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The State of Health of Migrant and Non-Migrant Filipino Families

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The State of Health of Migrant and Non-Migrant Filipino Families

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Introduction

One of the most popular narratives regarding left-behind families is that children are at a disadvantage when one or both parents are working overseas. The scientific findings on health outcomes, however, has been mixed. On one hand, some literature supports this narrative: Left-behind children have been shown to have poor physical and mental health and to engage in poor health behaviors like alcohol misuse and smoking (Dominguez & Hall, 2022; Fellmeth et al., 2020; Yang, 2022). It has also been noted that the children's carers may be less attentive than the primary caregivers, which contributes to low help-seeking behaviors and negative health outcomes (Dominguez & Hall, 2022).

On the other hand, some findings contended that health outcomes were comparable between children from migrant and non-migrant households (Dominguez & Hall, 2022). Other studies even found that health outcomes were better among children from migrant families (Asis, 2006; Jampaklay et al., 2013). Such findings may be due to virtual communication, which facilitates contact and bonding, consequently helping bridge the distance (Garabiles et al., 2017). Remittances also foster economic mobility and better living conditions (Jordan et al., 2024). Improved coping skills to manage physical separation was also cited (Asis, 2006), along with involved caretaking from the left-behind parent and other relatives (Asis, 2006; Garabiles et al., 2017).

This report aims to contribute to the knowledge about parental migration and health outcomes using the Child Health and Migrant Parents in South-East Asia (CHAMPSEA) Wave 3 dataset. The Philippines has been part of the CHAMPSEA research project since 2008. Three rounds of data collection were carried out in 2008 (Wave 1), 2016 (Wave 2) and 2023 (Wave 3) among migrant and non-migrant households in Bulacan and Laguna (see Appendix for further details). This report examines the levels of physical and mental health of young children and young adults from migrant and non-migrant households. Moreover, this report investigates the physical and mental health levels of carers of young children, a sample that has been overlooked in the literature. Key findings are organized according to the health outcomes of the carers of young children, the young children and the young adults.

Participants

The carers and the young children were new samples in CHAMPSEA Wave 3.

For this report, data from 505 carers of young children was analyzed. Of this number, 257 (51%) came from migrant families, while the remaining 248 (49%) were from non-migrant families.

Most of the carers were the children's mothers, more so in non-migrant families (38%) than migrant families (25%). On the other hand, there were more maternal and paternal grandmother carers in migrant families (13%) than in non-migrant families (5%).

The age of the carers ranged from 20 to 81, with a mean of 39.7 (SD = 12.71). The carers from migrant families were older (M = 42.8, SD = 13.2) than the carers from non-migrant families (M = 36.2, SD = 11.1), possibly because there were more grandparents in the former. On average, the carers have been caring for the child for 55.0 months (SD = 16.8) or about 4.6 years. Those from migrant families have cared for the child slightly less (M = 52.7 months or 4.4 years, SD = 17.7) than the those in non-migrant families have (M = 57.4 months or 4.8 years, SD = 15.4).

Each day, both groups of carers spend a comparable amount of time with the target young child (M = 16.5, SD = 7.8). Sixty-four percent of the carers also took care of at least one other child, while 36% also worked. Fifty-two percent of the carers had another person helping them tend to the child.

All the measures on the young children's health were answered by the carers; thus, all information were from the carers' perspectives. The 505 young children had an average age of 4.4 (SD = 1.12), with a range of 2-6 years old: 51% were male and 49% were female; 74% have not entered school yet, while 25% were in preschool. Two hundred fifty-seven of the young children (51%) came from migrant households, while the remaining 248 (48%) were from non-migrant families. No differences in demographic information were found between migrant and non-migrant families.

The young adults were young children (3-5 years old) in Wave 1, in middle childhood (9-11 years old) in Wave 2, and were young adults (17-21 years old) in Wave 3. The data on young adults had a sample size of 311. Forty-nine percent were male and 51% were female. On average, they were aged 19.17 years (SD = 0.9), with a range of 17-21 years old. There was a subsample of 63 young adults (20%) from migrant families, while the remaining 253 young adults (80%) were from non-migrant families. There were no differences in age, gender, and educational attainment based on the migration status of their household.

Data analysis

To analyze the three datasets, the mean, standard deviation, and frequencies were computed. Further, several statistical techniques were used, with the significance level set at 0.05. To compare two different groups (e.g., migrant families versus non-migrant families), independent samples t-tests and chi-square (χ^2) were used. To compare the same group (e.g., before and after the pandemic), paired samples t-tests and repeated measures ANOVA were used. Lastly, mixed-methods design ANOVA was used to investigate differences between groups across time. Jamovi version 2.3.8 was used to run all analyses. For brevity, the tables in this policy brief have been simplified. Expanded and detailed tables can be obtained upon request from the author or the Scalabrini Migration Center.

