ZUELLIG FAMILY FOUNDATION

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ANNUAL REPORT 2013

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Hope endures

Like thousands of poor mothers in Eastern Samar, Tricia Joy Gacho has reason to remain hopeful despite the massive loss of lives and property in her province following the onslaught of super typhoon Yolanda last November. The 28-year-old mother is among the beneficiaries of the "Recovery Assistance Program for Mothers" (RAP) that Zuellig Family Foundation launched with funding from the Washington-based US-Philippines Society and with help from CARD Inc. and Center for Community Transformation. RAP provides incentives for mothers and health workers to get natal checks and to provide quality care, respectively.

PROGRESS HIGHLIGHTS

₱339.4m
ZFF Expenditure since 2009

231
Partner-Municipalities

1,790
Health Leaders Trained

4.5m
Persons Benefitting from ZFF Programs

3,537
Frontline Health Workers Trained

82*
Health Facilities Funded

1.3m
Residents Benefitting from ZFF-sponsored Health Facilities

* 63 Operational, 19 Ongoing construction

"We will not progress as a healthy nation unless we progress in the health of our most disadvantaged segments."

Dr. Alberto Romualdez Jr.
1940 - 2013

Kasigod V. Jamias, Treasurer • Esperanza I. Cabral, MD • Ernesto D. Garilao, President • Daniel Zuellig • Roberto R. Romulo, Chairman • David Zuellig • Washington Z. SyCip • Reiner W. Gloor • Francisco R. Billano • Alberto G. Romualdez, MD†

REACHING AN INFLECTION POINT

Organizations do not survive and remain relevant by keeping the status quo.

Reform is the battle cry of dynamic and responsive organizations with a vision for progress founded on sustainable development.

The Zuellig Family Foundation (ZFF) is one organization seeking to improve the lives of the poor and the marginalized Filipinos by working on local health system reforms. The Foundation initiated its Health Change Model that targeted health leadership and governance—a vital yet often overlooked component of the health system.

Most health interventions have focused on technical skills to improve service delivery, access to medicines, information systems and health financing. Little has been done, however, to improve the leadership which could drive all the necessary components to bring improvements in the rest of the health system building blocks.

The Health Change Model is seen by ZFF as a way to reform local health systems, reduce health inequities and achieve better health outcomes for the poor.

DEVELOPING A STRATEGY

Capitalizing on the Zuellig family's experience and expertise in the health sector, ZFF crafted a strategy targeting health system improvements that can be realized following the transformation of local health leaders. It focused on municipal mayors who oversee primary healthcare systems, the most accessible to the poor.

The strategy dealt with identifying and addressing gaps in the health system that lead to significant discrepancies in the health outcomes of the rich and the poor. ZFF knows a systems change requires a long-term commitment and it is prepared to provide this.

SYSTEMS APPROACH—A MORE EFFICIENT WAY TO IMPROVE HEALTH INDICATORS

The strategy was piloted in 2009 and then modeled, scaled up and mainstreamed.

The modeling took place in five sets of 43 municipalities with high maternal and child health burdens, but with leaders committed to health reforms. These sets represented distinct characteristics that put ZFF's theory of change to test. As a result, ZFF came up with different models—for poor municipalities, for non-devolved health setup in the Autonomous Region in Muslim Mindanao and for geographically isolated and disadvantaged areas—yet kept the Health Change Model as the overarching change strategy.

Under a two-year formal partnership with these local governments, the mayors,

municipal health officers and community leaders underwent a series of training modules with practicum in between. Specific deliverables under the World Health Organization's six building blocks of the health system had to be fulfilled.

Based on their reported health statistics, which ZFF closely monitors, it was apparent that with a systematic approach, maternal mortality ratio (MMR) and other health indicators can improve in as short as two years' time.

The relatively rapid improvement in the 43 municipalities' health indicators, including MMR, a sentinel indicator that has proven difficult to reduce nationally, got other organizations involved in health interested in partnering with ZFF and adopting its change strategy.

SCALE-UP OPPORTUNITY

Forging partnerships has been ZFF's goal to reach more municipalities. Organizations that partnered with ZFF found merit in its leadership approach because it supplemented their own programs.

For ZFF, partnering with these organizations is an opportunity to see the extent of its Health Change Model's effectiveness as it gets applied in more municipalities.

After United Nations Population Fund (UNFPA) and Merck Sharp & Dohme (MSD), the Foundation secured partnerships with the United States Agency for International Development (USAID) and the United Nations Children's Fund (UNICEF). These partnerships will enable ZFF to reach over 200 more municipalities by the end of 2015.

MAINSTREAMING WITHIN THE BUREAUCRACY

In 2013, the Department of Health (DOH) sealed a partnership with the ZFF. The DOH saw the value of the local health leadership and governance transformative program, a relatively novel approach in improving the country's local health system. Moreover, the program's use of health indicators provided an objective basis to determine successes and failures. Among its notable success is the significant drop in the MMR of municipalities.

This unprecedented partnership involves the mainstreaming of ZFF's Health Change Model between 2013 and 2015 in 609 identified priority local government units (LGUs). Total actual number will probably be lower than the expected 609, because reaching all these LGUs will largely depend on the capacities of the academic partners (APs) to train and of the DOH personnel to coach.

The partnership will draw the active participation of APs and DOH regional executives in program implementation.

Mainstreaming will have the DOH bureaucracy working on the change strategy aimed at improving local health systems to achieve better health outcomes for the poor.

A NOTABLE YEAR

2013 was also the year the world witnessed the vast destruction caused by the strongest typhoon ever experienced in history. Thousands of lives were lost while thousands more need help to rebuild their lives. Previously, ZFF's Community Disaster Response Program was an undertaking that took a few days of relief distribution. The tragedy wrought by typhoon Haiyan (local name: Yolanda), however, led ZFF not only to a series of relief distribution drives but also to conduct an emergency medical mission and then start a recovery program with the help of Washington DC-based US Philippines Society.

This six-month recovery assistance program, a first for ZFF, is to ensure that quality health systems remain in 12 affected Eastern Samar and Samar municipalities, especially since these municipalities had good health indicators prior to Haiyan.

Under the program, almost 3,000 pregnant and lactating women will be given incentives to undergo proper natal checks and deliver in health facilities. Frontline health workers will be given kits useful in the performance of their duties. Mayors and municipal health officers, on the other hand, will be required to participate in ZFF's leadership program to make sure health will improve beyond the six-month program.

A LOSS TO THE FOUNDATION

The Foundation also lost one of its trustees in 2013. Former Health Secretary Alberto Romualdez Jr., M.D. was a champion of health reforms, tireless in his crusade to eliminate health inequities between the rich and the poor. It was this advocacy and his wisdom that inspired and guided the Foundation in formulating its strategy. Like him, ZFF will make sure its Health Change Model will result in health parity.

REACHING AN INFLECTION POINT

Indeed in 2013, ZFF reached an inflection point. From a disaster sprung a new program. From death has come an opportunity to learn more as the Foundation will provide funds for research on health leadership and system development through the "Dr. Alberto Romualdez Research Grants on Public Health Program."

And then, there is the partnership with the DOH, which has necessitated organizational changes and shifts in the processes of the parties involved. With more LGUs, ZFF must make sure its interventions remain relevant, effective and efficient. With the deadline to meet the Millennium Development Goals looming, the program must contribute to a significant drop in maternal deaths that will enable the Philippines to meet its MMR target of 52 in 2015.

That the shift seems to have come so soon to ZFF is a challenge it accepts. The Foundation had targeted to create a national impact through its strategy. The DOH-ZFF partnership is a huge step toward this target.

It will not be easy. But that is the reality. Long-standing organizations do not survive and remain relevant by holding on to the status quo. They learn. They adapt. They innovate. ZFF has been doing these because it knows these are necessary if genuine reform with sustainable and far-reaching impact must be attained.

CULTIVATING LEADERSHIP TRANSFORMATION STRATEGY FOR BETTER HEALTH OUTCOMES

Equitable health system starts with transformation of health leaders.

Zuellig Family Foundation's strategy to change health systems goes beyond providing infrastructure and technical support. The strategy, the Health Change Model (HCM), hinges on the principle that health leadership transformation is the first step towards better health outcomes for the poor.

On the basis of this principle, ZFF focuses on the training of municipal health leaders on the "Bridging Leadership" (BL) concepts of ownership, co-ownership and co-creation. The BL training program guides leaders to an understanding, appreciation, and acceptance of their responsibility for their constituents' health. Their response will inspire other stakeholders to act and move towards their preferred health reality. Their leadership will usher improvements in the health systems.

BRIDGING HEALTH LEADER

The training program equips leaders with increased capacities to understand and run their local health systems. As a bridging leader, one develops deeper self-awareness to be more prepared to face the tough health issues in one's community. One further develops the ability to work cooperatively, manage conflicts and bring stakeholders together. A bridging leader consequently becomes more creative in coming up with innovative solutions and adapting to changing situations.

The demands of bridging leadership require dedication and responsibility. This is why ZFF only chooses local government units (LGUs) with leaders committed to bringing better health outcomes for the poor. This is why ZFF has dropped LGUs that do not adhere to agreements.

SETTING THE BAR HIGH

Provided with a roadmap patterned after the six building blocks of the World Health Organization (WHO), the health leaders are given an opportunity to perform acts of leadership, particularly in the areas of financing, service delivery, workforce, information system and medicines and technology. It was in 2011 when ZFF introduced the roadmap containing these building blocks. For every building block, ZFF defined a specific set of targets that each municipality had to meet.

Aware of the challenges that local governments would face in accomplishing the roadmap, ZFF provided coaches to assist the leaders beginning 2012.

AN ACTIVE PARTNER IN THE JOURNEY TOWARD BETTER HEALTH

ZFF fielded account officers as frontline technical and leadership coaches to the health team leaders. They provided support and other relevant inputs outside of the classroom-based training days; linked health teams to experts who could give more appropriate inputs; and helped leaders manage the dynamic relationships of stakeholders within their areas of accountability.

ZFF's account officers constantly communicated with the health leaders. Health indicators, particularly the maternal mortality ratio (MMR: number of maternal deaths per live births multiplied by 100,000) and infant mortality rate (IMR: number of infant deaths per live births multiplied by 1,000), were gathered monthly. When there were reported death cases, ZFF would urge LGUs to investigate. As a result, LGUs became more active in conducting death reviews.

Having a coach, like the account officer, helped ensure the consistency in the performance of the health leaders. For many LGUs, the account officer was a partner in the journey towards better health.

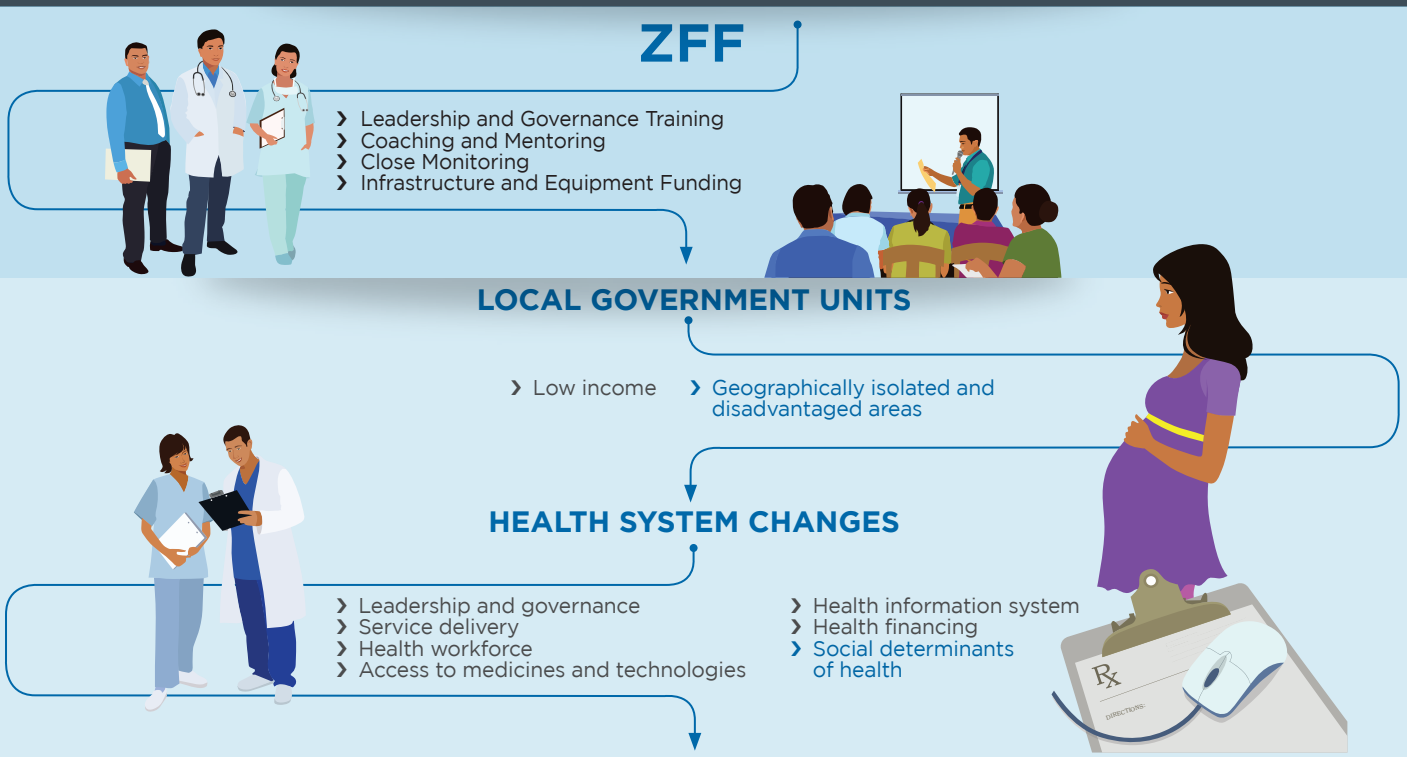
LESSONS FROM THE PIONEERS

In the first nine municipalities (Cohort 1) where the HCM was piloted, ZFF coupled training with infrastructure and equipment grants to ensure that the respective LGUs were equipped with the facilities to provide the services that residents need without having to travel far. *(See "The Case of Cohort 1" on page 6).*

ZFF HEALTH CHANGE MODEL:

Strengthening Leadership and Governance

Piloted in 2009, ZFF's Health Change Model has undergone modifications to strengthen its effectiveness and relevance in more areas with low incomes, remote communities, indigenous populations and even non-devolved health setup.



