**TITLE PAGE**

**Title:**

Children Sleep Habits Questionnaire (CSHQ) in two subpopulations from Cape Verde and Mozambique: exploratory and regression analysis

*Children Sleep Habits Questionnaire (CSHQ)* em duas sub-populações de Cabo Verde e Moçambique: análise exploratória e de regressão

**Authors:**

Inês Marques Carneiro1

1Departament of Pediatrics, Hospital Santa Maria (CHLN), Lisbon Academic Medical Centre, Portugal. Av. Professor Egas Moniz 1649-035, Lisbon, Portugal

Pedro Fonseca2

2Lisbon School of Economics and Management (ISEG), Center for Applied Mathematics and Economics (CEMAPRE), Lisbon, Portugal. Rua do Quelhas 6, 1200-781 Lisbon, Portugal

Rosário Ferreira3,4

3Respiratory Unit, Lung Function, Sleep and Ventilation Centre, Department of Pediatrics Hospital de Santa Maria (CHLN), Lisbon Academic Medical Centre,

4Faculty of Medicine, Lisbon University

Av. Professor Egas Moniz, 1649-035, Lisbon, Portugal

**Corresponding author**

Inês Marques Carneiro1

1Departament of Pediatrics, Hospital Santa Maria (CHLN), Lisbon Academic Medical Centre, Portugal. Av. Professor Egas Moniz 1649-035, Lisbon.

[inesmcarneiro@gmail.com](mailto:inesmcarneiro@gmail.com)

**Brief Title**

Children’s sleep habits, Mozambique and Cape Verde

**TITLE**

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**ABSTRACT**

**INTRODUCTION**

Children sleep habits are profoundly affected by socio-economic, cultural, and environmental factors. We aim to describe the sleep habits of pediatric sub-populations from Cape Verde and Mozambique using the Children Sleep Habits Questionnaire (CSHQ), and to ascertain the determinants of the CSHQ score.

**MATERIAL AND METHODS**

We conducted cross-sectional surveys in surveillance appointments in Cape Verde (CV), and in a school in Maputo (Mozambique-MZ). The CV sample includes 206 children (mean age=6.5) and the MZ sample 454 children (mean age=8). The Portuguese version of CSHQ was used to evaluate the children’s sleep habits. The distribution of the results across different values of demographic variables was evaluated using Mann-Whitney’s or Kruskal-Wallis’ tests. We used regression models to quantify the relation between the demographic variables and the CSHQ scores.

**RESULTS**

*CV sample*: Median CSHQ score: 50 (range 36-81). Prevalence of sleep problems: 29.9% (CSHQ *cut-off*=56). Prevalence of parent-reported sleep problems: 22.8%. Co-sleeping: 63%. Television before falling asleep: 30%. Daytime nap: 63%. Average CSHQ scores are associated to the Mother’s educational level.

*MZ Sample*: Median CSHQ score: 48 (range 35-77). Prevalence of sleep problems: 28.4% (CSHQ *cut-off*=52). Percentage of parent-reported sleep problems: 6.9%. Co-sleeping: 29%. Television before falling asleep: 33%. Daytime nap: 23%. %. Average CSHQ scores are associated to the Mother’s nationality.

**DISCUSSION AND CONCLUSION**

Parent-reported sleep problems underestimate the CSHQ results. This is not necessarily indicative of more disturbed sleep and might reflect differences in sleep behavior, childcare practice, and cognitions and attitudes towards the concept of “normal” sleep.

**Keywords:** sleep habits, child, culture,questionnaire

**INTRODUÇÃO**

Os hábitos de sono são influenciados por diversos factores. Pretendemos descrever os hábitos de sono de duas populações de países africanos aplicando o *Children Sleep Habits Questionnaire (*CSHQ) e avaliar variáveis determinantes do respectivo *score*.

**MATERIAL E MÉTODOS**

Realizámos 2 estudos transversais em consultas de saúde infantil em Cabo Verde (CV) e numa escola em Maputo, Moçambique (MZ). A amostra de CV incluiu 206 crianças (idade média 6,5 anos) e a amostra de MZ 445 crianças (idade média 8 anos). Aplicámos a versão portuguesa do CSHQ. A distribuição do *score* do CSHQ entre diferentes variáveis demográficas foi avaliada com os testes de Mann-Whitney ou Kruskal-Wallis. Utilizámos regressões lineares para quantificar a relação entre variáveis demográficas e o *score* do CSHQ.

