San Diego.

![Map showing awareness of First 5 by region](image)

**Awareness of First 5 San Diego by region**

There was a statistically significant difference (p ≤ .05) in the number of respondents who had heard of First 5 by region:

- 54.0% (n=107) in the East Region
- 48.7% (n=94) in the North Central Region
- 45.7% (n=91) in the South Region
- 42.3% (n=85) in the North Inland Region
- 40.3% (n=81) in the North Coastal Region
- 38.9% (n=77) in the Central Region
Awareness of First 5 San Diego by gender

Only 28.9% (n=74) of male respondents had heard of First 5 San Diego, compared to almost half (49.4%, n=461) of female respondents (p ≤ .01).

Awareness of First 5 San Diego by race/ethnicity

- 50.9% (n=268) of White/Caucasians had heard of First 5 San Diego.
- 41.4% (n=206) of Hispanic/Latinos had heard of First 5 San Diego.
- 38.2% (n=29) of Asian/Pacific Islanders had heard of First 5 San Diego.
- 35.7% (n=5) of American Indians had heard of First 5 San Diego.\(^{161}\)
- 33.3% (n=20) of African Americans had heard of First 5 San Diego.\(^{162}\)

Awareness of First 5 San Diego by language spoken at home

Almost half (49.6%, n=372) of English-speaking respondents had heard of First 5 San Diego, compared to 38.9% (n=144) of Spanish-speaking respondents and 27.5% (n=19) of those who reported speaking another language at home (p ≤ .01).

Awareness of First 5 San Diego by parental educational attainment

As the educational attainment level of respondents increased from those without a high school diploma to those who completed Bachelor’s degrees, the proportion of respondents that heard about First 5 San Diego increased (from 32.0% (n=74) to 52.5% (n=115), respectively), but then dipped slightly at the graduate school level (48.1%, n=89) (p ≤ .01).

Awareness of First 5 San Diego by annual household income

About half of the respondents at all income levels reported having heard about First 5 San Diego, except those with annual household incomes of under $25,000. Of this group, only 36.1% (n=105) reported knowing about First 5 San Diego (p ≤ .01).

Awareness of First 5 San Diego by first time parents

Parents who were raising their first child were more likely to have heard about First 5 San Diego (50.3%, n=267), compared to 40.7% (n=268) of parents who were raising subsequent children (p ≤ .01).

Awareness of First 5 San Diego by information requests

Approximately 34.7% (n=226) of respondents that had not heard of First 5 San Diego asked for information regarding the organization at the end of the Family Survey.

\(^{161}\) Due to sample size, caution should be taken when considering the validity of the data on American Indians.

\(^{162}\) Statistically significant at (p ≤ .01), with 2 cells with counts less than expected


County of San Diego Health and Human Services Agency, Public Health Services.  **Core Public Health Indicators.**  2004.


Federal Telephone Consumer Protection Act of 1991


<http://www.ccfc.ca.gov/sandiego/parent.html>

____.  **San Diego Family Survey.**  2005.


First 5 San Diego County Family Survey
(January 2005)

INT.  Hello, my name is _______________. I'm calling from the Social Science Research Lab at San Diego State University. We're conducting a brief survey for the First 5 Commission of San Diego County. The survey will help the County improve services for young children and their families. Is there a child under the age of six living there? Your household was randomly selected and your responses are important to us. [THANK AND CODE "NQR-NO5" IF NONE; THANK AND CODE "REF" IF THERE IS A CHILD UNDER SIX BUT NO ONE IN HOUSEHOLD IS WILLING TO PARTICIPATE; SCHEDULE CB IF NEEDED; IF ASKED:] The First 5 Commission of San Diego County is a county agency that supports programs to help children enter kindergarten ready to learn.

VER.  [VERSION OF INTERVIEW:] 1 - VERSION A  2 - VERSION B*

* = RESPONSE OPTIONS REVERSED ON VERSION B FOR ALL QUESTIONS INDICATED

CAR.  I would like to speak with an adult in this household who is a primary caregiver for any children under age six; that is, a person who is responsible for these children and makes sure they have what they need. Would that be you or someone else? [CONTINUE WITH PRIMARY CAREGIVER OR REINTRODUCE YOURSELF AFTER PRIMARY CAREGIVER IS LOCATED; ASK FOR FIRST NAME AND SCHEDULE CB IF NEEDED; THANK AND CODE "REF" IF NOT WILLING TO PARTICIPATE]

