



**ZUELLIG FAMILY
FOUNDATION**

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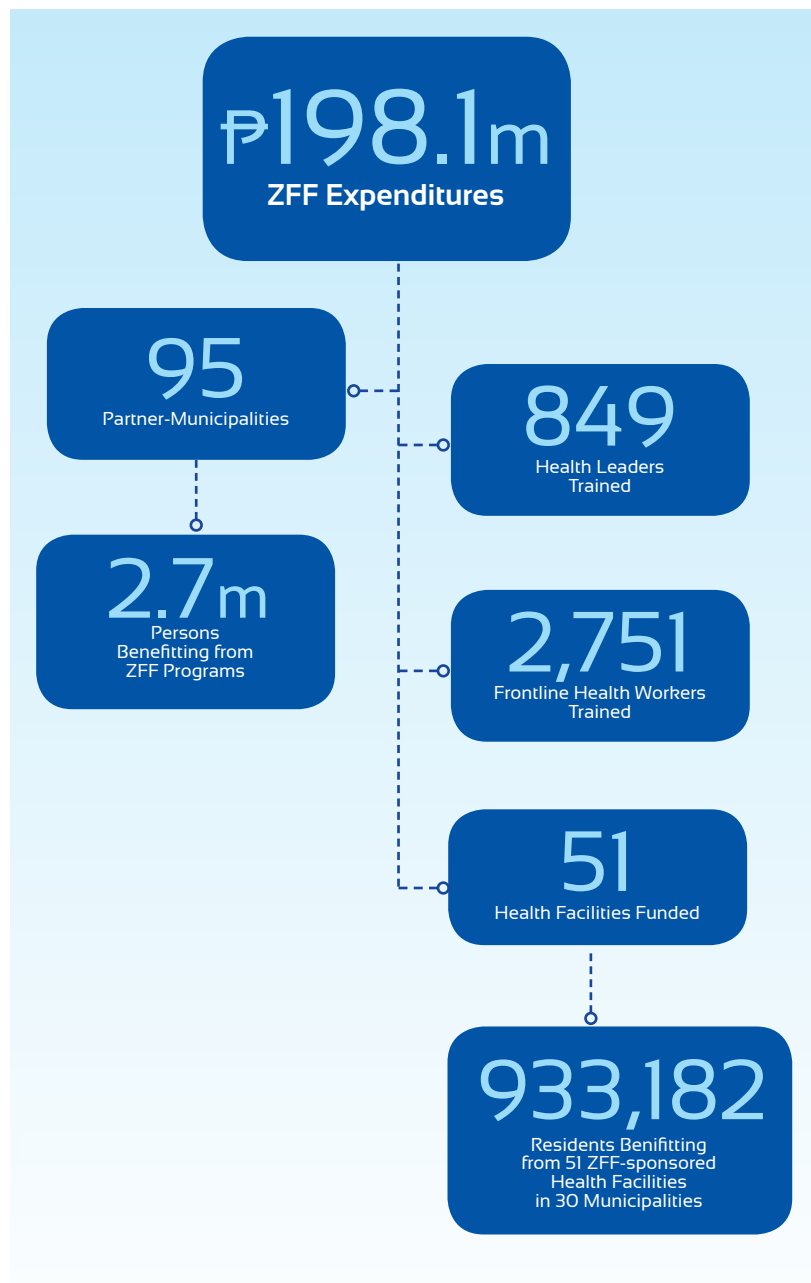
Health Challenges in Isolated and Disadvantaged Areas:

Difficult But Not Impossible

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Annual Report 2012

Progress Highlights



Daram, Samar

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Crossing Rivers to Get Pre-Natal Care

For some, getting healthcare requires literally going the extra mile – taking hours of boat rides, long walks, lengthy land travels or a combination of these. Such is the case of these three pregnant women who are boarding a boat with the help of midwife Elmer Estudillo. They need to cross the river that separates their village from the poblacion where the Rural Health Unit is located. The short one-way ride costs ₱5 a person. They can also use a hanging bridge but that is a longer and riskier alternative, especially for these expectant mothers.

Location: Barangay Calingnan, Catubig in Northern Samar

A Message from the Zuellig Family

Committed to Rural Health



Daniel Zuellig

David Zuellig

No social endeavor can be all things to all men and women. Without the dedicated focus on a well-defined field of action, charities and philanthropic organizations are at risk of wasting good intentions and squandering both money and time. Given our long-standing engagement in the Philippine health sector, we decided to focus our family foundation on health, and more specifically, on the improvement of health conditions in disadvantaged rural areas.

Primary Health System in Rural Areas

When we reframed our foundation's mission in 2008, we found that great inequities persisted in all health indicators between rural and urban areas. Even more than in cities, the rural poor depend on the services and amenities of the municipal health units.

Typically, primary health facilities are ill-equipped, inaccessible or offer only very limited services. We could have built hospitals, sponsored equipment and doled out medicine, but we were not convinced that such donations would have a lasting effect and address the systemic root causes of the deficient provision of primary healthcare.

We realized that sustainable improvements can be achieved only with the full engagement of the leaders of the local public health system, headed by the mayor. Therefore, we chose to engage the leaders of local

government units in programs to build specific capacities in health leadership and health governance.

ZFF Health Change Model

To guide us in our work, we developed a matrix we call the "ZFF Health Change Model." The modular syllabus of this program identifies major interventions to enable local health leadership and to institute good health governance, as well as a framework for improving critical elements of the local health system, primarily in terms of access and effectiveness.

It took us four years, from 2009 to 2012, to pilot the ZFF Health Change Model in five cohorts of 46 municipalities. Three cohorts have already completed their two-year partnership program with us. We are continuing our work with them along with 49 other municipalities.

Measuring Health Outcomes

The function of the ZFF Health Change Model is based on systematic data collection and measurement of health outcomes. The results of our initial cohorts of partner-municipalities show that, within two years, the maternal mortality ratio (MMR), one of the sentinel indicators for the performance of primary health systems, could be significantly reduced in most municipalities. Our findings give us the confidence that the achievement of the government's target for the reduction of maternal mortality is within reach. In line with the UN Millennium Development Goals, the Philippines is committed to bring the MMR below 52 maternal deaths per 100,000 live births by 2015, from 221 in 2011.

The positive results in our partner-municipalities were achieved through deliberate efforts of local health leaders. Still, many challenges remain, especially in geographically isolated and

disadvantaged areas, and continuous efforts will be required to ensure sustained improvement through the long-term adherence to good health practices.

Partnerships for Health

Good results have attracted good partners. The relevance and scope of the ZFF Health Change Model have been reinforced and expanded by a partnership with the United Nations Population Fund for nine provinces and a co-operation with Merck Sharp & Dohme in 21 municipalities on Samar Island.

We are particularly encouraged by an unprecedented Public-Private Partnership (PPP): the Department of Health (DOH) has committed to mainstream the ZFF Health Change Model to 609 priority municipalities, as well as to regional DOH officials who will provide both health leadership and technical assistance to mayors and municipal health officers.

In the next ten years, especially with the DOH-ZFF PPP, we will continue to focus on rural health. We have realized that improving health outcomes requires a long-term engagement. Founded on mutual trust, we have established solid relationships with our partners and health leaders throughout the country.

We will use this experience as we accompany many more mayors and local health officials through the transformation of their health systems towards the achievement of sustainable and measurable improvements of health outcomes in their communities. We will go forward on this journey with our partners to give rise to a better quality of life for Filipinos in disadvantaged rural areas.

Message from the Board of Trustees



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Challenging Health Inequities

Dear partners and fellow health workers:

Back in 2008, the decision to change the focus of the Zuellig Family Foundation (ZFF) to the health of the rural poor came at a critical, but also opportune time.

While Philippine health indicators showed gradual improvements, a closer look revealed a disturbing reality: growing health inequities between income classes, and among the richer and the poorer regions. For the poor, life expectancy was 60 years – 20 years shorter than for the rich. The incidence of maternal deaths was ten times higher among the poor than among the rich. And infants in poor areas were nine times more likely to die than those born in rich areas. In short, the poor, especially in rural areas, were being left out of the country's progress in health.

Strategic work with local political leaders

To address these inequities, we put forward a health change strategy that initially drew mixed reactions and some

reservations among health experts, even within the inner circle of our foundation. Concerns were raised about the strategic necessity of working with local political executives, specifically the mayors of rural municipalities, who were generally perceived to be unresponsive and oblivious to health matters. However, a consensus evolved that, as a result of the enactment of the Local Government Code in 1991, which devolved the responsibility for primary public healthcare to the local level, the mayor of each municipality holds the key and the power to oversee and effect changes in the provision of basic primary healthcare on which the rural poor depend. Rather than intervening in specific health programs and projects, or addressing short-term needs with a series of one-time donations, we set out to tackle the bigger challenge of system change to build sustainable and inclusive public healthcare system in rural areas. We realized that this approach to “health change” necessitates a long-term and replicative involvement with local government units in our target regions.

Five years after our start with a pilot set of nine municipalities, we now have worked with a total of 95 municipalities, primarily in regions facing the most challenging health issues – Mimaropa, Bicol, Eastern Visayas, Zamboanga Peninsula and the Autonomous Region in Muslim Mindanao (ARMM).

When we began our work, we were confronted with a daunting task. In line with the Philippine government's commitment to reaching the UN Millennium Development Goals (MDGs) by 2015, we focused on improving maternal health, in line with the MDG of reducing the country's maternal mortality ratio (MMR) to 52 maternal deaths per 100,000 live births by 2015. The United Nations Population Fund (UNFPA) projected that, in the absence of drastic interventions, the Philippines could meet its MMR target no earlier than in 2043, or 28 years after the 2015 MDG deadline. Contrary to such predictions, the experience with our partner-municipalities, however, showed that the MMR can be reduced to meet the target within two years.

Concerted Efforts

Despite these positive developments in our initial cohorts of partner-municipalities, serious healthcare inequities persist in many areas. Nevertheless, we have good reasons to be optimistic:

- The current political climate is conducive to health reforms.
- Our success has attracted other organizations to partner with us—the UNFPA and the Merck Sharp & Dohme (MSD).
- We have found partners to address the social determinants of health: Synergeia Foundation for education, CARD-MRI for livelihood, and the Jollibee Foundation for nutrition.
- We have established cooperations to address specific factors affecting healthcare. With the Wireless Access for Health, we can improve health information systems in local governments. Our Community Disaster Response Program supports communities affected by calamities. Among the contributors to this program is Zuellig Pharma, which donates relief goods, medicines and funds to build temporary shelters.
- The “ZFF Health Outlook Forum”, a regularly held public platform to present and discuss our rural health initiatives and results, led to the formation of private-public partnerships to help fast-track the reduction of maternal deaths in several provinces.

Mainstreaming

The widest potential impact will be gained through our work with the Department of Health (DOH), which has given recognition to the significant improvement of maternal health outcomes in the ZFF partner-municipalities. Our partnership with the DOH will allow us to replicate our health change strategy in 609 priority local government units in a three-year project that begins after

the 2013 elections. By mid-2014, health indicators, particularly maternal mortality, in these municipalities are expected to show substantial improvements.

From the start, we knew that we had to base our programs on a solid understanding of the healthcare sector and to employ a systematic and systemic approach in tackling the healthcare inequities in the Philippines. Our work over the past years has been a story of people coming together to implement real solutions to the challenges in our public healthcare system. This work and its measurable results are enabled by the dedication of our partners in the local and national governments, the private sector, the academe, in civil society and in the NGO community, as well as the commitment of our staff and volunteers. They all believe in our work, and that this is only the beginning.

We are confident that you will continue to support us on this journey and that the following pages inspire you to join us in working towards better health for all Filipinos.

Regions with Most Health Challenges



“Maternal mortality...is still a challenge that requires our fullest attention. With just three years left, the Philippines is behind its MDG 5 target.

All sectors—from the public to the private sphere, from government to our partners in civil society, can unite and make a strong push to attain MDG 5.”

President Benigno S. Aquino III

In a speech delivered on his behalf by Health Secretary Enrique Ona, MD during the 162-52 Summit held April 20, 2012 in Pasay City

2008-2012

The First Five Years: Testing the Health Change Model

In 2008, the Zuellig family knew that in order to make its contributions more relevant, significant and strategic, people in the rural communities must be given the fighting chance to attain their goals. A shift in focus was made to improving the health of the poor and the transformation started with a clear theory of change.

First, the Foundation looked into models that addressed inequities. Findings showed that where health inequities were serious, leadership and community participation were weak.