**RESULTADOS**

*CV*: Mediana do *score* CSHQ: 50 (36-81). Problemas de sono identificado pelo CSHQ: 29.9% (*cut-off*: 56). Problemas de sono reportados pelos pais: 22.8%. *Co-sleeping*: 63%. Televisão antes de adormecer: 30%. Sesta: 63%.

*MZ:* Mediana do *score* CSHQ: 48 (35-77). Problemas de sono identificado pelo CSHQ: 28.4% (*cut-off*: 52). Problemas de sono reportados pelos pais: 6.9%. *Co-sleeping*: 29%. Televisão antes de adormecer: 33%. Sesta: 23%.

Encontraram-se diferenças no *score* de acordo com o nível de educação da mãe (CV); e com a nacionalidade da mãe (MZ).

**DISCUSSÃO E CONCLUSÃO**

Os problemas de sono reportados pelos pais subestimam os resultados do CSHQ, o que pode traduzir diferentes expectativas e atitudes face ao sono e não necessariamente sono patológico. Estudos futuros devem estabelecer valores de *cut-off* do CSHQ adaptados a cada cultura.

Palavras chave: hábitos de sono, criança, cultura, questionário

**MANUSCRIPT**

1. **INTRODUCTION**

Sleep habits are known to be profoundly affected by population-specific cultural aspects, with great variation across different populations.1–7 Cultural values and social demands influence people’s sleep habits through several different channels including cultural norms, climatic factors, family size, and space availability.5 Chinese children, for example, typically sleep less than children from other countries because they systematically fall asleep later and wake up earlier due to an increased cultural pressure for academic success.2 Italian pre-school-aged children have been found to sleep less than children from the USA because they often participate in evening social activities with their parents.8 Daytime napping is another example of the impact that cultural and environmental aspects have on sleep habits, as this biphasic sleep pattern continues to be a predominant sleep practice in countries from South America, Africa and Asia.5,7,9 Co-sleeping is still the norm across different cultures, and bed-sharing is frequent in almost every culture in the world with the exceptions of Europe and North America. This is not necessarily due to overcrowding. Instead, it is motivated by principles like autonomy and individualism which are advocated instead of interdependence and solidarity. 4–7,8 The media are also known to have a considerable influence on sleep habits, which is a growing problem and has been associated to a variety of sleep disturbances across different ages, including insomnia and bedtime refusal.3,9 The children’s sleep habits questionnaire (CSHQ) is a 33 items questionnaire which was designed to assess children’s sleep habits according to their parents perception, and has been used in several studies to examine the sleep behavior of young children.2,3,11 The CSHQ has been adapted and validated for the Portuguese language.12,13As far as we know, no previously collected datasets regarding the sleep habits of pediatric populations from African countries were available *prior* to this study. Cape Verde and Mozambique are Portuguese-speaking African countries which are historically related to Portugal. Since Portuguese is the official language in both these countries, we used the Portuguese version of CSHQ to collect data regarding the sleep patterns and sleep disturbances of African children living in the aforementioned African countries.

1. **METHODS**

**2.1 Data collection**

***Cape Verde (CV) Sample***

Data collection took place in the São Vicente island between September and November of 2016, in surveillance appointments in the public health system. The included children were between 2 and 15 years old at the time of the inquiry and were waiting for a medical appointment. Only healthy children with acute illness were considered, and children with chronic diseases were excluded. The Portuguese version of the CSHQ13 was verbally answered by the children’s caregivers, with reference to the week before the children getting sick. All the caregivers were native Portuguese speakers. This study was authorized by the *Delegacia de Saúde of Mindelo* and by the Pediatric Department of the *Baptista de Sousa* Hospital. Individual consent of the respondents was obtained prior to the interviews.

***Mozambique (MZ) Sample***

Data collection took place in November of 2017 in a Portuguese private school in Maputo, the capital city of Mozambique. The Portuguese version of CSHQ13 was delivered to the parents of 600 children with ages ranging from 4 to 13 years old. Again, all the respondents were native Portuguese speakers. The study was authorized by the School’s Board and individual consent of the respondents was obtained prior to the interviews.

