LONGITUDINAL COHORT STUDY ON THE FILIPINO CHILD

WAVE 2 SURVEY
FINAL REPORT

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Disclaimer

All discussions and interpretations of study findings presented in this report are not necessarily that of UNFPA and the agencies which funded the survey.

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Findings from the Wave 1 Survey informed us about the status of the Filipino 10-year old children, how they fared in school, what risks they face, what aspects in themselves, their households and communities either ensured or threatened their safe passage through adolescence.

A little more than a year later, data from the second follow-up wave reveal so much more about the status and life circumstances of this cohort. We continue to examine their vulnerability in terms of school performance, health and nutritional status indicators, exposure to violence and risky behaviors. In comparing the proportions considered vulnerable in these domains, we observe a predominant downward trend between Waves 1 and 2. While this is certainly encouraging, it is important to note that these problems continue to affect these children at ages 11-12, albeit on average, on a lesser degree than when they were age 10. One distinct advantage of having data from two time points is the capacity to better characterize the children's risk status by identifying who among them are: persistently at risk, persistently safe from risk, newly at risk, and have recovered from risk. Classifying the children this way is essential in program targeting and knowing the factors that are associated with these categories have important policy implications.

In Chapter 6 we present some emerging issues that are worthy of further analysis and exploration to more fully understand the plight of these children. Among these are concerns on a) food security and adolescent nutrition, particularly in light of their increasing nutrient requirements as they undergo pubertal transition; b) child labor and child work, given a significant increase in the number of children currently doing paid/unpaid work by Wave 2, particularly among the boys; and c) the increasing internet utilization among the children, which could be taken advantage of to further expand the children's access to sources of information, which in the same vein warrants concern particularly given the sharp rise in online chatting which could possibly be a precursor to more risky behaviors.

New segments administered in Wave 2 add another layer of important contextual information to enhance our knowledge of this cohort. The Sexual Maturity Rating scales provide a more objective assessment of where they are in terms of pubertal stage. The Raven's Standard Progressive Matrices measured their cognitive ability and their Child Behavior Checklist scores rank them in terms of competency and psychosocial well-being. With these new data, additional dimensions to the risks involved as the cohort transitions from prepubertal to pubertal status are highlighted. The persistent gender disparity (with boys disproportionately disadvantaged compared to girls) is also examined further in the context of pubertal transition and psychosocial status.

As we continue to more closely examine and analyze the life circumstances and behaviors of this cohort, we hope to reveal crucial gaps in research, policy and program implementation, as well as identify initiatives that are improving their well-being.

CHAPTER 1
INTRODUCTION

Study objectives

The Longitudinal Cohort Study on the Filipino Child (Cohort Study)[1] was launched upon the initiative of the United Nations Population Fund (UNFPA) in coordination with the National Steering Committee (NSC) composed of government agencies led by the National Economic and Development Authority (NEDA; See Appendix 1 for a list of member agencies). The primary goal of the study is to examine how the lives of Filipinos are changed as our country implements policies and programs aimed to fulfill the Sustainable Development Goals (SDG) (United Nations, 2017). Specifically, the study aims to:

1. Contribute to the body of evidence on population dynamics and sexual reproductive health and rights, with a special focus on the SDG agenda.

2. Provide an evidence-based resource that will inform national policy making and development planning particularly on how the SDG agenda can contribute to maximizing the potentials of the Filipino youth.

The strategy is to prospectively observe a cohort of Filipinos, from ages 10 through 24, in the course of the SDG agenda implementation (from the 2016 Cohort Study Baseline Survey to the Endline Survey in 2030). The study is designed to conduct annual follow up surveys to collect data capturing significant milestones from childhood to young adulthood (i.e., puberty, school completion, entry into labor force, sexual activity initiation and marriage). Data collected at each survey round contribute to a comprehensive database of information on 13 of the 17 development goals[2]. This evidence-based resource will inform national policy making and program planning, particularly on how the development goals are contributing to maximizing the potentials of the Filipino youth. For more study details please refer to the Baseline Survey Final Report (OPS, 2018).

Study team

The Cohort Study is a research collaboration between the USC-Office of Population Studies Foundation, Inc. (OPS), the study's main implementing agency, and three of the renowned research institutions in the country: Demographic Research and Development Foundation (DRDF) of the University of the Philippines Population Institute, the Research Institute for

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[1] The study was launched in 2016 as the "Longitudinal Cohort Study on the Girl and Boy Child". In 2018, the study title was changed to "Longitudinal Cohort Study on the Filipino Child". Note that some documents featured in the Appendices may still carry the old title.
[2] excluding SDG 10 (Reduce inequalities within/among countries), 12 (Ensure sustainable consumption and production patterns), 15 (Protect...terrestrial ecosystems...) and 17 (Strengthen... global partnership...) that are obtainable more at the macro/country level rather than at the individual/household/community levels

Mindanao Culture (RIMCU) of Xavier University, and the Center for Social Research and Education (CSRE) of the University of San Carlos. Also joining the team are well-known experts in their respective fields, Dr. Alejandro N. Herrin (Policy Adviser), Dr. Erniel B. Barrios (Sampling and Statistical Consultant) and Dr. Delia E. Belleza (Psychologist Consultant).

The OPS team designed the study, handled data collection training and supervision, data processing and report writing. Data collection and field work were conducted by DRDF (Luzon), CSRE (Visayas) and RIMCU (Mindanao). See Appendix 2 for more information on the collaborating research institutions.

Overall oversight and study direction are handled by the UNFPA, in consultation with NSC. The UNFPA Team is led by Dr. Rena Dona, Mr. Jose Roi B. Avena and Dr. Joseph Michael Singh with assistance from Ma. Sylvia Nachura and Mr. Jose Nicomedes Castillo.

CHAPTER 2
WAVE 2 SURVEY SAMPLE

2.1 Baseline (Wave 1) sample

The Cohort Study sample was selected to be nationally representative of 10-year old Filipinos, from the country's three main island groups of Luzon, Visayas, and Mindanao, referred to in this report as sampling domains. The overall sampling goal was to recruit about 5,000 10-year old children at Baseline (Wave 1) and eventually retain, factoring in losses to follow-up, a sample size of about 2,000 by the 2030-31 Endline Survey (see OPS, 2018 for more details on the sampling scheme). The Baseline Survey recruited 4,952 households with 10-year old children which corresponded to a population of about two million 10-year old children from 345 barangays across the main sampling domains of Luzon, Visayas and Mindanao (Table 2.1).

Table 2.1 Wave 1 sample distribution by domain

Survey statistics	Luzon	Visayas	Mindanao	TOTAL
Sample barangays, n	115	115	115	345
Households interviewed, n	1,618	1,639	1,695	4,952
Index children (10-year old sample) interviewed[a], n	1,600	1,639	1,688	4,927
Population of 10-year old children per domain[b], n	1,134,854	414,228	561,308	2,110,179
Weighted proportion of sample across domains, %	53.8%	19.6%	26.6%	100.0%

[a]There were 25 children not interviewed [8 were with disabilities and incapable of being interviewed and 17 refused to be interviewed (but parents consented to participate in study) or were not available for interviews]
[b]Estimated based on the population of 9-year old children in 2015 Census Survey (age 10 in 2016)

2.2 Wave 2 sample

For the Wave 2 Survey, we enrolled cohort participants residing in the same municipality or city where they were interviewed at baseline (see Chapter 3 for more details on the inclusion criteria and tracking protocol). When logistically feasible, the field teams were asked to track participants who moved to adjacent municipalities/cities. There were also cases where sample households moved to another domain or area and were interviewed by a different data collection team.

Attrition

Table 2.2A presents the distribution of the Wave 2 sample and the reasons for attrition. We retained 95.6% of the baseline sample in Wave 2, and 92.2% , 98.2% and 96.3% of the Luzon, Visayas and Mindanao samples respectively. The unweighted attrition rate of 4.4% is slightly below the projected 5% attrition by Wave 2. Of the 217 index children lost to follow-up, about 53% (n=115) moved out of the Wave 1 municipality or city and were difficult to track, and about 30% (n=65) either refused to be interviewed or were unavailable or difficult to schedule which is often a form of soft refusal. Luzon experienced the highest attrition rate among the domains. We attribute this largely to the fact that Luzon had the most number of

urban barangays (see Table 4.1), and attrition rates were significantly higher among the urban versus rural samples. Similar urban/rural attrition behavior has been observed in other longitudinal studies in the country (Perez, 2015).

Table 2.2A Wave 2 sample distribution by domain

Survey statistics	Luzon	Visayas	Mindanao	TOTAL
Barangay coverage:				
Barangays in Wave 1, n	115	115	115	345
Barangays in Wave 2, n	141	142	132	415
Breakdown:				
Wave 1 barangays[a], n	114	115	115	344
New barangays in Wave 2, n	27	27	17	71
Households interviewed:				
Households in Wave 1, n	1,618	1,639	1,695	4,952
Households in Wave 2, n	1,492	1,610	1,633	4,735
Breakdown of Wave 2 households:				
Original domain sample, n	1,490	1,607	1,633	4,730
Migrant from Visayas, n	1			1
Migrants from Mindanao, n	1	3		4
Remained in Wave 1 barangay, n	1,460	1,576	1,615	4,651
Moved to another Wave 1 barangay, n	4	5	1	10
Moved to a new barangay, n	28	29	17	74
Households which moved to new barangays, n	32	34	18	84
Breakdown:				
New barangay, same municipality/city, n	17	18	11	46
New municipality, same province, n	2	6	3	11
New province, same region, n	2	7	4	13
New region, n	11	3	0	14
Breakdown of attrited sample within domain, n:	128	31	58	217
Reasons for attrition:				
IC died	1	1	2	4
Outmigrant	64	18	33	115
Unlocated	1	2	2	5
No eligible household respondent	1	0	0	1
Temporarily away	10	1	11	22
Unavailable	20	1	2	23
Refused	29	8	5	42
Invalid interview (no household interview)	2	0	3	5
Attrition rates				
Unweighted,%	7.9%	1.9%	3.4%	4.4%
Weighted[b],%	4.9%	0.4%	0.8%	6.2%

[a] There was one Wave 1 barangay in Luzon with only 2 sample households; both were not tracked in Wave 2

[b] Sampling weights calculated using population of 9-year old children in 2015 Census Survey (age 10 in 2016)

Barangay movements

Great effort was exerted by all data collection teams to track as many of the sample households who changed barangays (n=84) or moved to a different addresses within the barangay (n=3). Of the 84 households who moved to a different barangay, 74 moved to a new barangay not previously covered in the study. Of the 74 households: a) two sets of households made the same barangay movements between Waves 1 and 2 (these were likely households related to each other) and b) two households from different Wave 1 barangays moved to the same Wave 2 barangays. In all, 71 new sample barangays were added to the study. Of the 345 barangays in Wave 1, 344 were covered in Wave 2 bringing the total Wave 2 barangays to 415.

Twenty-five of the 84 households who moved to a different barangay moved for reasons related to work circumstances of family members. There were 5 households who changed barangays in order to move closer to the children's school. In Wave 2, about 90% of the index children were between grades 5 and 6. In subsequent waves when the children transition to high school, we anticipate greater migration to areas with junior and senior high school curricula available. There were 10 who changed barangays as a result of their houses being demolished. The rest of the movements were due to a range of personal reasons.

There were also corresponding region, province and municipality/city changes with these barangay movements. Table 2.2B presents a comparison of number of sample areas across the two waves.

Table 2.2B Number of sample areas in Wave 1 (W1) and Wave 2 (W2)

Sample area coverage	Luzon		Visayas		Mindanao		TOTAL	
	W1	W2	W1	W2	W1	W2	W1	W2
Regions,n	5	8	3	3	6	6	14	17
Provinces,n	15	19	14	15	25	25	54	59
Municipalites/cities,n	74	82	84	94	85	86	243	262
Barangays,n	115	141	115	142	115	132	345	415

2.3 Comparing the retained against the attrited sample

Weighted logistic regression analysis runs (results shown in Table 2.3A) indicate that Wave 1 households who were enrolled in the conditional cash transfer or Pantawid Pamilyang Pilipino Program (4Ps) program, who had mothers/caregivers who were working and were from Visayas or Mindanao were more likely to be in Wave 2. Those from urban areas were less likely to be retained in Wave 2.

Table 2.3A Odds ratios indicating associations between being in Wave 2 or not and selected index child/household/community characteristics[a]

Index child/household/community characteristics	In Wave 2 (n=4949) Odds Ratio (95% CI)
Male	0.68 (0.37,1.27)
Both parents in household	1.46 (0.83,2.54)
Mother/caregiver at least high school	0.76 (0.51,1.13)
Mother/caregiver currently working	1.97 (1.09,3.57)[**]
Household size	1.02 (0.94,1.11)
4Ps beneficiary	2.87 (1.89,4.35)[***]
With access to sanitary toilet	1.28 (0.65,2.52)
Self-classifed as Indigenous Peoples	0.77 (0.47,1.28)
Urban (1=yes; 0=no)	0.59 (0.35,0.99)[**]
Domain (living in Luzon as base group)	
Visayas	3.42 (1.88,6.23)[***]
Mindanao	2.10 (1.39,3.20)[***]

[a]Odds ratios (95% Confidence Interval) from weighted multivariable logistic regression models; Variables are dichotomous (coded as 1=yes; 0=no) except for household size (continuous variable. Significant at [**] p<0.05, [***] p<0.001

Table 2.3B shows when baseline household characteristics are controlled for, key vulnerabilities reported in Wave 1 such as being stunted, repeating grades, missing school or experiencing physical violence from peers or parents were not significantly associated with being in Wave 2 or not.