ZIP.  We're calling people in different areas. Could you please tell me your zip code? [CATI WILL CODE AS "NQR-ZIP" IF ZIPCODE NOT ON LIST]

99997 - DK
99999 - REF

ZIPa.  [IF DK/REF:] CATI TO IMPORT ZIP CODE FROM SAMPLE RECORD

AREA.  HHSA AREA [ASSIGNED BY CATI]

1 - NORTH COASTAL
2 - NORTH INLAND
3 - NORTH CENTRAL
4 - CENTRAL
5 - EAST
6 - SOUTH

SEX.  [RECORD GENDER OF RESPONDENT, PROBE IF NEEDED:]

1 - MALE
2 - FEMALE
INTERVIEWER: TO STOP INTERVIEW FROM THIS POINT FORWARD FOR ANY REASON, [CTRL] [END] AND OBTAIN NAME/INITIALS / QUOTA INFO--DO NOT BACK UP!

LP. [IF INDICATED BY AN ACCENT:] Would you prefer that we speak in English or Spanish?
   1 - ENGLISH
   2 - SPANISH ---> SWITCH TO SPANISH VERSION OR SCHEDULE SPAN CB

IC. Let me assure you this phone number was generated randomly, so no names or addresses are associated with the telephone numbers, and all responses are completely anonymous. You can refuse to answer any questions at any time. Your answers will be combined with those of other families, and only these combined results will be reported. To ensure that my work is done honestly and correctly, this call may be monitored by my supervisor. [ONLY IF ASKED ABOUT MONITORING:] My supervisor randomly listens to interviews to make sure we’re reading the questions exactly as written and not influencing answers in any way.

(Is this a good time to answer some questions?)

Q1. We'll start off with some questions about the health and development of a child under age six. Is there more than one child in the household under the age of six?
   1 - YES
   2 - NO
   9 - DK/REF

Q2. [INSERT THE NEXT PHRASE ONLY IF MORE THAN ONE CHILD UNDER SIX:] {For the following questions, please answer for only one of these children who are under the age of six, the one who is going to have their birthday next.} Is that child a boy or a girl?
   1 - BOY
   2 - GIRL
   9 - DK/REF

Q3. Can you tell me the age of this child, is (he/she)...[IF OVER 5 YEARS OLD, PROBE FOR OTHER CHILD IN HH UNDER AGE 6; IF NO CHILD UNDER 6, [Esc] BACK TO INTRO AND CODE “NQR-NO5”]
   1 - less than 6 weeks old,
   2 - at least 6 weeks old but less than 6 months old
   3 - at least 6 months old but less than 1 year old,
   4 - at least 1 year old but less than 3 years old, or
   5 - at least 3 years old but less than 6 years old?
   99 - DK/REF -------> NQR-AGECH

Q4. Is (he/she} the first child that you have raised?
   1 - YES
   2 - NO
   9 - DK/REF
Q5. Does {he/she} currently have any kind of health insurance, such as Medi-Cal, Healthy Families, insurance through an HMO, a private insurance company, or something else?

1 - YES -----------------------------------> GO TO Q6
2 - NO
9 - DK/REF -----------------------------------> GO TO Q6

Q5a. [IF NO:] Do you know where to find information about health insurance for this child?

1 - YES
2 - NO
9 - DK/REF

Q6. Does {he/she} currently have a doctor or other health professional, such as a physician's assistant, whom you consider {his/her} primary healthcare provider and whom you would take {him/her} to see for medical care? (This includes having access to an Urgent Care Facility or other clinic that maintains the child's health records.)

1 - YES
2 - NO
9 - DK/REF

Q7. Do you have an immunization card for {him/her}?

1 - YES
2 - NO -----------------------------------> GO TO Q8
9 - DK/REF -----------------------------------> GO TO Q8

Q7a. [IF YES:] Do you know where that card is?

1 - YES
2 - NO
9 - DK/REF

Q8. Overall, would you say {his/her} health is...

1 - excellent,
2 - very good,
3 - good,
4 - fair, or
5 - poor?
9 - DK/REF

Q9. Thinking now about the past 12 months, how many times did {he/she} receive a well-child checkup, that is, a general checkup when {he/she} was not sick or injured? (such as routine or preventive care; but not including going to the doctor only to get a vaccination; or only a vision or hearing check at school or other clinic)

____________ NUMBER OF VISITS IN PAST 12 MONTHS
99 - DK/REF
Q10. **[IF AT LEAST 1 YEAR OLD:]** About how long has it been since {he/she} last visited a dentist or a dental clinic? Include dental hygienists and all types of dental specialists.

