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# Working Paper Behind the slow start: An assessment of early childhood care and development in the Philippines

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DISCUSSION PAPER SERIES NO. 2024-04

# Behind the Slow Start: An Assessment of Early Childhood Care and Development in the Philippines

Valerie Gilbert T. Ulep, Lyle Daryll D. Casas, Aaron Carlos G. Manuel, John Paulo D. Mendoza, Joy Bagas, and Kim Leonard G. Dela Luna



Philippine Institute for Development Studies

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CONTACT US: RESEARCH INFORMATION DEPARTMENT Philippine Institute for Development Studies Behind the Slow Start: An Assessment of Early Childhood Care and Development in the Philippines

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# PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES SECOND CONGRESSIONAL COMMISSION ON EDUCATION (EDCOM II)

May 2024

# **Executive Summary**

This report assesses the Early Childhood Care and Development (ECCD) in the Philippines, aiming to support the Second Congressional Commission on Education (EDCOM2) of the Philippine Congress with empirical evidence for programmatic and legislative reforms. Our assessment uses a comprehensive framework that analyzes the health, nutrition, and early education outcomes of Filipino children and examines their access to essential health, nutrition, and early education services. We analyze demand- and supply-side inputs such as governance, financing, infrastructure, and human resources to identify factors that explain the poor and inequitable access to these basic services. Throughout our analysis, we highlight key principles for optimizing ECCD returns: (1) timely provision of crucial interventions during critical life stages, (2) ensuring comprehensive access to essential services, and (3) upholding quality standards with far-reaching impacts on health, nutrition, and education outcomes.

## These are our general observations.

Many Filipino children are failing to achieve their potential because of chronic malnutrition and inadequate early education. One in every three children is stunted, marked with alarming disparities, and nine out of ten children cannot read proficiently, characterizing a state of learning poverty. Our analyses look at various inputs and outputs to explain the country's poor performance on health, nutrition, and education outcomes, and three (3) general observations emerge:

- Inadequate and untimely access to high-quality early childcare and parental interventions. Empirical studies highlight the importance of timing in interventions, particularly during the first two years of a child's life, known as the "first 1,000 days." This period, from prenatal care to the child's second birthday, is crucial for receiving essential services. However, our findings reveal a significant gap in the delivery of necessary health and nutrition interventions during this critical window, contributing to the alarming levels of stunting among Filipino children. This deficiency has profound implications for their learning and cognitive development in later years. Moreover, evidence indicates delays in providing stimulation and early education participation, further impacting cognitive and learning abilities in the long term.
- Severe underinvestment in ECCD, yet greater injustice lies in allocating services with limited effects on nutrition and education outcomes. The Philippines tends to favor reactive and shortsighted health and nutrition interventions. For example, many resources are allocated to school feeding and regular supplemental immunization activities (SIAs). While it is true that school feeding programs may offer acute benefits such as temporary alleviation of hunger, they fail to tackle the underlying nutritional issue of stunting. Similarly, SIA cannot address the systemic issues around weak primary care systems that, in the first place, are the reason for poor immunization coverage. Reactive measures of this nature underscore institutional challenges in systematically delivering services. They result in reliance on temporary solutions, which yield suboptimal benefits and, worse still, divert resources from sustainable and impactful solutions. Addressing chronic malnutrition requires continuous, integrated, and comprehensive provision of health and nutrition services at critical life stages.

Weak institutions create a vacuum in the system, hindering early childhood care development intervention implementation. While multi-sectoral collaboration has been adopted in early education and health and nutrition policies, exemplified by the ECCD Council and National Nutrition Council (NNC), implementation of genuine multi-sectoral collaboration to 'align' nutrition and early education programs and policies remains a daunting challenge, making multi-sectoral approaches quixotic at best. Evidence indicates inefficiencies because of overlapping roles among key government agencies, lack of clarity in responsibilities resulting in poor accountability, duplication of efforts, weak vertical (i.e., between national and local governments) and horizontal coordination (i.e., among national agencies), and fragmentation in financing. Also, an inherent challenge is the limited technical capacity of secretariats of multi-sectoral agencies to execute their supposed strategic direction and stewardship functions effectively. Personality-based politics, rather than robust institutions and systems, primarily drive the variable implementation of ECCD among local governments.

## The following are our key findings per domain:

### • Outcomes

• The Philippines has significantly improved child survival over the past 50 years. Nevertheless, the pace of progress remains relatively modest, with the country trailing behind its regional counterparts and aspirational peers. Large health disparities persist across different regions and income groups and are characterized by challenges such as alarmingly high chronic malnutrition and learning poverty.

### • Access and participation

- Participation rates in pre-kindergarten programs for Filipino children aged 3-4 remain low, with only 20% participating in 2022. Disparities across regions range from 5% to 40%, indicating uneven access.
- Child health outcomes are impacted by maternal and child undernutrition and exposure to infections, which can result in chronic malnutrition and increased risk of mortality. In the Philippines, approximately 14% of women of reproductive age are underweight, increasing to 20% among poor young adolescents. Moreover, access to the most basic health services like prenatal care, child immunization, postnatal care, and other maternal and child services remains far from universal coverage.
- Only a quarter of Filipino children meet the recommended energy intake (REI), indicating challenges in addressing nutritional needs, especially among those aged 6-12 months from poor households.
- Despite government efforts such as school-based feeding programs, access remains limited, with only 23% of children benefiting. Even those attending daycare centers have not received government feeding programs.
- The impact of government school-based feeding programs on meeting REI is uncertain. Our analysis found no differences in REI between recipients and non-recipients, even after adjusting for selection bias through Propensity Score Matching.

# • Demand

- Cultural norms and lack of awareness influence limited participation in early education programs among children aged 3-4. Supply-side challenges exacerbate the issue, as evidenced in discussions with parents in specific regions highlighting disparities.
- A large portion of Filipino parents fail to involve their children in early stimulation activities, as only half of them (50%) consistently participate in reading and watching educational materials, with large socio-economic disparities.
- Discrepancies between parental knowledge and practice regarding health and nutrition, especially concerning breastfeeding and complementary feeding practices, are evident.

# • Supply

# • Governance

- Multi-sectoral collaboration in early education, and health and nutrition policies, exemplified by the ECCD Council and National Nutrition Council (NNC), faces challenges in genuine alignment of nutrition and early education programs, hindering effective implementation.
- Inefficiencies arise because of overlapping roles among key government agencies, lack of clarity in responsibilities leading to poor accountability, duplication of efforts, and weak vertical and horizontal coordination.
- Fragmentation in financing further complicates the situation, while limited technical capacity within multi-sectoral agencies hampers the effective execution of strategic direction and stewardship functions.
- Implementing ECCD among local governments is primarily driven by personality-based politics rather than robust institutions and systems.

# • Service Delivery and Infrastructure

- Almost 99% of the 70,000 public ECCD facilities are publicly owned. Although the Early Years Act (EYA) aims to convert daycare centers (DCCs) to child development centers (CDCs) to expand services and improve early education quality, the conversion rate remains below five percent even a decade later.
- The expansion of pre-kindergarten facilities over the years has been mainly led by the public sector, with minimal involvement from the private sector. This is potentially due to limited demand, as low participation rates across different socio-economic levels indicate.
- The increase in pre-kindergarten facilities is primarily attributed to the public sector. However, there are indications of poor quality.
- Approximately 85% of children have access to public DCC/CDC within their barangay, conveniently within walking distance, although this share decreases with higher socio-economic status. Almost all barangays in the Philippines have at least one public daycare/child development center and about 89% of municipalities and cities meet the DCC/CDC to barangay ratio requirement per RA 6972.
- There is a socio-economic gradient in DCC/CDC to barangay ratios, with poorer municipalities exhibiting lower ratios than wealthier first-class municipalities and highly urbanized cities. The DCC/CDC to population ratio is smaller in cities and first-class municipalities, with 12 daycare/child

development centers per 1000 population in cities and 19 in poorer municipalities.

- While the ratio of DCC/CDC to currently enrolled children indicate adequacy, it may not be sufficient to achieve universal ECCD enrollment. On average, there are 22 children per DCC/CDC. Still, there is a socioeconomic gradient, with cities and first-class municipalities reaching up to 37 children per DCC/CDC due to higher population densities. In comparison, poorer municipalities have a lower ratio of 19 children per DCC/CDC.
- Overall, the current supply of capital investments for ECCD in the country falls short of meeting the goal of universal access for children aged 3-4 to ECCD services. The country's current facilities are insufficient by around 33,000 to meet the 96,000 daycare/child development centers required to meet 100% of the demand.

### o Human Resource

- Existing facilities and daycare/child development workers (DCWs/CDWs) are insufficient to meet current demand, raising concerns about whether the current supply, already of questionable quality, can adequately cater to increased demand.
- The ratio of daycare/child development workers to enrolled children in the Philippines appears to surpass the standard set by the ECCD Council (1 DCW/CDW:10 enrolled children), which may affect the quality of care and attention given to each child. On average, there are 19 enrolled children per DCW/CDW, with variations depending on the location. For example, this ratio can increase to 30 in urban areas, surpassing the standard threefold.
- To meet the goal of universal access for children, the country needs three times its current stock of daycare/child development workers (around 89,000) or approximately 240,000 DCWs/CDWs.
- Around 50% of daycare/child development workers in the Philippines are high school graduates, with the remaining half being college graduates. The distribution of college graduates among DCWs/CDWs varies across local governments and is influenced by income class, with cities and first-class municipalities having more college-educated DCWs/CDWs.
- There is no standardized salary for daycare/child development workers, and the compensation system varies widely among local governments. Legislative support is needed to establish minimum salaries and other nonwage benefits for DCWs/CDWs.

#### • Financing

- Public and private sources fund ECCD programs, e.g., early education, health, and nutrition. However, accurately estimating spending on ECCD remains challenging.
- Despite decentralization, the national government remains the primary source of financing for early education, health, and nutrition services, with its contribution steadily rising. In a decentralized regime, national government grants for health, nutrition, and early education should ideally incentivize local governments to allocate more resources to ECCD services. However, evidence suggests that this may not be the case. Many health, nutrition, and early education interventions are "passive," merely filling the

financing gap in local governments. They are not designed to mobilize more local government resources or use them to incentivize local governments to implement high-quality early childhood care services.

- Efforts by the national government to increase fiscal space for early childhood education have been made, largely facilitated by support from PAGCOR. However, questions arise on the sustainability of national government spending.
- Household out-of-pocket (OOP) spending on preprimary education amounts to PHP 8 billion, with a significant disparity between the poorest and richest households. Attendance in early childhood education may not be entirely free, as half of those attending (48%) pay participation fees.

## How should the country move forward?

Our recommendations target the three key areas highlighted in our general observations: low participation and access to early education, health and nutrition, inefficient use of resources, and governance challenges:

- Improve participation rates in early education and essential health and nutrition services.
  - Roll out innovative financing mechanisms to improve participation in early education. The national government could pilot PPP models, such as voucher and block grant systems, and assess their impact on access and supply-side growth before implementing them on a larger scale (*short to medium-term*).
  - **Invest in science-based behavioral change communication (BCC) campaigns.** The national government should allocate resources to implement innovative BCC strategies, utilizing targeted messaging for diverse sociodemographic groups across various media platforms. This approach involves community engagement, continuous monitoring mechanisms, and potential collaboration with institutions/firms to develop comprehensive plans to effectively reach and engage the target audience *(short-term)*.

# • Increase public spending on ECCD and improve efficiency by investing resources in services that dramatically affect health, nutrition, and early education outcomes.

• Use national resources to leverage LGU spending on ECCD. In a decentralized regime, the responsibility for implementing ECCD programs (i.e., early education, primary healthcare, and nutrition) lies within the jurisdiction of local governments. To address performance variability, the government can strategically allocate resources to influence the ECCD spending of local governments, directing funds toward cost-effective and impactful services. For example, a small portion of IRAs (Internal Revenue Allotment) is earmarked to provide a predetermined set of services that make a significant difference. The national government could match grants for the delivery of specific services in high-income local governments and equitably allocate national resources to local governments with limited technical and financial capacities to implement early education, nutrition, and health services rather than spreading resources thinly. For example, the DOH had adopted an

allocation framework as part of the Devolution Transition Plan (DTP). This is critical in a more decentralized regime because of *Mandanas-Garcia Ruling* of the Supreme Court. However, this requires the national governments to improve the capacity to monitor performance effectively *(medium to long-term)*.

- Implement the UHC Act, which underscores the importance of investing in primary healthcare (PHC). The UHC Act could be significant in financing the delivery of essential maternal and child health and nutrition in a comprehensive and integrated way. In addition, the UHC Act could be used to ring-fenced financing for local governments through PhilHealth primary care/outpatient reimbursements. While the law is already in place, it has yet to be fully implemented. Also, the government must ensure that the revenues from PhilHealth primary care benefits to local governments are used only for PHC services, not inpatient and non-health/nutrition projects. This requires amending the UHC, which does not mandate that PhilHealth revenues allocated to local governments be spent exclusively for PHC services (*medium to long-term*).
- Reevaluate the implementation framework of the government's school feeding 0 program based on a comprehensive understanding of its advantages. Chronic malnutrition indicates persistent and systematic exposure to early childhood shocks such as illness and inadequate nutrition within the first two years of life. Hence, addressing this issue largely through school feeding interventions at a later developmental stage may not effectively address the underlying causes of chronic malnutrition or stunting. Despite mixed global empirical evidence regarding the effectiveness of school feeding programs in alleviating hunger and acute malnutrition, our findings do not demonstrate any significant improvement in the nutritional status of children, as measured by Recommended Energy Intake (REI). The government should comprehensively evaluate the school feeding program, starting with a thorough analysis of the adaptive challenges inherent in its implementation. These challenges may include issues such as the adequacy of program benefits and delays in rollout due to bureaucratic hurdles, which could explain the observable impact, at least on improving REI. Given the scarce resources, we recommend a targeted allocation of resources to areas with the greatest need, aiming to improve the program's efficacy rather than dispersing resources indiscriminately across the country (short-term).
- Increase investment in healthcare workers who can track the whole journey of mothers and children. Implement a program within the PHC system to enhance healthcare workers' capacity to monitor mothers throughout pregnancy and until the first few years of life. These healthcare workers will ensure regular monitoring of children, guaranteeing they receive essential healthcare, nutrition, early education, and stimulation until the age of 2-4. Equipping and incentivizing these healthcare workers with a well-designed strategy is essential. The government could implement a small-scale program and conduct rigorous evaluations (*short to medium-term*).
- Address governance challenges.
  - Transfer the chairship of multi-sector councils (i.e., NNC and ECCD council) to the Office of the President or a senior cabinet. The transfer signals the significance of nutrition and ECCD and ensures focused attention and support. Placing these councils under the oversight of the Office of the President removes

the co-equal dynamics among national agencies. It promotes better coordination and accountability among government agencies, leading to more integrated governance addressing ECCD issues (*short to medium-term*).

