

Online-only supplementary material

Most instruments used in the study were available in Brazilian Portuguese. For any measures that were not available in Brazilian Portuguese, we used a “modified committee approach” to translate the instrument.¹ This method relies on several translators, each responsible for translating a portion of the instrument, rather than on a single translator. The committee approach allows for a more accurate instrument in the target language as compared to back translation, because it entails consensus among several translators. A process of translation and back-translation was however used after the initial translation was completed for evaluation of equivalence by a trained bilingual committee of experts. The internal consistency and factor structure of these translated instruments were examined and compared with the English version. Accuracy of the translation was assessed in a pilot study.

Table S1 Exposure variables based on ecodevelopmental theory used in parent / caregiver interviews

Outcome (time to assess)	Description of instrument
Macrosystem variables: urban violence, neighborhood characteristics, and social capital	
Neighborhood conditions (5-10 minutes)	Interviewees were asked to report on two dimensions of their neighborhood, based on questions obtained from the Project on Human Development in Chicago Neighborhoods Community Survey ^{2,3} : physical (e.g., garbage, needles on the street, physical conditions of buildings) and social disorder (e.g., loitering, drunks on the street); and 2) perceived community violence.
Neighborhood disadvantage*	Data from the Brazilian Institute of Geography and Statistics (IBGE: http://www.ibge.gov.br) were used to assess area-level disadvantage through measures such as social stratification, percent of residents in the lowest social class, and proportion of residents eligible for public assistance. Stratification was made for each block face, based upon housing conditions (e.g., type of door, size of front lawn), urban surroundings (types of roadways and streets), and zone where the block is located. In addition, the SEADE, a São Paulo state governmental agency has created, based upon IBGE Census data, a São Paulo neighborhood vulnerability index, the IPVS (which measures social vulnerability and poverty, ranging from very high vulnerability to low vulnerability neighborhoods. See http://www.seade.gov.br/projetos/ipvs) as well as a similar neighborhood index focusing only on youth, the juvenile vulnerability index, or IJV (see http://www.seade.gov.br/produtos/ivj) to calculate area-level disadvantage).
Income inequality*	We used data from IBGE, IPVS, and IJV to document income distribution by neighborhood. We used these data to calculate the Gini coefficient by neighborhood.
Residential segregation*	Data on the IBGE social stratification distribution of residents in the neighborhoods, comprising each area, were used to calculate measures of income and racial residential segregation, such as the dissimilarity index (which characterizes the unevenness of racial/ethnic group distribution) and the isolation index (which measures the extent to which a member of a racial/ethnic group is likely to be in contact with members of this same group as opposed to members of other groups). ⁴⁻⁶
Homicide rate*	Updated data on the annual homicide rate per 100,000 persons/young persons in each selected neighborhood were obtained from the São Paulo state police records.

Mesosystem variables: parental social network and social support

Caregiver social support and social networks (10 minutes) A validated Brazilian version of the Medical Outcomes Study was used to measure social support.⁷⁻¹¹ Social support questions ask about emotional, informational, financial, and appraisal support, including questions regarding whether or not participants have support (e.g., persons to whom they can turn for help or from whom they can borrow money). Social network questions were about the number of close friends and relatives and the frequency with which respondents see these friends and relatives. In a previous validation study in Rio de Janeiro, Cronbach's alpha for social support measures was >0.83 in all domains.¹⁰

Parent/caregiver perception of social capital (1 minute) Interviewees were asked about four items related to trust and reciprocity based on the concept of social capital and health.¹² Respondents were asked if, in general 1) they feel that most people can be trusted, 2) their neighbors can be trusted or if you couldn't be too careful in dealing with them, 3) most of the time their neighbors try to be helpful or are mostly looking out for themselves, and 4) in an emergency, they can borrow \$25 from a neighbor.¹²⁻¹⁵

Microsystem variables: family structure and functioning, family violence, parental mental health, parent-child relationship, parental stress, food insecurity