What happened in Cohort 1 was that maternal deaths decreased over time as the number of births occurring in a birthing facility or attended by skilled health professionals increased. From this, one can conclude the importance of well-equipped health facilities and competent health workers available and accessible to reduce maternal deaths.

To sustain the availability and accessibility of quality healthcare services, having ordinances and policies promoting the use of such services is helpful. One critical policy is the establishment of a pregnant client tracking system. This system of identifying high risk pregnant women has been proven beneficial to the Rural Health Units (RHUs) as it ensures the identification of pregnant women who may be too young, too old or too sick. This way, health workers can better manage the patients by anticipating possible complications during delivery, and therefore, preventing deaths.

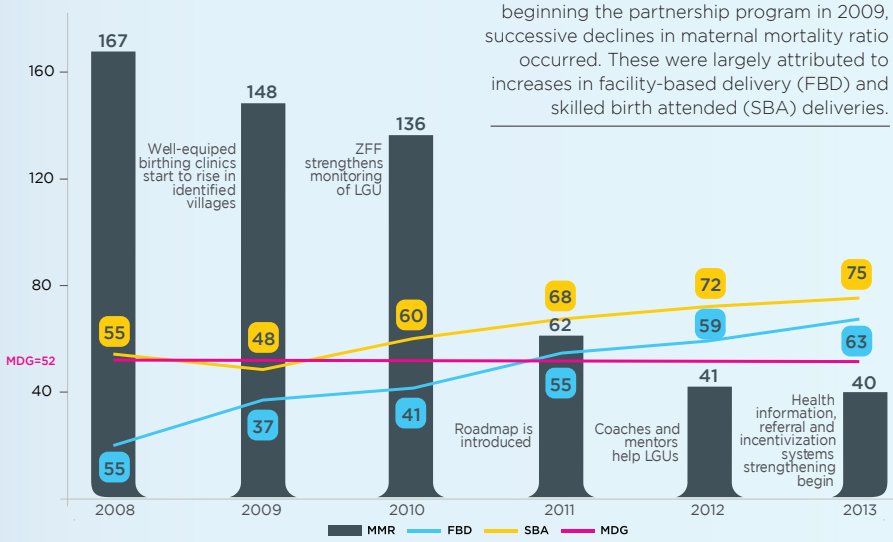
SUSTAINABILITY OF OUTCOMES DESPITE POLITICAL CHANGES

One challenge ZFF soon faced with its program was mayoralty changes. Fortunately, the positive health outcomes were more than enough to encourage successors to continue the partnership with ZFF. The Foundation reached out to new mayors to attend the same training program.

Between the 2010 and 2013 elections, ZFF has had to deal with nine leadership changes in its Cohorts 1 and 2. Yet, the LGUs' health indicators showed the continued decline of maternal and infant mortalities.

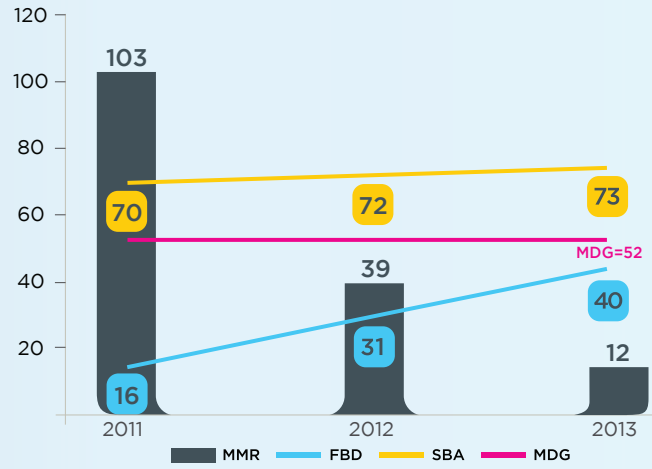
THE CASE OF COHORT 1

Nine municipalities comprise Cohort 1. Since beginning the partnership program in 2009, successive declines in maternal mortality ratio occurred. These were largely attributed to increases in facility-based delivery (FBD) and skilled birth attended (SBA) deliveries.



Cohort 1	2010	2011	2012	2013
MMR	136	62	41	40
IMR	9	4	3	4
FBD	41	55	59	63
SBA	60	68	72	75
MALNUTRITION RATE	10	8	9	8
Cohort 2	**2010**	**2011**	**2012**	**2013**
MMR	139	44	44	49
IMR	7	6	7	4
FBD	46	63	75	84
SBA	59	69	80	85
MALNUTRITION RATE	13	13	12	11

COHORT 3



With the lessons learned from Cohorts 1 and 2, ZFF engaged three more cohorts that had, in addition to the shared common denominator of low income, high maternal health burdens and leadership commitment to health, unique characteristics that required distinct interventions. The inclusion of specific municipalities in ZFF's social laboratory gave the Foundation the opportunity to address unique issues compounding health challenges.

A UNIQUE HEALTH SYSTEM SETUP FROM THE REST

ZFF's experience with four Autonomous Region in Muslim Mindanao (ARMM) municipalities in Cohort 1 led it to form an all-ARMM set, Cohort 3. In ARMM, despite a non-devolved health system, mayors nevertheless accepted the responsibility to raise the health standards of their people. Local chief executives provided expectant mothers with financial and transportation means to deliver in health facilities. And in consideration of the deeply traditional practice of delivering in homes, the mayors instead pushed for having a skilled birth attendant instead of *hilot* (traditional birth attendant) present during deliveries. These efforts have led to consistent declines in the MMR and improvements in other indicators as shown in the Cohort 3 chart found on this page.

The ARMM experience also underscored the importance of establishing trust relationships with political leaders in the region. The engagement with ARMM has taught ZFF how important it is to be grounded with local leaders, establishing a trusting relationship between the ZFF account officers and the local health leaders and closely accompanying them throughout the duration of the program as coach and mentor.

COMPOUNDING HEALTH ISSUES

Looking at the experiences of its first three cohorts, ZFF realized that the incidence of maternal and infant deaths

is highest in areas that are either hard-to-reach or too distant from the town's center. The families who live in these places are usually very poor and do not have resources to access facilities and services mostly concentrated in the town proper.

An example of such is Cohort 4, where municipalities have a considerable number of far-flung villages. One municipality, Del Carmen in Surigao del Norte, focused on strengthening its barangay leadership and came up with the Seal of Good Governance for villages. Such initiative enabled health programs to reach the grassroots and helped keep maternal mortality at bay. *(See story on page 10).*

The Cohort 4 experience brought to fore the importance of improving barangay (village) health leadership and community participation on top of making facilities and services available. Because of this, ZFF streamlined its Barangay Health Leadership and Management Program to make it more relevant to the needs of health workers and leaders working in far-flung villages of their municipalities.

As shown below, there was an increase in the MMR of Cohort 4 in 2013. All the maternal deaths occurred following home deliveries. This prompted ZFF to help LGUs devise incentive schemes for *hilots* (traditional birth attendants) to bring pregrant women to health facilties and for *habal-habal* (motorcycle taxi) drivers to transport women.

Cohort 4	2011	2012	2013
MMR	140	47	113
IMR	8	6	6
FBD	44	59	70
SBA	52	61	71

EXTRA CHALLENGE OF PREVENTING MATERNAL DEATHS

ZFF then formed a cohort composed of LGUs considered geographically isolated and disadvantaged areas (GIDAs). The first was Cohort 5 in 2012 and then Cohort 7 in 2013. Maternal deaths in these municipalities were common among poor women who were not enrolled in either the PhilHealth or the Conditional Cash Transfer program of the government. Lack of money, distance and inaccessibility prevent them from receiving medical services.

GIDA municipalities are usually far from district hospitals or provincial hospitals, where higher level of care is provided. Not only are they far, travel is also difficult due to terrain. Thus, transporting a pregnant woman requiring hospital care raises the risk of her death. Worse, some of those who reach referral hospitals in time could still die because the medical facility may lack the proper equipment or health specialists, or both. This is the reality many poor pregnant women in GIDAs face.

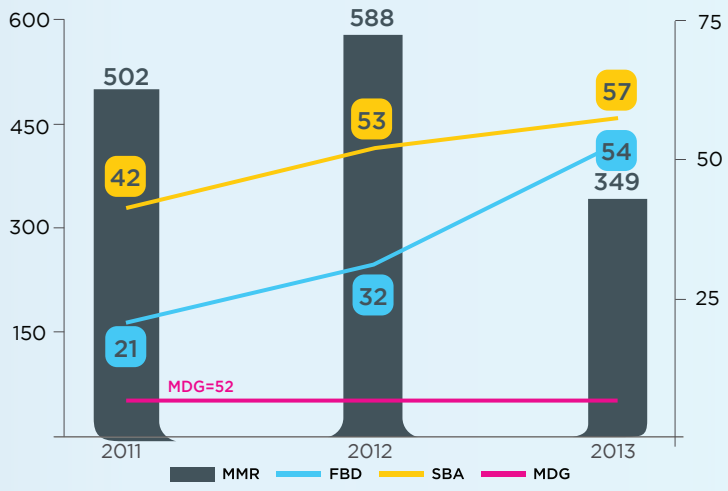
This made ZFF take a closer look at both ends of the referral system: at the barangay level, where functional and sustainable barangay health governance should be in place, and at the referral hospital level, where coordination between the LGU and the hospital must be present. To help the poor patients seek medical attention, an incentives program is highly recommended not only to reward good health seeking behavior, but more importantly, to provide temporary support to the very poor whose willingness to seek healthcare is precluded by their lack of resources. Living in GIDAs can also mean difficulty in access to education and the scarcity of livelihood opportunities; hence, being kept in a poverty trap. So alongside conducting programs for municipal health leaders, ZFF has also been working to link them to organizations that can provide much-needed support. These include Synergeia Foundation for education and CARD MRI for livelihood.

Despite the compounding challenges, Cohort 5 outcomes show promising results. Their MMR, though, is still far from the target of 52. *(See Cohort 5 chart below).*

REFORMS THROUGH TRANSFORMED LEADERSHIP

Different and additional challenges notwithstanding, ZFF's Health Change Model has remained relevant because in these areas, transformed health leadership paved the way for the successive initiation of reforms. This is reflected in the declines in the MMR and IMR of

COHORT 5



the rest of the cohorts, even in GIDAs, where the Foundation was aware that it would face tough challenges. In fact, in most ZFF municipalities, modified health programs that leaders put in place effectively addressed a number of causes of preventable maternal and infant deaths.

STRENGTHENING TIES, SHARING KNOWLEDGE

As successes were being achieved during the implementation of its strategy, other challenges were still emerging. As such, ZFF continues to build on the health gains of LGUs such that other barriers to health system reforms are identified and overcome.

In particular, leaders from LGUs that ended their two-year partnership program with ZFF, or the "alumni," must continue to work on their local health systems. This is to ensure sustainability of health gains and creation of a healthy community, where issues on social determinants of health like education and livelihood are also addressed upon.

More importantly, with ZFF able to closely scrutinize the progress of its change strategy, it has come up with analysis useful in strengthening its Health Change Model. And it is able to turn its findings into concrete action plans useful for more local governments to adopt.

PREVENTING MATERNAL AND INFANT DEATHS

Maternal and infant deaths remain a concern despite improving numbers. It is necessary that local chief executives remain vigilant and accountable for the health outcomes of their people. Based on the Foundation's analysis of its cohorts, ZFF came up with the following interventions:

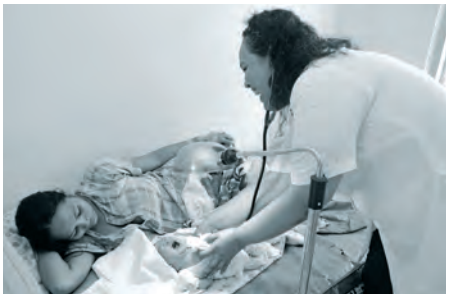
- A pregnancy tracking system must be in place to make sure every case is documented. More importantly, the system must make use of modern information and communications technology to make it more accurate and efficient.
- Well-equipped health facilities must be made accessible and these should be regularly manned by competent health workers.
- Barangay health systems must be activated because barangay leadership is important in making sure health information and programs reach everyone.
- If LGUs provide incentives for very poor mothers, facility-based deliveries will rise and prevent maternal deaths. Incentives include provision of transport vehicles, financial assistance and accommodations.

While municipal healthcare systems have been improving and more mothers are delivering in safer environments and/or in the hands of skilled health personnel, deaths following birthing complications continue in referral hospitals. As a result ZFF must also:

- Work with municipal governments so they can give high risk pregnant women requiring hospital care the support they need, such as means of transportation, accommodation and money. Otherwise, these women will not proceed to the hospital, raising the chances of their own mortality.
- Actively engage provincial governors and DOH Regional Directors to improve capacities of referral hospitals to handle high-risk pregnancy cases, through such measures as having adequate blood supply, a surgeon and an anesthesiologist.

FINDINGS: THE POORER, THE HIGHER THE RISK OF MATERNAL DEATHS

From the results in cohort municipalities, ZFF found that it is more difficult to bring down maternal deaths among the very poor. Therefore, to bring down MMR, it is strategic to target this population from the very start of a program.



As Del Carmen, Surigao del Norte Mayor Alfredo Coro II and his municipal health officer Joy Vizconde, M.D. were going around the municipality visiting health stations, they chanced upon Nasan Compra, 24, and reminded her to make sure she delivered in a health facility. Early the next day, Compra gave birth to a baby girl at the Rural Health Unit. Photo shows Dr. Vizconde checking on the mother and child.

Among the effective early interventions for the very poor is having a tracking system that records and documents all pregnancy cases in a municipality, no matter the distance of a woman's residence from the town proper.

So that very poor pregnant women will be encouraged to seek proper medical care, assistance in terms of financial, transportation and accommodation must be given to them. Without these, a poor woman will take the risk of delivering at home.

For women requiring higher level of care, a properly functioning referral system must be in place. Again, women must be given support to have the means to reach and get admitted in the referral hospital.

Based on its findings, ZFF sees great value in interventions that target the very poor segments of the population at the onset of implementation. By reducing inequities where they are greatest early on during the program, reforms become systematic and results are immediate and sustainable.

Sources of health indicators in Cohorts 1 to 5 and UMak: 2011 and 2012 - Field Health Service Information Systems (FHSIS); 2013 - preliminary FHSIS or reports from Municipal Health Offices

Moving health leadership program towards efficiency

Seeing how quickly maternal mortality ratio dropped using its Health Change Model, the Foundation began creating a program designed to be more efficient in terms of time and cost. This way, the program becomes more attractive for other organizations and institutions to adopt, thereby allowing the strategy to be implemented in more municipalities in the country.