1 - HAS NEVER VISITED
2 - LESS THAN 6 MONTHS AGO
3 - 6 MONTHS UP TO 1 YEAR AGO
4 - 1 YEAR UP TO 2 YEARS AGO
5 - 2 YEARS UP TO 5 YEARS AGO
6 - MORE THAN 5 YEARS AGO
9 - DK/REF

Q11. **[IF AT LEAST 3 YEARS OLD:]** Has a pediatrician, eye doctor, or other professional ever checked {his/her} vision?

1 - YES
2 - NO
9 - DK/REF

Q11a. **[IF YES:]** About how many months ago did {he/she} last receive a vision check or exam? [CONVERT YEARS INTO MONTHS]

_______ MONTHS AGO
99 - DK/REF

Q12. **[IF AT LEAST 1 YEAR OLD:]** Has a doctor or another professional ever had {him/her} pick up small objects, stack blocks, throw a ball, or recognize different colors? (Has a doctor or another professional ever asked you questions about the way the child walks, plays, or learns? This includes a teacher, therapist, etc.)

1 - YES
2 - NO
9 - DK/REF

Q12a. **[IF YES:]** About how many months ago was that? [CONVERT YEARS INTO MONTHS]

_______ MONTHS AGO
99 - DK/REF

Q13. **[IF AT LEAST 6 WEEKS OLD:]** Was {he/she} breastfeeding at all when {he/she} was 6 weeks old?

1 - YES
2 - NO
9 - DK/REF

Q14. **[IF AT LEAST 6 MONTHS OLD:]** Was {he/she} breastfeeding at all when {he/she} was 6 months old?

1 - YES
2 - NO
9 - DK/REF
[IF AT LEAST 1 YEAR OLD, ASK Q15-Q17:]

Q15. Now I would like you to think about this child compared to other children {his/her} age. Compared to other children {his/her} age, how often does this child… Would you say more often than the average child, about as often as the average child, less often than the average child, or do you not have a chance to see this child with other children {his/her} age?*

[RECORD AS "7" IF DON'T SEE CHILD WITH OTHER CHILDREN ---> GO TO Q18]

<table>
<thead>
<tr>
<th>More often</th>
<th>As often</th>
<th>Less often</th>
<th>DK/REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) throw temper tantrums when {he/she} doesn’t get {his/her} way? ........................................ 1 2 3 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) hit, kick or bite others when {he/she} is angry? ............. 1 2 3 9</td>
<td></td>
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</tr>
<tr>
<td>3) use words to say how {he/she} is feeling? (such as &quot;I am happy,&quot; &quot;I am sad,&quot; &quot;I am frustrated&quot;) ...... 1 2 3 9</td>
<td></td>
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</tr>
<tr>
<td>4) calm {himself/herself} down when {he/she} is angry or sad? ............................................................ 1 2 3 9</td>
<td></td>
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</tr>
<tr>
<td>5) use words to say what {he/she} wants? ............................... 1 2 3 9</td>
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</tbody>
</table>

Q16. Again, compared to other children {his/her} age, how well would you say {he/she} gets along with other children? Would you say...*

1 - better than the average child,
2 - about the same as the average child, or
3 - not as well as the average child?
9 - DK/REF

Q17. And how well does {he/she} get along with adults, such as parents, teachers, child care providers, or relatives? Would you say...*

1 - better than the average child,
2 - about the same as the average child, or
3 - not as well as the average child?
9 - DK/REF

[ASK EVERYONE:]

Q18. The following few questions refer to your day care or child care needs during the day, before and after school, or in the evening while you are at work or school, as well as any preschool this child might have attended. These questions do not apply to babysitting needed for fun or social activities. [PAUSE:] If you needed someone to take care of this child, would you know how to locate a child care center or provider?