Parental substance use disorder (SUD) (10 minutes) We assessed individual and parental/caregiver mental health history using measures from a previous work.^{16,17} This section also used questions from the National Women's Study¹⁸ on family history of SUD. Information obtained includes the number of biological parents with SUD, and the types of drug abuse-related social, occupational, or legal problems experienced by biological parents. The ASSIST screening test (eight questions) was used to detect substance use-related problems. Alcohol, tobacco, cocaine, and marijuana use are examined with the ASSIST test.¹⁹

Parental/caregiver psychopathology (15-35 minutes) We used a validated depression scale from the Patient Health Questionnaire (PHQ-9). The PHQ-9 consists of 9 items, each of which is scored 0 to 3, providing a 0 to 27 severity score.^{20,21} Additionally, the Generalized Anxiety Disorder 7-item scale (GAD-7), an anxiety measure developed after PHQ but incorporated into PHQ-SADS, was used to capture interviewee anxiety disorders. Each of the seven items of GAD-7 is scored 0 to 3, providing a 0 to 21 severity score. GAD-7 has good sensitivity and specificity for generalized anxiety disorder, panic, social anxiety, and post-traumatic stress disorder.²² The consequences of various traumatic experiences was assessed with the Post-Traumatic Stress Disorder Checklist - Civilian Version (PCL-C), a 17-item screening measure in which each item is scored from 1 to 5.²³

Violence within the family (5-10 minutes) We used the Section B of the Brazilian version of the World Studies of Abuse in Family Environments Core Questionnaire (WorldSAFE), which measures intra-familial violence.^{24,25} Section B of the WorldSAFE Core Questionnaire on Domestic Violence identifies 33 punishment methods used by parents or caregivers in the previous 12 months, such as choking or shaking.

Parent-child relationship: Protective Factors Survey (4 minutes) We used the Protective Factors Survey (PFS) from the *FRIENDS National Resource Center for Community-Based Child Abuse Prevention*.²⁶ The interviewee was asked to discuss various aspects of his/her relationship with the child, including the amount and quality of time spent with the child, the type of parental discipline and supervision, the ability of the child to confide in the parent/caregiver, among other aspects.

Parental Stress Index (2 minutes) Dysfunctional Parent-Child Interaction (DPCI) from the Parental Stress Index – Short Form (PSI/SF): this is one of the three sub-scales of the 36-item PSI/SF, consisting of 12 items with a 5-point Likert scale that are scored from 12-60. Higher scores indicate more stress. The PSI reflects the parents' view of the child's temperament, defiance, demandingness, and if child meets parental expectations.²⁷ It has been used extensively in diverse populations (e.g., adolescent and minority U.S. parents and internationally).²⁸ The PSI has internal consistency of 0.88 to 0.91 and test-retest correlations of $r=0.75$ after 1 year ($p<0.001$).²⁹ It is related to both parenting and child behavior.²⁹

Maternal quality of life (2 minutes) We used the WHOQOL-BRIEF, which is an abbreviated 26-item version of the Quality of Life Scale developed by the World Health Organization.³⁰⁻³²

*Archival measures characterizing key neighborhood conditions, 2015-2017.

Table S2 Demographic and outcome variables in parent/caregiver interviews

Socio-demographics

Demographic characteristics (5 minutes) Demographic information was collected about the parent/caregiver and child, including age, sex, years of education, race, birthplace, time of residence in São Paulo, family composition and structure, maternal and parental figures, and residential location (including length of time residing in a particular neighborhood). Information on the respondent's current address was also collected to map respondents to neighborhoods.

Socioeconomic status (SES) (3 minutes) SES was assessed using a standard index designed by the Brazilian Association of Research Agencies, the ABEP index. The ABEP index is based upon the educational achievement of the head of the household, ownership of various types of household goods (e.g., television sets), and housekeepers. This scale sorts participants into standardized subgroups labeled from A to E (A1, A2, B1, B2, C1, C2, D, E; where A1 is the highest economic stratum).