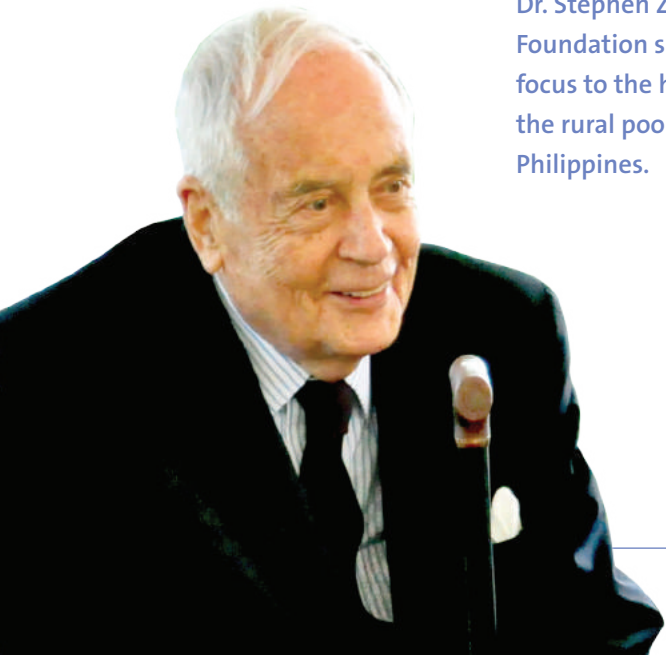
A change strategy was developed, the Health Change Model. The model

asserts that if the poor are to have better health outcomes, they must have easier access to health products and services. These will be available if institutional arrangements are improved such that they are favorable to the poor. And to make such arrangements possible, leaders must be responsive.

Empowering key local leaders

The strategy has two main interventions—a leadership and governance capability-building training program and a framework based on the World Health Organization’s building blocks of health system.

In building capacity, the Foundation helps local political leaders, health officers and community leaders become “bridging leaders” who own up to health issues, take action to address these and get other people involved. When relevant stakeholders get together and acknowledge the issues, they usually arrive at a common vision and response. They can then work collaboratively towards creating the necessary arrangements to improve the health system. And as new institutional arrangements are made, the more empowered communities become. As a result, more programs become innovative and responsive, which then lead to health equity.



In 2008, upon the expressed desire of Dr. Stephen Zuellig, the Foundation shifted its focus to the health of the rural poor in the Philippines.

ZFF HEALTH CHANGE MODEL

Leadership and Governance

Improved Health System

Targeted and Pro-Poor Health Programs

Better Health Outcomes:

- Lower IMR, MMR and Malnutrition Rates
- Lower Incidence of Communicable and Non-Communicable Diseases





Poverty, lack of livelihood and insufficient health services are evident in the interior barangay of Vienna Maria, Catubig in Northern Samar. Here lives the Beconia family, which counts ten children, their children's spouses and three grandchildren.

The capability-building program for cohort-municipalities is called the "Health Leaders for the Poor," a four-module, two-year program given to all mayors, municipal health officers and community leaders of cohort-municipalities.

Each training module is followed by a practicum period. Guiding the leaders on what to do is a technical leadership roadmap that shows specific items they need to accomplish under each of the WHO's six building blocks:

leadership and governance, health workforce, medicines and commodities, information system, health financing and service delivery.

"Empowered LGUs have the capacity to carry out much-needed reforms in the health system although (they may be) saddled with limited resources."

Message of Health Secretary Enrique T. Ona, MD during the formal end of ZFF's partnership with Cohort 2 municipalities



2008-2012

The First Five Years: Testing the Health Change Model

Piloting the strategy

To put the Health Change Model to test, the Foundation piloted it in 2009 in nine fourth- to fifth-class municipalities in Luzon, Visayas and Mindanao. These areas shared common characteristics: high health burdens, poorly maintained or inexistent health centers, low community participation in health programs, and more importantly, a mayor highly committed to health reforms. This initial group of municipalities was called “Cohort 1”.

Next, ZFF chose municipalities from five priority regions in the country where poverty incidence was highest and health indicators were poorest. If ZFF could positively turn around the health outcomes in these regions, then the chances of attaining the country’s health MDGs could vastly improve.

In 2010, 13 more municipalities (Cohort 2) were brought into the program. The following year, Cohort 3 was formed, comprising eight municipalities in the Autonomous Region in Muslim Mindanao (ARMM), where health inequities were widespread due to years of armed conflict.

With just three years left before the MDG deadline, ZFF added eight more municipalities from the Bicol and Caraga regions, which formed Cohort 4. In the same year, the Foundation reached out to eight partner-municipalities (Cohort 5) in geographically isolated and disadvantaged areas, so-called GIDAs.

Once operational, the Foundation made sure it was constantly around to help, listen and push municipal leaders. They were monitored. When they encountered difficulties, they were coached.

Since a reality for most rural municipalities is the lack of a functioning health center, grants were given to build and equip health stations.

Different approaches

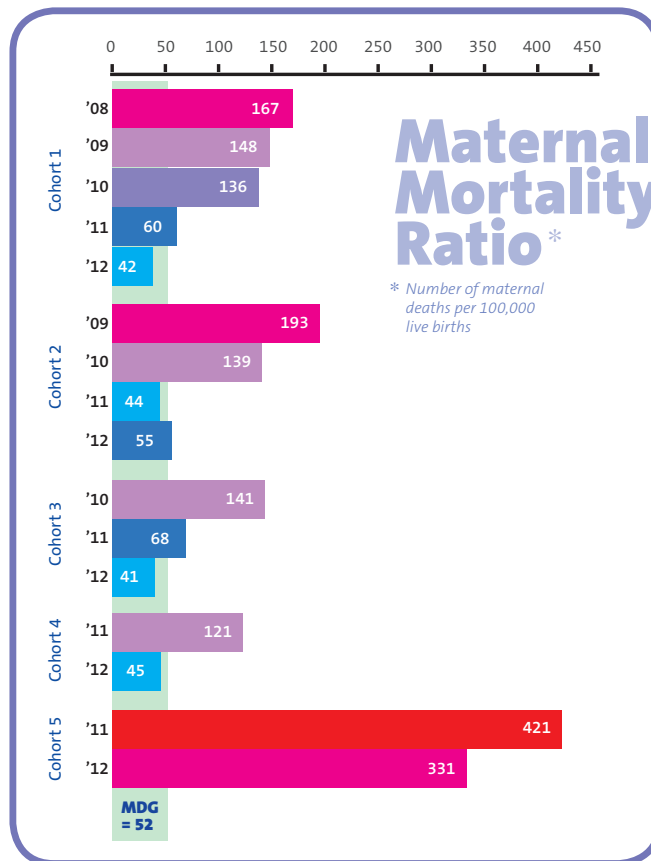
As every place presents unique challenges for health interventions, the Foundation uses different approaches for the ARMM, GIDAs and poor municipalities, while keeping the Health Change Model as the main framework for interventions.

The Foundation also consciously tweaked its interventions based on its findings and experiences as more municipalities were being added.

When Cohort 2 started, a leadership roadmap was immediately laid out to serve as a systematic guideline to the health leaders. The Barangay Health System Strengthening Program was first introduced in this cohort so that both municipal and barangay leaders were on the same page when it came to the importance of health.

The Foundation also started getting the Department of Health’s Centers for Health Development (CHD) involved. Their DOH Representatives helped reactivate local health boards and became more active participants in the planning and programming of the municipalities. This involvement of the CHD would later significantly contribute to the integration of ZFF’s programs at various levels of the Philippine health system.

In the ARMM, where health is not devolved, mayors need to know the real health situation in their towns. Hence, the first important step to health reform is gathering the latest accurate health data. Regional government involvement was sought to provide municipalities with additional funding for medicines, personnel and facilities.





In far-flung, hard-to-reach barangays without health facilities, residents usually rely on visits of health personnel for their healthcare needs. Such is the case in this upstream barangay of Naparasan in Mapanas, Northern Samar.

In GIDAs, getting the immediate involvement of different municipal department heads was seen as vital. This is because health in these areas is greatly affected by the interplay of several socio-economic forces.

By the end of the program, these local leaders—specifically, the mayor and the municipal health officer—have been transformed into healthcare champions. More importantly, their towns and villages – where mothers and babies dying from childbirth were once commonplace – have now become showcases for better health outcomes.

Reduced maternal deaths

To establish benchmarks and track its progress, ZFF collects health data, including statistics on maternal and infant mortality, from all its municipalities.

When it began its work with Cohort 1 municipalities in 2009, the municipalities' MMR in 2008 was 167. It has since declined to only 42 in 2012. This simply means that Cohort 1 has already outperformed the MDG target of 52. The Infant Mortality Rate (IMR, the number of infant death per 1,000 live births) likewise dropped from 4.2 to 2.8 in the same period. Similar transformations took place in other ZFF cohorts. However, GIDAs pose a serious concern.

Statistics showed that MMR could be significantly reduced in two years to meet the MDG target if the municipalities adopted the Health Change Model.

After just four years of implementation, ZFF has effectively proven that focusing on local health leadership and governance pays off. It worked because the mayors became aware of the

health burden and were committed to change. The Foundation kept a constant presence in the municipalities— monitoring progress and mentoring and coaching leaders through difficulties. ZFF employed a systems approach to change rather than short-term program interventions. And more importantly, it worked because leaders developed accountability for all the health results of their decisions and actions.

The question the Foundation faces now is how it can sustain its work in the longer term. What can it do in the next ten years to realize its vision of achieving better health outcomes for the poor through sustainable healthcare programs and services?

The journey has just begun.

2008-2012

Leadership Transformation and Health Reforms

Cohort 1

As the pilot set of municipalities, the challenge for the Zuellig Family Foundation was finding mayors who would be willing to participate in an unprecedented health change program.

Critical to the selection were municipalities with high health burdens but whose mayors were committed to improve health indicators. Help was sought from other organizations that have had good experiences with mayors in their projects. Following an evaluation, 11 municipalities were chosen but later reduced to nine due to the leaders' absences in some of the training sessions.

While the mayors possessed the desire to improve the lives of their constituents, they admitted that health was an overlooked issue. They believed they had limited ability to make meaningful changes since they were not doctors. For as long as they were approving the requests of their municipal health officers (MHOs) and providing budgets for medicines, mayors thought they were already fulfilling their duties.

The Foundation's program opened their minds to the potential far-reaching impact of improved health systems. ZFF's training served as a venue for the mayors to engage in health-related discussions with their MHOs and community leaders. Mayors began being more mindful of their local health systems—carefully planning programs and infrastructures, building better

Did ZFF's program create enough impact to encourage the newly elected mayors to continue the program?

relations with their doctors as well as the entire public healthcare personnel, and involving various sectors of society.

Midway through the program, three mayoralty changes occurred, putting ZFF's strategy to test. Did ZFF's program create enough impact to encourage the newly elected mayors to continue the program? Fortunately, all three did. For them, it was not merely a

matter of continuing the program but of building on the health successes of their predecessors. It was a case of sustainability.

The municipality of Bacolod, Lanao del Norte is one such case. Under the terms of the former and the incumbent mayors, death cases among mothers and infants were contained while children became better nourished.

Cohort 1 Health Indicators

	2010	2011	2012
Maternal Mortality Ratio	136.0	60.0	42.0
Infant Mortality Rate	8.7	3.8	2.8
Skilled Birth Attendant	56.8	63.4	69.3
Facility-Based Delivery	41.2	53.1	59.2
Malnutrition Rate	10.4	7.6	8.9
Health Budget (% of IRA*)	12.5	10.4	13.4

* Internal Revenue Allotment

Surviving the test of sustainability Bacolod, Lanao del Norte

Less than 15 years ago, residents of the town of Bacolod, Lanao del Norte faced the debilitating effects of armed conflict when some 700 armed rebels raided army detachments and turned the town into an evacuation center for about a million displaced people.

Now, the town has an enviable health system delivery in place, and maternal and infant deaths have been unheard of since 2008.

Health ownership

How Bacolod managed to rise from the rubbles of conflict is a story of transformative leadership. As part of ZFF's Cohort 1 partnership program, Bacolod was blessed with a health leadership team that showed staunch ownership of issues and collaborative effort in their pursuit of health-related goals.

Mayor Joselito Miquiabas, who served for three terms from 1998 to 2007 before his wife Judith took over for a single term, says he is now "more deliberate" in approaching the town's health agenda. After "inheriting" the ZFF partnership from his wife, he immediately took himself to task on how he could leave his own mark on the project.

When his MHO, Dr. Jaime Magat, retired in August, Mayor Miquiabas immediately sought a replacement. To supplement the town's Rural Health Unit (RHU) and two birthing clinics, he facilitated the construction of additional health centers for maternal care and tuberculosis. A new ambulance with its own dedicated driver is now permanently stationed at the RHU.