Table 2.3B Odds ratios indicating associations between being in Wave 2 or not and selected vulnerabilities[a]

Vulnerabilities	In Wave 2 Model 1[b] Odds Ratio (95% CI)	In Wave 2 Model 2[c] Odds Ratio (95% CI)
Stunted (n=4925)	1.86 (1.02,3.42)[**]	1.25 (0.77,2.05)
Repeated grade (N=4952)	0.93 (0.50,1.74)	0.67 (0.39,1.17)
Missed school (n=4877)	1.21 (0.91,1.62)	1.14 (0.86,1.52)
Experienced violence from friends (n=4823)	0.94 (0.67,1.32)	0.93 (0.67,1.30)
Experienced violence from parents[d](n=4817)	1.17 (0.65,2.09)	0.72 (0.45,1.15)

[a]Odds Ratios (95% Confidence Interval) from weighted logistic regression models; Variables are dichotomous (1=yes; 0=no)
[**] Significant at p<0.05
[b] Unadjusted
[c] Controlling for mother/caregiver currently working, 4Ps beneficiary, urban and domain (separate model for each vulnerability)
[d] Forcefully hurt by parents

2.4 Wave 2 sampling weights

Given that the Waves 1 and 2 samples were not substantially different and that about 98% of the sample (4,651 of 4,735 as shown in Table 2.2A) continued to reside in the baseline barangay, the baseline sampling weights (calculated based on the 2015 Census data) were still applied in the Wave 2 data analysis.

CHAPTER 3
WAVE 2 SURVEY PROTOCOL

3.1 Data collection period

The Baseline Survey was carried out from October 2016 to January 2017 (with 91% of the interviews conducted in 2016). This was the earliest survey period feasible, given funding availability and other logistics. Since the main objective is to assess the effects of the SDGs on the sample, it was important to start the study close to the 2015 SDG declaration to ensure that the baseline data captured the circumstances prior to the full implementation of the SDG agenda.

Given study preparation and logistical requirements, the study team decided to schedule subsequent data collection waves between February to April of each year when most of the index children are still in school and thus easier to track. Maintaining the same schedule is essential in controlling for the effects of seasonality on the data. For the Wave 2 Survey, about 98% of the data collection was carried out from February to April 2018. Efforts to track and interview the outmigrant sample or those who moved outside of the baseline sample areas continued until June 2018. The mean interval in years between Waves 1 and 2 is 1.3 (SD $\pm$ 0.04) and ranged from 1.2 to 1.6 years.

3.2 Cohort tracking protocol

<u>Cohort masterlist.</u> In view of the study's longitudinal design, a masterlist of all sample households recruited at baseline is maintained and updated after each wave throughout the study. This file contains information on each household such as the name, sex and unique identification number of the index child (IC), and for each wave: the interview status, name of the eligible household respondent (HR)[3], the HR's relationship to the IC and the household's contact information (phone numbers, addresses and residence landmarks). The masterlist is critical in successfully tracking the cohort through the years. In Wave 2, each field team leader was provided printed copies of the masterlist containing information on the cohort participants assigned to the team. All office and field personnel were instructed to ensure confidentiality of data and personal identifiers obtained in the study, and were required to sign the OPS Data Confidentiality Agreement (See Appendix 5). After the survey, the printed masterlist copies were retrieved by OPS from each of the institutions collecting the data.

<u>Wave 2 inclusion criteria and tracking protocol.</u> We tracked all the baseline ICs and enrolled those residing in the same municipality or city where they were interviewed at baseline. ICs who moved out of the baseline sample municipalities/cities (called outmigrants or OMs) were tracked and enrolled if the new barangays of residence were adjacent to or near the baseline

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[3] The primary household respondent is the index child's mother. If the mother is not a household member, the child's caregiver, who must be an adult household member, is the designated respondent.

municipalities/cities. All efforts were made to track and enroll ICs who moved to other sample municipalities/cities whether in the same domain or in another domain for as long as within the logistical capacities of the study teams assigned to these areas.

Tracking protocol. Prior to starting any data collection, the ICs and their households were contacted using information from the masterlist. Tracking is done in two tiers (see Appendix 3 for tracking protocol details):

Step 1: Phone Tracking. Calls were made to all 4,952 IC households using the cell phone numbers obtained at baseline. Once contact was made, the current address of the IC was determined and eligible HR was identified.

Step 2: Home Tracking. Whether the households were reached by phone or not, a home visit was required, to the address in the masterlist or obtained in the phone tracking.

If the household could not be tracked or scheduled for an interview, interviewers filled out an IC attrition form. Index children who had migrated to another domain, for which new contact information was obtained, were reported to OPS who arranged for transfer interviews to the other domains.

3.3 Verifying identities of index children and the household respondents

Once an IC is tracked, the identities of the IC and HR (if the same person as in previous wave) are then verified using a standard screening script which asks a few simple questions regarding their participation at baseline (information found in masterlist; see Appendix 3 for screening protocol details). This step is necessary particularly in cases where a new or different interviewer is assigned to the household for this wave. Once identities are verified, the interviewer proceeds with the consenting process. If identities cannot be ascertained, this is reported to OPS and domain leaders for further strategizing.

3.4 Survey components

a) Community survey

Prior to any data collection at each wave, the teams are required to conduct courtesy calls to the Provincial Governors or City/Municipal Mayors, who then endorse the project to the barangay captains of the respective sample barangays. In Wave 2 each team carried with them endorsement letters from the UNFPA, NEDA and the Department of Health (DOH).

The Community Survey collects barangay-level information that are relevant in contextualizing the household and individual data collected in each survey. The Community questionnaire consists of several modules and responses are obtained from multiple key informants. The Wave 2 Community Survey collected information that were likely to change since Baseline. In

cases where the IC moved to a non-baseline barangay, a full Community Survey was administered in the new sample barangay.

At each wave, the data collection teams start completing the Community Survey questionnaire as soon as the Barangay Captain consents to the survey. The goal is to complete the questionnaire within the duration of the team's stay in the barangay. If there are questionnaire components not completed by the end of the team's barangay visit, follow-up phone calls are made to the informants to fill out missing sections of the questionnaire.

b) Home Visit

At each wave, all household and IC questionnaires are administered at the homes of the ICs. Each home visit begins with a consenting process, to obtain permission from the HR to interview him/her and IC (see Appendix 4 for a copy of the consent form). The HR is always the first to be interviewed. This gives time for the ICs to observe the process and make them feel more comfortable when it was their turn. The ICs are interviewed at their convenient time (usually before or after school, during noon breaks, or on weekends). Just like at baseline, the Wave 2 IC interview began by reading an IC assent script (see Appendix 4) to obtain the child's consent to be interviewed. There are two IC questionnaires: the interviewer- and the self-administered questionnaires. The latter consists of simple but more sensitive questions that the IC responds to by checking yes or no boxes in the questionnaire. Just like in Wave 1, data collection in Wave 2 was done through pen-and-paper interview method.

The ICs' weight was measured using a portable bathroom scale. Height was measured using the SECA 206 microtoise or bodymeter. All instruments were calibrated prior to field use, before these were shipped out of OPS to the respective institutions. Prior to each home visit, each interviewer was trained to conduct simple calibration techniques to ensure that these instruments remained accurate. All interviewers were trained by experienced OPS staff who were trained in measuring weight and height among children in the CLHNS (Adair, et al, 2010).

About 85% of the home visits were completed in one day while the rest took 2-3 days. At the end of each home visit, the household was given:

1. P200 for the HR and gel pens for the IC. The value of the tokens corresponded to the peso value of work time possibly lost by the respondents in spending time for the interview.

2. A card with the IC's baseline (at age 10) height and measurements. A brief statement explained whether the IC's height was shorter, of the same height or taller than an average 10-year old child. Similarly, if the IC weighed less than, the same as or heavier than the average reference child. The Wave 2 height and weight measurements were handwritten by the interviewer on the same card.

3. Resource list. Some of the questions asked in the interviews were on domestic violence or experiences with physical or emotional aggression. We provided each HR information on the agencies and their contact numbers (when available) that handle cases of violence against women and children. The list included contact information of other agencies and institutions (i.e., police department, fire department, nearby hospitals) to mask the focus on violence and not make the respondents feel that they were being singled out because of their reported experiences with violence, thereby avoiding unnecessary psychosocial trauma to the respondents.

3.5 Ethics review

The survey design, protocol and instruments were reviewed by the University of San Carlos Research Ethics Committee (REC) and approved on January 17, 2018. Please see Appendix 4 for the REC Certificate of Approval, approved consent form and IC assent script. All project and field staff were also asked to sign the OPS confidentiality and child protection agreement (see Appendix 5).

3.6 Data collection teams and survey training

The number and composition of data collection teams assigned to each domain are determined by both OPS and the research institution assigned to the domain. Each team has a Team Leader and 3-5 interviewers, depending on the number and geographic distribution of households assigned to the team. See Appendix 2 for the list of data collection teams per domain. Data collection training in each domain lasted a week. All sessions were held at the respective research institutions assigned to the domains. Please see Appendix 6 for the topics covered during the training.

3.7 Data processing

All completed questionnaires were shipped to OPS from all data collection centers for recording and final office editing. Prior to encoding questionnaire data into electronic data format, a group of office editors, mostly experienced field interviewers, went through the questionnaires for consistency, logic and range checks, and to assign numeric codes to open-ended and other alphabetic string responses. A data entry program with built-in range and logic checks was customized by the OPS Data Manager specifically for this study. A data entry team encoded the data. Quality control procedures included random double data entry and electronic data editing and verification runs.

See Appendix Tables_1 (Matrix of Quantitative Variables) for a complete listing of variables collected at each survey wave.

CHAPTER 4
WAVE 2 SURVEY SAMPLE AREAS

4.1 Profile of Wave 2 sample barangays

Community characteristics significantly influence the status of children and their households. In addition to studying changes in the lives of the index children and their households, this study also monitors changes in their barangays of residence through Community Surveys conducted at each wave. Data are collected from multiple respondents or key informants using a semi-structured questionnaire. Barangay administrative data are provided mostly by the Barangay Captain, Secretary, Treasurer and Councilors. Barangay health center personnel are sourced for health-related data. Other community informants include personnel from the Municipal Social Welfare and Development Office, Philippine National Police and local businesses. The Community Survey is mostly completed during the period when the field team is also completing the household survey in the barangay. Follow up visits or phone calls to key informants may be required to complete the Community Survey.

There were a total of 415 barangays represented in the Wave 2 household sample, 344 of which were barangays enumerated in Wave 1 and 71 were new barangays (see Table 2.2A). Of the 71 new barangays, only 47 had community data in Wave 2. The Community Survey was not administered in 24 barangays: Luzon=13 barangays (corresponding to 13 households), Visayas=9 barangays (11 households), Mindanao=2 barangays (2 households). This was primarily due to time and logistical constraints. In most of the new barangays, only one household needed to be visited and the field team's time in the barangay was therefore limited. There was not enough time to obtain all the required community data.

Table 4.1 compares selected characteristics of the study barangays, among original Wave 1 barangays (across domains) and new barangays (more community-level data are shown in Appendix Tables_2). At baseline, Luzon had significantly more urban barangays than the Visayas and Mindanao. In both Waves 1 and 2, barangays across the three domains significantly differed in terms of population size, population density (with Luzon having the most densely populated barangays), Internal Revenue Allotments, agriculture being the main source of income, 4Ps households and presence of indigenous populations. In Wave 2, the new barangays had significantly higher population densities compared to the original barangays. It is likely that the migrant households in Wave 2 moved to more densely populated areas.