• Augment the capacity of multi-sectoral secretariats. Multisectoral agencies (e.g., NNC and ECCD council) should strengthen their stewardship and strategic direction functions rather than spreading themselves too thinly on program/project implementation functions, which are not their primary function. Interventions include providing organizational incentives to hire and retain highly competent NNC and ECCD Council staff (*short to medium-term*).

Keywords: early childhood care and development (ECCD), early education, health and nutrition, Philippines

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# Behind the Slow Start: An Assessment of Early Childhood Care Development in the Philippines

Valerie Gilbert T. Ulep, Lyle Daryll D. Casas, Aaron Carlos G. Manuel, John Paulo D. Mendoza, Joy Bagas, Kim Leonard G. Dela Luna <sup>\*</sup>

# 1. Introduction

Millions of Filipino children are failing to reach their full human development potential because of poor health, inadequate nutrition, and limited learning capacity. While the Philippines has made strides in improving the well-being of children in recent decades, they were modest. For example, the child death rate, on average, the most sensitive indicator of population health and well-being, has only declined by 2.5% annually, in contrast with the 4% reduction observed among its regional peers (World Bank 2024). Socio-economic and regional disparities are pervasive. Children from areas with high poverty incidence exhibit health outcomes comparable to those in the poorest countries in the world. Chronic malnutrition is prevalent, with one in three Filipino children under five years old experiencing stunting — a condition that has persisted for the past three decades. Stunting is a human development crisis. Overwhelming empirical evidence suggests the detrimental effects of stunting on cognition, learning abilities, and long-term health and productivity outcomes (Soliman et al. 2021). The learning gap among Filipino children is large. They lag their expected academic level by six years compared to learners in other countries (Bautista and Aranas 2023). These outcomes highlight Filipino children's challenges and raise concerns regarding their prospects and the country's economic competitiveness.

Countries with large improvements in child outcomes have adopted Early Childhood Care Development (ECCD) at the forefront of their strategy. ECCD offers a window of opportunity to shape the course of holistic development of children and build a foundation for them to reach their full potential (UNICEF 2023). It emphasizes the importance of providing children aged 0-4 with high-quality nutrition and healthcare, especially during the first 1,000 days of life, and access to early education that supports their development. Parents and caregivers should be supported with nurturing care and positive parenting skills (UNICEF 2017).

Child health and early education programs have existed in the Philippines since time immemorial. Still, recognition as a holistic approach only materialized through the enactment of the Early Childhood Care and Development (ECCD) Act in 2000 and then again in the Early Years Act in 2013. Challenges in the ECCD system include fragmentation in governance and institutional arrangements and inefficiencies and inequities in capital infrastructure, financing, and human resources.

In this report, we assess the implementation of ECCD in the Philippines, analyzing population surveys and administrative records collected from government and multilateral agencies. We

<sup>&</sup>lt;sup>•</sup> VGU is a Senior Research Fellow, LDC is a Research Specialist, ACM is a Project Technical Specialist, JPM was a research analyst to VGU, JB is a consultant, and KLDL is a consultant at the Philippine Institute for Development Studies. The authors would like to thank the excellent administrative assistance of Junalyn T. Bayona, and the assistance on the statistical and data access concerns of Mr. Eldridge B. Ferrer, Science Research Specialist II and Ms. Ma. Lynell V. Maniego, Senior Science Research Specialist of the Food and Nutrition Research Institute for National Nutrition Survey data.

supplement our findings with qualitative investigations and case studies. Our analysis covers key input domains for ECCD, such as governance and institutional arrangements, financing mechanisms, the healthcare and education workforce, and delivery and capital infrastructures. The report is structured as follows: Section II provides an overview of the methodology employed in this study. Section III explores the concept of ECCD, including a brief historical overview of ECCD in the Philippines. Section IV assesses health and early education outcomes and input domains. Finally, Section V outlines specific recommendations and legislative actions.

# 2. Methods

a. Assessment Framework

In this study, we propose a conceptual framework to guide our assessment (see **Figure 1**). We argue that limited access and participation in **high-quality** early education programs and health and nutrition services during the early years equitably contribute to poor education and health outcomes. Supply- and demand-side inputs influence poor access and participation. Supply-side factors include human resources, governance and institutional arrangements, financing, service delivery, and infrastructure. Demand includes perceptions, behaviors, and existing practices of parents and caregivers - all factors that shape access and participation.







# b. Data collection

This is a mixed-methods study. We analyzed existing population surveys and administrative data from various government agencies. To supplement our quantitative analysis, we conducted policy scanning, key informant interviews, and focus group discussions with stakeholders from national and local governments. Key informants include representatives from government agencies involved in ECCD policymaking and implementation. In contrast, focus group discussions include provincial and municipal social welfare and development officers, health officers, and nutrition action officers.

# 3. Early Childhood Care Development: A Brief Overview

a. What is Early Childhood Care Development (ECCD)?

**ECCD is a comprehensive approach.** It captures all the aspects of a child's early years, including physical, cognitive, social, and emotional development. ECCD programs provide nurturing environments, health care, nutrition, early learning opportunities, and support for caregivers and families (UNICEF 2023). Effective delivery requires converging multi-sectoral initiatives involving different agencies such as health, education, and social protection. This convergence mandates policy alignment, integrated service delivery mechanisms, data sharing, and community-based approaches.

**ECCD is time-sensitive.** Empirical studies show that by age five, around 90% of a child's brain development is complete, laying the foundation for future success in school (Zubairi and Rose 2017). Early learning experiences influence later development, with a child's nutritional status before starting school affecting their learning ability once enrolled. Many sensitive developmental stages begin during prenatal, where maternal health and nutrition critically impact fetal development (Almond and Currie 2011). The most rapid brain growth occurs in the last trimester of pregnancy and the first two years of life or the first 1000 days. Inadequate nutrition during this period can lead to lifelong consequences such as stunting (Zubairi and Rose 2017). Effective health, nutrition, and early learning delivery for 0-4-year-olds must be delivered comprehensively and consistently during these critical periods.

**ECCD has multiplier and latent effects.** ECCD yields positive outcomes in education, health, and overall well-being. These benefits extend beyond individual gains, impacting broader societal dimensions such as economic productivity and social stability. However, these benefits are often latent, manifesting in later stages of development during adolescence and adulthood (Braveman, Sadegh-Nobari, and Egerter 2011). This has implications for how decision-makers assess the costs and benefits of ECCD programs amid competing government priorities for resource allocation and budgeting. This perspective should change government budgeting and reporting of ECCD inputs. Unlike capital infrastructure (e.g., civil works), ECCD infrastructure is considered expenditure or consumption rather than investments or assets. From an accounting standpoint, governments do not amortize the cost over the lifespan of ECCD infrastructure, and the expense is recorded annually (Myers 2008).

# b. Why is ECCD important?

**Early childhood education is widely recognized as fundamental in building "more efficient and effective education systems**" (UNICEF 2019a). Studies show that participation in early education can help children avoid special education, grade repetition, early parenthood, and incarceration due to delinquent behaviors—outcomes that imply high costs for the government to curb or support (The Center for High Impact Philanthropy 2015). The SDG targets "all girls and boys to have access to quality early childhood development, care, and preprimary education so they are ready for primary education" by 2030. The continuum of education services could typically be divided into three stages: (1) Neonatal (for children aged 0 to 2, or the "first 1,000 days"), (2) Pre-Kindergarten (for children aged 3 to 4) and about early

childhood education that is either home, community, or center-based, and (3) Kindergarten (for children aged 5).

**Poor participation in early childhood education has short- and long-term consequences on educational outcomes.** Children without access to early education have higher chances of dropping out and lower chances of attaining upper levels of schooling (Baum 2020). Also, studies in the Philippines and Argentina illustrate large gains in literacy and numeracy following pre-primary schooling (UNICEF 2019b). The 2012 Program for International Student Assessment (PISA) results confirm this, showing how learners with access to at least one year of pre-primary schooling performed 53 percentage points higher in secondary math than those without (Zubairi and Rose 2017).

Health and nutritional status during children's early years, particularly during the first two years (i.e., first 1,000 days), profoundly impacts health, education, and labor productivity in later life. Proper nutrition during the first two years of life prevents stunting and plays a critical role in brain development. It is important that after this period, poor nutrition has been seen to have irreversible consequences on her physical, cognitive, and socioemotional growth, thus posing nontrivial implications on the child's health, education, and even economic trajectories (World Bank 2013).

**Improved child health correlates with favorable labor market outcomes.** Carba, Tan, and Adair (2009) show that Filipino males no longer in school had a higher height-for-age z-score associated with a 40% increase in the likelihood of formal work compared to not working. Among females, each unit increase in height-for-age z-score is associated with a higher likelihood of formal work (Carba et al. 2009). These are consistent with global findings that, in the long run, children unable to access ECCD are more likely to be unemployed, earn less, be unhealthy, and have lower life expectancy (Jeong, Pitchik, and Fink 2021).

# c. ECCD in the Philippines

**Early childhood education programs have a long history in the Philippines** (see Figure 2). The policy framework governing early childhood education traces back to 1974 through Presidential Decree (PD) 603 or the Child and Youth Welfare Code, which established a nursery for children aged six and below. This initiative was formalized with RA 6972, the Barangay-Level Total Development and Protection of Children Act 1990. This law mandated the establishment of a daycare center in every barangay. While the Department of Social Welfare and Development (DSWD) was responsible for setting guidelines and providing funding under this law, the actual implementation relied on local government units (LGUs). The following year, RA 7160 (Local Government Code) later fully devolved this responsibility to the LGU through the barangays, reliant on the funding allocated by the Local School and Health Boards and the priorities of the Local Development Council (Manuel and Gregorio 2011).

The holistic needs of children were only recognized twenty years ago with the passage of RA 8980, known as the ECCD Act of 2000. The law intended to cover the "full range of health, nutrition, early education, and social services programs" (Section 4a); the law brought together nine (9) executive agencies to craft national policies and programs while relying on LGUs to implement and fund the programs (Section 7). The law mandated the establishment of a National Coordinating Council for ECCD, including provincial, city municipal, and barangay coordinating committees, to oversee the effort (Section 8). Following the passage of

RA 10157 or the Kindergarten Education Act in 2012 making pre-primary education at age five a prerequisite to entry to Grade 1 (Section 3c), the ECCD space was once again reorganized under RA 10410 or the Early Years Act (EYA) of 2013, with the expressed aim of facilitating "a smooth transition from care and education provided at home to the community or school-based setting and kindergarten" (Section 3), carried through the (1) establishment of standards for ECCD programs and professionals, (2) coordination of ECCD programs of DepEd, DSWD, DOH, and NNC, and (3) the targeting of ECCD programs, funds, and supports to the poorest communities (Section 10).



Figure 2. History of Early Childhood Education Program

Source: Authors' illustration of the policies based on the Presidential Decree (RP 1974) and Republic Acts (RP 1990, 1991, 2000, 2012a, 2013).

Child health and nutrition have been part of the government agenda for decades (see Figure 3). National policies have been implemented to reinforce children's health and nutritional well-being during crucial developmental stages. For instance, the Expanded Program for Immunization (EPI), established in 1976 (PD 996), promotes timely vaccination against common vaccine-preventable diseases (VPDs) like measles, diphtheria, tetanus, and pertussis. The Milk Code (EO 51), enacted in 1986, offers guidance on optimal breastfeeding practices, particularly during the first six months of life. Subsequent legislative actions and laws, such as the International Code of Marketing of Breast-milk Substitutes (1981), numerous World Health Assembly resolutions, the Baby-friendly Hospital Initiative (BFHI) in 1990, the Maternity Protection Convention in 2000, and the Global Strategy for Infant and Young Child Feeding in 2002, have been passed to reinforce breastfeeding practices. More recently, RA 10354, also known as the Responsible Parenthood and Reproductive Health (RH) Act of 2012, is a significant legislative milestone. This law ensures access to reproductive health information, facilities, and services, particularly for marginalized populations, through sustainable reproductive health programs. Moreover, the RA 11037, or the Masustansyang Pagkain para sa Batang Pilipino Act of 2018, complements the First 1,000 Days law (RA 11148) by institutionalizing a National Feeding Program in public daycare centers, kindergartens, and elementary schools. This program includes micronutrient supplements, health examinations, vaccinations, deworming services, WASH facilities, and health information campaigns, focusing on promoting healthy dietary practices for infants and children. Given its broad scope, the IRR of the law indicated priority areas being LGUs with the highest prevalence of undernutrition aged three years old to Grade 6, those with the capacity to implement the programs, or those willing to prioritize and provide counterpart funds (Section 6).

The Universal Health Care (UHC) Act of 2019 (RA 11223) was enacted to address the need to provide accessible, affordable, and comprehensive healthcare services to all (Section 3b). Implementing the Universal Health Coverage (UHC) Act in the Philippines marks a significant step towards ensuring healthcare access for all citizens. The UHC Act addresses crucial health and nutrition service delivery gaps by guaranteeing PhilHealth coverage to every Filipino and expanding primary healthcare benefits. Furthermore, it aims to broaden the role of insurance and address governance structures at both local and national levels to enhance care delivery. Through financing pooling and quality improvement initiatives, the UHC Act seeks to improve healthcare services' efficiency and effectiveness while strengthening health promotion efforts. The UHC Act has yet to be fully implemented.



#### Figure 3. History of Health and Nutrition Programs

Source: Authors' illustration of the policies based on Presidential Decree (RP 1976), Executive Order (RP 1986), and Republic Acts (RP 2012b, 2018a, 2019)

**Social protection policies are in place to improve the well-being of children**. The enactment of the Child and Youth Welfare Code of 1974 was crucial in establishing children's rights and responsibilities and relevant stakeholders, such as the Council for the Welfare of Children (CWC). This legislation laid the groundwork for subsequent initiatives to safeguard Filipino youth's welfare. One such initiative is the *Pantawid Pamilyang Pilipino Program Act (RA 111310)*, which prioritizes inclusivity by providing comprehensive preventive health and nutrition services. These services encompass regular prenatal check-ups, vaccinations for children aged 0 to 5, deworming treatment for those aged 1 to 14, and mandatory enrollment in daycare or preschool for children aged 3 to 4. Families who adhere to these requirements are eligible for financial support in the form of conditional cash grant, including a monthly subsidy per child enrolled in daycare and additional assistance for health and nutrition needs.