Health of the carers of young children

The carers gave an overall rating of their physical health twice. They rated their physical health before the pandemic or before March 2020, and after the pandemic or during the time of the interview. They used the following scale: 1 = excellent, 2 = very good, 3 = good, 4 = fair and 5 = poor. The carers gave an overall rating of their mental health and their isolation levels, both before and after the pandemic. For the overall rating of their mental health, they used the scale where 1 = excellent, 2 = very good, 3 = good, 4 = fair and 5 = poor. For isolation levels, they used the scale of 1 = never, 2 = rarely, 3 = sometimes, 4 = most of the time and 5 = always. They also evaluated their psychological distress levels (e.g., depression, anxiety and psychosomatic symptoms) in the last 30 days, using the 20-item Self-Reporting Questionnaire (SRQ)[1], where 0 = no and 1 = yes.

Social support was measured in several ways: (1) if there was anyone there for them when they had problems [0 = no, 1 = yes], (2) if they received caregiving assistance [0 = no, 1 = from an individual/s, 2 = from an organization/s, 3 = from an individual/s and an organization/s], (3) if they knew the people in their neighborhood [0 = no, 1 = yes], (4) if they thought their neighbors were sources of support [0 = no, 1 = yes], and (5) if they knew anyone or any group assisting migrants [0 = no, 1 = yes].

The carers perceived their overall physical health as good, both pre-pandemic and post-pandemic. However, the carers in migrant families fared better, having better ratings of their current overall physical health than the carers in non-migrant families (see Table 1).

For all carers, overall mental health and isolation levels have gotten worse post-

[1] The Self-Reporting Questionnaire (SRQ) is a screening tool answerable by yes or no developed by the World Health Organization to identify symptoms of psychological distress (Beusenberg et al., 1994).

Table 1. Results on carers' health.

Carers' variables	Total sample (N = 505)	Migrant families (n = 257)	Non-migrant families (n = 248)
Physical health (*M*)			
Physical health before the pandemic	2.30	2.32	2.40
Physical health after the pandemic*a	2.39	2.31	2.52
Mental health and support system (*M*)			
Mental health before the pandemic+	2.36,	2.28,	2.33
Mental health after the pandemic*b	2.41	2.33	2.45
Psychological distress*c	4.12	3.73	4.53
Isolation levels before the pandemic	7.96	7.87	8.05
Isolation levels after the pandemic***d	8.63	8.65	8.60
Social support system (%)			
If there is anyone for them (Yes)	97	98	96
If they received childbearing support (Yes)	6	5	6
If they knew the names of their neighbors (Yes)	88	8	90
If neighbors are a source of support (Yes)	68	72	65
If they knew of anyone assisting migrants (Yes)	2	2	2

Notes: (a) Better among carers in migrant families (F(1,503) = 4.73, p < 0.05);
(b) Worse overall mental health post-pandemic (F(1,501) = 5.18, p < 0.05);
(c) Less among carers from migrant families (*Welch's t* =-2.36, p < 0.05);
(d) Greater isolation post-pandemic (F(1,503) = 31.04, p < 0.001).
* p < 0.05
*** p < 0.001

pandemic, and this did not differ based on migration status. In terms of psychological distress, though, the carers from migrant families had lower levels than those from non-migrant families.

While almost all of them (97%) had someone to turn to when they had problems, they hardly received childrearing support. Most of the carer-respondents knew their neighbors (88%), though only 68% saw them as sources of support. Further, only 2% knew anyone or any group providing assistance to migrant families. For these variables, there were no differences between migrant and non-migrant families.

Health of young children

The carers were asked to evaluate the health status of the young children. First, they answered how much healthier the children were compared with other children their age (1 = much more, 5 = much less). Second, they rated the young children's overall physical health, both pre- and post-pandemic (1 = excellent, 5 = poor). Third, they were asked if the young children experienced any illnesses during the past two weeks (0 = no, 1 = yes). They were presented with several illnesses, such as high fever, malaria, diarrhea, etc. Fourth, they reported if the young children were involved in any accident (0 = no, 1 = yes). Fifth and last, the carers were asked about the young children's immunization history. This included questions on whether the child has been vaccinated with Polio 0, 1, 2, 3; Diphtheria, Pertussis, and Tetanus (DPT) 1, 2, 3; Measles, etc.

