ALL OUR FAMILIES STUDY

WOMEN'S WELLNESS DESCRIPTIVE REPORT: 12-14 YEAR FOLLOW-UP

WINTER 2025

UCALGARY.CA/ALLOURFAMILIES

Suzanne Tough, PhD (Principal Investigator)
Professor
Department of Paediatrics, Cumming School of Medicine, University of Calgary
Burns Memorial Fund and Max Bell Foundation Policy Fellow
389, 3820 24th Avenue NW
Calgary, Alberta, T3B 2X9
Email: stough@ucalgary.ca

Sheila McDonald, PhD (Co-Principal Investigator)
Manager
Early Years Health Promotion Team, Healthy Children and Families
Promoting Health, Provincial, Population & Public Health
Alberta Health Services
Adjunct Assistant Professor
Department of Paediatrics, Cumming School of Medicine, University of Calgary
2255, 10101 Southport Road SW
Calgary, Alberta, T2W 3N2
Email: sheilaw.mcdonald@ahs.ca

Kristan Kushlyk, MA
Research Analyst
3820 24th Avenue NW
Calgary, Alberta, T3B 2X9
Email: kristan.kushlyk@ucalgary.ca

Muci Wu, BSc
Research Program Manager
3820 24th Avenue NW
Calgary, Alberta, T3B 2X9
Email: muci.wu@ucalgary.ca

Julia Wilson, MSc
Research Analyst
3820 24th Avenue NW
Calgary, Alberta, T3B 2X9
Email: julia.wilson2@ucalgary.ca

This publication is not copyrighted and is in the public domain. Duplication is encouraged.

Suggested reference for this report: Tough SC, McDonald SW, Kushlyk KE, Wu M, Wilson J. All Our Families Study: Women's Wellness Descriptive Report: 12-14 Year Follow-Up, University of Calgary. 2025.

CONTENTS

TABLES 5
ACKNOWLEDGEMENTS 6
TECHNICAL SUMMARY 6
HISTORY OF THE ALL OUR FAMILIES STUDY 6
OBJECTIVES 7
METHODS 7
DATA COLLECTION 7
ANALYSIS 8
ETHICS APPROVAL 8
HIGHLIGHTED RESULTS 8
DESCRIPTIVE STATISTICS 10
DEMOGRAPHICS 10
Employment, Schooling, and Volunteerism Arrangements 11
IN THE HOUSEHOLD 13
People and Pets in the Home 13
Perceptions of Household Financial and Food Security 15
EMOTIONAL WELL-BEING & MENTAL HEALTH SERVICE USE 16
Life Satisfaction 16
Spiritual Well-being 17
Stressful Life Events and Discrimination 18
Anxiety and Depression Symptoms, and Perceptions of Stress 19
Time Pressure 20
Flourishing and Languishing 20
PHYSICAL HEALTH AND HEALTH SERVICES ACCESS 21
Sleep 21
Physical Activity 22
Health Diagnoses 22
Aches and Pains 23
Migraines and Headaches 25
Cervical Screening 25
Urinary Incontinence and Pelvic Floor Health 27
Menstruation, Menopause, and Gynecological Interventions 28
LIFESTYLE AND LEISURE 32

Leisure and Physical Activity ... 32
Substance Use ... 33
Digital Device and Web Use ... 34
Web-based Executive Function ... 35
Parental Technology Management ... 36
IN THE COMMUNITY ... 38
Community Belongingness and Social Standing ... 38
Perceptions of Neighbourhood Cohesion ... 38
Perceptions of Social Support ... 39
BIVARIATE ANALYSES ... 41
Household Income and Mental Health ... 41
Time Pressure and Mental Health ... 42
WOMEN-YOUTH ASSOCIATIONS ... 44
Flourishing ... 44
Mental Health ... 44
Chronic Pain ... 45
HIGHLIGHTED RESULTS ... 45
CONCLUSION ... 45
REFERENCES CITED ... 47
APPENDIX A: Maternal QUESTIONNAIRE AND INSTRUMENT INFORMATION ... 48

TABLES

Table 1: Demographics 10
Table 2: Schooling and volunteerism 12
Table 3: Employment sectors, working location, and satisfaction with arrangement 12
Table 4: Family status and living arrangements 13
Table 5: Household pets 14
Table 6: Perceptions of household financial and food security 15
Table 7: Life satisfaction Measure 17
Table 8: Adaptation of Fisher's Spiritual Well-being Scale 17
Table 9: Raine Stressful Events Scale 18
Table 10: Stressful life events and discrimination experiences 18
Table 11: Mental health and perceived stress 19
Table 12: Perceived stressors 20
Table 13: Time pressure 20
Table 14: Flourishing 21
Table 15: Sleep habits 22
Table 16: Physical activity duration 22
Table 17: Health diagnoses 23
Table 18: Women's and other biological parent's aches and pains 24
Table 19: Aches and pain duration 24
Table 20: Aches and pains locations 25
Table 21: Women's and parental migraines 25
Table 22: Cervical screening 26
Table 23: Reasons for not undergoing pap test 26
Table 24: Sandvik severity index for urinary incontinence 27
Table 25: Urinary incontinence interference with everyday life 28
Table 26: Pelvic floor health 28
Table 27: Disruption to menstruation 29
Table 28: Age at which menstruation stopped or uterus removed 30
Table 29: Reasons for menstrual cessation 30
Table 30: Gynecological surgeries 30
Table 31: Menopause symptoms 30
Table 32: Hormone replacement therapies 31
Table 33: Pregnancies and live births 31
Table 34: Family leisure activities 32
Table 35: Substance use 33
Table 36: Technology engagement and screen time 35
Table 37: Frequency of digital device interrupting engagement among youth 35
Table 38: Web-based executive function 36
Table 39: Parental management of youth digital activities 37
Table 40: Belongingness 38
Table 41: Subjective social status 38
Table 42: Neighbourhood cohesion. 39
Table 43: Neighbourhood cohesion, NLSCY-PNC 39
Table 44: Social support 40

Table 45: Relationship happiness 41
Table 46: Household income and mental health proportions 42
Table 47: Time pressure and mental health proportions 43
Table 48: Women and youth flourishing proportions 44
Table 49: Women and youth anxiety proportions 44
Table 50: Women and youth depression proportions 44
Table 51: Women and youth's chronic pain reporting proportions 45

ACKNOWLEDGEMENTS

We are extremely grateful to all of the families who have and continue to take part in this study, including both the women and their youth. In addition, we acknowledge and express our gratitude to the investigators, coordinators, and research staff for their hard work designing and piloting research surveys, communicating with families, and analyzing and sharing data. We also respectfully acknowledge and pay tribute to the traditional territories of the peoples of Treaty 7 on which the University of Calgary operates, which include the Blackfoot Confederacy, the Tsuut'ina First Nation, and the Stoney Nakoda, as well as the lands of the Métis Nation of Alberta, Districts 5 and 6, upon which the City of Calgary is situated.

Initial funding for these cohorts was provided by Three Cheers for the Early Years, the Alberta Youth Hospital Foundation, and through Alberta Innovates Health Solutions Interdisciplinary Team Grants #200700595 and #200700586. Funding has also been received from the Alberta Children's Hospital Foundation, Canadian Institutes of Health Research, Institute of Digital Media and Child Development Inc and Social Sciences Humanities Research Council.

TECHNICAL SUMMARY

HISTORY OF THE ALL OUR FAMILIES STUDY

The All Our Families (AOF) study began as the All Our Babies (AOB) study in 2008. It is a prospective cohort study of approximately 3,200 mothers and their children in Calgary, Alberta. AOF was initially designed to examine maternal and infant outcomes during the perinatal period and to identify barriers and facilitators to accessing health care services. Mothers who agreed to participate were asked to complete three surveys: the first during the second trimester (<25 weeks gestation), the second during the third trimester (34-36 weeks gestation), and the third at four months postpartum. Participants were also asked to provide consent to the research team to access their obstetrical and birth records (McDonald et al., 2013; Tough et al., 2017).

Compared with parents with young children in Calgary, Alberta and the broader Canadian context during a similar timeframe, the sociodemographic attributes of AOF participants at enrollment resembled the population of urban families who had children at the time in terms of age and education (Tough et al., 2017). However, a higher percentage of participants within the AOF cohort reported annual household earnings exceeding $60,000 (82%), in contrast to their counterparts in Calgary (65%), Alberta (61%), and the nationwide figure (56%) at the start of the study. Additionally, the proportion of AOF participants who were married (83%) was

elevated when compared with parenting females in Calgary (73%), Alberta (70%), and across Canada (60%).

Subsequent follow-up surveys were developed and administered to consenting and eligible participants to examine child development and parenting outcomes at 1, 2, 3, 5, and 8 years postnatally. Development of the next study follow-up survey began in August 2018 but was delayed due to the COVID-19 pandemic. Data collection for three maternal and youth COVID-19 Impact Surveys occurred between May 2020 through to January 2022. Survey design for the 12–14-year follow-up resumed in early 2023 and was completed by Spring of 2023. Data collection occurred at the beginning of 2023, concluding in July of 2023 with a 65% response rate to the women's survey. Participants were also asked to consent to having their youth participate in a youth survey, and among those who consented, 93% of youth completed the questionnaire. Additional information and previous reports can be found at the AOF website: https://ucalgary.ca/allourfamilies.

To recognize the developmental stage of life, this report will use the word 'women' in place of 'mother' or 'maternal' where appropriate to recognize the individuality of our All Our Families participants. We acknowledge that not all participants are mothers, and not all birthing parents identify as women. This language was selected to align with the existing literature and is not intended to exclude or diminish the experiences of individuals with diverse gender identities.

This report presents a summary of the data collected from AOF women in the study when their youth were 12-14 years of age. Descriptive statistics are provided for women based on demographics, community and peer connections, household dynamics, lifestyle, well-being, and development. Bivariate analyses also describe the relationships between various women's demographics, social stressors, and health outcomes.

OBJECTIVES

The objectives of this report are as follows:

1) To describe the AOF women's cohort with respect to demographics, social connections, mental and physical health, parenting, and lifestyle factors between 12 and 14 years post-delivery.
2) To examine bivariate associations between sample sociodemographic variables and women's health and youth outcomes.

METHODS

DATA COLLECTION

Between May 2008 and May 2011, a cohort of 3,387 pregnant individuals, ranging in age from 19 to 47, were recruited from a pool of eligible participants (n=4,003) in Calgary, Canada. To qualify for the study, participants needed to be under 25 weeks pregnant at the time they

joined, at least 18 years of age, receiving prenatal care within Calgary, Canada, and were capable of filling out questionnaires in English (McDonald et al., 2013; Tough et al., 2017). Current AOF participants were eligible for this follow-up study if they (1) agreed to additional research, (2) were currently active in the study, and (3) had an email address on file. All AOF surveys have been circulated to content experts, subspecialists, and clinical experts and pilot tested prior to distribution. Starting January 16th, 2023, the study invited women and their youth to participate in the 12–14-year follow-up through a personalized online link to University of Alberta's REDCap survey platform. Participants were sent email reminders and received phone calls from study research assistants to complete the questionnaire and were regularly reminded to provide consent for their child to participate in their own youth survey. Participants received between $15-25 gift cards for completing the survey, as well as an opportunity to win an Apple iPad if they completed early. After 24.5 weeks of active data collection, the 12–14-year surveys closed on July 7th, 2023.

Of the 2362 participants eligible to participate in this survey, 1529 responded to the survey (response = 65%).

Data was exported from REDCap on July 7th, 2023, into IBM SPSS, where data cleaning, management, and coding began shortly afterwards by the research team.

ANALYSIS

Data management and statistical analyses were performed using IBM SPSS. Descriptive statistics were calculated for all quantitative variables collected. Categorical variables are presented as proportions, and continuous variables are presented as sample means with standard deviation, minimum, and maximum values. Bivariate associations between categorical variables were conducted using Chi-square crosstabulations. Associations between categorical and continuous variables were conducted using t-tests. Continuous variable associations were conducted as correlations with Pearson's correlation coefficient. Statistical significance for all relevant analyses was set at $p<0.05$.

ETHICS APPROVAL

This original study was approved by the Child Health Research Office and the Conjoint Health Research Ethics Board of the Cumming School of Medicine, University of Calgary (Ethics ID 20821 and 22821). Participants provided consent at the time of recruitment to participate in the initial study and to be contacted for additional future research (REB13-0868).

HIGHLIGHTED RESULTS

Demographics

- The average age for women at this analysis was 44.0 (SD 4.3) years. Most identified as White/Caucasian (80.3%), were married or partnered (90.9%), heterosexual (84.3%), had a household income of $125,000 or greater (62.2%), and had graduated from a post-

secondary institution (59.7%). One in 10 participants reported some food insecurity (11.4%).

- Over 75% of women were employed and, of those, 73.5% worked 30 hours or more a week. Most commonly, participants reported employment in the health and social sector (26.7%), professional services (23.0%), or educational services (19.7%). Over one third (41.5%) of women worked entirely on-site, while 13.7% and 15.3% reported working mostly or entirely remotely, respectively. A hybrid model combining equally remote and on-site activities was reported by 15.8% of respondents. Over 90% of women were satisfied (48.9%) or very satisfied (39.4%) with their current work arrangements.

Mental Health and Life Satisfaction

- Overall, most (78.1%) women reported high life satisfaction in domains of work, family, housing, partner relationships, and social activities. The majority (75.5%) expressed contentment in their friendships and relationships and 74.0% reported feeling quite or extremely happy. The mean score for flourishing, defined as overall well-being and positive mental health, was high (87.76, SD 15.22, range of 21.00-120.00) suggesting that most participants were flourishing, felt supported and were satisfied in various domains of their lives.
- In terms of mental health, approximately one in three women (29.9%) exhibited symptoms of depression and one in four (24.8%) displayed elevated symptoms of anxiety. One in four (25.5%) had high scores on the perceived stress measure.
- The vast majority (81.4%) of respondents reported moderate or high social support in terms of emotional/information support, tangible support, affectionate support, and positive social interactions.
- Most women with household incomes above $125,000 reported high flourishing scores (89.6%) and low symptoms of stress (79.2%), depression (74.9%), and anxiety (79.1). Among respondents with household incomes below $125,000, 76.2% reported high flourishing scores and low symptoms of stress, depression, and anxiety were reported among 68.2%, 62.6%, and 69.2% participants, respectively.
- Increased time pressure was associated with increased symptoms of depression and anxiety.
- Women’s scores on flourishing, anxiety symptoms, depression symptoms and chronic pain were not associated with their youth’s scores on flourishing, anxiety symptoms, depression symptoms and chronic pain.

Lifestyle and Physical Health

- Most women were meeting Canadian physical health guidelines; this included sleeping between 7 to 9 hours on a regular basis (68.0%), having no more than 3 hours of recreational screen time per day, and obtaining at least 150 minutes of moderate- to vigorous-intensity physical activity each week (mean 3.47 hours per week, SD 3.71).

Moreover, most participants (89.2%) report meeting Canadian guidelines for receiving Pap tests for cervical cancer screening every 3 years or less.

- Over half (62.0%) of women reported some level of loss of bladder control and urinary leakage (urinary incontinence). Of these, 75.2% indicated some interference in their everyday life.
- The majority of women (77.8%) identified as premenopausal and still experienced menstrual cycles.
- Over half (62.8%) of respondents reported experiencing aches and pains at least once a month for three consecutive months.
- Within their communities, the majority of women reported a strong (25.9%) or somewhat strong (50.1%) sense of belonging within their local community and perceptions of neighbourhood cohesion were high among the sample.

DESCRIPTIVE STATISTICS

DEMOGRAPHICS

Demographic data were updated through the 12–14-year questionnaires. Almost all those who responded to this questionnaire identified as women (98.0%). Most participants were married or partnered (90.9%), had a household income of $125,000 or greater (62.2%), and had completed college, trade school, university, or higher (81.9%). The average age in this cohort was 44.0 (SD 4.3) years and the most common self-reported ethnicity was White/Caucasian (80.3%). Among participants, most identified as heterosexual (84.3%) (Table 1).