A feeding program helps in the progressive decline of malnutrition among schoolchildren. Ten Botikang Barangays throughout Bacolod thrive, bringing affordable medicines and supplies to its 21,000 residents. Mayor Miquiabas also has instructions for any department activity to devote a session on promoting health awareness, a sign of the town's unending focus on health.

Reactivating the Local Health Board

Far from being the result of a solitary undertaking, these headways were achieved through teamwork. Specifically, the local chief executive resurrected and empowered the Local Health Board (LHB), which used to be "seasonal."

"For the past nine years, our LHB had slowly become irrelevant," Mayor Miquiabas says.

Instrumental in activating and expanding the Board was civic leader-turned-town councilor Effimaco "Mccoy" Duhaylungsod. The professional nurse was the vice president of Bacolod's Business Chamber of Commerce when he was tapped by then-Mayor Judith Miquiabas to become the third member in her team participating in the ZFF program.

Realizing he could do much more in an official capacity, Mccoy ran and won a council seat. He then set his sights on engaging the people in the grassroots to further improve health outcomes. He convened and expanded the membership of the LHB to include his 16 counterparts in the barangay (village) level, barangay chairpersons, representative from the barangay health workers group, midwives, and



Mayor Joselito Miquiabas talks to Dr. Ana Maria Arnado about the numbers shown on the pregnancy data board at the Rural Health Unit. Looking on is Councilor Mccoy Duhaylungsod.

rural health nurses. He also enjoined each barangay to formulate localized systems for monitoring and issues resolution.

The response has been nothing short of overwhelming. "Finally, they will be able to do something relevant for their barangays," he adds.

Transformed leadership among both veteran and the neophyte politicians marked the beginning of meaningful reforms in health. For four years now, this continuing commitment has led to significant progress in Bacolod.

When Mayor Miquiabas took over from his wife in 2010, the reforms survived its first test of sustainability. With the healthy progress that Bacolod residents had witnessed, there is now no turning back.

	2009	2010	2011	2012
MMR	0	0	0	0
IMR	0	0	0	0

"Yet far from being a result of a solitary undertaking, these headways were achieved through teamwork."

Mayor Joselito Miquiabas
Bacolod, Lanao del Norte

2008-2012

Leadership Transformation and Health Reforms

Cohort 2

Like Cohort 1, ZFF chose municipalities for its second cohort based on the commitment of their leaders to make health improvements. Thirteen rural towns from the regions of Mimaropa, Bicol, Eastern Visayas and Zamboanga Peninsula became partners.

At the time, ZFF's strategy was still new. But the Foundation had been quick to learn from its experiences in Cohort 1. Training interventions were reinforced with a technical leadership roadmap that clearly showed what health leaders needed to do to improve their health systems.

As municipal health leadership was being improved, the Foundation also introduced a health leadership strengthening program for the barangays (villages). The almost simultaneous training of leaders at both levels led to greater community involvement in health. This, in turn, helped health leaders identify pressing health issues at grassroots level.

After training sessions and technical working groups, municipalities implemented various programs to address their respective concerns. These programs include Minalabac, Camarines Sur's "Project Mama" to improve maternal health and Pinabacdao, Samar's "Piso" program that enhanced its local health system financing scheme.

These municipalities' health improvements and innovations were presented during the 2012 colloquium that marked the conclusion of their two-year partnership with ZFF. Impressed by these health

"I could sense that the training they got on health delivery is having spillover effects in other areas of governance."

Boo Chanco
Columnist, Philippine Star

transformations, Philippine Star columnist Boo Chanco wrote: "As I was listening to the mayors in Cohort 2 describe what they are doing and have achieved by way of improving the health situation in their areas, I could sense that the training they got on health delivery is having spillover effects in other areas of governance."

Another inspiring story occurred in Lapuyan, Zamboanga del Sur. Without ZFF's emphasis on maternal deaths, the local government would not have discovered that the deaths reported in the town were being greatly understated. Learning the truth prompted the mayor and her health team to seek ways to rectify the problem.

Cohort 2 Health Indicators

	2010	2011	2012
Maternal Mortality Ratio	139.0	44.0	55.0
Infant Mortality Rate	7.3	5.7	6.5
Skilled Birth Attendant	58.9	68.6	80.4
Facility Based Delivery	46.0	63.2	74.8
Malnutrition Rate	13.0	12.8	12.0
Health Budget (% of *IRA)	9.8	11.3	12.1

* Internal Revenue Allotment

Bringing health to the Subanen people Lapuyan, Zamboanga del Sur

In Lapuyan, Zamboanga del Sur, a leader's strategic combination of firmness and adaptability had produced deeply felt changes in this third-class municipality's long-ignored health system.

As a member of Cohort 2, this coastal town has benefited from Mayor Daylinda Sulong's decisive and collaborative partnership with Zuellig Family Foundation, especially in dealing with health challenges that prove to be unique to Lapuyan.

Its ethnic Subanen population, which makes up around 80 percent of the residents, had long practiced various birthing rituals and pregnancy-related beliefs that sometimes conflict with medical methods. As such, facility-based deliveries were unheard of and

most mothers preferred to give birth at home, where they could undergo traditional Subanen ceremonies. While this conformed with centuries-old customs, it also placed a lot of new mothers and babies at risk.

Mayor Sulong, herself a Subanen, knew that this clash in belief systems could potentially hinder the implementation of health reforms. "Culture is something that is hard to dismiss," she says. It was a factor equally important as financing or infrastructure.

Instead of just enforcing ordinances that would have been poorly received by her constituents, the energetic second-term mayor sought to find a middle ground by consulting tribal and religious leaders before any steps were undertaken.



When making health plans, programs and policies, Mayor Daylinda Sulong makes sure tribal leaders are consulted especially since Subanens make up 80 percent of her town's population.

"There is no need for culture and medicine to clash, if we just try to understand each other," she says.

From *hilot* to chaperone

As a compromise, pregnant women in Lapuyan can have relatives and tribal leaders perform rituals before and after giving birth, so long as they do so in a proper birthing facility with skilled midwives performing the delivery. The neighborhood *hilot* (traditional birth attendants), who used to perform unsafe home deliveries, were given a new role as "chaperones" of pregnant mothers on their way to the facility. These measures only demonstrate how Mayor Sulong's dynamic leadership has served as a catalyst in transforming Lapuyan's health system, a commitment that was years in the making and kicked off in 2010 with a simple pledge to take ownership of the problem.

"Before the partnership with ZFF, no one was focused on the problem," she says. "We underwent capability-building programs, all of which had been eye-openers."

The organization of the Barangay Health Boards became first on the agenda. Armed with a clear directive, barangay health workers were tasked to collect data and regularly monitor pregnant mothers throughout Lapuyan's 26 barangays. The allocation

for health was also increased to 13 percent from 7 percent in 2009, while PhilHealth coverage for residents was strengthened through a P500,000 annual fund to spur enrolment.

To effectively manage health service delivery, the town was divided into three strategic groups, each served by a capable facility. The Rural Health Unit is open 24 hours a day and caters to 11 barangays. Birthing clinics in barangays Tiguha and Muring, constructed with the help of ZFF, handle the remaining 15 barangays and recorded 132 successful deliveries in 2012. Maternal shelters were built beside the birthing clinics to minimize labor complications, especially for mothers who live in remote barangays.

	2009	2010	2011	2012
MMR	1600	236	0	0
IMR	0	7	0	0

"There is no need for culture and medicine to clash if we just try to understand each other."

Mayor Daylinda Sulong
Lapuyan, Zamboanga del Sur

Changing mindsets

With health reforms successfully reaching the grassroots, the health-seeking behavior of the people of Lapuyan changed, says Mayor Sulong. "They are now aware that they are entitled to seek health services from our facilities, which are within their reach," she adds.

This will be hard to reverse and may be the greatest legacy of her administration. But she is quick to point out that credit goes to her entire health team. "We always need to work hand in hand in finding solutions to our problems," she says. "There is always something more that we can do."



2008-2012 Leadership Transformation and Health Reforms

Cohort 3

It is a region that consistently tops the list of the country's poorest. Worse, until recently, residents of the Autonomous Region in Muslim Mindanao (ARMM) have lived under constant threats of violence and armed conflict.

Faced with these serious concerns, most local chief executives tend to overlook the health issues of their municipalities. It does not help that health in the region, unlike the rest of the country, is not devolved to the local government units. Mayors, therefore, felt no obligation to get involved in their health systems.

It was enough for the Department of Health-ARMM to drive healthcare reforms especially since health statistics have been showing improvements. Giving dole-outs during times of family medical emergencies was deemed sufficient by mayors to help their people.

For ZFF, the role of mayors is critical because they have more intimate knowledge of what their people need. Their involvement can lead to innovative programs in support of health.

Being part of the all-ARMM Cohort 3, mayors realized their crucial role. But before they could act, they needed to see the real picture. Thus, municipalities worked to ensure the accuracy of their data and from the verified information, health programs and plans were developed.

Mayors established better rapport with their municipal health officers. Pouring in more resources to health, funds have been used to make medicines regularly available in health centers, hire

Mayors also took it upon themselves to engage their local and religious leaders to help promote proper health behavior.

additional health personnel, provide health workers with additional benefits, track every pregnant woman and enroll poor constituents in PhilHealth.

Mayors also took it upon themselves to engage their local and religious leaders to help promote proper health behavior and encourage people to avail of the

health services being provided by the government. This was essential to wean people off their traditional practices that are medically unsafe. Among the mayors who made collaboration with their people a cornerstone of his governance is Mayor Datu Armando Mastura, a leader determined to improve the health of his people.

Cohort 3 Health Indicators

	2010	2011	2012
Maternal Mortality Ratio	141.0	68.0	41.0
Infant Mortality Rate	2.2	2.6	2.0
Skilled Birth Attendant	71.8	69.4	73.3
Facility-Based Delivery	19.8	20.3	38.8
Malnutrition Rate	11.2	11.8	16.0

Consulting people on health needs Sultan Mastura, Maguindanao

"If the people cannot go to the mountain then we shall bring the mountain to the people."

This was the brave promise of Mayor Datu Armando Mastura on the heavy task of bringing social services within reach of the 21,000 people who call Sultan Mastura in Maguindanao home.

The reluctant politician, now on his third term, points to his experience as a poor boy which continues to serve as an inspiration in his commitment to cater to the poorest of the poor in his town.

"When I was a child, when one of us got sick, it became a big problem. And so I know what the poor needs because it was the same things that we needed back then," he narrates.

Beyond relief

In 2012, two years after his municipality started its partnership with ZFF, the mayor's good intentions produced

irrefutable results. Maternal mortality is down to zero and the Rural Health Unit, operating 24 hours, has been so efficient that it attracts patients from nearby towns.

A birthing clinic located in Barangay Tapayan, constructed with a grant from ZFF, now caters to all 13 barangays (villages) and averages around 30 deliveries a month at no cost to the mothers. An ambulance is also available to transport mothers to and from their homes, while PhilHealth enrolment is at an astonishing 100 percent, bucking the trend of underutilization in the region and bringing relief to the town's coffers. With additional funds, the municipality has been able to hire more midwives, as well as allocate more funds toward medicine and supplies.

Most importantly, Mayor Mastura's visible and tireless campaign on the importance of facility-based deliveries and PhilHealth strengthens the sustainability of these improvements.



Mayor Datu Armando Mastura presides over the town's Asoora, a regular consultative meeting participated by different sectors of the municipality.

The town's highly regarded BISITA Program (Bringing Integrated Services & Innovation thru Team Approach) is proving to be a long-term vehicle in the institutionalized delivery of basic social services. Under the program, residents are eligible for a wide array of medical benefits, including check-ups, basic medicines, dental care for children and immunization for schoolchildren and pregnant mothers.

The mayor acknowledges how participating in ZFF programs and workshops fine-tuned his approach to achieving health-related reforms. His style of leadership has always been consultative in nature, adhering to the Koran-enshrined principle of Shura ("Asoora" as the local government calls the regular consultative meetings that they initiated).

"ZFF's Bridging Leadership Program introduced me to the concept of self-mastery, which gave me a better

understanding of myself and other people... I came to appreciate the processes involved in dialogue and the entire bridging leadership framework," the Mayor says.

Today, he holds a monthly meeting that is attended by several stakeholders. And since all sectors of society are ably represented, the agenda is not limited to health. His next step is to replicate this clarity of process at the barangay level where some factors, particularly the inadequate capabilities of some barangay captains, pose a challenge.