Table 4.1 Comparing selected barangay characteristics in Waves 1 and 2 by island group[a]

Selected community characteristics	Luzon		Visayas		Mindanao		ALL		New Wave 2 barangays
	Wave 1 (n=115)	Wave 2 (n=114)	Wave 1 (n=115)	Wave 2 (n=115)	Wave 1 (n=115)	Wave 2 (n=115)	Wave 1 (n=345)	Wave 2 (n=344)	(n=47)
Urban barangays[*],%	66.1		34.8		27.8		42.9		53.2
Distance from town center (km), mean±SD	7.3±8.1 (n=104)		6.3±5.6 (n=114)		9.1±12.9 (n=114)		7.6±9.5 (n=332)		5.6±(5.1) (n=44)
Land area (km^2),mean±SD	2,485.7± 13,016.8 (n=98)		25,003.1± 163,937.8 (n=101)		4,220.6± 43,868.3 (n=111)		10,443.2± 97,668.6 (n=310)		1,036.3± 4,969.6 (n=35)
Population[*,#],mean±SD	24,673.2± 46,923.4 (n=113)	39,168.1± 121,140.0 (n=112)	5,963.2± 9,829.1 (n=115)	6,066.6± 9,461.3 (n=114)	9,499.9± 16,529.6 (n=113)	10,138.3± 17,449.5 (n=112)	13,335.2± 30,227.3 (n=341)	18,384.3± 71,981.7 (n=338)	11,193.4± 12,976.5 (n=43)
Population density (persons/km^2)[*,#,$], mean±SD	14,112.5± 26,492.1 (n=98)	16,639.5± 30,004.7 (n=96)	3,882.1± 13,358.2 (n=101)	3,744.2± 12,108.3 (n=101)	4,323.0± 8,577.4 (n=109)	4,511.6± 9,166.3 (n=108)	7,293.2± 18,098.7 (n=308)	8,074.8± 19,825.3 (n=305)	17,042.8± 7,482.4 (n=33)
Internal Revenue Allotment (in pesos)[*,#], mean±SD	In 2016 11,015,370± 19,480,693 (n=99)	In 2017 12,763,481± 23,511,295 (n=104)	In 2016 3,948,215± 7,185,689 (n=110)	In 2017 4,137,395± 5,672,960 (n=110)	In 2016 5,253,258± 7,629,480 (n=113)	In 2017 6,000,181± 8,655,106 (n=113)	In 2016 6,579,017± 12,757,827 (n=322)	In 2017 7,524,575± 14,986,022 (n=327)	In 2017 6,139,560± 7,117,428 (n=43)
Agriculture as main source of livelihood[*,#],%	48.7	41.2	67.0	69.6	72.2	59.1	62.6	56.7	48.9
With local waterworks,%	62.3 (n=114)	78.1	61.7	64.0 (n=114)	73.9	69.6	66.0 (n=344)	70.6	68.1
Households enrolled in 4Ps[*,#],mean±SD (among barangays with 4Ps)	In 2016 251.9± 396.2 (n=65)	In 2017 360.6± 740.4 (n=86)	In 2016 136.8± 121.2 (n=100)	In 2017 151.2± 133.3 (n=110)	In 2016 252.1± 216.8 (n=95)	In 2017 379.0± 352.1 (n=110)	In 2016 207.7± 254.2 (n=260)	In 2017 291.9± 463.3 (n=306)	In 2017 288.0± 505.3 (n=39)
With barangay health station/rural health unit/city health office,%	87.8	88.5 (n=113)	80.9	83.4	89.6	90.4	86.1	87.5 (n=343)	93.5 (n=46)
With indigenous peoples[*,#],%	21.9 (n=114)	20.3 (n=113)	7.8	5.3 (n=113)	81.6 (n==114)	83.5	37.0 (n=343)	36.7 (n=341)	43.5 (n=46)

[a]Unweighted results presented as percentage of barangays or mean ± SD; Wave 1 data presented for non-varying attributes
[*]Significantly different between domains at p<0.05 in Wave 1; [#]in Wave 2 [$]between original and new barangays; Test for significant differences were based on chi-squared test of independence, mean comparison tests, and one-way analysis of variance tests.

CHAPTER 5
PROFILE OF THE FILIPINO CHILD AT AGES 11-12

This chapter presents results characterizing the status of the index children (ICs) by the Wave 2 Survey in 2018. More in-depth analysis are currently being undertaken by the study team on the Waves 1-2 study findings. Thus, certain results will be released through these upcoming publications. The complete data on the SDG indicators from Waves 1 and 2 are shown in the Appendix Tables_2.

5.1 Basic profile of the index children

Table 5.1 presents some basic characteristics of the index children at this age. In Wave 2 the index children had a mean age of 11.8 years. Since the Wave 1 data collection began in the last quarter of 2016 and Wave 2 started within the first few months of the year (mean interval in years of 1.3), 72.4% of the children were aged 11 and 27.1% were aged 12[4].

As explained in Chapter 3, the main respondent for the household survey is either the mother (81%) or the child's main caregiver. About 93% of the Wave 2 household respondents were the same people interviewed in Wave 1. Similar to what was observed in Wave 1 (OPS, 2018), about three-fourths of the households had both parents in the household, on average there were 6 persons living in the household and about 49% of the households were 4Ps beneficiaries (47% in Wave 1).

Just like in Wave 1, about 98% of the children were in school by Wave 2. Depending on whether they started first grade at ages 6 or 7, the index children were either in Grades Four (29.1%) or Five (62.0%) in Wave 1. Correspondingly, the Wave 2 sample were in Grades Five (27.7%) or Six (61.5%). Compared to those lost to follow-up, children in higher grade levels in Wave 1 were significantly likely to be retained in Wave 2[5].

At baseline, about 12% of the index children were reported to have ever repeated a grade since they started school. In Wave 2 we followed up with a question on whether they had to repeat a grade at the start of the 2017-2018 school year. As shown in Table 5.1, about 3% reported to have done so. Repeating a grade is among the vulnerabilities that these children face and is examined further in Section 5.2.

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[4] In longitudinal surveys, data edits are likely to happen as current survey data are checked against previously collected data. In Wave 2 we discovered that 44 ICs (0.89% of unweighted baseline sample) were not age 10 at baseline but were instead ages 8 (n=2), 9 (n=24), 11 (n=17) or 12 (n=1). At baseline, interviewers checked reported IC birthdates against birth certificates (when available). Given the mininal age discrepancy, we did not exclude these 44 cases from the sample.
[5] Weighted results from a logistic regression model controlling for sex (Odds Ratio [95% Confidence interval]: 1.25[1.06,1.49]).

Table 5.1 Basic characteristics of index children at Wave 2[#]

Characteristics	Luzon (n=1,492)	Visayas (n=1,610)	Mindanao (n=1,633)	ALL (N=4,735)
Age in years, n	11.8 ± 0.01	11.8 ± 0.01	11.8 ± 0.02	11.8 ± 0.01
Males,%	52.5	49.5	52.3	51.8
Main household respondent, %	(n=1,491)			
Mothers	82.1	79.8	80.2	81.1
Fathers	5.4	7.5	7.1	6.3
Grandmothers	8.7	8.6	8.8	8.7
Other household members	3.8	4.1	3.9	3.9
Parents in household, %:				
Both parents	76.2	76.8	75.8	76.2
Mother only	12.5	12.5	13.4	12.7
Father only	3.8	3.7	3.4	3.7
No parents	7.6	7.0	7.4	7.4
Household size[b,c], n	6.3±0.08	6.3±0.10	6.6±0.11	6.3±0.06
4Ps beneficiary household[a,b,c], %	42.0	51.0	59.3	48.6
Currently in school,%	98.3	98.9	98.2	98.4
Current grade[##,b,c],%				
Grade 3 or below; SPED	2.8	2.7	7.9	4.2
Grade 4	5.5	3.5	7.7	5.7
Grade 5	27.0	28.0	28.9	27.7
Grade 6	63.6	65.2	54.9	61.5
Grades 7/8	1.0	0.6	0.8	0.8
Repeated a grade in current school year, %	3.2	2.4	3.0	3.0

[#]Weighted results presented as percentages or mean ± standard error (SE). Test for significant differences in weighted proportions and means were based on Pearson chi-square test for independence and adjusted Wald test respectively

[##] Current grade if in school; last grade completed if not in school

[a] Significantly different at p<0.05 between Luzon and Visayas; [b] Luzon and Mindanao; [c] Visayas and Mindanao

5.2 Status of children's vulnerabilities

In Wave 1, we assessed the vulnerability levels of the 10-year old index children based on how they performed in seven (7) key areas of concern of the SDG and the Convention on the Rights of the Child (UN General Assembly, 1989). We identified 16 dichotomous variables (1=yes/0=no) that represent these domains:

1. Education (GOAL 4): ever repeated a grade
2. Health (GOAL 3): reported any illness in the past 6 months, reported any disability
3. Nutritional status (GOALS 2/3): low diet diversity scores (DDS), underheight for age (stunting), below (severely thin/thin) or above normal (overweight/obese) body mass index (BMI)-for-age
4. Food Security (GOAL 2): experienced hunger but did not eat
5. Child labor (GOAL 1): reported doing any work (whether paid or unpaid) at age 10
6. Exposure to physical violence (GOAL 3/5): reported being physically hurt by friends/classmates, parents or any adult
7. Precedents to risky behaviors (GOAL 3): currently smoking, currently drinking, experienced more than kissing, ever watched pornographic movies, chats with strangers on internet

Table 5.2 compares data on these vulnerabilities between sexes and survey waves (among those retained in Wave 2). With data on two time points, some data verifications and cleaning were done on a few variables, particularly with the anthropometric data (see 5.1 footnote # 4). We shifted to using the zanthro macro commands in Stata to define stunting and bmi-for-age categories. For Table 5.2 we define thin (below normal bmi-for-age) using z-score values less than zero (Vidmar et al, 2013). The combination of these changes has resulted to slight differences in previously reported Wave 1 proportions for both indicators. We also added a few more qualifying questions on disability in Wave 2. This may likely explain the increase in the number of index children with disability (n=65 in Wave 1 to n=114 in Wave 2). As we gather more data points in future waves, true as well as incident cases will be more confidently established.

A persistent theme is that at ages 10-12, males appear to be proportionally disadvantaged in terms of repeating grades, experiencing hunger and exposure to violence. In both waves, more boys than girls reported to have watched pornographic movies and engaged in sexual activities that went beyond kissing. In the combined two-wave sample and given the changes mentioned above, a higher proportion of males were categorized as stunted in both waves compared to girls. Using the revised definition of thin, more boys than girls were classified as thin in Wave 2. While there were more boys than girls who reported doing any kind of work (paid or unpaid) in Wave 1, the difference ceased to be significant in Wave 2 as more girls were reported to be working than in the previous wave. The difference in the proportion of girls working in Wave 1 vs. those working in Wave 2 was borderline significant (p<0.10). The proportion who reported to be currently smoking decreased in Wave 2. However, there were significantly more boys than girls who reported smoking in Wave 2, with the proportion of girls who were smoking in Wave 2 being significantly less than in Wave 1. Being self-reported data, it is difficult to assess whether this translates to an actual change in behavior or a change in how they responded to the question. A striking difference between waves is the sharp increase in the proportion of

those who reported chatting with strangers online (from 4.1% to 16.3% for both sexes). This pattern was observed alongside an increase in internet use (from 41.4% in Wave 1 to 56.8% in Wave 2).

Tests for differences in proportions between Waves 1 and 2 indicate significant downward trend in ever being sick in the last six months, being stunted, being thin, experiencing hunger, experiencing violence and watching porn. An upward trend was observed in the proportion of children with disability and drinking alcoholic beverages (please see a possible explanation on this discussed above). Given the predominant decline in proportions between waves, the overall vulnerability score in Wave 2 significantly dropped for both sexes.

A more in-depth analysis on these vulnerabilities controlling for pubertal status (Section 5.3) will be the focus of an upcoming paper submission[6].

Table 5.2A Comparing vulnerabilities by sex between Waves 1 and 2[a]

Vulnerabilities	Wave 1			Wave 2		
	Boys	Girls	All	Boys	Girls	All
Ever repeated a grade[b]	14.2***	9.1	11.7	4.2***	1.9	3.1
Ever sick last 6 months	30.0	27.3	28.7	19.6	18.6	19.1###
With disability	1.3	1.7	1.5	2.2	2.3	2.2###
Stunted	35.9***	23.2	29.8	29.7***	19.0	24.6###
Thin (<normal BMI-for-age)[c]	37.8	40.6	39.2	37.4**	33.3	35.4###
Low diet diversity score[d]	54.2	56.3	55.2	57.3	53.8	55.6
Hungry but did not eat	48.1***	39.5	43.9	37.5***	30.7	34.2###
Currently working (paid/unpaid)	5.4**	3.8	4.6	6.0	5.1	5.6
Physically hurt by friends	43.1***	33.4	38.5	33.6***	24.8	29.4###
Forcefully hurt by parents	19.0***	13.0	16.1	17.0***	8.2	12.8###
Physically hurt by adults	28.4***	16.3	22.5	18.4***	9.8	14.2###
Currently smoking	4.4	3.6	3.8	3.7***	1.1	2.4##
Currently drinks alcohol	6.0***	3.1	4.6	8.4***	3.2	5.9##
More than kissed	5.7***	3.7	4.8	5.7***	2.1	4.0
Watched porn movies	19.8***	15.1	17.6	14.0***	5.6	10.0###
Chats with strangers	4.2	3.8	4.0	20.9***	11.3	16.3###
Vulnerability scores[e]	3.5 ± 0.1***	2.9 ± 0.1	3.2± 0.05 (n=4,385)	3.1 ± 0.1***	2.3 ± 0.05	2.7± 0.05### (n=4,403)

[a] Weighted bivariate results are presented as percentages or mean ± standard error; We used linear combination of estimators (LINCOM) to test for significant differences in proportions between boys/girls within waves, and between Waves 1 and 2 for both sexes. Sample size for those in both waves is 4,735; sample sizes for variables in this table range from 4,603 to 4,735.
[b] Repeated a grade in Wave 1 means ever repeated a grade; in Wave 2 means repeated grade within current school year; excluded from LINCOM testing
[c] Classified using the 2007 WHO Reference Standards (update);   Thin is BMI-for-age zscore <0
[d] Consumed less than 4 of 9 food groups the previous day
[e] Among those with non-missing values on the 16 vulnerability variables
** Significant between boys and girls at p<0.05; *** at p<0.01
Significant between Waves 1 and 2 for both sexes at p<0.05; ### at p<0.01

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[6] Borja, Mayol, Duazo, Barrios, Adair, Herrin, Bautista, Jurlano "Characterizing child development in the pubertal transition " (tentative title; for journal submission). Some of the results will be presented at the 2019 Philippine Statistical Authority National Conference (October 1-3, 2019)

5.3 Sexual maturity rating

The pubertal transition, or the sequence of changes that occur in children that mark their entry to adolescence and into adulthood, is an important process to capture in this study. It is the period when a child's body is physiologically transformed to prepare them for sexual reproduction. In addition to these physical milestones, psychosocial changes also take place as the children mature into more adult realities. Thus, pubertal status provides an important context in assessing physical growth trajectories and understanding emotional and behavioral issues these children are confronted with (Rosen, 2004; Lee and Styne, 2013; Chulani and Gordon, 2014).