A partnership with the University of Makati (UMak) paved the way for the piloting in 2011 of a shortened program that was given to mayors and municipal health officers of eight of Makati City's sister-municipalities.

ZFF saw its agreement with UMak as a synergistic partnership given the latter's trailblazing efforts in governance education and the Foundation's expertise in health leadership development. For UMak, the course on public health governance was a timely offering because of the approaching Millennium Development Goals deadline in 2015 and the fact that health, according to UMak executive vice president Edita Chan, "is a necessary factor if we are to achieve genuine sustainable development for our nation in the long run."

The training modules, designed by ZFF, were given by the university's faculty.

This one-year program had all the strategic elements of the two-year program: close monitoring, mentoring, coaching and roadmap. It had no grants for the construction of health facilities, however. Still the program generated promising outcomes.

MMR AND IMR: OVERLOOKED PROBLEMS

One leader who took part in the UMak-ZFF program was Santol, La Union Mayor Daisy Sayangda. For her, the program was a reality check because poor health indicators did not bother her before.

"There I was with the other participants, excited to present our mission, vision and accomplishments. We did not expect that ZFF would show the health indicators of all our municipalities—revealing disturbing statistics such as maternal and infant mortality." She adds: "I was aware of all these problems, but I guess they did not sink in before because we had received many awards on our performance as a municipality—such as good housekeeping and clean and green awards."

The program, according to Mayor Sayangda, made her realize that providing good health services to the people must start with a good leader. Construction of health facilities catering to cluster villages has begun alongside the upgrading of existing facilities.

Philippine Vice President Jejomar Binay (left) graces the signing of the partnership agreement between the University of Makati (UMak) and Zuellig Family Foundation (ZFF) for the one-year certificate course on public health governance. At the signing were UMak executive vice president Edita Chan, ZFF president Ernesto Garilao and ZFF chairman Roberto Romulo.

Even with a shortened program, UMak municipalities showed improvements *(See chart below).*

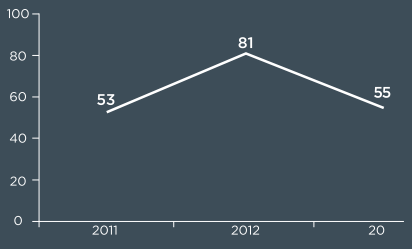
SHORTER, LESS-COSTLY BUT JUST AS EFFECTIVE

ZFF also deemed it wise to have an outside expert look into its programs to see their effectiveness. University of the Philippines professor Alvin Caballes, M.D. conducted a study, and his regression analysis showed that improvements in the maternal mortality ratio (MMR) and facility-based deliveries (FBD) in cohort municipalities were both "striking" and "statistically significant." A sustained downward trend in MMR in these cohorts, according to him, will enable them to achieve the Millennium Development Goal (MDG) target ahead of the 2015 deadline.

Comparing the one-year and two-year programs, Dr. Caballes found that, at a fraction of the cost of doing the two-year Community Health Partnership Program, municipalities under the one-year program experienced positive though less dramatic turnaround in their health status. According to Dr. Caballes, ZFF's program, which also puts emphasis on pregnancy tracking and strengthening information campaigns, could be among the major contributing factors to the improvement.

ZFF, thus, had a more cost-efficient yet effective program offering for other groups to adopt for expansion and replication.

UMAK Batch 1 MMR



UMak municipalities, at the start of the program, had relatively low MMR, which caused the statistic to spike with two additional cases, as was the case in 2012. Number of maternal death cases increased from 10 in 2011 to 12 in 2012. This led MMR to rise from 53 to 81.

Taking the plunge: from MNC manager to 5th class municipality CEO

The devolution of health services to local government units (LGUs) called for mayors to manage their health systems and make them responsive to the needs of their people, especially the poor. Many LGUs however failed to maximize the potential benefits of devolution. Addressing the challenges requires improved leadership, strategic thinking and innovative mind.

Stepping up to the challenge is Del Carmen Mayor Alfredo Coro II. Part of a new breed of politicians, Coro is a young professional who has worked in companies that exposed him to work cultures outside the Philippines. As mayor, he not only brought his managerial and administrative expertise in running the municipal government but also made sure barangay (village) leadership had the capacity to meet the health and other needs of those at the grassroots level.

MAYOR ALFREDO CORO II
Del Carmen, Surigao del Norte

He must have known, or at least have had some idea, that his destiny was inextricably linked to the circumstances of his birth and lineage. After all, he descended from a well-known political family, with generations steeped in public service in the province of Surigao del Norte.

But seemingly disinclined to rush to this destiny, he chose instead to cut his teeth in a multinational information technology firm in the corporate jungle, worlds away from his home province.

After a decade, though, it became more and more difficult to ignore the call of public service. So in 2010, Alfredo Matugas Coro II quit his job, ran for mayor, won and began the transition from being manager of a multinational firm to chief executive of a fifth class municipality.

And while his is probably not an amazing career jump as the corporate world would see it—it may turn out to be the progress leap that Del Carmen sorely needs.

For Coro has brought the fruits of his corporate knowledge and training in management to local government administration.

BRINGING MANAGEMENT EXPERTISE TO PUBLIC SERVICE

In keeping with good management practice, the mayor began by requiring the submission of weekly management reports among the LGU staff.

"I introduced the practice of submitting those kinds of reports because I want to instill discipline and accountability," he said. "We failed miserably in the first six months. We're still recovering until now but (we are getting there)."

Coro sought out the Zuellig Family Foundation (ZFF) after he had heard a lot about the Foundation and its programs in meetings with other LGU officials.

"I was told that a lot changed in their lives," he explained. And when his municipality finally got into a partnership program with ZFF, Coro took the training seriously.

"It was in Module 2 when I began to understand everything and then started the health governance program in Del Carmen," he said. "Previous to this, I didn't have any experience in the government, how much more in public health. So the training really helped."

Integrating the new knowledge and skills from the training with his corporate experience in the positive results of a rewards system, the mayor introduced the Seal of Good Governance for the villages.

EMBRACING HEALTH PROGRAMS IN EVERY VILLAGE

"We realized that in health, if you're not going to cascade the program to the barangay (village) level, it's useless. You can build as many birthing facilities but as long as the barangays don't embrace the program, it wouldn't matter," Coro said.

"We needed to facilitate a process where they could function on their own. We had to figure out an innovative way for them to embrace it directly," he added.

The Seal of Good Governance is given to barangays that meet the targets that the program sets for them. Instead of awarding first, second or third placers, the program recognizes Gold, Silver, and Bronze achievers on the basis of a points system.

"It's alright if we don't have a silver or a gold awardee yet, the important thing is that we have set the goals and made them embrace the program. Who doesn't want an award?" he explained.

While having successfully kept maternal death at zero for three straight years, infant deaths hit 12 cases in 2012. Last year there were five cases. The goal is to bring that number down to zero.

BRINGING HEALTH SERVICES TO ISOLATED AND DISADVANTAGED AREAS

In serious pursuit of this goal, Coro has sought out various partners to help build birthing facilities.

For its part, the local government has attended to the improvement of roads and bought a sea ambulance "because we need to fix the access to far-flung barangays." The mayor has also stationed midwives in geographically isolated and disadvantaged areas in his municipality.

FIXING REFERRAL SYSTEM FOR HIGH-RISK PREGNANCY CASES

Hopefully, the mayor added, through the recently formed nine-municipality Metro Siargao Alliance for Health, of which Del Carmen is a part, they can start improving on their referral system so that a patient who needs to be transferred to another facility will be ensured of receiving quality healthcare.

Like his barangay leaders who aspire for the gold Seal of Good Governance, Del Carmen's Mayor Alfredo Coro II is on a constant quest to level up his municipality in what he has come to believe is the core of progress.

"The partnership with ZFF helped me to figure out what to do," Coro said. "I wanted to do something for public health but I didn't have the tools to do it. HLP (Health Leaders for the Poor) helped me make government services reach the people every day."

Del Carmen, Surigao Del Norte	2011	2012	2013
MMR	0	0	0
IMR	14	10	11
FBD	76	89	90
SBA	76	92	90

Sources: 2011 and 2012 - Field Health Service Information System (FHSIS); 2013 - preliminary FHSIS

LEVERAGING RESULTS, FORGING ALLIANCES

ZFF seeks a strategic fit with other organizations' programs to keep the integrity of its health change strategy while carrying out interventions in more areas in partnership with these groups.

Following the evidence-based results, ZFF found itself in a position to leverage the effectiveness of its Health Change Model to form partnerships. In partnering, ZFF seeks a strategic fit with other organizations' programs. This is meant to keep the integrity of ZFF's health change strategy while it carries out interventions in more areas in partnership with other groups.

UNFPA-ZFF PARTNERSHIP FOR REPRODUCTIVE HEALTH

In 2012, the Foundation partnered with the United Nations Population Fund (UNFPA), which had been providing technical assistance related to reproductive health. The integration of their program with ZFF's focus on health leadership and governance was seen to create an effective synergy to improve maternal and child health in the identified nine provinces. Under this partnership, modular training programs are conducted among governors and provincial health officers (PHOs). A practicum in between modules encourages these provincial health leaders to improve on their health systems with the help of senior coaches like former Health Secretaries Esperanza Cabral, M.D. and Jaime Galvez Tan, M.D.

Among the participating governors is Gov. Johnny Pimentel of Surigao del Sur. A health champion prior to becoming a governor, Pimentel's health programs are being replicated elsewhere in the country *(See article on Gov. Pimentel on page 16).*

In 2013, health leaders from some 45 municipalities of the nine provinces also began their journey towards leadership transformation. Like the governors and provincial health officers, mayors and municipal health officers have undergone their first training module on health leadership and governance.

Three of these partner-municipalities—General MacArthur, Giporlos and Salcedo in Eastern Samar—suffered the brunt of super typhoon Haiyan. With funding and assistance from various organizations and donors, ZFF held relief distribution drives in these municipalities. Soon after, ZFF organized a recovery program for them and nine other municipalities in the province and in Samar *(See more about the health recovery program on page 20).*

As a result of the partnership, ZFF started monitoring the contraceptive prevalence rate (CPR) of municipalities.

Rising teenage pregnancy issues in partner municipalities also moved ZFF, particularly its UNFPA team, to start planning for interventions to help municipalities implement the National Adolescent Health Development program.

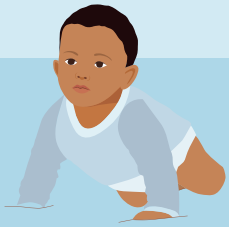
MSD-ZFF PARTNERSHIP FOR GIDAS

In the Samar Island provinces, where maternal mortality is a serious problem given their geographical realities, ZFF forged a partnership with Merck Sharp and Dohme (MSD). The partnership is part of the Merck for Mothers Global Giving Program. To address the challenge in these geographically isolated and disadvantaged areas of Samar and Northern Samar provinces, leadership and governance training programs are provided to the municipal health leaders. The programs have been helping leaders put measures in place to address difficulties faced by poor mothers. These include:

- Making local health boards functional
- Improving facilities such that they get PhilHealth-certified
- Having transport facilities available for emergency cases
- Providing logistical and financial support to mothers so they seek proper healthcare
- Pregnancy tracking

EXPANDING THROUGH STRATEGIC PARTNERSHIPS

	UNFPA	MSD	USAID	UN
PARTNERSHIP DURATION	2012-2016	2013-2015	OCTOBER 2013 – SEPTEMBER 2016	FEBRUARY 2014 APRIL 2016
NO. OF LOCAL GOVERNMENT UNITS	**62** Municipalities	**21** Municipalities in geographically isolated and disadvantaged areas in Samar & Northern Samar	**37** Municipalities in ARMM	**36** Municipalities and cities
	9 Provinces	**2** Provinces	**84** Municipalities and cities in non-ARMM regions	
TARGETED HEALTH OUTCOMES	› Maternal and Child health › Reproductive Health	› Maternal and Child health	› Maternal and Child health › Tuberculosis	› Maternal and Child health
PROJECT COST	P70.4M	P21.4M	P65.6M	P25.6M



HEALTH INDICATORS OF UNFPA-ZFF PROVINCES

Province	MMR			IMR			FBD (%)			SBA (%)			CPR (%)		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
Ifugao	53	28	55	11	10	12	60	72	74	85	85	88	48	48	50
Mt. Province	69	105	35	19	14	18	59	62	68	83	82	85	40	41	43
Albay	59	79	31	9	8	7	70	80	90	76	84	76	26	33	39
Camarines Norte	45	47	197	15	14	5	38	38	68	64	77	76	36	40	41
E. Samar	110	141	98	12	9	1	66	72	81	69	83	85	35	34	39
Surigao del Sur	51	49	148	7	7	7	72	80	84	79	81	85	49	41	44
Compostela Valley	147	70	185	5	6	5	65	70	77	72	76	84	66	63	66
Sarangani	218	142	79	5	3	3	46	59	65	57	64	68	43	51	58
Sultan Kudarat	96	78	90	4	12	8	69	77	77	72	79	79	52	57	56

Following the partnership with UNFPA, the Foundation also started monitoring the contraceptive prevalence rate (CPR) of local government units. An earlier analysis of the statistics showed that chances of maternal mortality decrease if LGUs have CPR of at least 50%.

Sources: 2011 and 2012 - Field Health Service Information System (FHSIS); 2013 - preliminary FHSIS

Leadership and governance training programs will also be provided to barangay leaders. Given the distance and isolation of certain villages from the town proper, a strong barangay health leadership is needed to have a functional health system. Capacities of midwives will be improved through training, such that they too become capable trainers of barangay health workers.

This mix of interventions is expected to strengthen leadership and governance—both at the municipal and barangay levels—and fix the local health system while also improving health seeking behavior of mothers.

There are 21 GIDA municipalities under the MSD-ZFF partnership.

USAID-ZFF PARTNERSHIP FOR MATERNAL AND CHILD HEALTH AND TB

The United States Agency for International Development (USAID) and ZFF entered into a cooperative agreement to implement the Health Leadership and Governance Program (HLGP) in USAID target areas. This agreement is under USAID's Global Development Alliance (GDA) and will run for three years, from October 1, 2013 to September 30, 2016.

The goal is to improve health outcomes—maternal and child health (MCH), family planning (FP) and tuberculosis (TB)—in USAID areas by enhancing leadership and governance capabilities of local chief executives and local health officers.

This project has the following objectives:

- Train local chief executives and local health officers on Bridging Leadership competencies.
- Improve local health systems to make them more responsive to the needs for MCH, FP and TB prevention and control.
- Increase community participation and health-seeking behavior in target areas through improved local health systems and local health leadership.