The carers were asked to compare the young children's level of happiness (1 = much more, 5 = much less) and positive attitude with that of other young children (1 = much better, 5 = much worse). In addition, they rated the young children's overall mental health, pre- and post-pandemic (1 = excellent, 5 = poor).

The carers answered the Strengths and Difficulties Questionnaire (SDQ) for Carers that measures emotional problems, conduct problems, hyperactivity and inattention, peer relationship problems, and prosocial behaviors. Two versions were used; one was for carers with young children ages 3-4, and another for carers with young children age 5 (0 = not true, 2 = certainly true).

Table 2. Results on young children's health.

Young child variables	Total sample (N = 505)	Migrant families (n = 257)	Non-migrant families (n = 248)
Physical health			
Comparison with other young children – Health (M)	2.13	2.10	2.16
Physical health before the pandemic (M)	2.14	2.12	2.16
Physical health after the pandemic***a (M)	1.98	1.93	2.04
Illnesses**b (in %)			
Flu, cough, fever (Yes)	62	60	64
No appetite (Yes)	19	20	18
Accidents (Yes) [in %]	1	2	1
With vaccination records*c (in %)	(n = 209)	(n = 102)	(n = 107)
Polio 0 (birth)	69	74	65
Polio 1	94	95	93
Polio 2	92	95	90
Polio 3	63	61	64
DPT 1	93	96	91
DPT 2	93	96	91
DPT 3	92	95	90
Measles (MMR)	90	94	87
BCG	93	95	91
Japanese encephalitis	6	10	2
Hepatitis B1	79	81	77
Hepatitis B2	26	26	25
Hepatitis B3	21	20	21
COVID-19	10	14	7
If vaccination is complete	96	95	97
Without a vaccination record	(n = 276)	(n = 144)	(n = 132)
Polio (%)	98	99	98
Number of doses (M)	2.77	2.83	2.72
DPT (%)	99	99	98
Number of doses (M)	2.7	2.73	2.66
Measles (MMR) [%]	98	97	98
BCG (%)	99	9	99
COVID-19 (%)	13	16	11
If vaccination is complete (%)	98	99	97
Mental health and support system (M)			
Comparison with other children - Happiness	1.81	1.79	1.83
Comparison with other children - Positive attitude	1.92	1.92	1.96
Mental health before the pandemic	2.13	2.10	2.16
Mental health after the pandemic*d	2.05	2.01	2.09
Emotional problems**e (3-4 years old)	2.27	1.95	2.64
Conduct problems*f (3-4 years old)	2.85	2.52	3.24
Hyperactivity and inattention (3-4 years old)	4.90	4.81	5.00
Peer relationship problems (3-4 years old)	3.07	2.95	3.21
Prosocial problems (3-4 years old)	7.69	7.87	7.48
Emotional problems (5 years old)	2.14	2.07	2.21
Conduct problems (5 years old)	1.22	1.22	1.23
Hyperactivity and inattention (5 years old)	3.93	3.95	3.92
Peer relationship problems (5 years old)	2.65	2.64	2.66
Prosocial problems (5 years old)	8.59	8.55	8.64

Notes: (a) Better physical health after the pandemic (F(1,486) = 18.55);
(b) More among children from migrant families (χ^2(1) = 7.84);
(c) Greater among children from migrant families (χ^2(8) =15.66);
(d) Better after pandemic (F(1,485) = 5.66);
(e) Less among children from migrant families (*Welch's t* = -2.84);
(f) Less among children from migrant families (*Welch's t* = -2.35).
* p < 0.05
** p < 0.01
*** p < 0.001

Results revealed that, for the carers, the children under their care were perceived as being healthier than other children (see Table 2). Moreover, results showed that from the carers' perspective, there was an improvement in the young children's physical health across time given higher scores post-pandemic than pre-pandemic. The most commonly reported illnesses were colds and flu at 62%. Almost half of the children experienced a form of body pain, such as toothaches (17%), headaches (14%), and stomachaches (11%). Nineteen percent reported not having an appetite, 4% had diarrhea, and 2% had vision problems. Children from migrant families had vision problems significantly more than children from non-migrant families, though the incidence was still low.

Almost all the young children were reported to be vaccinated (99%), mostly through the government's immunization campaign (94%). More than half (55%), though, did not have immunization records. The findings in migrant and non-migrant families were comparable. A few children (2%) had major illnesses, namely, amoebiasis and primary complex. One percent met accidents; specifically, one got bitten by a dog whereas another had a head injury after a vehicular accident.