TABLE 1: DEMOGRAPHICS

Characteristic	N (%)
Relationship to AOF youth	
Mother	1467 (99.9)
Other caregiver	**
Relationship status	
Has a spouse/partner	1346 (90.9)
Does not have a spouse/ partner	135 (9.1)
Total household income (before taxes and deductions)	
$79,999 or less	201 (13.9)
$80,000-$99,999	137 (9.5)
$100,000-$124,999	208 (14.4)
$125,000-$174,999	330 (22.8)
$175,000 or more	572 (39.4)

Characteristic	N (%)
Education level	
Some elementary or high school (Grades 1-12)	23 (1.6)
Graduated high school	61 (4.1)
Some college/trade/university	183 (12.4)
Graduated college/trade/university	877 (59.7)
Some graduate school	41 (2.8)
Completed graduate school	285 (19.4)
Ethnicity	
White/ Caucasian	1201 (80.2)
Indigenous (First Nations, Inuk/Inuit, Métis)	9 (0.6)
Black / African North American	16 (1.1)
East Asian	84 (5.7)
Southeast Asian	45 (3.0)
South Asian	45 (3.0)
Middle Eastern	17 (1.2)
Latin American	25 (1.7)
Other ethnicity	53 (3.5)
Gender identity	
Woman	1440 (98.0)
Man	19 (1.3)
Prefers not to answer	6 (0.4)
Gender-fluid, Trans man, Two-spirit, or does not identify with any options	**
Sexual orientation	
Heterosexual	1238 (84.3)
Asexual	94 (6.4)
Prefers not to answer	51 (3.5)
Bisexual	47 (3.2)
Does not identify with any of the options	20 (1.4)
Pansexual	10 (0.7)
Gay, Lesbian, Queer, or Two-spirit	**
	Mean (SD)
Age at 12–14-year follow-up	44.0 (4.3)

** denotes data suppression due to small cell sizes.

Employment, Schooling, and Volunteerism Arrangements

Employment status revealed that 75.9% of women were employed by an individual or company. Among these, 44.5% worked 30-44 hours per week, 20.1% worked part-time (less than 30 hours per week), and 11.3% worked more than 44 hours per week (Table 2). One in five participants (21.7%) were self-employed and, of them, most worked less than 30 hours per week (63.1%). Approximately half (53.6%) volunteered.

The sector of employment varied, with a large portion of respondents working in health care and social assistance (26.7%); professional, scientific, and technical services (23.0%); and educational services (19.7%).

Work or school arrangements due to recent changes (possibly due to events like the COVID-19 pandemic) are listed in Table 3. Work arrangements varied with 41.5% reporting working exclusively at the workplace or school and 15.3% working exclusively remotely. Hybrid arrangements were also common with 15.8% working mostly in-person, 13.7% working half remotely, and 13.7% working mostly remotely. Satisfaction with the current work arrangement suggested that most respondents were satisfied (48.9%) or very satisfied (39.4%). Conversely, one in ten women were either unsatisfied (5.9%) or very unsatisfied (5.8%) with their current work arrangement. When asked about their ideal work/school arrangement, approximately a third of the sample (32.0%) reported favouring an even split between remote work and being at the workplace or school. About one in five (18.2%) reported their ideal arrangement would be entirely at the workplace and 15.3% would ideally work entirely remotely (Table 3).

TABLE 2: SCHOOLING AND VOLUNTEERISM

Question	Yes, less than 30 hours per week N (%)	Yes, 30-44 hours per week N (%)	Yes, more than 44 hours per week N (%)	No N (%)
Are you working for pay for an individual or a company?	302 (20.1)	670 (44.5)	170 (11.3)	362 (24.1)
Are you self-employed?	205 (13.7)	77 (5.1)	43 (2.9)	1174 (78.3)
Are you attending school?	96 (6.4)	26 (1.7)	9 (0.7)	1360 (91.2)
Do you volunteer?	782 (52.4)	9 (0.6)	8 (0.6)	692 (46.4)

TABLE 3: EMPLOYMENT SECTORS, WORKING LOCATION, AND SATISFACTION WITH ARRANGEMENT

Category	Response	N (%)
What sector do you work in or did you work in most recently?		
	Health and social work	402 (26.7)
	Professional, scientific, technical services	345 (23.0)
	Educational services	296 (19.7)
	Oil and gas	91 (6.1)
	Wholesale and retail	67 (4.5)
	Construction	47 (3.1)
	Art and entertainment	40 (2.7)
	Agriculture, forestry, fishing and hunting	18 (1.2)
	Hospitality	34 (2.3)
	Other	161 (10.7)
What is your current work/school arrangement?		
	Entirely at workplace	553 (41.5)
	Mostly at workplace	210 (15.8)
	Half at workplace	182 (13.7)

Category	Response	N (%)
	Mostly remotely	182 (13.7)
	Entirely remote	203 (15.3)
How satisfied are you with this current arrangement?		
	Very unsatisfied	77 (5.8)
	Unsatisfied	79 (5.9)
	Satisfied	651 (48.9)
	Very satisfied	524 (39.4)
What would be your ideal work/school arrangement?		
	Entirely at workplace	272 (18.2)
	Mostly at workplace	233 (15.6)
	Half at workplace	478 (32.0)
	Mostly remotely	283 (18.9)
	Entirely remote	229 (15.3)

** denotes data suppression due to small cell sizes.

IN THE HOUSEHOLD

People and Pets in the Home

The majority of respondents indicated that they lived in a two-parent family with both biological parents of their youth (84.5%) (Table 4). Fewer lived in a two-parent family with one biological and one non-biological parent (4.1%), a single-parent family (9.4%), or other arrangements (2.0%). For the 15.4% not living in a two biological parent home of their youth, a large proportion (68.1%) reported that their youth lived with them more than 60% of the time in the previous 12 months. Fewer (3.1%) indicated that their youth lived with them less than 40% of the time or not at all. When considering the number of people in the household, most women reported living with one other adult (79.0%). Moreover, a significant number of households contained two youth aged 10-17 (58.2%) (Table 4). 41.3% of households had children aged 5-9 and most households did not have children under 5 years old (91.3%).

The presence of household pets was common, with 71.3% of the sample having pets (Table 5). Dogs were the most common pet, with 59.6% of pet owners having one dog and most having only one pet (46.0%).

TABLE 4: FAMILY STATUS AND LIVING ARRANGEMENTS

	N (%)
Two parent family (both biological parents)	1246 (84.5)
Two parent family (one biological parent, one non-biological parent)	60 (4.1)
Single parent family	138 (9.4)
Other	29 (2.0)
If not in a two biological parent home: **In the past 12 months, what percentage of the time did your child live with you?**	

	N (%)
None or Less than 40% (If not in a two biological parent home)	7 (3.1)
Between 40% and 60% (If not in a two biological parent home)	65 (28.8)
More than 60% (If not in a two biological parent home)	154 (68.1)
Number of adults in household	
1 adult	143 (9.7)
2 adults	1160 (79.0)
3 adults	113 (7.7)
4 adults	43 (2.9)
5 or more adults	9 (0.7)
Number of youth in household	
1 youth aged 10-17	453 (30.8)
2 youths aged 10-17	856 (58.2)
3 youths aged 10-17	135 (9.2)
4 or more youths aged 10-17	26 (1.8)
Number of children aged 5-9 in household	
0 children aged 5-9	468 (49.4)
1 child aged 5-9	391 (41.3)
2 children aged 5-9	78 (8.2)
3 or more children aged 5-9	10 (1.1)
Number of children under 5 in household	
0 children under 5	629 (91.3)
1 child under 5	48 (7.0)
2 or more children under 5	12 (1.7)

TABLE 5: HOUSEHOLD PETS

		N (%)
Do you have any household pets?	Yes	1050 (71.3)
	No	423 (28.7)
If has pets: total number of household pets	1	483 (46.0)
	2	274 (26.1)
	Other	293 (27.9)
How many: Dogs?	0	175 (19.4)
	1	536 (59.6)
	2	158 (17.6)
	3 or more	31 (3.4)
How many: Cats?	0	268 (38.7)
	1	231 (33.3)
	2	150 (21.6)
	3 or more	44 (6.4)
How many: Birds?	0	460 (90.5)
	1	18 (3.5)

	2	15 (3.0)
	3 or more	15 (3.0)
How many: Reptiles?	0	446 (83.9)
	1	72 (13.6)
	2	9 (1.7)
	3 or more	4 (0.8)
How many: Rodents? (e.g., hamster)	0	425 (77.9)
	1	81 (14.9)
	2	27 (5.0)
	3 or more	12 (2.2)
Any additional household pets?	Yes	147 (9.6)
	No	1382 (90.4)

Perceptions of Household Financial and Food Security

The Food Insecurity Screener, used to identify households at risk for food insecurity, revealed that 11.4% of respondents were food insecure (Appendix A). Almost 90% of participants indicated that they had the financial resources needed to meet their family's needs, with 49.2% reporting they always had the necessary resources (Table 6). However, a small portion of the sample expressed financial difficulties, with 1.5% stating they rarely or never had sufficient financial resources.

When asked about worries concerning having enough money for important family matters, 28.6% reported they rarely or never worry. Conversely, 9.7% of respondents stated they always worry about this issue.

Most women reported never worrying about running out of food before they had money to buy more (89.5%) and 93.5% said the food they bought lasted and they did not run out of money to get more. Nevertheless, there were families that sometimes or often faced food insecurity. Among these, one in ten sometimes (8.9%) or always (1.6%) worried about running out of food before they had the money to buy more. Few reported sometimes (5.3%) or often (1.2%) experiencing food not lasting before having the money to buy more (Table 6).

TABLE 6: PERCEPTIONS OF HOUSEHOLD FINANCIAL AND FOOD SECURITY

	Response	N (%)
Please indicate if you have the financial resources you need to meet your family's needs		
	1 Rarely/Never	22 (1.5)
	2	20 (1.4)
	3	53 (3.6)
	4	98 (6.7)
	5	204 (13.9)
	6	348 (23.7)
	7 Always	722 (49.2)

How often do you worry about having enough money to do what is important for your family?		
	1 Rarely/Never	421 (28.6)
	2	228 (15.5)
	3	101 (6.9)
	4	126 (8.6)
	5	239 (16.2)
	6	213 (14.5)
	7 Always	143 (9.7)
Food Insecurity Screener score	Not food insecure	1306 (88.6)
	Food insecure	168 (11.4)
Within the past 12 months, we worried whether our food would run out before we got money to buy more.		
	Never true	1317 (89.5)
	Sometimes true	131 (8.9)
	Often true	23 (1.6)
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.		
	Never true	1367 (93.5)
	Sometimes true	77 (5.3)
	Often true	18 (1.2)

EMOTIONAL WELL-BEING & MENTAL HEALTH SERVICE USE

Life Satisfaction

The Life Satisfaction Measure determines satisfaction in various domains such as work, family, housing, partner relationships, and social activities (Appendix A). Life satisfaction scores had a range of 0-40. Respondents reported a mean life satisfaction score of 26.9 (SD 6.0) (Table 7). With higher scores indicating a greater level of satisfaction, this score suggests that the majority of respondents were content with their achievements in various life domains.

The data highlighted high satisfaction levels in work, career, and work-life balance, with most being "quite a bit" or "very much" satisfied. Most respondents expressed contentment by being "quite a bit" and "very much" satisfied with housing and family relationships. While satisfaction was predominant in partner and closest personal relationships, friendships, and social activities, a small fraction reported lower satisfaction levels. In contrast, the relationship between their youth displayed substantial satisfaction, with only a few expressing dissatisfaction. Overall, this indicated high life satisfaction among AOF women in various domains.

TABLE 7: LIFE SATISFACTION MEASURE

Mean Score Range	N (%)
Scored < 10	6 (0.4)
Scored 10 - 20	146 (10.0)
Scored 20 - 30	802 (55.0)
Scored > 30	504 (34.6)

N	Minimum	Maximum	Mean	Std. Deviation
1458	0.00	40.00	26.92	6.03

Spiritual Well-being

Spiritual well-being encompasses one's sense of purpose, values, and connectedness to the environment and/or a higher spiritual power. The Fisher's Spiritual Well-being (SWB) scale assesses spiritual health in multiple domains including personal, communal, environmental, and transcendental (Appendix A). Participants reported a mean spiritual well-being score of 31.8 (SD 4.8) on the adapted version of the SWB scale, where scores can range from 8.00-40.00 (Table 8), with higher scores suggesting greater SWB. On average, respondents reported a high level of SWB with the majority reporting higher scores.

Regarding the importance of feeling that life has meaning or purpose, the majority rated it as either important (41.7%) or very important (43.7%). Similarly, when assessing the importance of experiencing joy or happiness in life, most respondents found it important (44.4%) or very important (49.6%).

Further, these data indicated that respondents highly value prosocial aspects of SWB. A majority considered being kind to others and forgiving of others as important (32.4% and 44.2%, respectively) or very important (64.0% and 37.1%, respectively). In terms of the importance of feeling connected to nature and caring for the natural environment, there were varying levels of concern. However, a notable proportion rated these aspects as important (36.1% and 42.4%, respectively) or very important (36.5% and 30.3%, respectively). Participants showed a range of perspectives on the importance of feeling a connection to a higher spiritual power and the importance of meditating or praying, with some rating these as less important (19.5% and 22.1%), average importance (21.5% and 24.2%), or very important (24.8% and 20.5%).

TABLE 8: ADAPTATION OF FISHER'S SPIRITUAL WELL-BEING SCALE

Mean Score Range	N (%)
Scored < 16	**
Scored 16 - 24	95 (6.5)
Scored 24 - 32	715 (48.9)
Scored > 32	650 (44.4)

N	Minimum	Maximum	Mean	Std. Deviation
1463	14.00	40.00	31.81	4.81

** denotes data suppression due to small cell sizes.

Stressful Life Events and Discrimination

Life events from the past 12 months were assessed using the Stressful Life Events Questionnaire (SLEQ) (Appendix A). The mean total score observed was 1.32 (SD 1.28), with a minimum of 0.00 and maximum of 8.00 (Table 9) and a higher score suggesting greater impact of stressful events. Overall, this indicates a relatively low impact from stressful events occurring over the previous year on participants at the time of the survey.

In the past year, over one-third (37.9%) of women reported that a close friend or family member had a serious accident or illness, and among this group, 53.0% reported that it affected them "a lot". 29.5% of respondents indicated that a close friend or relative had died in the past year. One third of women (34.8%) reported a serious argument with their partner, and separation or divorce was experienced by 5.1% of respondents within the previous year at the time of the survey. Emotionally cruel treatment by a partner was reported by 13.4% of respondents, and physical cruelty by a partner affected 0.5% of respondents. Moreover, 0.03% of respondents indicated that they had experienced sexual abuse in the past year (Table 10).

Respondents' experiences of discrimination varied across demographic factors (Table 10). Discrimination, defined as treating people differently, negatively or adversely because of their race, age, religion, sex, etc., was experienced by 13.5% of respondents. Among these, 95.5% reported feeling somewhat affected or affected a lot by it. Among those who reported experiencing discrimination, a substantial proportion of participants reported experiencing discrimination based on “Sex or gender expression” (40.6%), "Race, ethnic origin, or religion" (34.2%), “Physical appearance” (23.3%), and “Age” (20.8%). Further, participants reported experiencing discrimination based on “Physical or mental disability” (11.4%) and “Sexual orientation” (4.0%). Some women are experiencing discrimination based on more than one domain.

TABLE 9: RAINE STRESSFUL EVENTS SCALE

Mean Score Range	N (%)
Scored < 3	1337 (94.0%)
Scored 3-6	82 (5.4)
Scored > 6	**

	N	Minimum	Maximum	Mean	Std. Deviation
	1423	14.00	8.00	1.32	1.28

** denotes data suppression due to small cell sizes.

TABLE 10: STRESSFUL LIFE EVENTS AND DISCRIMINATION EXPERIENCES

Question	Yes N (%)	No N (%)
A close friend/family member had a serious accident/illness	570 (37.9)	932 (62.1)
You had a serious argument with your partner (if partnered)	480 (34.8)	898 (65.2)
A close friend or relative died	438 (29.5)	1045 (70.5)
Your partner was emotionally cruel to you (if partnered)	184 (13.4)	1188 (86.6)
You were separated/divorced (if partnered)	76 (5.1)	1417 (94.9)
Your partner was physically cruel to you (if partnered)	7 (0.5)	1365 (99.5)
You were sexually abused	5 (0.3)	1477 (99.7)
You experienced discrimination of any kind	202 (13.5)	1293 (86.5)

Question	Yes N (%)	No N (%)
Sex or gender expression	82 (40.6)	120 (59.4)
Race, ethnic origin, or religion	69 (34.2)	133 (65.8)
Physical appearance	47 (23.3)	155 (76.7)
Age	42 (20.8)	160 (79.2)
Physical or mental disability	23 (11.4)	179 (88.6)
Sexual orientation	8 (4.0)	194 (96.0)
Other	44 (21.8)	158 (78.2)

Anxiety and Depression Symptoms, and Perceptions of Stress

The short-form version of the Spielberger State Anxiety Inventory (SSAI-SF) (Appendix A) was used to assess state anxiety symptoms in participants. State anxiety refers to perceived feelings, tension, apprehension, and heightened autonomic nervous system activity. Higher scores on the scale indicated higher state anxiety. One in four (24.8%) displayed elevated symptoms of anxiety (scoring 14 or higher) (Table 11). Similarly, depressive symptoms were evaluated using the Center for Epidemiologic Studies Depression Scale (CES-D). Responses showed that one in three (29.9%) of participants exhibited symptoms of depression (scoring 10 or greater). Perceived stress refers to the thoughts or feelings that one may have about the stress they are experiencing. The Perceived Stress Scale (PSS) scores among respondents revealed one in four women (25.2%) reported higher symptoms of stress. Overall, this indicated a notable prevalence of stress, depressive, and anxiety symptoms among women in the cohort.