With these workshops and modules as takeoff point, he says only decisive action can lead to the enviable health outcomes of his programs. "Don't just talk about it," he stresses. "Do something."

Now on his last term, Mayor Mastura is confident that the good work he has started in the municipality will not go to waste when he steps down after the 2013 elections. His son, he says, can hopefully continue his legacy, taking Sultan Mastura to the promise of "even greater heights."

	2010	2011	2012
MMR	292	136	0
IMR	11.7	5.4	8.6

"Only decisive action can lead to enviable health outcomes. Don't just talk about it. Do something."

Mayor Datu Mastura
Sultan Mastura, Maguindanao



Cover Story

Health challenges in isolated and disadvantaged areas: **Difficult but not impossible**

The term “geographically isolated and disadvantaged areas” (GIDAs) conjures up images of places lacking in paved roads, electricity, phone and internet connections, and transportation facilities. Such images are a reflection of a challenging reality.

Isolated due to distance, weather and lack of transport systems, GIDAs are characterized by the Department of Health (DOH) as having a high incidence of poverty and communities in a crisis or affected by armed conflict.

One of the first GIDAs Zuellig Family Foundation engaged with was Daram, Samar, an island municipality with no road network and barangays that can only be reached by boat. Daram consistently had the highest number of infant deaths among all the municipalities in Cohorts 1,2 and 3.

While health numbers were improving in other cohort-municipalities, the high incidence of infant death in Daram marred their collective results.

Ensuring good health leadership

Seeing the gravity and extent of health inequities in GIDAs, ZFF decided to accept the challenge of addressing them. Aside from having an all-GIDA set of municipalities (which formed Cohort 5), ZFF forged a partnership with MSD’s Merck for Mothers Global Giving Program for 21 GIDA municipalities on the island of Samar.

Recognizing the unique challenges that GIDAs pose, ZFF needed to differentiate its GIDA strategy from that applied in other rural, non-GIDA towns.

First, since villages are usually located far from each other, it is important to immediately strengthen the leadership at the barangay (village) level; enable the village leaders to effectively look after their community’s health; and activate their own health systems to complement that of their municipal institutions.

ZFF also saw the need to have a multi-disciplinary approach in employing its Health Change Model. So apart from the mayor and municipal health officers, ZFF decided to get the heads of municipal departments on board early on and give them health leadership and governance training. Their understanding and support for health are needed to facilitate the immediate implementation of programs addressing the social determinants of health like education and livelihood.

It is also crucial for municipalities to have a sufficient number of midwives who must be given well-defined assignments so that all villages are served regularly.

While building a clinic in every village may be impractical, having an actively roving midwife could be a more efficient way to promote better health.

In Daram, while infant deaths are still a serious concern, the local government has managed to keep maternal deaths in check. A shift in the mindset of midwives and a performance management system kept them active in combing through their assigned villages. As a result, the rate of births assisted by skilled birth attendants (SBA) increased to 80 percent in 2012 from 45 percent in 2010 while facility-based deliveries (FBD) improved to 66 percent from six percent during the same period.

Infant Deaths	2011	2012
Cohort 1 (9 municipalities)	19	13
Cohort 2 (13 municipalities)	57	58
Cohort 3 (8 municipalities)	20	15
Total (30 municipalities)	96	86
Daram (of Cohort 2)	21	20
% of Daram to total	22%	23%



In geographically isolated and disadvantaged areas, makeshift hammocks are often used to bring the sick to health facilities. Location: Barangay Naparasan, Mapanas, Northern Samar

However, poor post-natal care services due to lack of health personnel training contributed to the high incidence of infant deaths. Families shied away from transportation difficulties and only sought medical care when illnesses turned serious. Lack of money was often the cause for not seeking professional medical care.

In the coming years, ZFF will continue to address what may turn out to be one of its toughest challenges. The difficulty of improving health outcomes in these GIDAs is exemplified in the stories of two Northern Samar towns, Mapanas and Catubig.



From the town proper of Talalora in Western Samar, a boat ride is the fastest and most convenient way to reach barangay Placer. But a one-way ride costs over P500. Barangay residents usually take the land route, a strenuous one-to-two hour hike on a footpath through the hills of the Talalora peninsula.

Samar provinces: Poverty, governance and health

Nature's bounty is all too evident in the fourth-class municipality of Mapanas in Northern Samar. In this seaside town, the horizon is green with the endless rows of coconut trees, the sea teems with fish, and the people – the Mapanasnons – are good-natured, always with a ready smile for their fellow Warays or the occasional tourists.

Amid the seeming abundance, the familiar sights around this municipality tell a different story: idle people on the streets, ill-maintained roads and school buildings, and children whose smiles, no matter how winning, are unable to hide the lack of nourishment.

As with most parts of the Philippine countryside, Mapanas has long suffered from persistent problems of

underdevelopment. Poverty incidence is high, livelihood opportunities are scarce, and access to social services, such as education and health, remains limited.

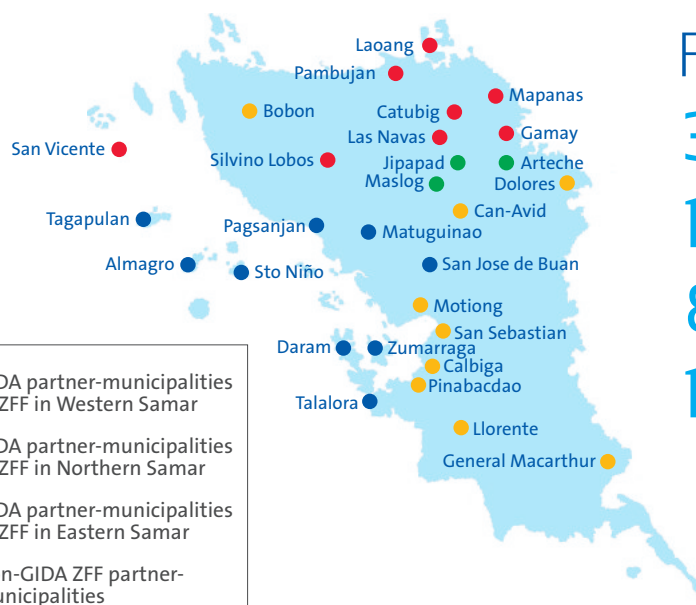
“Here, we really have to stand up on our own,” says Dr. Gabriel Mark Casuga, the town’s soft-spoken Municipal Health Officer (MHO). “We could really use some help.”

Challenging conditions

Classified as a GIDA by the DOH, Mapanas is four hours away from the provincial capital of Catarman. The journey to Mapanas involves crossing the Catubig River from Laoang to Palapag and braving kilometers of macadam road. Going to one of its six upstream barangays, the hike through mountainous terrain adds an hour or two to the already gruelling trip.

Inclement weather can pose even more problems for this town on the east coast of Samar island facing the Pacific Ocean. A sudden torrential downpour makes roads and footpaths risky, while low tide means some parts of the region’s extensive river system become practically un-navigable. It is easy to imagine how these difficulties can affect the delivery of health services for the town’s 12,000 residents.

First-term Mapanas Mayor Leonida Laodenio knows this only too well. When she was pregnant with her second child, she went into labor almost a month earlier than what her doctor advised. “I knew that I needed to give birth in a hospital but I had no choice. It was midnight when my water broke. The nearest hospital was in Gamay, the next town. We wouldn’t make it. I could feel



Facts about Samar

- 3rd** Poorest region (EASTERN VISAYAS) in the Philippines
- 134** Maternal Mortality Rate - WESTERN SAMAR
- 89** Maternal Mortality Rate - NORTHERN SAMAR
- 110** Maternal Mortality Rate - EASTERN SAMAR

Source: National Statistical Coordination Board



Lack of money and access to health services force poor women to seek “hilots” (traditional birth attendants) when giving birth. In 2012, in ZFF’s 66 partner-municipalities, 53 percent of maternal deaths occurred following deliveries assisted by “hilots”.



Running a fever for days, this one-year old girl from Villareal, Samar gets treated in the Rural Health Unit. She was then referred to the Eastern Visayas Regional Medical Center in Tacloban, but died on the day she arrived at the hospital.

that the baby was ready to come out so my husband, who was then mayor, called a *hilot* (traditional birth attendant). We had no choice,” she narrates. At the time, in 1980, a 1.5-hour boat ride was needed to get from Mapanas to Gamay as there was no road connecting these neighboring towns.

It was not the first time for the mother of three to realize the value of proper healthcare. When she was 14, her brother Joseph, the last in her parents’ brood of ten, died five days after he was born. Complications arose from the unhygienic operation, conducted by a *hilot* who used a sharpened bamboo instrument to cut the umbilical cord. “That was the practice then, and up to now some still do it. Mothers didn’t have a choice. There was no Rural Health Unit (RHU) or district hospital. All mothers gave birth at home,” the mayor says.

In Catubig, some 60 kilometers away, Municipal Health Officer Dr. Sylvia Paclé relates a recent case when an ambulance got stuck in the mud while trying to cross a dirt road after a downpour. The patient it was carrying – a mother in labor – died. She says this reflects the appalling health conditions in the third-class municipality.

“Kids still die from loose bowel movement because their parents don’t know that their children are already dehydrated until it’s too late. It takes weeks before kids with common colds and coughs are brought to health centers,” she adds. Cases of tuberculosis, schistosomiasis and even leprosy continue to be prevalent, largely neglected.

Catubig, a massive interior municipality of 47 barangays is classified as a GIDA. While a road network connects

some barangays to the poblacion, the municipality’s territory straddles some 200 square kilometers of challenging terrain and waterways.

Even Dr. Paclé admits she has yet to visit the remotest barangays which are accessible only after hours of trekking in mountainous terrain. Sick people have to be carried in makeshift hammocks for the risky trek down to the poblacion.

“We have a district hospital but patients ran the risk of contracting tetanus from all its rusty dilapidated beds,” says Mayor Fredicanda Dy, a first-termer like Mayor Laodenio of Mapanas. “The lack of clean water was also a big problem. We even got featured on TV because our town is called Catubig (tubig=water) and yet you see long lines of people getting water from pumps.”



Poor road conditions hamper the delivery of quality health services. In this photo, the service vehicle of the Mapanas Rural Health Unit gets stuck in an unfinished portion of a road construction.

These factors, in addition to sporadic armed encounters between the New People's Army and the military, contribute to the poor health-seeking behavior of its residents. Most still believe that healthcare is a privilege only available to those who can afford it. Those who cannot might as well seek alternative ways.

As someone who has experienced both facility-based delivery and a *hilot*, Mayor Laodenio says there is an unparalleled sense of security when you know you are in a safe environment under the care of trained professionals. It is this sense of wellbeing that she wants for her constituents in Mapanas.

As soon as she was elected mayor in 2010, health became her priority. At the time, the RHU languished from



Construction of a road connecting the towns of Gandara and Matuguinao is at a standstill after workers (above) refused to proceed without first receiving their salaries. The road can cut travel time to less than an hour. Currently, Matuguinao residents take 4-5 hour boat rides to reach Gandara where they can receive emergency medical care.

years of neglect. There was no doctor and midwives were disorganized. There was no health system in place. She immediately requested for a doctor and started hiring casual midwives. Then she laid out the plans for building health stations in underserved far-flung barangays, now all under construction.

Despite her efforts, mothers and newborns continued to die, access to clean water remained a problem, and many children were still malnourished. Barangay leaders and even health workers remained uninvolved in their town's struggling agenda.

ZFF introduces Health Change Model

Mayor Laodenio realized that her approach to health still lacked a clear direction. When ZFF invited her to join its partnership program in 2012, she

immediately agreed. She knew that she may have gained some ground in her health advocacy, but much still needed to be done.

"All I knew before was, as long as I have a doctor and some midwives, that's enough," admits the outspoken chief executive. "Concepts like maternal and infant mortality were completely alien to me. Marami pa palang kailangang gawin (A lot still needed to be done)."

In November 2012, Dr. Casuga – "Doc Gab" to his patients – came to Mapanas and assumed the role of MHO. The town had been without a resident doctor for just four months, but its RHU was like "barren land" when he found it. The head nurse was new, the midwives lacked initiative, and there were no health programs to speak of. Fresh from a training session with ZFF, Mayor Laodenio immediately took steps

to enhance her working relationship with Doc Gab. She even insisted that the doctor live in her house "so that he is always just a knock away."

"When we're at home, there is no mayor, no doctor. We're family," says Mayor Laodenio. Barangay captains, upon her prodding, have started to look at health differently.

"Marami pa palang kailangang gawin (A lot still needed to be done)."