# 4. Key Findings and Results

a. Health and education outcomes of Filipino children

The scale of poor health and nutrition

Over the past century, developing countries, including the Philippines, have experienced significant improvements in life expectancy. This can be attributed to improved child survival rates because of the decline in infant mortality. Factors contributing to this trend include improved nutrition, advancements in public health infrastructure (e.g., sanitation), and increased access to life-saving medical interventions, such as vaccines. From the 1960s to 2020, life expectancy at birth in the Philippines has risen by ten years. A child born in the Philippines in 2020 can anticipate living a decade longer than a counterpart born in 1960. However, it's essential to note that these improvements are modest compared to regional and aspirational peers. Figure 4 depicts the gradual progression of life expectancy at birth over time. In the 1960s, the Philippines had one of the highest life expectancies at birth in Asia, surpassing post-war Korea and China. However, by 2020, the position of the Philippines (indicated by the red line) had fallen behind to a level comparable to Cambodia, which began from an exceptionally low starting point. The infant mortality rate in the Philippines, standing at 26% infant deaths per 1,000 live births in 2020, remains high in comparison to many other nations. This rate highlights the persistent challenges in attaining universal access to life-saving health interventions and nutrition services. The failure to achieve its Millennium Development Goals (MDGs) aimed at reducing infant mortality suggests the need for pathbreaking maternal and child health interventions to prevent a similar outcome concerning the country's Sustainable Development Goals (SDGs).



Figure 4. Life expectancy at birth, Philippines with comparator countries

Source: Authors' analysis and visualization of data from the World Development Indicators (World Bank 2024).

Substantial disparities in child health outcomes persist in the Philippines, hindering overall progress. Significant variations exist in child health outcomes throughout the country, with certain regions reflecting the health status observed in the poorest nations globally. For instance, the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) demonstrates an infant mortality rate twice that of the national average. Children from the poorest households have five times worse outcomes than their wealthiest counterparts.



Figure 5. Infant mortality rate per 1,000 livebirths and GNI per capita (in USD), Philippines and ASEAN

Source: Authors' analysis and visualization of the World Development Indicators (World Bank 2024) and 2022

National Demographic and Health Survey (PSA 2022b).

**Many Filipino children are chronically malnourished or stunted.** In 2019, approximately 29% (about 3.3 million) of children under five years old were stunted (too short for their age), a marker of chronic malnutrition, making the Philippines one of the high-burden countries. (UNICEF 2020). Stunting has a profound impact on human development and the economy. It has negative effects on cognitive and learning abilities, health and labor productivity during adult years. Hence, it exacerbates intergenerational cycles of poverty with far-reaching consequences (Georgiadis and Penny 2017). The economic cost of stunting is staggering in the Philippines, estimated at PHP 174.4 billion per year (UNICEF 2019c).

The Philippines has not experienced a significant reduction in stunting. Chronic malnutrition has remained persistently high in the past three decades. While it has shown improvement since the early 1990s, the rate of decline compared to other countries could have been faster. Many developing countries have recorded significant declines in stunting, including those with initially high levels of chronic malnutrition. Still, the Philippines has only experienced an annual decline of about 1%, in stark contrast to the 5-6% declines observed in countries like Vietnam and China. Ulep, Uy, and Casas (2022) have argued the paradoxical relationship between economic growth and child health outcomes in the Philippines. Despite experiencing rapid economic growth over the past two decades, the prevalence of chronic malnutrition remains high. While many believe that macroeconomic growth is the primary driver of improved health and nutritional outcomes, this notion assumes that economic growth

will translate into higher incomes, especially among people experiencing poverty, thereby improving nutritional status and well-being. However, empirical evidence contradicts this assumption (Ulep et al. 2022). This highlights the complex relationship between economic growth and nutrition outcomes in the Philippines. This suggests the role of income inequality and government resource allocation efficiency in high-growth regimes. **Figure 6** illustrates the relationship between regional income growth and the prevalence of stunting. The growth in regional income (per capita constant terms) is not commensurate with the growth improvement in stunting. Some regions (e.g., NCR and Region XII) have experienced increased stunting rates.



Figure 6. Average annual growth rate of regional GDP per capita vis-a-vis stunting growth rate (2000-2018)

Source: Authors' analysis and visualization of 2000-2019 data from the Expanded National Nutrition Survey (DOST-FNRI 2019) and Regional Accounts of the Philippines (PSA 2023).

The disparity in chronic child malnutrition in the Philippines is striking, manifesting even at an early age, and placing poor children at a disadvantage from the start. There exists a substantial gap in stunting prevalence across various socio-economic groups. In 2019, approximately 42% of children from the lowest quintile (Q1) were stunted, contrasting sharply with the 11% prevalence among children from the highest quintile (Q5). This absolute difference of 31 percentage points between the poorest (Q1) and wealthiest (Q5) quintiles positions the Philippines among countries with the most pronounced inequality in this regard. Of particular concern is the timing at which this disparity emerges. While the gap remains relatively narrow during the neonatal period, it begins to widen notably after five months of age. This sharp acceleration in the gap between the poorest and richest is illustrated until 24 months, after which it stabilizes (see Figure 7). This highlights the importance of the first 1,000 days in addressing chronic malnutrition.

Figure 7. Prevalence of stunting among children under five from the top 20% and bottom 20% wealth quintiles by age in months, 2019.



Source: Authors' analysis and visualization of 2019 Expanded National Nutrition Survey data (DOST-FNRI 2019).

The scale of learning crisis

Learning poverty presents a significant challenge in the Philippines, with a staggering 91 percent of children in late primary school lacking proficiency in reading. The country grapples with one of the highest rates of 'learning poverty' in the ASEAN region (World Bank 2022). Despite substantial increases in basic education participation in recent decades, with most regions achieving a 100% enrollment rate, the quality of learning has not seen commensurate improvement. As of 2023, the harmonized test score, a widely used indicator of school learning quality, revealed that the Philippines trails behind in reading, math, and science performance. The underperformance of Filipino learners may stem from persistent supply issues in the education sector, reflecting broader challenges in early childhood education, health, nutrition, and overall well-being.

While various metrics exist to assess cognitive ability, data indicates the presence of inequality in intelligence quotient (IQ) tests among Filipino learners. Analysis of data from the UNFPA indicates that Filipino children from higher socio-economic backgrounds tend to achieve higher scores on IQ tests compared to their counterparts from lower socio-economic backgrounds. This gradient likely reflects a range of factors, including disparities in access to quality education, cognitive stimulation in the home environment, and economic resources that facilitate intellectual development. However, it is critical to recognize that IQ tests represent just one facet of cognitive ability and may not fully capture the breadth of human intelligence or potential.

Figure 8. Distribution of Raven Progressive Matrices Score of Filipino children aged 10. across the socioeconomic status of children.



Source: Authors' analysis and visualization of UNFPA's Longitudinal Cohort Study on the Filipino Child (UN 2021). Note: The Raven Progressive Matrices (RPM) is a non-verbal test designed to measure abstract reasoning ability, often considered a measure of fluid intelligence. It's commonly used in psychology and education settings to assess cognitive abilities, particularly in problem-solving, pattern recognition, and logical reasoning.

#### b. Access to early education, health, and nutrition services

Participation in early childhood education

**Participation in early education among Filipino children aged 3-4 years old is low.** Between 2011 and 2017, despite the implementation of significant legislation such as the "Kindergarten Education Act" in 2012, the "Enhanced Basic Education Act," and the "Early Years Act" in 2013, participation rates in pre-kindergarten programs targeting children aged 3-4 remained stagnant. Analysis of multiple rounds of the Annual Poverty Indicators Survey (APIS) indicates modest progress during this period. However, the onset of the pandemic resulted in a drastic decline in participation rates to less than 2%. By 2022, the participation rate had recovered to 20%, yet it still falls below pre-pandemic levels (see Figure 9).

**Disparities in participation rates in early childhood education are evident across different regions of the Philippines**. The lowest participation rates in pre-kindergarten programs are observed in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), where less than 5% of children are enrolled, compared to almost 40% in the Ilocos Region. While participation in pre-kindergarten programs is generally low nationwide, significant variations exist across regions. Participation rates remain relatively low even in affluent areas such as

Region IV-A (CALABARZON) and the National Capital Region (NCR). This disparity challenges the notion that higher regional income levels necessarily translate to increased access to early education, highlighting the presence of other barriers or factors influencing participation rates (see Figure 10).





Source: Authors' analysis and visualization of 2011-2022 Annual Poverty Indicators Survey rounds (PSA 2022a)





Source: Authors' analysis and visualization of 2022 Annual Poverty Indicators Survey (PSA 2022a).

**Participation rates in pre-kindergarten programs exhibit significant market segmentation between the public and private sectors.** Following the implementation of compulsory Kindergarten education in 2013, efforts have concentrated on enhancing participation in early childhood education for children aged 3 to 4. Nonetheless, challenges persist in ensuring equitable access to pre-kindergarten programs. Examination of different rounds of the Annual Poverty Indicators Survey (APIS) reveals that participation rates in pre-kindergarten programs in 2022 varied significantly across socioeconomic strata. Participation rates ranged from 19% among the top 20% wealth quintile to 21% among the bottom 40%. Moreover, analysis suggests a trend wherein a disproportionate share of children from affluent households are enrolled in pre-kindergarten programs offered by private institutions. This observation underscores the existence of market segmentation in early childhood education, indicating potential disparities in both the provision and perceived quality of services.

# Figure 11. The percentage of children aged 3-4 years old attending school (public and private) is in the bottom 40% and top 20% income quintile, 2022.



Source: Authors' analysis and visualization of 2022 Annual Poverty Indicators Survey (PSA 2022a).

Access to health and nutrition services

Child health outcomes result from cumulative exposure to shocks experienced from pregnancy to early childhood. These shocks include maternal undernutrition during pregnancy, nutritional deficiencies in early childhood, and infections or diseases. These shocks directly contribute to chronic malnutrition and increase the risk of death in children. This analysis delves into the challenges hindering access to essential health and nutrition services during these critical developmental stages.

Around 14% of women of reproductive age in the Philippines are undernourished, with this percentage climbing to 20% among poor young adolescents. Malnourished mothers are confronted with an elevated likelihood of giving birth to infants with low birth weights, a circumstance that may entail both short-term and enduring consequences. The fetal origins hypothesis suggests that shocks experienced during pregnancy, such as inadequate nutrition, expose the fetus to significant stress, leading to repercussions in later life, including lower test scores, educational achievements, income levels, and poorer health outcomes (Almond and Currie 2011).

A significant proportion of pregnancies in the Philippines coincide with young adolescence, a period characterized by heightened maternal undernutrition. Figure 12 shows a notable propensity for pregnancies during young adolescence, particularly among women from low-income households. This adolescent period coincides with a high prevalence of undernutrition (i.e., BMI of less than 18). The primary challenge lies in the insufficient access of Filipino women, particularly young adolescents, to essential family planning resources. Moreover, in the event of pregnancy, access to maternal nutrition, micronutrient supplementation, and prenatal care is often limited, exacerbating the shocks experienced by the infant in utero.



Figure 12. The proportion of underweight women and proportion of pregnant women by age.

Source: Authors' analysis and visualization of the 2019 Expanded National Nutrition Survey (DOST-FNRI 2019).

	Pre-pregnancy	Pregnancy				
	Access to modern contraceptives	Prenatal care during the first trimester	Micronutrient supplementation	Checkup after discharge/delivery		
Bottom 40%						
Young adolescent	60.02%	54.04%	81.74%	52.62%		
All mothers	54.42%	62.70%	83.01%	49.65%		
<i>Top 20%</i>						
Young adolescent	76.40%	29.74%	80.04%	49.88%		
All mothers	52.64%	86.69%	94.03%	65.60%		
All sample						
Young adolescent	60.76%	56.20%	80.30%	56.45%		
All mothers	53.16%	71.62%	87.71%	55.81%		

Table 1. Coverage of essential health services during pre-pregnancy and pregnancy amongFilipino mothers by socio-economic status and age, 2022

Source: Authors' calculation and tabulation of data from the 2022 National Demographic and Health Survey (PSA 2022b)

Many children are not receiving essential healthcare services, which are needed to improve health and nutritional status, particularly in preventing infections and reducing severe complications of infectious diseases. Illnesses contribute to chronic malnutrition. They decrease appetite, resulting in insufficient nutrient intake. Also, they are stressors to the child, increasing the risk of malabsorption and nutrient loss. In the Philippines, the incidence of diarrhea varies significantly across socioeconomic status and regions. Children from lowincome households are twice as likely to experience infectious diseases compared to their affluent counterparts (PSA 2022b). Differences in sanitation and hygiene practices and access to essential health services such as vaccination and diarrhea treatment drive this disparity. Only 75% of Filipino children are fully immunized, indicating that a large segment of the children population remains vulnerable to vaccine-preventable infections. The country falls short of the recommended 95% coverage for population protection against diseases. This places the Philippines among the countries with the lowest vaccination coverage in the ASEAN region, with large regional inequality. In the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), merely 30% of children receive the required DPT3 vaccination. This figure is even lower than in fragile states, where only 15% of children have received vaccinations.

Figure 13. DPT3 vaccination coverage, Philippines regions, and neighboring countries, 2022



Source: Authors' analysis and visualization of the 2022 National Demographic and Health Survey (PSA 2022b) and World Development Indicators (World Bank 2024).

The prevalence of poor nutrition among Filipino children, particularly during critical developmental stages, is a matter of concern. Many children in the Philippines fail to meet the Recommended Energy Intake (REI), particularly among children aged 6-12 months from poor households, where only 24.8% achieve the recommended energy intake (DOST-FNRI 2022a). Regarding macronutrient distribution, carbohydrates contribute the largest to the child's energy intake, with an average intake of around 230 grams, followed by protein (45 grams) and fat (25 grams), varying across wealth quintiles. Among children from the bottom 40% quintile, protein intake is around 19 grams and 40 grams compared to their richest counterparts, at 35 grams and 50 grams, respectively. Protein is essential for growth and development, playing a crucial role in tissue growth, including muscles and bones, to prevent stunting (Xiong et al. 2023). The Minimum Acceptable Diet (MAD), an alternative metric for assessing nutritional adequacy, accounts for the quality and quantity of food intake that shows low levels. In 2019, a mere 12% of children aged 6-23 months old met the criteria for the MAD (DOST-FNRI 2022b). These tracer indicators highlight the challenges faced by Filipino children in achieving adequate and balanced nutrition during critical developmental stages.