**2.2 Measure**

We used the Portuguese version of CSHQ.13 Respondents were asked to recall their children’s sleep behavior with reference to the week before the survey or, in case that week was in any way atypical, any other recent “typical” week. Each CSHQ item refers to a sleep habit and is rated according to a 3-point scale: ‘‘usually’’ for 5 to 7 times/week (3 points), ‘‘sometimes’’ for 2 to 4 times/week (2 points) and ‘‘rarely’’ for 0 to 1 time/week (1 point). CSHQ items are conceptually grouped into eight subscales representing the following sleep domains: 1) Bedtime Resistance, 2) Sleep Onset Delay, 3) Sleep Duration, 4) Sleep Anxiety, 5) Sleepwalking, 6) Parasomnia, 7) Sleep Disordered Breathing and 8) Daytime Sleepiness. We computed the CSHQ total scores and the CSHQ subscale scores for every child, with the full-scale score including every item from the eight subscales, although consisting of only 33 items because there are two items (4 and 6) that belong to two subscales. In order to consistently have higher scores associated with more disturbed sleep, the scores respecting to items 1, 2, 3, 10, 11, and 26 were reversed. In addition to the CSHQ standard questions we have also collected information regarding demographical characteristics of the children, including the nationality of the family, parents’ age and educational level, number of cohabitants and children cohabitants, and possession of own beds and bedrooms. The CSHQ also collects information respecting to additional items which are not supposed to be accounted for in the CSHQ score but will be used in exploratory and regression analysis, including the frequency of daytime napping and the frequency of bedtime television.

* 1. **Study Design and Statistical Analysis**

We computed the median and the range of the CSHQ total score, as well as the median and the range of every CSHQ subscale score and item score. We decided to use median and range instead of mean and standard deviation due to the asymmetry in the distribution of CSHQ scores (skewness coefficients: 0.76 for the CV sample and 0.72 for the MZ sample). Using Mann-Whitney’s U-Test, we assessed the existence of differences in item scores, subscale scores, and total scores across subgroups of children differing by gender and by prevalence of parent-reported sleep problems. Kruskal-Wallis’ Rank Sum Test was used to assess the existence of differences in CSHQ scores amongst subgroups of children differing by age group, father’s and mother’s years of education, number of cohabitants and children cohabitants, and mother’s nationality. We used Cronbach’s alpha (MZα=0.78; CVα=0.77) and standardized Cronbach’s alpha (MZαS=0.81; CVαS=0.78) to assess the internal consistency of the questionnaires. Both the aforementioned measures of internal consistency are above recommended threshold of 0.70, which supports the adequacy of the questionnaires. Internal consistency within CSHQ subscales ranged from α=0.41 to α=0.75 and from αS=0.48 to αS=0.73 in the MZ sample and from α=0.37 to α=0.80 (and αS=0.35 to αS=0.82) in the CV sample. Reliability analysis shows that there is no item that, if dropped, would result in an increase of either α or αS. There is a positive and statistically significant correlation between each of the CSHQ subscale scores and the CSHQ total score (every correlation that we present is a Spearman correlation). The correlation between each item’s score and the CSHQ total score is also positive. Sensibility and specificity were examined with a receiver operation characteristic (ROC) curve using the children with parent-reported sleep problems as clinical sample. We sought the *cut-off* values that maximized the squared sum of sensibility and specificity, hence weighing both measures of performance equally. This resulted in an optimal *cut-off* value of 52 for MZ sample and 56 for CV sample, which gives a sensitivity of 0.89 and a specificity of 0.71 for the MZ sample and a sensitivity of 0.62 and a specificity of 0.76 for the CV sample. Heterogeneity between the two samples with respect to the demographic variables was assessed through chi-squared tests of homogeneity (Table 1) which lead us to conclude that the two populations are not homogeneous. Two independent analysis will therefore be conducted.