The Sexual Maturity Rating (SMR) scales developed by Marshall and Tanner for girls (1969) and boys (1970) have been widely used as a self-assessment tool where children identify which pubertal stage they are in. While a pubertal assessment through physical examination by a health practitioner may be more accurate, the SMR has been established as sufficiently valid to distinguish children who are prepubertal and pubertal (Rasmussen et al, 2015). The SMR scales consist of sets of 5 body drawings depicting pre-pubertal stage (drawing 1) through adult stage (drawing 5). The girls' scale consists of a set of breast drawings showing various stages of breast and nipple changes and another set showing various stages of pubic hair development. The boys' scale consists of a set of drawings of the penis, scrotum and testes and another on pubic hair.

The baseline visit was the first encounter between the index children and the study team, and perhaps the children's first experience in participating in a survey and being asked a lot of questions. This visit was the ideal time to establish rapport between the children and interviewers. Given the graphic depictions of breast and external genitalia in the SMR scales, the OPS project management team felt that administering this segment may discourage some children from participating in the next survey. A decision was thus made to defer the SMR administration for Wave 2, when the children and their mothers/caregivers would be more comfortable with the study team and more confident in the study's credentials.

In Wave 1 we did ask the girls if they have started menstruating (about 3% said yes and mean age at menarche was 9.7 years) and asked the boys if they have experienced voice change (about 46% said yes). By Wave 2 about 25% of the girls were menarcheal and mean age at menarche increased to 10.8 years. About 53% of the boys reported voice change in Wave 2. Menarcheal status appears more strongly associated with SMR scales (among the girls) than is voice change with SMR pubertal stages (about the boys)[7].

The SMR results shown in Table 5.3 indicate that at ages 11-12, most of the girls categorized their breast development to be between stages 2-3. The boys' penile/testicular development was assessed as between stages 2-3 as well. For both sexes, pubic hair development was rated between stages 1-2.

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[7] Pairwise correlation coefficients (significant at $p<0.05$): menarcheal (0=no; 1=yes) and breast (0.42); and pubic hair (0.41); voice change (0=no; 1=yes) and penis (0.11); and pubic hair (0.10).

Table 5.3 Sexual maturity ratings by sex

Pubertal stages		Weighted %	Mean Stage ± SE
Girls: breast development (n=2,330)			
Stage 1	Prepubertal	20.10	
Stage 2	Breast bud stage	41.26	
Stage 3	Further breast enlargement	30.11	
Stage 4	Areola form a secondary mound	7.74	
Stage 5	Mature stage	0.79	
All girls			2.28±0.03
Girls: pubic hair development (n=2,327)			
Stage 1	Prepubertal	57.09	
Stage 2	Sparse growth	29.85	
Stage 3	Darker, coarser growth	9.07	
Stage 4	Adult hair, covering small area	3.27	
Stage 5	Adult hair in type and quantity	0.72	
All girls			1.61±0.02
Boys: penile/testicular development (n=2,349)			
Stage 1	Prepubertal	15.35	
Stage 2	Enlargement of scrotum and testes	28.65	
Stage 3	Enlargement of penis (length)	30.56	
Stage 4	Increased size of penis, scrotum, testes	17.95	
Stage 5	Adult genitalia	7.48	
All boys			2.74±0.04
Boys: pubic hair development (n=2,341)			
Stage 1	Prepubertal	48.66	
Stage 2	Sparse growth	34.09	
Stage 3	Darker, coarser growth	13.40	
Stage 4	Adult hair, covering small area	2.71	
Stage 5	Adult hair in type and quantity	1.14	
All boys			1.74±0.02

5.4 Raven's Standard Progressive Matrices (RSPM)

To obtain an objective measure of the index children's cognitive ability, we administered the Raven's Standard Progressive Matrices in the Wave 2 Survey. Developed by John C. Raven (1938), RSPM consists of 60 items, divided into five sets of diagrammatic puzzles with each set made up of 12 problem items. The sets and the items within each set are sequenced in progressing difficulty. Each correct item is scored one point. The RSPM is a culture bias-free test that measures non-verbal, abstract reasoning and is designed to be useful with persons of all ages, across different backgrounds.

Of the 4,735 households representing index children in Wave 2, 45 children did not take the test: 27 were not available, seven refused to take the test, two found the test difficult and nine were children with disabilities. There were 47 who started taking the test but discontinued: 30 found the test difficult, 13 got tired of answering, two were not feeling well and two were children with disabilities. For those who completed the test, the mean testing time was 25.0 ($\pm$SD 9.2) minutes and ranged from 5 to 87 minutes. The children were instructed to complete as many sets in the test booklet for which they felt comfortable in answering. Per the interviewers' reports, this was one segment most children tackled enthusiastically. In fact, about 98% of those who completed the test, answered all items in the last set.

Among the 4,643 children who completed the test, the weighted mean raw RSPM score was 29.5$\pm$(SE 0.3) and ranged from 2-57 (the highest score being 60). Figure 5.4A presents mean standardized RSPM scores (z-scores) by sex, current grade level and stratum. Figure 5.4B shows the score distribution by domain. Bivariate analysis showed significant differences in RSPM scores between sex, strata and across current grade levels and domain. Consistent results were obtained from a weighted multivariable regression model where being female, higher grade levels (compared to those lower than grade 4), urban residence and being from Luzon (compared to being from the Visayas or Mindanao) were associated with significantly higher RSPM scores (results not shown).

While the linear difference in scores across grade levels are expected, the score differences across domains appear consistent with Wave 1 Survey findings (OPS, 2018). In section 5.2 of this report we discussed the apparent disadvantage of males vs. females, and among children in the Visayas and Mindanao (compared to their Luzon counterparts) in terms of school performance and other vulnerabilities. In the analysis of Wave 1 results, stratum was also seen as a significant predictor of child outcomes, with urban children enjoying a distinct advantage over rural children.

Gathering information on children's cognitive ability is important because such ability may have important consequences for health, human capital formation and other outcomes in adolescence and adulthood, as shown in previous studies. Feinstein and Bynner (2004) found that cognitive performance in middle childhood (between ages 5 to 10), predicted adult outcomes such as income, educational success, household worklessness, criminality, teen parenthood, smoking, and depression. The Carolina Abecedarian Project which did a long-term

follow up on a childhood intervention found that disadvantaged children randomly assigned to the treatment group and received the interventions (including cognitive and social stimulations) had lower risk for cardiovascular and metabolic diseases at their mid-30s compared to the control group (Campbell et al., 2014). Others found low cognitive ability in childhood to be associated with illness (Martin et al. 2004), anxiety (Martin et al., 2007), risk of depression (Dobson et al. 2016), psychosis (MacCabe et al., 2013) and risk mortality (Martin & Kubzansky, 2005) in adulthood.

Figure 5.4A RSPM z-scores by sex, current grade and stratum[#]
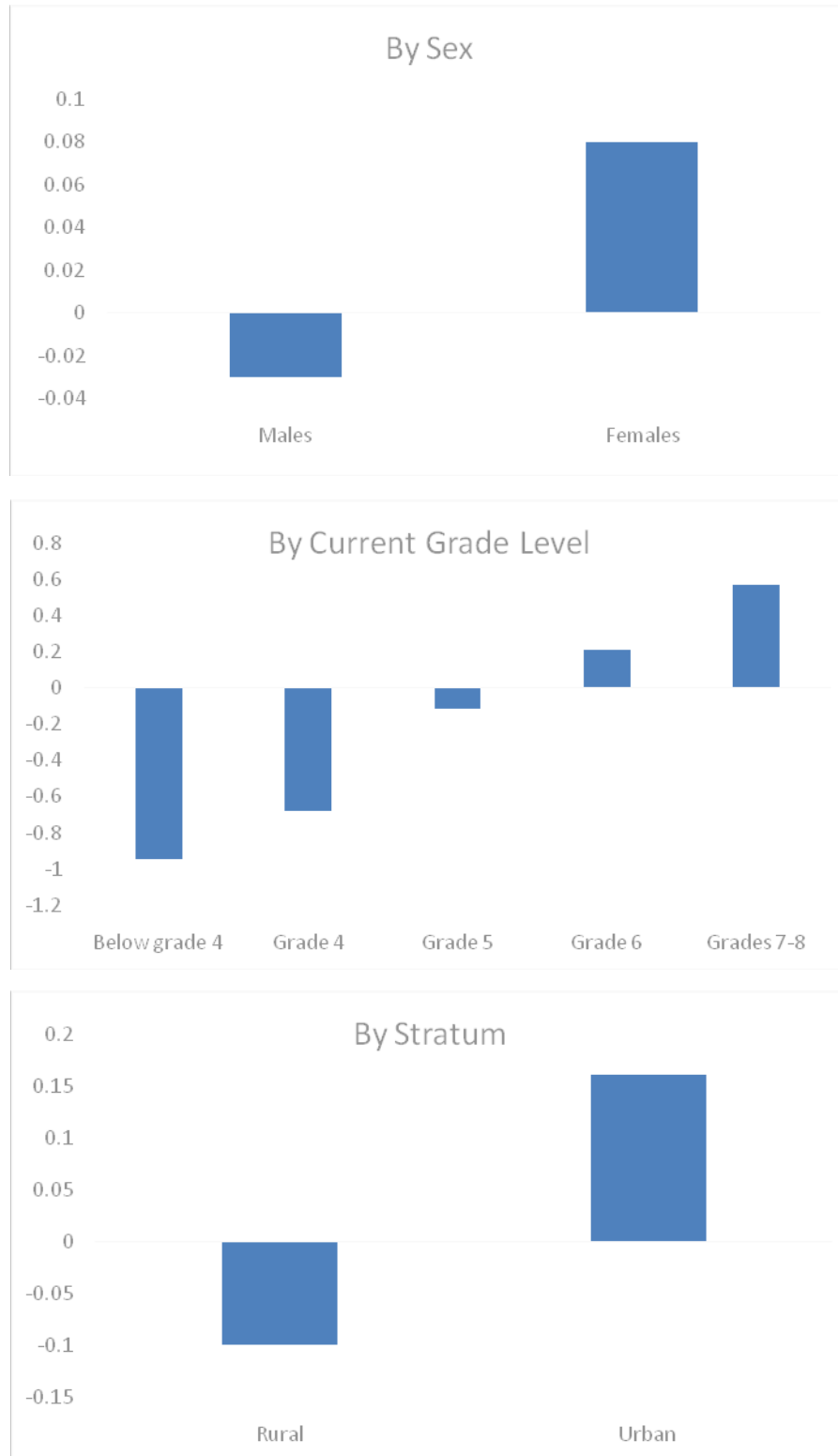
[#] Differences between sex, strata and across grade levels are significantly different at p<0.01. Test for significant differences in means (weighted) based on adjusted Wald test. Current grade refers to grade currently enrolled in if in school or last grade completed if not in school.

Figure 5.4B RSPM z-scores by domain[#]
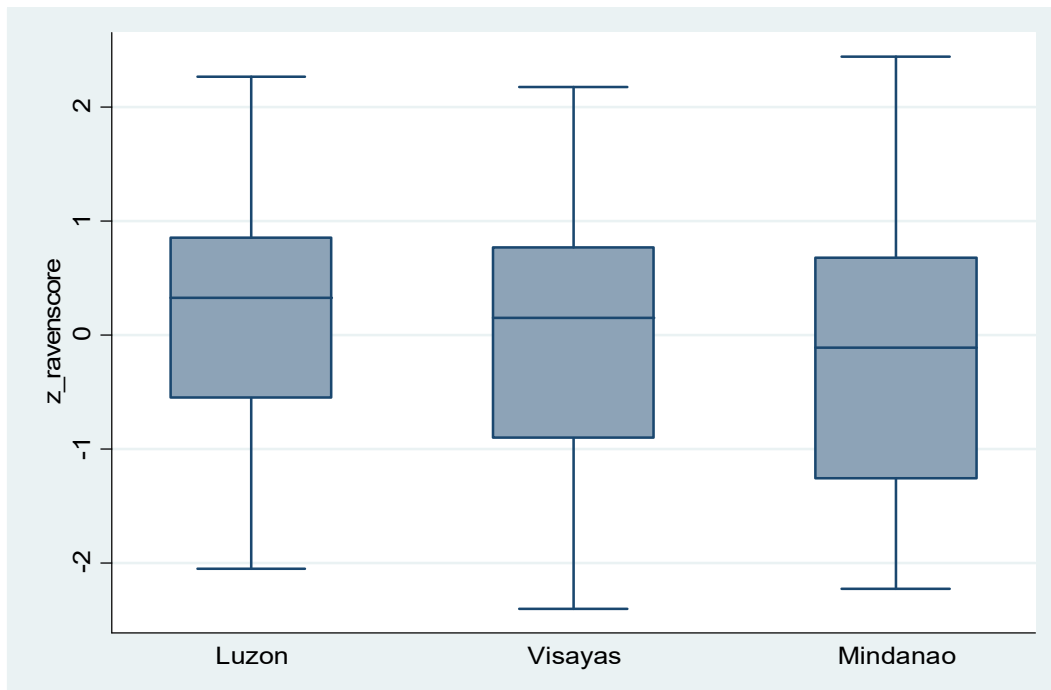
#Figure above compares the scaled raven scores across the 3 domains. As shown, Luzon performed better in cognition compared to the other 2 domains. Spread of scores in Visayas and Mindanao shows that Visayas scores are skewed to the left compared to that in Mindanao which are skewed to the right.