Figure 14. Share of children meeting energy intake of children under five from the top 20% and bottom 20% wealth quintiles by age in 2018-2019.



Source: Authors' analysis and visualization of pooled 2018-2019 Expanded National Nutrition Survey (DOST-FNRI 2019).





Source: Author's analysis and visualization of the 2019 Expanded National Nutrition Survey (DOST-FNRI 2019). Note: Carbohydrates include cereals and cereal products, starchy roots and tubers, sugars and syrups, and vegetables and fruits. Protein includes fish, meat, poultry, eggs, milk and milk products, dried beans, nuts, and seeds. Fats include all kinds of fats and oils.

The government acknowledges the insufficient food and nutrient intake among Filipino children. It has instituted feeding programs as primary interventions, but uptake still needs to be improved and shows signs of inefficiency. In 2017, the Philippine Congress enacted the National School-Based Feeding Program (SBFP) in public daycare centers, kindergartens, and elementary schools to address undernutrition under RA 11037 (National Feeding Act) alongside other initiatives such as the DSWD Supplemental Feeding Program. Under the SBFP, undernourished kindergarten and elementary pupils are provided with deworming tablets, at least one fortified meal, and micronutrient supplementation for at least 120 days annually. The DSWD and DEPED feeding programs are expected to spend PHP 11 billion in 2024 (RP 2023). However, access to these programs remains limited, particularly during the crucial early years of life, when chronic malnutrition tends to establish irreversibly (i.e., the first 1000 days).

According to the 2022 APIS, only 23% of children have benefited from any government feeding program. From an equity standpoint, while only 28% of poor children in need of feeding support have received assistance, a considerable percentage from the richest quintile has also benefited from government feeding programs. We observe a higher percentage of children aged four years old receiving government feeding programs, which reflects the implementation of school feeding initiatives in daycare centers and kindergarten schools. This low percentage of children benefiting from SFP is also reflected in the administrative data of DSWD, which is lower than estimates from national surveys (see Figure 16). The percentage of children under two years of age, a critical period for development, who received government feeding programs only stands at 17%.





Source: Authors' analysis and visualization of the 2022 Annual Poverty Indicators Survey (PSA 2022a)





Source: Authors' compilation and visualization of the program data (DSWD 2023b).

While daycare centers are mandated to provide feeding programs, many enrolled children have yet to access government-sponsored feeding programs. Among children aged 3-6 attending daycare or kindergarten, only around 35% are benefiting from the government feeding program (see Figure 18). Only 34% of children aged 3-4 attending daycare centers have received feeding programs. However, children attending pre-primary education are twice as likely to receive school feeding programs from the government compared to their non-attending counterparts.





Source: Authors' analysis and visualization of 2022 Annual Poverty Indicators Survey (PSA 2022a).

We have yet to observe the impact of SFP on meeting the recommended energy intake (REI). The lack of observed impact of the School Feeding Program (SFP) on meeting recommended energy intake (REI) raises significant implications. Despite its potential effectiveness depending on overarching objectives, our analysis, which uses REI, does not reveal differences in the percentage of children meeting REI between SFP and non-SFP recipients. Moreover, even after conducting a Propensity Score Matching (PSM) analysis to adjust for selection bias, we did not observe significant differences in the proportion of children meeting total energy and protein intake even after adjusting for possible selection bias. This suggests further investigation and potential adjustments to the program to ensure its effectiveness in addressing nutritional needs (see Table 2).

Variable	Sample	Treated	Controls	Difference	S.E.	T-stat
Meeting energy intake	Unmatched	0.082	0.104	-0.022	0.013	-1.73
	ATT	0.082	0.094	-0.012	0.014	-0.86
Protein intake (in grams)	Unmatched	26.93	26.76	0.020	0.641	0.03
	ATT	26.91	27.06	0.167	0.675	0.25

Table 2. Results of the Propensity Score Matching

Source: Authors' calculation and tabulation of 2018-2019 Expanded National Nutrition Survey (DOST-FNRI 2019). Note: The propensity scores for participation in a Supplementary Feeding Program (SFP) were predicted from a multiple logistic regression model. The model includes child age, sex, wealth quintile, region (residence), WASH sanitary practices, deworming participation, vitamin supplementation participation, mother's educational attainment, and mother's nutritional status (BMI). Propensity scores matching analysis used the Kernel matching technique, which takes the local averages of the comparison group observations near each treated observation to construct the counterfactual for that observation (Cameron and Trivedi 2005).

### c. Demand for early education, health, and nutrition.

Demand pertains to the readiness and capacity of parents and caregivers to enroll their 3- to 4-year-old children in early education programs, considering various factors that influence their decision-making process. These include disparities in access to information, which affect awareness and practices, thereby influencing child development outcomes.

Many parents of 3- to 4-year-old children opt out of early education programs because they believe it is premature for educational activities, a perception observed across poor and affluent households. While financial constraints and the availability of early education services are more significant factors for low-income families, they only contribute minimally to the overall reasoning. In our focus group discussions with mothers in the poorest provinces of the Philippines, financial limitations emerged as a prominent barrier, making formal daycare services unaffordable due to prohibitive opportunity costs and related expenses, particularly for certain socioeconomic groups. Details are shown in Table 3.

Table 3. Top reasons for non-attendance	in schools for children aged 3-4, by wealth quintile,
2019.	

Top reasons	Bottom 40%	Тор 20%
Too young to go to school	97.30%	99.07%
Financing reasons	0.61%	0.00%
Supply-side issues (e.g., distance, transportation)	0.90%	0.00%
Others (e.g., lack of personal interest, illness disability)	1.18%	0.93%

Source: Authors' calculation and tabulation of 2019 Functional Literacy, Education, and Mass Media Survey data (PSA 2019).

Low attendance in early education, particularly among 3- to 4-year-old children, may be attributed to various factors. Cultural beliefs, developmental misconceptions, and a lack of awareness about the benefits of early education contribute to parents perceiving it as premature or unnecessary. Additionally, inadequate government initiatives to emphasize the significance of early education exacerbate this issue. Our focus group discussions with mothers in BARMM highlighted supply-side challenges as well (LDS 2023).

"The facilities are not conducive. Those who can afford it bring their children to private schools. So those in public schools, what I see, lack workforce, teachers, and facilities." [LDS1]

"I took my child to an Arabic school, and she didn't go back to that school because the facilities were bad—dark rooms. This provides many not-so-good experiences for the learners." [LDS2]

These concerns have been amplified by the recent pandemic, man-made conflicts, and political climate in various regions that deter parents from utilizing formal childcare services (LDS 2023) (MC 2023).

"In certain areas, the distribution of commodities is being politicized. Barangay captains refuse to distribute supplies to those not part of their political alliance, leading to deprivation for individuals in those communities." [LDS5]

"The system was developed and downloaded to the LGUs for use as a reporting system. However, the pandemic disrupted the full rollout of the system." [MC1]

This is compounded by transportation and logistical challenges that increase the opportunity cost of sending children to daycare centers, further discouraging enrolment due to difficulties in commuting to and from such facilities (NV 2023) (LDS 2023). The discussants stated that:

"These reasons include lack of time for the mother to fetch the child, the mother being with her child when she is out, the child being affected by a fire, or being moved to another barangay." [NV1]

"There needs to be a pathway to school. Until now, water has been a problem for us. Even our temporary evacuation centers still lack water. Personally, I and everyone else have been traumatized." [LDS3]

Many parents and caregivers need to engage in early stimulation activities during the critical period of their child's development, with disparities across different socioeconomic status. Early learning stimulation enhances cognitive abilities and fosters positive outcomes, including improved language development and critical thinking skills. For example, early exposure to stimulating activities like reading and watching educational materials enriches children's cognitive abilities and lays a foundation for lifelong learning and academic success (Lurie et al. 2021). However, in the Philippines, only around 50% of the children frequently read and watch educational media with their caregivers, with a significant socio-economic gradient.





Source: Authors' analysis and visualization of pooled 2019 Expanded National Nutrition Survey (DOST-FNRI 2019).
Regarding health and nutrition, there seems to be a disconnect between knowledge and practice for selected tracer indicators (e.g., breastfeeding, and complementary feeding) we analyzed. Approximately 90% of mothers receive nutrition-related counseling during prenatal care (PSA 2022b). Lower-income mothers often seek prenatal care from nurses or midwives, while those from higher-income households tend to consult doctors. Disparities exist in the types of facilities used, with mothers from high-income households opting for hospitals and those from poorer households accessing clinics. However, knowledge is not translated into practice. Among those children with mothers who received nutrition counseling, only 55% were exclusively breastfed during their first five months, and 87% were introduced to complementary foods for 6-8 months, with socioeconomic growth (see Figure 21). Children from low-income households were more likely to be exclusively breastfed than those coming from rich counterparts. This disconnect in knowledge and practice could be driven by awareness of the benefits and the conduciveness of environment to practice these critical nutrition-related behaviors.



Figure 20. Prenatal care provider of mothers, by wealth quintile, 2018

### Figure 21. Percentage of children with mothers who received nutrition counseling practiced exclusive breastfeeding for 0-5 months and introduced complementary foods among 6-8 months, by wealth quintile, 2019.



Source: Authors' analysis and visualization using 2019 Expanded National Nutrition Survey data (DOST-FNRI 2019).

Source: Authors' analysis and visualization of the 2018 Expanded National Nutrition Survey (DOST-FNRI 2019).

### d. Supply-side Factors

### Governance

The government acknowledges that ECCD requires a multi-sectoral collaboration for effective implementation, as stipulated in RA 10410 of 2013, which mandates the establishment of the ECCD Council. Comprised of key sectors such as DepEd, DSWD, DOH, and ULAP, the ECCD Council is tasked to set national standards and support ECCD programs. With the enactment of the EYA, the role of the ECCD Council has become more focused, including responsibilities such as formulating policies, ensuring adherence to standards, and offering technical assistance to ECCD service providers. These providers, including professionals, paraprofessionals, and volunteer caregivers, operate at various levels, from provincial to barangay.

	Legal Bases	<b>Policy on ECCD Governance</b>
1974	PD 603: The Child and Youth Welfare Code	Established the Council for the Welfare Children (CWC)
1991	RA 7160: Local Government Code	Devolution of ECCD services to the LGUs
2000	RA 8980: ECCD Act	CWC was designated to function as the National ECCD Coordinating Council (NECCDCC) (Section 8a)
2004	EO 349: Establishing Clear Lines of Authority Over the CWC/NECCD Coordinating Council Secretariat	DepEd and DSWD secretaries to exercise oversight over CWC for ECCD and other concerns
2008	EO 760: Transferring the CWC/NECCD Coordinating Council from the DSWD to the Office of The President	Pres Arroyo formally transferred CWC from DSWD to the Office of the President.
2009	EO 778: Transforming the CWC into the ECCD Council	Provided an unequivocal focus on the early years (0 to 6) and abolished the CWC as the mandated NECCDCC, creating a new agency, the ECCD Council, as the lead agency for ECCD (0 to 6)
2009	EO 806: Affirming of the Roles of ECCD Council and the CWC	Delineate the functions of the two Councils, expressly giving the ECCD Council authority over programs for children aged 0 to 6, and then to CWC to retain its original mandate under the Child and Youth Welfare Code
2013	RA 10410: Early Years Act	The same law made the ECCD Council an attached agency of DepEd. It gave the ECCD Council a mandate to set policies and programs for children aged zero (0) to four (4) years while designating DepEd to cover the formative needs of children aged five (5) to eight (8) years.

### Table 4. Governance History of ECCD

Source: Authors' analysis and illustration of the Presidential Decree (RP 1974), Executive Orders (RP 2004, 2008, 2009), and Republic Acts (RP 1991, 2000, 2013)

The primary role of the ECCD Council is to establish national standards for early childhood education. However, under the Early Years Act of 2013, it is also mandated to not only set standards, provide training, and monitor and evaluate but also to deliver and finance ECCD services by "providing funds to poor and disadvantaged communities for the establishment and expansion of public ECCD programs, improvement of physical facilities and for hiring of ECCD service provider (Sec. 10)" and by "establishing National Child

Development Centers and the conversion of existing Day Care Centers into Child Development Centers in LGUs upon approval of this Act (Sec. 11)". While local governments are expected to "provide facilities" for childcare" and "counterpart funding" from local government resources as stipulated by the Early Years Act, the ECCD Council assumes multiple roles, including standard setting, performance monitoring, and delivering and financing ECCD services.

	N based on	<b>landates/Funct</b> the Early Years	ions Act of 2013	Mandates/Functions based on the First 1000 Days Law			
	<b>Financing</b> <sup>1</sup>	Delivery <sup>2</sup>	Standards and Regulations <sup>3</sup>	Financing	Delivery	Standards and Regulations	
National	ECCD	ECCD	ECCD Council	ECCD	ECCD	ECCD Council	
level	Council Council DepEd DepEd			Council	Council		
			DepEd -	-	DepEd	DepEd	
	DSWD	DSWD	DSWD	DSWD	DSWD	DSWD	
	DOH	DOH	DOH	DOH	DOH	DOH	
	NNC	NNC	NNC	NNC	NNC	NNC	
	ULAP	ULAP	ULAP	-	-	-	
Local level	province	province	province	province	province	province	
	city/municipal	city/municip	-	city/municip	city/munici	city/municipalit	
	ity	ality		ality	pality	y I	
	barangay	barangay	-	-	barangay	barangay	

Table 5.	Actors in	ECCD	Services	based	on	policy.
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Source: Authors' analysis and illustration of the Republic Acts (RP 2013, 2018b).

Notes: <sup>1</sup>Financing refers to funding, resource allocation, and augmentation. <sup>2</sup>Delivery refers to program implementation, planning participation, coordination and collaboration, and technical assistance. <sup>3</sup>Standards and regulation refer to standard and guidelines setting, monitoring and evaluation, and capacity building.