***Table 1***

To quantify the impact that the demographic variables, as well as bedtime TV and daytime napping, have on the CSHQ scores we used log-linear regression models with the CSHQ scores as dependent variable. The regression that was fitted to the CV sample (Table 2) resulted in a R-squared of 0.15, which is evidence of a reasonably good fit. The Breusch-Pagan test finds no evidence of heteroscedasticity (p-value = 0.693) but the Durbin Watson test signals possible residual correlation (p-value = 0.004), and hence the standard errors of the regression that we used to calculate p-values were obtained with Newey-West’s robust covariance matrix. In this model, mother’s nationality was not included as a regressor because all mothers in the CV sample are Cape Verdean. With the regression that was fitted to the MZ sample (Table 3), we obtained an R-squared of 0.15, which again signals a reasonably good fit. The Breusch-Pagan test and the Durbin-Watson test found no evidence of heteroscedasticity or residual correlation, respectively. Note that in the MZ sample we did not include daytime napping as a regressor since the subgroup of children who “usually” took a daytime nap consisted of 25 children only.

***Table 2***

***Table 3***

1. **RESULTS**

***3.1 Sample***

***CV sample***

We gathered information from a total of 206 questionnaires. Approximately 90.3% of the questionnaires were answered by the children’s mothers, 1.9 % by fathers, 6.3% by grandmothers, and 1.5% by other relatives. Children’s ages ranged from 2 to 15 years old, with a median age of 6, and most children came from families with low educational levels (Table 1). Using the CSHQ scores, together with the optimal *cut-off* value of 56, we estimated a 29.9% prevalence of sleep disorders in this sample, which is above the prevalence of parent-reported sleep problems (22.8%).

***MZ sample***

We gathered information from a total of 445 questionnaires (74% of the delivered questionnaires). There were 105 missing values, and only complete cases with respect to the variables of interest were considered. Children’s ages ranged from 3 to 13 years, with a median age of 8. Using the CSHQ scores, together with the optimal *cut-off* value of 52, we estimated a 28.4% prevalence of sleep disorders in this sample, which is above the prevalence of parent-reported sleep problems (6.9%). Children in this sample originated mostly from families with high levels of education (Table 1). Note that 93% of the children in this sample had their own beds, and 53% had their own bedrooms.

***3.2 CSHQ scores***

Table 4 summarizes the distribution of CSHQ scores in both samples by subgroups of sex, age, parents’ educational level, and number of cohabitants and number of children cohabitants. CSHQ scores ranged from 36 to 81 in the CV sample, with a median score of 50, and ranged from 35 to 77 in the MZ sample, with a median of 48. For each sample, either Mann-Whitney’s test or Kruskal-Wallis’ test was used to assess the existence of differences in CSHQ scores within different levels of each demographic variable. CSHQ scores only seem to differ within different levels of mother’s educational level (in the CV sample) and mother´s nationality (MZ sample).

**Table 4**

* 1. ***Item analysis: Individual Sleep Problems and Other Sleep Habits***

***CV Sample***

Using the items nomenclature, the most prevalent individual sleep problems in the CV sample are: “restless sleep” (67%), “falling asleep in another’s bed” (63%), “awakening one time during night” (63%), “awakened by others in the morning” (46%), “talking during sleep” (45%), and “being afraid of sleeping in the dark” (43%). The less prevalent individual sleep problems are: “awaken screaming, sweating” (6%), “alarmed by scary dream” (10%), “holding breath or stop breathing” (13%), “sleepwalking” (14%), “snorting and gasping” (16%), “struggling at bedtime” (17%), and “moving to other’s bed at night” (19%). It was found that about 30% of all children in this sample “usually” or “sometimes” watch television in order to fall asleep. We found a positive sample correlation between the CSHQ total score and the score of the item “watching television to fall asleep” (correlation=0.18, p=0.01). In what respects to other sleep habits, about 12% of the children in this sample “usually” or “sometimes” need a special object to fall asleep, and about 6% “usually” or “sometimes” need slumbering in order to fall asleep.