1 - YES
2 - NO
9 - DK/REF
Q19. Has this child ever spent time in a group child care setting or gone to preschool? This would include any kind of program where the child is learning with other children of his/her age. (could be private, faith-based, public, state, Headstart, or another kind)

1 - YES  
2 - NO  
9 - DK/REF

Q19a. In the last 12 months, which of the following best describes who provided most of the child care this child received, if any? [IF MORE THAN ONE TYPE OF CARE, RECORD THE ONE IN WHICH THE CHILD SPENT THE MOST TIME]

1 - Preschool or child care in a center-based program (not in anyone's home)  
2 - Child care in a family child care home (not in your home; but where the provider has a home business of caring for other people's children)  
3 - A child care provider in your home (i.e., nanny, live-in or au pair; but more than a babysitter, and not a friend, neighbor or relative)  
4 - A family member or relative (in either your home or theirs)  
5 - A friend or neighbor (in either your home or theirs)  
6 - OTHER, SPECIFY: ___________________________________________  
7 - NO CHILD CARE/PRESCHOOL IN LAST 12 MONTHS -------> GO TO Q19c  
9 - DK/REF

Q19b. Last week, approximately how many total hours did this child spend in any type of child care or preschool, if any? Please include time spent at [RESPONSE TO Q19A] and time spent in any other child care or preschool setting. [FROM SUNDAY THROUGH SATURDAY; RECORD TOTAL HOURS IN ALL FORMS OF CHILD CARE AND PRESCHOOL; ROUND TO THE NEAREST HALF HOUR (.0 or .5); CLARIFY RANGES AND USE UPPER END OF RANGE IF UNABLE TO CLARIFY]

_________ TOTAL HOURS LAST WEEK  
97.7 - 97.7+ HOURS  
99.9 - DK/REF

Q19c. Has this child ever been sent home from a child care setting or preschool because of {his/her} behavior or have you ever lost a provider because of {his/her} behavior?

1 - YES  
2 - NO  
9 - DK/REF

Q20. [IF AT LEAST 1 YEAR OLD:] On average, about how many hours a day does this child watch television or videos in your household on weekdays, that is, Mondays through Fridays? [CONFIRM:] So, that's about ____ hours per day Mondays through Fridays, right? [ROUND TO THE NEAREST HALF HOUR (.0 or .5); CLARIFY RANGES AND USE UPPER END OF RANGE IF UNABLE TO CLARIFY; IF ASKED, INCLUDE ANY TIME THE TV IS ON AND THE CHILD IS WITHIN EARSHT]

_________ HOURS PER WEEKDAY DAY  
97.7 - NO TV IN HOUSEHOLD VOLUNTEERED  
99.9 - DK/REF
Q21.  **[IF AT LEAST 1 YEAR OLD:]** On average, how many hours a day does {he/she} watch television or videos on weekends?  **[CONFIRM:]** So, that's about ____ hours per day on Saturdays and Sundays, right?  **[ROUND TO THE NEAREST HALF HOUR (.0 or .5); CLARIFY RANGES AND USE UPPER END OF RANGE IF UNABLE TO CLARIFY; IF ASKED, INCLUDE ANY TIME THE TV IS ON AND THE CHILD IS WITHIN EARSHOT]**

**HOURS PER WEEKEND DAY**

97.7 - NO TV IN HOUSEHOLD VOLUNTEERED  
99.9 - DK/REF

Q22.  In a typical week, how often do you, other people in the household, or other family members not living in the household... Would you say not at all, one or two times a week, three to six times a week, or every day?  **[REPEAT FOR EACH ITEM]**

<table>
<thead>
<tr>
<th></th>
<th>Not</th>
<th>1-2X</th>
<th>3-6X</th>
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Q23.  **[IF AT LEAST 1 YEAR OLD:]** Now, as I’m sure you know, every child has moments when he or she gets frustrated or upset. These moments can be just as frustrating and upsetting for us raising the child. Everyone deals with a child’s behavior differently. What have you found to be the most effective way to get this child to behave well? (What do you do if you really need {him/her} to do something, or to stop doing something?)  **[PROBE AND CLARIFY CAREFULLY]**

99 - DK/REF
Q24. Please tell me how much you agree or disagree with the following two statements. The first one is... Would you say you strongly agree, somewhat agree, somewhat disagree, or strongly disagree?*

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<th>SA</th>
<th>Smt Ag</th>
<th>Smt Dis</th>
<th>SD</th>
<th>DK/REF</th>
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<tr>
<td>1)</td>
<td>I am this child's first and most important teacher.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2)</td>
<td>I feel confident as a caregiver about how to help this child grow and learn to the best of {his/her} ability.</td>
<td>1</td>
<td>2</td>
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Q25. Of the following statements, please tell me the one that best describes how you feel about yourself as a caregiver for this child...*

1 - I am not very good at being a caregiver,
2 - I have some trouble being a caregiver,
3 - I am an average caregiver,
4 - I am a better than average caregiver, or
5 - I am a very good caregiver?
9 - DK/REF

Q26. In the last 12 months, have you participated in a community service or other volunteer activity that helped local children and families, or not?