Among those with immunization records (n = 209), 96% believed they were up-to-date and complete. However, upon inspection, a good number of the children had incomplete vaccinations. Based on the records, only 69% of the children had polio 0 at birth, but this increased to 94% for polio 1 and 92% for polio 2. There was a decline, though, for polio 3 at 63%. The numbers were better for DPT, Bacillus Calmette-Guérin (BCG), and measles, mumps, and rubella vaccine (MMR). 93% were vaccinated for DPT 1 and DPT 2, and 92% had DPT 3, while 93% had the BCG and 90% had the MMR vaccine.

The vaccination rate for hepatitis was lower. Seventy-nine percent were given Hepatitis B1, but the numbers dropped to 26% for Hepatitis B2 and 21% for Hepatitis B3. Vaccinations for COVID-19 and for Japanese encephalitis were low at 10% and 6%, respectively. For those with immunization records, the only difference in vaccination rates between the children from migrant (95%) and from non-migrant families (91%) was for BCG, though the rates for both groups were high.

Among those without immunization records (n = 276), 98% believed the children's vaccination was up-to-date and complete. On the other hand, the results again showed incomplete immunization. Most reported the children were vaccinated for polio (98%), with an average of 2.77 times (SD = 1.08). Forty-three percent had the polio vaccine at birth, and at a later time, 35% had it after birth, and 20% had it at birth. However, only 72% were given the polio vaccine three times, whereas 11% had it twice, 10% had it four times, and 7% only had it once.

For DPT, 99% said the children were given this vaccine. Reported uptake of measles and BCG vaccines was also high, at 98% and 99%, respectively. On the flipside, a small number of the children (13%) had the COVID-19 vaccine. For those without records, no differences were found based on migration status of household.

Young children's mental health and support system.

Results showed that, from the viewpoint of the carers, the children under their care were happier and had slightly more positive attitude than other children. Further, there was also an improvement in overall mental health when comparing pre- and post-pandemic scores. These findings were true regardless of migration status.

Results from the SDQ for Carers of young children ages 3-4 showed that the children had average levels of emotional and conduct problems, and hyperactivity and inattention levels. They were also evaluated as having average prosocial behaviors but slightly raised peer problems. It should be noted, though, that the carers of young children from migrant households rated the children significantly lower in emotionality and conduct problems

than the children from non-migrant households.

Results from the SDQ for Carers of young children aged 5 were almost the same. The children were also seen as having average levels of emotionality, conduct problems, hyperactivity and inattention, and prosociality. In terms of peer relationships, though, the 5-year-olds were rated as having average peer problems. No differences were found between the children from migrant and non-migrant families.

Health of young adults

Participants were asked to assess how healthy they were in general (1 = very poor, 5 = very good). They also recounted if they had a severe or debilitating illness in the past 6 months and any physical or mental health problems since 2016 (0 = no, 1 = yes). Among those who answered yes, they were asked what those illnesses were and if they received medical attention. Further, questions about the experience of major accidents in the past 6 months were asked (0 = no, 1 = yes).

The young adults' health behaviors were also evaluated. First were about smoking or vaping behaviors. They were asked if they have ever tried smoking or vaping (0 = no, 1 = yes), their smoking onset, smoking frequency during the past month (0 = not at all, 4 = everyday), and if they had peers and family members who smoked or vaped (0 = no, 1 = yes).

Alcohol use was then appraised. This included questions about if they have ever drunk alcohol more than 2-3 times (0 = no, 1 = yes), if they have drunk without an older family member around (0 = no, 1 = yes), their drinking onset, drinking frequency in the past month and how often they got drunk (0 = not at all, 4 = everyday), if they had peers or family members who drank (0 = no, 1 = yes), and how many of their friends drank at least once a month (1 = all of my friends, 5 = don't know).

Questions about sexual experiences were also asked. This included questions on whether they had friends who have had sex, who encourage them to have sex, and who force them to have sex (all used the scaling 0 = no, 1 = yes). They were also asked if they themselves have engaged in sex and how old they were when this first happened (0 = no, 1 = yes).

The SRQ was used to measure the young adults' experiences of psychological distress in the past month (0 = no, 1 = yes). Further, subjective wellbeing was measured by the question, "Overall, are you happy or sad?" (1 = very happy, 5 = very unhappy). They were also asked about their top reason for feeling happy, and they chose from the following options: whole family being together, mother at home, father at home, mother, father, toys/presents, friends, doing sports, good grades/praise at school/work, praise from parent/family, entertainment, praying, helping family, and others.