#### Box 1. Multi-sectoral collaboration and the National Nutrition Council (NNC)

Legally mandated platforms for multi-sector collaboration are not new in the Philippines. However, their impact on the issues they were meant to address remains to be demonstrated and documented. For instance, the National Nutrition Council (NNC) was created in 1978 through the Nutrition Act to oversee the implementation of hunger mitigation programs, formulate national food and nutrition policies and strategies, and coordinate the planning, monitoring, and evaluation of the national nutrition program. Over the course of its 45-year history, its chairship moved from DSWD to DA to DOH. The governing board of NNC includes members from various sectors such as DepEd, DA, DOLE, DTI, DSWD, DILG, among others. This perhaps demonstrates the challenges in designating a lead among co-equals, as similarly experienced by the ECCD Council.

This also highlights the important role of the secretariat, which is responsible for ensuring that the designated chair can effectively hold others accountable given the availability of reliable monitoring data. The secretariat should fulfill administrative and technical and strategic roles, with the latter being necessary for effective stewardship. However, there are limitation in technical capacity, as the council and its secretariat often prioritize implementation work or program-related tasks (such as supplementary feeding programs) over strategic technical secretariat work. This preference may stem from the fact that the former is more easily appreciated and offers more controllable outcomes.

Source: Authors' review of the Key Informant Interview with the National Nutrition Council (NNC 2023).

While theoretically beneficial, multi-sector collaboration poses challenges in implementing accountability to key line agencies. In this context, multi-sectoral collaboration is quixotic at best. Multi-sectoral collaborations provide a platform for bureaucrats to discuss cross-sectoral issues on ECCD. Still, challenges arise in the alignment of programs given the co-equal nature of government departments in the governing council. Although alignment plans may be in place, as envisioned in the EYA — 'so their work and financial plans that will coordinate their technical assistance and support for the National ECCD Program' — there is no guarantee of implementation by line agencies. Collaboration efforts may become merely an exercise depending on these line agencies' priorities and personalities. Also, while in theory, multi-sectoral collaboration provides a platform for high-level strategic coordination, this may not be occurring, as reflected in the quality of discussions during governing meetings aimed at setting direction for the national ECCD system.

### Box 2. What is the quality of ECCD Council Governing Board Meetings?

The ECCD Council, mandated by the Early Years Act (RA 10410) to oversee the ECCD system, is tasked with convening its Governing Board monthly. These meetings bring together decision-makers from various central agencies, including the Department of Education, Department of Social Welfare and Development, Department of Health, National Nutrition Council, Union of Local Authorities of the Philippines (ULAP), and a private ECCD practitioner representative. Their purpose is to discuss the Council's strategies and actions to ensure effective implementation of ECCD services at scale. However, between 2021 and 2023, the Governing Board met irregularly, convening only five times (36th-40th), with an average interval of three months. These meetings typically included reports on sector specific ECCD programs from the different member agencies; however, there was a lack of discussions on integrating these programs into a convergent multi-sectoral approach. This has left the ECCD system functioning primarily on a programmatic level, without strategic coordination among member agencies.

Additionally, during these meetings, there were discussions among the Governing Board members about clarifying the Council's respective roles and responsibilities. The ECCD Council recognized that certain functions of member agencies were not being fully carried out. In one of the meetings, the DSWD and ECCD Council had to deliberate on who should handle the ECCD facility accreditation, citing their own interpretations of the laws. A preview of these meetings showed a need for better clarity of functions, strategic and integrative program planning, and streamlined coordination among member agencies to effectively implement ECCD at scale.

Source: Authors' review of GB 34th, 36th-40th meeting minutes (ECCD Council 2023a).

The high expectations placed on the ECCD Council, including setting standards, monitoring, regulation, financing, and delivery, appear disproportionate to its available technical and financial resources. Given the substantial coordination responsibility, the ECCD Council, operating from a single office with 46 personnel, cannot effectively oversee services to ECCD beneficiaries nationwide (EDCOM2 2023). This limited capacity for coordination and provision of capital investments (i.e., NCDC) is compounded by the complex nature of ECCD programs, including various sectors and requiring coordination with multiple stakeholders at different levels of government. As a result, the ECCD Council could be struggling to fulfill its mandate effectively.

Despite multi-sector collaboration, evidence indicates fragmentation within horizontal and vertical tiers of the government, posing a significant challenge to ECCD implementation in the Philippines. Horizontally, some national government agencies are not aware of their respective roles within the council, leading to disjointed functions. This is evident among different agencies, resulting in the duplication of efforts (NNC 2023) (MC 2023). This is a consistent observation based on the responses of the informants and discussants suggesting that:

"There is an overlap between ECCD and DSWD, and there's a need to define early childhood care and development coverage. While Basic Ed considers the age range to be 0 to 4, DepEd suggests extending it to 0 to 5, aligning with the transition to formal schooling at age five." [NNC]

"We were confused because our boss was two agencies, the DSWD and ECCD Council. No one officially told us from DSWD or ECCD that it is no longer called Daycare and is already ECCD. And who we should follow when it comes to our curriculum." [MC1]

In addition, vertical fragmentation (national to local) is a challenge. Based on key informant interviews, fragmentation arises because of the strategic cascading of ECCD standards and insufficient training and guidance to effectively operationalize them locally. Poor feasibility in implementing these standards is often attributed to the need for more local government resources. Furthermore, centrally set standards must be adequately contextualized to local settings, resulting in unattained objectives.

The variability in ECCD implementation across different LGUs is evident. The effectiveness of ECCD programs in LGU is influenced by the priorities set by local leaders and the political environment. One notable finding is that exclusive control exercised by local chief executives over ECCD implementation tends to be less effective than a more inclusive and institutionalized decision-making process involving various societal actors. Hence, the quality and adequacy of ECCD facilities are also highly dependent on the priorities of LGUs. DCC/CDC/NCDC facilities vary across the country depending on LGU's support. Sole control by local leaders, including barangay captains, often creates a vacuum in the system, leading to disorderly and unsustainable implementation of ECCD programs. In certain local government contexts, we examined, prevailing conditions often breed a culture of risk aversion among daycare workers, impeding both the adoption of innovative teaching approaches and the implementation of health and nutrition programs. For instance, our key informant interviews show a reliance on local executives for the implementation of ECCD rather than a well-defined system in the locality. Consequently, daycare workers find themselves subject to the discretion of these community leaders, lacking a transparent system of implementation with clear accountability and standards. This uncertainty fosters anxiety among educators, hindering their capacity to effectively discharge their duties, as they fear potential repercussions from local authorities in the event of adverse outcomes. This concern is particularly problematic in implementing school feeding programs, where daycare workers dread shouldering blame in the wake of any untoward incidents (e.g., poisoning). Compounding these challenges is the fact that many of these educators serve voluntarily, contending with insufficient compensation and security.

### Box 3. Local implementation of ECCD (1)

A good example of institutionalized ECCD program is in the Province of Batanes. The provincial and municipal governments collaborate, and they establish their own local policies on its implementation, spearheaded by focal persons championing ECCD. The line of authority and communication were in place, and this has been noted during by the discussants from proper coordination with NGOs, local chief executives of the municipalities and barangays, political commitment of local chief executives and exemption of government services to politics. It was noted that:

"Our NGOs have agreements from PSWD down to Barangays. So, what we used to call there is like a tripartite agreement." [BB1]

"Because we focus on service. Even if the political parties are different, that's not an issue especially when it comes to programs, because that's how we Ivatans are. So, when it comes to the election period, there may be conflicts. But when the election is over, it's gone, and most of it just accept it and then back to normal." [BB2]

"It seems that it can be said that no matter what, the political affiliation of the politician does not affect the individual issues." [BB3]

Well-institutionalized decision-making is in place. Through the LCPC (Local Council for the Protection of Children) *that is*, an umbrella organization composed of the provincial, city/municipal, and barangay level representatives for all children-related concerns, the ECCD services have been well-planned and coordinated in the province of Batanes. The Province and Municipal Social Welfare and Development Officer (P/MSWDO) facilitate coordination, holding LCPC meetings wherein concerns raised by each municipality are addressed through resolutions. The mitigated political interference in the province significantly benefits service delivery, as the involvement of the Local Chief Executives (governor, mayors, and barangay captain) in meetings facilitate funding approval.

The well-coordinated programming of ECCD services and implementation resulted to positive outcomes including the accreditation status of all day care centers, timely provision of other ECCD programs including health and nutrition, and high morale among ECCD workers. The discussants mentioned that:

"I'm telling my PES to the parents, so that they can be encouraged because their children, the ones below 6 years old, who think 80-90% of the brain develops during the age. So, in the ECCD Act, we must take it seriously. Not only because of the functionality, but also because we want our children to grow up with proper discipline." [BB2]

"They are concerned about bringing their children to us. So, our most responsibility is to see that their child is safe with us. And then so that they can be more attractive, and they can tell the society that here is the MSWDO, PSWDO that our concentration is that of their age, that of the children. Because later, when they grow up, the others will go to DepEd." [BB3]

"We have a certification from the budget, where you can see all the funds that are utilized and allocated for children." [BB4]

"It is sustainable when it comes to wages and the provision of supplies for our ECCD workers" [BB5]

See Appendix B for photos.

Source: Authors' review of the Focus Group Discussion with Basco, Batanes (BB 2023).

### Box 4. Local implementation of ECCD (2)

Insufficient guidance from the central level, lack of political commitment, and fragmented delivery of services can result to several problematic issues in terms of ECCD program implementation. This is evident in a selected site in BARMM region wherein the implementation of ECCD programs in the grassroot level is highly dependent on volunteers. It was also noted that many centers were having inadequate infrastructure, such as non-conducive classrooms, lack of play areas and materials, and basic amenities. Furthermore, ECCD workers are not compensated and solely relying of what the local chief executive can provide. Discussants mentioned that:

"Especially for those in the 5th and 6th class, it's not that they do not prioritize the social services intended for their constituents, rather, they have other pressing priorities, such as infrastructure." [LDS1]

"There is already a policy, it's just not implemented by the LGU, a little push is needed. If they adopt it, because in the policy, the creation of the barangay nutrition committee is there. The main problem is the lack of LGU involvement at the grassroots level." [LDS3]

"Of course, they are more focused on constructing their municipal hall, roads, and barangay roads. But when you talk about human development—it's a bit difficult for us. Because we're talking about, for example, helping a drug addict, counseling them—successful outcomes are not immediate, it would take years." [LDS4]

Source: Authors' review of the Focus Group Discussion with Lanao del Sur (LDS 2023).

Service Delivery and Infrastructure

Access to ECCD infrastructure, such as daycare/child development centers, is crucial for ECCD implementation. Inadequate infrastructure hampers access to ECCD services, thereby limiting opportunities for the learning and development of children. To ensure an adequate number of daycare facilities, RA 6972 mandates that each barangay (village) should have at least one (1) daycare center, which offers programs for 3- to 4-year-olds (PreK1 and PreK2). In virtue of the Early Years Act of 2013, the ECCD Council began modeling/converting Day Care Center (DCC) to become Child Development Center (CDC), which offers programs for children aged 0-4, including the Infant Toddlers Early Development (ITED) program for 0-2 years old, PreK1 and PreK2, and the Family Support Program (FSP). During the same year, the ECCD started building National Child Development Centers (NCDC), which serves as the flagship project integrating programs and services to promote health, nutrition, early education, and social development programs for children aged 0-2 and 3-4 years old (ITED, PreK1, and PreK2), providing a separate facility to meet the needs of the LGU. NCDCs function as model centers for introducing best practices in ECCD, laboratories for conducting research and innovations, and resource and training centers for enhancing the skills of parents and ECCD program providers within the community. While NCDCs are built by the national government through the ECCD Council, they are managed by LGUs (Section 7b, RA 10410).

**Most ECCD facilities are publicly owned.** Based on the ECCD-IS database, more than 99% of the total center-based facilities are public (327 vs. 62,791). Time trends also reveal that the number of DCCs/CDCs increases in absolute value and population growth. This growth is driven mostly by the public sector (see **Figure 22**). While this figure may be underestimated in the private sector due to reporting mechanisms to the IS, a census of private businesses

showed that there are only around 3,000 public pre-primary schools, which may still include kindergarten (PSA 2021). The absence of a comprehensive database on private ECCD facilities further highlights challenges in monitoring and regulating the private sector's involvement. Low demand due to parental preferences (i.e., a child might be too young) and affordability concerns (see Financing section) dissuade private investment. Information gaps about private options and concerns about quality standards further contribute to the lack of market response.

ECCD Facilities	Total	Public	Private*
Center-based	63,046	62,791	327
Child Development Center/DCC	63,018	62,691	327
Child Minding Center	28	28	-
Community-based	6,743	6,661	82
Neighborhood-based Play Groups	5,966	5,893	73
Day Care Mothers	28	28	-
Family Day Care	36	36	-
Parents to Other Parents	31	30	1
Barangay Base	682	674	8
TOTAL	69,789	69,380	409

#### Table 6. Inventory of ECCD Facilities by type

Source: Authors' calculation and tabulation of the ECCD-IS data (DSWD 2023a) and the 2023 NETIS data (ECCD Council 2023b).

Note: The completeness and veracity of data are dependent on the encoding capacity of each LGU. Data used in this report is ECCD-IS export as of September 2023. NCDC counts are as of December 2023.

\*Data on private facilities is based on the encoded dataset in the ECCD-IS. According to the latest Census of Philippine Business and Industry, this number may be an underestimate of the actual count of private ECCD facilities, which is estimated to be around ~3,000 (PSA 2018a).





Source: Authors' analysis and visualization of the ECCD-IS data (DSWD 2023a) and World Population Prospects data (UN 2022).

**Based on a population survey, most Filipino children, including those from the poorest households, report having public facilities within their local communities** (see Figure 23). Approximately 85% of children have access to public DCC/CDC within their barangay, conveniently situated within walking distance, yet the share with children with DCC decreases

with higher socio-economic status. Conversely, while private DCC/CDC is generally low nationwide, it becomes more prevalent among affluent households.



Figure 23. Spatial access to daycare centers in the Philippines

The Early Years Act (EYA) aims to convert DCC to CDC to expand services and enhance the quality of early education. However, data indicates that the conversion rate remains below five percent even a decade after the law was promulgated (see Table 7 and Figure 24). This implies that the quality of the ECCD center-based facilities is nowhere near the objective of the Act and the standards set by the ECCD Council at the national level. In select interviews with local governments, they cannot satisfy the criteria for their DCCs to be converted into CDCs.