Mapanas Mayor
Leonida Laodenio



Mapanas Mayor Leonida Laodenio holds a dialogue with health personnel at the Rural Health Unit to discuss prevailing health issues in the community and ways to address them.



Dr. Gabriel Casuga on his motorcycle, with midwife Bronilda Cafe, on the way to remote barangays in Mapanas, Northern Samar

“Before, health was absent in their agenda. They only focused on things like basketball courts and tournaments. Now, little by little, we’re injecting issues on health and education. We expect their participation to pick up more when the barangay health stations are built and we have midwives stationed there permanently,” the mayor says.

For Doc Gab, the leadership training with ZFF helped him organize his staff for the implementation of programs. While he sees himself more as a troubleshooter, he says this is not enough for an MHO since he also has administrative duties such as medicine procurement, running PhilHealth and the RHU.

Need for adaptive leadership

In Doc Gab’s previous assignment at a Western Samar town along the national road, terrain and geography were not major considerations when formulating health plans. In Mapanas, he realizes he needs a lot of creativity because of the challenges unique to a GIDA.

For instance, instead of buying a laptop computer, he decided to get a motorbike. It is common for townfolk to see the doctor riding on his bright red motorcycle, either responding to a patient’s phone call or visiting a far-flung barangay.

During extreme emergencies, a motorcycle can only do so much. Thus, Doc Gab proposed a mini-emergency room at the RHU where patients can be stabilized to prepare them for the long journey to the hospital.

“For example, if a mother is really bleeding, the most we can do is refer her to either Gamay or Catarman. That’s not enough. Before hospital care, we should have emergency intervention to buy them more time,” he says.

In Catubig, facility-based delivery jumped from zero percent in 2011 to a remarkable 44 percent the following year, thanks to a combination of creativity and, when necessary, intimidation. Even during a stormy day, the town’s Buntis Congress drew some 200 pregnant women from several barangays, all because of Dr. Sylvia Pacle’s creative marketing of the program.

“We held a beauty pageant called ‘Mutya ng mga Buntis’ to liven things up instead of just holding the usual lectures and speeches. We gave away free items and held games. Food was also served,” she says.

Aside from pregnant mothers, the *hilots* were invited to the Buntis Congress. There, they were made to surrender their tools and make a public vow that they would no longer assist in deliveries. Those reluctant to follow the ordinance on facility-based delivery (FBD) received unexpected visitors on their doorsteps. “They got visits from barangay officials or the police who read them the ordinance,” Doc Sylvia says.

Still, there is a pressing need to make sure the programs are inclusive. Out of the 47 barangays, several continue to be practically out of the reach of their initiatives.

Despite the improvements, Catubig’s maternal mortality ratio increased between 2011 and 2012, from 524 to 884. This shows that health statistics will not stabilize unless the entire health system is addressed.

In Mapanas, though strides have been made, both Mayor Laodenio and Doc Gab know they still have a long way to go. The town recorded zero maternal deaths in 2012. Like in other GIDAs, frontline health workers must be mobilized, health ordinances need to be strictly enforced, data has to be accurate and collected, and people's mindset has to change.

Accomplishing these tasks is arduous. Progress will neither be fast nor easy, but, at least, the change process has been set in motion. And it is now a matter of keeping the momentum.



A health data board provided by ZFF is displayed in the Rural Health Unit of Matuguinao, Western Samar, which is headed by Municipal Health Officer Jeremiah Calderon, MD, a member of the Doctors to the Barrios program. While there are still maternal and infant death cases, maternal mortality fell from two cases in 2011 to just one in 2012. In the same period, infant death cases dropped from 15 to nine.



Midwives Letecia Tejana and Janejayrel Tenedero (right) walk through rice fields and difficult terrain to deliver health services to the people of Mapanas, Northern Samar.

2013-2015

Scaling up the Health Change Model

End goal is sustainability of good health outcomes

Politics often gets in the way of a good thing. In the Philippines, public healthcare is often neglected by politicians, as it is seen to lack political appeal, unlike more attractive endeavors, such as constructing a basketball court or other traditional infrastructure projects.

Not too many politicians summon the courage to go against the current and to invest in public healthcare reforms. In the first place, it is not easy for local executives to sell to their people the idea of taking ownership of their health and improving their health-seeking behavior.

To nurture empowered health leaders requires continuous training and education so that local leaders — from the mayor to the barangay captains — learn to embrace health

as a continuing priority despite the changing political tides. Investing in healthcare is investing in better human capital.

In the Philippines, where local chief executives run for election every three years for up to three terms, sustaining public healthcare reforms is a particularly tough task. Zuellig Family Foundation took on this challenge as its contribution to nation-building. It believes that the key lies in the local chief executive, who has the authority to make the rural health system more accessible, effective and responsive.

ZFF's journey using the Health Change Model (HCM) has been making headways despite the changes in the political leadership. Since starting the initiative in 2009, three groups of 30 municipalities

have completed the two-year formal partnership program. By the end of 2012, two of them had a MMR below the 2015 MDG target of 52.

However, every election season, ZFF's partnerships with municipalities undergo the political litmus test. The first came during the May 2010 elections when three mayors from ZFF's first batch of nine partner-municipalities were replaced. Recognizing the significant health improvements in their towns, their political successors continued the ZFF program and successfully reduced infant and maternal deaths to zero.

Three years later, ZFF's model is again undergoing the litmus test. Twenty of its 30 partner-municipal mayors sought reelection in the Philippine mid-term elections last May 2013.

“In line with the Philippine government’s mandate of Universal Health Care, MSD is strong in its commitment in its mission of saving and improving the lives of Filipinos in most need. This year, MSD has partnered with the Zuellig Family Foundation to reduce the maternal mortality in one of the poorest areas in the country - Samar.”



MSD Asia Pacific President Patrick Bergstedt during the formal launch of the “MSD for Mothers-ZFF Community Health Partnership Program: Joint Development Initiative”



A father brings his sick boy for a check-up to the Rural Health Unit of Pinabacdao, Samar. A ZFF partner, this town had no maternal death and one infant death in 2012.

ZFF's commitment to municipalities is not a commitment to the chief executives alone but to all the health personnel and to the people. When mayors change, the municipal health officers and community leaders who are also engaged help in making new mayors accept the interventions and continue the program.

The changes require ZFF to speak to new mayors; make them understand the HCM; and get them up to speed with health reforms and developments.

Thus, any possible changes in the leadership may need a fresh round of investments on leadership and governance training program and practicum.

Scaling up

The challenges of sustainability do not end with the present set of

municipalities. The greater task is in scaling up the success of the model for national impact on the country's attainment of its health targets under the UN Millennium Development Goals by 2015.

Initially, ZFF trained its sights on having within ten years 485 municipalities in the priority regions. Bringing the HCM to these municipalities could drive the country's MMR closer to the target by 2015.

For this, ZFF committed to allocate P1.123 billion over the next decade, or an average of P100 million a year, to help bridge the gap in local health systems.

In 2012, improved health outcomes in ZFF municipalities caught the attention of other organizations—both public and private. The United Nations Population Fund (UNFPA) recognized the need for

improved local health leadership and governance to complement its own programs on maternal and reproductive health in nine provinces and their municipalities.

Global healthcare company Merck Sharp & Dohme (MSD) through the "MSD for Mothers Global Giving Program", also saw the value in ZFF's strategy and formed a joint initiative to help mothers in 21 geographically isolated and disadvantage areas in the three Samar provinces. With more funds flowing into the municipalities, MSD and ZFF will improve both the supply side and demand side of healthcare.

The decision of the UNFPA and MSD to partner with ZFF gives credence to its health change strategy. With their help, ZFF moved closer to its vision of reaching a third of all the country's municipalities.

Replication

In the last quarter of 2012, the Department of Health, through Health Secretary Enrique Ona, MD, opened talks for the possible replication of ZFF's change model. Being asked by the nation's lead agency in health is an official validation of the Foundation's strategy.

Replicating with the DOH will cover 609 priority local government units identified by the National Anti-Poverty Commission. The project will run for three years and start after the 2013 mid-term elections.

The challenge is not merely in the great number of LGUs involved but also in ensuring that the implementation of this scale-up is well-planned and sustainable.

The Health Department's involvement provides legitimacy to ensure health officials and LGU officials will follow the necessary adjustments and changes

that will inevitably take place. While there may be resistance to the strategy along the way, ZFF and the DOH have been working closely to garner support especially within the department. Among the early important steps taken for the replication is the leadership training of regional and provincial health officials.

ZFF's "Health Leadership and Management for the Poor" program is still anchored on the HCM and also uses the "Bridging Leadership" framework for regional and provincial officers, not just of the DOH but also of the Philippine Health Insurance Corp. (PhilHealth), and academic institutions. The goal is to raise these officials' capacities and commitment in supporting province-wide health system reforms. They can become coaches of municipal leaders and play a crucial role in helping institutionalize the change model in their organizations or areas of operation.

Need for Funds and Academic Partners

While working to get the full support of people in the DOH, there is also the matter of cost, estimated at US\$20 million. The initially planned allocation will be insufficient. And even if the DOH provides funding, ZFF still sees the need to tap other organizations.

The project entails partnerships with different academic institutions. They do not only provide venues for training but also have the faculty and personnel to run the training program, in this case, the "Health Leadership and Governance Program" for mayors and municipal health officers (MHOs). With more schools able to implement the training, there will be more opportunities for interested health leaders to enroll in the program. Currently, ZFF has partnerships with the University of Makati, where mayors and MHOs of Makati City's sister-municipalities can take up a course in public health leadership and governance. Other academic partners are the Ateneo de Zamboanga University, Benguet State University, Davao Medical School Foundation, Development Academy of the Philippines, University of the Philippines (Palo), UP College of Public Health, University of St. La Salle and Xavier University.

"The Department of Health marks another milestone in its history as it seals its partnership with one of the nation's recognized foundation. This public-private partnership with the Zuellig Family Foundation aims to strengthen leadership and service delivery both at the national and local levels."

Health Secretary Enrique T. Ona, MD during the signing of the Memorandum of Understanding between DOH and ZFF



**ZUELIG FAMILY
FOUNDATION**



Signing of the DOH-ZFF partnership agreement on May 16, 2013 (from left): DOH Director Nestor Santiago Jr., MD, DOH Undersecretary Gerardo Bayugo, MD, DOH Secretary Enrique Ona, MD, ZFF trustee Daniel Zuellig and ZFF chairman Roberto Romulo

ZFF as Bridge between LGUs and DOH

In the replication of ZFF's Health Change Model with the DOH in 609 LGUs, the Foundation sees its role as a bridge linking the national and regional levels of the DOH with local, provincial and municipal governments units.

Once its approach is institutionalized in the DOH, ZFF expects a sustained flow of technical, financial and logistical support for health system reforms from the DOH to local governments. And with more academic institutions being able to

offer health leadership and governance program, more incumbent and aspiring local political leaders will become aware of the importance of health for national and local development. The Foundation's role is in monitoring the program, and coaching and mentoring regional and provincial health leaders.

The DOH partnership has given ZFF the opportunity to realize its goal of ensuring the sustainability of its interventions. The true test of the Health Change Model approach is when it has improved health outcomes on a national scale.