Program interventions include the:

- Provincial Leadership and Governance Program (PLGP) that will build the health leadership capacities of the provincial governors and their provincial health officers to develop the provincial health system.
- City Leadership and Governance Program (CLGP), a strategic and focused health leadership and governance program that will help city mayors and health officers address the challenges of rapid urbanization to health outcomes in urban areas.
- Municipal Leadership and Governance Program (MLGP), a leadership program for mayors and municipal health officers who are expected to improve their municipal health indicators and engage other local stakeholders.
- Health Leaders for the Poor (HLP), which will be implemented in municipalities in the Autonomous Region in Muslim Mindanao, wherein the municipal health officer is expected to provide technical coaching to the Mayor.

The program covers 118 municipalities in eight provinces: Batangas, Iloilo, Zamboanga Norte, Zamboanga Sibugay, Zamboanga Sur, Misamis Oriental, Tawi-Tawi and Lanao del Sur. There are also three cities covered: Batangas City, Cagayan de Oro City and Iloilo City.

UNICEF-ZFF PARTNERSHIP FOR CHILDREN

Before the end of 2013, ZFF also forged a partnership with the United Nations Children's Fund (UNICEF). This partnership will bring ZFF's leadership and governance program to UNICEF's 36 priority local government units (LGUs), of which 21 already have existing ZFF partnership programs.

Improved health leadership is expected to lead to the activation of local health boards, improvements in health information systems, increase in PhilHealth-accredited facilities and the promulgation of more health policies. Through the interventions, too, there is an expected 15% increase in the coverage of births attended by skilled birth attendants with postnatal care by 2015 in partner municipalities.

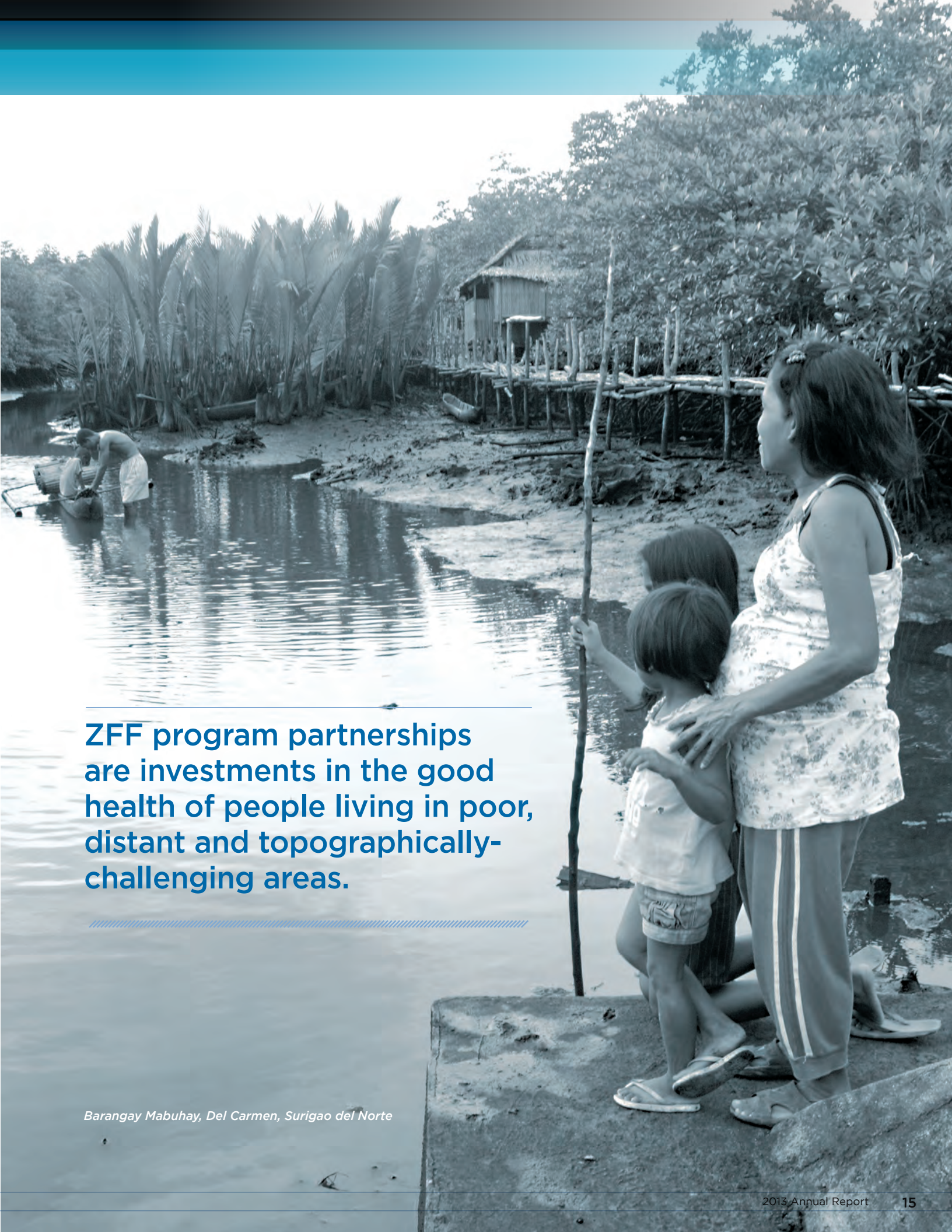
UNICEF's priority areas will also benefit from training on Evidenced-Based Approach to Planning and Budgeting. This will help LGUs understand and analyze their actual health challenges and anchor their budgetary priorities on these.

ZFF also sees an opportunity to learn from UNICEF's life-cycle approach to child development. This concept, according to the UNICEF, "provides a holistic and integrated methodology that connects and reinforces the various policy support measures in a coherent manner." The Foundation recognizes the fact that developments during pregnancy will have significant effects on an infant, and that a child's health can be influenced in turn by the mother's health. And since young or teenage pregnancy is also of concern, the life-cycle approach of UNICEF can also help in the implementation of adolescent health programs.

INVESTING IN GOOD HEALTH

ZFF sees that program partnerships are investments in the good health of people living in poor, distant and topographically-challenging areas.

Healthy pregnancy raises the chances of having equally healthy children, who can grow up to become productive individuals.



ZFF program partnerships are investments in the good health of people living in poor, distant and topographically-challenging areas.

Barangay Mabuhay, Del Carmen, Surigao del Norte

Quick response to disturbing maternal death numbers

GOV. JOHNNY T. PIMENTEL
Surigao del Sur

Governors exercise supervision and control over all programs and services of the provincial government. Except for the Department of Health retained facilities, it is the provincial government that directly supervises provincial and district hospitals. As governor, one must ensure that hospitals have the sufficient capability to provide higher medical care for patients whose cases are beyond the capacity of primary healthcare facilities like the Rural Health Units (RHUs).

In Surigao del Sur, Gov. Johnny Pimentel not only works to ensure that his province's district hospitals are functional, he provides local government units with much needed support to develop RHUs and barangay (village) health stations (BHS) to a point that one such BHS in Barangay Aras-Asan, Cagwait became the country's first Basic Emergency Obstetric and Newborn Care certified BHS.

If a political name, reputation and legacy of public service were enough to make personal and provincial dreams come true, then Gov. Johnny Pimentel could very well have just sat back and waited for all these factors to work wonders for Surigao del Sur.

But Governor Johnny, the fifth member of the Serra Ty Pimentel clan to serve as the province's chief executive, knows all too well that more than just a good name and lofty aspirations are needed to deal with the many challenges confronting the province.

For one thing, he had served as Provincial Administrator for nine years immediately preceding his election as governor. This put him "on the frontline of the delivery of administrative support services" to the people and gave him first-hand knowledge on what the province needed.

IMMEDIATE RESPONSE TO ADDRESS MATERNAL MORTALITY

One of the harsh realities in Surigao del Sur that Pimentel was made starkly aware of was its high maternal mortality ratio (MMR) – actually one of the highest in the country in 2005 with 272 maternal deaths for every 100,000 live births. The Philippine Millennium Development Goal (MDG) is 52.

"That was very alarming," he said. And it was what motivated him to make the improvement of health services a particular mission.

His administration was able to bring it down to 51 in 2011. "But we relapsed in 2013 with 16 deaths (for an MMR of 148)," he said. "We are trying to find out the cause. MDG deadline is in 2015 so we need to bring it back down."

In the course of determining its cause, the local government stumbled on another problem – the under-utilization of hospitals.

REINVIGORATING PROVINCIAL HOSPITALS

"We had only 70 percent occupancy rate," he said. "It only means that our people are not using the hospitals and medical facilities. We also saw that the hospitals were very old and dilapidated."

The Governor then set out to identify all the problems of the health sector and begin programs to address them.

One of the provincial government's innovations is a halfway house for pregnant women, where they can stay when they are close to their due dates. This has been replicated in other provinces, according to the governor.

"Our main objective is to reduce maternal deaths," he explained. "If we send them back to their far-flung barangays just because the infant is not about to come out yet, then we are exposing them to the danger of dying."

He built halfway houses that had two bedrooms to accommodate at least six pregnant women, a bathroom, kitchen and dining area, and even a living room. The women staying are allowed to bring companions to look after them.

READY FUNDS ENSURE HOSPITALS RUN SMOOTHLY

To address the problem of funds for the hospitals' operational expenses, Pimentel established an Income Retention System where retained income is put into a trust fund.

"Normally, hospitals remit their income to the provincial treasury, and it becomes part of the province's general fund," he explained. "Then if they need funds to purchase medicines or medical equipment, they have to go through the usual bureaucratic process of sending a request, waiting for approval, etc."

The trust fund comes from PhilHealth reimbursements, income from pharmacy sales and direct payments by patients for drugs and medicines. The fund will only be used for hospital needs – purchase of medicines and equipment or hiring of medical personnel.

At present, hospitals in the province have millions of pesos in the trust fund. Most of these are now used to renovate the hospitals and purchase ambulances.

ADDRESSING HEALTH DOWN TO THE BARANGAY LEVEL

At the barangay level, the Surigao del Sur governor set up a pregnancy tracking system where the barangay health workers assist women all throughout the pregnancy. And to encourage facility-based deliveries, he formed a Women's Health Team (WHT), composed of barangay health worker, midwife, and *hilots*, to assist pregnant women.

Even with all of the programs already in place, Governor Pimentel still enthusiastically joined the health leadership program under the United Nations Population Fund (UNFPA) and Zuellig Family Foundation partnership.

ROADMAP CLEARLY SHOWING PROGRESS AND BOTTLENECKS

"ZFF added value to our programs by giving us a roadmap and guiding us in making them even more sustainable," he said, noting that the monitoring system set up by ZFF actually helps them track where they are now on the roadmap.

Governor Pimentel has adopted the suggestion of ZFF to appoint a PhilHealth provincial coordinator "because the bulk of the income of hospitals is in PhilHealth. This is to monitor unclaimed funds that can be used for other medical needs."

A CONCERN FOR THE FUTURE OF HIS CONSTITUENTS' HEALTH

The governor's focus on the health of the poor comes from his own experience of trying to help save a life. When he was the provincial administrator, he gave money to pay for the anti-rabies vaccinations of a girl, 9, bitten by a dog. Lack of money kept the family from getting immediate and follow-up care. The child died.

It is understandable, therefore, that he is most concerned that his constituents continue to get the basic health services even if his term as governor ends, so Pimentel has institutionalized the programs through ordinances.

"The enabling laws will protect whatever programs we have put in place," he said.

"The most basic service that we can give to people is health," he added. "It is the most visible, the most tangible, and directly benefits them. I believe that although we are a poor province, we should not deny access to good health services to our people."

Surigao del Sur	2011	2012	2013
MMR	51	49	148
IMR	7	7	7
FBD	72	80	84
SBA	79	81	85
CPR	49	41	44

Source: Field Health Service Information System

Governor Pimentel (center) is shown with the Hinatuan District Hospital medical team that had concluded a death review. With the governor are district hospital chief Dr. Danilo Viola, Hinatuan Mayor Candelario Viola, provincial health officer Algerico Irizari, M.D. and Hinatuan municipal health officer Emelie Viola, M.D.

HEALTH RECOVERY POST-HAIYAN: RESPONSIBLE LEADERSHIP + HELPING HANDS

Mayor Mergal of Salcedo, Eastern Samar had an advantage — his earlier participation in the leadership program under the UNFPA and ZFF partnership.

Nothing it seems could ever have prepared Eastern Visayas' leaders for the vicious onslaught of super typhoon Haiyan (Yolanda).

Count among them Mayor Melchor Mergal, who had been serving Salcedo, Eastern Samar for only four months when Yolanda lashed at his town.

"Honestly, I was not prepared. I really didn't know what to do," Mergal admits.

RETURNING HOME TO BRING CHANGES

A typhoon cutting through Eastern Samar might not otherwise have been too much of a challenge to the neophyte mayor, even considering the fact that he had spent many years in Metro Manila prior to his election as town chief.

Barangay Jagnaya, Salcedo, Eastern Samar

Mergal had been away from Salcedo to pursue a law degree, and after this worked in the National Bureau of Investigation and became a partner in a law firm. But he had also nurtured a dream to bring positive changes in his hometown, where his mother, to this day, continues to serve as a barangay health worker.

Having run and won in the 2013 mayoralty election, he was on his way to the dream's fulfillment when the killer typhoon almost derailed him.

Eastern Samar is no stranger to typhoons, but Haiyan was something else. When the super storm struck, livelihood opportunities in Salcedo and its neighboring municipalities and provinces in the region were swept away in an instant, along with the once-abundant tracts of coconut trees and clusters of fishing boats. The extent of the damage left the mayor overwhelmed...but not for long.

Mayor Mergal had an advantage—his earlier participation in the leadership program under the United Nations Population Fund (UNFPA) and Zuellig Family Foundation (ZFF) partnership.

"My participation in the program made me realize that everything that happens in my town is my responsibility," Mayor Mergal says, explaining that to him this meant that no one else but him could and should help his town get back up.

BREAKING POLITICAL BARRIERS

The Salcedo mayor recalls that he had been hesitant at first to join the ZFF program because of an initially shaky relationship with the Municipal Health Officer (MHO), a sister of his opponent in the 2013 mayoralty elections.

"But I was happy because we eventually came to know each other better and became friends," he continues, adding that the ZFF program paved the way for the "very excellent relationship" he currently has with Salcedo's MHO, Dr. Socorro Campo.

Mayor Mergal says the ZFF program opened his eyes to the health situation in his municipality, a situation he admits "was not so good."

"The program made me realize that it is within my function to address the health problems in my town," he says.