Table 7. Day Care, Child Development, and National Child Development Centers

% Share of Child Development Centers (converted) to Total DCC/CDC	3.4%
Day Care or Child Development Centers	Count
Child Development Centers*	2,150*
(conversion assistance from the national government)	
Day Care Centers/Child Development Centers	63,018**
National Child Development Center	955*

Source: Authors' calculation and tabulation of ECCD-IS data (DSWD 2023a) and the 2023 NETIS data (ECCD Council 2023b).

Note: The number of converted CDCs with assistance from the ECCD Council.

Source: Authors' analysis and visualization of UNFPA's Longitudinal Cohort Study on the Filipino Child (UN 2021).

Figure 24. Number of daycare centers, child development centers, and % share of converted CDC to DCC, by Philippine regions, 2023



Source: Authors' analysis and visualization of ECCD-IS data (DSWD 2023a) and the ECCD Council Annual Report data (ECCD Council 2023b).

Nearly all barangays in the Philippines have at least one public daycare center/child development center. About 89% of municipalities and cities meet the DCC/CDC to barangay ratio requirement per RA 6972. However, there is a socio-economic gradient in DCC/CDC to barangay ratios, with poorer municipalities exhibiting lower ratios than wealthier first-class municipalities and highly urbanized cities (see Table 8). While this suggests equitable access to DCCs/CDCs across the country, the DCC/CDC to barangay ratio may need to accurately reflect the actual supply level relative to the population. Adjusting for population size, it becomes evident that the DCC/CDC to population ratio is smaller in cities and first-class municipalities. While the number of barangays is high, the ratio of daycare centers to the population aged 3-4 years is lower in cities than in poorer municipalities. On average, there are 12 daycare/child development centers per 1000 population in cities and 19 in poorer municipalities. There is no established standard regarding the optimal ratio of DCCs/CDCs relative to population. At least one DCC/CDC in nearly all barangays suggests equitable access to early education facilities nationwide. However, the disparity in DCC/CDC to population ratios highlights the need for a more nuanced approach in ensuring equitable distribution of DCC/CDC, particularly in cities and first-class municipalities where the demand may be higher.

The ratio of DCC/CDC to currently enrolled children indicate adequacy, yet more is needed to achieve universal ECCD enrollment objectives, particularly given the current low enrollment levels. Analysis of the data from the DSWD revealed that, there are, on average, 22 children per DCC/CDC. However, there is a socioeconomic gradient, with cities and first-class municipalities reaching up to 37 children per DCC/CDC, reflecting higher population densities. In comparison, poorer municipalities have a lower ratio of 19 children per DCC/CDC (see Table 8). Despite these figures aligning with current enrollment levels of

less than 30%, achieving universal access would require a greater DCC/CDC to accommodate the increasing demand. We also developed a logit model to examine the determinants of local governments with having one (or higher) DCC to barangay ratio (see Table 9).





Source: Authors' compilation and visualization of ECCD-IS data as of September 2023 (DSWD 2023a). Note: The completeness and veracity of the data depend on the encoding capacity of each LGU.





Source: Authors' compilation and visualization of ECCD-IS data as of September 2023 (DSWD 2023a). Note: The completeness and veracity of data depend on the encoding capacity of each LGU.

# Table 8. The ratio of mean Daycare/Child Development Center to enrolled children, numberof barangays, and 1,000 children population (aged 3-4) by LGU income class, 2023.

Income Class	DCC/CDC to enrolled children ratio	DCC/CDC to # of barangays ratio	DCC/CDC to children population (per 1,000) ratio		
Philippines	22	1.86	24		
1st-2nd Class	19	2.19	19		
3rd-6th Class	21	1.56	29		
CC, HUC, ICCs	37	2.62	12		

Source: Authors' calculation and tabulation of 2023 ECCD-IS data (DSWD 2023a) and World Population Prospects data (UN 2022).

Note: The completeness and veracity of data depend on the encoding capacity of each LGU.

Factors	Odds Ratio	p-value	Sig
Region (ref: NCR)			
Region I	2.651	.401	
Region II	2.359	.469	
Region IV-A	15.198	.015	**
Region V	2.012	.55	
Region VI	2.204	.483	
Region VII	.175	.229	
Region VIII	3.819	.236	
Region IX	.589	.685	
Region X	.503	.589	
Region XII	4.717	.2	
CAR	.372	.499	
BARMM	14.774	.028	**
CARAGA	.571	.665	
MIMAROPA	1.195	.884	
LGU Income Class (Ref: 1 <sup>st</sup> class)			
2nd Class	2.318	.033	**
3rd Class	2.123	.04	**
4th Class	2.131	.029	**
5th Class	3.023	.003	***
6th Class	1.359	.789	
CC	1.246	.666	
HUC	18.755	.001	***
Poverty Incidence	1.017	.112	
Share of children aged 3-4 to total	0	.165	
population			
LGU's education expenditure, per capita	1	.637	
Constant	.027	.003	***

### Table 9. Determinants of Barangay to Daycare/Child Development Center

\*\*\* p<.01, \*\* p<.05, \* p<.1

Source: Authors' calculation and tabulation of the 2023 ECCD-IS data (DSWD 2023a)

Note: RA 6972 states that each barangay should have at least one DCC/CDC (RP 1990). An odds ratio greater than one (1) would indicate that the odds of having a ratio of 1 or more DCC to barangays is higher in the group of local governments (municipalities or cities) compared to the reference group. If the odds ratio (OR) is 2, the odds of having a ratio of 1 or more DCC to barangay is twice as high in the group of local governments compared to the reference group. The country's current supply of capital investments for ECCD needs to be increased to meet the goal of universal access for children aged 3-4 to ECCD services. The current facilities are short of around 33,000 to meet the 96,000 child development centers required to meet 100% of the demand (see Figure 27). This requires about PHP 95 billion in capital investments to ensure that these facilities meet the standards of a National Child Development Center.





Source: Authors' analysis and visualization of the ECCD-IS data (DSWD 2023a) and World Population Prospects data (UN 2022).

Note: The projections are calculated with the following parameters: One facility will cater for 50 children, with 2 sessions per day to meet the standard of 1 facility: 25 children (per session). The cost of one (1) facility costs 2.9M, pegged from the unit cost of a National Child Development Center according to the ECCD Council. The contents of the center (i.e., appliances, furniture, educational paraphernalia, etc.), which is priced at PHP1M still needs to be included in this cost.

Access to primary care facilities, which provide essential health and nutrition services, still needs to be improved and varies across provinces. Barangay health stations (BHS), Rural Health Units (RHUs), and Health Centers (HCs) shall be the established entry points of mothers, children, families, and communities for primary care needs such as but not limited to counseling, antenatal check-ups, breastfeeding stations, micronutrient supplementation, and reproductive health services. In practice, however, patients can go directly to hospitals and other specialized clinics, resulting in a large gap in primary healthcare outcomes. The Philippines has around 3,900 PCFs, of which 2,593 are RHU/HCs. There should be at least one BHS in every barangay. Despite the number of BHS doubling from 11,000 in 1990 to around 22,000 in 2019, only half of the barangays have at least one BHS. On average, only half of the population has access to health facilities within a 30-minute travel time, regardless of the mode of transportation. BARMM, Bicol, and MIMAROPA are the three regions with the highest proportion of residents without access to an RHU/HC within a 30-minute travel time. Most of this number, however, is concentrated in high-income highly urbanized cities and individual component cities (HUCs/ICCs).

### Human Resource

The effectiveness of early childhood education exhibiting returns hinges significantly on the quality and quantity of daycare workers. Based on a systematic review, a key principle underlying effective ECD initiatives is providing well-trained and adequately compensated teaching staff, ideally holding bachelor's degrees with specialization in early childhood education, accompanied by relevant certifications. Moreover, reviews suggest that maintaining child-to-staff ratios below 9 to 1 in center-based preschool settings is conducive to program success (Reynolds, Temple, and White 2009). In the Philippines, the adherence to fundamental principles governing DCW/CDW remains a significant challenge. Table 10 illustrates the chronological progression of policies to enhance the quantity and quality of DCW/CDW in the Philippines.

Policies	Key provisions
Improving quantity	2004: Administrative Order 2004-029 (Standards for Day Care, Other ECCD Centers And Service
	Providers: For Children aged 0-5.11 years)
	- Adult-child ratio, where adult is a service provider, teacher aide or parent volunteer:
	• ratio of 1 adult: 2 children 0-1 years old
	<ul> <li>ratio of 1 adult: 3 children 1-2 years old</li> </ul>
	• ratio of 1 adult: 6 children 2-3 years old
	• ratio of 1 adult: 10 children 3-4 years old
	2015: Resolution No. 15-03 (Standards and Guidelines for Center-based Programs for 0-4 Years
	of Filipino Children, ECCD Council)
	- Teacher-child ratio, where teacher is a service provider (CDW/CDT)
	• ratio of 1 teacher :10; however, if it reaches the maximum of 1:25, there is a
	teacher-aide/assistant/trained parent or trained adult volunteer.
Improving quality	2004: Administrative Order 2004-029 (Standards for Day Care, Other ECCD Centers And Service
	Providers: For Children aged 0-5.11 years)
	<ul> <li>Daycare Worker (DCW) – at least HS Graduate</li> </ul>
	2015: Resolution No. 15-03 (Standards and Guidelines for Center-based Programs for 0-4 Years
	of Filipino Children, ECCD Council)
	<ul> <li>Child Development Worker (CDW) – at least a bachelor's degree in any field</li> </ul>
	- Child Development Teacher (CDT) - a bachelor's degree in childhood education or
	Elementary Education preferably with a Specialization in Early Childhood or any
	degree related to Education like a bachelor's degree in psychology, Child Study, Family
	Life, and Child Development
Compensation and benefits	<b>1990:</b> RA 6972 (Barangay-Level Total Development and Protection of Children Act)
	- Day care workers in accredited day care centers shall receive a monthly allowance
	of not less than five hundred pesos (P500.00) to be charged to the annual appropriations
	of the DSWD (Section 5c).
	<b>2004:</b> Administrative Order 2004-029 (Standards for Day Care, Other ECCD Centers And Service
	Providers: For Children aged 0-5.11 years)
	- Assigns contractual or MOA status (i.e., yearly service contract) to the service provider.
	- Pays the service provider compensation not lower than Salary Grade 6.
	- Provides maternity/paternity, sick, and vacation leaves.
	<b>2015</b> : Resolution No. 15-05 (Standards and Guidelines for Center-based Programs for 0-4 Tears
	of Filipino Children, ECCD Council)
	- CDW/CD1/Teacher Alde: monthly salary/nonorarium shall be shouldered by the LGU/NGA/GOCC
	- CDW/CDT will be based on the Salary Grade of Teacher I (SG 11) of the Department
	of Education. Still, the amount will depend on the monthly salary schedule of the local
	government personnel per DBM Local Budget Circular No. Dated May 25, 2012.
	- Teacher Aide in the public CDC is paid on an honorarium basis as approved by the
	Sangguniang Bayan Resolution of the Local Government Unit or Resolution by the NGA
	or GOCC.
Source: Authors' compilat	tion of policies of the Republic Act (RP 1990). Administrative Order (DSWD 2004), and

### Table 10. Policies on Human Resources for ECCD

Source: Authors' compilation of policies of the Republic Act (RP 1990), Administrative Order (DSWD 2004), and Resolution (ECCD Council 2015).

The ratio of Day Care Workers/Child Development Workers (DCWs/CDWs) to enrolled children appears to exceed the standard set by the ECCD Council, indicating potential implications for the quality of care and attention provided to each child. The ECCD Council has established a 1 DCW/CDW ratio per 10 children, a standard also observed in countries with well-established early childcare systems. However, in the Philippines, the average ratio is 19 enrolled children per DCW/CDW, with variations depending on the location. For instance, this ratio can escalate to 30 in urban areas, exceeding the standard threefold. The current nationwide enrollment rate is at less than 30%, indicating a need for strategies to boost the supply of DCW/CDW in conjunction with efforts to enhance demand through universal access to early childhood education.

## Figure 28. Distribution of mean Daycare/Child Development Workers to 1,000 children aged 3-4 across municipalities, 2023.



Source: Authors' compilation and visualization of ECCD-IS data as of September 2023 (DSWD 2023a). Note: The completeness and veracity of data depend on the encoding capacity of each LGU.

Table 11.	The ratio of mean	Daycare/Child	Development	Workers to	enrolled ch	ildren by
	LGU income class,	2023.				

Income Class	DCW/CDW to enrolled children ratio
Philippines	18
1st-2nd Class	16
3rd-6th Class	17
CC, HUC, ICCs	30

Source: Authors' calculation and tabulation of 2023 ECCD-IS data (DSWD 2023a) and World Population Prospects data (UN 2022).

Note: The completeness and veracity of data depend on the encoding capacity of each LGU.

The country needs three-fold or 240,000 of its current stock (around 89,000) of daycare/child development workers to equip the system for universal access of children (see Figure 29). They must be competent in catering to the diverse needs of children. Given our projected high demand and the existing gap based on nationally set standards, the government needs to undertake a more comprehensive and rigorous labor market analysis,

which delves into various aspects such as education, training, and other pertinent factors and determine the most effective approach for addressing the shortfall. Strategies may involve increasing the supply of qualified child development workers through investments and adjustments in the education system. Additionally, efforts to enhance efficiency, such as task shifting, could be explored if the measures cannot meet the demand.





Source: Authors' analysis and visualization of the ECCD-IS data (DSWD 2023a) and World Population Prospects data (UN 2022).

Note: The projections are calculated with the following parameters: One worker will cater for 20 children, with 2 sessions per day to meet the standard of 1 facility: 10 children (per session).

Approximately 50% of child development workers in the Philippines are high school graduates, while the remainder are college graduates. The distribution of college graduates among DCW/CDW varies across local governments and is also influenced by income class, with cities and first municipalities having a higher proportion of college-educated daycare workers. This is expected because of the path dependency of previous policies; that is, the 2004 Administrative Order of DSWD stipulates that DCWs are only required to have a high school degree. However, recent efforts in the last few years to convert DCCs into Child Development Centers (CDCs) aim to improve the quality standards of early education, requiring that daycare workers must be college graduates. Nevertheless, given the expected qualifications of current daycare workers, achieving this level of qualification takes time to navigate. It is critical to analyze the age distribution of the workforce and determine appropriate strategies, such as natural attrition, re-tooling of the current workforce, and scholarships to accommodate the existing workforce. The average age of DCW/CDW is 45, with 50% of this mid-age group high school graduates.



Figure 30. Highest educational attainment of DCW/CDW, by age among municipalities and cities by income classification

Source: Authors' analysis and visualization of the ECCD-IS data (DSWD 2023a).