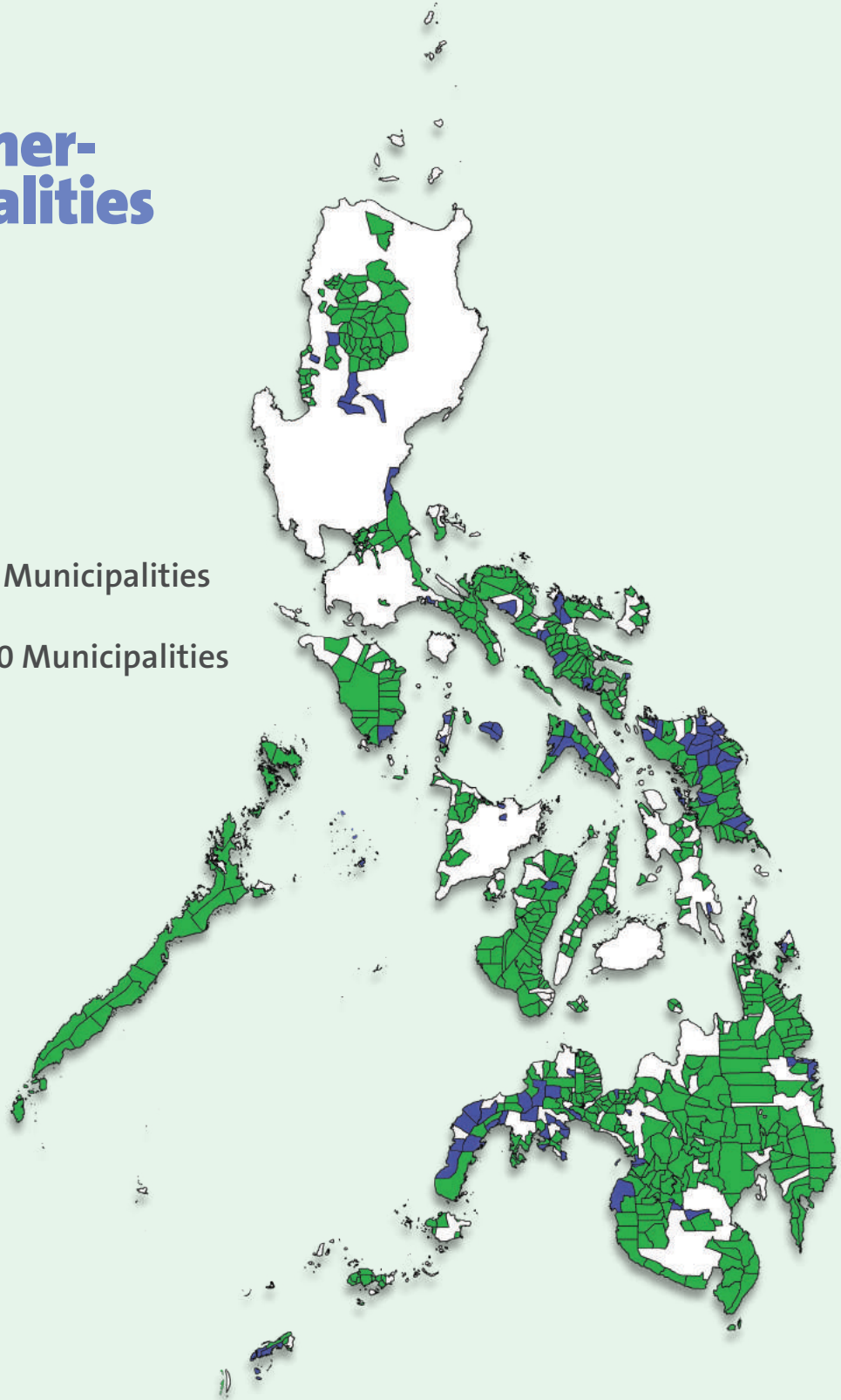
But while scaling up is expected to bring improvements in the country's health situation, other factors affecting health such as employment, income, access to sanitary facilities and safe water and literacy, must also be addressed.

It is through strong partnerships that the Philippines can reverse the tide that has saddled the local health systems for years and deprived the poor of their fighting chance to survive.

The challenge of sustainability may be daunting, but it is not an impossible dream.

ZFF Partner-Municipalities

- End 2012 = 95 Municipalities
- End 2015 = 700 Municipalities



FINANCIAL Highlights

The Zuellig Family Foundation, Inc.

Statements of Assets, Liabilities and Fund Balance

December 31

	2012	2011
ASSETS		
Current Assets		
Cash and cash equivalents	₱98,764,468	₱61,476,111
Receivables	304,093	254,836
Prepaid and other current assets	494,865	402,138
Total Current Assets	99,563,426	62,133,085
Noncurrent Asset		
Property and equipment	11,664,079	7,588,568
	₱111,227,505	₱69,721,653
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables	₱19,374,571	₱18,215,000
Deferred revenue	110,000	-
Due to a related party	279,709	232,740
Total Current Liabilities	19,764,280	18,447,740
Noncurrent Liability		
Retirement liability	11,571,103	11,571,103
Fund Balance	79,892,122	39,702,810
	₱111,227,505	₱69,721,653

The Zuellig Family Foundation, Inc.

Statements of Revenues, Expenses and Fund Balance

Years Ended December 31

	2012	2011
REVENUES		
Donations	₱127,961,309	₱96,060,335
Interest	2,189,299	1,475,422
Others	2,614	287
	130,153,222	97,536,044
EXPENSES		
Materials and supplies	16,271,818	21,254,927
Salaries, wages and other benefits	13,635,450	11,548,164
Training and seminars	13,120,296	9,152,771
Professional fees	12,258,975	10,634,198
Infrastructure projects	10,711,136	18,430,821
Donations and contributions	9,286,892	9,887,541
Transportation and travel	6,286,562	5,721,322
Depreciation and amortization	4,049,831	2,460,458
Utilities	2,710,881	2,248,669
Representation and entertainment	175,621	665,247
Unrealized foreign exchange losses	119,721	20,781
Retirement costs	-	3,705,231
Others	1,336,727	754,799
	89,963,910	96,484,929
EXCESS OF REVENUES OVER EXPENSES	40,189,312	1,051,115
FUND BALANCE AT BEGINNING OF YEAR	39,702,810	38,651,695
FUND BALANCE AT THE END OF YEAR	₱79,892,122	₱39,702,810

The complete audited financial statement report can be found in the CD

Zuellig Family Foundation

Management and Staff

Office of the Chairman

ROBERTO R. ROMULO
Chairman

MEL REYES
Executive Assistant

Office of the President

ERNESTO D. GARILAO
President

VINCE MAGTIBAY
Executive Assistant

RAMON R. DERIGE, MDM
Vice President

Institute

JUAN VILLAMOR
Director

JULES BENITEZ
Project Associate

RAMIR BLANCO, M.D.
Program Associate

HEIDEE EXCONDE, M.D.
Project Associate

BIEN NILLOS, M.D.
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CELNA TEJARE, M.D.
Project Associate

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Project Assistant

MIKKA YAP, R.M., R.N.
Project Assistant

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Project Assistant

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Technical Services

VITO DY
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CARA TIZON
Project Associate

MARICAR TOLOSA
Program Associate

SHEN BELMONTE
Project Assistant

PAM LOMAAD
Project Assistant

Support Group

LERMA TAN, CPA, CIA
Finance Manager

WESLEY VILLANUEVA
Program Manager

JOHN TIMMY MERJUDIO, CPA
Program Associate

GILMER CARIAGA
Program Assistant

BARBARA JAMILI
Project Assistant



The inside pages of this Annual Report were printed on the Forest Stewardship Council (FSC)-certified paper. In an effort to reduce the consumption of resources from printing and distributing hard copies, an electronic copy of this report and the complete 2012 audited financial statements are contained in the CD. The Report may also be downloaded from our website, www.zuelligfoundation.org.



Duly certified by the Philippine Council for NGO Certification (PCNC)

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Fax No. (632) 776-4727

www.zuelligfoundation.org

**The Zuellig Family Foundation, Inc.
2012 Audited Financial Statement**

INDEPENDENT AUDITORS' REPORT

The Board of Trustees
The Zuellig Family Foundation, Inc.
5F Zuellig Pharma Bldg.
Km. 14, West Service Road
South Super Highway, Sun Valley
Parañaque City

Report on the Financial Statements

We have audited the accompanying financial statements of The Zuellig Family Foundation, Inc. (a nonstock, nonprofit corporation), which comprise the statements of assets, liabilities and fund balance as at December 31, 2012 and 2011, and the statements of revenues, expenses and fund balance and statements of cash flows for the years then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Philippine Financial Reporting Standard for Small and Medium-sized Entities, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with Philippine Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of The Zuellig Family Foundation, Inc. as at December 31, 2012 and 2011, and its financial performance and its cash flows for the years then ended in accordance with Philippine Financial Reporting Standard for Small and Medium-sized Entities.

Report on the Supplementary Information Required Under Revenue Regulations 19-2011 and 15-2010

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information required under Revenue Regulations 19-2011 and 15-2010 in Note 11 to the financial statements is presented for purposes of filing with the Bureau of Internal Revenue and is not a required part of the basic financial statements. Such information is the responsibility of the management of The Zuellig Family Foundation, Inc. This information has been subjected to the auditing procedures applied in our audit of the basic financial statements. In our opinion, the information is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole.

SYCIP GORRES VELAYO & CO.

Roel E. Lucas
Partner
CPA Certificate No. 98200
SEC Accreditation No. 1079-A (Group A),
February 3, 2011, valid until February 2, 2014
Tax Identification No. 191-180-015
BIR Accreditation No. 08-001998-95-2011,
February 4, 2011, valid until February 3, 2014
PTR No. 3669694, January 2, 2013, Makati City

May 2, 2013

STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE

	December 31	
	2012	2011
ASSETS		
Current Assets		
Cash and cash equivalents (Note 4)	₱98,764,468	₱61,476,111
Receivables (Note 5)	304,093	254,836
Prepaid and other current assets	494,865	402,138
Total Current Assets	99,563,426	62,133,085
Noncurrent Asset		
Property and equipment (Note 6)	11,664,079	7,588,568
	₱111,227,505	₱69,721,653
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables (Note 7)	₱19,374,571	₱18,215,000
Deferred revenue (Note 8)	110,000	-
Due to a related party (Note 8)	279,709	232,740
Total Current Liabilities	19,764,280	18,447,740
Noncurrent Liability		
Retirement liability (Note 10)	11,571,103	11,571,103
Fund Balance	79,892,122	39,702,810
	₱111,227,505	₱69,721,653

See accompanying Notes to Financial Statements.

STATEMENTS OF REVENUES, EXPENSES AND FUND BALANCE

	Years Ended December 31	
	2012	2011
REVENUES		
Donations (Note 8)	₱127,961,309	₱96,060,335
Interest (Note 4)	2,189,299	1,475,422
Others	2,614	287
	130,153,222	97,536,044
EXPENSES (Note 9)		
Materials and supplies	16,271,818	21,254,927
Salaries, wages and other benefits	13,635,450	11,548,164
Trainings and seminars	13,120,296	9,152,771
Professional fees	12,258,975	10,634,198
Infrastructure projects	10,711,136	18,430,821
Donations and contributions	9,286,892	9,887,541
Transportation and travel	6,286,562	5,721,322
Depreciation and amortization (Note 6)	4,049,831	2,460,458
Utilities (Note 8)	2,710,881	2,248,669
Representation and entertainment	175,621	665,247
Unrealized foreign exchange losses	119,721	20,781
Retirement costs (Note 10)	–	3,705,231
Others	1,336,727	754,799
	89,963,910	96,484,929
EXCESS OF REVENUES OVER EXPENSES	40,189,312	1,051,115
FUND BALANCE AT BEGINNING OF YEAR	39,702,810	38,651,695
FUND BALANCE AT END OF YEAR	₱79,892,122	₱39,702,810

See accompanying Notes to Financial Statements.

STATEMENTS OF CASH FLOWS

	Years Ended December 31	
	2012	2011
CASH FLOWS FROM OPERATING ACTIVITIES		
Excess of revenues over expenses	₱40,189,312	₱1,051,115
Adjustments for:		
Depreciation and amortization (Note 6)	4,049,831	2,460,458
Interest income (Note 4)	(2,189,299)	(1,475,422)
Unrealized foreign exchange losses	119,721	20,781
Retirement costs (Note 10)	—	3,705,231
Operating revenues before working capital changes	42,169,565	5,762,163
Decrease (increase) in:		
Receivables	(52,887)	366,994
Prepaid and other current assets	(92,727)	(60,135)
Increase in:		
Accrued expenses and other payables	1,159,571	9,437,892
Deferred revenue	110,000	—
Due to a related party	46,969	10,244
Net cash generated from operations	43,340,491	15,517,158
Interest received	2,192,929	1,482,090
Net cash provided by operating activities	45,533,420	16,999,248
CASH FLOW FROM AN INVESTING ACTIVITY		
Additions to property and equipment (Note 6)	(8,125,342)	(5,377,210)
NET INCREASE IN CASH AND CASH EQUIVALENTS	37,408,078	11,622,038
EFFECT OF FOREIGN EXCHANGE RATE		
CHANGES ON CASH AND CASH EQUIVALENTS	(119,721)	(20,781)
CASH AND CASH EQUIVALENTS		
AT BEGINNING OF YEAR	61,476,111	49,874,854
CASH AND CASH EQUIVALENTS		
AT END OF YEAR (Note 4)	₱98,764,468	₱61,476,111

See accompanying Notes to Financial Statements.

NOTES TO FINANCIAL STATEMENTS

1. General Information

The Zuellig Family Foundation, Inc. (the Foundation) is a nonstock, nonprofit corporation registered with the Philippine Securities and Exchange Commission (SEC). Its registered office address is 5F Zuellig Pharma Bldg., Km. 14, West Service Road, South Super Highway, Sun Valley, Parañaque City. The primary purpose of the Foundation is to act as a modernizing force in shaping sound and effective policies in public health and nutrition in the Philippines. The Foundation has 17 regular employees in 2012 and 2011.