They were likewise asked about their top reason for feeling lonely. They had the following options: mother away, father away, quarrel with siblings, rejection/bullying/quarreling with classmates, getting in trouble from parents or carer, bad grades/bad reports at work, being alone, nothing, not having enough money, and others.

The young adults also answered questions about the trustworthiness of the people around them. General trust for others was measured by how much they agreed with the statement, "Overall, most people can be trusted" (1 = strongly agree, 5 = strongly disagree). Trust for family, friends, and neighbors was also measured (1 = very much, 5 = not at all). Under family, they evaluated how trustworthy their fathers and mothers were (1 = very much, 5 = not at all).

Additionally, the young adults appraised their family experiences. Family functioning was measured using 5 items, which included: being able to approach one's family to ask for help; talking to family; being allowed by family to do

things they want; liking what family does when they are angry, sad, happy, or being affectionate; and liking how family spends time together. They used this rating scale 1 = never, 5 = always. They also evaluated how close they were to their parents and their perception of how close their parents are with each other and how much they trusted one another (1 = very much, 5 = not at all).

The young adults answered more questions about their support system. An additional question about friends or peers was asked, specifically, how often they saw their friends (0 = less than once a week, 3 = everyday). Two more questions about neighbors were asked, specifically if they knew most of the names in their neighborhood and if they could receive support from their neighbors (0 = no, 1 = yes).

They likewise answered items on who they approached when they had problems with homework or school exams or work, problems with peers, classmates or workmates and when they felt sad. For each item, they chose from a list that included their mother, father, classmates, friends, neighbors and others.

Young adults' physical health and health behaviors.

The young adults perceived themselves to be above-average healthy. There were comparable ratings between those from migrant and non-migrant families. Only a handful experienced major health problems, and similar experiences occurred across the migration status of parents.

In terms of health behaviors, 41% have tried smoking. On average, they smoked for the first time at the age of 16.55 (SD = 2.38). The earliest smoking onset was at 7 years old. The majority have smoked in the past month: 18% smoked daily, 13% smoked nearly every day, and 36% smoked once or twice a week. Over a third did not smoke in the past month (33%). Smoking is a norm in their surroundings: 76% had friends who smoked and 62% had family members who engage in this behavior. All smoking behaviors were similar among young adults from migrant and non-migrant families.

Alcohol use was higher, with 81% have tried drinking alcohol two to three times. The onset of alcohol use was at around the same time as smoking onset, specifically at the age of 16.40 (SD = 2.35). The earliest onset was younger, however, at 3 years old. Seventy-seven percent have drunk alcohol without a parent or older family member around. In the past month, 60% drank alcohol once or twice, while only a few drank every day (1%), once or twice a week (1%), and nearly every day (3%). More than a third did not drink at 36%. Among those who did drink alcohol, a fourth reported getting drunk, with 19% experiencing this once or twice the past month, 1% getting drunk once or twice in a week, 2% getting drunk nearly every day, and 1% getting drunk every day. Drinking was a normative behavior in their environment, more so than smoking. Ninety-four percent of them had friends who drink. Among those whose friends drink alcohol, 22% reported that all of their friends drank alcohol, 42% said most of their friends drank, and 34% had few friends who engaged in alcohol drinking. Further, 85% of all the young adults had family members who drink alcohol. Like smoking behaviors, all drinking behaviors were comparable among young adults from migrant and non-migrant households.

The participants also answered questions about sex. When asked if they had friends who engage in sex, 53% said yes; 11% had friends who encouraged them to have sex and 4% even pushed them to have sex. A fourth have had experience of having sex. On average, they started having sex when they were minors or at age 17.34 (SD = 1.44), with the earliest at age 13. No differences in sexual behaviors were found between young adults from migrant and non-migrant households (see Table 3).

Young adults' mental health and support system

The results showed that the young adults were happy. Further, they had low levels of

Table 3. Results on young adults' health.