There is no standard salary for daycare workers, and the compensation system varies among local governments. The compensation system for daycare workers varies widely across local governments, and more legislative support is needed to establish minimum salaries and other non-wage benefits. Many daycare workers rely solely on honorariums, some even volunteer for their services. This setup deters qualified individuals from entering the profession and exposes workers to various risks. In our discussions with teachers, some admitted using personal funds to support daycare operations. Teachers are hesitant to take on additional responsibilities in politically charged areas due to increased risks. For example, concerns about child health issues like food poisoning make them reluctant to provide feeding programs. The volunteer nature of their work makes them susceptible to local political influences and creates uncertainty. Furthermore, most local governments need more training and professional development opportunities, which affects the quality of ECCD services due to limited access to resources and programs. This lack of training and development is primarily due to inadequate funding allocations.

### Box 4. The Case of Batanes: A Coordinated Compensation System for Day Care Workers

The province of Batanes sets aside funds during the initial semester, while the LGUs (municipalities) are responsible for funding during the second semester. In 2023, they have allotted PHP 180,000.00 for wages of the daycare workers of 27 DCCs in the province. The funding came from the GAD (Gender and Development) fund in accordance with the mandate on the Early Years Act of 2013 (RA 10410). The compensation per worker is dependent on the wage ordinance in the LGU and is prorated based on accreditation. For instance, a worker without accreditation ranges from PHP 400-420 per day, while accredited workers usually receive PHP 520 per day. The hiring practices for DCWs in Batanes are free from political interference and all workers are under job order (JO) contracts.

Source: Author's review of the Focus Group Discussion with Basco, Batanes (BB 2023).

### Financing

In the Philippines, ECCD programs covering early education, health, and nutrition are funded by a combination of public and private sources. Under a decentralized system, local governments are tasked with financing and delivering primary healthcare services. In contrast, the national government, including agencies like the DOH and NNC, provides standards and financial support. As the national purchaser, PhilHealth offers limited primary healthcare services through various benefit packages. However, there can be overlap and ambiguity in delineating these services. For early education, both national and local governments contribute to pre-kindergarten funding, with the national government providing technical and financial assistance. The ECCD Council also plays a role in constructing child development centers and offering training. Other government entities, like the Department of Social Welfare and Development (DSWD), contribute through social protection programs. Additionally, the private sector contributes significantly through household expenditures, reflecting a multifaceted approach to ECCD financing in the country.

**Estimating spending on ECCD remains a challenge.** Health spending by national and local governments is closely monitored through the national health accounting system of the Philippine Statistical Authority (PSA) using SHA 2011, albeit with some limitations. However, tracking early education expenditure presents a challenge. Unlike high-income countries (i.e., OECD) that employ social accounting systems to monitor childcare and early education spending, the Philippines lacks a readily accessible system. The complexity and multi-sectoral nature of ECCD, combined with the absence of standardized definitions for its components, make it challenging for national and local governments to estimate public spending on ECCD and compare it with other countries.

With health spending, the Philippine National Health Accounts (NHA) suggests that the country spends around PHP 1.1 trillion (PHP 10,000 per person) on health (including nutrition), with 45% attributed to government spending and the rest being out-of-pocket Health Organization (WHO) expenses. The World recommends prioritizing government/public financing over out-of-pocket payments to minimize inefficiencies and inequities in the health sector. When disaggregated by age, the country spends 49 billion pesos on healthcare for children aged 0-4, translating to 8,600 PHP per child. However, considering that government spending constitutes only 45% of the overall health expenditure, the government allocates only 3,870 pesos per child for health. The average government spending per person on health in a lower-middle-income country is 150 USD. Furthermore, most health and nutrition services with enormous impact on children's wellbeing are delivered through primary healthcare (including vaccination, micronutrient supplementation, prenatal care, and

nutrition interventions) such as RHUs and clinics. However, 38.9% of health expenditure in the country is hospital-related spending. The absence of a comprehensive spending accounting system for childcare and early education poses challenges in accurately estimating expenditure towards these services.



Figure 31. Health spending per capita by 0-4 years old, 2015-2022 (in PHP).

**Despite decentralization, the national government continues to be the primary source of financing for early education, health, and nutrition services, with its contribution steadily increasing**. The national government accounts for 48% of total government spending in the health sector, with its share rising over time, while local government spending is plateauing. PhilHealth, which is meant to be the country's purchaser of health services, should also finance maternal and child health services as per the UHC law. Recent years have witnessed significant growth in health spending, primarily driven by increased national government (i.e., DOH) expenditure, with limited growth in PhilHealth and local government funding.

**Regarding early education, measuring local government spending on the prekindergarten program is challenging due to the need for more reliable data. However, available information indicates limited local government spending on early education (see Table 14). The national government on ECCD has experienced substantial growth in recent years, most of which are capital investments for the construction of NCDCs. The national government, facilitated by the ECCD Council, has funded the construction of the NCDC on behalf of local governments. Also, the Early Years Act mandated PAGCOR to provide funding for the construction of NCDC. As of 2018, PAGCOR has already allocated PHP 4.25 billion to construct NCDCs (Tongson, Antonio, and Centeno 2023).** 

Source: Authors' analysis and visualization of Philippine National Health Accounts (PSA 2022c)

Program Classification	AIP	GAD	Total	% share	Expenditure per capita (in PHP)
Nutrition-sensitive	584.84	1,202.77	1,787.25	88.65%	111.84
Access to healthcare services	45.63	113.41	159.04	8.67%	9.95
Adolescent health and education	41.96	54.12	96.08	5.24%	6.01
Agriculture (food security and availability) and fisheries	40.66	90.56	131.23	7.16%	8.21
Disease prevention and management	11.95	45.98	57.93	3.16%	3.62
Early childhood care and development (ECCD)	0.27	180.89	19.16	1.05%	1.20
Family planning and responsible parenting	2.36	17.10	19.50	1.06%	1.22
Gender, women's empowerment, and child protection	2.28	196.74	199.02	10.86%	12.45
Humanitarian relief and emergency fund	2.94	1.22	4.16	0.23%	0.26
Maternal and neonatal health	3.53	195.39	198.92	10.85%	12.45
Oral health	1.43	61.24	62.67	3.42%	3.92
Social welfare and peace and order	19.02	85.25	104.27	5.69%	6.52
Water, sanitation (environment), and waste management	412.46	160.87	573.33	31.27%	35.88
Nutrition-specific	70.41	40.52	110.94	6.05%	6.94
Infant and young child feeding	2.59	6.13	8.73	0.48%	0.55
Integrated management of acute malnutrition	1.21	9.74	10.95	0.60%	0.69
Micronutrient supplementation	0.56	3.20	3.76	0.20%	0.24
Nutrition specific support	65.91	20.92	86.83	4.74%	5.43
Overweight/obesity management and prevention	0.14	0.02	0.16	0.01%	0.01
Supplementary feeding	-	0.50	0.50	0.03%	0.03
General enabling	95.70	0.00	95.70	5.22%	5.99
Unknown	0.61	0.88	1.49	0.08%	0.09
Grand Total	751.22	1,082.18	1,833.40	100%	114.72

# Table 12. Nutrition-related expenditures of the select local governments\* (PHP millions),by intervention domain, 2019.

Source: Lifted in full from (Silvestre et al. 2023)

Note: Expenditure data from selected cities/municipalities in the provinces of Camarines Sur (Camaligan, Naga City, Libmanan), Catanduanes, Iloilo, Maguindanao, Misamis Oriental, and Samar (Catarman, Sta. Rita, Pampanga, Zamboanga Del Norte, NCR (Caloocan, Valenzuela, Manila, San Juan

	1	r	1	1	1	1	1	1	
Program Classification	CamSur	Ilo	Mag	MisOr	NCR	NSam	Pam	Sam	Zam
Nutrition-sensitive	99	74.6	96	95.24	94.3	99.11	84.4	92.3	96.5
Access to healthcare services	2.11	17.5	22.7	48.54	6.56	0.33	0	1.52	0.37
Adolescent health and education	0.0001	6.94	2.03	2.5	0.48	0	1.24	14.7	0.51
Agriculture (food security and availability) and fisheries	1.07	14.8	1.69	0	0.004	0	63.3	4.3	9.59
Disease prevention and management	0.06	2.88	32.9	2.08	6.2	1.33	1.14	0.98	0
Early childhood care and development (ECCD)	0	0.06	1.77	18.15	1.63	0	0	2.31	2.76
Family planning and responsible parenting	0.04	0.6	0	0.63	4.43	0	2.04	0.29	1.83
Gender, women's empowerment, and child protection	9.66	3.64	26.7	16.94	14.3	97.45	2.79	14	0.11
Humanitarian relief and emergency fund	0	0.03	3.73	5.89	0.01	0	0	0.23	0
Maternal and neonatal health	0.0001	0.14	3.54	0.53	23.22	0	13.9	35.3	0.92
Oral Health	0.06	10.5	0	0	0.005	0	0	0.03	0
Social welfare and peace and order	0.005	17.4	0	0	2E-05	0	0	0.21	0
Water, sanitation (environment), and waste management	85.99	0	0.87	0	37.46	0	0	18.5	80.4
Nutrition-specific	0.95	9.2	4	4.76	5.7	0.89	15.3	7.49	3.45
Infant and young child feeding	0.03	0.03	1.21	0	1.74	0	0	0.54	1.4
Integrated management of acute malnutrition	0.24	0	0	0	0.5	0	15.3	1.12	0.55
Micronutrient supplementation	0	0.08	0	0	0.81	0.89	0	0.01	1.14
Nutrition specific support	0.68	9.09	2.79	4.76	2.48	0	0	5.78	0.36
Overweight/obesity management and prevention	0.0001	0	0	0	0.01	0	0	0.04	0
Supplementary feeding	0	0	0	0	0.17	0	0	0	0
General enabling	0.02	16.1	0	0	0	0	0	0.12	0
Unknown	0.05	0.16	0	0	0	0	0.27	0.06	0.08
Grand Total	100	100	100	100	100	100	100	100	100

Table 13. Share of nutrition-related expenditures of select local governments byintervention domain.

Source: Lifted in full from (Silvestre et al. 2023).

Note: Expenditure data from selected cities/municipalities in the provinces of Camarines Sur (Camaligan, Naga City, Libmanan), Catanduanes, Iloilo, Maguindanao, Misamis Oriental, Samar (Catarman, Sta. Rita, Pampanga, Zamboanga Del Norte, NCR (Caloocan, Valenzuela, Manila, San Juan)

The national government has made efforts to increase fiscal space for early childhood education, largely facilitated by support from PAGCOR. Recognizing the need to address gaps in early education, the national government mandated PAGCOR through the EYA of 2013 to allocate funds for establishing NCDCs in target LGUs. Over the years, PAGCOR allocated as much as PHP 4.25 billion towards this initiative (Tongson et al. 2023). However,

the sustainability of national government expenditure is now at risk due to the expiration of this provision. Consequently, there is a need to encourage increased spending by LGUs<sup>†</sup>.

	Adjusted Appropriations	Adjusted Allotments	Obligations Incurred	Unobligated Amount	BUR
Agency Speci	ific Budget				
PS	15,681,000	15,681,000	13,965,425	1,715,575	89.06%
MOOE	225,722,000	225,722,000	188,426,390	37,295,610	83.48%
CO	1,380,000	1,380,000	1,254,929	125,071	90.94%
Subtotal	242,783,000	242,783,000	203,646,743	39,136,257	83.88%
Automatic Ap	propriations				
RLIP	267,000	267,000	0	267,000	0.00%
Subtotal	267,000	267,000	0	267,000	0.00%
<b>Continuing</b> A	ppropriations				
MOOE	31,564,896	31,564,896	23,680,197	7,884,699	75.02%
CO	66,815	66,815	0	66,815	0.00%
Subtotal	31,631,711	31,631,711	23,680,197	7,951,514	74.86%
PAGCOR Fu	ınd				
Current Year	Budget Appropriation	ıs			
MOOE	12,562,000	12,562,000	12,525,715	36,285	99.71%
Subtotal	12,562,000	12,562,000	12,525,715	36,285	99.71%
Grand Total	287,243,711	287,243,711	239,852,655	47,391,056	83.50%

Table 14. Appropriations, Allotment, and obligations of the ECCD Council, 2022

Source: 2022 Commission on Audit Annual Audit Report for ECCD Council (COA 2023).

In a decentralized regime, national government grants for health, nutrition, and early education should ideally incentivize local governments to allocate more resources to ECCD services. However, evidence suggests that this may not be the case. Many interventions in health, nutrition, and early education are passive, merely filling the financing gap in local governments, and are not designed for local governments to mobilize more resources or use them to achieve the desired goals or objectives. In essence, these national grants do not stimulate proactive investment by local governments. Consequently, passive financing from the national government may foster dependency among local governments and fail to ensure the sustainability of ECCD financing. Moreover, it remains unclear how national resources are equitably allocated to address local governments' variable needs and capacity.

Despite decentralization, the national government remains the primary funding source for early education, health, and nutrition. Whether a more decentralized regime (i.e., *Mandanas* Supreme Court ruling<sup>‡</sup>) will lead local governments to spend more on health,

<sup>&</sup>lt;sup>†</sup> Although, Results for Development 2016 stated that there have been issues in the use of funds transferred to the LGUs by the ECCD Council in which the funds were not properly utilized.

<sup>&</sup>lt;sup>‡</sup> In 2018, the Supreme Court (SC) addressed the petitions brought by Congressman Hermilando I. Mandanas and Congressman Enrique T. Garcia, et al., regarding the method employed by the National Government to calculate the Internal Revenue Allotment (IRA) shares for local government units (LGUs). The SC determined that the

**nutrition, and early education**. Amid rising revenues of local governments (from national transfers), many need to allocate more funds to these critical areas, which poses challenges to equitable service delivery. For health and nutrition spending, we conducted a fixed-effects model in panel data of local government revenues and primary healthcare or PHC spending (essential health and nutrition). We answer the policy question of whether local government revenues will lead to greater investment in PHC. Our findings show that, in general, public spending on PHC generally appears to be inelastic with respect to total revenues, but this varies between municipalities and cities. Our findings also show that local revenues are completely fungible with respect to public spending on PHC in municipalities. The source of revenue does not matter. In contrast, our findings suggest that IRA will increase public spending on PHC in cities even though it is not specifically earmarked for health and nutrition, which is not the case for municipalities. In other words, when revenues from the national transfer increase, municipalities are more likely to spend on other items outside of health and nutrition.