5.5 Child Behavior Checklist (CBCL)

In this Wave we administered the CBCL (Achenbach and Rescorla, 2001) to add a measure of the index children's social competencies and adaptive functioning from the point of view of their mothers/caregivers. The CBCL is a tool that measures competency levels in terms of activity levels (sports, hobbies, household chores, jobs), social skills, and school performance. The CBCL questionnaire also includes a suite of 113 questions from which are derived scores measuring mental and behavioral syndromes anchored on the Diagnostic and Statistical Manual for Mental Disorders (Achenbach, 2013). The syndrome scales consist of factors that represent internal (emanating from within) or external (projected outwardly) factors and problem behaviors (manifestations of social problems, unusual behaviors, attention-seeking and related problems). The internalizing factors are reported behaviors that depict anxious/depressed, withdrawn/depressed and include somatic complaints. Rule-breaking and aggressive behaviors are considered externalizing factors.

Mental health practitioners often use CBCL as a diagnostic screening to determine the presence of mental health issues among children and adolescents. Validated across different cultures, it includes multicultural norming sets to incorporate variations across diverse societies (Achenbach and Rescorla, 2007). Apart from diagnostic screening, CBCL can be utilized in epidemiological research when determining the prevalence of behavior and emotional problems within a population (Achenbach and Rescorla, 2001). Longitudinal studies, as well, make use of CBCL for a developmental perspective of social behavior and psychological functioning.

We received license from the Achenbach group to use the CBCL Cebuano and Tagalog versions (we administered the latter in non-Cebuano speaking study areas). The questionnaire was interviewer-administered to mothers/caregivers. While all but one household was administered the CBCL, given the scoring protocol, only 4,611 had valid total competency scores (the sum of the scores from the activity, social, and school scales). Higher values correspond to higher competency. There were 4,732 children who obtained valid syndrome scale scores. Higher values correspond to having more mental and behavioral problems.

Table 5.5A presents mean competency scale scores (raw and t scores) by sex, current grade level, domain and stratum, and corresponding bivariate analysis results. Significant score differences between males and females, and across domains were observed in the social and school scales. Rural children appeared to have higher school scale scores than their urban counterparts. Compared to children who were of age-appropriate grade levels or higher, children who were in lower grades had significantly lower scores in all competency categories. Results (not shown) from a weighted multivariable regression model show that older age, higher grade levels (compared to those lower than grade 4) and rural residence were associated with higher standardized total competence scores (t scores).

Table 5.5A CBCL competency scores by categories[#]

Categories	Activity scale Raw score (n=4,723)	Social scale Raw score (n=4,721)	School scale Raw score (n=4,635)	Total competency t score (n=4,611)
By sex:				
Male	6.47±0.09	6.78±0.06[**]	4.86±0.03[***]	34.99±0.27
Female	6.41±0.09	6.60±0.06	5.09±0.02	35.18±0.24
By grade levels[##]:				
Below grade 5	5.12±0.42[***]	5.98±0.15[***]	4.15±0.05[***]	30.03±1.02[***]
Grades 5-8	6.58±0.05	6.77±0.04	5.05±0.01	35.56±0.15
By domain:				
Luzon	6.39±0.07	6.84±0.06[b,c]	5.04±0.02[a,b]	35.34±0.21
Visayas	6.46±0.12	6.76±0.08	4.93±0.03	35.26±0.34
Mindanao	6.52±0.24	6.36±0.09	4.87±0.05	34.45±0.62
By stratum:				
Rural	6.34±0.07	6.67±0.04	5.02±0.02[***]	34.90±0.18
Urban	6.53±0.14	6.72±0.08	4.92±0.03	35.25±0.38

[#]Weighted results presented as mean ± standard error (SE). Test for significant differences in means based adjusted Wald test.
[##]Current grade if in school; last grade completed if not in school
[**] Significantly different between categories at p<0.05; [***] at p<0.01
[a] Significantly different at p<0.05 between Luzon and Visayas; [b] Luzon and Mindanao; [c] Visayas and Mindanao

Table 5.5B presents mean standardized syndrome scale scores (t scores) by sex, current grade level, domain and stratum. Bivariate analysis results indicate that males obtained higher scores (more problematic behaviors) compared to females in both internalizing and externalizing factors and in the total syndrome scale. Grade levels and domain categories (except for internalizing factors) were not associated with syndrome scales. Compared to rural children, urban children had higher values in externalizing factors and in total syndrome scale. Results (not shown) from a weighted multivariable regression model reveal similar patterns except that residing in the Visayas (compared to being from Luzon) was associated with higher total syndrome scale score.

The CBCL data will be explored in greater depth in an upcoming manuscript for publication submission[8].

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[8] Borja, Belleza, Barrios, Mayol, Duazo, Bautista, Jurlano "The current state of Filipino children's competency levels and mental health status" (tentative title; for journal submission)

Table 5.5B CBCL syndrome scale scores by categories[#]

Categories	Internalizing factors t score (n=4,732)	Externalizing factors t score (n=4,732)	Total syndrome scale t score (n=4,732)
By sex:			
Male	53.74±0.39[***]	51.39±0.36[***]	50.87±0.44[***]
Female	51.60±0.39	48.56±0.37	49.20±0.45
By grade levels[##]:			
Below grade 5	52.61±1.98	50.13±1.88	49.23±2.54
Grades 5-8	52.72±0.29	50.02±0.26	50.16±0.31
By domain:			
Luzon	51.66±0.43[a,b]	50.47±0.42	49.80±0.48
Visayas	53.75±0.43	50.15±0.40	51.01±0.45
Mindanao	53.94±0.95	49.10±0.76	49.87±1.13
By stratum:			
Rural	52.88±0.39	51.25±0.38[***]	51.27±0.44[***]
Urban	52.56±0.56	48.94±0.46	48.99±0.64

[#]Weighted results presented as mean ± standard error (SE). Test for significant differences in means based adjusted Wald test.

[##]Current grade if in school; last grade completed if not in school

[**] Significantly different between categories at p<0.05; [***]at p<0.01

[a] Significantly different at p<0.05 between Luzon and Visayas; [b] Luzon and Mindanao; [c] Visayas and Mindanao

CHAPTER 6
FUTURE DIRECTIONS FOR POLICY RECOMMENDATIONS

As we continue to follow up the index children as they get older, and with the additional data collected in Wave 2 such as the SMR, RSPM and CBCL, we are presented with more opportunities for getting to know these children more intimately and using the data to better inform policies relevant to this age group. From the Wave 1 Survey results, supplemented with contextual data from the Baseline Qualitative Study, we produced policy notes on Stunting, Bullying and Disability, issues that we deemed required immediate attention by policy makers.

As the cohort turned a year older, the Wave 2 results highlighted in this report suggest further exploration of pertinent issues that could be the focus of the next set of policy notes. First of all, there is a need to examine other vulnerability issues in Wave 1 not yet addressed by the first round of policy notes that now acquire added concern in view of either their continued high prevalence rate or even increasing rates. This set of vulnerability issues includes the following:

Food security and adolescent nutrition. In Wave 1 we examine stunting and thinness in view of their relative high prevalence among the index children. But there were other indicators related to nutrition that were not yet addressed. These include low diet diversity score and hunger, both indicators exhibiting high rates in both Wave 1 and Wave 2. Policy discussion on these concerns will, on the one hand, touch on the importance of addressing adolescent nutrition in view of their higher nutrient requirements in this period of rapid growth, and, on the other hand, raise issues on food security. On the latter there is a need to relate discussions on (1) the level of income needed to afford energy requirements vs nutrient requirements highlighted in recent estimates provided by WFP and FNRI (2018); (2) the impact of the National Feeding Program (RA 11037 – Masustansyang Pagkain Para sa Batang Pilipino Act of 2018); and (3) the impact of the 4Ps on nutrition, through its effect on income, and nutrition knowledge obtained from Family Development Sessions (Republic Act No. 11310 – Pantawid Pamilyang Pilipino Program (4Ps) Act of 2019).

Child labor and child work. As children grow older, there is increasing demand from the family for children to either contribute to household chores (child work) or to household income through their labor (child labor). One outcome of the latter could be increased absences from school that could lead to dropping out of school altogether. The percentage of index children reported as currently working (paid/unpaid) was 5.6 in Wave 2, slightly higher than 4.6 in Wave 1, and is higher among boys than girls. National data on child labor is available from the *Survey of Child Labor 2011* by the Philippine Statistics Authority (2011). We need to better understand the determinants of both child labor and child work, review what policy safeguards are in place (i.e., international conventions and national laws), and the effect of these policies.

Internet use and chatting with strangers. Wave 2 results show a sharp increase in reported online chatting with strangers, from 4% in Wave 1 to 16% in Wave 2. The concern is not only on how this behavior affects the children's school performance, but also their social network and

propensity for risky behaviors. There are advantages of greater access to the internet (quick access information for school-related assignments), but there are also disadvantages (fake news, wrong information about sex and sexuality, cyber bullying). Chatting with strangers can even be more concerning since this could lead to invitation for risky behavior. There is a need to discuss a number of policy directions including what parents and schools can do to prepare children/adolescents to identify fake news, develop capacity to fact-check what they are "learning" online, and better understand the dangers of chatting with strangers.

In addition to the above vulnerability issues, Wave 2 obtained new data on additional concerns. These include the transition to puberty through the Sexual Maturity Rating (SMR) scales, children's cognitive ability through the Raven's Standard Progressive Matrices (RSPM), and children's social competencies and adaptive functioning through the Child Behavior Checklist (CBCL). These new data raise new concerns that include the following:

Transition to puberty. Aside from being an important covariate in the analysis of children's physical growth trajectories as well as their psychosocial development, it is also essential to identify the risks that they are confronted with as a greater number of them enter their reproductive phase. What are their sources of information and who are providing them the much-needed support regarding their reproductive health? What behaviors are changing as they transition to adolescence? In this regard, it is important to discuss the status of sexuality education mandated by the RPRH law (RA 10354 – Responsible Parenting and Reproductive Health Act of 2012). In the meantime, what can parents and schools do to prepare children/adolescents to fact-check information about sexuality that they see on the internet or when they chat with strangers.

Children's cognitive ability. Studies predicting adult outcomes and well as impact of interventions show that children's cognitive ability has important consequences for health, human capital formation and other outcomes in adolescence and adulthood, such as income, educational success, teen parenthood and depression. There is a need to better understand the potential consequences and explore how best to mitigate such consequences through timely interventions at this period in the children's lives.

Children's social competencies and adaptive functioning. The CBCL has often been used as a diagnostic screening to determine the presence of mental health issues among children and adolescents. It is also useful in determining the prevalence of behavior and emotional problems within a population. There is a need for better understanding of the results obtained from Wave 2 and how to relate them to the larger, albeit neglected, societal concern about mental illness and related behaviors (anxiety, depression, aggressive behaviors). There is also a need to assess the effect of existing policies such as the recently enacted Mental Health Act (RA 11036 of 2018) and how they can be applied effectively to children in need of services, terms of access to services, affordability of services, privacy and prevention and elimination of stigma.

Gender disparity. The Wave 2 results reveal that boys continue to be disproportionately disadvantaged compared to girls in terms of schooling. There are also gender disparities in terms of the indicators of vulnerability described above (hunger- more boys than girls; currently working -more girls than boy; chatting with strangers – more boys than girls). The CBCL results also show a higher risk profile among boys than girls, while cognitive ability show higher scores for girls than boys. There is a need to better understand the sources of these disparities and the implications for future well-being.

As the Study Team begins to more closely examine and analyze the data and share their findings to the broader research and policy community, we hope to unravel more ways by which this study can truly contribute to the welfare of the Filipino children.

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Republic Act No. 11036 – Mental Health Act of 2018: An Act Establishing a National Mental Health Policy for the Purpose of Enhancing the Delivery of Integrated Mental Health Services, Promoting and Protecting the Rights of Persons Utilizing Psychiatric, Neurological and Psychosocial Health Services, Appropriating Funds Therefor, and for Other Purposes https://www.officialgazette.gov.ph/downloads/2018/06jun/20180620-RA-11036-RRD.pdf

Republic Act No. 11037 – Masustansyang Pagkain Para sa Batang Pilipino Act of 2018: An Act Institutionalizing a National Feeding Program for Undernourished Children in Public Day Care Kindergarten and Elementary Schools to Combat Hunger and Undernutrition among Filipino Children and Appropriating Funds Therefor. https://www.officialgazette.gov.ph/downloads/2018/06jun/20180620-RA-11037-RRD.pdf

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APPENDIX 1

**Representatives to the Steering Committee for the
Longitudinal Cohort Study on the Filipino Child
(as of April 11, 2019)**

Agency	Principal Representative
National Economic and Development Authority (NEDA)	Usec. Rosemarie G. Edillon
Department of Health (DOH)	Asec. Maria Rosario S. Vergeire, MDm MPH, CESO IV
Department of Education (DepEd)	Usec. Jesus Lorenzo R. Mateo
Department of Social Welfare and Development (DSWD)	Asec. Glenda D. Relova
National Youth Commission (NYC)	Comm. James Ceasar A. Ventura
Philippine Statistics Authority (PSA)	ANS Wilma Guillen
Philippine Commission on Women (PCW)	Dep. Dir. Maria Kristine Josefina G. Balmes
Council for the Welfare of Children (CWC)	ED Mary Mitzi Cajayon-Uy
Philippine Statistical Research and Training Institute (PSRTI)	ED Josefina C. Venegas-Almeda, PhD

USC- Office of Population Studies Foundation, Inc.
W. Flieger Bldg., University of San Carlos
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History, Mission and Vision

The USC-Office of Population Studies Foundation, Inc. (OPS) is a non-stock and non-profit population and health research institute affiliated with the University of San Carlos (USC), Cebu City, Philippines. It was established in 1971 by a German demographer and SVD priest, Dr. Wilhelm Flieger, in response to the government's call for more academic involvement in national development and to formalize demographic and related-research activities at USC. From an extension office of the Sociology-Anthropology Department and later, of the university, OPS became a USC foundation in 2005 with links to various academic units in the interest of promoting multi- and inter-disciplinary research. Through the years, OPS has evolved into one of the country's leading population and health research institutions.