Young adult variables	Total sample (*N*=315)	Migrant families (*n*=63)	Non-migrant families (*n*=253)
Physical health			
Overall rating of health (*M*)	3.84	3.73	3.87
Mental health			
Psychological distress	5.47	5.47	5.47
Subjective wellbeing	1.94	1.90	1.95
Social support system			
Trust			
General trust	2.97	3.06	2.94
Trust for:			
Family***a	1.46	1.56	1.43
Friends	2.18	2.13	2.2
Neighbors	3.38	3.29	3.41
Father	1.40	1.46	1.38
Mother***b	1.27	1.37	1.24
Family functioning	22.52	22.92	22.42
Family relationships			
Closeness with mother***c	1.40	1.41	1.40
Closeness with father	1.72	1.63	1.74
Perception of parents' relationship			
Close with each other	1.49	1.59	1.46
Trust for each other	1.54	1.60	1.52
Relationship with peers (How often see peers)	1.43	1.37	1.45

Notes: (a) Family trusted most, then friends, then neighbors (F (2,608) = 380.18);
(b) Mothers trusted more than fathers (*Wilcoxon W* = 310.00);
(c) Closer with mothers than fathers (*Wilcoxon W* = 591.50).
*** p< 0.001

psychological distress. There were no statistical differences between young adults from migrant and non-migrant families. When asked what made them the happiest, their top reason was family-focused, as 48% cited being the happiest when their whole family is together. The other top answers were friends (12%) and entertainment (11%). The top reasons for feeling happy were comparable between young adults from migrant and non-migrant households.

In terms of what made them feel the loneliest, no answers stood out because varied options were chosen. The top answer was that there was nothing that made them feel lonely (12%). The other top answers were related to family, namely, when they were scolded by a family member (11%), when their father was away (8%), and 5% when their mother was away. Others said they felt the loneliest when they got bad grades (10%) or when they were alone (10%). There were no differences in the top reason for feeling lonely between young adults from migrant and non-migrant households.

The results also showed they had an average belief that people can be trusted, with no difference relative to household migration status. They trusted their family a lot and significantly more than their friends and neighbors.

Overall family functioning was good. They found both their parents trustworthy, with comparable scores among those from migrant and non-migrant families. Mothers were rated significantly higher than the fathers and were assessed more favorably in terms of closeness. On average, they reported being close with both their mothers and fathers, again regardless of migration status.

Moreover, for them, their parents' relationship was very good because they believed their parents were close with each other and that they trusted each other. This was true whether the parents were together in the Philippines or if one or both parents are abroad. The young adults felt that they can somewhat trust their friends, and no difference was found between

those from migrant and non-migrant households. Friends were also deemed more trustworthy than the neighbors.

In general, the young adults had good peer relationships. The majority were able to see their friends or cousins weekly; 16% saw them every day, 26% nearly every day, and 37% saw them once or twice a week. The peer group was also regarded as the main source of support for different aspects of their lives. They approached their peers like friends (32%), classmates (17%), or boyfriend/girlfriend (3%) the most for homework and other school concerns. A good number asked their family for help, specifically their mothers (11%), sisters (5%), brothers (3%), female relatives (3%), fathers (2%), and male relatives (1%). Some young adults relied on themselves (6%) or did not know who to turn to (3%).

Moreover, when they had problems with peers, most turned to their peer group, like friends (29%), boyfriend/girlfriend (7%), or classmates (2%). Some discussed peer problems with their family, with 20% going to their mothers, 2% approaching their fathers, 2% both parents, 7% their sisters, 1% their brothers, 3% other female relatives, and 1% their grandparents. Ten percent did not turn to anyone, and 9% only depended on themselves. In addition, when they felt sad, most went to their peer group, notably their friends (41%), boyfriend/girlfriend (8%), or classmates (1%). Some went to their family, particularly their parents (mother at 15%, father at 25%, and both parents at 2%), siblings (sister at 4% and brother at 2%), or other relatives (grandmother at 1% and female relative at 1%). Others relied on themselves (8%) or had no one to talk to (9%).

The young adults did not trust their neighbors so much, with no difference between young adults from migrant and non-migrant households. Nonetheless, while least trusted, the majority (77%) were aware of who their neighbors were and most (62%) believed that their neighbors were a source of support. No differences were observed relative to the presence of a migrant in the household.

Discussion

This study reported the findings on the health of carers of young children, of young children (as perceived by the carers), and of young adults. Comparisons in scores between those from migrant households and those from non-migrant households were also shown.

One highlight was that the carers had greater feelings of isolation and worse overall mental health after the pandemic. This could be remnants of feelings of isolation during the pandemic, especially in the Philippines which had longer periods of home confinement and quarantine than other countries. These findings point to the importance of promoting healthcare, especially after a debilitating event. This includes the need to foster better awareness on how to improve one's mental health and greater access to healthcare, e.g., more accessible and affordable psychological assistance.