Table 15.	5. Elasticity of per capita public health spending on per capita revenue (	district fixed
	effects)	

	All	City	Municipality
Total revenue	0.2677***	1.3103***	0.3278***
	[0.0729]	[0.5326]	[0.1211]
Interaction terms with revenue shares			
IRA	0.0577	0.6084***	-0.0321
	[0.0437]	[0.2099]	[0.0513]
Local tax	0.0544	0.0907	0.0300
	[0.0475]	[0.1842]	[0.0500]
Local non-tax	0.0720	0.1304	0.0373
	[0.0471]	[0.1886]	[0.0490]
Other national transfers	-0.007]	-0.1167	-0.0370
	[0.0438]	[0.2341]	[0.0453]
Aid/grant	0.0257	-0.0998	0.0138
_	[0.0466]	[0.1918]	[0.0486]

Source: Authors' calculation and tabulation of BLGF data (DOF-BLGF 2024).

Note: a balanced panel of 1,455 municipalities and cities and 2,844 observations, 2010 and 2015. All models control for demographic and economic variables and time effects. The Hausman test reports p-values for rejecting the hypothesis that the coefficient difference is not systematic. Standard errors in brackets.

**Household out-of-pocket (OOP) spending on preprimary education totaled PHP 8 billion, with a large disparity between the poorest and richest households.** Around PHP 180 is spent per child aged 3-6 years old, coming from the bottom 40% of households, while around PHP 8,000 is spent by the richest households (See Figure 32). This includes kindergarten education; thus, lower spending is expected for pre-Kindergarten. This accounts for 0.06% of total household spending on education (around PHP 156 billion).

Rightful share of LGUs from national taxes should be based not only on the national internal revenue taxes collected by the Bureau of Internal Revenue (BIR) but also on all national taxes, which were deemed final and executory. This decision significantly broadened the tax base used to calculate LGUs' shares, thereby reinforcing fiscal decentralization.



Figure 32. Total annual household and per capita expenses for preprimary education, 2018

Source: Authors' analysis and visualization of 2018 Family Income and Expenditure Survey (PSA 2018b).

Attendance in early childhood education may not be fully free. Half of those attending early childhood education (48%) pay out-of-pocket for participation fees (38% among those belonging to 1st-2nd class LGUs, whereas 57% among those belonging to cities).





Source: Authors' analysis and visualization of ECCD-IS data (DSWD 2023a).

### 5. Conclusion and Recommendations

In conclusion, this report comprehensively assesses ECCD in the Philippines. Through our analysis, we identified significant challenges hindering the effective implementation of ECCD programs, including poor access to high-quality early childcare, underinvestment in ECCD, and governance issues leading to fragmented service delivery. Our findings underscore the urgent need for strategic interventions to improve participation rates in early education and essential health and nutrition services, increase public spending on ECCD, and address governance challenges. Implementing these recommendations will be critical in ensuring equitable access to ECCD services and improving outcomes for Filipino children, especially those from disadvantaged backgrounds.

Our recommendations target the three key areas highlighted in our general observations: low participation and access to early education, health and nutrition, inefficient use of resources, and governance challenges:

- Improve participation rates in early education and essential health and nutrition services.
  - Roll out innovative financing mechanisms to improve participation in early education. The national government could pilot PPP models, such as voucher and block grant systems, and assess their impact on access and supply-side growth before implementing them on a larger scale (short—to *medium-term*).
  - **Invest in science-based behavioral change communication (BCC) campaigns.** The national government should allocate resources to implement innovative BCC strategies, utilizing targeted messaging for diverse sociodemographic groups across various media platforms. This approach involves community engagement, continuous monitoring mechanisms, and potential collaboration with institutions/firms to develop comprehensive plans to effectively reach and engage the target audience *(short-term)*.
- Increase public spending on ECCD and improve efficiency by investing resources in services that dramatically affect health, nutrition, and early education outcomes.
  - Use national resources to leverage LGU spending on ECCD. In a decentralized regime, the responsibility for implementing ECCD programs (i.e., basic education, primary healthcare, and nutrition) lies within the jurisdiction of local governments. To address performance variability, the government can strategically allocate resources to influence the ECCD spending of local governments, directing funds toward cost-effective and impactful services. For example, a small portion of IRAs or NTAs is earmarked to provide a predetermined set of services proven to make a significant difference. The national government could match grants for the delivery of specific services in high-income local governments and strategically allocate national and local governments with limited technical and financial capacities to implement early education, nutrition, and health services rather than spreading resources thinly. This is even more important in a more decentralized regime because of *Mandanas Ruling*. However, this requires the national governments to improve the capacity to monitor performance effectively (medium to long-term).

- Implement the UHC Act, which underscores the importance of investing in primary healthcare (PHC). The UHC Act could be significant in financing the delivery of essential maternal and child health and nutrition in a comprehensive and integrated way. In addition, the UHC Act could be used to ring-fenced financing for local governments through PhilHealth primary care/outpatient reimbursements. While the law is already in place, it has yet to be fully implemented. Also, the government must ensure that the revenues from PhilHealth primary care benefits to local governments are used only for PHC services, not inpatient and non-health/nutrition projects. This requires amending the UHC, which does not mandate that PhilHealth revenues allocated to local governments be spent exclusively for PHC services (medium to long-term).
- Reevaluate the implementation framework of the government's school feeding 0 program based on a comprehensive understanding of its advantages. Chronic malnutrition indicates persistent and systematic exposure to early childhood stressors such as illness and inadequate nutrition within the first two years of life. Hence, addressing this issue largely through school feeding interventions at a later developmental stage may not effectively address the underlying causes of chronic malnutrition or stunting. Despite mixed global empirical evidence regarding the effectiveness of school feeding programs in alleviating hunger and acute malnutrition, our findings do not demonstrate any significant improvement in the nutritional status of children, as measured by Recommended Energy Intake (REI). The government should comprehensively evaluate the school feeding program, starting with a thorough analysis of the adaptive challenges inherent in its implementation. These challenges may include issues such as the adequacy of program benefits and delays in rollout due to bureaucratic hurdles, which could explain the observable impact, at least on improving REI. Given the scarce resources, we recommend a targeted allocation of resources to areas with the greatest need, aiming to improve the program's efficacy rather than dispersing resources indiscriminately across the country (short-term).
- Increase investment in healthcare workers who can track the whole journey of mothers and children. Implement a program within the PHC system to enhance healthcare workers' capacity to monitor mothers throughout pregnancy and until the first few years of life. These healthcare workers will ensure regular monitoring of children, guaranteeing they receive essential healthcare, nutrition, early education, and stimulation until the age of 2-4. Equipping and incentivizing these healthcare workers with a well-designed strategy is essential. The government could implement a small-scale program and conduct rigorous evaluations.
- Address governance challenges.
  - Transfer the chairship of multi-sector councils (i.e., NNC and ECCD council) to the Office of the President or a senior cabinet. The transfer signals the significance of nutrition and ECCD and ensures focused attention and support. Placing these councils under the oversight of the Office of the President removes the co-equal dynamics among national agencies. It promotes better coordination and accountability among government agencies, leading to more integrated governance addressing ECCD issues.

• Augment the capacity of multi-sectoral secretariats. Multisectoral agencies (e.g., NNC and ECCD council) should strengthen their stewardship and strategic direction functions rather than spreading themselves too thinly on program/project implementation functions, which are not their primary function; this is the responsibility of local governments and national agencies. This includes providing organizational incentives to hire and retain highly competent staff.

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## 7. Appendices

	Model 1 (All Sample)	Model 2 (Bottom 40%)	Model 3 (Top 20%)
Child age – 4 years old (ref: 3 years old)	1.897***	1.806***	1.778***
	(.119)	(.173)	(.294)
Sex of child: female (ref: male)	.211**	.218	.123
()	(.099)	(.144)	(.251)
The child was ill the previous month	09	.165	237
	(.163)	(.233)	(.424)
Household head's age	004	01*	.009
C	(.004)	(.006)	(.008)
Sex of HH head: female (ref: Male)	.019	432**	025
	(.128)	(.213)	(.269)
HH head's highest educational attainment: Early education	356	188	387
	(.393)	(.465)	(1.229)
Elementary graduate	288	.11	979
	(.386)	(.462)	(1.103)
High school graduate	378	013	716
	(.389)	(.468)	(1.067)
College graduate	437	152	505
	(.421)	(.646)	(1.067)
Above college graduate	027		223
	(.761)		(1.312)
Region II - Cagayan Valley	-1.086***	-1.071*	-2.256***
	(.332)	(.612)	(.758)
Region III - Central Luzon	-1.375***	655	-1.931***
	(.282)	(.513)	(.583)
Region IVA - CALABARZON	-1.241***	-1.075*	-1.947***
	(.313)	(.642)	(.604)
Region V- Bicol	587**	092	-1.733**
	(.279)	(.458)	(.74)
Region VI - Western Visayas	109	.528	875
	(.282)	(.468)	(.602)
Region VII - Central Visayas	399	015	904
	(.301)	(.492)	(.658)
Region VIII - Eastern Visayas	-1.177***	554	-2.003***
	(.307)	(.482)	(.765)
Region IX - Zamboanga Peninsula	-2.126***	-1.81***	-2.168***

### Appendix A. Factors affecting school attendance.

	(.383)	(.605)	(.744)
Region X - Northern Mindanao	84***	406	-1.37**
C	(.283)	(.475)	(.656)
Region XI - Davao	99***	343	-1.852**
C	(.304)	(.482)	(.749)
Region XII -	135	.295	226
SOCCSKSARGEN			
	(.28)	(.454)	(.649)
National Capital Region	-1.558***	984*	-2.193***
	(.299)	(.552)	(.609)
Cordillera Administrative	194	.911**	-1.658***
Region			
C C	(.278)	(.461)	(.622)
BARMM	-2.901***	-2.161***	< , , , , , , , , , , , , , , , , , , ,
	(.36)	(.5)	
Region XIII - Caraga	.002	.692	-1.329**
0	(.28)	(.455)	(.639)
MIMAROPA	641**	288	-1.875**
	(.286)	(.474)	(.795)
Place of residence: Urban	05	29*	.027
(ref: Rural)			
	(.117)	(.175)	(.311)
			~ /
Household's membership to	001	107	
4Ps			
	(.316)	(.408)	
Wealth quintile – Q2	.311**		
(ref: Q1)			
	(.137)		
Q3	.242*		
	(.146)		
Q4	.526***		
	(.164)		
_cons	-1.443***	-2.008***	424
	(.518)	(.715)	(1.321)
Observations	5393	2610	859
Pseudo R <sup>2</sup>	. Z	.Z	.Z

Standard errors are in parentheses \*\*\* p<.01, \*\* p<.05, \* p<.1

Source: Authors' analysis and visualization of 2022 Annual Poverty Indicators Survey (PSA 2022a).



Appendix B. Photos of Daycare/Child Development Centers in the Basco, Batanes

## Multimedia corner and computer, with printer



Learning materials and school supplies, activity guides







### WASH Facilities



## Proof of recognition and local policies

blicies, Guidelines and Internal Rules of	a fair and the second sec
1. Admission	
Child must be 4 years old on October 31.	
2. Snacks and tood stuffs	
Child must be given nutritious and healthy snacks by their Parents/Guardian	
Junk foods and money are not allowed to be given to the child inside the classroom.	
3. Typnoon signals	ECO
Casses will automatically be suspended once storm signal # 1 is announced.	COUNCIE
<ul> <li>Casses will be subjeticed once intere is nearly rain of very Windly even there is no storm signal or it will depend on the discretion of the accents whether to send or not to send their child to </li> </ul>	
the center, However, the Child Development Worker may suspend the classes when the	
attendance is less 50% or half of the class.	Republic of the Philippines
4. Suspension of classes	Early Childhood Care and Development Council
There will be no classes on National, Legal and Special Holidays.	
Classes will be suspended once or when the Child Development Worker is called or will attend	
for emergency meetings with prior notice to be sent to Parents & Guardians through Promoter	H
day before the Scheduled day of meeting and it will be posted at child development Bulletin	GOVERNMENT RECOGNITION
Board.	
5. Time	
1 Session only	By virtue of the authority vested in me by Republic Act 10410 (Early Years Act of 2013) and
<ul> <li>Parents, guardians and yayas are not allowed to stay inside the classroom/center during class hours. Persent are adviced to wait their shift outside/ within the assenter but if</li> </ul>	in behalf of the ECCD Council, I, ROMMEL J. ISIP, OFFICER-IN-CHARGE, OFFICE OF THE VICE-
norship and see burber child	CHAIRPERSON AND EXECUTIVE DIRECTOR, do hereby grant
Parents are advised NOT to send their child TOO FARLY or to bring their child at least 10	
minutes before the start of classes and NOT TO LEAVE their child in the center premises	
unattended or in the absence of child development worker.	LEVEL III RECOGNITION
Parents MUST pick their child on time or 10 minutes before the dismissal.	to
Child Development Worker will not be responsible to any untoward incident that may happen	
after dismissal time.	
6. Parents monthly Participation Fee and Registration	
Registration fee of P100.00 must be paid upon enrolment.	
Participation fee of 200.00/month.	for the Quality Center-Based ECCD Programs offered to 0 - 4 years old children effective for
7. Day Care Parents Meeting	5 school years covering 2023 - 2028 .
Day care refers to are required to accelle regularity/enlegency meeting cared by the clinic     Development Worker	It is provided, however, that the Local Government Unit where the Center/Learning Center
Parents who fail to attend Day Care meetings/activities that requires attendance and presence	is located reserves the right to satisfy the standards of the ECCD Council in the delivery of
of parents called by the Child Development Worker will pay the amount of P200:00.	integrated ECCD services.
8. Activities	In case of failure of the Center/Learning Center to observe and maintain any of the required
Parents are required to accompany their child in all activities conducted by the Provincia	standards set by the ECCD Council affecting the program herein approved, the Recognition
Municipal Social Welfare and Development Office and Child Development Worker.	hereby granted shall be re-evaluated.
9. school uniforms	
Day care children are required to wear the prescribed uniform:	Given at Pasig City, Metro Manila, this 10th day of March, Two Thousand Twenty Three
Monday-uniform	
Uussay Uniform     Wedgerday, Erre day	
Thursday-uniform	
Ficial-PE Lucion	
	SOUNTER SOUNTER SOUNTER
	and the second se