On April 12, 2005, the Philippine Council for Non-Government Organization Certification (PCNC) granted the Foundation a five-year certification for donee institution status in accordance with the provision of Revenue Regulations (RR) No. 13-98 dated January 1, 1999. Accordingly, donations received shall entitle the donor to deductions subject to the provisions of Section 3 of Republic Act No. 8424, “An Act Amending the National Internal Revenue Code, as amended, and For Other Purposes.” The accreditation shall be valid for a period of five years from the date of certification unless sooner revoked by the Bureau of Internal Revenue. The grant was renewed on November 15, 2010 and shall be valid until August 25, 2015.

The Foundation, being a nonstock, nonprofit corporation, is not subject to income tax under Section 30 (e) of the National Internal Revenue Code with respect to income received such as donations, gifts or charitable contributions. However, income from any of its properties, real or personal, or from any of its activities conducted for profit shall be subject to regular corporate income tax.

The financial statements were authorized for issuance by the Board of Trustees (BOT) on May 2, 2013.

2. Summary of Significant Accounting Policies

Basis of Preparation

The financial statements have been prepared using the historical cost basis. The financial statements are presented in Philippine peso and all values are rounded to the nearest peso, unless otherwise stated.

Statement of Compliance

The financial statements of the Foundation which were prepared for submission to the SEC and the Bureau of Internal Revenue, have been prepared in accordance with the Philippine Financial Reporting Standard for Small and Medium-sized Entities (PFRS for SMEs).

Cash and Cash Equivalents

Cash includes cash on hand and in banks. Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash with original maturities of three months or less and that are subject to an insignificant risk of change in value.

Receivables

Receivables, which are based on normal credit terms and do not bear interest, are recognized and carried at original invoice amounts. Where credit is extended beyond normal credit terms, receivables are measured at amortized cost using the effective interest method. At the end of each reporting period, the carrying amounts of receivables are reviewed to determine whether there is any objective evidence that the amounts are not recoverable. If so, an impairment loss is recognized immediately in profit or loss.

If there is any objective evidence that an impairment loss on receivables has been incurred, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate (i.e., the effective interest rate computed at initial recognition). The carrying amount of the asset shall be reduced either directly or through the use of an allowance account. The amount of the loss shall be recognized in statement of revenues, expenses and fund balance for the period.

Property and Equipment

Property and equipment is stated at cost less accumulated depreciation, amortization and any accumulated impairment loss. The initial cost of property and equipment comprises its purchase price, and other directly attributable costs of bringing the asset to its working condition and location for its intended use. Such cost includes the cost of replacing part of such property and equipment when that cost is incurred if the recognition criteria are met. It excludes the costs of day-to-day servicing.

Depreciation and amortization are computed using the straight-line method over the following estimated useful lives of the assets:

Transportation equipment	5 years
Office equipment	3-5 years
Furniture and fixtures	3-5 years
Office improvements	3 years

If there is any indication that there has been a significant change in depreciation rate, useful life or residual value of an asset, the depreciation of that asset is revised prospectively to reflect the new expectations.

An item of property and equipment is derecognized upon disposal or when no future economic benefits are expected from its use or disposal. Any gain or loss arising on derecognition of the asset (calculated as the difference between the net disposal proceeds and the carrying amount of the asset) is included in the statement of revenues, expenses and fund balance in the year the asset is derecognized.

Impairment of Property and Equipment

At each reporting date, property and equipment is reviewed to determine whether there is any indication that those assets have suffered an impairment loss. If there is an indication of possible impairment, the recoverable amount of any affected asset (or group of related assets) is estimated and compared with its carrying amount. If estimated recoverable amount is lower, the carrying amount is reduced to its estimated recoverable amount, and an impairment loss is recognized immediately in the statement of revenues, expenses and fund balance for the period.

If an impairment loss subsequently reverses, the carrying amount of the asset (or group of related assets) is increased to the revised estimate of its recoverable amount, but not in excess of the amount that would have been determined had no impairment loss been recognized for the asset (or group of related assets) in prior years. A reversal of an impairment loss is recognized immediately in the statement of revenues, expenses and fund balance for the period.

Accrued Expenses and Other Payables

Accrued expenses and other payables are recognized in the period in which the related money, goods or services are received or when legally enforceable claim against the Foundation is established or when the corresponding assets or expenses are recognized.

Revenue

Revenue is recognized to the extent that it is probable that the economic benefit associated with the transaction will flow to the Foundation and the amount of the revenue can be measured reliably. Revenue is measured at fair value of the consideration received.

The following specific recognition criteria must also be met before revenue is recognized:

Donation. The Foundation recognizes donations, including unconditional promises to give, as revenue in the period received.

Interest Income. Revenue is recognized as the interest accrues, taking into account the effective yield on the asset.

Other Income. Revenue is recognized when earned.

Expenses

Expenses are decreases in economic benefits during the accounting period in the form of outflows or decrease of assets or incurrence of liabilities that result in decreases in fund balance. Expenses are recognized in the statement of revenues, expenses and fund balance in the year these are incurred.

Retirement Costs

The Foundation follows the minimum requirements set forth by Republic Act (RA) No. 7641, "An Act amending Article 287 of Presidential Decree no. 442, as amended, otherwise known as the Labor Code of the Philippines", covering all regular employees based on current monthly basic salaries. The retirement cost is determined using the projected unit credit method. Projected unit credit method reflects services rendered by employees to the date of the valuation and incorporates assumptions concerning employees' projected salaries. The present value of an entity's obligations reflects the discounted estimated amount of benefit that employees have earned in return for their service in the current and prior periods. This requires the entity to determine how much benefit is attributable to the current and prior periods based on the plan's benefit formula and to make actuarial assumptions about demographic and financial variables.

Provisions

Provisions are recognized when the Foundation has a present obligation (legal or constructive) as a result of a past event, it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Contingencies

Contingent liabilities are not recognized in the financial statements. These are disclosed unless the possibility of an outflow of resources embodying economic benefits is remote. Contingent assets are not recognized in the financial statements but are disclosed in the notes to financial statements when an inflow of economic benefits is probable.

Events after the Financial Reporting Date

Post year-end events that provide additional information about the Foundation's financial position as of the reporting date (adjusting events) are reflected in the financial statements. Post year-end events that are not adjusting events are disclosed in the notes to the financial statements when material.

3. Significant Accounting Judgments and Estimates

Judgment

Management makes judgments in the process of applying the Foundation's accounting policies. Judgment that has the most significant effect on the reported amounts in the financial statements is discussed below.

Classification of Expenses. The Foundation classifies and allocates its expenses between project and general and administrative expenses according to their nature. Project expenses are expenses which are directly incurred for the completion of the Foundation's activities relating to community health partnership programs, training and capability programs and other projects. General and administrative expenses are expenses which are not directly related to project expenses.

Project expenses in 2012 and 2011 amounted to ₱72.4 million and ₱78.0 million, respectively, while general and administrative expenses in 2012 and 2011 amounted to ₱17.5 million and ₱18.5 million, respectively (see Note 9).

Estimates

The key sources of estimation uncertainty at the reporting date that have a significant risk of causing material adjustment to the carrying amounts of assets within the next financial year is discussed below.

Estimating Useful Lives of Property and Equipment. The useful life of each item of the Foundation's property and equipment is estimated based on the period over which the asset is expected to be available for use. The estimation of the useful lives of property and equipment is also based on collective assessment of industry practice, internal technical evaluation and experience with similar assets. The estimated useful life of each asset is reviewed if there is any indication that expectations differ from previous estimates due to physical wear and tear, technical or commercial obsolescence and legal or other limitations on the use of the asset. It is possible, however, that future results of operations could be materially affected by changes in these factors and circumstances. A reduction in the estimated useful life of any property and equipment would increase the recorded expenses and decrease noncurrent assets.

In 2012, the Foundation's management reassessed the useful lives used in depreciating and amortizing the Foundation's property and equipment. Based on the Foundation's reassessment, a change in useful lives is necessary based on the collective assessment of experience with similar assets. Changes in the useful lives are as follows:

	2012	2011
Transportation equipment	5 years	4 years
Office equipment	3-5 years	3 years
Furniture and fixtures	3-5 years	3 years

These changes resulted to a decrease of ₱555,023 in the Foundation's annual depreciation expense in 2012.

There were no changes in estimated useful lives of property and equipment for the year ended 2011.

The carrying value of property and equipment amounted to ₱11.7 million and ₱7.6 million as of December 31, 2012 and 2011, respectively (see Note 6).

Impairment of Property and Equipment. The Foundation assesses impairment on its property and equipment whenever events or changes in circumstances indicate that carrying amount of an asset may not be recoverable. The factors that the Foundation considers important which could trigger an impairment review include significant underperformance relative to expected historical or projected future operating results and significant changes in the manner of use of the acquired assets.

No impairment losses were recognized for the years ended December 31, 2012 and 2011. The carrying value of property and equipment amounted to ₱11.7 million and ₱7.6 million as of December 31, 2012 and 2011, respectively (see Note 6).

Valuation of Retirement Liability. The determination of the liability (asset) and cost (income) of retirement benefits is dependent on the selection of certain assumptions used by the Foundation's management. Those assumptions used in the calculation of retirement cost are described in Note 10 to the financial statements

The Foundation follows the minimum requirements set forth by RA No. 7641 covering all regular employees. The Foundation's cost and obligation to make payments to employees are recognized during the employees' period of service. The cost and obligation are measured using the projected unit credit method, assuming 10 percent average salary increase using the current market yield for government securities. While it is believed that the Foundation's assumptions are reasonable and appropriate, significant differences in actual experience or significant changes in assumptions may materially affect the Foundation's retirement liability.

The Foundation's retirement liability amounted to ₱11.6 million as of December 31, 2012 and 2011, respectively (see Note 10).

4. Cash and Cash Equivalents

This account consists of:

	2012	2011
Cash on hand and in banks	₱13,379,143	₱10,054,146
Short-term placements	85,385,325	51,421,965
	₱98,764,468	₱61,476,111

Cash in banks earn interest at the respective bank deposit rates. Short-term placements are made for varying periods of up to three months depending on the immediate cash requirements of the Foundation, and earn interest at the prevailing short-term placement rates.

Interest income earned from cash in banks and short-term placements amounted to ₱2.2 million and ₱1.5 million in 2012 and 2011, respectively.

5. Receivables

As of December 31, 2012, this account consists of receivable from Campaigns and Grey amounting to ₱0.2 million for the Foundation's excess payment of video production costs and receivable from employees amounting to ₱0.1 million. These receivables were subsequently collected in 2013.

In May 2011, the Foundation and Pfizer Parke Davis, Inc. (PPD), a non-stock, non-profit organization, entered into a Memorandum of Agreement where PPD agreed to donate ₱1.2 million to be specifically used for the construction of a birthing center in the municipality of Minalabac, Camarines Sur. The donation was fully received in 2011. However, the cost of constructing the birthing center exceeded the donation by ₱0.2 million which was subsequently reimbursed by PPD in February 2012. This is shown as part of "Receivables" in the 2011 statement of assets, liabilities and fund balance.

6. Property and Equipment

This account consists of:

	2012				
	Transportation Equipment	Office Equipment	Furniture and Fixtures	Office Improvements	Total
Cost					
Balance at beginning of year	₱3,867,530	₱6,100,463	₱2,130,778	₱1,594,546	₱13,693,317
Additions	900,000	4,521,634	509,790	2,193,918	8,125,342
Balance at end of year	4,767,530	10,622,097	2,640,568	3,788,464	21,818,659
Accumulated Depreciation and Amortization					
Balance at beginning of year	2,274,438	2,234,351	1,584,713	11,247	6,104,749
Depreciation and amortization (see Note 9)	713,070	1,991,365	384,911	960,485	4,049,831
Balance at end of year	2,987,508	4,225,716	1,969,624	971,732	10,154,580
Net Book Value	₱1,780,022	₱6,396,381	₱670,944	₱2,816,732	₱11,664,079
	2011				
	Transportation Equipment	Office Equipment	Furniture and Fixtures	Office Improvements	Total
Cost					
Balance at beginning of year	₱3,867,530	₱2,690,787	₱1,757,790	₱-	₱8,316,107
Additions	-	3,409,676	372,988	1,594,546	5,377,210
Balance at end of year	3,867,530	6,100,463	2,130,778	1,594,546	13,693,317
Accumulated Depreciation and Amortization					
Balance at beginning of year	1,307,555	1,377,245	959,491	-	3,644,291
Depreciation and amortization (see Note 9)	966,883	857,106	625,222	11,247	2,460,458
Balance at end of year	2,274,438	2,234,351	1,584,713	11,247	6,104,749
Net Book Value	₱1,593,092	₱3,866,112	₱546,065	₱1,583,299	₱7,588,568

7. Accrued Expenses and Other Payables

This account consists of:

	2012	2011
Accrued expenses	₱16,036,208	₱17,724,480
Withholding taxes and other payables	3,338,363	490,520
	₱19,374,571	₱18,215,000

Accrued expenses pertain to payable to contractors, unpaid utilities, materials and supplies and professional fees. Withholding taxes and other payables in 2012 include payable to United Nations Population Fund (UNFPA) amounting to ₱2.0 million which represents the excess of UNFPA's donation over the cost of the project.