Child medical history and gestational information

General medical history of the child (2-5 minutes) We gathered information about the medical history of the child, including medical diagnosis of ear and throat infections, meningitis, coma or head trauma, epilepsy, asthma, allergic reactions, or another disease. Additionally, we asked whether or not the child had ever been hospitalized, had a surgical intervention, or seen any specialists.

Pregnancy (2-5 minutes) We collected information about pregnancy, including whether or not the pregnancy was planned and desired, age of the mother at pregnancy, complications during pregnancy, and maternal substance use during pregnancy.

Childbirth and the neonatal period (2-5 minutes) We obtained information about the location of childbirth (e.g., hospital, home), timing of childbirth (premature, term, late), infant weight and height at birth, complications during childbirth, and interventions used by medical staff during childbirth (medications, oxygen introduction, resuscitation). Information about postpartum depression and duration of exclusive breastfeeding was also collected.

Child developmental outcomes

Social-emotional development (12-20 minutes) We assessed social-emotional development with the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE).³³ The ASQ:SE is composed of a series of questionnaires designed for use with a child's parent or primary caregiver, and has eight separate intervals for children aged 6 to 60 months. The ASQ:SE focuses on seven areas: self-regulation, compliance, communication, adaptive behavior, autonomy, affect, and

interactions with people. Internal consistency is high with an overall alpha of 0.82 in the U.S.. Test–retest reliability between parents' classifications on two ASQ:SE questionnaires completed 1–3 weeks apart was 0.94.^{34,35} In Brazil, 45,640 children distributed in 468 public daycare centers were evaluated with the Brazilian Portuguese- adapted version of ASQ questionnaires. The Brazilian Portuguese ASQ presented adequate internal consistency.

Parent reports of child psychopathology (10-20 minutes)	Lifetime psychopathology of the offspring was measured with the Child Behavior Checklist (CBCL). ³⁶⁻³⁹ The CBCL is widely used especially because administration is easy and fast, with versions for children aged 1.5 to 5 years (CBCL 1.5-5) and a version for children aged 6 to 18 years. The questionnaire consists of descriptions of child behaviors in the previous 6 months. The CBCL 1.5-5 presents 99 items that are grouped into seven syndromes: I. Emotionally Reactive, II. Anxiety/Depression, III. Somatic Complaints, IV. Withdrawal, V. Aggressive Behavior, VI. Attention Problems and VII. Sleep Problems. The scales can be grouped into two major syndromes: internalizing (scales I to IV) and externalizing (scales V and VI). The Sleep Problems syndrome is a separate domain. CBCL 1.5-5 has been successfully tested in 19,106 children aged 18-71 months from 23 countries. ⁴⁰ The validated CBCL Brazilian version ⁴¹ revealed that when the total score for behavior problems was used to identify clinical cases, CBCL achieved good sensitivity (80.4%), correctly identifying 70% of mild cases, 86.4% of moderate, and 100% of severe cases. ⁴¹
Child language development by parent/caregiver (20 minutes)	We used the Evaluation of Expressive Vocabulary List (Language Development Survey-LDS), ⁴² which is a list of 307 high-frequency words in Brazilian Portuguese grouped into 14 semantic categories. The survey evaluates expressive language and verbal production delays. It was translated and validated in Brazil in 124 children aged 2 to 6 years, ⁴³ and in 122 children aged 3 to 5 years. ⁴⁴
Child neuro-development (3-6 minutes)	We examined a range of neurodevelopmental outcomes, including speech, walking, crawling, smiling, sitting, and sleeping behaviors. Further, eating problems, motor skills, and potty training were addressed in this section. ⁴⁵
Daily habits of physical activity (2 minutes)	To assess daily habits of physical activity, we gathered information about child leisure time activities, general activity levels, hours spent watching television, involvement with sports, and sleeping habits based on a Brazilian national school health survey, Pesquisa Nacional de Saúde do Escolar (PeNSE) survey. ⁴⁶
Child post-traumatic stress disorder (1-5 minutes)	The Young Child PTSD screen (YCPS) is a 6-item measure intended to quickly screen for PTSD. Each item is scored 0 to 2. Positive screen and further referring for treatment is considered if 2 or more items are endorsed (a score of either 1 or 2). ⁴⁷