***MZ Sample***

The most prevalent individual sleep problems in the MZ sample are: “awakened by others in the morning” (85%), “does not wake by himself” (75%), “does not fall asleep in 20 min” (60%), “hard time getting out of bed” (49%), “restless sleep” (41%), and “being afraid of sleeping in the dark” (41%). The less prevalent individual sleep problems are: “wets the bed at night” (7%, only for children ≥4 years old), “stops breathing” (5%), “awakens screaming, sweating” (4%), “sleepwalks” (4%), and “awakes more than once” (5%). About 33% of the children in this sample “usually” or “sometimes” watch television in order to fall asleep. We found a positive sample correlation between the CSHQ total score and the score of the item “watch television to fall asleep” (correlation=0.36, p<0.001). In what respects to other sleep habits, about 16% of the children in the MZ sample “usually” or “sometimes” need a special object to fall asleep, about 5% “usually” or “sometimes” need slumbering in order to fall asleep, and 29% “usually” or “sometimes” fall asleep in another’s bed.

***3.4. Regression Analysis***

***CV Sample***

The output of the log-linear model that was fitted to the CV sample can be found in table 2. In this sample, three variables have a statistically significant effect on the CSHQ score: age, mother’s educational level, and daytime napping. Cape Verdean children older than 8 years old are estimated to have CSHQ scores approximately 9% lower, on average, than Cape Verdean children younger than 8 years old. The CSHQ score is also estimated to be approximately 7% lower, on average, on children whose mothers have more than 9 years of education. Another interesting finding is that children who “usually” take a daytime nap are estimated to have CSHQ scores approximately 7% lower, on average, when compared to children who “rarely” take a daytime nap. There is no evidence of changes in the CSHQ score for children who “sometimes” take a daytime nap.

***MZ Sample***

The output of the log-linear model that was fitted to the MZ sample can be found in table 3. In this model, the demographic variables with a statistically significant impact on the CSHQ scores are the father’s educational level and the mother’s nationality. According to this model, children whose fathers have more than 11 years of education are estimated to have CSHQ scores approximately 4% lower, on average, than children whose fathers have 11 or less years of education. Furthermore, the CSHQ scores of the children of Portuguese mothers are estimated to be approximately 3% lower, on average, than the scores of the children of Mozambican mothers. Regarding bedtime television, this model finds evidence that children who “sometimes” fall asleep while watching TV have CSHQ scores approximately 12% higher, on average than children who “rarely” fall asleep while watching TV. On the other hand, children who “usually” fall asleep while watching TV are estimated to have CSHQ scores approximately 7% higher, on average, than children who “rarely” fall asleep while watching TV.

***3.5. Sleep/Wake Patterns***

Some descriptive statistics respecting to wake up time, bedtime, and average sleep duration (including naptime, weekdays and weekends) are presented in table 5.

**Table 5**

***CV Sample***

The average sleep duration in the CV sample is 12.5 hours (including naps, weekdays and weekends), with a standard deviation of 2.01. In this sample about 64% of children take a nap (“usually” or “sometimes”), 78% of whom are under 4 years old, 80% between 4 and 7 years old, 46% between 7 and 10 years old, and 29% older than 10 years old.

***MZ sample***

The average sleep duration in the MZ sample is 9.45 hours (including nap, weekdays and weekends), with a standard deviation of 0.94. In the MZ sample only about 23% of the children take a nap (“usually” or “sometimes”): 62% of whom are under 4 years old, 22% between 4 and 7 years old, 16% between 7 and 10 years old, and 27% older than 10 years old.

1. **DISCUSSION**

The two sub-populations that have been analyzed in this study exhibited a high prevalence of sleep disturbances. We have obtained *cut-off* values that are higher than the ones that could previously be found in the relevant CSHQ-related literature, which suggests that individual sleep problems are more prevalent in the sub-populations that we have analyzed than in the sub-populations that were used in previous studies. The *cut-off* values used by Owens,11 Arriaga,14 and Silva12 would not be appropriate for our samples as they would result in 95%, 87%, and 62% of the children testing positive for sleep disturbances in the CV sample, respectively, and in 96%, 88%, and 63% of the children testing positive for sleep disturbances in the MZ sample, respectively. Parent’s perception of disturbed sleep has been found to be lower than the percentage of sleep disturbances identified by the CSHQ. This, together with the high *cut-off* values that we have obtained, is not necessarily indicative of more disturbed sleep but instead can reflect the existence of different cultural expectations that result in different perceptions of whether or not certain sleep practices are considered to be normal.5,6 Since sleep deprivation is deleterious to cognition and to emotional and social behavior, also having negative metabolic effects, it is important to stipulate what it is considered to be a good sleep practice in each population.1,15

In the CV sample, the average CSHQ score is estimated to be lower for children whose mothers have more than 9 years of education, children older than 8 years old, and children who “usually” take a daytime nap. In the MZ sample, the average CSHQ score is estimated to be lower for children whose fathers have more than 11 years of education, children with Portuguese mothers, and children who “rarely” watch television to fall asleep.