1 - YES
2 - NO
9 - DK/REF

Q27. Besides family or friends, do you know anywhere else to call to get help with the stresses of taking care of a child, if needed?

1 - YES
2 - NO
9 - DK/REF

Q28. Have you ever received a "Kit for New Parents," a brightly colored box that contains videos and other information about child development? These kits are provided by doctors' offices, hospitals, clinics, and other programs in the county.

1 - YES
2 - NO
9 - DK/REF

Q29. Before this interview, had you heard of "First 5 San Diego"?

1 - YES
2 - NO
9 - DK/REF

Q30. Have you ever heard of the "San Diego Young Children's Foundation"?

1 - YES
2 - NO
9 - DK/REF
Q31. In closing, the following questions are for comparison purposes only. What is the highest grade or year of school that you have completed and received credit for... (This can be in the United States or another country.)

1 - did not graduate high school,
2 - a high school degree or G.E.D.;
3 - at least one year of college, trade or vocational school;
4 - graduated college with a bachelor's degree; or
5 - at least one year of graduate work beyond a bachelor's?
7 - DK
9 - REF

Q32. Which of the following ethnic groups do you most closely identify with...

1 - African, (Eritrean, Ethiopian, Somali, Sudanese, other African)
2 - African American or Black,
3 - American Indian or Alaskan Native,
4 - Asian, (Cambodian, Chinese, Hmong, Indian, Japanese, Korean, Filipino, Thai, Vietnamese, other Asian)
5 - Hispanic or Latino, (Central or South American, Mexican, Puerto Rican, other Hispanic/Latino)
6 - Middle Eastern, (Afghan, Arab, Assyrian, Chaldean, Iranian, Kurdish, other Middle Eastern such as Israeli)
7 - Pacific Islander, (Guamanian, Native Hawaiian, Samoan, other Pacific Islander)
8 - White or Caucasian, or
9 - another ethnic group? [SPECIFY: ________________________________]
   [INCLUDE COMBINATIONS ABOVE IF EQUAL]
97 - DK
99 - REF

Q33. Which one language do you and your family speak the most at home? [IF COMBINATION, PROBE FOR ONE SPOKEN MOST AT HOME]

1 - AMHARIC
2 - ARABIC
3 - CHINESE
4 - ENGLISH
5 - LAO
6 - SOMALI
7 - SPANISH
8 - TAGALOG
9 - VIETNAMESE
10 - OTHER, SPECIFY: ________________________________
97 - DK
99 - REF

Q34. How many adults age 18 or older, including yourself, live in your household?

____________ ADULTS
97 - DK
99 - REF
Q35. How many children under age 6 live in your household?

___________ CHILDREN UNDER 6
97 - DK
99 – REF

Q36. How many children between the ages of 6 and 17 live in your household?

___________ CHILDREN 6 TO 17
97 - DK
99 - REF

Q37. Please tell me when I mention the category that contains your age...

1 - 18 to 24,
2 - 25 to 34,
3 - 35 to 44,
4 - 45 to 54,
5 - 55 to 64, or
6 - 65 or over?
7 - DK
9 – REF

Q38. Now, we don't want to know your exact income, but just roughly, could you tell me if your annual household income before taxes is...

1 - under $25,000,
2 - $25,000 up to but not including $50,000,
3 - $50,000 up to (but not including) $75,000,
4 - $75,000 up to (but not including) $100,000, or
5 - $100,000 or more?
7 - DK
9 - REF

Q39. What is your relationship to the child we have been talking about today?

[CLARIFY PER CATEGORIES BELOW BEFORE CODING; IF "MOTHER" OR "FATHER," PROBE:] And would that be the birth {mother/father}, step-{mother/father}, adoptive {mother/father}, or foster {mother/father}?

1 - BIRTH MOTHER
2 - BIRTH FATHER
3 - STEPMOTHER
4 - STEPFATHER
5 - ADOPTIVE MOTHER
6 - ADOPTIVE FATHER
7 - FOSTER MOTHER
8 - FOSTER FATHER
9 - FEMALE PARTNER OF MOTHER
10 - MALE PARTNER OF MOTHER
11 - FEMALE PARTNER OF FATHER
12 - MALE PARTNER OF FATHER
13 - GRANDMOTHER
Q40. Can you tell me {his/her} birth date? Let's start with...

the month? __________ (1-12)
99-DK/REF

the day? __________ (1-31)
99-DK/REF

the year? __________ (1999-2005)
9999-DK/REF

Q41. I have some contact numbers and some information about: INFO LINE, resources for parenting, immunizations, healthcare insurance, and child care services. Are you interested in finding out more about... [IF NO/DK/REF, CODE AND GO TO NEXT QUESTION; IF YES, READ INFORMATION AS INDICATED; REFER TO INFO LINE OR PARENTING LINK FOR THE WIDEST RANGE OF SERVICES]

a. ...INFO LINE?