Responses to specific sources of stress varied (Table 12). When asked if they felt unable to control important things in life, most reported "never" (15.5%), "almost never" (37.8%), or "sometimes" (30.9%) feeling this way. The majority of respondents felt confident to handle their personal problems "fairly often" (42.6%) or "very often" (25.9%). Furthermore, most felt that things were going their way "fairly often" (42.9%) or "sometimes" (34.9%). Lastly, most women "never" (27.7%) or "almost never" (35.8%) felt their difficulties were piling up so high they could not overcome them; meanwhile, 26.0% of respondents felt this "sometimes" and one in ten reported experiencing this "fairly often" (8.3%) or "very often" (2.2%).

TABLE 11: MENTAL HEALTH AND PERCEIVED STRESS

Women's Mental Health	N (%)
Stress (PSS)	
Low symptoms of stress, scored < 1 SD below mean (8)	1099 (74.8)
Symptoms of stress, scored ≥ 1 SD above mean (8)	371 (25.2)
Depression (CES-D)	
Low symptoms of depression, scored < 10	1007 (70.1)
Symptoms of depression, scored ≥ 10	430 (29.9)
Anxiety (SSAI-SF)	
Low symptoms of anxiety, scored < 1 SD below mean (14)	1087 (75.2)
Symptoms of anxiety, scored ≥ 1 SD above mean (14)	359 (24.8)

TABLE 12: PERCEIVED STRESSORS

In the past month, how often have you:	Never N (%)	Almost never N (%)	Sometimes N (%)	Fairly often N (%)	Very often N (%)
…felt that you were unable to control the important things in your life?	244 (16.5)	559 (37.8)	457 (30.9)	168 (11.4)	51 (3.4)
… felt confident about your ability to handle your personal problems?	10 (0.7)	73 (4.9)	383 (25.9)	631 (42.6)	383 (25.9)
… felt that things were going your way?	18 (1.3)	108 (7.3)	515 (34.9)	633 (42.9)	200 (13.6)
… felt difficulties were piling up so high that you could not overcome them?	410 (27.7)	530 (35.8)	385 (26.0)	123 (8.3)	32 (2.2)

Time Pressure

Time pressure was defined as feelings of being unable to manage time, being rushed, pressured, or too busy. Over 80% of women felt time pressure daily or a few times per week (39.1, 41.4%). 5.3% of the respondents experienced time pressures once a month, while 12.8% felt them about once a week. A small fraction of the participants (1.4%) never felt time pressure. Overall, this indicated that most women regularly felt time pressure with most feeling rushed, pressure, or too busy a few times a week or every day (Table 13).

TABLE 13: TIME PRESSURE

Time pressure	N (%)
Frequency of feeling rushed, pressured, or too busy	
Never	21 (1.4)
About once a month	79 (5.3)
About once a week	192 (12.8)
A few times a week	620 (41.4)
Everyday	585 (39.1)

Flourishing and Languishing

The Secure Flourish Measure (SFM) assesses psychological well-being and positive mental health. It assesses well-being in multiple domains including happiness and life satisfaction, physical and mental health, meaning and purpose, character, relationships, and financial stability. Total continuous scores, based on 12 items, ranged from 21.00 to 120.00, with higher scores suggesting greater self-perceived flourishing. AOF women had a mean score of 87.76 (SD 15.22) (Table 14). Overall, this indicated the majority of women experienced qualities of flourishing.

The average subscale scores for the SFM items can be found in Table 12. Most participants reported high levels of life satisfaction, with 78.1% expressing substantial satisfaction and only 0.5% reporting not being satisfied at all. Furthermore, 74.0% of respondents reported feeling "quite a bit" or "extremely" happy in general. Approximately two-thirds rated their physical

health and mental health 7-10 out of 10 (67.1% and 66.8%, respectively). Respondents generally felt that their activities were worthwhile, with 82.0% considering them "completely" or "quite a bit" worthwhile. Most women also understood their life's purpose (77.1%) and consistently acted to promote good in all circumstances, even in difficult and challenging situations (87.8%). 75.5% expressed contentment with their friendships and relationships, and 67.3% rated their relationships as satisfying. Overall, this indicated that the majority of participants were flourishing with regards to life satisfaction and physical and mental health.

TABLE 14: FLOURISHING

	Minimum	Maximum	Mean	SD
Flourishing total score	21.00	120.00	87.76	15.22
Overall, how satisfied are you with life as a whole these days?	0	10	7.3	1.57
In general, how happy or unhappy do you usually feel?	1	10	7.1	1.56
In general, how would you rate your physical health?	0	10	6.9	1.75
How would you rate your overall mental health?	0	10	6.9	1.80
Overall, to what extent do you feel the things you do in your life are worthwhile?	0	10	7.8	1.64
I understand my purpose in life.	0	10	7.5	1.84
I always act to promote good in all circumstances, even in difficult and challenging situations.	2	10	7.9	1.29
I am always able to give up some happiness now for greater happiness later	1	10	7.6	1.43
I am content with my friendships and relationships.	0	10	7.5	1.71
My relationships are as satisfying as I would want them to be.	0	10	7.1	1.91
How often do you worry about being able to meet normal monthly living expenses?	0	10	6.9	2.90
How often do you worry about safety, food, or housing?	0	10	7.6	2.74
Total				1481

PHYSICAL HEALTH AND HEALTH SERVICES ACCESS

Sleep

The Canadian 24-Hour Movement Guidelines recommend adults to get between 7 to 9 hours of good-quality sleep on a regular basis. The sleep habits of participants were evaluated based on an average week. Respondents reported meeting the Canadian Guidelines by sleeping 7 or more hours of sleep 6-7 nights a week (36.0%) or 4-5 nights a week (32.0%). One in four (26.3) reported sleeping 7 or more hours only 1-3 nights a week and 5.7% reported not sleeping for that long for a single night in an average week (Table 15).

TABLE 15: SLEEP HABITS

Sleep Habits	N (%)
Number of nights with 7 or more hours of sleep in an average week	
0 nights a week	84 (5.7)
1-3 nights a week	390 (26.3)
4-5 nights a week	475 (32.0)
6-7 nights a week	534 (36.0)

Physical Activity

The current Canadian physical activity guidelines for adults recommend 150 minutes (2.5 hours) of moderate- to vigorous-intensity physical activity every week. Among participants in the sample, 3.47 hours per week (SD 3.71) was the average amount of physical activity obtained. This indicates that, on average, participants were meeting guidelines for physical activity (Table 16).

TABLE 16: PHYSICAL ACTIVITY DURATION

Physical activity, hours/week of moderate-to-vigorous physical activity	
Minimum	0.00
Maximum	60.00
Mean	3.4712
Median	3.000
Std. Deviation	3.71230

Health Diagnoses

Depression (25.9%) and anxiety (22.8%) symptoms were experienced at some point (ever) by participants with the majority experiencing them in the previous 5 years (73.7% and 83.6%, respectively). Asthma (14.4%), thyroid disorders (11.5%), and arthritis (11.1%) were the most common physical diagnoses, and most women reported experiencing these in the previous 5 years (59.8%, 65.9%, and 83.0%, respectively). 1 in 10 participants (9.3%) reported having experienced high blood pressure, most (81.0%) within the previous 5 years. Moreover, approximately 1 in 20 participants reported having experienced cancer (5.5%), polycystic ovary syndrome (5.3%), endometriosis (5.0%), or an eating disorder (4.0%) (90% in the past 5 years) (Table 17).

3.6% of participants reported having experienced inflammatory bowel disease with 67.9% of these individuals experiencing so in the previous 5 years. The prevalence of type 1 and type 2 diabetes was low in the cohort with 2.2% experiencing this condition and 78.9% of those reporting having diabetes within the past 5 years. Least common was heart disease (0.9%) and multiple sclerosis (0.8%). However, of those individuals, the majority experienced these conditions in the past 5 years (76.9% and 66.7%, respectively) (Table 17).

TABLE 17: HEALTH DIAGNOSES

Condition	Ever experienced?		If yes, condition experienced in the past 5 years?	
	Yes N (%)	No N (%)	Yes N (%)	No N (%)
Depression	383 (25.9)	1098 (74.1)	280 (73.7)	100 (26.3)
Anxiety disorder	337 (22.8)	1142 (77.2)	281 (83.6)	55 (16.4)
Other condition	185 (14.5)	1089 (85.5)	153 (84.1)	29 (15.9)
Asthma	214 (14.4)	1269 (85.6)	125 (59.8)	84 (40.2)
Thyroid disorder	171 (11.5)	1314 (88.5)	112 (65.9)	58 (34.1)
Arthritis	165 (11.1)	1320 (88.9)	137 (83.0)	28 (17.0)
High blood pressure	138 (9.3)	1352 (90.7)	111 (81.0)	26 (19.0)
Cancer	81 (5.5)	1397 (94.5)	48 (60.0)	32 (40.0)
Polycystic ovary syndrome	79 (5.3)	1400 (94.7)	38 (48.1)	41 (51.9)
Endometriosis	74 (5.0)	1399 (95.0)	44 (61.1)	28 (38.9)
Eating disorder	59 (4.0)	1407 (96.0)	31 (54.4)	26 (45.6)
Inflammatory bowel disease	53 (3.6)	1425 (96.4)	36 (67.9)	17 (32.1)
Type 1 or 2 diabetes	33 (2.2)	1449 (97.8)	26 (78.8)	7 (21.2)
Heart disease	13 (0.9)	1470 (99.1)	10 (76.9)	3 (23.1)
Multiple sclerosis	12 (0.8)	1469 (99.2)	8 (66.7)	4 (33.3)

Aches and Pains

Data indicated that most participants experienced aches and pains regularly with some interference in their daily lives. Over half of the sample (62.8%) reported experiencing aches or pains at least once a month for three consecutive months in the recent past (chronic pain) (Table 18). Among those who reported chronic aches and pains, the vast majority (89.5%) said the pain had been present when they were parenting their youth. When asked about the health of their youth's other biological parent, 42.6% reported similar chronic aches or pains. Of these, the vast majority (95.4%) experienced these conditions during the youth's lifetime (Table 18).

When considering the impact of pain on daily activities, about 15% reported pain interfered with daily, household and social activities quite a bit or very much (Table 18). Specifically, pain interfered either "a little bit" or "somewhat" with day-to-day activities for over half of participants (66.0%). 16.0% reported more interference in day-to-day activities due to aches and pains. Similarly, the majority reported pain interfering with work around the home "a little bit/somewhat" of the time (59.2%) or "quite a bit/very much" (15.0%). A similar pattern was reported when asked about pain interference with household chores. Pain interference with social activities was only slightly less common with 40.2% of participants reporting feeling aches and pains never interfered. Meanwhile, the majority still indicated interference "a little bit/somewhat" (47.2%) or "quite a bit/very much" (12.6%) (Table 18).

When asked further about the duration of aches and pain, most (74.3%) reported experiencing pains for 6 months or less. 16.1% of women reported aches and pains for 7-11 months while only 1 in 10 reported one year or more (9.6%) (Table 19).

In terms of ache and pain location, the most common body parts affected were muscles and joints (67.2%), followed by the head (36.1%), and legs (20.7%). Stomach pains were less common, reported by 17.4%, and chest pains were the least reported, affecting only 5.5% of respondents (Table 20).

TABLE 18: WOMEN'S AND OTHER BIOLOGICAL PARENT'S ACHES AND PAINS

Question	No N (%)	Yes N (%)	Don't know N(%)
Aches or pains monthly for 3 months (recent)	555 (37.2)	935 (62.8)	-
Aches or pains monthly for 3 months (lifetime)	570 (38.5)	909 (61.5)	-
Aches/pains during child's lifetime (mom)	95 (10.5)	811 (89.5)	-
Aches/pains monthly for 3 months in other parent (lifetime)	632 (42.6)	632 (42.6)	218 (14.8)
Aches/pains during child's lifetime (other parent)	16 (2.5)	599 (95.4)	13 (2.1)
	Not at all N (%)	**A little bit/ Somewhat N (%)**	**Quite a bit/ Very much N (%)**
Pain interference with day-to-day activities	168 (18.0)	614 (66.0)	149 (16.0)
Pain interference with work around the home	239 (25.8)	550 (59.2)	139 (15.0)
Pain interference with social activities	373 (40.2)	439 (47.2)	117 (12.6)
Pain interference with household chores	269 (29.1)	523 (56.5)	133 (14.4)

TABLE 19: ACHES AND PAIN DURATION

Months	N (%)
1	12 (7.1)
2	17 (10.1)
3	17 (10.1)
4	17 (10.1)
5	15 (8.9)
6	47 (28.0)
7-11	27 (16.1)
12 or more	16 (9.6)

TABLE 20: ACHES AND PAINS LOCATIONS

Body Part	Yes N (%)	No N (%)
Muscles and joints	628 (67.2)	307 (32.8)
Head	338 (36.1)	597 (63.9)
Legs	194 (20.7)	741 (79.3)
Stomach	163 (17.4)	772 (82.6)
Chest	51 (5.5)	884 (94.5)
Other	156 (16.7)	779 (83.3)

Migraines and Headaches

When asked about the prevalence of migraines among participants, the majority (58%) reported not getting migraines. However, 1 in 5 (21.1%) have been diagnosed with migraines by a health professional, while 20.9% suspected migraines without a formal diagnosis (Table 21). Regarding migraines of the youth's other biological parent, 6.0% reported their child's other parent had been diagnosed by health professionals, while 8.9% suspected migraines without a diagnosis. 3 in 4 other biological parents (76.1%) experienced no migraines.

TABLE 21: WOMEN'S AND PARENTAL MIGRAINES

	N (%)
No, I do not get migraines	860 (58.0)
No, I suspect that I have migraine but I have not been diagnosed by a health professional	310 (20.9)
Yes, I have been diagnosed by a health professional	313 (21.1)
Other parent reporting migraine	
No migraines	1132 (76.1)
No, suspects they have migraine but have not been diagnosed	132 (8.9)
Yes, has been diagnosed	89 (6.0)
Don't know	135 (9.1)

Cervical Screening

In Canada, cervical screening guidelines recommend that screening begin at age 21-25 and that a Pap test should be completed every 3 years. The majority of participates reported adhering to these guidelines. The overwhelming majority (98.5%) of women reported having undergone a Pap test, with only 1.5% indicating they had never had one (Table 22). Among those who have had the test, 68.5% started having Pap tests before the age of 25 and 20.4% of individuals began between the ages of 25-29. Overall, this indicated that the majority adhered to the Canadian guidelines. The timing of the last Pap test showed that 40.2% had their most recent test less than a year to one year previously, and 34.5% had it more than 1 year up to 2 years ago. Only 4.3% of participants responded that their last test was over 5 years ago.

Regarding the frequency of Pap tests, over half of the respondents (51.0%) reported having the test between once a year to less than every 3 years, and 37.0% adhered to the recommended frequency of every 3 years. The reported frequency suggests regular screening

practices among the majority. For the small fraction of women who had not had a Pap test in the last 3 years, the reasons included lack of perceived necessity (21.7%), their doctor either not thinking it necessary or not discussing it (26.1%), or feelings of fear and discomfort (21.7%) (Table 23).

TABLE 22: CERVICAL SCREENING

		N (%)
Ever had a Pap test		1465 (98.5)
Age started having Pap tests:		
	<25 years	1001 (68.5)
	25-29 years	298 (20.4)
	30-34 years	84 (5.7)
	35-39 years	47 (3.2)
	40-44 years	24 (1.6)
	45 years or older	8 (0.6)
Last Pap test:		
	<1 year to 1 year ago	587 (40.2)
	>1 year to 2 years ago	504 (34.5)
	>2 years to 3 years ago	208 (14.2)
	>3 years to 5 years ago	100 (6.8)
	>5 years ago	63 (4.3)
Pap test frequency:		
	First time	**
	More than once a year	17 (1.2)
	Once a year to < every 3 years	746 (51.0)
	Every 3 years	541 (37.0)
	Less often than every 3 years	61 (4.2)
	No fixed frequency	93 (6.4)

** denotes data suppression due to small cell sizes.

TABLE 23: REASONS FOR NOT UNDERGOING PAP TEST

Reason	Selected N (%)	Unselected N (%)
Lack of time	**	**
Did not think it was necessary	5 (21.7)	18 (78.3)
Doctor did not think it was necessary or never brought it up	6 (26.1)	17 (73.9)
Feeling of fear or discomfort	5 (21.7)	18 (78.3)
Don't have a doctor	**	**
Other	8 (34.8)	15 (65.2)

** denotes data suppression due to small cell sizes.

Urinary Incontinence and Pelvic Floor Health

Urinary incontinence (UI) is the loss of bladder control. According to scores from the Sandvik Severity Index, UI severity among participants varied, with 38.0% scoring no UI severity, 34.5% slight UI severity, 16.4% moderate UI severity, and 11.1% severe UI severity (Table 24). Severity was based on a combination of UI frequency and the amount of leakage. In terms of the frequency of urinary leakage over the previous 12 months, 37.9% of respondents never experienced leakage, while 24.8% reported leakage less than once per month. A smaller percentage experienced more frequent leakage, with 8.0% once per month, 12.4% 2-3 times per month, 8.1% about once per week, and 8.7% almost every day. Regarding the amount of urine leaked, most respondents (52.3%) reported leaking only a few drops, while 44.8% said enough to wet their underwear, and 2.9% experienced leakage enough to wet outer clothing. Overall, this indicated that the majority of AOF women experience UI at least once a month.