In what respects to sleeping routines, neither the utilization of “transitional objects” (with the exception baby pacifiers) nor the habit of “slumbering to fall asleep” have been found to be common practices in any of sub-populations that we have analyzed. Bed time rituals are known to be more prevalent in western countries than in more traditional cultures.4–6 As the children’s age increases, bedtime has been found to be increasingly delayed and sleep duration has been found to decrease in both sub-populations. Watching television is a frequent behavior in both samples. This habit is associated with more disturbed sleep across subgroups of children of different nationalities, which is why international recommendations advise against the practice of watching television before going to sleep.16 Taking a daytime nap has been found to be very common in the CV sample, even for the older children. Daytime sleep practices vary widely across different cultures and races, with daytime napping being very popular, for example, in places with high daytime temperatures.4 Co-sleeping has been found to be frequent in the CV sample. The high prevalence of breastfeeding is one factor that can contribute to a greater proximity between the mother and the younger children, hence influencing routine sleep habits since birth.4,5,7 Bed-sharing raises the parents’ awareness regarding their children’s sleep habits and can explain the higher prevalence of parent-reported individual sleep problems.17 The CV sample has a higher prevalence of individual problems when compared to the results of similar surveys conducted in the USA and China2, with every individual sleep problem being present in more than 10% of the observations with exception of the item “awaken screaming, sweating”. The MZ sample exhibited a higher prevalence of individual sleep problems when compared to the USA and China, but showed a lower prevalence when compared to CV.2 Co-sleeping has been found to be associated with increased nocturnal enuresis in children aged from 9 to 12 years old.18 Nocturnal enuresis is known to be more prevalent in the black race.19 Wetting the bed has been found to be common in the CV sample, and even more prevalent when compared to other studies.2,14

The main limitation of this study is the possible presence of sample selectivity bias, aggravated by self-selection in the MZ sample, which means that this study’s conclusions do not necessarily generalize to the entire population of the analyzed countries. This is, however, one of the few studies that uses the CSHQ in a low-income context and it has allowed us to evaluate children’s sleep habits across subgroups with the same scholar routines and environmental and solar exposition but with different cultural backgrounds.

**Conclusion**

As far as we know, this is the first study to address the topic of sleep habits and sleep disturbances using data from subpopulations of African children living in African countries. We found higher than usual CSHQ scores, which is not necessarily indicative of more disturbed sleep but instead might reflect differences in sleep behavior, childcare practice, and different cognitions and attitudes towards normal sleep behavior. CSHQ scores have been found to be associated with the children’s age, mother’s educational level, and daytime napping in the CV sample and with the mother’s nationality, father’s educational level, and frequency of bedtime television in the MZ sample. Sleep habits like bedtime, bedtime rituals, co-sleeping, and daytime napping are influenced by cultural, socio-economic, and environmental factors and hence the background of the family should be taken into consideration when evaluating children’s sleep habits. Future research should seek optimal CSHQ *cut-off* values for different cultures and assess the existence of differences in sleep habits across different populations by measuring the impact that particular sleep practices have on cognition, behavior, emotions, and metabolic factors in order to adapt sleep recommendations to individual populations.

1. **ACKNOWLEDGMENTS**

We would like to thank the Board of the private school in Maputo, the *Delegacia de Saúde* of Mindelo and Department of Pediatrics of *Hospital Baptista de Sousa* in Cape Verde, for granting us permission to conduct the questionnaire, and to the caregivers of children that agreed to participate in the study.