IMPROVED LEADERSHIP STYLE

The ZFF program also helped Mayor Mergal understand the concepts of "bridging leadership," which enabled him to appreciate and deal with Salcedo's many health issues, and "ownership," which allowed him to claim his town's health realities as his responsibility.

"I also learned about the concept of co-creation, which opens up opportunities to engage in and establish relationships with stakeholders." He adds that co-creation has also empowered the town's citizenry, ultimately resulting in responsive health programs and leading to health equality.

"The program changed my leadership style, because in allowing myself to understand the current reality of my town's health situation, I eventually discovered my preferred health reality," the mayor says.

RISING ABOVE CRISIS

The mayor's newfound confidence in his leadership skills after completing the ZFF program greatly helped him in facing typhoon Yolanda's aftermath. Their Rural Health Unit was badly damaged after the truss of an adjacent basketball court fell on it. "I prayed and asked help from other institutions," Mayor Mergal recalls, adding that they were ready with the needed data three days after the typhoon and were able to ensure that the municipality's roads were cleared. "These institutions were able to respond because of our readiness."

To continue the delivery of health services, the municipality used a small section of the RHU to receive patients. A nearby undamaged building served as a lying-in clinic while Medecins San Frontieres set up a temporary birthing clinic in front of the RHU.

Mayor Mergal is especially grateful for the ZFF's Recovery Assistance Program *(See more about the program on page 20)*, which helped track the town's pregnant women—who are among the most vulnerable sectors during calamities. The ZFF's incentive programs for pregnant and lactating mothers ensure that no pregnant woman will be among the casualties in the event of a calamity, Mayor Mergal explains.

Salcedo's barangay health workers were also given incentives and the opportunity to become members of a micro-finance bank.

ZFF has likewise facilitated meetings with other stakeholders who are willing to support Salcedo's recovery efforts, particularly in the livelihood sector, according to the local chief executive.

KEEPING ACCOUNTABILITY FOR THE TOWN'S HEALTH

Mayor Mergal says he wants his people to regain their trust in their municipal government by continuously "owning" the problems and issues concerning the town, coordinating closely with different stakeholders, and implementing programs and projects that respond to his people's needs.

"It is good that our rehabilitation and recovery efforts are succeeding. I now have to be quick because three years is too short for me to make my constituents feel that I have delivered what is due to them," the mayor underscores.

Salcedo, Eastern Samar	2012	2013
MMR	0	0
IMR	17	0
FBD	84	88
SBA	90	93

Source: 2012 - Field Health Service Information System (FHSIS), 2013 - preliminary FHSIS

Mayor Melchor Mergal (standing, left) and municipal health officer Maria Socorro Campo. M.D. (standing, second from left) check on patients and medical personnel in the temporary clinic put up after the town's Rural Health Unit was badly damaged during super typhoon Haiyan.

Ensuring mothers and babies remain healthy despite massive destruction

The onslaught of super typhoon Haiyan (local name: Yolanda) in November 2013 caused such widespread and extensive damage in the Visayas, particularly in Eastern Visayas, that recovery seemed almost impossible.

Before Haiyan, the three Samar Island provinces had already been known for their beautiful beaches and breathtaking landscapes, perfect for surfing, hiking through forests or exploring caves. The island also stands out in historical significance. Homonhon, in the municipality of Guiuan in Eastern Samar, holds the distinction of being the first landing site of Ferdinand Magellan on Philippine soil in the 16th century.

Historic Homonhon was a direct hit and completely devastated by the 21st century superstorm. Also bearing the brunt of Haiyan were the south coasts of Samar and Eastern Samar, which suffered from massive storm surges and powerful winds. Tragically, these areas are also among the provinces with high poverty populations and poor health indicators, with 2013 figures showing maternal mortality ratio at 98 in Eastern Samar and 193 in Samar.

With health infrastructures destroyed and local health personnel themselves affected by Haiyan, ZFF had to craft an immediate and relevant response, creating a health recovery program targeted at the vulnerable populations of pregnant women and infants.

Four days after typhoon Haiyan struck, the US-Philippines Society held a forum in Washington, D.C. entitled, "Public Health in the Philippines: Progress and Challenges." Aside from discussing the successes and challenges of public-private partnerships in healthcare, the forum became a venue to get help for Haiyan victims. Photo shows Ambassador to the US Jose Cuisia Jr. thanking the US government and the Americans for the support they gave to the victims.

Using funds given by the Washington-based US Philippines Society (US-PS) the "Recovery Assistance Program for Mothers" (RAP) was implemented in 12 municipalities. These are the 10 Eastern Samar municipalities of Balangkayan, Hernani, Gen. MacArthur, Salcedo, Mercedes, Guiuan, Quinapondan, Giporlos, Lawaan and Balangiga and two Samar municipalities of Marabut and Basey.

The recovery program was a departure from the Foundation's usual disaster response program, which entailed the distribution of relief goods to affected communities. ZFF did distribute relief goods in the Capiz municipalities of Dao and Ivisan and in the Eastern Samar municipalities of General MacArthur, Giporlos and Salcedo. For the first time, it also conducted a medical mission in Capiz. It was the scale of damage that prompted ZFF to do more.

BENEFITS TO MOTHERS

The six-month program aims to ensure that pregnant women, lactating mothers and infants continue to receive proper medical care despite damages to health facilities. Cash incentives are handed out to the beneficiaries by ZFF's partners, CARD Inc. and Center for Community Transformation (CCT). If the mothers are also members of these organizations, they can secure loans to fund their planned livelihood projects.

LEADERSHIP PROGRAM PARTICIPATION FOR SUSTAINABILITY

The long-term viability of the recovery program will be ensured through ZFF's requirement that mayors and municipal health officers of the 12 municipalities undertake ZFF's capacity building program. Their participation will enable them to establish and sustain a responsive and inclusive local health service system.

RAP BENEFICIARIES: MOTHERS

Total number of mothers:	**2,890**
Cash incentives:	
Natal checks:	**P250** for every pre and post natal check
Facility delivery:	**P1,000** for normal delivery
	P2,500 for caesarean delivery
Plus: Maternal and infant toiletry kits	

RAP BENEFICIARIES: BHWS AND MIDWIVES

To help frontline health workers, incentives are also made available to them.	
Total number of barangay health workers (BHWs):	**1,547**
Total number of midwives:	**74**
Cash incentives:	
Initial pregnancy tracking report:	**P300**
Updated tracking report:	**P100/month**
Insurance in CARD or savings in CCT:	**P100**
Plus: Kits with equipment and instruments for their job	

RAP MUNICIPALITIES

Municipalities	MMR		IMR		FBD		SBA		CPR	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Mercedes, E.Samar	0	0	0	7	99	99	99	100	58	15
Balangkayan, E.Samar	0	0	34	0	58	73	75	86	34	33
Lawaan, E. Samar	0	0	10	0	91	99	91	99	37	48
Hernani, E. Samar	0	0	58	59	94	88	98	96	37	42
Balangiga, E. Samar	0	0	13	0	78	88	90	92	34	40
Quinapondan, E.Samar	0	0	19	19	74	80	84	84	33	33
Giporlos, E. Samar	0	0	11	0	85	83	85	83	26	25
Guiuan, E. Samar	100	0	4	10	41	85	97	98	28	35
Salcedo, E. Samar	0	0	17	0	84	88	90	93	50	58
Gen.McArthur, E.Samar	667	312	10	6	84	86	84	86	43	56
Basey, W. Samar	0	0	3	9	25	74	95	96	10	20
Marabut, W. Samar	0	441	8	0	69	32	69	32	29	14

Sources: 2012 - Center for Health Development (Region 8); 2013 - Field Health Service Information System

Joyce Javillonar (standing, right) of US Philippines Society personally hands over a maternal kit to one of the RAP beneficiaries in Salcedo, Eastern Samar. Looking on is Salcedo Mayor Melchor Mergal.

About US-PS

The **US Philippines Society** is a 501c3 non-profit, non-partisan and independent organization that receives neither funding nor direction from either the United States or Philippine government institutions. The Washington D.C. based organization aims to elevate the Philippines' profile in the US through its various programs on trade and investment, culture and education and community outreach. It relies on donors and active member support for its programs.

Other donors:

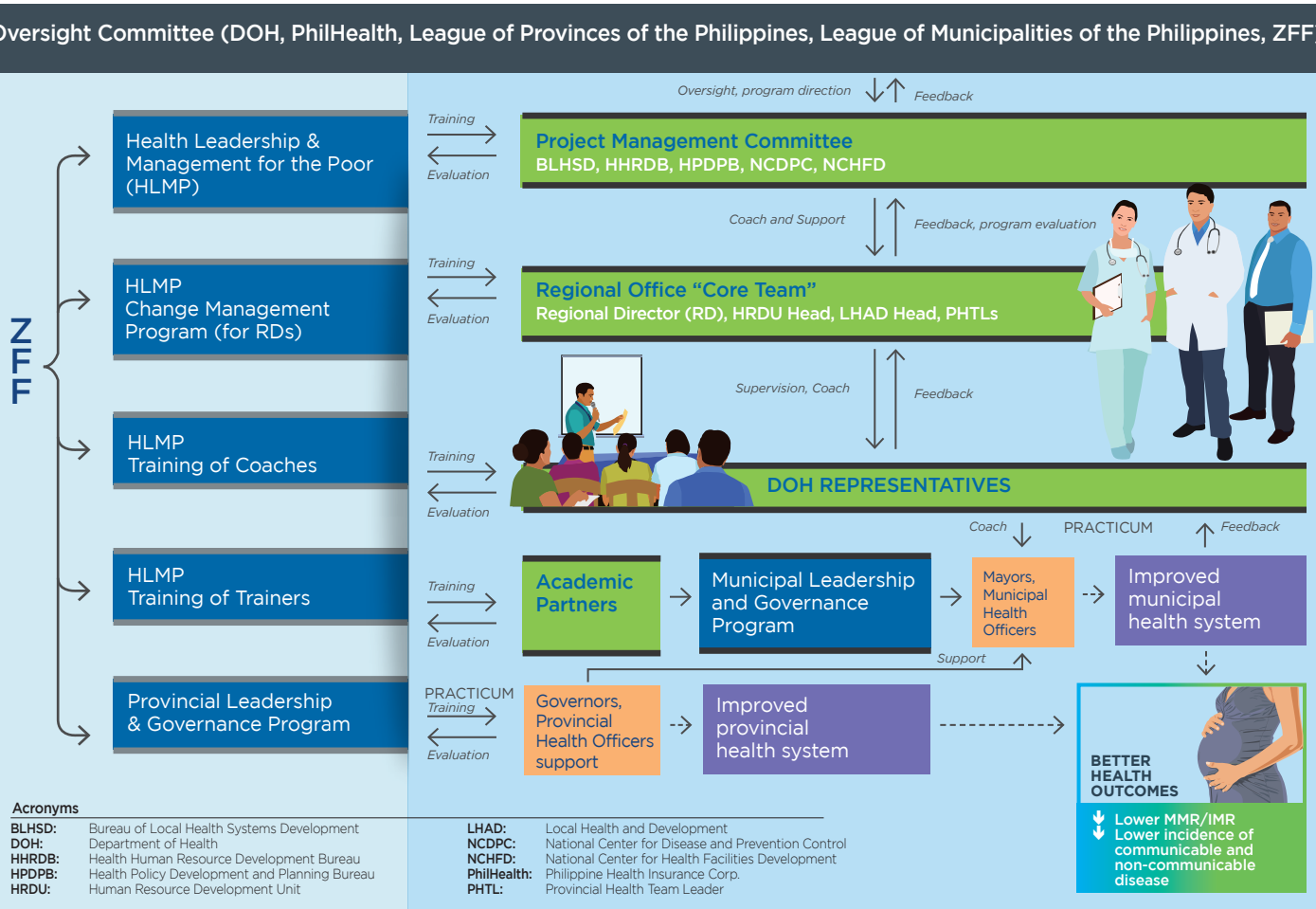
- B.Braun Medical Supplies Inc. (Philippines and Malaysia)
- CARD Inc.
- Careerplus Group SA
- Center for Community Transformation
- Naspers Limited
- PT Tokobagus
- ROK Water Technologies Inc.
- Skidmore, Owings & Merrill LLP partners
- Stiftung Solarenergie Philippines
- ZFF management and staff
- Zuellig family
- Zuellig Pharma

ZFF HEALTH CHANGE MODEL: MOVING FROM CONCEPT TO STANDARD PRACTICE

The partnership with the Department of Health (DOH) in 2013 was the vehicle for the Foundation to replicate its Health Change Model (HCM). This partnership led to the Health Leadership and Governance Program (HLGP), which involves 609 priority local government units (LGUs) as identified by the National Anti-Poverty Commission. Through the program, the Foundation brings leadership and governance into the mainstream of public health system. The three-year partnership involves DOH committing P740 million that goes directly to Academic Partners (APs) and LGUs. ZFF's contributions amount to P124 million.

Whereas ZFF worked directly with municipalities when it modeled and scaled up its Health Change Model, mainstreaming the approach to the DOH required a different approach. The approach calls for the replication of the strategy within the DOH and its subsequent modifications. For the HLGP, ZFF needed to engage the DOH and its regional offices. Academic institutions like the Davao Medical School Foundation *(See story on page 26)* were also tapped to provide the leadership and governance training to the LGUs.

The operational framework of the program is shown and explained below.



Acronyms

BLHSD: Bureau of Local Health Systems Development
DOH: Department of Health
HHRDB: Health Human Resource Development Bureau
HPDPB: Health Policy Development and Planning Bureau
HRDU: Human Resource Development Unit
LHAD: Local Health and Development
NCDPC: National Center for Disease and Prevention Control
NCHFD: National Center for Health Facilities Development
PhilHealth: Philippine Health Insurance Corp.
PHTL: Provincial Health Team Leader

RETOOLING THE CHANGE ACTORS

The replication and mainstreaming of the HCM required the retooling of the three organizations involved: ZFF, the DOH and the APs.

For the foundation

Retooling for ZFF meant having its training products vetted by the DOH Health Human Resource and Development Bureau, and their subsequent transfer to the APs. With the training no longer directly given by the Foundation, quality assurance (QA) systems had to be set up to ensure the integrity of the ZFF brand. The QA system is in place to monitor and assess the quality of the training interventions.

With a growing number of municipalities in the program, a monitoring and evaluation system had to be established to determine the health status of the LGUs. A functional knowledge management system has also been in place to capture learnings and experiences.

Finally, ZFF had to increase its staff that now has to deal with DOH senior officials, governors and other senior level government bureaucrats. They also have to deal with the ambiguities and complexities as the program requires new institutional arrangements.