The impact of leaking urine on everyday life varied, with 23.8% indicating that urine leakage did not interfere with their everyday life at all. The remainder (76.2%) reported that leaking urine had at least some interference on their everyday life (Table 25). Among those who reported leaking urine, 1.4% of respondents reported it affected their everyday life a great deal.

The usual cause of urine loss was primarily due to physical activities such as coughing, sneezing, laughing, or exercising for 66.7%, while 10.1% attributed it to a sudden or urgent need to go to the bathroom, and 19.5% reported both causes equally. Overall, when asked about the presence of a bulge or something falling out in the vaginal area, most (91.9%) respondents reported no such issue (Table 26).

TABLE 24: SANDVIK SEVERITY INDEX FOR URINARY INCONTINENCE

Question	N (%)
Sandvik Severity Index Score	
No UI severity (scored 0)	564 (38.0)
Slight UI severity (scored 1-2)	513 (34.5)
Moderate UI severity (scored 3-4)	243 (16.4)
Severe UI severity (scored >6)	165 (11.1)
Leakage frequency:	
Never	564 (37.9)
Less than once per month	370 (24.8)
Once per month	119 (8.1)
2-3 times per month	185 (12.4)
About once per week	121 (8.1)
Almost every day	130 (8.7)
Leakage amount:	
A few drops	482 (52.3)
Enough to wet underwear	413 (44.8)
Enough to wet your outer clothing	26 (2.9)

TABLE 25: URINARY INCONTINENCE INTERFERENCE WITH EVERYDAY LIFE

	Frequency	Percent (%)
0 Not at all	219	23.8
1	221	23.9
2	151	16.4
3	103	11.2
4	45	4.9
5	53	5.7
6	41	4.4
7	42	4.6
8	26	2.8
9	8	0.9
10 A great deal	13	1.4
Total	922	100.0

TABLE 26: PELVIC FLOOR HEALTH

Question / Status	N (%)
If lost control of urine: When you lose urine, what is the usual cause?	
Coughing, sneezing, laughing or doing physical activity	616 (66.7)
A sudden or urgent need to go to the bathroom	93 (10.1)
Both A and B equally	180 (19.5)
Other circumstances	34 (3.7)
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area?	
No vaginal bulge	1369 (91.9)
Yes, doesn't bother me at all	39 (2.6)
Yes, bothers me somewhat	51 (3.4)
Yes, bothers me moderately	20 (1.3)
Yes, bothers me quite a bit	10 (0.8)

Menstruation, Menopause, and Gynecological Interventions

Eleven percent (11.2%) of women reported their natural menstrual periods had stopped permanently. A large portion of the sample (77.8%) identified as premenopausal and still experienced menstrual cycles. Among those who still had menstrual periods, 67.9% reported their periods remained about the same in the previous 12 months, 25.5% became less regular, and 6.5% became more regular. 10.4% of respondents were unsure of their menopausal status (Table 27).

Among the 11.2% of participants whose menstrual cycle had stopped, the mean age was 43.7 years (SD 6.2 years) (Table 28). Most of these individuals reported cessation was due to natural reasons or without any obvious reason (50.3%). Surgical interventions were also a significant cause for 42.0%, and chemotherapy or radiation therapy was the reason for 7.7% of respondents (Table 29).

Regarding surgical interventions, 90 participants (6.1%) confirmed they had their uterus removed (Table 30). The age at surgery ranged from 25 to 53 years old with the average age being 39.1 years (SD 5.5 years) (Table 28). Regarding oophorectomy, the removal of ovaries, 52 participants (3.5%) had at least one ovary surgically removed (Table 30). Among them, 59.6% reported having one ovary remaining, while 40.4% had both removed.

At some point during the two weeks prior to data collection, participants reported experiencing common menopausal symptoms such as hot flashes or flushes (20.6%), night sweats (34.5%), or heart palpitations (32.4%) (Table 31). Difficulty sleeping was more commonly reported, with 66.0% experiencing it at least once in the previous 14 nights. Among those who reported trouble sleeping, the most common frequency was between 1 and 5 nights in the past two weeks (41.3%). Mood swings were also prevalent, with 61.2% experiencing them at some point over the previous two weeks. Of those, nearly half (47.5%) reported having them between 1 and 5 days in the past two weeks. Weight gain was experienced by 39.0% of respondents, while vaginal dryness and itching was reported by 26.5%. In the previous two weeks, 13.3% of respondents indicated some occurrence of painful intercourse. Over half (57.1%) reported stomach bloating, joint stiffness or soreness (63.3%), irritability (70.5%), and/or forgetfulness (64.5%) for some duration over the previous two weeks.

Excluding birth control pills, 15.3% of participants reported ever taking hormone replacement therapy. Of these, on average, 29.2% were currently taking prescribed female hormones, while the majority (70.8%) were not at the time of the survey. The mean duration of female hormone use was 88.64 months in length (SD 88.28), equating to approximately 7.4 years with a large amount of variability among the sample (Table 32). The median duration of female hormone use was 60.00 months in length, equating to 5 years of use.

When asked about the number of pregnancies and live births experienced by women in the sample, the most common number reported was two pregnancies (36.6%) and two live births (57.5%). Three pregnancies (28.4%) and four pregnancies (13.9%) were also commonly experienced. 1 in 5 reported 3 live births (22.3%) (Table 33).

TABLE 27: DISRUPTION TO MENSTRUATION

Question / Status	N (%)
Menstrual periods stopped permanently	
No: Premenopausal	1148 (77.8)
Yes: No menstrual periods	166 (11.2)
Yes: Had menopause but now have periods induced by hormones	**
Not sure (e.g., perimenopausal)	159 (10.8)
Regularity of menstrual periods in past 12 months	
Periods remain about the same	865 (67.9)
Periods become less regular	325 (25.5)
Periods become more regular	83 (6.6)

** denotes data suppression due to small cell sizes.

TABLE 28: AGE AT WHICH MENSTRUATION STOPPED OR UTERUS REMOVED

Age at menstrual cessation (years)	
Minimum	24
Maximum	56
Mean (SD)	43.7 (6.2)
N (%)	166 (11.2)
Age at hysterectomy (years)	
Minimum	25
Maximum	53
Mean (SD)	39.1 (5.5)
N (%)	90 (6.1)

TABLE 29: REASONS FOR MENSTRUAL CESSATION

Reason for Menstrual Periods Stop	N (%)
Natural/no obvious reason	85 (50.3)
Surgery	71 (42.0)
Chemotherapy or radiation therapy	13 (7.7)
Pregnancy or breastfeeding	**
Other	9 (5.3)

** denotes data suppression due to small cell sizes.

TABLE 30: GYNECOLOGICAL SURGERIES

	No N (%)	Yes N (%)	Total N (%)	One N (%)	None N (%)
Have you had your uterus removed?	1390 (93.9)	90 (6.1)	1480 (100.0)		
Have you had either of your ovaries surgically removed?	1435 (96.5)	52 (3.5)	1487 (100.0)		
If ovaries removed: How many ovaries do you have remaining?			52 (100.0)	31 (59.6)	21 (40.4)

TABLE 31: MENOPAUSE SYMPTOMS

Frequency of experiences (per week)	Not at all N (%)	1-5 days N (%)	6-8 days N (%)	9-13 days N (%)	Everyday N (%)
Hot flashes or flushes	1175 (79.4)	213 (14.4)	26 (1.8)	20 (1.4)	44 (3.0)
Night sweats	970 (65.5)	382 (25.8)	53 (3.6)	28 (1.9)	47 (3.2)
Heart palpitations or sensation of butterflies in the chest or stomach area	999 (67.6)	379 (25.6)	47 (3.2)	20 (1.4)	33 (2.2)
Difficulty falling or staying asleep	506 (34.0)	614 (41.3)	123 (8.3)	100 (6.7)	144 (9.7)

Frequency of experiences (per week)	Not at all N (%)	1-5 days N (%)	6-8 days N (%)	9-13 days N (%)	Everyday N (%)
Mood swings	577 (38.8)	707 (47.5)	115 (7.7)	52 (3.5)	36 (2.5)
Weight gain	903 (61.0)	366 (24.7)	76 (5.1)	39 (2.6)	96 (6.5)
Vaginal dryness or itching	1088 (73.5)	267 (18.0)	57 (3.9)	28 (1.9)	40 (2.7)
Painful intercourse	1280 (86.7)	146 (9.9)	16 (1.1)	17 (1.1)	18 (1.2)
Stomach bloating	634 (42.9)	568 (38.5)	140 (9.5)	65 (4.4)	69 (4.7)
Joint stiffness or soreness	545 (36.7)	472 (31.8)	171 (11.5)	112 (7.6)	183 (12.3)
Irritability	438 (29.5)	742 (50.0)	181 (12.2)	78 (5.3)	45 (3.0)
Forgetfulness	527 (35.5)	584 (39.3)	155 (10.4)	99 (6.7)	120 (8.1)

TABLE 32: HORMONE REPLACEMENT THERAPIES

Question	Yes N (%)	No N (%)
Have you ever taken prescription female hormones (not including birth control pills)?	227 (15.3)	1256 (84.7)
If taken female hormones: Are you currently taking prescription female hormones?	66 (29.2)	160 (70.8)
If taken female hormones: In total, for how many months did you use, or have you been using, prescription female hormones?		
N	214	
Mean	88.64	
Median	60.00	
Std. Deviation	88.28	
Range	359.00	

TABLE 33: PREGNANCIES AND LIVE BIRTHS

Number of Pregnancies	N (%)
1	87 (5.9)
2	541 (36.6)
3	420 (28.4)
4	205 (13.9)
5	120 (8.1)
6	55 (3.7)
7	31 (2.1)
8	7 (0.5)
9	5 (0.3)
10 or more	7 (0.5)
Number of Live Births	**N (%)**
1	163 (11.0)

Number of Pregnancies	N (%)
2	849 (57.5)
3	330 (22.3)
4	104 (7.0)
5	20 (1.4)
6 or more	11 (0.8)

LIFESTYLE AND LEISURE

Leisure and Physical Activity

Regarding leisure activity participation, 86.7% of respondents engaged in 1-15 hours of leisure activities per week for their own pleasure (Table 34); this included hobbies and other activities. Only 5.7% of women indicated 0 hours of leisure activities per week and 6.1% reported spending more time (16-24 hours each week) on leisure activities (Table 34).

Families participated in various leisure activities together. The highest participation in the previous 12 months was in audio-visual and interactive media (96.5%), indoor games (92.0%), and urban outdoor activities (90.4%). Also common was domestic activities and household projects (90.3%), wilderness activities (76.6%), creative activities (52.1%), or educational activities (49.3%). Few women reported no family leisure activities (Table 34).

TABLE 34: FAMILY LEISURE ACTIVITIES

Category		N (%)
Domestic activities and household projects		1353 (90.3)
Educational activities		739 (49.3)
Indoor games		1378 (92.0)
Audio-visual and Interactive Media		1445 (96.5)
Urban outdoor activities		1354 (90.4)
Wilderness activities		1147 (76.6)
Creative activities		781 (52.1)
None of the above		**
Other		126 (8.4)
	Hours of participation in average week	**N (%)**
Leisure activities for own pleasure	0 hours	85 (5.7)
	1-15 hours	1297 (86.7)
	16-24 hours	91 (6.1)
	25-34 hours	11 (0.7)
	35 hours or more	12 (0.8)

** denotes data suppression due to small cell sizes.

Substance Use

Weekly consumption patterns of various substances among women included alcoholic drinks, tobacco or nicotine products, cannabis, and other recreational drugs.

The current low-risk alcohol drinking guidelines indicate no more than 2 standard drinks per day or 10 standard drinks per week. The number of alcoholic drinks in a standard week ranged from 0 to 35, with the average being 2.13 (SD 3.68) among the sample. Overall, this indicated that, on average, individuals in the cohort were adhering to Canadian low-risk alcohol drinking guidelines. The majority (64%) of women reported some alcohol consumption. Among those, 43.2% drank less than twice per week and one quarter (24.8%) drank 2-4 times per week. Meanwhile, 32% of individuals in the sample reported drinking four or more times per week. A small percentage of women indicated engaging in 4+ drinks on one occasion once a week or more (3.7%) or 2-3 times per month (5.0%) (Table 35).

Less than 5% reported tobacco or nicotine use (4.9%). The number of tobacco or nicotine products used per week ranged from 0 to 210, with the average being 2.28 consumed (SD 15.11) among women. Among those who reported tobacco or nicotine, 86.9% used it ten or more times per week (Table 35).

Cannabis usage was reported by 12.6% of respondents. The number of times cannabis was used per week ranged from 0 to 49. Of those who reported using cannabis products, 45.1% used it less than once per week. One third (34.8%) used cannabis 4 or more times per week (Table 35).

Other recreational drug use was not common in the sample, with 11 participants (0.7%) indicating recreational drug use (Table 35).

TABLE 35: SUBSTANCE USE

Substance	Minimum	N (%)
Consumes alcohol		
	Yes	949 (64.0)
	No	534 (36.0)
Number of alcoholic drinks per week		
	Minimum	0.00
	Maximum	35.00
	Mean (SD)	2.13 (3.68)
If drinks alcohol…		
	<1 per week	284 (30.0)
	1-1.99 per week	125 (13.2)
	2-3.99 per week	235 (24.8)
	4+ per week	303 (32.0)
Number of times had 4+ drinks on any one occasion (since Jan 2022)		
	Never	861 (57.7)
	Less than once a month	385 (25.8)
	Once a month	117 (7.8)
	2-3 times a month	75 (5.0)
	Once a week or more	54 (3.7)

Substance	Minimum	N (%)
Uses tobacco or nicotine products		
	Yes	73 (4.9)
	No	1416 (95.1)
Number of tobacco or nicotine product used per week		
	Minimum	0.00
	Maximum	210.00
	Mean (SD)	2.28 (15.11)
If uses nicotine…		
	<10 per week	8 (13.1)
	10+ per week	53 (86.9)
Uses cannabis		
	Yes	187 (12.6)
	No	1301 (87.4)
Number of cannabis use per week		
	Minimum	0.00
	Maximum	49.00
	Mean (SD)	0.60 (3.27)
If uses cannabis…		
	<1 per week	83 (45.1)
	1-1.99 per week	14 (7.6)
	2-3.99 per week	23 (12.5)
	4+ per week	54 (34.8)
Uses other recreational drugs		
	Yes	11 (0.7)
	No	1477 (99.3)
Number of other recreational drug use per week		
	Minimum	0.00
	Maximum	14.00
	Mean (SD)	0.01 (0.36)

Digital Device and Web Use

Women's recreational screen time averaged 2.98 hours per day with a range of up to 15 hours in an average week (Table 36). Using the Canadian 24-Hour Movement Guidelines to limit sedentary behaviour, it is recommended that no more than 3 hours of recreational screen time occurs in a day. Nearly two-thirds (64.9%) of the sample were meeting this standard, whereas 30.8% spent between 3 and 6 hours, and 4.3% spent more than 6 hours for recreational screen time in a typical week.

The frequency of phone-checking was evaluated using the Technology Engagement Scale (Appendix A). A range of 1 to 4 was used in this subscale, with 1 indicating low phone-checking behaviour and 4 indicating greater phone-checking. Among individuals in the cohort, an average score of 2.44 (SD 0.6), which indicated moderate engagement with technology (Table 36).

Device interruptions during parent interactions with their youth varied. Most commonly, a frequency of 2 to 3 times per day was reported in one third (36.8%) of the sample. 29.9% reported a frequency of once per day and 20.3% reported no interruptions while interacting with their youth. A smaller percentage indicated greater frequency of device interruption (Table 37). This indicated that, overall, women's device usage did not frequently interrupt interactions with their youth.

Regarding phone checking for new activity, a majority reported doing so often or sometimes (48.4% and 41.5%, respectively). The frequency of posting public status updates was lower, with 60.3% never doing so. Checking the phone during spare moments was common, with 48.6% often and 23.3% almost always engaging in this behaviour. Lastly, phone checking during conversations or hanging with friends was reported as sometimes (55.5%) or never occurring (35.7%).