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Table 1. Sample demographics and chi-squared homogeneity test comparing the distributions of gender, age category, father and mother education, number of cohabitants and children cohabitants, and mother nationality across samples.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Cape Verde N=206** | **Mozambique N=445** | ***p*-*value*** |
| **Sex, n (%)** | **n=206** | **n=438** |  |
| **Female**  **Male** | 111 (53) | 225 (51) | 0.609 |
| 95 (46) | 213 (49) |
| **Age Group (Years), n (%)** | **n=206** | **n=441** |  |
| **2-7**  **8-10**  **11-15** | 125 (61) | 208 (47) | <0.001 |
| 50 (24) | 179 (40) |
| 31 (15) | 57 (13) |
| **Father Education, n (%)** | **n =136** | **n=407** |  |
| **<10 years** | 93 (68) | 33 (8) | <0.001 |
| **≥10 years** | 43 (32) | 374 (92) |
| **Mother Education, n (%)** | **n=165** | **n=413** |  |
| **<10 years** | 122 (74) | 23 (6) | <0.001 |
| **≥10 years** | 43 (26) | 390 (94) |
| **No. of Cohabitants, n (%)** | **n=167** | **n=433** |  |
| **<5** | 62 (37) | 305 (70) | <0.001 |
| **≥5** | 105 (63) | 128 (30) |
| **No. of Cohabitant Children, n (%)** | **n=167** | **n=439** |  |
| **<3** | 97 (58) | 344 (80) | <0.001 |
| **≥3** | 70 (42) | 88 (20) |
| **Mother Nationality, n (%)** | Cape Verdean 206 (100) | Mozambican 275 (64)  Portuguese 129 (30)  Other 35 (6) | - |

Table 2. Log-linear regression model- CV sample

|  |  |  |  |
| --- | --- | --- | --- |
|  | | **Coefficient Estimate** | **P-value** |
| **Intercept** | | 4.019 | **<0.001** |
| **Age (years)** | **8-10** | -0.090 | **0.010** |
| **11-15** | -0.095 | **0.043** |
| **Sex** | **Male** | 0.015 | 0.559 |
| **No. of Cohabitants** | **≥5** | 0.057 | 0.196 |
| **No. of Cohabitant Children** | **≥3** | -0.057 | 0.192 |
| **Father Education (years)** | **≥10** | -0.035 | 0.315 |
| **Mother Education (years)** | **≥10** | -0.075 | **0.016** |
| **Falls asleep while watching TV** | **Sometimes** | 0.007 | 0.798 |
| **Usually** | 0.021 | 0.514 |
| **Takes a Nap** | **Sometimes** | -0.056 | 0.131 |
| **Usually** | -0.068 | 0.094 |
|  | | | |
| **Multiple R-squared** | | 0.146 | - |
| **Residual standard error** | | 0.152 | - |
| **F-statistic** | | 1.831 | 0.056 |
| **Breusch-Pagan statistic** | | 8.228 | 0.693 |
| **Durbin-Watson statistic** | | 1.571 | 0.004 |

Table 3. Log-linear regression model - MZ sample

|  |  |  |  |
| --- | --- | --- | --- |
|  | | **Coefficient Estimate** | **P-value** |
| **Intercept** | | 3.895 | **<0.001** |
| **Age (years)** | **8-10** | -0.009 | 0.596 |
| **11-15** | -0.036 | 0.158 |
| **Sex** | **Male** | -0.011 | 0.478 |
| **No. of Cohabitants** | **≥5** | -0.020 | 0.482 |
| **No. of Cohabitant Children** | **≥3** | 0.018 | 0.572 |
| **Father Education (years)** | **≥12** | -0.040 | **0.044** |
| **Mother Education (years)** | **≥12** | 0.018 | 0.410 |
| **Mother Nationality** | **Portuguese** | -0.039 | **0.022** |
| **Other** | 0.055 | 0.066 |
| **Falls asleep while watching tv** | **Sometimes** | 0.111 | **<0.001** |
| **Usually** | 0.077 | **<0.001** |
|  | | | |
| **Multiple R-squared** | | 0.149 | - |
| **Residual standard error** | | 0.133 | - |
| **F-statistic** | | 4.531 | **<0.001** |
| **Breusch-Pagan statistic** | | 14.379 | 0.213 |
| **Durbin-Watson statistic** | | 2.040 | 0.610 |