For the DOH

In the DOH, the HLGP had to be established as a regular program with dedicated personnel and budget in its Bureau of Local Health Systems Development, as well as in its regional offices.

Retooling required DOH key officials in the national bureaus and regional offices to undergo capability building interventions on "Bridging Leadership" through the Health Leadership and Management program for the Poor (HLMP).

Critical DOH players in the HLGP are the DOH Regional Directors *(See story of Director Abdullah Dumama, M.D. on page 28)* and the DOH representatives (DOH Reps), with the latter now serving as coaches to the local government health teams. It was, therefore, necessary to identify, select and make DOH Reps undergo the HLMP training modules and the training of coaches programs. *(See story of Genie Daradal on page 30).*

The HLGP also requires the DOH's support for participating municipalities. This comes in the form of improvements in health facilities through its "Health Facilities Enhancement Program," deployment of human resources, procurement of medicines and supplies and new systems on health information, among others.

For the academic partners

Under the HLGP, academic institutions had to go through a certification process for them to run the leadership and governance program for LGU health leaders.

The faculty were required to complete the two-module HLMP as well as finish the modules on training of trainers. This is to ensure that these institutions run a quality training program, known as the Municipal Leadership and Governance Program (MLGP).

They are also encouraged to develop public health cases as training materials, preferably in their vernacular, and refine teaching methodologies to suit the requirements of the LGU health teams.

As program partners, the APs had to integrate health leadership and governance in their curricula. Like in the DOH, the program was lodged in specific units of the academic structure, providing strategic direction and mandate to

The framework identifies the partnership's major stakeholders that include the Department of Health (DOH), Academic Partners (APs), Zuellig Family Foundation (ZFF) and municipal mayors. Representatives of national agencies and ZFF comprise the oversight committee.

The project management committee (PMC), which develops policy issuances and mobilizes needed resources for the partnership program, is composed of relevant DOH bureaus including the Bureau of Local Health Systems Development and Health Human Resource Development Bureau (HHRDB). APs located across the country provide the health leadership and governance training program to mayors and municipal health officers.

The framework identifies the capability building programs that relevant officers and personnel of the DOH and AP faculty must take so they can implement and manage the health leadership and governance programs. These training programs, along with those for municipal and provincial health leaders were vetted by the PMC, the HHRDB in particular.

To ensure sustainability of interventions and outcomes, mechanisms such as the practicum for municipal and provincial health leaders and training evaluation are also in place. The framework also the shows the relationships and new institutional arrangements between stakeholders. This includes the need for DOH Representatives (DOH Reps) to coach municipal health leaders and for ZFF to do the same for provincial health leaders to make sure system-wide health reforms are accomplished in their areas. There must also be constant feedback given to the DOH and evaluation on academic partners to guarantee effectiveness and quality of program.

Finally, the framework shows how provincial government support, in the form of technical, financial and logistical, is needed to help municipalities make their health systems responsive to the needs of the people and lead to the better health outcomes especially of the poor.

Health Secretary Enrique Ona (right) listens as Regional Director Jaime Bernadas, M.D. (leftmost) reports on the MMR and IMR of the Region 7. Looking on is ZFF trustee David Zuellig (second from right).

the partnership with ZFF, the DOH and the LGUs.

The APs are encouraged to offer academic units and either certificates or diplomas to those who complete the MLGP courses. Finally, a sustainable business model must be developed.

NEW INSTITUTIONAL ARRANGEMENTS

The newness of the program to all three organizations meant a need for tighter coordination to ensure problems and challenges are identified and addressed immediately.

Overall, there is the oversight committee to provide strategic direction. It is headed by DOH Undersecretary Janette Garin, M.D. More importantly, there is the project management committee (PMC), headed by director Nestor Santiago Jr. and which approves all activities, changes and innovations introduced in the program.

At the regional level, coordination is done in the Regional Implementation and Coordinating Team (RICT), where HLGP has become a regular item in the agenda for planning, monitoring and assessment purposes. ZFF and academic partners sit in the RICT, where discussions include issues on training, practicum and DOH resource support.

INITIAL RESULTS AND CHALLENGES

By the end of 2013, 140 municipalities from 10 regions had undergone training. The cumulative maternal mortality ratio of these LGUs was 93 while infant mortality rate was 7.

From the initial rollout of the program, the Foundation realized that while APs were able to provide the training with the assistance of ZFF, there is still a need to address the adequacy and capacity of faculty members from the APs to ensure consistency and quality of training.

The need for more coaching was also identified, and alongside this, the problem of availability of DOH Reps as coaches. Among the changes in the course of a recent organizational overhaul in the DOH was the upgrading of the position of DOH Rep. As a result, some DOH Reps retired or had to be transferred, leading to vacancies that could not be filled immediately. The ensuing lack of DOH Reps caused the slowdown of training activities.

It also became evident that an alternative information system has to be put in place to ensure that accurate health indicators are available immediately. The current DOH information system, however, is not

able to provide these indicators until a year after. The same is true for the results of maternal death reviews. This means no timely and accurate system provides information on whether health indicators are improving or deteriorating. Timely information is required if HLGP is to address health system gaps, especially those relevant to bringing down maternal mortalities, such as facility based deliveries and skilled birth attendants.

There are also bottlenecks in the support system for public health systems, specifically in the areas of health infrastructure, health information systems, barangay health systems or community health teams, medicines and supplies, and health human resources, etc.

Each of these areas is critical to reducing maternal and infant deaths, highlighting the importance of addressing these gaps to ensure the achievement of HLGP objectives.

While the Foundation is hopeful that the program can bring significant declines in the MMR of LGUs, the challenges it found and the risks ahead will impact on the attainment of the program's objectives for both the DOH and ZFF.

The risks include the lack of organization-wide changes in systems and cultures needed to support the program implementation. In all three organizations, there could be leaders and personnel who only have hollow commitment for the program. *(See "Change Management Risks" for more details).*

The partnership program with the DOH will be continuously evolving. Hence, challenges and risks will arise. The DOH and ZFF must therefore be constantly prepared to make corrections and adjustments to its strategy, explore new areas for collaboration, as well as calibrate its interventions to keep them responsive to the needs of its principal stakeholders.

Change Management Risks

As the Foundation carries out the replication and mainstreaming of the Health Change Model, it identified the risks of the Department of Health (DOH) and ZFF as the latter institutionalizes the Health Leadership and Governance Program (HLGP) in the DOH. These risks could block the progress of HLGP.

SOME OF THE IDENTIFIED RISKS ARE GIVEN BELOW.

DOH RISKS:

Risk of pseudo ownership

While DOH top leadership is expected to take ownership of the program and subsequently use their leadership capital to ensure its success, there may be those not fully committed to the program. If this is the case, then there could be minimal changes in the systems and improvements in health outcomes.

Change management failure

There is the possibility that while the health leadership takes full ownership of the program, they are unable to translate their personal commitment to an organization-wide commitment that is needed to attain better health outcomes. This change management failure can cause the limited co-ownership among personnel, leading to subsequent discouragement and then disengagement.

Capacity-building failure

There is the risk that not all regional health leaders will be able to change their organizational systems, accountabilities and incentives to meet new challenges. Such scenario will result in regional organization not responsive to the needs of the municipalities to improve health outcomes.

ZFF RISKS:

Not just straightforward replication and scaling-up of HCM

Beyond replication and scaling up, ZFF's Health Change Model (HCM) must be mainstreamed and institutionalized in a significantly different environment. Thus, there may come a point when HCM must be revisited and adjusted to keep it responsive to the specific needs of main stakeholders.

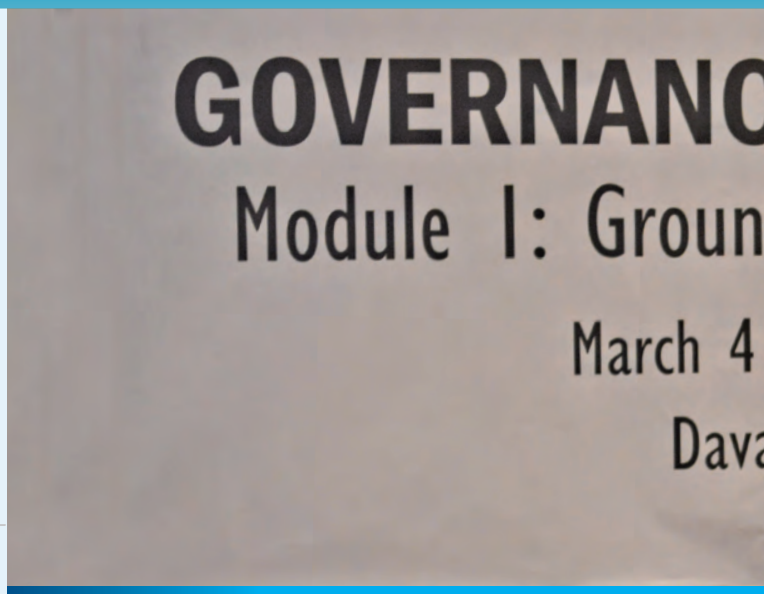
Constrained ability to support

The scale of the program inevitably led to the increased work load of ZFF's management and staff. But what is more important for ZFF is for the staff to remain committed while having the appropriate mix of skills to see the program through. Interpersonal skill is of primary importance as ZFF mainly manages its relations with the DOH and the Academic Partners.

To always be on-track to achieve the desired health outcomes, the DOH and ZFF must regularly assess the risks of HLGP implementation so as to mitigate such risks early on.

Sources:
Agerico Lacanlale, Ph.D., "Risk Assessment of ZFF Scale-up and Change Management Strategy"
Elmer Soriano, M.D., "ZFF Scale-up and Change Management Strategy"

Moving from barangay training to municipal leadership training



JOSEPHINE LITTAUA-QUIANZON
Executive Director
Institute of Primary Health Care

Under the Health Leadership and Governance Program (HLGP), academic partners provide the training component for mayors and municipal health officers (MHOs). Expectedly, the quality of teaching of these academic institutions is vital to ensure that municipal health leaders receive quality training to address the health issues and challenges they face in their municipalities. To guarantee this, the Zuellig Family Foundation provides various training programs for the faculty. The school's readiness to execute and sustain the program is regularly assessed. A monitoring and evaluation tool has likewise been designed to ensure that facilitators are competent and effective.

Among the academic institutions involved in this program is the Davao Medical School Foundation (DMSF) through its Institute of Primary Health Care, which has been involved in the training of health workers in various communities. The introduction of the leadership and governance program for mayors and municipal health officers opened new opportunities for the Institute to further its primary healthcare advocacy.

For a long time, the faculty members of the Davao Medical School Foundation (DMSF) took the "sanctity" of their local leaders' executive time seriously.

"We were happy and proud if the mayor could sit for 30 minutes with us," Cynthia Manlapus, DMSF Community Extension Services Unit Head, recalls.

"We had always assumed that the mayor was too busy to sit with us for a whole day," adds Manlapus, who also acts as Municipal Leadership and Governance Program (MLGP) coordinator.

But their perspective changed when Zuellig Family Foundation partnered with DMSF in bringing the MLGP to local health leaders—mayors and municipal health officers in particular.

"Our advocacy before was focused on helping the Regional Health Units. But with the MLGP, it has become clearer: to help our mayor through this innovative leadership program," says Josephine Littaua-Quianzon, DMSF Institute of Primary Health Care (IPHC) Executive Director.

Quianzon says that by providing them with a clearer approach in terms of leadership formation, the ZFF program has taught the DMSF-MLGP faculty how to "concretely" mobilize the local chief executive.

Through the Bridging Leadership (BL) framework, the DMSF-MLGP faculty encourages leaders to own up to their unique roles in solving the problems in their communities.

FRAMEWORK IRONS DIFFERENCES

"The concepts of ownership and co-ownership, which are emphasized in the MLGP through the BL framework, are very important. The different stakeholders should have the

same vision and 'own' it, in order to be part of the problem solution," Quianzon explains.

Manlapus agrees, revealing that the BL framework has also helped them enhance—and in some instances, repair—the relationship between the mayor and the MHO.

The DMSF-MLGP coordinator explains that sometimes, the local chief executive and MHO "clash" because they come from different political parties—a scenario that is reflective of Filipino political culture, especially in the provinces.

"Through the BL framework, the mayor and the MHO can now see themselves not as officials but as individuals and partners working toward a common goal," Manlapus says.

She happily adds that unlike before, the mayor now sits for four whole days with them—despite the local chief executive's usual busy schedule.

"We have now found the 'missing link' in our advocacy: a local chief executive who is aware that he or she is an indispensable factor in problem solution," she says.

Quianzon notes that the BL framework has helped the MLGP faculty as well, enhancing both their leadership skills and their confidence as training facilitators.

The program has also helped the DMSF staff expand their network, forging partnerships at the provincial level.

"We were really excited when we began our partnership with ZFF. As their academic partners, we wish to maintain the quality of training that ZFF has shared with us," Quianzon says.

DMSF AREAS
Davao, CARAGA and Soccsksargen

NOT ALL WILL BE EASY

The DMSF IPHC executive director adds that their role as program partners is not without challenges. As with most developing programs, DMSF has to deal with personnel and budgetary constraints.

"When we started, we were very enthusiastic in the hands-on aspect of implementing the MLGP, "Quianzon says.

However, the DMSF-MLGP faculty soon realized that they needed a full-time coordinator to oversee the program, in order for the pool of trainers to be able to focus on their tasks.

"We have to strike a balance in what we're committing to our trainees," Quianzon stresses.

The management costs that the additional manpower would entail have prevented DMSF from hiring a coordinator. But the members of the DMSF-MLGP faculty are hopeful that they would be able to do so soon.

They are also looking forward to improving their training quality through continuing faculty development.

"We really appreciate ZFF's efforts in giving us feedback on how we are facilitating the program," Quianzon adds.

In terms of sustaining the fruits of their "labors," DMSF will integrate the MLGP in the school's Masters in Community Health (as a six-unit elective) and Masters in Participatory Development (integrated in two subjects: Integrated Approaches to Development and Current Trends in Development).

The members of the DMSF-MLGP faculty are also enthusiastic about the program's positive outcome on the communities.

"By bringing down the BL framework to the community level, we foresee that the leaders will become more dynamic—enhancing the way they work," Quianzon stresses.