TABLE 36: TECHNOLOGY ENGAGEMENT AND SCREEN TIME

	Minimum	Maximum	Mean (SD)	N
Phone-checking behaviour subscale - mean (of 3 items)	1.00	4.00	2.44 (0.55)	1485
Screen time per day, average recreational screen use in a typical week	0.00	15.00	2.98 (1.64)	1488
				N (%)
3 hours or less per day				965 (64.9)
3.1- 6.0 hours per day				458 (30.8)
6.1 – 9 hours per day				55 (3.7)
9.1 hours or more per day				10 (0.6)

TABLE 37: FREQUENCY OF DIGITAL DEVICE INTERRUPTING ENGAGEMENT AMONG YOUTH

Frequency Range (per day)	N (%)
None	304 (20.3)
Once	435 (29.1)
2 to 3 times	551 (36.8)
4 to 5 times	131 (8.8)
6 to 10 times	51 (3.4)
11 to 20 times	11 (0.7)
More than 20 times	14 (0.9)

Web-based Executive Function

Increased difficulties with web-based executive functioning have been correlated with personality-based executive functioning such as neuroticism and low conscientiousness in the literature (Buchanan, 2016). The Executive Function Scale contains 6 items scored on a 4-point scale ranging from "no problems experienced" to "a great many problems experienced". Responses are summed and higher scores indicate greater problems with executive function consequent to navigating information on the internet (Appendix A).

The first item evaluated attention to tasks and indicated that 30.1% experienced no problems in doing so. Meanwhile, the majority indicated either a few problems (47.5%) or more than a few problems (14.8%) in keeping attention on tasks. The evaluation of concentration reflected a similar pattern among participants. A greater percentage (44.1%) indicated having no problems with carrying out more than one task while 37.9% had a few problems. A tendency to lose train of thoughts was more common among participants with the majority indicating a few problems (47.0%), more than a few problems (16.1%), or a great many problems (6.0%). Problems with acting on impulse was split between participants with 55.5% not experiencing problems, 31.3% experiencing a few problems, and the remainder 10% experiencing more problems with impulse.

Total summed scores were dichotomised at 1 SD above the sample mean. According to participants, 21.5% experienced problems with executive function (e.g., concentration and memory) while most (78.5%) had less executive functioning problems (Table 38).

TABLE 38: WEB-BASED EXECUTIVE FUNCTION

Question	No problems experienced N (%)	A few problems experienced N (%)	More than a few problems experienced N (%)	A great many problems experienced N (%)
Difficulty keeping attention on tasks	460 (30.1)	726 (47.5)	227 (14.8)	67 (4.4)
Problems concentrating on a task	512 (33.5)	672 (44.0)	228 (14.9)	63 (4.1)
Difficulty carrying out more than one task	675 (44.1)	580 (37.9)	173 (11.3)	48 (3.1)
Tend to lose train of thoughts	420 (27.5)	718 (47.0)	246 (16.1)	91 (6.0)
Difficulty seeing through something started	641 (41.9)	585 (38.3)	183 (12.0)	65 (4.3)
Acting on impulse	845 (55.3)	479 (31.3)	122 (8.0)	30 (2.0)
Executive Function Score			**Score**	**N (%)**
			Less problems	1143 (78.5)
			More problems	313 (21.5)

Parental Technology Management

Overall, the majority of women reported some involvement in their youth's digital activities. In terms of parental awareness and management of youth screen time, 58.6% of parents were aware of their youths' media activities most of the time and 14.0% were always aware. Further, most women discussed the content their youth encountered online always (24.4%), often (38.4%), or some of the time (36.8). Most also reported some limitation to youth screen time with 23.9% reporting doing so always, 31.9% most of the time, and 39.7% some of the time. Moreover, a similar pattern of reporting was shown for limiting their youth's content on

technology. The use of parental control options was prevalent, with 29% almost always employing such measures. However, 66.1% of parents did not enforce a nightly home internet shutdown. 48% of parents always kept devices outside the youth's room at night, while 27.5% never did so. One third (33.9%) always removed screen privileges for misuse or overuse. App purchases always required parental approval for 87.9% of the sample. Engagement with youth during screen time was common, with 38.9% often participating in digital activities together. Lastly, a majority consider themselves good media and technology role models for their youth (63.8% most of the time, 17.6% always), reflecting a positive self-assessment of their influence on their youth's digital habits (Table 39).

TABLE 39: PARENTAL MANAGEMENT OF YOUTH DIGITAL ACTIVITIES

	Always/ Almost Always N (%)	Most of the time/Often N (%)	Some of the time/Once in a while N (%)	Never N (%)
Awareness of youth's media device use	204 (14.0)	856 (58.6)	394 (27.0)	6 (0.4)
Discussion about online content	355 (24.4)	561 (38.4)	538 (36.8)	6 (0.4)
Limitation of youth's screen time	348 (23.9)	455 (31.2)	578 (39.7)	76 (5.2)
Limitation of content on technology	417 (29.0)	468 (32.6)	433 (30.2)	118 (8.2)
Use of parental controls or apps	421 (29.0)	260 (17.9)	278 (19.2)	491 (33.9)
Shutoff of home internet at night	290 (20.0)	87 (6.0)	115 (7.9)	961 (66.1)
Checking content of devices/social media	225 (15.6)	361 (24.9)	611 (42.2)	251 (17.3)
Keeping devices outside youth's room at night	697 (48.0)	144 (9.9)	212 (14.6)	399 (27.5)
Removal of screen privileges	494 (33.9)	260 (17.8)	512 (35.1)	191 (13.2)
Limitation of own screen time around children	301 (20.7)	596 (41.0)	510 (35.1)	45 (3.2)
Approval requirement for app purchases	1272 (87.9)	105 (7.3)	41 (2.8)	29 (2.0)
Engagement with youth on screen devices	175 (12.1)	563 (38.9)	659 (45.6)	49 (3.4)
Do you believe you are a good role model for media and technology?	256 (17.6)	930 (63.8)	229 (15.7)	43 (2.9)

IN THE COMMUNITY

Community Belongingness and Social Standing

Women most frequently reported either a very strong (25.9%) or somewhat strong (50.1%) sense of belonging to their local community (Table 40). A smaller percentage indicated somewhat weak (20.5%) or very weak (3.5%) feelings of belonging.

The MacArthur Scale of Subjective Social Status (SSS) was used to determine perceived social status rank relative to others in their community (Appendix A). A higher score indicates a higher perceived standing in the community. A significant number of women positioned themselves in the middle of the subjective social status ladder (Table 41). The largest percentage placed themselves at levels 7 (27.7%) and 8 (20.6%). This suggests that many respondents perceived themselves as having a moderate to high social standing within their community (Adler et al., 2000; Centre for Addiction and Mental Health (CAMH), 2018).

TABLE 40: BELONGINGNESS.

Sense of Belonging	N (%)
Very strong	394 (25.9)
Somewhat strong	764 (50.1)
Somewhat weak	312 (20.5)
Very weak	53 (3.5)

TABLE 41: SUBJECTIVE SOCIAL STATUS

Ladder Position	N (%)
10 Top of ladder	27 (1.8)
9	73 (4.8)
8	314 (20.6)
7	423 (27.7)
6	289 (19.0)
5	223 (14.6)
4	72 (4.7)
3	59 (3.9)
2	29 (1.9)
1 Bottom of ladder	15 (1.0)

Perceptions of Neighbourhood Cohesion

Highly cohesive neighbourhoods are characterized by neighbour trust, community engagement, and cooperation (Appendix A). The National Longitudinal Survey of Children and Youth (NLSCY) Perceived Neighbourhood Cohesion Scale was used to assess the perception of neighbourhood cohesion among women in the sample. The scores on this scale ranged from a minimum of 0 to a maximum of 15 and were the summation of five questions. The mean total score was 10.57, with a standard deviation of 2.96 (Table 42). Overall, this indicated moderately high level of perceived neighbourhood cohesion among participants.

Most respondents expressed positive sentiments, with high levels of either agreement or strong agreement, for questions related to neighbourly assistance (92.9%), the presence of adult role models (88.9%), trust in neighbours' vigilance during absences (86.1%), and the expectation of adults safeguarding children (83.6%). Additionally, a large proportion either agreed or strongly agreed that neighbours would come together to address problems in their community (69.0%) (Table 43). Overall, this indicated high levels of cohesion, trust, engagement, and cooperation among neighbours of respondents.

TABLE 42: NEIGHBOURHOOD COHESION.

NLSCY Perceived Neighbourhood Cohesion Scale Score	
N	1,497
Minimum	.00
Maximum	15.00
Mean	10.5705
Std. Deviation	2.95587

TABLE 43: NEIGHBOURHOOD COHESION, NLSCY-PNC

Statement	Strongly Disagree N (%)	Disagree N (%)	Agree N (%)	Strongly Agree N (%)
People around here are willing to help their neighbours.	19 (1.2)	90 (5.9)	867 (56.9)	548 (36.0)
There are adults in the neighbourhood that children can look up to.	29 (1.9)	141 (9.2)	900 (59.1)	454 (29.8)
When I'm away from home, I know that my neighbours will keep their eyes open for possible trouble.	28 (1.8)	184 (12.1)	723 (47.6)	585 (38.5)
You can count on adults in this neighbourhood to watch out that children are safe and don't get in trouble.	28 (1.8)	221 (14.6)	843 (55.5)	426 (28.1)
If there's a problem around here, the neighbours get together to deal with it.	71 (4.7)	399 (26.3)	799 (52.6)	249 (16.4)

Perceptions of Social Support

The Medical Outcome Study Social Support (MOS-SS) Abbreviated scale (Appendix A) was used to assess the levels of four types of perceived social support. These four types include emotional/information support, tangible support, affectionate support, and positive social interaction. Four subscales were used to investigate the four types of social support on a 5-point scale and were summed to determine a final score for overall perceived social support.

Results indicated that most (81.4%) perceived moderate or high social support (scored greater than 52), while 18.6% had low social support (scored 52 or less) (Table 44).

In terms of tangible support, the majority indicated feeling practically supported all of the time (31.2%) or most of the time (31.9%). Only 1 in 20 respondents (5.6%) indicated never feeling tangible or practical support (Table 44).

High emotional support was also perceived by most respondents all of the time (39.2%), most of the time (33.8%), or some of the time (16.9%). Only 32 participants (2.2%) never felt that they received emotional/informational support (Table 44).

Positive social interaction, indicated by whether participants felt they had someone to do something enjoyable with, was experienced by the overwhelming majority of participants with only 0.7% indicating that they never received positive social interaction.

Lastly, affectionate support was experienced all of the time by half (50.3%) and most of the time by 39.9%. This indicated that most participants felt affectionately supported (Table 44).

When asked to rate their happiness within their relationship with a spouse or partner, the majority of women reported being at least happy. Among these, 30.2% reported being very happy, 26.6% extremely happy, and another 23.5% happy. Only 1 in 20 felt either extremely unhappy (1.6%) or fairly unhappy (3.7%). Lastly, in terms of resolving arguments with a spouse or partner, 39.2% reported no difficulty, while over half (53.1%) faced some difficulty (Table 45).

Overall, the results depicted a generally positive level of social support among women. Most participants felt they received emotional, tangible, and affectionate social support at least most of the time. Furthermore, most participants reported satisfaction with their relationships and the support they received.

TABLE 44: SOCIAL SUPPORT

Question	None of the time N (%)	A little of the time N (%)	Some of the time N (%)	Most of the time N (%)	All of the time N (%)
Someone to help with daily chores if you were sick	83 (5.6)	194 (13.1)	270 (18.2)	473 (31.9)	462 (31.2)
Someone to turn to for suggestions about dealing with a personal problem	32 (2.2)	117 (7.9)	249 (16.9)	499 (33.8)	580 (39.2)
Someone to do something enjoyable with	11 (0.7)	106 (7.2)	272 (18.4)	588 (39.9)	498 (33.8)
Someone to love and make you feel wanted	58 (3.9)	83 (5.6)	168 (11.4)	424 (28.8)	741 (50.3)
	Moderate or High Social Support N (%)			**Low Social Support N (%)**	
Social Support Score Total	1192 (81.4)			273 (18.6)	

TABLE 45: RELATIONSHIP HAPPINESS

Category	Response	N (%)
Please pick the number that corresponds best to your relationship with your spouse/partner.		
	Extremely unhappy	21 (1.6)
	Fairly unhappy	50 (3.7)
	A little happy	150 (11.2)
	Happy	315 (23.5)
	Very happy	404 (30.2)
	Extremely happy	356 (26.6)
	Perfect	43 (3.2)
Do you and your spouse/partner work out arguments with:		
	Great difficulty	104 (7.7)
	Some difficulty	715 (53.1)
	No difficulty	527 (39.2)

BIVARIATE ANALYSES

Household Income and Mental Health

Cross-tabulations were conducted to assess the associations between total household income and the prevalence of symptoms related to anxiety, depression, and stress. Ordinal household income categories were dichotomised at the cut point (+/- $125,000) most closely approximating the median total household income for the province of Alberta ($123,800) (Government of Alberta, 2023). Criteria for the dichotomised cut-off points for the instruments measuring three mental health outcomes; the Spielberger State Anxiety Inventory (SSAI-SF), the Center for Epidemiologic Studies Depression Scale (CES-D), and the Perceived Stress Scale (PSS) can be found in Appendix A.

There was a significant association between household income and anxiety, depression, and stress levels among women in the sample. Among those with incomes below $125,000, 30.8% of individuals exhibited elevated symptoms of anxiety compared to 20.9% in the higher income category ($p < 0.001$; Table 46). For depression, among participants with household incomes below $125,000, 37.4% exhibited elevated symptoms of depression, compared to 25.1% among those with household incomes of $125,000 or more ($p < 0.001$; Table 46). Perceptions of stress among participants with household incomes below $125,000 were also observed, as 31.8% reported high symptoms of stress compared to 20.8% among those with household incomes of $125,000 or more ($p < 0.001$; Table 46). These findings suggest a higher prevalence of anxiety symptoms, depression symptoms, and stress among women living in lower income households in comparison to their higher-income counterparts.

Examining the impact of income on flourishing, as measured by the Secure Flourish Measure (SFM) (Appendix A), participants were divided into two income groups: those earning between $0 and $124,999 (n = 533), and those earning $125,000 or more (n = 879). SFM responses were

analysed categorically. The data were categorized into two groups, with low flourishing dichotomised at less than or equal to 1 standard deviation below the sample mean, and high flourishing greater than 1 standard deviation above the sample mean. Among participants with household incomes below $125,000, 23.8% were categorized as low flourishing compared to 10.4% of participants with higher income (p < 0.001). Higher income participants reported higher flourishing levels (89.6%) compared to that of lower income counterparts (76.2%) (p < 0.001; Table 46). This indicated a relationship between income and flourishing levels.

TABLE 46: HOUSEHOLD INCOME AND MENTAL HEALTH PROPORTIONS

	Household Income $0- $124,999		$125,000 or more		Total		p-value
	N	%	N	%	N	%	
Anxiety symptoms							
Low symptoms of anxiety (<14)	367	69.2	697	79.1	1064	75.4	< 0.001
Symptoms of anxiety (14 or greater)	163	30.8	184	20.9	347	24.6	
Total	530	100.0	881	100.0	1411	100.0	
Depression symptoms							
Low symptoms of depression (< 10)	328	62.6	660	74.9	988	70.3	< 0.001
Symptoms of depression (10 or greater)	196	37.4	221	25.1	417	29.7	
Total	524	100.0	881	100.0	1405	100.0	
Stress Proportions							
Low symptoms of stress (< 8)	369	68.2	709	79.2	1078	75.1	< 0.001
Symptoms of stress (8 or greater)	172	31.8	186	20.8	358	24.9	
Total	541	100.0	895	100.0	1436	100.0	
Dichotomised Flourishing Score Proportions							
Low flourishing (Scores below 78)	127	23.8	91	10.4	218	15.4	< 0.001
Higher flourishing (Scores of 78 and above)	406	76.2	788	89.6	1194	84.6	
Total	533	100.0	879	100.0	1412	100.0	

Time Pressure and Mental Health

Cross-tabulations explored the association between reported time pressure and symptoms of anxiety and depression. Time pressure is defined as feeling unable to manage time, feeling too busy, or pressured for time. Participant responses to the frequency in which they felt pressed for time were categorized as “never”, “about once a month”, “about once a week”, “a few times a week”, or “everyday”. Most respondents experienced time pressure a few times a week or daily.

A statistically significant association between the frequency of time pressure and the prevalence of anxiety symptoms was found. Among those who felt time pressure daily, 39.3% indicated elevated symptoms of anxiety compared to symptoms among those who experienced time pressure less often such as “a few times a week” (18.3%), or “about once a week” (11.8%) ($p < 0.001$; Table 47). This indicated that women who experienced time pressure more often, such as daily, may have experienced elevated symptoms of anxiety in comparison to those who experienced time pressure less often.