Accrued expenses and other payables are due for settlement within the following year.

8. Related Party Transactions

Parties are considered to be related if one party has the ability to control the other party or exercise significant influence over the other party in making financial and operating decisions. This includes entities that are under common control with the Foundation, its donors, the BOT and their close family members.

In the ordinary course of operations, the Foundation is engaged in the following transactions with entities that are considered related parties.

Related Party	Nature of transaction	Year	Amount	Outstanding balance	Terms	Conditions
Zuellig Group, Inc.	Donations (a)	2012 2011	₱119.9 million 90.4 million	₱- -	None	Unrestricted
Zuellig Pharma Corporation (ZPC)	Share in utilities (c)	2012 2011	0.7 million 1.0 million	0.3 million 0.2 million	90 days upon receipt of billings; non-interest bearing	Unsecured
	Donations	2012 2011	0.5 million -	- -	None	Restricted (see Note 9)
Roberto R. Romulo	Donations (b)	2012 2011	0.1 million 0.1 million	0.1 million -	None	See note b

- These donations were not restricted for use to specific projects of the Foundation. These were recorded as part of "Donations" account in the statements of revenues, expenses and fund balance.
- The donation received from Roberto R. Romulo (member of the BOT) in 2012 pertains to donation earmarked for 2013 activities. The amount, which will be utilized in 2013, is shown as part of "Deferred revenue" account in the 2012 statement of assets, liabilities and fund balance. The donation received in 2011 is unrestricted and is recorded as part of "Donations" account in the 2011 statements of revenues, expenses and fund balance.
- The Foundation occupies an office space in ZPC's head office building, free of any rental charges. ZPC bills the Foundation for its share in utilities. ZPC's charges to the Foundation

were recorded as part of “Utilities” account in the statements of revenues, expenses and fund balance. Unpaid utilities as of December 31, 2012 and 2011 were recorded under “Due to a related party” account in the statements of assets, liabilities and fund balance.

9. Expenses

The Foundation’s expenses consist of the following for the year ended December 31:

	2012		
	Project Expenses	General and Administrative Expenses	Total
Materials and supplies	₱15,384,033	₱887,785	₱16,271,818
Salaries, wages and other benefits	8,109,737	5,525,713	13,635,450
Trainings and seminars	12,852,372	267,924	13,120,296
Professional fees	9,281,329	2,977,646	12,258,975
Infrastructure projects	10,711,136	–	10,711,136
Donations and contributions	9,286,892	–	9,286,892
Transportation and travel	6,139,723	146,839	6,286,562
Depreciation and amortization (see Note 6)	–	4,049,831	4,049,831
Utilities (see Note 8)	–	2,710,881	2,710,881
Representation and entertainment	–	175,621	175,621
Unrealized foreign exchange losses	–	119,721	119,721
Others	665,422	671,305	1,336,727
	₱72,430,644	₱17,533,266	₱89,963,910

	2011		
	Project Expenses	General and Administrative Expenses	Total
Materials and supplies	₱20,509,048	₱745,879	₱21,254,927
Infrastructure projects	18,430,821	–	18,430,821
Salaries, wages and other benefits	6,299,941	5,248,223	11,548,164
Professional fees	6,452,126	4,182,072	10,634,198
Trainings and seminars	8,613,331	539,440	9,152,771
Donations and contributions	9,887,541	–	9,887,541
Transportation and travel	4,878,633	842,689	5,721,322
Retirement costs (see Note 10)	2,762,569	942,662	3,705,231
Depreciation and amortization (see Note 6)	–	2,460,458	2,460,458
Utilities (see Note 8)	–	2,248,669	2,248,669
Representation and entertainment	–	665,247	665,247
Unrealized foreign exchange losses	–	20,781	20,781
Others	180,007	574,792	754,799
	₱78,014,017	₱18,470,912	₱96,484,929

Project expenses were incurred due to the following activities:

a. Community Health Partnership Program

Municipal Health Systems Strengthening and Other Health Programs. To increase community awareness and participation on health programs and planning, the Foundation encouraged local leaders to form Core Groups and to hold Community Health Summits and “Buntis” Congresses.

Infrastructure grants. The Foundation provided infrastructure and small equipment grants to chosen municipalities so that more people can avail of health services.

Barangay Health Systems Strengthening Program. The program involved Barangay Captains and Councilors on Health learning about bridging leadership and creating their own barangay plans on health.

Behavior Change Communication. To establish a baseline of key health indicators and know where to start towards improving people’s health-seeking behaviors, the Foundation conducted focus group discussions and in-depth interviews which aim to know the locals’ current behaviors and practices on health in relation to pregnancy and delivery, tuberculosis and child health.

Health Information System (HIS). To improve the data gathering and consolidation capabilities of partner municipalities, the Foundation developed a platform for HIS that allows the generation of a more timely, complete and accurate health statistics.

National Forums. The Foundation aimed to bring together government and private-sector stakeholders to form partnerships in addressing inequities in the health system of the country. The Health Outlook Forum served as a venue for stakeholders across the country to have an understanding of health problems and share emerging best practices in response to these challenges.

b. Training and Capability Programs

Health Leaders for the Poor (HLP). The two-year, four-module program aims to improve the leading and managing practices of local health leaders to address the inequities in the health system. It incorporates classroom sessions and fieldwork for key municipal stakeholders working as convergence teams anchored on Bridging Leadership and multi-stakeholder engagement.

Municipal leadership and governance program (MLGP). A one-year, two-module capability building program for local chief executives and municipal health officers to facilitate transition from old arrangements, both at the level of the personal and the community, in relation to leadership in the health sector, as well as in helping achieve better health outcomes for the community, especially the poor, through effective leadership and management of local health systems.

Provincial Leadership and governance program (PLGP). A workshop for governors and provincial health officers (PHO) that aims to introduce health systems framework as a guide for analyzing the capacity of the province-wide health system to attain millennium development goals on health and bridging leadership framework as a practical model for improving health leadership and governance in the province. The learning will be applied in

the analysis of their own provincial health situation, particularly with regards to maternal and child health, and in coming up with key strategic interventions for the province. It is a 3-year program with 1 module per year and a practicum period of 12 months after each module. There is a coaching program for governors and PHOs after each module.

Continuing Professional Education (CPE). The CPE program is one of the core programs of the Foundation aimed at improving the delivery of healthcare services at the community level. The Foundation introduced this program to upgrade the health skills and knowledge of public health workers and professionals, especially those in local health systems.

Health Leadership and Management for the Poor (HLMP). A training program designed to improve the leadership and management capability of health professionals of Provincial Health Offices, Centers for Health Development and other health agencies and organizations at the regional, provincial and district levels. It is expected that the improved leadership and management capabilities of key health professionals will lead to a more effective collaboration with other stakeholders, the implementation of innovative projects and programs, and improved support to local health systems.

Strengthening Provincial and Municipal Champions in Health Program with United Nations Population Fund. The program covers leadership and training programs for the governors and mayors, provincial and municipal health officers and senior and mid-level professionals. This translates to empowered local chief executives and local health leaders who are able to improve institutional arrangements and craft responsive policies and programs particularly for the poor.

c. Other Projects

Access to Affordable Medicines-Zuellig Family Foundation Center for Agricultural and Rural Development-Mutually Reinforcing Institutions (CARD-MRI) Project. A partnership program was entered by the Foundation and CARD-MRI to give CARD members access to quality and low cost medicines.

Busog-Lusog-Talino Program with Jollibee Foundation, a partnership for nutrition. A total of 4,001 pupils in public elementary schools in 20 municipalities are being served daily lunch while their parents are being educated on cooking, budgeting, health and nutrition. The program started in July 2011.

Washington Sycip - Zuellig Family Foundation Initiative in Synergeia. An initial grant was given to Synergeia Foundation to start integrating health in its education programs in 20 partner-municipalities in response to the call of Mr. Washington Sycip to combine health, education and micro-finance in programs geared towards uplifting the lives of the Filipinos.

SLAM Water Sanitation and Hygiene Project. The project, done with financial assistance from the Embassy of Canada, involved the installation of appropriate low-cost communal water systems to help chosen Maguindanao municipalities to have access to potable water and sanitary toilets. There are now 14 water systems in four barangays of the four SLAM Maguindanao municipalities.

Action Research and Policy Studies. The Foundation conducted action research on policy environments to determine and address factors that would contribute to the success and sustainability of the health programs of the Foundation.

Community Disaster Relief Program. The Foundation distributed consumable and non-consumable kits to 6,092 families. These were the victims of flooding brought by typhoons Gener, which intensified the southwest monsoon, and Pablo, which was deemed the worst to hit the country. The Foundation also received cash from ZPC for victims of Typhoon Pablo.

One-half was earmarked by the Foundation to Ateneo de Davao University for the construction of temporary shelters in New Bataan. The other half was given to the Department of Health for the medicines and supplies of hardest hit towns in Compostela Valley and Davao Oriental.

10. Retirement Costs

The Foundation has an unfunded, noncontributory defined benefit retirement plan covering all permanent employees. The benefits are based on employees' projected salaries and length of service.

The Foundation provided for the estimated retirement cost (based on current monthly basic salaries) required under RA No. 7641.

The Foundation's retirement liability as of December 31, 2012 and 2011 based on the minimum requirements of RA No. 7641 is as follows:

	2012	2011
Liability at beginning of year	₱11,571,103	₱7,865,872
Retirement costs (see Note 9)	–	3,705,231
Liability at end of year	₱11,571,103	₱11,571,103

The Foundation did not provide for an additional retirement liability in 2012 since the management assessed that the current amount of retirement liability is already sufficient.

The Foundation is currently in the process of establishing a retirement plan asset and has allocated part of its short-term benefits to fund its retirement plan.

11. Supplementary Information Required Under Revenue Regulations 19-2011 and 15-2010

On December 28, 2010, Revenue Regulations (RR) No. 15-2010 became effective and amended certain provisions of RR No. 21-2002 prescribing the manner of compliance with any documentary and/or procedural requirements in connection with the preparation and submission of financial statements and income tax returns. Section 2 of RR No. 21-2002 was further amended to include in the notes to financial statements information on taxes, duties and license fees paid or accrued during the year in addition to what is mandated by PFRS.

Moreover, on December 9, 2011, RR No. 19-2011 became effective where it prescribes the new income tax forms to be used effective December 31, 2011. The Foundation is now required to include as part of the notes to the financial statements the schedules and information on taxable income and deductions.

Below is the additional information required by RR No. 15-2010:

a. Taxes and Licenses

Taxes and licenses, local and national, include licenses and permit fees under “Others” in the statements of revenues, expenses and fund balance.

	Official Receipt No.	Date of payment	
Business permit	9538541	January 16, 2012	₱19,369
	00626962 and	January 11	
Community tax certificate	00165044	and 12, 2012	2,005
Others	various	various	1,195
			₱22,569

b. Withholding Taxes

Expanded withholding taxes	₱2,157,632
Withholding taxes on compensation and benefits	1,890,820
	₱4,048,452

Below is the additional information required by RR No. 19-2011:

- a. Donations and other revenues amounting to ₱127,963,923 are exempt from income tax under Section 30 (E) of the Republic Act No. 8424.
- b. Interest income amounting to ₱2,189,299 for the year ended December 31, 2012 is subject to final withholding tax.
- c. Itemized deductions for the year ended December 31, 2012 consist of:

Materials and supplies	₱16,271,818
Trainings and seminars	13,120,296
Salaries, wages and other benefits	13,046,048
Professional fees	12,258,975
Infrastructure projects	10,711,136
Charitable contributions	9,286,892
Transportation and travel	6,286,562
Depreciation	4,049,831
Communication, light and water	1,377,274
Other services	1,114,213
Insurance	790,722
SSS, GSIS, Philhealth, HDMF and other contributions	589,402
Repairs and maintenance	219,394
Representation and entertainment	175,621
Rental	48,526
Taxes and licenses	22,569
Losses	20,781
Others	474,910
	₱89,864,970