Our mission is to strengthen local, regional, and national development initiatives through the conduct of quality, multi-disciplinary and socially responsible research on population, health, nutrition, and all other aspects of human development. The OPS is also committed in enhancing research capacities at USC and in the greater community. We aim to disseminate our research findings to relevant stakeholders through publications, lectures, and policy briefs, and share our research expertise through teaching and extension work.

Our vision is to become a world-renowned research organization with a credible track record in relevant research and related activities that influence programs and policies for uplifting human and social development.

Research Staff

The OPS research core group consists of 9 locally and internationally trained Research Fellows and Associates with expertise in the fields of demography, economics, nutrition, epidemiology, sociology, and reproductive health. In addition, most are survey specialists with vast experiences in designing and implementing surveys. Many have risen from the ranks of field supervisors and data managers. Former Research Fellows/Associates continue to actively engage in OPS research as consultants. In support of research, OPS has a programmer/network administrator, GIS personnel, as well as a Data manager who takes charge of data processing (encoding, editing and validation), documentation, and storage. Administrative work is handled by a Human Resources Manager and a Finance/Grants Officer and their respective staff members. The OPS also has a pool of field research staff, office data editors, and encoders that are hired on a contractual basis for survey operations.

Research Services

The OPS has an established track record in conducting large-scale, multi-site, multi-level (person, household, community, facility, line agencies) surveys that require elaborate data collection protocols and the construction of complex, hierarchical data file structures. The OPS Research Fellows/Associates are also trained to analyze data, run statistical programs, and write research papers and grant proposals.

For more details on our governance, research portfolio and research collaborators, please visit the OPS website at: http://opsusc.org.

Longitudinal Cohort Study on the Filipino Child
Wave 2 Survey
OPS Project Management Team

Principal Investigator: Dr. Judith Rafaelita B. Borja
Co-Investigator: Dr. Nanette L.. Mayol

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                             Christian Sarlatan
                             Velyn B. Señor

Demographic Research and Development Foundation (DRDF, Inc.)

About Us

The Demographic Research and Development Foundation, Inc. (DRDF), established in 1983, is a non-stock, non-profit organization registered with the Philippine Securities and Exchange Commission that aims to promote and undertake research, training and other related activities in population and development. More specifically, DRDF as a group of population and development specialists aims to: (1) undertake studies in the general area of population and development; (2) lend technical expertise in planning, policy formulation, project conceptualization, project implementation, human resource development in population and development; and (3) disseminate important, policy-relevant and research-based information.

In pursuing its mission and vision, DRDF works closely with the University of the Philippines Population Institute (UPPI), with whom it has special working relationship and arrangements. DRDF is temporarily housed in the UPPI premises. They share library resources (e.g. books, journals, electronic references), facilities and human resources, creating a synergistic environment for the improvement of the quality of demographic studies and research outputs.

DRDF is an active player in the Philippine demographic arena, working closely with other organizations. It is an active member of the Philippine Population Association (PPA), Philippine NGO Council on Population, Health and Welfare, Inc. (PNGOC), and Reproductive Health Advocacy Network (RHAN). It is accredited by theDepartment of Science and Technology.

ACTIVE MEMBER:

ACCREDITED:
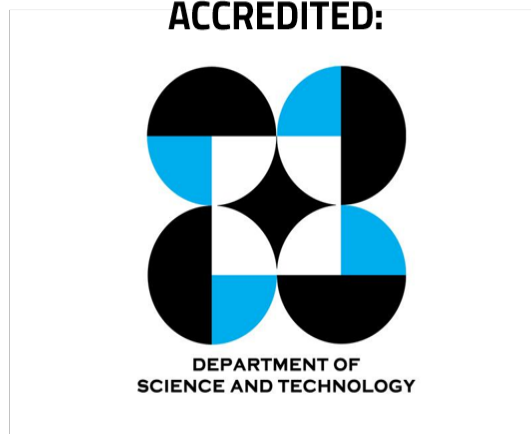
Longitudinal Cohort Study on the Filipino Child: Wave 2 Survey
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Demographic Research and Development Foundation (DRDF, Inc.)

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Field Supervisor: Ernesto C. Escanillan, Jr.	Sylvarstein Razner Sursigis
	Erwin C. Escanillan
	Maricar Ymata
	Norlyn Salazar
Field Supervisor: Cristina Javier	Gamela Ann Septo
	Rizal Alonzo
	Melanie Zamora
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Field Supervisor: Celia E. Abbago	Lorelie Joy Estudillo
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	Vanessa Mae Abril
	Abner Alusen
	Catherine Coronel
Field Supervisor: Andrea Baoalan	Erna Canale
	Lourdes Oliver
	Jane Cabalonga
	Glen Cabrera

CENTER FOR SOCIAL RESEARCH AND EDUCATION
Harnessing Research, Building Better Communities

The Center for Social Research and Education (CSRE) was established as the research arm, research coordinating body and grant-seeking center of the School of Arts and Sciences, University of San Carlos. It aims to establish strategic alliances and collaborative agreements with other research organizations and professional groups, and produce relevant, timely and interdisciplinary research that could be utilized in community development efforts. CSRE, formerly the Social Science Research Center, undertakes research and development work in areas that relate to: (i) environment (including disaster risk-reduction), water and sanitation; (ii) women, gender and health (including MCH, HIV and AIDS, reproductive health, ethno-medicine); (iii) food, culture and local knowledge; (iv) poverty, child labor and migration; and (v) other development-related concerns e.g. assessment and social acceptability. Technical assistance for community-based initiatives (community assessment, project planning, monitoring and evaluation) is also part of the services it offers. To do this, CSRE harnesses social science researchers and occasionally invites practitioners from other disciplines within and outside USC for endeavors that require their expertise. For many years now, the research associates and field personnel of CSRE have been involved in several collaborative undertakings, advocacy endeavors, consultancy, and networking activities.

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LONGITUDINAL COHORT STUDY ON THE FILIPINO CHILD
WAVE 2 QUANTITATIVESTUDY
LIST OF PROJECT STAFF

Project Coordinator:	Fiscalina Amadora-Nolasco
Field Supervisor:	Andrew John B. Fernandez
Cebuano Team A Leader:	Balatayo, Ma. Cristina
Cebuano Team A Interviewers:	Quiamco, Ana Ruth
	Sanchez, Cherryline
	Ceniza, Sean Ignatius
	Aldaba, Mary Cris Lyn
Cebuano Team B Leader:	Llopes, Fedilyn
Cebuano Team B Interviewers:	Ramas, Ralphie
	Casinillo, Lilibeth
	Señor, Velyn
	Toring, Romeo Jr.
Ilonggo Team Leader:	Doregnil, Lina
Ilonggo Team Interviewers:	Eucariza, Faith
	Desales, Jomel
	Jabican, Rhea
Waray Team Leader:	Recolito, Maria Amancia/Tampil, Flora/Lagbo, Paul Reynier
Waray Team Interviewers:	Retaga, Mat Dustin
	Oliva, Dayanara Dely
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RIMCU Profile

The **Research Institute for Mindanao Culture (RIMCU)** was founded in 1957 by Rev. Francis C. Madigan, S.J., PhD. RIMCU's mandate is the pursuit of high-quality social science research to advance the development of the Philippines, in general, and Mindanao in particular. RIMCU envisions of becoming a leading research institute in the country that produces high-quality research that informs both policy and practice in the areas of socially just and sustainable development. It aims to: a) pursue academic and research excellence, professionalism, interaction with its network in an inclusive and empowering environment; b) contribute to societal transformation and development through research and training; and c) engage in socially and ethically responsible and evidence-based advocacy.

RIMCU has conducted a considerable number of locally, nationally, and internationally funded studies. Moreover, it established not only a track record in research but also as a social and cultural center where research findings are generated and shared to a wider audience of students, policy-makers, line agency executives, local government units, non-government organizations, and research respondents/participants. Included in these research studies conducted are their engagements with the IP communities as well as in health-related issues.

To date, more than 600 research undertakings have been successfully completed and disseminated and to some extent utilized by planners and decision-makers. These undertakings cover a wide range of interest, such as:

- conflict situations, peace, and ethnic relations
- preventing/countering violent extremism
- operations research on health
- development studies (socio-economic and cultural factors of the development process)
- violence against women and children, women's concern and gender relations/issues
- sexual and reproductive health and rights
- demographic studies on mortality, fertility, and migration
- natural disasters
- poverty and employment-related issues
- ecological and environmental concern
- evaluation studies
- anthropological studies
- governance and democratization

The research experiences and skills are closely intertwined with education and training, communication and advocacy, and networking endeavors. The twin-affiliation of senior research associates in both the Institute and the Department of Sociology & Anthropology fuels and feeds upon their research and teaching in the academe.

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RIMCU envisions of becoming a leading research institute in the country that produces high-quality research that informs both policy and practice in the areas of socially just and sustainable development. It aims to: a) pursue research excellence, professionalism, and interaction with its network in an inclusive and empowering environment; b) contribute to societal transformation and development through research and training; and c) engage in socially and ethically responsible and evidence-based advocacy.

To fulfill its aim, RIMCU engages with policymakers, civil society, researchers and students to promote their use of RIMCU's research to strengthen their research capacity and to create opportunities for analysis, reflection and debate.

RIMCU conducts discussions and sharing of research outputs with stakeholders within and outside the university. Within the university, RIMCU shares research experiences and utilizes findings in appropriate courses/subjects. Doing so would increase students' awareness and appreciation of research and research utilization

Thus, it is reflected in its Strategic Plan for 2016-2018 under Mission 2 – "Contributes to societal transformation and development through Research and Teaching;" and under its Goal 3: Informed policymakers and practitioners. Its strategies are
1. Popularize research outputs in tri-media through linkages with academic units with communication courses
2. Establish strong linkages and partnership with GOs, NGOs, POs, and CSOs
3. Establish strong linkages with policy-makers, planners and political leaders
4. Conduct capability building project/activities in utilizing research outputs in policy-making

At present, the Institute Staff is composed of 8 senior research associates, an experienced administrative staff headed by the Institute's Operations Manager, data processing unit, and a pool of field operation's personnel (survey specialists/field supervisors and data collectors/ interviewers). It has also established a network of relationship and partnerships with the academe, LGUs, and NGOs.

RIMCU's research projects were funded locally, nationally, and internationally. International agencies include World Bank, USAID, DFAT (formerly AusAid), International Development Studies (IDS), UN agencies such UNICEF, UNFPA, ILO, WHO, and FAO, and Oxfam GB, among others; while local or national institutions include the Department of Health (DOH), the Philippine Commission for Health Research and Development (PCHRD), the National Commission for Culture and the Arts (NCCA), and the Philippine Center for Population and Development (PCPD).

UNFPA QUANTITATIVE – WAVE 2

TEAM	INTERVIEWER
Team 1	**Field Supervisor**
	ABILIJA, Rowena F.
	Field Interviewers
	JAMIN, Ildilyn I.
	Basilan
	1. DAGGONG, Nurima T.
	2. PIOH, Alshairra A.
	3. SALIP, Nasiba S.
	Sulu
	1. ANNUARI, Berhamin S.
	2. KASHIM, Alshim S.
	3. SANOH, Nasir A.
	4. NAGDER, Nurshida J.
	Tawi-Tawi
	1. GONZALES, Ferdiza M.
	2. HAKIM, Ramona
	3. JUMDANI, Alvin
	4. JAYARI, Al-Rahimin
	Zamboanga
	1. SALAPI, Nhurfaida E.
	2. NAGDER, Nurshida J.
	3. PIOH, Alshairra A.
	4. DAGGONG, Nurima T.
Team 2	**Field Supervisor**
	RODERO, Idna
	Field Interviewers
	PONDOC, Alberta A.
	TELECIO, Teofilo Jr. C.
	MABAQUIAO, Ricky John P.
	ANG, Valerie E.

Team 3	Field Supervisor
	VEGA, Prospercora S.
	Field Interviewers
	BARILLO, Eil Ryan E.
	ANG, Bobby Rey E.
	LINGCONG, Cindy A.
	RODERO, Paula
Team 4	Field Supervisor
	BOAC, Vergil
	Field Interviewers
	GUIMALAN, Pamela Pauline A.
	ELAGO, Alyanna Marie D.
	VERANO, Joel M.
	UCAT, Roxendo Jason A.
Team 5	Field Supervisor
	MONTEJO, Michael Lou U.
	Field Interviewers
	BRIONES, Esther V.
	CAMACHO, Gennie C.
	SUTACIO, Rex Adryann R.
	BACOL, Marilou G.

APPENDIX 3

LONGITUDINAL COHORT STUDY ON THE FILIPINO CHILD
Wave 2 Survey
Data Collection Protocol Overview

Data collection period: January to March 2018

Project management:

Fund management: United Nations Population Fund (UNFPA)

Study implementation and oversight: USC-Office of Population Studies Foundation, Inc. (OPS)

Research collaborators:

Luzon:	Demographic Research and Development Foundation (DRDF)
Visayas:	Center for Social Research and Education (CSRE)
Mindanao:	Research Institute for Mindanao Culture (RIMCU)

Operational Objectives:

This prospective cohort study is designed to observe Filipino boys and girls from 2016-2030, or throughout the implementation of the Sustainable Development Goals (SDG) Agenda. The goal is to put a human face to the SDGs by assessing how the policies and programs fulfilling the SDG Agenda influence the lives of a cohort of Filipinos from childhood (age 10) through adulthood (age 24).