Similarly, a statistically significant association between the frequency of time pressure and the prevalence of depressive symptoms was found. Specifically, a notable prevalence of depression symptoms was experienced by 42.4% of respondents who felt time pressure daily. Among those who felt time pressure less often, such as a “few times per week” or “about once a week”, depressive symptoms were less prevalent (24.7% and 17.6%, respectively). This indicated that a relationship between time pressure and depressive symptoms existed where those experiencing time pressure more often had an increased prevalence of symptoms of depression ($p < 0.001$; Table 47).

TABLE 47: TIME PRESSURE AND MENTAL HEALTH PROPORTIONS

	Time Pressure												
	Never		About once a month		About once a week		A few times a week		Everyday		Total		p-value
	N	%	N	%	N	%	N	%	N	%	N	%	
Anxiety Symptoms													
Low symptoms of anxiety (<14)	18	85.7	74	94.9	165	88.2	488	81.7	342	60.7	1087	75.2	<0.001
Symptoms of anxiety (14 or greater)	3	14.3	4	5.1	22	11.8	109	18.3	221	39.3	359	24.8	
Total	21	100.0	78	100.0	187	100.0	597	100.0	563	100.0	1446	100.0	
Depression Symptoms													
Low symptoms of depression (<10)	13	68.4	71	92.2	150	82.4	448	75.3	325	57.6	1007	70.1	<0.001
Symptoms of depression (10 or greater)	6	31.6	6	7.8	32	17.6	147	24.7	239	42.4	430	29.9	
Total	19	100.0	77	100.0	182	100.0	595	100.0	564	100.0	1437	100.0	

WOMEN-YOUTH ASSOCIATIONS

Flourishing

Women and their youth's flourishing were compared to determine whether there was an association. Categorical dichotomisation of both women and youth flourishing scores and significance testing for a relationship between the two revealed no significant association between women and youth flourishing (p = 0.908) (Table 48).

TABLE 48: WOMEN AND YOUTH FLOURISHING PROPORTIONS

	Women flourishing scores				Total		p-value
	Low flourishing		High flourishing				
Youth Flourishing	N	%	N	%	N	%	
Low flourishing (Scores below 78)	156	77.6	811	78.0	967	77.9	0.908
Higher flourishing (Scores of 78 and above)	45	22.4	229	22.0	274	22.1	
Total	201	100.0	1040	100.0	1241	100.0	

Mental Health

The relationship between women and their youth's mental health was assessed using cross-tabulations. Associations between women's anxiety (SSAI-SF) and depression (CES-D) symptom scores and youth anxiety and depression (BASC-3) symptom scores were examined. There was no statistically significant association between youth anxiety levels and women's anxiety levels (p = 0.786) (Table 49). For depression, no statistical significance was observed between youth depression levels and women's depression levels (p= 0.232) (Table 50). Overall, this indicated no significant relationship between women and their youth's mental health scores.

TABLE 49: WOMEN AND YOUTH ANXIETY PROPORTIONS

	Women's anxiety scores (SSAI)				Total		p-value
	Lower symptoms		Higher symptoms				
BASC-3 Anxiety T-scores	N	%	N	%	N	%	
Low to average anxiety	646	69.3	223	70.1	869	69.5	0.786
At-risk or clinically significant anxiety	286	30.7	95	29.9	381	30.5	
Total	932	100.0	318	100.0	1250	100.0	

TABLE 50: WOMEN AND YOUTH DEPRESSION PROPORTIONS

	Women's depression scores (CES-D)				Total		p-value
Youth Depression T-scores (BASC-3)	Lower symptoms		Higher symptoms				
	N	%	N	%	N	%	
Low to average depression	652	76.3	284	73.2	936	75.4	

At-risk or clinically significant depression	202	23.7	104	26.8	306	24.6	0.232
Total	854	100.0	388	100.0	1242	100.0	

Chronic Pain

Finally, cross-tabulations between women and their youth's chronic pain found no significant association between these experiences (p = 0.180) (Table 51).

TABLE 51: WOMEN AND YOUTH'S CHRONIC PAIN REPORTING PROPORTIONS

Youth chronic pain	Women's chronic pain				Total		p-value
	No		Yes				
	N	%	N	%	N	%	
No	230	58.5	339	54.2	569	55.9	0.180
Yes	163	41.5	286	45.8	449	44.1	
Total	393	100.0	625	100.0	1018	100.0	

HIGHLIGHTED RESULTS

Demographics

- The average age for women at this analysis was 44.0 (SD 4.3) years. Most identified as White/Caucasian (80.3%), were married or partnered (90.9%), heterosexual (84.3%), had a household income of $125,000 or greater (62.2%), and had graduated from a post-secondary institution (59.7%). One in 10 participants reported some food insecurity (11.4%).
- Over 75% of women were employed and, of those, 73.5% worked 30 hours or more a week. Most commonly, participants reported employment in the health and social sector (26.7%), professional services (23.0%), or educational services (19.7%). Over one third (41.5%) of women worked entirely on-site, while 13.7% and 15.3% reported working mostly or entirely remotely, respectively. A hybrid model combining equally remote and on-site activities was reported by 15.8% of respondents. Over 90% of women were satisfied (48.9%) or very satisfied (39.4%) with their current work arrangements.

Mental Health and Life Satisfaction

- Overall, most (78.1%) women reported high life satisfaction in domains of work, family, housing, partner relationships, and social activities. The majority (75.5%) expressed contentment in their friendships and relationships and 74.0% reported feeling quite or extremely happy. The mean score for flourishing, defined as overall well-being and positive mental health, was high (87.76, SD 15.22, range of 21.00-120.00) suggesting

that most participants were flourishing, felt supported and were satisfied in various domains of their lives.

- In terms of mental health, approximately one in three women (29.9%) exhibited symptoms of depression and one in four (24.8%) displayed elevated symptoms of anxiety. One in four (25.5%) had high scores on the perceived stress measure.
- The vast majority (81.4%) of respondents reported moderate or high social support in terms of emotional/information support, tangible support, affectionate support, and positive social interactions.
- Most women with household incomes above $125,000 reported high flourishing scores (89.6%) and low symptoms of stress (79.2%), depression (74.9%), and anxiety (79.1). Among respondents with household incomes below $125,000, 76.2% reported high flourishing scores and low symptoms of stress, depression, and anxiety were reported among 68.2%, 62.6%, and 69.2% participants, respectively.
- Increased time pressure was associated with increased symptoms of depression and anxiety.
- Women's scores on flourishing, anxiety symptoms, depression symptoms and chronic pain were not associated with their youth's scores on flourishing, anxiety symptoms, depression symptoms and chronic pain.

Lifestyle and Physical Health

- Most women were meeting Canadian physical health guidelines; this included sleeping between 7 to 9 hours on a regular basis (68.0%), having no more than 3 hours of recreational screen time per day, and obtaining at least 150 minutes of moderate- to vigorous-intensity physical activity each week (mean 3.47 hours per week, SD 3.71). Moreover, most participants (89.2%) report meeting Canadian guidelines for receiving Pap tests for cervical cancer screening every 3 years or less.
- Over half (62.0%) of women reported some level of loss of bladder control and urinary leakage (urinary incontinence). Of these, 75.2% indicated some interference in their everyday life.
- The majority of women (77.8%) identified as premenopausal and still experienced menstrual cycles.
- Over half (62.8%) of respondents reported experiencing aches and pains at least once a month for three consecutive months.
- Within their communities, the majority of women reported a strong (25.9%) or somewhat strong (50.1%) sense of belonging within their local community and perceptions of neighbourhood cohesion were high among the sample.

CONCLUSION

Through the 12–14-year follow-up questionnaire, women reported on their relationships with their youth and partners, and other family dynamics. Physical and mental well-being, life satisfaction, and connectedness generally showed positive outcomes among women in the cohort. As well, potential relationships between income, time pressure, and mental health issues were identified. Reports from women in the cohort suggest that resources are needed for mental health, as experienced by a notable prevalence of the cohort. The next wave of questionnaires, at the 15–17-year follow-up, will seek to further investigate mental well-being and factors that impact flourishing.

REFERENCES CITED

Adler, N. E., Epel, E. S., Castellazzo, G., & Ickovics, J. R. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy, White women. *Health Psychology*, *19*(6), 586–592. https://doi.org/10.1037/0278-6133.19.6.586

Buchanan, T. (2016). Self-report measures of executive function problems correlate with personality, not performance-based executive function measures, in nonclinical samples. *Psychological Assessment*, *28*(4), 372–385. https://doi.org/10.1037/pas0000192

Centre for Addiction and Mental Health (CAMH). (2018). *Association between family subjective social status and mental health among high school students in Ontario* (19(3); CAMH Population Studies eBulletin). Centre for Addiction and Mental Health. https://www.camh.ca/en/science-and-research/institutes-and-centres/institute-for-mental-health-policy-research/publicationsf

McDonald, S. W., Lyon, A. W., Benzies, K. M., McNeil, D. A., Lye, S. J., Dolan, S. M., Pennell, C. E., Bocking, A. D., & Tough, S. C. (2013). The All Our Babies pregnancy cohort: Design, methods, and participant characteristics. *BMC Pregnancy and Childbirth*, *13*(1), S2. https://doi.org/10.1186/1471-2393-13-S1-S2

Tough, S. C., McDonald, S. W., Collisson, B. A., Graham, S. A., Kehler, H., Kingston, D., & Benzies, K. (2017). Cohort Profile: The All Our Babies pregnancy cohort (AOB). *International Journal of Epidemiology*, *46*(5), 1389–1390k. https://doi.org/10.1093/ije/dyw363

APPENDIX A: MATERNAL QUESTIONNAIRE AND INSTRUMENT INFORMATION

NLSCY PERCEIVED NEIGHBOURHOOD COHESION SCALE

Concept: Neighbourhood cohesion
Description: This scale developed by the National Longitudinal Survey of Children and Youth (NLSCY) asks five questions which are scored on a 4-point scale ranging from "strongly disagree" to "strongly agree." It assesses the perception of neighbourhood cohesion. Highly cohesive neighbourhoods are characterized by neighbour trust, community engagement, and neighbour cooperation to attain shared goals. Cronbach's alphas ranging from 0.86-0.90 have been determined for this scale.
Scoring Information: Scores on these items are summed to create a total neighbourhood social cohesion score, ranging from 0 to 15; higher scores indicate greater neighbourhood cohesion. When 1 or more items is missing from the scale, no score is calculated.
References:

1) Kingsbury M, Kirkbride JB, McMartin SE, Wickham ME, Weeks M, Colman I. Trajectories of childhood neighbourhood cohesion and adolescent mental health: evidence from a national Canadian cohort. Psychol Med. 2015;45(15):3239-48.

CCHS BELONGING MEASURE

Concept: Community belonging
Description: This question was used in the Canadian Community Health Survey (CCHS) to address the sense of belonging to a local community, as an indication of social well-being. The question uses 4 answer categories ranging from "Very Strong" to "Very Weak."
Scoring Information: No scoring information provided. Response classification structure-category
References:

1) Statistics Canada. Canadian Community Health Survey (CCHS- 2021): General Health (GEN) > GEN_Q20. 2021.

MACARTHUR SCALE OF SUBJECTIVE SOCIAL STATUS – ADULT VERSION

Concept: Perceived Social status
Description: This single-item measure, created by Adler et al., assesses an individual's perceived social status rank relative to others in their community, using a 10-point scale. The original measure had two questions which asked about status relative to the United States, and status relative to the community, respectively. AOF adjusted the wording to create one question which applies to communities in the context of a Canadian population.
Scoring Information: No scoring information provided. Each rung of the ladder corresponds with numbers from 1 (bottom) through 10 (top). 1 corresponds with a low perceived standing in the community. 10 corresponds with a high perceived standing in the community.
References:

1) Adler NE, Epel ES, Castellazzo G, Ickovics JR. Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy, White women. Health Psychology, 2000;19(6), 586-592.

2) Stanford University Sparq Tools. MacArthur Scale of Subjective Social Status – Adult Version. 2022.
3) All Our Families Study Team. Internal Development. Personal Communication. 2022.

SECURE FLOURISH MEASURE
Concept: Perceived Social status, languishing/flourishing
Description: The Secure Flourish measure, developed by VanderWeele et al., assesses flourishing, which consists of doing or being well in six broad domains: (i) happiness and life satisfaction; (ii) health, both mental and physical; (iii) meaning and purpose; (iv) character and virtue; (v) close social relationships, and (vi) financial and material stability. The scale asks two questions about each domain, and combines scores from all six domains to obtain a holistic measure of flourishing. Evidence of validity and reliability (Cronbach's α=0.86) have been determined.
Scoring Information: Each question is assessed on a scale of 0-10. The Secure Flourish measure is obtained by summing the scores from all six domains. Scores range from 0-120 with higher scores indicating greater flourishing. When 1 or more items is missing from the scale, no score is calculated.
References:
1) VanderWeele TJ. On the promotion of human flourishing. Proc Natl Acad Sci U S A. 2017;114(31):8148-8156.

ADAPTATION OF FISHER'S SPIRITUAL WELL-BEING SCALE
Concept: Spiritual Well-being
Description: This eight-item version of the Fisher's Spiritual Well-being scale assesses spiritual health in terms of four domains: personal, communal, environmental and transcendental. The original scale contained 24 items, with 6 in each domain. This 8-item adaptation was used by the 2014 Health Behavior in School-aged Children (HBSC) study. It contains two items about each domain, and each question uses a 5-point scale ranging from "not important at all" to "very important." The scale was adapted to include response wording and opening sentence from the 4-Item Spiritual Well-Being Index (4-ISWBI). The scale has excellent psychometric properties (Cronbach's alpha 0.83 with high factor loadings).
Scoring Information: The scores across all 4 domains are summed to give an overall score of spiritual well-being. Scores range from 8-40 with higher scores indicating greater well-being. When 1 or more items is missing from the scale, no score is calculated.
References:
1) Freeman, Gregory J. Health Behaviour in School-aged Children (HBSC) in Canada: Focus on Relationships. 2020.
2) Michaelson V, Freeman J, King N, Ascough H, Davison C, Trothen T, Phillips S, Pickett W. Inequalities in the spiritual health of young Canadians: a national, cross-sectional study. BMC Public Health. 2016;16(1):1200.

CURRENT EMPLOYMENT STATUS
Concept: general routines, employment, schooling, volunteering
Description: This is a self-developed question intended to record respondent employment, education, and volunteer routines.
References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

FINANCIAL IMPACT: SECTOR SPECIFIC WORK
Concept: Sector work
Description: This is a self-developed question intended to assess the work sector of participants. Hover text in online survey for question 2a, code 6 read the following:
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

WORK AND SCHOOL ARRANGEMENT
Concept: work/school arrangement satisfaction
Description: These questions were adapted from the Statistics Canada Labour Force Survey. They address participants' current work or school arrangement, their level of satisfaction with this arrangement, and their ideal arrangement.
References:
1) Labour Force Survey. Statistics Canada. 2022.

LIFE SATISFACTION
Concept: Life satisfaction
Description: The original set of life satisfaction measures is from the Australian Longitudinal Study on Women's Health. AOF adapted this measure to address 10 areas using a 5-point scale ranging from "not at all" to "very much." The responses were modified by AOF as follows:

- New additions: "Work-life balance," "Housing," and "Shared responsibilities in the home"
- Response options were changed from "not applicable," "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied" to "not at all," "a little bit," "somewhat," "quite a bit," and "very much."

Scoring Information: No scoring information provided from Australian Longitudinal Study. AOF summed all items so that the range is between 0-40. Higher scores indicate greater life satisfaction. When 1 or more items is missing from the scale, no score is calculated.
References:
1) Eighth survey for women of the 1973-78 cohort. Australian Longitudinal Study on Women's Health. 2018.
2) All Our Families Study Team. Internal Development. Personal Communication. 2022.

RAINE STRESSFUL EVENTS SCALE AND DISCRIMINATION EXPERIENCES
Concept: stressful events, abuse, discrimination
Description: This 8-item list was adapted from the Raine Study Stressful Events Scale and APrON Study Stressful Life Events List. It addresses stressful events that have happened in the past year, and the level of effect they had. It also addresses whether the respondent has experienced discrimination in the past year, the basis of discrimination, and the effect it had. From Bräuner et al: In order to apply the Tennant inventory (original Stressful Life Events Questionnaire, SLEQ) to stressful life events in pregnant women, the Raine study created a 10-item inventory that included at least one item from each dimension. To allow women to include stressful events that were not included in the 10-item scale, an option to report 'other

problems' was created for pregnant women recruited to the Raine Study. AOF did not include an "other" option.