Other Academic Partners:

Ateneo de Zamboanga University, Benguet State University, Development Academy of the Philippines, University of the Philippines - Manila, University of the Philippines - Palo, Xavier University

Moving from programmatic approach to health system transformation

DR. ABULLAH DUMAMA JR.
DOH Regional Director-Region 11

Crucial to the success of the partnership between the Department of Health (DOH) and the Zuellig Family Foundation is for the DOH regional offices to take principal ownership of the program. With this in place, the directives and actions from these offices will have immediate and direct impacts on the provincial and municipal health systems. As heads of the regional offices, Regional Directors' (RD) active involvement in the program's activities and their accountability for the health outcomes will have significant impact on the success of the partnership program. One RD who has given his full support for the program is Dr. Abdullah Dumama of Region 11.

The road not taken is one Dr. Abdullah Dumama seldom if ever wonders about. For one, he has been kept busy over the past two decades since he began trekking the other road–one that has led him to a life of community service in public health. For another, and perhaps more importantly, he has found fulfillment along this path.

Dr. Dumama is the Department of Health (DOH) Regional Director for Region 11, in a career he chose over orthopedic surgery, which was his original goal. He might have pursued the latter, if fate had not stepped in early on.

A stint as municipal health officer (MHO) in North Upi, Maguindanao made him realize "that my fellow Muslims needed me more, especially those who were really hard up," Dr. Dumama said. Without a place to sleep in the Rural Health Unit, he requested to stay in the provincial hospital, where he became more exposed to the needs of the poor people. Being in the midst of their situation made him see that "for many of them, just having access to a doctor was already a luxury."

Dr. Dumama knows the limitations of the government and is thus well aware that every little bit of support from beyond it helps. So he welcomed the Zuellig Family Foundation (ZFF) partnership with the DOH, anticipating positive results for the region.

Regional Director Abdullah Dumama, M.D. presents to Secretary Enrique Ona (second from right) the maternal mortality ratio and infant mortality rate of Davao region provinces during a learning forum held as part of the Health Leadership and Governance Program.

Though not initially familiar with the programs of the Zuellig Family Foundation (ZFF), he knew the framework used – Bridging Leadership (BL).

"BL has taught me to immediately identify the societal divides. I can identify what the problems are, who to approach to help me solve the problem, and how to approach the problem. I know who my potential partners are, as well as what to tell them to get their involvement," he noted.

THE RIGHT APPROACH TO FIX HEALTH SYSTEM

Eventually discovering more about the program and its focus, Dr. Dumama is convinced it is the right approach, and therefore, will work.

"The difference is its focus on health leadership and governance," Dr. Dumama explained. "Before, the focus was always on manpower when talk of health system issues arises. The root of the problem was not identified."

The program gives health leaders the tools to recognize critical areas and act on them as soon as necessary. Mayors will be able to fully understand the health system and appreciate why certain health programs need to be implemented. It will also help them identify stakeholders who will be able to help them.

DOH REGIONAL OFFICERS PLAY CRITICAL ROLES

To make this program work, Dumama believes regional directors should make time for the training programs. "Presence is very important. It is a huge deal for mayors when regional directors are present in the training activities. It encourages mayors to complete the training program and pushes them to act fast."

"The DOH Reps (Department of Health representatives) are also critical," he explained. "They really need to regularly gather information and let LGUs know what is happening in their local health situation so that problems will have solutions. And given their roles, it is important to incentivize them to do their job well: give them allowances for transportation, call cards, and food."

REGION XI- DAVAO

MONUMENTAL BUT SURMOUNTABLE CHALLENGES AHEAD

Dr. Dumama knows there is a monumental task ahead of him and other health officials. But from what he has learned as a bridging leader, taking baby steps can take one further.

"To make this program sustainable, go for small wins. I did and it led me to my goals," he said. "Since mayors have limited terms, we have to give our support to the mayoralty office, whoever may be sitting in that office. We should not politicize our support."

As in any other endeavor, Dr. Dumama knows there are challenges ahead. Apart from budget, he is concerned about "the possibility of encountering resistance from those involved in the program. How do we make mayors attend and stay during the entire duration of the four-day training?"

He related that during the final selection, he asked each of the mayors if they could commit to the program. Majority of those who agreed kept their word and completed the four-day training program.

Looking back, Dr. Dumama believes that he did the right thing in sticking to public health.

"There's this unquantifiable sense of fulfilment when you serve your people, especially the poor," he said. "It gave me a real sense that I have achieved something."

Region 11-Davao Region	2012	2013
MMR	77	127
IMR	8	10

Source: Field Health Service Information System

Moving from data gatherer to LGU coach

When assigned to Daram, Samar, Genie Daradal, a DOH representative, decided to buy her own motorboat so she can visit the island-municipality more often at lesser time and cost.

At the Department of Health regional offices are DOH representatives (DOH Reps), who serve as liaison officers of the regional offices with the different municipalities under their jurisdiction. Aside from communicating national and regional health programs and policies to the local government units, DOH Reps' other duties include verifying statistical reports, ensuring program implementation and assisting municipal health leaders during planning.

Recently, a new responsibility was added to these duties–one that is crucial in ensuring that municipalities achieve improved health outcomes. DOH Reps must now be able to guide and coach mayors and municipal health officers through program implementation.

It can be a difficult task, but the outcome is always rewarding, as Deogenes "Genie" Daradal has discovered, working first as a nurse and now as a dedicated DOH Rep rising up to meet new challenges.

For a responsible health professional or health worker, "need to" is reason enough to get the job done. And "love to" is an added bonus.

"Love to" is where Deogenes "Genie" Daradal is at now, as she considers her present responsibilities as a Department of Health representative (DOH Rep), especially in the light of the partnership between the DOH and the Zuellig Family Foundation (ZFF).

FULFILLING A LONG-HELD DREAM

Daradal was a practicing nurse in Calbiga, Samar when the health department made her a DOH Rep for two municipalities in the province in 1993. It was an unexpected journey, but she chose to accept the new role, learn her tasks, and do her job as best as she could. After all, it was an opportunity to chart a career in public health, a dream she nurtured since her younger days.

Daradal recalls that it was a midwife in their community, Verginia Cabuenas, who inspired her to become one. She still looks up to and expresses deep admiration for Cabuenas, whom she describes as "my idol."

"She went around, gave vaccinations and even talked to the kids and educated them about proper health. She was kind and she really worked hard," Daradal says of Cabuenas. "When my six-month old niece had measles, she went to our house, checked on her and told us what we should do." She had witnessed a public health worker's dedication to her job and carried those memories with her when she eventually became one, she adds.

SOUTH MAQUEDA BAY HEALTH NET, SAMAR [Inter-Local Health Zone (ILHZ)]

It was not easy getting there, however. Lack of money nearly kept Daradal from pursuing her dream of being a midwife. Fortunately, her father did not let poverty stand in the way. He reached out to an elementary school classmate, Dr. Lilia Arteche, who at the time was the provincial health officer. Arteche gave Daradal a recommendation letter that opened for her the door to the University of the Philippines School of Health Sciences in Palo, Leyte, where she completed the midwifery and the nursing courses.

TRANSFORMATIVE PROGRAM

As a DOH Rep today, Daradal is thankful for the training provided by ZFF. Although the DOH has been regularly providing DOH Reps with a variety of training programs, she acknowledges, the ZFF program was life changing.

"It was not just a realization but more of a transformation, she said. "The training made me realize that I was part of the problem and so must also become part of the solution. I should be mindful of what we must accomplish to reach our goals."

Under the program, a DOH Rep's responsibility goes beyond simply liaising between mayors and municipal health officers. The partnership between ZFF and DOH offers an opportunity for DOH Reps to extend and deepen their involvement in their region's health governance.

Daradal is presently in charge of six Samar municipalities. In 2013, there were two maternal death cases *(See table on this page)*. Both occurred in the island-municipality of Daram. Classified as geographically isolated and disadvantaged area, the municipality has no road network, making travel from one village to the next difficult and costly.

With the DOH-ZFF partnership, she shares in the responsibility of making sure the Health Leadership and Governance Program (HLGP) is successful.

"I think it will be all about communicating the message with people concerned," she says of her new assignment. "I will always go back to what our goals are and what we want to achieve."

For her, DOH Reps must convince mayors and municipal health officers (MHOs) to participate in the program. And once they do, "DOH Reps must be able to do the coaching far better than what is expected of us."

NOT REALLY A NEW TASK

Coaching is a new task for DOH Reps as a result of the partnership program. But for Daradal, this is not new because she has been doing it for some time. "It was just not labeled as such and there was neither a system in place nor documentation on it."

This is why she is grateful for the HLGP because her work has become easier. First, the training program has become a venue for mayors and their MHOs to discuss and plan. This effectively eliminates the invisible wall between the two that deprived the people from getting quality health services.

Daradal said the program has also put in place a system and set of tools she can use to monitor progress and base her coaching.

"All I need to do now is look into their municipal health plans which they need to have as part of the program. Based on their plans and status reports, I can easily spot the gaps. From there, I can discuss with the mayors and MHOs on the necessary next steps."

ANTICIPATING LIKELY CHALLENGES

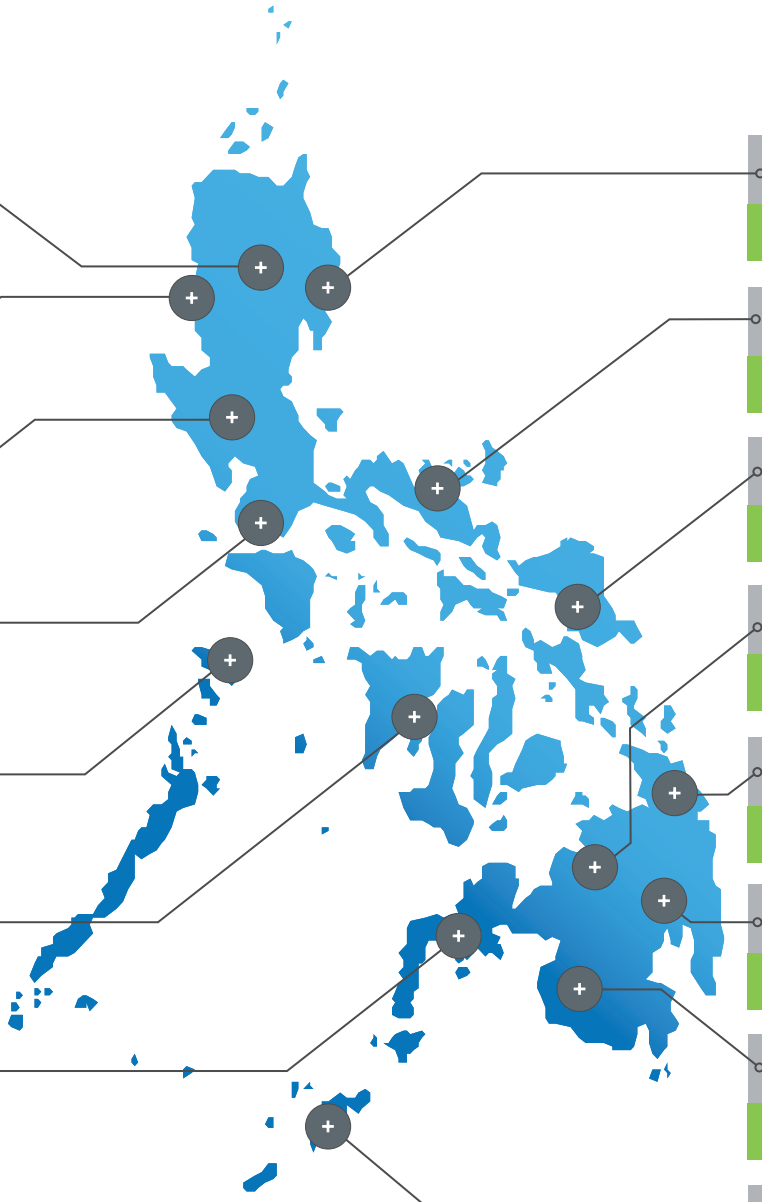
She knows there will be challenges ahead, such as getting mayors' commitment, dealing with new MHOs, smoothening ties between mayors and MHOs, etc. But she is aware of the responsibilities she must accomplish.

"I need to do these because this is my job. And I do these because I love my job – and I love the people in my community."

ILHZ health indicators			
	2011	2012	2013
MMR	79	79	93
IMR	13.0	12.2	12
FBD	40	52	73
SBA	52	73	78

Source: Field Health Service Information System

ZFF PARTNER-LOCAL GOVERNMENT UNITS, END 2013



CAR	5	14	219
REGION 1	2	2	24
REGION 3	1	1	11
REGION 4A	2	23	690
REGION 4B	4	24	458
REGION 6	2	3	42
REGION 9	3	20	456
REGION 2	1	3	61
REGION 5	5	40	1307
REGION 8	4	31	823
REGION 10	4	16	349
REGION 13	2	9	148
REGION 11 DAVAO REGION	3	19	348
REGION 12 SOCCSKSARGEN	2	9	172
ARMM	5	17	331

TOTAL		
45 PROVINCES	231 MUNICIPALITIES	5,439 BARANGAYS

THE ZUELLIG FAMILY FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE

	December 31	
	2013	2012
ASSETS		
Current Assets		
Cash and cash equivalents	**₱119,462,277**	₱98,764,468
Receivables	**236,631**	304,093
Prepayments and other current assets	**618,238**	494,865
Total Current Assets	**120,317,146**	99,563,426
Noncurrent Assets		
Property and equipment	**10,829,899**	11,664,079
Retirement asset	**824,923**	–
Total Noncurrent Assets	**11,654,822**	11,664,079
	₱131,971,968	₱111,227,505
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables	**₱29,363,153**	₱19,374,571
Deferred revenue	**18,355,451**	110,000
Due to a related party	**63,345**	279,709
Total Current Liabilities	**47,781,949**	19,764,280
Noncurrent Liability		
Retirement liability	**–**	11,571,103
Fund Balance	**84,190,019**	79,892,122
	₱131,971,968	₱111,227,505

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

THE ZUELLIG FAMILY FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF REVENUES, EXPENSES AND FUND BALANCE

	Years Ended December 31	
	2013	2012
REVENUES		
Donations	**₱137,492,538**	₱127,961,309
Reversal of accrual of retirement costs	**6,865,002**	–
Interest income	**1,211,266**	2,189,299
Others	**6,865**	2,614
	145,575,671	130,153,222
EXPENSES (INCOME)		
Donations and contributions	**27,946,806**	23,297,978
Infrastructure projects	**23,254,801**	10,711,136
Professional fees	**21,995,416**	12,258,975
Trainings and seminars	**20,784,012**	13,981,253
Salaries, wages and other benefits	**15,779,963**	13,224,523
Transportation and travel	**15,734,881**	6,216,062
Depreciation and amortization	**4,721,560**	4,049,831
Utilities	**4,435,459**	2,710,881
Materials and supplies	**4,099,464**	2,057,162
Representation and entertainment	**1,505,831**	723,711
Unrealized foreign exchange losses (gains)	**(30,714)**	119,721
Others	**1,050,295**	612,677
	141,277,774	89,963,910
EXCESS OF REVENUES OVER EXPENSES	**4,297,897**	40,189,312
FUND BALANCE AT BEGINNING OF YEAR	**79,892,122**	39,702,810
FUND BALANCE AT END OF YEAR	**₱84,190,019**	₱79,892,122