The Baseline or Wave 1 survey was conducted from October 2016 to January 2017. The plan is to conduct follow-up surveys every year from 2018 to 2020, then at two-year intervals from 2022 to 2030. For each survey round we will collect data on the cohort participants or index children (IC) and their mothers or main caregivers, households and communities.

Study sample:

The sample is distributed across Luzon, Visayas and Mindanao and is proportionate to the number of 10 year-old boys and girls in each island group. The sampling design ensured that marginalized sectors, specifically children in indigenous communities and children with disabilities, are included in the frame. The study aims to retain about 2000 of the cohort participants by the Endline Survey in 2030. To achieve this, the Baseline Survey sampling frame included 5175 ten-year old boys and girls equally distributed across three island groups. ***The Wave 2 sampling frame consists of the 4952 households with ICs enrolled at Baseline.***

	Luzon	Visayas	Mindanao	TOTAL
No. of barangays enumerated (community surveys)	115	115	115	345
Expected households to be interviewed (15/barangay)	1,725	1,725	1,725	5175
No. of households screened	26,729	12,763	21,491	60,983
No. of households interviewed	1,618	1,639	1,695	4,952
No. of ICs interviewed	1,600	1,639	1,693	4,932

Wave 2 Sample

Follow-up surveys will continue to collect data on households with ICs. Specifically, for **Wave 2, we will continue to enroll IC households remaining in the same baseline municipality or city.** To minimize attrition, we will aim to enroll as many **OUTMIGRANT ICs**, the term we will use for ICs who have moved out of the Wave 2 recruitment area or the baseline municipality or city. **The project management at OPS must be immediately informed of such cases**. Project management teams at UNFPA, OPS, CSRE, DRDF, RIMCU will decide, on a case-to-case basis, on which outmigrant ICs to tract within the limits of project resources.

Strategies in locating baseline sample.
In tracking the IC Households, we first need to track the Baseline Household Respondents who gave us consent to interview the IC. If the Baseline Household Respondent is not located, we identify a new Household Respondent or IC Caregiver (household member > age 17 who is mainly responsible for the care of the IC) and obtain consent to interview the IC.

Prior to actual data collection, the 4952 Baseline Household Respondents will be contacted as follows:

Step 1: Phone Tracking. Calls will be made to all 4952 respondents using the cell phone numbers they provided at baseline. Once contact is made, the whereabouts of the index child is determined and current address is verified.

> Materials needed:
> a) Master List – with address and main phone numbers (printed and electronic file)
> b) List of respondents' with second set of phone numbers (printed and electronic file)
> c) Monitoring Sheet (printed) –   for recording names of new household respondents, new addresses and phone numbers
> d) IC Tracking Protocol and Script: Phone Tracking Script

> Decision flow:
> a) If Baseline Household Respondent reached:
> > Respondent with IC:
> > > In same baseline address or municipality/city: schedule interview
> > > Outmigrant: inform OPS
> > Respondent NOT with IC but IC still alive: get information on new caregiver
> > > In same baseline address or or municipality/city: schedule interview
> > > Outmigrant: inform OPS
> b) If Baseline Household Respondent NOT reached: obtain as much contact information on
> > Baseline Household Respondent and track by phone.

Important!: refusals for scheduling in the phone tracking should be confirmed with a home visit. At this point IC Attrition form should not yet be filled up unless a home visit (Step 2 below) is not possible.

Step 2: <u>Baseline Barangay Tracking.</u> Whether Baseline Household Respondents are reached by phone, or not, a visit to the baseline address is required (unless a new address has been confirmed by phone and a home visit has been scheduled).

Materials needed:
a) Master List – with address and main phone numbers (printed and electronic file)
b) Monitoring Sheet (printed) – for recording names of new household respondents, new addresses and phone numbers
c) List of Interview dates and Names of Baseline Interviewers per Baseline barangay
- this is needed in screening for correct identities of Baseline Household Respondent and IC
d) IC Tracking Protocol and Script: Home Visit Tracking Script

<u>Decision flow:</u>
a) If Baseline Household Respondent reached and IC in household:
  Validate identities: Household Respondent (Screener 1) and IC (Screener 2)
  Schedule interview
b) If only IC in household:
  Validate identity of IC (Screener 2)
  Identify eligible new Household Respondent
  Schedule interview
c) if only Baseline Household Respondent is reached: obtain IC contact info
  If IC in same baseline address or municipality/city: schedule interview
  If outmigrant IC: inform OPS

If IC Household could not be scheduled for an interview: fill out the IC Attrition form.

If IC identity verified AND Baseline Household Respondent or the new Household Respondent agrees to be interviewed ***proceed with consenting process (see Wave 2 home visit components).***

Wave 2 Community Survey:

Prior to conducting home visits in the Baseline barangays (or new barangays where outmigrant ICs are residing, courtesy calls must be made to the **Municipal/City Mayor AND the Barangay Captains.**

We will also collect information about the barangay where the IC is residing. Multiple key informants will be interviewed and secondary data will be collected for this survey. This survey is expected to be completed at the completion of all household interviews in the barangay.

Instrument:
a) Wave 2 Community Survey Questionnaire

Wave 2 home visit components:

Data on the IC household will be conducted through home-based interviews. The IC's mother will be the main respondent. In her absence, the IC'S main caregiver will be interviewed. The IC will be interviewed at home at his/her convenient time (usually before school, at noon, after school, or on weekends).

1. Consenting process
>Important: please obtain respondents' contact information and alternate contact
> information

>Instrument:
>a) Wave 2 Consent Form (please complete 2 copies, leave one copy to the household
>respondent)

2. Household Respondent interview– with either the IC's mother or main caregiver as respondent. If caregiver, some sections specific to the IC mother will be skipped.

>Instruments:
>a) Form 1: 2018 Wave 2 Household Survey Questionnaire
>b) Child Behavior Checklist (CBCL)
>c) CBCL intro script

3. IC components – data on the ICs will be collected through a direct interview as well as using self-administered modules

>Instruments:
>a) IC Assent Form (**Important!:** please read intro script before each component)

>b) Raven's Standard Progressive Matrices (Important!: administer first among components)
>Raven's administration protocol script

>c) Form 2: 2018 Wave 2 Index Child Interviewer-Administered Questionnaire
>This includes weight and height measurements

>d) Form 3: 2018 Wave 2 Index Child Self-Administered Questionnaire
>Questionnaire pages for filling out (2 pages)
>**Important!:** please bring an envelope for filled out self-administered questionnaire

>e) Pubertal Assessment (for either Male or Female IC)
>Pubertal assessment administration script
>Answer Sheet (2 pages with just the drawings)

4. At the completion of the protocol, we will give (these are standard for all study areas):

>a) P200 to the household respondent (the person who was interviewed!)
>b) Set of gel pens for the ICs.
>c) IC height and height card – WITH TODAY'S WEIGHT AND HEIGHT MEASUREMENTS

Data collection teams:

There will be 4-5 teams per domain, with 1 Team Leader and 4 interviewers per team. Interviewers will conduct the household interviews and are responsible for field editing their completed questionnaires. The team leader oversees all operations within the team, and does the final field editing of all completed questionnaires. He or she is the lead interviewer for the community questionnaire (with assistance from the interviewers).

Ethics Review and Consenting Process

The OPS has a Child Protection Policy and all data collection will comply by these guidelines. The study protocol, copies of the survey instruments and consent forms (English and translated in applicable languages) was reviewed by the University of San Carlos Institutional Ethics Review Committee. Interviews of cohort participants (for surveys where cohort participants are below 18) will require parental permission. Proper consenting procedures (informed consents, brief orientation of respondents on what the study is about and their participation) will be administered prior to the collection of any data from the household. The respondents can withdraw from the study at any point during the current home visit and in follow-up visits. In extreme cases where the safety of the interviewers is threatened during the visit scheduling or in the course of the home visit, we have the option to withdraw the respondent's participation in the current and upcoming surveys. Standard procedures in maintaining data confidentiality and the protection of study subjects will be observed.

All personnel involved in this study will be required to sign the OPS Confidentiality and Child Protection Agreement Form.

APPENDIX 4

UNIVERSITY of SAN CARLOS
SCIENTIA · VIRTUS · DEVOTIO

CERTIFICATE OF APPROVAL

January 17, 2018

PROTOCOL NUMBER :   068/2017-12-borja

PROTOCOL TITLE :   Wave 2 Survey for Longitudinal Cohort Study on the Girl and Boy Child

RESEARCH TEAM :   Dr. Judith R. Borja

SPONSOR(S) :   United Nations Population Fund

STUDY SITE :   Luzon, Visayas and Mindanao

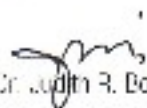TYPE OF REVIEW :   ✓ Full Review   _____ Expedited Review

This is to inform you that your study has been reviewed and **APPROVED** by the University of San Carlos Research Ethics Committee (USC REC) for *1 year* from *January 17, 2018 to January 16, 2019.*

Please take note of your responsibilities:

- submission of *Study Completion Report Form* and *Final Report* to USC REC within the approved period;
- comply with all relevant international and national guidelines and regulations; and
- abide by the principles of ethical research.

Atty. ArchHill Niña F. Capistrano
Chair, USC REC

Conforme:

Dr. Judith R. Borja
Date: 1/19/18

CONSENT FORM FOR MOTHERS AND CAREGIVERS

Consent Form Approval Date: January 17, 2018

Title of Study: LONGITUDINAL COHORT STUDY ON THE FILIPINO CHILD (Wave 2 Survey)

Fund Management: United Nations Population Fund (UNFPA)

Study Contact:
Judith Rafaelita B. Borja
Director
USC-Office of Population Studies Foundation, Inc. (OPS)
Telephone number: 63-32-3460102
Email: opsfoundation@opsusc.org

What you need to know about this study and participating in this study

Research studies are done to obtain new information to help us learn more about certain aspects in life that may help people in the future. People like you are asked to participate in these studies so that researchers can collect important information for their research.

The **USC-Office of Population Studies Foundation, In**c., with the **Center for Social Research and Education of the University of San Carlos** in Cebu City, **Demographic Research and Development Foundation of the University of the Philippines** in Diliman, Quezon City and **Research Institute for Mindanao Culture of Xavier University** in Cagayan de Oro City are conducting a research on a group of children from the time they are age 10 until they reach the age of 24. The purpose of this study is to find out how their lives are changed by programs that are run by the government and non-government agencies. This information is important because the country is implementing special programs under the Sustainable Development Goals Agenda which are aimed to improve the health and well-being of all Filipinos. These programs will be implemented until 2030 or when these children reach the age of 24.

When we started this project about a year ago, your household was among the households in your community which was selected to participate in this study. NAME OF INDEX CHILD, who was then 10 years old, is among the children we wish to study until the age of 24. Not everyone is asked to participate in a research project. Our researchers followed a special procedure in selecting households with 10-year old children for this study.

In our first visit to your household, we interviewed you (or NAME OF BASELINE HOUSEHOLD RESPONDENT) and <u>NAME OF INDEX CHILD</u>. You agreed to have our researchers visit you and <u>NAME OF INDEX CHILD</u> again in the next few years.

This year, we would like to interview you and <u>NAME OF INDEX CHILD</u> once again. Participation in the study is voluntary. Even if you have already agreed to participate, you may withdraw from the study for any reason and at any time without penalty. You can also choose to participate in some parts of the study but not others. The researchers also have the right to stop your participation at any time. This may happen because you have failed to follow instructions, or because the entire study has been stopped.

You should not hesitate to ask me any question you may have about this study. When I have answered all your questions, you can decide if you want to remain in the study or not.

How many people will take part in this study?

<u>(NAME OF INDEX CHILD)</u> is one of about 5,000 children across the country who are participating in this study.

How long will your participation last in this study?

For this year, we will visit your household at least twice. Each visit may take about 1-2 hours. If you agree to participate in this study, we can start today or whenever it is convenient for you while our research team is in your area.

In the next few years you and <u>NAME OF INDEX CHILD</u> will be visited again in your home until 2030 or until he/she reaches the age of 24.

What will happen if you take part in the study?

1. Just like in our first visit, we will ask you questions about your household, family, work, pregnancy experiences and family planning, and health.

2. You will once again be asked questions about the schooling, health, diet, activities and behaviors of <u>NAME OF INDEX CHILD</u>. His/her height and weight measurements will again be taken.

3. With your permission and if <u>NAME OF INDEX CHILD</u> agrees to do this, we will ask him/her some questions about friends, his/her experiences and opinions on certain things. We also have a questionnaire which he/she will fill out him/herself. We will also be giving <u>NAME OF INDEX CHILD</u> a test to measure how he/she thinks and reasons. We will also show him/her drawings of a child's body and ask which drawing is closest to his/her body.

INTERVIEWER: SHOW MOTHER/CAREGIVER COPIES OF THE QUESTIONNAIRES.

What are the possible benefits for being in this study?

There are no direct benefits to you for participating in this study. However, what we learn from the study may be useful in improving government and non-government programs. Thus, we feel that you are making a very important contribution. You will know about <u>NAME OF INDEX CHILD</u>'s height and weight at each visit. We will provide you a card which records his/her weight and height measurements from the previous visit and how these compare to those of children his/her age.

What are the possible risks or discomforts involved from being in this study?

We think the risks related to your participation are very small. Some of the questions may make you uncomfortable, but you can choose to not answer these questions. None of the measurements we will take on your child will cause him/her any physical discomfort or pain.

All the information you give will be kept confidential. There is a very small chance that someone who is not part of this research might learn of your responses to our questions. We will take great care to prevent this from happening.