1 - YES
2 - NO
9 - DK/REF

[IF YES, READ BELOW BEFORE CODING:]
For general referrals, call INFO LINE by region: (bilingual Spanish)

Greater San Diego: 619-230-0997
North County Coastal: 760-943-0997
North County Inland: 760-740-0997
Outlying Areas Only: 800-227-0997
TTY: 858-300-1311

b. ...parenting information?

1 - YES
2 - NO
9 - DK/REF

[IF YES, READ BELOW BEFORE CODING:]
For parenting information, call the Parenting Link: 619-297-9600 or 1-866-4-FAMILIES (1-866-432-6457); www.informsandiegofamilies.com/

for adult education classes: [SEE INFO LINE ABOVE]
c. ...immunization services?

1 - YES
2 - NO
9 - DK/REF

[IF YES, READ BELOW BEFORE CODING:]
For immunization services provided by the San Diego County Immunization Initiative, call the Baby Shots Line: 619-692-6600 (Staffed by an immunization nurse during regular business hours. Call to check immunization records over the telephone, and get referrals for free immunization services for infants and toddlers under 2 years of age throughout the county. More than 40 public clinic locations in San Diego County.) www.immunization-sd.org/eng/programs.html

d. ...healthcare insurance?

1 - YES
2 - NO
9 - DK/REF

[IF YES, READ BELOW BEFORE CODING:]
For healthcare insurance by region:

- Central: SAY San Diego at 619-582-9056
- East: Neighborhood Health Care at 619-517-7993
- North Central: SAY San Diego at 858-974-3603, ext. 238 or ext. 244
- North Coastal: Rosie Rodriguez, Vista Community Clinic at 760-407-1220 x)126
- North Inland: Anita Inigez, North County Health Services at 760-736-8716
- South: Home Start at 619-422-9208

ALSO: San Diego Kids Health Assurance Network at 1-800-675-2229
www.co.san-diego.ca.us/sdkhan/

e. ...child care services?

1 - YES
2 - NO
9 - DK/REF

[IF YES, READ BELOW BEFORE CODING:]
For free child care referrals and other services, call the YMCA Child Care Resource Services: 1-800-481-2151 (from San Diego County only) or 619-521-3070 (outside San Diego County) Parents may call the toll free line to talk to a child care consultant about finding care for their child(ren) including smoke-free environments. Bilingual consultants are available in Spanish and Vietnamese. The consultant will interview the parent to find out the ages of the children, the type of care needed, the hours of care, and much more, in order to find the child care that fits the parent's need. The interview is completed when referrals are given to the parent. Also offers a behavioral health line (1-800-908-8883) where parents can talk with someone about aggression, biting, separation anxiety, or other behavioral concerns.
www.ymcacrs.org/home.html
f. ...other information about First 5 or the survey itself?

1 - YES
2 - NO
9 - DK/REF

[IF YES, READ BELOW BEFORE CODING:]
For questions about "First 5 Commission of San Diego County": 866-726-8831
www.ccfc.ca.gov/sandiego

For questions about the survey itself: Michelle Plata at Harder+Company Community Research, 619-398-1980 (English and Spanish)

Q42. I'd like to thank you for speaking with me today. Your responses will help shape future services for young children and their families in San Diego County. Do you have anything else you would like to add?

____________________________________________________________

________________________________

99 - NO/DK/REF

LAN. [LANGUAGE OF INTERVIEW:] 1 - ENGLISH 2 - SPANISH

NAM. Those are all the questions I have. In case my supervisor should need to verify this interview, may I please have just your first name or initials? Your name and phone number will be separated from your responses to these questions and destroyed after the data has been processed.

[VERIFY AND INSERT RESPONDENT'S NAME:] __________________________

[THANK RESPONDENT; RECORD REMAINING INFORMATION BELOW]

TIN. [INTERVIEWER NUMBER:] __________

LEN. [LENGTH OF INTERVIEW IN MINUTES:] __________

DAT. [DATE OF INTERVIEW:] __________________________

REC. [CATI RECORD NUMBER:] ________________