- AOF adapted items 4-6 to include an N/A option for those who do not have a partner.
- AOF also modified discrimination questions (items 8 and 9) to include more detail. The grounds for discrimination were based on the Canadian Human Rights Act. The specific questions were taken from a Statistics Canada Crowdsourcing initiative.
    - The categories "race or skin colour" and "ethnicity or culture" were combined as "race, ethnic origin, or religion"
    - An "age" category was added
    - A "physical appearance" category was added
    - The "sex" category was modified to "sex or gender expression"
    - The "physical disability" category was modified to "physical or mental disability"

Scoring Information: Recode N/As to 0s. From the Raine study, a continuous variable of the total number of maternal stressful life events reported was calculated. When 1 or more items is missing from the scale, no score is calculated.

References:

1) Bräuner EV, Koch T, Juul A, Doherty DA, Hart R, Hickey M. Prenatal exposure to maternal stressful life events and earlier age at menarche: the Raine Study. Human Reproduction. 2021 Jun 18;36(7):1959-1969.
2) Statistics Canada. Experiences of discrimination during the COVID-19 pandemic. 2020.
3) Centers for Disease Control and Prevention. Office of Equal Employment Opportunity and Workplace Equity (OEEOWE): Types of Discrimination. 2021.
4) Canada Justice Laws Website. Canadian Human Rights Act (R.S.C., 1985, c. H-6). 2022.
5) All Our Families Study Team. Internal Development. Personal Communication. 2022.

MATERNAL TECHNOLOGY USE

Concept: Weekend and weekday electronic devices use

Description: These self-developed questions are intended to assess parental perception of their own weekday and weekend electronic device use, and how often device use interrupts conversations or activities. These questions are designed to align with parent-report of children's screen time (see screen time section), focus on recreational vs. educational instead of device breakdown. These questions were adapted from one item in the Common Sense Media report, *The Common Sense Census: Media Use by Tweens and Teens.* The survey questions were part of an ongoing study tracking social media use among American pre-adolescents and teenagers, aged 8- to 18-years. The original survey questions were developed by the study investigators.

Important Note: Questions 1 and 2 were adapted from the original AOF Youth COVID-19 survey such that, "during COVID-19" was switched to, "in the last two weeks" in this survey. The questions were also adapted from the original AOF survey such that, instead of a multiple-choice response, respondents were prompted to give a typed estimate of the number of hours spent on the activity per day. The adapted item and responses are provided below.

Additional notes on screen time:

- According to the new Canadian 24-Hour Movement Guidelines, adults should limit their sedentary time to eight hours or less per day, including three hours or less of recreational screen time. (https://csepguidelines.ca/guidelines/adults-18-64/)

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

TECHNOLOGY ENGAGEMENT SCALE
Concept: Device usage, impulse control, smartphone habits
Description: This scale was created by Wilmer et al. to index technology engagement patterns including device usage, intertemporal preference, impulse control, and reward sensitivity. The original scale included three components: (1) frequency of public status updating, (2) phone-checking behaviour, and (3) phone-based social media use. AOF did not use the third component. Each question uses a 4-point Likert scale with responses ranging from "Never" to "Almost Always." A Cronbach's alpha of 0.65 has been determined for the full scale.
Scoring Information: Calculate mean for phone-checking behaviour subscale. When 1 or more items is missing from the scale, no score is calculated.
References:
1) Wilmer, H.H., Chein, J.M. Mobile technology habits: patterns of association among device usage, intertemporal preference, impulse control, and reward sensitivity. Psychon Bull Rev. 2016;**23,** 1607–1614.

FAMILY ACTIVITIES
Concept: Family Activities, creative activities, outdoor activities
Description: This question was designed to determine creative and outdoor activities done as a family in the past year. It was modified from the Statistics Canada Canadian Social Survey-Well-being, Activities and Perception of Time (2020/21) Outdoor Activities (ODA) and Creative Activities (LCD) questions, as well as an open-ended question asked in the AOF Covid-19 #3 questionnaire. The wording was changed from "In the past 12 months, which of the following [outdoor or wilderness] activities have you participated in?" to "We are interested in activities you enjoy doing as a family. In the past 12 months, which of the following activities have you participated in together? Please select all that apply" to make the question specifically about activities done as a family.
Scoring Information: No scoring information provided. All options are given a score of 1.
References:
1) Statistics Canada. General Social Survey C31 MAIN SURVEY- Well-being, Activities and Perception of Time (2020/21). 2021.
2) All Our Families Study Team. Internal Development. Personal Communication. 2022.

PHYSICAL ACTIVITY
Concept: Physical activity
Description: This self-designed question is intended to assess physical activity, though wording recommended from ParticipACTION work based on their data collection approach (Q8 asked whether mom meets Canadian PA guidelines, viewed as leading by ParticipACTION).
Scoring Information: No scoring information is necessary. Answers are numerical-based.
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

LEISURE ACTIVITIES
Concept: Leisure time
Description: This question was adapted from the Australian Longitudinal Study on Women's Health's 2018 survey for the 19-73-78 cohort. It addresses the time spent on leisure activities.

- The question stem was modified from "In a usual week, how much time in total do you spend doing the following things: Passive leisure (eg. TV, music, reading, relaxation)?" to "In an average week, how many hours do you engage in leisure activities for your own pleasure? (eg. reading, arts and crafts, self-care)?"
- The answer option "I don't do this activity" was modified to "0 hours"

References:

1) Australian Longitudinal Study on Women's Health. Eighth survey for women of the 1973 – 78 cohort. (2018).
2) All Our Families Study Team. Internal Development. Personal Communication. 2020.

TIME MANAGEMENT

Concept: Feeling rushed/busy/pressured

Description: This question was adapted from the Australian Longitudinal Study on Women's Health's 2018 survey for the 19-73-78 cohort. It addresses perceptions of time and feelings of being rushed, pressured, or busy.

Scoring Information: This question uses a 5-point scale with answers ranging from "never" to "every day." Higher scores indicate greater frequency of feeling rushed, pressured, or too busy.

References:

1) Eighth survey for women of the 1973-78 cohort. Australian Longitudinal Study on Women's Health. 2018.

ALCOHOL USE

Concept: Alcohol use

Description: These self-developed questions are intended to assess the participants alcohol usage. For the purposes of this question, 1 drink = a 5-ounce glass of wine, 12 ounces of beer, a mixed drink or cooler with 1.5 ounces of liquor. Researchers define binge drinking as having many drinks on one occasion: five or more drinks for a male, or four or more drinks for a female.

Scoring Information: No scoring information is provided. For question 9, answers are numerical and text based. For question 10, higher scores indicate a higher frequency of binge-drinking events, defined by Canada's Low Risk Alcohol Drinking Guidelines as consuming four or more drinks on a single occasion.

References:

1) Canadian Centre on Substance Use and Addiction. Canada's Low-Risk Alcohol Drinking Guidelines. 2018.
2) All Our Families Study Team. Internal Development. Personal Communication. 2020.

TOBACCO, NICOTINE, AND CANNABIS USAGE

Concept: Tobacco, Nicotine, and Cannabis Usage

Description: These self-developed questions are intended to assess the participants' tobacco, nicotine, and cannabis use. This is a new set of question with this wording but has been asked at Q7 and Q8, similar format but expanded to include any tobacco/nicotine product and broken down by product type.

Scoring Information: No scoring information is provided. Answers are numerical and text based.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2020

RECREATIONAL DRUG USAGE

Concept: recreational drug use

Description: These self-developed questions are intended to assess the participants' recreational drug usage.

Scoring Information: No scoring information is provided. Answers are numerical and text based.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2020.

MEDICAL DIAGNOSES

Concept: Health, medical diagnosis, treatment

Description: These questions are intended to record medical diagnosis and treatment by a registered Health Practitioner. Part of this list of conditions was from Q8 and has been updated.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

PROMIS ACHES AND PAINS

Concept: Aches, pains

Description: These self-designed questions are intended to assess the prevalence, location, and duration of aches or pains for the participant, and the child's father. Additionally, the 4-item Patient Reported Outcomes Information System (PROMIS) Pain Interference Short Form tool (item 2d) was adapted to evaluate the interference of aches and pains with daily life, work, social activities, and family. This tool contains 4 items which are answered on a 5-point scale ranging from "not at all" to "very much. It is intended to assess self-reported consequences of pain on one's life. Cronbach's alphas range from 0.88-0.97.

Scoring Information: No scoring information provided for questions 2a-c, 3a-b, and 5. For question 2d (PROMIS), higher scores indicate greater pain interference.

References:

1) All Our Families Study Team. Internal Development (Serena Orr, Katie Birnie, and Melanie Noel). Personal Communication. (2022).
2) Chen CX, Kroenke K, Stump TE, Kean J, Carpenter JS, Krebs EE, Bair MJ, Damush TM, Monahan PO. Estimating minimally important differences for the PROMIS pain interference scales: results from 3 randomized clinical trials. Pain. 2018;159(4):775-782.
3) PROMIS measures website: https://www.healthmeasures.net/index.php?option=com_instruments&task=Search.pagination&Itemid=992

MIGRAINE QUESTIONS

Concept: Migraines

Description: These questions are intended to assess the prevalence of migraines, as diagnosed by a medical practitioner. An additional question assesses migraine prevalence in the

biological father of the child. These questions were derived and modified from the National Longitudinal Survey of Children and Youth. Hover text in online survey for question 4 and 6 read the following:

health professional

An individual primarily concerned with diagnosing and treating health problems in humans and with providing related services such as pharmacy, nutrition, physiotherapy, and occupational therapy. In addition to specialist physicians and general practitioners, dentists, optometrists, pharmacists, dietitians and nutritionists, physiotherapists, and occupational therapists, this group includes nurses—both registered and licensed practical nurses.

References:

1) Statistics Canada. National Longitudinal Survey of Children and Youth User Guide, Cycle 8, September 2008 to July 2009. 2010. Available at: http://www23.statc an.gc.ca/imdb-bmdi/docum ent/4450_D4_T9_V8-eng.pdf. Accessed March 22, 2019.

PAP TEST FOR CERVICAL CANCER SCREENING

Concept: pap testing

Description: These questions are intended to assess the frequency, age, and recency of pap testing, or the reasons for not undergoing pap testing. Pap tests are crucial for identification of cervical cancer before symptom presentation. The Canadian Cancer Society recommends pap testing every 1-3 years for sexually active individuals over the age of 21. Questions 7a, 7c, 7d, and 7e were adapted from the Canadian Community Health Survey. Question 7b was self-developed.

Scoring Information: No scoring information provided. For question 7b, higher scores indicate greater age. For question 7c, lower scores indicate more recency. For question 7e, higher scores indicate greater frequency, with the exception of “8,” which indicates no fixed frequency.

References:

1) Statistics Canada. Canadian Community Health Survey (CCHS). 2020.
2) Canadian Cancer Society. Screening for cervical cancer. 2022.

SANDVIK SEVERITY INDEX

Concept: Urinary incontinence

Description: The Sandvik Severity Index is a scale used to determine urinary incontinence severity in females. AOF has used an adaptation of the index developed by the Nurses’ Health Studies in the United Kingdom. The index is based on information about incontinence frequency and the amount of leakage. An additional question addresses the usual cause for incontinence. UI is classified into three subtypes: stress UI (SUI), urge UI (UUI), and mixed UI. The Sandvik Severity Index is well validated in epidemiological studies and shows good internal consistency (Cronbach’s alphas range from 0.78-0.84).

Scoring Information: The Sandvik Index is calculated by multiplying the reported frequency of UI (less than once per month, one to three times per month, once per week, once per day) by the amount of leakage (drops, more than drops). Scores range from 1-8, with higher scores indicating greater severity. Those who reported “Never” leaking or losing urine control receive “0” – no severity on the Sandvik Index.

Urinary incontinence severity (SSI) = Frequency X Leakage

According to the Sandvik index, scores of 1-2 are classified as “slight” UI severity, scores of 3-4 are classified as “moderate” UI severity, and a score of 6 or higher is classified as “severe” UI.

References:

1) Sandvik H, Hunskaar S, Seim A, Hermstad R, Vanvik A, Bratt H. Validation of a severity index in female urinary incontinence and its implementation in an epidemiological survey. J Epidemiol Community Health 1993;47:497–9.
2) Minassian VA, Devore E, Hagan K, Grodstein F. Severity of urinary incontinence and effect on quality of life in women by incontinence type. Obstet Gynecol. 2013;121(5):1083-1090.
3) Hendriks, E.J., Bernards, A.T., Staal, J.B. et al. Factorial validity and internal consistency of the PRAFAB questionnaire in women with stress urinary incontinence. BMC Urol 8, 1. 2008.

URINARY INCONTINENCE IMPACT ON QUALITY OF LIFE

Concept: Urinary incontinence, quality of life

Description: This question measures the impact of urinary incontinence on quality of life. It was adapted from the International Consultation on Incontinence Questionnaire Short Form, a three-question questionnaire. AOF has used one question from this short form, which addresses quality of life.

Scoring Information: The amount of interference of leakage with everyday life is ranked from 0 (not at all) to 10 (a great deal). Higher values indicate a greater impact of urinary incontinence on quality of life.

References:

1) Grøn Jensen LC, Boie S, Axelsen S. International consultation on incontinence questionnaire - Urinary incontinence short form ICIQ-UI SF: Validation of its use in a Danish speaking population of municipal employees. PLoS One. 2022;7(4):e0266479.

PELVIC FLOOR DISTRESS INVENTORY

Concept: Pelvic organ prolapse symptoms

Description: This question was taken from the Pelvic Floor Distress Inventory (PFDI-20). It is intended to identify the presence of pelvic organ prolapse symptoms. The PFDI-20 is a 20-question inventory which measures the presence of pelvic organ prolapse. AOF used 1 item from this inventory. The PFDI-20 shows good reliability and internal consistency (Cronbach’s alpha=0.69-0.96).

Scoring information: No scoring information provided. This is not a scale.

References:

1) Mattsson NK, Nieminen K, Heikkinen AM, Jalkanen J, Koivurova S, Eloranta ML, Suvitie P, Tolppanen AM. Validation of the short forms of the Pelvic Floor Distress Inventory (PFDI-20), Pelvic Floor Impact Questionnaire (PFIQ-7), and Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12) in Finnish. Health Qual Life Outcomes. 2017;15(1):88.

MENOPAUSE AND PERIMENOPAUSE QUESTIONS

Concept: perimenopause, menstruation

Description: These questions are adapted or modified from ALSPAC (Children of the 90s study, #10a, b) and the Menopause Rating Scale (#13). These questions are intended to assess the

prevalence, age, and symptoms of menopause and perimenopause as part of women's health later in life. The Menopause Rating Scale's Cronbach's a=0.6 to 0.9 across countries, moderately associated with validated quality of life and existing menopausal index (Heinemann 2004).

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.
2) Heinemann K, Ruebig A, Potthoff P, et al. The Menopause Rating Scale (MRS) scale: a methodological review. *Health Qual Life Outcomes*. 2004;2:45. Published 2004 Sep 2. doi:10.1186/1477-7525-2-45.

SURGICAL REMOVAL OF THE UTERUS OR OVARIES

Concept: uterus removal, ovary removal

Description: These self-developed questions are intended to determine the prevalence and age of surgical uterus and ovary removal.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

HORMONE REPLACEMENT THERAPY

Concept: prescription female hormones

Description: These questions were adapted from the Nurses' Health Study. They are intended to assess the prevalence, age, and duration of hormone replacement therapy use, excluding oral contraceptives. The wording of question 14a was changed from "Have you ever taken **prescription** female hormones (not including oral contraceptives)?" to "Have you ever taken **prescription** female hormones (not including birth control pills)?"

References:

1) Day A. Lessons from the Women's Health Initiative: primary prevention and gender health. CMAJ. 2002;167(4):361-362.
2) All Our Families Study Team. Internal Development. Personal Communication. 2022.

PREGNANCY AND BIRTHS

Concept: Pregnancy and live births

Description: These self-designed questions were designed to determine the number of pregnancies and live births experienced.

Scoring Information: No scoring information provided. Answers are numerical.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

MATERNAL HEIGHT AND WEIGHT

Concept: Height, weight

Description: These self-developed questions are intended to record participant height and weight.

Scoring Information: No scoring information provided. The questions require a numerical response.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

ABBREVIATED SOCIAL SUPPORT INSTRUMENT (MOS-SSS)
Concept: Social support
Description: The instrument is an abbreviated version of the Medical Outcome Study Social Support Survey (MOS-SSS) containing 4 items scored on a 5-point scale. The original MOS contained 19 items. There is one question each from four subscales including: emotional/informational support, tangible support, affectionate support, and positive social interaction. The 4-item reliability for social support was 0.83, with a high correlation with the MOS.