How will your privacy be protected?

Participants in this study will NOT be identified in any report or publication about this study. Except for the researchers involved in this study, no one else will know about your responses to our questions or of the results of our measurements. All documents related to this research study will be kept in locked files at the offices of participating research institutions. Only authorized research personnel will have access to your name, address and phone numbers.

Will you receive anything for being in this study?

In appreciation of your time, you will receive P200 and a small gift for NAME OF INDEX CHILD for completing the study this year. We will also give you a card with the weight and height measurements of NAME OF INDEX CHILD.

Will it cost you anything to be in this study?

There will be no costs to you for being in the study.

What if you have questions about your rights as a research participant?

If you have questions, complaints, concerns, or if an injury occurs as a result of this visit, you should contact the researchers listed on the first page of this form. All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. The project has been reviewed and approved by the Institutional Ethics Review Committee at the University of San Carlos in Cebu City, Philippines. This group is responsible for judging whether research participants are treated fairly and not exposed to harm. If you have questions or concerns about your rights as a participant in this study, or if you would like to obtain information or offer input, you may contact:

Institutional Ethics Review Committee
University of San Carlos Talamban Campus
Email: usc.ierc@gmail.com
Tel: 2547742 and 2531000 loc 204

Do you agree to participate in this study?

Do you give your consent to participate in this study this year and in the next visits?
___ YES   ___ NO

IF CONSENT IS GIVEN TO PARTICIPATE:

Do you give your consent for our research team to measure <u>NAME OF INDEX CHILD's</u> height and weight?
___ YES   ___ NO

Do you give your consent for our research team to directly ask questions to <u>NAME OF INDEX CHILD</u>?
___ YES   ___ NO

Do you give your consent to have <u>NAME OF INDEX CHILD</u> fill out our questionnaire on his own?
___ YES   ___ NO

Since you have agreed for us to visit you again in future surveys *in the next few years* being able to reach you will be important to us.

May we ask for a cell phone number where we can reach you?
___ YES   ___ NO

Will you give us permission to contact other members of your family or a close friend, in the event that we have problems in reaching you for our future visit?

___ YES   IF YES: Will you kindly ask their cell phone numbers for us? Please tell them too that you
                 will be giving us their numbers.
____NO

Certification of interviewer obtaining consent:

I certify that I have read and explained the contents of this consent form to the respondent. The respondent's responses above were given freely without any due influence from me.

_____   _____

Printed name and signature of study staff obtaining consent   Date

_____

Printed Name of Research Participant

IC ASSENT FORM

INTRO SCRIPT: Hello, my name is _____ and I am a researcher/interviewer from <u>DRDF, RIMCU or CSRE</u> (SHOW YOUR ID). I am here because your household has been chosen to participate in a research study about the health and well-being of children your age. I have already talked to your mother (or MENTION HIS/HER RELATIONSHIP TO CAREGIVER) to ask some questions about your household and you. Just like what was done in our last visit, I will ask you a few questions too, about your schooling, your activities, the things you like to do, your friends and other questions like these. I will measure your weight and height. In this visit, I will be showing you some drawings and ask you a few questions about these. No one else except me and our researchers will know about your answers. All these will take about an hour.

Are you okay with all these? Do you have any questions? IF CHILD GIVES ASSENT START WITH A.

A. PRIOR TO ADMINISTERING THE RAVEN'S SPM PLEASE READ THE PROTOCOL SCRIPT

IF CHILD GIVES ASSENT: PROCEED WITH ADMINISTERING RAVEN'S SPM.

B. PRIOR TO ADMINISTERING THE INTERVIEWER-ADMINISTERED QUESTIONNAIRE:

Now I have some questions for you, is that okay with you?

IF CHILD GIVES ASSENT: PROCEED WITH INTERVIEWER-ADMINISTERED QUESTIONNAIRE

C. PRIOR TO ADMINISTERING THE SELF-ADMINISTERED QUESTIONNAIRE, SAY:

Now I have a few more questions for you, but this time, I will ask you to read the questions yourself and write down your answers on this questionnaire (SHOW QUESTIONNAIRE). Please give your most honest answers. There are no right or wrong answers for any of these questions.

Are you willing to fill out this questionnaire? Before we start do you have any questions?

IF CHILD GIVES ASSENT:

Please mark your responses to the questions with a **check** (√). If you don't know the answer or don't want to answer the question, just leave it blank. Please only check one answer –either check the space for YES or NO. After you finish answering, please fold the page, place it inside the envelope and seal it.

D. PRIOR TO ADMINISTERING THE SMR:

Now I will show you drawings of a child's body. I will ask you to choose which drawing is closest to how your body looks at this time. A child who is growing experiences changes in his/her body. These drawings show the different changes that happen to a child's body as he/she grows up to become a teenager, then later into an adult. Once again, no one else except me and our researchers will know about your answers. Are you willing to do this?

SHOW THE CHILD THE CORRESPONDING SMR SETS FOR MALES AND FEMALES. MAKE SURE THE CHILD GIVES ASSENT BEFORE PROCEEDING WITH THE MODULE.

APPENDIX 5

USC-Office of Population Studies Foundation, Inc.
University of San Carlos
Talamban, Cebu City, Philippines
Phone #: (63-32) 346-0102, Fax #: (63-32) 346-6050
Website: http://opsusc.org

Data Confidentiality and Child Protection Agreement

This confidentiality agreement takes effect on this date: _____ between the USC-Office of Population Studies Foundation, Inc. (OPS), University of San Carlos, Talamban Campus, Cebu City, represented by its Director, Dr. Judith Rafaelita B. Borja and

Name of Researcher: _____

Residing at: _____

This agreement is to acknowledge that any data gathered in the conduct of the **Longitudinal Cohort Study on the Filipino Child (Wave 2 Survey)** including names, addresses, and contact information of study participants are confidential. As a Researcher involved in this study, I agree to respect and preserve the privacy, confidentiality, and security of these information. I also fully understand that I am not allowed to disclose any of these information in writing, orally or otherwise to unauthorized study personnel or people who are not part of this OPS study including family members and friends of the study participants.

I further certify that I have read the OPS Child Protection Policy and have been briefed on its guidelines. I agree to abide by these guidelines throughout the conduct of this study.

The parties agree to this agreement by executing this below

_____   _____
Signature and Printed Name of Researcher   Date Signed

Judith Rafaelita B. Borja
OPS Director
Lead Investigator

The OPS Child Protection Policy

The OPS is an academic research institution that conducts data collection, other research-related and outreach activities involving direct contact with children and their caregivers. As an institution and as individuals, we advocate for the rights, protection and general welfare of children. Through the years, the OPS research activities have included studies that increase knowledge and inform policies on the improvement of children's nutritional status, physical and cognitive health, as well as their health and social capital potentials as adults.

We therefore abide by the Philippine government's stand regarding the rights and protection of children as mandated in Article XV, Section 3 of the 1987 Constitution[2], stating that the "*State shall defend… (2) The right of children to assistance, including proper care and nutrition, and special protection from all forms of neglect, abuse, cruelty, exploitation, and other conditions prejudicial to their development;*".

All OPS staff (management officers, personnel and research collaborators) are asked to abide by this mandate in their professional and personal lives. All activities conducted in the name of OPS will ensure the general safety and protection of the children that OPS staff are in direct contact with, or have direct knowledge of by way of our data collection or outreach activities.

All OPS staff will be informed and briefed of this policy. Strict compliance of the policy guidelines presented below takes effect **25 September, 2015.**

Definitions
1. *Children* refers to persons under the age of 18.
2*.* The term *OPS staff* refers to:
> OPS management officers: OPS Board of Trustees, Director, and Management Council
> OPS personnel: all OPS Fellows, Research Associates, and regular/contractual/daily office and field staff
> OPS research collaborators: all local and international experts/researchers/consultants conducting research or related activities in the name of OPS.
3. The term "OPS activity/ies" refers to data collection, research-related, outreach or any other activities conducted in the name of OPS
4. The term "child abuse" refers to the neglect or physical, sexual, verbal or psychological abuse of a child and other forms of child cruelty or maltreatment specified in DepEd Order No. 40, s. 2012.
5. The term "child exploitation" includes sexual and economic exploitation and refers to any form of using a child (which often translates to child abuse) for someone's advantage or gratification as specified in DepEd Order No. 40, s. 2012.

CHILD PROTECTION POLICY GUIDELINES

1. All members of the OPS staff must:

a) immediately report to authorized *barangay* officials **any verifiable evidence or justifiable concern that a child is a victim of abuse or exploitation;**

b) upon consultation with authorized officials and whenever possible within their capacities, assist children who are victims of child abuse or exploitation with the children's general welfare and safety in mind;

c) when called upon by authorized officials, cooperate fully and confidentially in any investigation of concerns and/or allegations of child abuse/exploitation;

d) ensure that audio recording, photographs and videos of children that are used professionally and personally are decent and respectful, not sexually suggestive, and not subject to abuse by any irresponsible members of the public;

e) avoid involving children in any activity or undertaking that presents any possibility of putting the children at risk of abuse/exploitation

2. All members of the OPS staff must *never*:

a) physically hurt or abuse children;

b) engage in any form of sexual activity or inappropriate behavior, or have sexual intercourse with children. Claiming being misinformed of the child's age is not an excuse;

c) engage in a relationship with children that could in any way be deemed exploitative or abusive;

d) treat children or behave in the presence of children in ways that may be inappropriate, sexually provocative or abusive

e) use language, make suggestions or offer advice which is inappropriate, offensive or abusive to

 children;

f) spend an inappropriate time alone with children with whom they are working. **All data collection activities will be conducted within sight of mothers or responsible adult household members (but not within hearing distance).**

g) sleep in the same room with children with whom they are working

h) condone or participate in any activity involving children that are illegal, unsafe, abusive or exploitative;

i) behave in ways intended to shame, humiliate, belittle or degrade children, or otherwise perpetrate any form of emotional abuse on children;

j) discriminate against, show unfair differential treatment to, or favor particular children to the exclusion of others;

k) engage or assist in the negotiation of any financial settlement between the family of a child victim of

sexual abuse or exploitation and the perpetrator.

3. The following applies to all OPS activities:

a) If any of the incidences cited in #1 and #2 above is encountered in the course of an OPS activity: **immediately report this to your direct OPS supervisor** or the Director for immediate proper assessment and action.

b) Notify your direct OPS supervisor or the Director of any concerns regarding an OPS staff member violating any of the items in #1 and #2.

c) All OPS activities that require direct contact with children **must be done with the consent of the children's parent(s) or legal guardian(s).**

d) The design, supervision and implementation of data collection activities involving children or households with children must comply with the OPS Child Protection Policy and the Institutional Review Board (IRB) child protection stipulations specific to a research grant/ project. All involved OPS staff must be trained on and monitored for compliance with said OPS/IRB stipulations.

e) All physical assessments required in data collection (e.g. anthropometric measurements, biospecimen extraction) on children must be done under the supervision of a parent, caregiver or a responsible adult member of the household

f) **All data, whether quantitative, qualitative, voice (audio) or image (photographic or video)** involving children must be kept confidential, and used only for research purposes (without personal identifiers) by authorized researchers and in compliance with the OPS Child Protection policy.

g) All OPS staff undertaking any new OPS activity involving children must undergo an OPS Child Protection policy briefing.

APPENDIX 6

LONGITUDINAL COHORT STUDY ON THE FILIPINO CHILD
Wave 2 Survey Training

Training Schedule

Date/Time	Topics covered	Person in charge
Day 1: **AM**	Wave 2 Survey overview Tracking of Index Children (ICs) Wave 2 Master List/Sample Monitoring Sheet Respondent/IC identity verification Confidentiality and Consenting Process Home visit and interview protocols	Judith Borja
Day 1: **PM**	Anthropometric measurements (IC) Form 1: Household Questionnaire Block ID: ID/Call Record Block X: Info asked if new household respondent/new address Block A: Household Composition	Nicola Belarmino Lorna Perez Marilyn Cinco
Day 2: **AM**	IC anthropometry reliability runs Block A: Household Composition Block B: Basic Utilities, Sanitation	Nicola Belarmino Lorna Perez Marilyn Cinco
Day 2: **PM**	IC anthropometry reliability runs Block B: Basic Utilities, Sanitation (con't) Block C: Household Assets	Nicola Belarmino Lorna Perez Marilyn Cinco
Day 3: **AM**	Block D: IC Schooling/Employment Block E: Food Insecurity Experience Block F : Access to Facilities	Lorna Perez Marilyn Cinco
Day 3: **PM**	Block G: IC's mother: Preg/FP updates Block H: Violence Against Women Block I: Morbidity/Health Care Block J: Other Health Information on IC Block K: Index Child Diet Diversity Block L: Stress Scale and Depressive Symptoms	Lorna Perez Marilyn Cinco
Day 4: **AM**	Raven's Standard Progressive Matrices	Dr. Delia Belleza
Day 4: **PM**	IC anthropometry reliability runs Child Behavior Checklist Form 2: Index Child Interviewer-Administered	Nicola Belarmino Dr. Delia Belleza Lorna Perez Marilyn Cinco
Day 5:	Form 3: Index Child Self-Administered Questionnaire Sexual Maturity Ratings Form 4: Community Survey	Judith Borja Lorna Perez Marilyn Cinco
Day 6: **AM**	Child Behavior Checklist (wrap-up) Basic Psychological First Aid	Dr. Delia Belleza
Day 7: **PM**	IC tracking sheet Wave 2 Sample Monitoring Sheet Results of reliability runs Final reminders	Judith Borja Lorna Perez Marilyn Cinco