It is interesting to note that carers from migrant households had better post-pandemic physical health and lower psychological distress. Compared with non-migrant families, migrant families have been found to have higher income, wealth index, and asset index (Jordan et al., 2024). In turn, it is possible that economic resources (i.e., through remittances) enable migrant families to cope with crises (Jordan et al., 2024), both physically and mentally. However, it is also noteworthy that there was low recognition of community support for migrant families despite several programs by the national government and by some local government units. This is reminiscent of past findings that migrants relied on their personal resources instead of partaking in government programs for their families (Asis & Garabiles, 2023). It is, therefore, suggested that the government reach out to migrant families more directly (i.e., at the community or barangay level) to inform them of programs they could avail. Service provision should also be quicker (i.e., lessen paperwork) to encourage migrant families to acquire them (Garabiles et al., 2024).

There were also notable findings with regard to the young children. The results on incomplete immunization concur with findings from the National Economic and Development Authority & United Nations Children's Fund (2018), which found a low 62% childhood vaccination coverage among Filipino children. Compared to another report, however, where 87.8% of children had BCG and 79.2% had MMR, the children in this sample had higher uptake of BCG and the MMR vaccines (*Immunization*, n.d.).

It is worth mentioning that children from migrant families had greater BCG vaccination than those from non-migrant families. This suggests that the carers of the left-behind children are involved in keeping them healthy.

There were still children in this study's sample who have not received or have incomplete vaccination, despite it being mandatory and free. Further, many carers did not have copies of immunization records, which could lead to difficulties tracking vaccination and boosters and to problems in school enrollment or travel. It is, thus, recommended that immunization records be digitalized to increase ease in access. More effective immunization campaigns are also needed, including countering misinformation about negative effects of vaccines.

The young children had improvement in physical and mental health post-pandemic, regardless of the migration status of the household. There was a difference however, in terms of emotionality and conduct problems, where 3–4-year-olds from migration families were rated lower than 3–4-year-olds from non-migration families. These could again be due to remittances, which could have been used for promoting and sustaining the children's wellbeing (Lam & Yeoh, 2018). In addition, a good number of carers were also working and therefore contributed to the families' finances, which could be used to ensure that the children are healthy. This supports past findings that non-reliance on migrants and financial contributions on the part of the left-behind adults promote resilience in the family (Garabiles et al., 2017).

As for the young adults, the findings revealed comparable physical and mental health status. This disputes the narrative that they are at a disadvantage for having just one or no parent at home.

One highlight was that more than half smoked or vaped in a month. This is in stark contrast with the Young Adult Fertility Survey 5 (YAFS5) results (University of the Philippines Population Institute [UPPI], 2022) where 12% were current smokers and 3% were current vapers. The sample in this study might have easy access to cigarettes or vapes. Further, they reported smoking or vaping as normative in their environment, which could motivate them to do the same. Smoking and vaping are of public health concern, especially with the young being targeted by cigarette and vape companies. This should therefore be addressed by the government's health and education agencies. Other health behaviors were comparable with the YAFS5 results, though. That is, there were similar rates of drinking and engagement in sex as the UPPI study.

The young adults perceived having good relationships with their families and peers. The finding on the family being the main reason for one's happiness is similar to a past report's results (*Reason for happiness*, n.d.). The parents' marital relationship was also appraised positively, even among those from migrant households. These comparable scores between migrant and non-migrant families could be due to greater ease in communication across space with improved technology, especially since the pandemic.

However, the young adults' relationships with their neighbors are not as well regarded. This is reminiscent of past findings on low rates of community socialization among Filipinos (Porio & See, 2017). Further, there are those who do not have people they can turn to, which aligns with a finding that Filipinos ranked in the top five in self-reported feelings of aloneness

(Meta-Gallup, 2022). However, another study (*Reasons for happiness*, n.d.) showed friends were cited much higher at 37-38% than the young adults did in this study. This suggests that there is room to expand the social network of young adults, specifically to include their peer group and community more in their daily activities. For example, activities such as sports or the arts at the barangay level can help facilitate greater socialization among this age group.

Conclusion

Using CHAMPSEA Wave 3 datasets, this report investigated the physical and mental health status of carers of young children, young children, and young adults. This report likewise showed similarities and differences between migrant and non-migrant households. The findings suggest that parental migration has positive influences on the health of left-behind family members, particularly the carers and young children. On the other hand, physical and mental health among young adults from migrant households are comparable with that of young adults from non-migrant households. These findings counter the narrative that migration negatively affects left-behind families and instead show the bright side with parental migration.