Table 4. CSHQ scores by sex, age, parent education, number of cohabitants and mother’s nationality

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Cape Verde** | | | **Mozambique** | | |
|  | **n (%)** | **CSHQ**  **(Median, range)** | ***p-value*** | **n (%)** | **CSHQ**  **(Median, range)** | ***p-value*** |
| **Sex** |  |  |  |  |  |  |
| Female | 111 (54) | 50 (36-81) | 0.80 | 225 (51) | 48 (38-77) | 0.25 |
| Male | 95 (46) | 51 (36-77) | 213 (49) | 47 (35-69) |
| **Age Group (Years)** |  |  |  |  |  |  |
| ≤ 7 | 125 (61) | 51 (38-77) | 0.34 | 208 (47) | 50 (35-77) | 0.08 |
| 8-10 | 50 (24) | 50 (36-81) | 179 (40) | 47 (37-69) |
| 11-15 | 31 (15) | 50 (37-68) | 57 (13) | 45 (38-68) |
| **Parent Education (years)** |  |  |  |  |  |  |
| **Father**  <12 in MZ | <10 in CV  ≥12 in MZ |≥10 in CV | 93(68)  43(32) | 50 (36-77)  49 (36-77) | 0.36 | 126(31)  281(69) | 48 (38-72)  47 (35-69) | 0.1 |
| **Mother**  <12 in MZ | <10 in CV  ≥12 in MZ | ≥10 in CV | 122 (74)  43 (26) | 50.5 (37-81)  49 (36-68) | 0.03 | 115(28)  298(72) | 47(39-72)  48 (35-69) | 0.89 |
| **No. of Cohabitants** |  |  |  |  |  |  |
| <5 | 62 (37) | 49 (36-72) | 0.07 | 305 (70) | 48 (38-72) | 0.95 |
| ≥5 | 105 (63) | 50.5 (37-81) | 128 (30) | 48 (35-77) |
| **No. of Cohabitant Children** |  |  |  |  |  |  |
| <3 | 97 (58) | 50 (36-75) | 0.55 | 344 (80) | 48 (38-69) | 0.82 |
| ≥3 | 70 (42) | 50 (37-81) | 88 (20) | 48.5 (35-77) |
| **Mother Nationality** | CV 206 (100) | 50 (36-81) | - | MZ 275 (63)  PT 129 (29)  O 35 (8) | 48 (35-77)  46 (37-69)  53 (38-62) | 0.003 |

MZ- Mozambique, PT- Portugal, O- Other, CV – Cape Verde

Table 5. Sleep patterns by age

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CV** | | | | **MZ** | | | |
|  |  | **Wake Up Time**  **Week Days** | **Go to Bed Time**  **Week Days** | **Total Sleep Duration** |  | **Wake Up Time**  **Week Days** | **Go to Bed Time**  **Week Days** | **Total Sleep Duration** |
| **Age Group (years)** | **n** | **Average**  **(SD)** | **Average**  **(SD)** | **Average Hours (SD)** | **n** | **Average**  **(SD)** | **Average**  **(SD)** | **Average Hours (SD)** |
| **≤ 3** | 55 | 07:28  (1.11) | 20:38  (00:56) | 12.85 (1.84) | 6 | 06:29  (00:32) | 20:10  (00:40) | 11.35 (1.53) |
| **4-7** | 70 | 06:59  (00:48) | 20:20  (00:59) | 12.81 (1.91) | 169 | 06:03  (00:28) | 20:18  (01:07) | 9.7 (0.89) |
| **8-10** | 47 | 07:21  (00:54) | 20:41  (00:51) | 12.04 (2.26) | 153 | 05:47  (00:23) | 20:23  (01:14) | 9.19 (0.76) |
| **>10** | 31 | 07:19  (01:14) | 20:56  (00:56) | 11.7 (1.87) | 47 | 05:43  (00:27) | 20:46  (01:50) | 9.13 (1.04) |
| **Overall** | 203 | 07:15  (1:02) | 20:35  (0:57) | 12.47 (2.01) | 375 | 05:54  (00:28) | 20:23  (01:07) | 9.45 (0.94) |