Table S3 Direct assessment of child, teacher and school outcomes

Outcome (time required to assess)	Description of assessment
Child language development (30-40 minutes of child evaluation)	Evaluation of Language Development ⁴⁸ was used by speech pathologists to directly assess receptive and expressive language in children aged 12 to 83 months. This includes assessment tools of 75 sheets of color illustrations, with 51 pages concerning comprehensive language and 24 concerning expressive language. Separate scores can be given to understanding language; expressive language; and global language (total score).

Child motor-development (40-60 minutes of child evaluation)	Motor development throughout childhood is characterized by the acquisition of a broad spectrum of motor skills that allow the child to control his or her body in different postures (static and dynamic), getting around the environment in various ways (walking, running, jumping) and manipulating various objects and instruments (receiving and throwing a ball, kicking). To evaluate motor development, we used the Motor Development Scale - MDS, which evaluates fine motor skills, overall motor skills, balance, body scheme, spatial organization, temporal organization, and laterality. The construct validity was good in the Brazilian Portuguese version. ⁴⁹
Body composition (40-70 minutes)	We used anthropometry and bioelectrical impedance (BI) to measure body composition. Anthropometry involves measures of weight, height, skinfolds, and circumferences, alone or in combinations (indices or indicators) – such as body mass index (BMI) for age and sex. ⁵⁰ Skinfolds were measured at specific anatomical points (tricipital and subscapular folds) using adipometers, at a constant pressure of 10 g/mm ² . BI relies on a low intensity electric current that flows through the body. BI reflects the resistance offered by tissues to the flow of a low-voltage current. BI analysis is used to distinguish the amount of body water, body fat, and skeletal muscle in the body. ⁵¹
School readiness (15-20 minutes)	The Engle Scale of Child Development (ESCD), version B, ⁵² was developed by the Inter-American Development Bank as part of the <i>Programa Regional de Indicadores de Desenvolvimento Infantil</i> (PRIDI, Regional Project on Child Development Indicators), in 2015. The ESCD has been validated in Latin-American countries. It includes 62 tasks that assess motor, cognitive, and language skills. The ESCD is scored based on the number of tasks performed correctly. The total score ranges from 0 to 62.
Teacher-student interaction (20-30 minutes)	We evaluated the teacher-student interaction using the Student-Teacher Relationship Scale (STRS), short-form (STRS-SF). ⁵³ Teachers answered this 15-item instrument in order to evaluate their perception about the quality of their relationship with each student. The scale evaluates two dimensions: proximity (positive relationship) and conflict (negative relationship).
Teacher self-efficacy and burn-out (10 minutes)	The teacher sense of self-efficacy was measured using the General Self-Efficacy Scale, ⁵⁴ a Likert scale consisting of eight items ($\alpha=0.79$) that evaluate the sense of competence in five points (0 - totally disagree, to 4 - totally agree). We evaluated burnout using the Maslach Burnout Inventory (22-item Likert scale), previously translated and validated in a population of teachers from southern Brazil. ⁵⁵ The inventory has high internal consistency, with Cronbach's alpha ranging from 0.71 to 0.90, test and retest coefficients from 0.60 to 0.80. It evaluates a three-dimensional construct: emotional exhaustion, depersonalization, and professional achievement. ⁵⁶
School environment (1 hour of observation at classroom)	We used the Early Childhood Environment Rating Scale – Revised version (ECERS-R) ⁵⁷ to measure the quality of pre-school classroom environments. This instrument has served as the gold standard to measure early childhood education environments for more than 25 years. The ECERS-R includes 43 items focusing on the following dimensions of school environment: space and furnishings, routines, language reasoning, activities, interactions, and curriculum. A single, overall global measure of the quality of an early childhood environment is computed as the average of 43 items, with scores ranging from 1 to 7 (inadequate to excellent quality). This scale was validated by our research team. ⁵⁸

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