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Appendix

About CHAMPSEA

As in other parts of the world, in Southeast Asia, many parents leave their families to work abroad in the hopes of providing a better, brighter future for their children. However, parental absence has fueled concerns about children growing up without one or both parents, casting doubts on the hoped-for benefits from working abroad.

The Child Health and Migrant Parents in South-East Asia (CHAMPSEA) research project was launched to examine the impact of parental migration on the health and well-being of the children remaining in the origin communities. Since destination countries in Asia do not allow migrant workers in less skilled occupations to bring their families with them, migrants and their families are separated, with the latter being left behind in the origin countries. CHAMPSEA collected data in four origin countries—Indonesia, the Philippines, Vietnam and Thailand—to provide a comparative perspective on how the absence of parents due to migration affect the children who remain at home. The longitudinal and mixed methods design and the comparison between migrant and non-migrant households add to the unique and strong features of the project. For the baseline survey, the children of interest to CHAMPSEA (referred to as the index child per household) were young children in the formative years (3-5 years old) and children in middle childhood (9-11 years old), an age group that is under-researched compared to young children and adolescents. These children and their families were tracked, revisited and reinterviewed in two further rounds of data collection in Indonesia and the Philippines.

The first wave or baseline survey, CHAMPSEA I, was conducted in 2008, covering circa 1,000 households in each country, followed by qualitative interviews with a small number of households in 2009. In 2016, CHAMPSEA II tracked and reinterviewed 756 households in the Philippines, supplemented by qualitative interviews with selected households in 2017. CHAMPSEA III was carried out in 2023, reinterviewing the tracked households and drawing a new sample of 506 households with young children. Combining the tracked households from the previous surveys and the new sample, 1,506 unique households were enrolled in CHAMPSEA in the Philippines

For each Wave, 2 to 3 face-to-face interviews were conducted in each sampled household involving a responsible adult (a person who is knowledgeable about household matters), a carer (someone who was identified as the main carer of 3-5 years old and 9-11 years old children), the index child aged 9-11 years old or the young adult (the index child aged approximately 17-21 years old) at the time of the follow-up survey. An overview of how the children were followed up at different points in time and the respondents per sampled household are outlined in Table 1.

Table 1. Research participants in CHAMPSEA I, II and III.

Age of index child (at first interview)	**2008 CHAMPSEA I**	**2016 CHAMPSEA II**	**2023 CHAMPSEA III**
3-5 years old	3-5 years old (2 interviews: Responsible adult; Carer)	11-13 years old (3 interviews: Responsible adult, Carer, Index child)	17-21 years old (2 interviews: Responsible adult; Young adult)
9-11 years old	9-11 years old (3 interviews: Responsible adult; Carer; Index child)	17-19 years old (2 interviews: Responsible adult; Young adult)	-
3-6 years old (new sample)	-	-	3-6 years old (2 interviews: Responsible adult; Carer)

In the Philippines, CHAMPSEA was implemented in two high out-migration provinces in Luzon, Laguna (San Pablo City and Bay) and Bulacan (Malolos City and Calumpit). As in the other countries, the project adopted a flexible quota sampling design to ensure a sufficient number of migrant households with key features. The sample is not nationally representative. The sampling considered two-parent households, the migration status of the household, the gender of the migrant parent and the gender and age of the index child (3-5 years old and 9-11 years old) in the first survey. The project defined an international or transnational migrant household as one where the father, mother or both parents have been working abroad continuously for at least six months prior to the survey, while a usual resident or non-migrant household means both parents and the index child were living together continuously for at least six months prior to the survey. In the recruitment of a fresh sample of households with young children in CHAMPSEA III, the Philippines adopted the same adjustments that were made in Indonesia: the six months of continuously working abroad to define international migration was reduced to one month, and the age range of young children was extended to 3-6 years old from 3-5 years old.

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For a list of journal articles, reports and multi-media knowledge products from CHAMPSEA, see https://ari.nus.edu.sg/champseapublications/

Filipinos have gone global in the search for employment opportunities and higher incomes for more than five decades. The family is the reason why migrants leave the comforts of home, the site of migration decision-making, the direct beneficiary of the benefits of migration, and the all-around safety net of its members throughout their individual and family life stages. The Child Health and Migrant Parents in South-East Asia (CHAMPSEA) research project inquires into the impact of transnational labor migration on the families and children left-behind in origin communities while fathers, mothers or both parents work abroad. Conducted in the Philippines and Indonesia in three waves—in 2008, 2016 and 2023—findings from the CHAMPSEA project provide insights on the family as it strives to meet the economic, social, care and emotional needs of its members amid the changing geography of family life.

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