1) Subscale 1: Emotional/Informational Support
   …Someone to turn to for suggestions about how to deal with a personal problem (item 2)
2) Subscale 2: Tangible Support
   … Someone to help with daily chores if you were sick (item 1)
3) Subscale 3: Affectionate Support
   … Someone to love and make you feel wanted (item 4)
4) Subscale 4: Positive Social Interaction
   … Someone to do something enjoyable with (item 3)

Scoring Information: The respondent indicates on a 5-point scale the extent to which each statement describes her current social network. Responses range from 1 (none of the time) to 5 (all of the time). Higher scores indicate higher levels of social support availability. On the original MOS-SSS, scale developers suggest allowing a final score if at least one item is answered.
(Instructions from scoring Q1-Q3 full MOS-SSS scale): When scoring the scales, use this formula:
100 x [(observed score - minimum possible score) ÷ (maximum possible score - minimum possible score)]
This will give you a score out of 100 for that subscale. The minimum possible score will be the number of items on that subscale, since 1 is the minimum score for each item. For the maximum score, multiply the number of items on the subscale by 5. Using tangible support as an example from Q1 survey:

100 x (((ssbed+ssdr+ssmeal+sschore)-4) ÷ (20-4))

If you write out the equation, you can then highlight the parts that you want to put in brackets and click the brackets button, and it will put them around what you specified, making things easier. Do this for each of the subscales. If you want to check that you did the calculation properly, use the 'analyze – frequency' function and find out the minimum and maximum of the scores on the subscale that you just calculated, which should fit into the 0-100 range.
To calculate the overall score, use the same formula but include all of the items that you bubble in (not the one where the participant writes out the number), including number 14 but <u>not</u> including the last item, which we added.

100 x (((ssbed+sslisten … +sswant)-19) ÷ (95-19))

This will give you the overall social support score out of 100.
References:

1) Sherbourne CD, Stewart AL. The MOS social support survey. Soc Sci Med. 1991;32(6):705-14.
2) Gjesfjeld CD, Greeno CG, Kim KH. A confirmatory factor analysis of an abbreviated social support instrument: The MOS-SSS. Research on Social Work Practice. 2008;18(3), 231–237

MATERNAL SLEEP HABITS
Concept: Sleep
Description: This self-designed question addresses maternal sleep habits, per nights a week..
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

SPOUSE/PARTNER SUPPORT
Concept: Spousal presence, spousal support, emotional, social, practical
Description: These self-developed questions are intended to assess the social, emotional, and practical support received from the respondents' partners and have been repeated from previous data collection waves.
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

DYADIC ADJUSTMENT SCALE (DAS)
Concept: Relationships
Description: This question was taken from the Dyadic Adjustment Scale. The Dyadic Adjustment Scale is a 32 item, self-administered questionnaire which was designed to measure satisfaction, consensus, cohesion, and affectional expression. This question is intended to assess relationship satisfaction using a 7-point scale with answers ranging from "extremely unhappy" to "perfectly happy." In 2020, the Early Intervention Society determined the overall scale to have a Cronbach's alpha of 0.96, with the satisfaction section having a Cronbach's alpha of 0.94.
Scoring Information: Higher scores indicate increased relationship satisfaction.
References:
1) Sharpley CF, Cross DG. A psychometric evaluation of the Spanier Dyadic Adjustment Scale. Journal of Marriage and Family. 1982;44(3): 739-741.

SPOUSE CONFLICT RESOLUTION
Concept: Spousal presence, spousal support, practical
Description: These self-developed questions are intended to assess the conflict resolution of respondents with their partners.
References:
1) All Our Families Study Team. Internal Development. Personal Communication 2020.

SPIELBERGER STATE ANXIETY SCALE
Concept: Anxiety
Description: The Spielberger State Anxiety Scale is a self-report instrument measuring state anxiety. State anxiety refers to "subjective, consciously perceived feelings, tension and apprehension and heightened autonomic nervous system activity." The state anxiety scale consists of 20 items rated on a 4 point intensity scale based on "how you feel right now." Cronbach's alpha values for the State Anxiety Scale were found to be 0.83 for males and 0.92 for females. The original study consisted of both state and trait anxiety, however, only state anxiety was included in the AOF. Marteau and Bekker (1992) developed a 6-item short form of the Spielberger anxiety scale based on a sample of 200 pregnant women. Correlations between the 6 items were reported at $r = 0.95$ and reliability coefficient of $\alpha=0.82$.

Scoring Information: Responses are scored from 1-4; items 1, 4, and 5 need to be reverse coded. All responses are summed for a possible range of scores of 6-24. Higher scores represent higher state anxiety. When 1 or more items is missing from the scale, no score is calculated.

References:

1) Spielberger, CD, Gorsuch, RL, Lushene, RE. State-Trait Anxiety Inventory for adults (Form X). Palto Alto, CA: Consulting Psychologists Press. 1970.
2) Gaudry, E, Vagg, P, & Spielberger CD. Validation of the State-Trait Distinction in Anxiety Research. Multivariate Behavioral Research, 1975;10(3), 331-341.
3) Marteau TM, Bekker, H. The development of a six-item short-form of the state scale of the Spielberger State-Trait Anxiety Inventory (STAI). British Journal of Clinical Psychology. 1992;31, 301–306.

CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE (CES-D)

Concept: Depression

Description: The CES-D scale is a short self-report scale designed to measure depressive symptomatology in the general population. The items of the scale are symptoms associated with depression which have been used in previously validated longer scales. The scale contains 20 symptoms, any of which may be experienced occasionally by healthy people. A 10-item version of the CES-D has been tested in both household and psychiatric settings. Although the CES-D is not designed for clinical diagnosis, it is based on symptoms of depression as seen in clinical cases. A Cronbach's alpha of 0.77 has been found by AOF. For the 10 item: CESD-10 showed an expected positive correlation with poorer health status (r=0.37) and a strong negative correlation with positive affect (r=-0.63). Retest correlations for the CESD-10 were comparable to those in other studies (r=0.71). The CES-D scale proved acceptable to both general and clinical populations.

Scoring Information: Create a sum of all 10 items; total score should range between 0 and 30. Higher scores indicate higher levels of distress. A score ≥ 10 suggests a clinically significant level of psychological distress. (Andresen, 1994). One missing response (9 out of 10 complete) is permissible, substitute mean for missing response (AOF chose to omit scores for 1 missing response). Items 5 and 8 should be reverse coded. When 1 or more items is missing from the scale, no score is calculated.

- Recode each to range from 0 – 3 instead of 1-4
    - Rarely or none of the time = 0
    - Some or a little of the time = 1
    - Occasionally or a moderate amount of the time = 2
    - Most or all of the time = 3
- Reverse code items 5 and 8
- Create a sum of all 10 items; total score should range between 0 and 30.
    - A score ≥ 10 indicates the presence of significant depressive symptoms.

References:

1) Radloff, LS. The CES-D Scale. A Self-Report Depression Scale for Research in the General Population. 1977;1(3), 385-401.
2) Wang LT, Anderson JL, Florence JE. Prevalence and risk factors of maternal depression during the first three years of child rearing. Journal of Women's Health. 2011;20(5): 711-718.

3) Zhang W, O'Brien N, Forrest JI, Salters KA, Patterson TL, Montaner JS, Hogg RS, Lima VD. Validating a shortened depression scale (10 item CES-D) among HIV-positive people in British Columbia, Canada. PLoS One. 2012;7(7):e40793.
4) Andresen EM., Carter WB., Malmgren JA., Patrick DL. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. Am J Prev Med. 10(2):77-84.

PERCEIVED STRESS SCALE (PSS-4, ABBREVIATED)
Concept: Perceived stress
Description: The Perceived Stress Scale (PSS) is a ten-item scale which assesses the degree to which individuals perceive situations in their lives to be stressful. Respondents are asked to rate how often they have felt or thought a certain way with the response choices ranging from "never" to "very often." The shortened PSS uses 4 items. The scale shows adequate internal consistency and reliability, with Cronbach's alphas ranging from 0.67-0.91. Cronbach's a=0.78 (AOF), high correlation with SF12-mental health (Karam 2012).
Scoring Information: Code items from 1-5 to 0-4. Items 2 and 3 should be reverse coded, then the answers from all items should be added to obtain a total stress score. Total stress scores can range from 0 to 16, with higher scores indicating more perceived stress. When 1 or more items is missing from the scale, no score is calculated.
References:
1) Cohen S, Kamarck, T, Mermelstein R. A global measure for perceived stress. Journal of Health and Social Behavior. 1983;24, 385-396.
2) Roberti JW, Harrington LN, & Storch EA. Further psychometric support for the 10-item version of the Perceived Stress Scale. *Journal of College Counseling*. 9:135-147.
3) Karam F, Bérard A, Sheehy O, et al. Reliability and validity of the 4-item perceived stress scale among pregnant women: results from the OTIS antidepressants study. *Res Nurs Health*. 2012;35(4):363-375. doi:10.1002/nur.21482.

EXECUTIVE FUNCTION SCALE
Concept: Executive functioning
Description: This scale is based on the Web-Based Executive Function Questionnaire (Webexec) developed by Buchanan et al. The scale is designed to assess experiences of problems with different aspects of executive functioning. It contains 6 items scored on a 4-point scale with answers ranging from "no problems experienced" to "a great many problems experienced." Responses to the Webexec have shown correlation with personality-based executive function measures. For instance, self-reported problems with executive function have shown correlation with neuroticism and low conscientiousness in non-clinical populations. The tool has demonstrated good internal consistency reliability (Cronbach's alpha=0.785).
Scoring Information: The 6 items are scored on a 4-point scale, shown below. The score for all 6 items is summed to give an overall score of executive function problems. Scores range from 6-24, with higher scores indicating greater problems with executive function. When 1 or more items is missing from the scale, no score is calculated.
References:
1. Buchanan T, Heffernan TM, Parrott AC., Ling, J, Rodgers J, Scholey, AB. A short self-report measure of problems with executive function suitable for administration via the Internet. *Behavior Research Methods*. 2010;*42*(3), 709-714.

2. Buchanan T. Self-report measures of executive function problems correlate with personality, not performance-based executive function measures, in nonclinical samples. Psychological Assessment 2016;28(4), 372.
3. Keen, L., George, L., Williams, G., Blanden, G., & Ramirez, M. Assessing the validity of the Self-Report Webexec Questionnaire: Self-report vs performance neurocognitive inferences. Applied Neuropsychology: Adult, 1-9. 2020.
4. Friedman-Krauss AH, Raver CC, Neuspiel JM, Kinsel J. Child behavior problems, teacher executive functions, and teacher stress in Head Start classrooms. Early education and development. 2014;*25*(5), 681-702.

PERCEPTION OF MENTAL HEALTH AND FLOURISHING
Concept: flourishing, mental health
Description: This self-developed question is intended to gauge participants' perception of whether they are flourishing, and what factors they consider to be important for flourishing.
References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

MARITAL STATUS
Concept: Marital status
Description: This self-developed question is intended to record the marital status of the respondent.
References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

GENDER IDENTITY AND SEXUAL ORIENTATION
Concept: Gender and sexuality
Description: These questions were taken from the Canadian Institute of Health Research Equity, Diversity, and Inclusion questions. The questions address current gender identity and sexual orientation
References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.
2) Canadian Institution of Health Research. Canada Research Chairs Program Self-Identification Form. 2022.

CHILD CUSTODY
Concept: Child custody and living arrangement
Description: These questions were designed to evaluate family status and child custody arrangements. Question 4a was self-designed. Question 4b question was modified from a Statistics Canada General Social Survey C31-Family (Gss-2017). It is intended to gauge child custody arrangements and the proportion of time the respondent lives with their child.

- AOF added the description: "*For example, 30% of a year is equivalent to every other weekend and one overnight visit a week.*"

Scoring Information: No scoring information is provided. For question 4b, higher scores indicate a higher proportion of time for the child living with the participant.
References:

1) Statistics Canada. General Social Survey C31 MAIN SURVEY- FAMILY. 2017.

2) All Our Families Study Team. Internal Development. Personal Communication. 2022.

HOUSEHOLD DEMOGRAPHICS
Concept: household members, pets
Description: These self-designed questions are intended to determine household member composition, and the number and types of pets in the household.
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

FINANCIAL RESPONSIBILITIES
Concept: Financial resources, financial responsibilities
Description: These were self-developed questions intended to assess the self-perceived ability to fulfill financial.
Scoring Information: No scoring information provided for the questions. Scales were indicated on a 7-point scale ranging from 1 (rarely/never) to 7 (always).
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

FOOD INSECURITY SCREENING TOOL
Concept: Food insecurity
Description: This 2-item food insecurity screening tool is used to identify households at risk for food insecurity. It was adapted from the US Household Food Security Scale. The tool has been found to be sensitive, specific, and valid. Affirmative responses to either item is associated with an increased risk of poor/fair child health.
Scoring Information: Hager et al. combined "often true" and "sometimes true" as one answer category in order to compare affirmative and non-affirmative answers. From Hager et al, "An affirmative response to question 1 and/or question 2 of the HFSS provided a sensitivity of 97% and specificity of 83%; therefore, these are the criteria that comprise the FI screen."
References:
1) Hager ER, Quigg AM, Black MM, Coleman SM, Heeren T, Rose-Jacobs R, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. Pediatrics. 2010;126(1):e26–32.
2) Economic Research Service, USDA. U.S. Household food security survey module: three stage design, with screeners. 2012.

MATERNAL EDUCATION LEVEL
Location: Section 6: Demographics; Question 11
Concept: Highest level of education
Description: This self-designed question is intended to gauge the highest level of education attained by participants.
Scoring Information: No scoring information is provided for this question. It is not a scale.
References:
1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

HOUSEHOLD INCOME AND POSTAL CODE
Concept: Household income and postal code

Description: These self-developed questions are intended to record the income of the respondents' family as well as their postal code

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

PRIMARY HEALTH CARE

Concept: Primary health care

Description: This self-designed question addresses whether the youth has a regular source of primary health care.

References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

COMMON SENSE MEDIA – SCREEN TIME DURATION, AWARENESS/MONITORING, AND DISCUSSION/DIALOGUE

Concept: Screen time

Description: The weekend and weekday questions (1a/1b) were adapted from one item in the Common Sense Media report, *The Common Sense Census: Media Use by Tweens and Teens.* The survey questions were part of an ongoing study tracking social media use among American pre-adolescents and teenagers, aged 8- to 18-years. The original survey questions were developed by the study investigators. The questions were adapted from the original item, "Thinking about yesterday, how much TIME did you spend doing each activity?" and responses included: "using a computer for homework", "using a tablet for homework", or "using a smartphone for homework". The questions were also adapted from the original AOF Youth COVID-19 surveys such that, "during COVID-19" was switched to, "in the past two weeks" in this survey. Finally, the questions were adapted from the original AOF survey such that, instead of a multiple-choice response, respondents were prompted to give a typed estimate of the number of hours spent on the activity per day. The adapted items and responses are provided below.
The awareness question (2) and the question about talking to the child (3) were developed by the AOF team.

Additional notes on screen time:

- Canadian Pediatric Society and the US no longer adopt the 2-hour guidelines; however, the World Health Organization still has the 2-hour guidelines. (https://cps.ca/en/documents/position/digital-media)
- CPS recommends the 4 M's: manage screen use, encourage meaningful screen use, model healthy screen use, and monitor for signs of problematic screen use.

Scoring Information: No scoring information provided. Generally, higher values indicate a higher awareness of child media activities.

References:

1) Rideout, V, Robb MB. The Common Sense census: Media use by tweens and teens. San Francisco, CA: Common Sense Media. 2019.
2) Canadian 24-Hour Movement Guidelines. The Gold Standard in Exercise Science and Personal Training. https://csepguidelines.ca/guidelines/children-youth/. 2021.
3) All Our Families Study Team. Internal Development. Personal Communication. 2022.

YOUTH SCREEN USE RESTRICTIONS & GUIDELINES
Concept: Screen use, time, rules, restriction
Description: These questions are intended to gauge child screen, availability and screen use, as well as screen time restrictions. Some of these items were used at Q8 and additional items are modified to match Common Sense Media's most recent youth survey 2019. Modifications were made to add examples to the listed items for clarity.
Scoring Information: A 4-point Likert scale with answers ranging from 1 (never or strongly disagree) to 4 (almost always or strongly agree) was used. For question 4, higher values indicate greater restrictions on technology use.
References

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.
2) Common Sense Media, 2019 Youth Survey.

YOUTH RELATIONSHIPS
Concept: Youth relationships with siblings and parents
Description: These self-designed questions were designed to gauge the youth's relationships with their siblings, participant mother, and other parent. (1) and (3) are repeat questions from Q8.
Scoring Information: No scoring information is given for these questions. This is not a scale. Each question involves a ranking from 1 (very poor/ very unsatisfied) to 7 (very good/very satisfied) or N/A (0).
References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022.

MATERNAL COMMENTS
Concept: Additional comments
Description: These were self-developed questions by principal investigators and intended to capture any information not explicitly asked in the questions.
References:

1) All Our Families Study Team. Internal Development. Personal Communication. 2022

ALL OUR FAMILIES
STUDY