The complete audited finacial 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

BONG VILLAMOR
Director

RAMIR BLANCO, M.D.
Manager

HEIDEE EXCONDE, M.D.
Manager

TERESA FABUGAIS, MPM
Manager

JESS LORENZO, MPM
Manager

JULES BENITEZ
Associate

CATHERINE CHUNG, M.D.
Associate

ANGELI COMIA, M.D., MPM
Associate

LENA LAGON, M.D.
Associate

SHERWIN PONTANILLA, R.N, M.D.
Associate

SHERRYL SEW, M.D.
Associate

CAMILLE CHUAQUICO
Assistant

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

FAITH FAMORCAN, R.N.
Assistant

Operations

DORIE BALANOBA, M.D., MPH
Manager

JERRY JOSE
Manager

BIEN NILLOS, M.D.
Manager

JOYCE ARANDIA, M.D.
Associate

CZARINNAH ARANETA
Associate

CHARISSE CANTOR, M.D., MPM
Associate

ELLEN LICUP, M.D.
Associate

PAM LOMAAD
Associate

JENNY CHRISTY MACARAAN
Associate

JELICS NACNAC, M.D.
Associate

LIANE PUNSALAN
Associate

DONNA MEDINA, R.N.
Assistant

CATHERINE PANTI, R.M., R.N.
Assistant

Technical Services

VITO DY
Associate

ANA GO
Associate

SEALDI GONZALES
Associate

MARICAR TOLOSA
Associate

SHEN BELMONTE
Assistant

Support Group

LERMA TAN, CPA, CIA
Manager

WESLEY VILLANUEVA
Manager

JOHN TIMMY MERJUDIO, CPA
Associate

GILMER CARIAGA
Assistant

BARBARA JAMILI
Assistant

MISSION

To enhance the quality of life of the Filipino
by focusing on the achievement of targets in the country's
Millennium Development Goals for health, in partnership with
government and other stakeholders in the health sector

VISION

To be a catalyst for the achievement
of better health outcomes for the poor through sustainable
healthcare programs and services, with a primary focus on health
inequities in rural areas of the Philippines

GOALS

Empower and build the capability of
communities and individuals

Train local health leaders to establish equitable and effective
local health systems and to be responsive and accountable for
better health outcomes for the poor

Disseminate information to health leaders and professionals
as well as to healthcare institutions

Advocate equitable policies in public health

Form partnerships with other agencies

Establish better access to affordable, high-quality essential
medicines for poor communities

This Annual Report was 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 2013 audited financial statements are contained in the CD. The Report may also be downloaded from our website, www.zuelligfoundation.org.

ZUELLIG FAMILY FOUNDATION

Duly certified as a development agency by the
Department of Social Welfare and Development (DSWD)
and accredited by the Philippine Council for NGO Certification (PCNC)

Km. 14 West Service Road corner Edison Avenue
Barangay Sun Valley, Parañaque City 1700, Philippines
Tel. No. (632) 821-4332, 821-4428, 821-3329
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ZUELLIG FAMILY FOUNDATION

FINANCIAL STATEMENTS

ANNUAL REPORT 2013

The Zuellig Family Foundation, Inc.
(A Nonstock, Nonprofit Corporation)
INDEPENDENT AUDITORS' REPORT

The Board of Trustees
The Zuellig Family Foundation, Inc.

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, 2013 and 2012, 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.

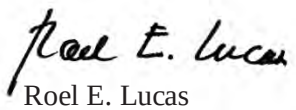
Opinion

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, 2013 and 2012, 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 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 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-AR-1 (Group A),
March 4, 2014, valid until March 3, 2017
Tax Identification No. 191-180-015
BIR Accreditation No. 08-001998-95-2014,
January 22, 2014, valid until January 21, 2017
PTR No. 4225185, January 2, 2014, Makati City

April 30, 2014

The Zuellig Family Foundation, Inc.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE

	December 31	
	2013	2012
ASSETS		
Current Assets		
Cash and cash equivalents (Note 4)	**₱119,462,277**	₱98,764,468
Receivables (Note 5)	**236,631**	304,093
Prepayments and other current assets	**618,238**	494,865
Total Current Assets	**120,317,146**	99,563,426
Noncurrent Assets		
Property and equipment (Note 6)	**10,829,899**	11,664,079
Retirement asset (Note 10)	**824,923**	–
Total Noncurrent Assets	**11,654,822**	11,664,079
	₱131,971,968	₱111,227,505
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables (Note 7)	**₱29,363,153**	₱19,374,571
Deferred revenue (Notes 8 and 9)	**18,355,451**	110,000
Due to a related party (Note 8)	**63,345**	279,709
Total Current Liabilities	**47,781,949**	19,764,280
Noncurrent Liability		
Retirement liability (Note 10)	**–**	11,571,103
Fund Balance	**84,190,019**	79,892,122
	₱131,971,968	₱111,227,505

See accompanying Notes to Financial Statements.

The Zuellig Family Foundation, Inc.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF REVENUES, EXPENSES AND FUND BALANCE

	Years Ended December 31	
	2013	2012
REVENUES		
Donations (Note 8)	**₱137,492,538**	₱127,961,309
Reversal of accrual of retirement costs (Note 10)	**6,865,002**	–
Interest income (Note 4)	**1,211,266**	2,189,299
Others	**6,865**	2,614
	145,575,671	130,153,222
EXPENSES (INCOME) (Note 9)		
Donations and contributions	**27,946,806**	23,297,978
Infrastructure projects	**23,254,801**	10,711,136
Professional fees	**21,995,416**	12,258,975
Trainings and seminars	**20,784,012**	13,981,253
Salaries, wages and other benefits	**15,779,963**	13,224,523
Transportation and travel	**15,734,881**	6,216,062
Depreciation and amortization (Note 6)	**4,721,560**	4,049,831
Utilities (Note 8)	**4,435,459**	2,710,881
Materials and supplies	**4,099,464**	2,057,162
Representation and entertainment	**1,505,831**	723,711
Unrealized foreign exchange losses (gains)	**(30,714)**	119,721
Others	**1,050,295**	612,677
	141,277,774	89,963,910
EXCESS OF REVENUES OVER EXPENSES	**4,297,897**	40,189,312
FUND BALANCE AT BEGINNING OF YEAR	**79,892,122**	39,702,810
FUND BALANCE AT END OF YEAR	**₱84,190,019**	₱79,892,122

See accompanying Notes to Financial Statements.

The Zuellig Family Foundation, Inc.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF CASH FLOWS

	Years Ended December 31	
	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES		
Excess of revenues over expenses	**₱4,297,897**	₱40,189,312
Adjustments for:		
Reversal of accrual of retirement costs (Note 10)	**(6,865,002)**	–
Depreciation and amortization (Note 6)	**4,721,560**	4,049,831
Interest income (Note 4)	**(1,211,266)**	(2,189,299)
Unrealized foreign exchange losses (gains)	**(30,714)**	119,721
Operating revenues before working capital changes	**912,475**	42,169,565
Decrease (increase) in:		
Receivables	**67,462**	(52,887)
Prepayments and other current assets	**(123,373)**	(92,727)
Increase (decrease) in:		
Accrued expenses and other payables	**9,988,582**	1,159,571
Deferred revenue	**18,245,451**	110,000
Due to a related party	**(216,364)**	46,969
Net cash generated from operations	**28,874,233**	43,340,491
Contributions to retirement fund	**(5,531,024)**	–
Interest received	**1,211,266**	2,192,929
Net cash provided by operating activities	**24,554,475**	45,533,420
CASH FLOW FROM AN INVESTING ACTIVITY		
Additions to property and equipment (Note 6)	**(3,887,380)**	(8,125,342)
NET INCREASE IN CASH AND CASH EQUIVALENTS	**20,667,095**	37,408,078
EFFECT OF FOREIGN EXCHANGE RATE CHANGES ON CASH AND CASH EQUIVALENTS	**30,714**	(119,721)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	**98,764,468**	61,476,111
CASH AND CASH EQUIVALENTS AT END OF YEAR (Note 4)	**₱119,462,277**	₱98,764,468

See accompanying 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 2013 and 2012.

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 (BIR). 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 April 30, 2014

2. Summary of Significant Accounting Policies

The significant accounting policies and practices applied in the preparation of these financial statements are set forth to facilitate the understanding of data presented in the financial statements.

Basis of Preparation
The financial statements have been prepared using the historical cost basis. The financial statements are presented in Philippine peso which is the Foundation's functional and presentation currency 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 BIR, 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. No restriction is attached to cash account.

Receivables

Receivables, which are based on normal credit terms and do not bear interest, are recognized and carried at transaction price. Where credit is extended beyond normal credit terms, receivables are measured at amortized cost using the effective interest method less provision for impairment. 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 the statement of revenues, expenses and fund balance.

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 the statement of revenues, expenses and fund balance for the period.

Prepayments

Prepayments are expenses paid in cash and recorded as assets before they are used or consumed, as the service or benefit will be received in the future. Prepayments expire and are recognized as expenses either with the passage of time or through use or consumption.

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.

Subsequent expenditures relating to an item of property and equipment that have already been recognized are added to the carrying amount of the asset when it is probable that future economic benefits, in excess of the originally assessed standard of performance of the existing asset, will flow to the Foundation.

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

The useful lives, depreciation and amortization method are reviewed periodically to ensure the period and method of depreciation and amortization are consistent with the expected pattern of economics benefits from items of property and equipment. 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.

Fully depreciated assets are retained in the accounts until they are no longer in use and no further charge for depreciation is made in respect of those assets.

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, the Foundation assesses whether there is any indication that any of its assets that are subject to depreciation or amortization may have suffered an impairment loss. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss, if any. When it is not possible to estimate the recoverable amount of an individual asset, the Foundation estimates the recoverable amount of the cash-generating unit to which the asset belongs. When a reasonable and consistent basis of allocation can be identified, assets are also allocated to individual cash-generating units, or otherwise they are allocated to the smallest group of cash-generating units for which a reasonable and consistent allocation basis can be identified.

Recoverable amount is the higher of fair value less costs to sell and value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset for which the estimates of future cash flows have not been adjusted.

If the recoverable amount of an asset or cash-generating unit is estimated to be less than its carrying amount, the carrying amount of the asset or cash-generating unit is reduced to its recoverable amount. An impairment loss is recognized as an expense.

When an impairment loss subsequently reverses, the carrying amount of the asset or cash generating unit is increased to the revised estimate of its recoverable amount, but only to the extent of the carrying amount that would have been determined (net of any depreciation) had no impairment loss been recognized for the asset or cash-generating unit in prior years. A reversal of an impairment loss is recognized 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:

Donations. The Foundation recognizes donations, including unconditional promises to give, as revenue in the period received. Donations which are restricted and deferred for future projects are shown separately in the statement of assets, liabilities and fund balance as “Deferred revenue.”

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 on the basis of:

a. a direct association between the costs incurred and the earning of specific items of income

b. systematic and rational allocation procedures when economic benefits are expected to arise over several accounting periods and the association with income can only be broadly or indirectly determined; or

c. immediately when an expenditure produces no future economic benefits or when, and to the extent that future economic benefits do not qualify, or cease to qualify, for recognition in the statement of assets, liabilities and fund balance

Retirement Costs

The Foundation has a funded, non-contributory defined benefit plan covering all regular employees. Retirement costs are actuarially determined using the projected unit credit method and incorporates assumptions concerning employees' projected salaries. The retirement cost is recognized during the employees' period of service and discounted using market yields on government bonds. Actuarial gains and losses are recognized as part of profit or loss in the statement of revenues, expenses and fund balance for the period.

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 2013 and 2012 amounted to ₱119.1 million and ₱72.0 million, respectively, while general and administrative expenses in 2013 and 2012 amounted to ₱22.2 million and ₱18.0 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.

There is no change in the estimated useful lives of property and equipment in 2013. 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.

The carrying value of property and equipment amounted to ₱10.8 million and ₱11.7 million as of December 31, 2013 and 2012, 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 the 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, 2013 and 2012. The carrying value of property and equipment amounted to ₱10.8 million and ₱11.7 million as of December 31, 2013 and 2012, 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's retirement liability amounted to nil and ₱11.6 million as of December 31, 2013 and 2012, respectively (see Note 10).

4. Cash and Cash Equivalents

This account consists of:

	2013	2012
Cash on hand and in banks	**₱36,318,855**	₱13,379,143
Short-term placements	**83,143,422**	85,385,325
	₱119,462,277	₱98,764,468

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 ₱1.2 million and ₱2.2 million in 2013 and 2012, respectively.

5. Receivables

This account consists of:

	2013	2012
Receivables from:		
Social Security System	**₱69,000**	₱–
Suppliers	**58,703**	192,660
United Nations Population Fund (UNFPA)	**50,818**	–
Employees	**41,410**	111,433
Others	**16,700**	–
	₱236,631	₱304,093

a. Receivables from program partners and suppliers are noninterest-bearing and are generally on a 30 to 120-day term.

b. Receivables from officers and employees pertain to cash advances which are subject to liquidation.

c. Other receivables are due for settlement within the following year.

6. Property and Equipment

This account consists of:

	2013				
	Transportation Equipment	**Office Equipment**	**Furniture and Fixtures**	**Office Improvements**	**Total**
Cost					
Balance at beginning of year	**₱4,767,530**	**₱10,622,097**	**₱2,640,568**	**₱3,788,464**	**₱21,818,659**
Additions	**900,000**	**1,177,024**	**37,280**	**1,773,076**	**3,887,380**
Balance at end of year	**5,667,530**	**11,799,121**	**2,677,848**	**5,561,540**	**25,706,039**
Accumulated Depreciation and Amortization					
Balance at beginning of year	**2,987,508**	**4,225,716**	**1,969,624**	**971,732**	**10,154,580**
Depreciation and amortization (see Note 9)	**735,275**	**2,247,590**	**263,413**	**1,475,282**	**4,721,560**
Balance at end of year	**3,722,783**	**6,473,306**	**2,233,037**	**2,447,014**	**14,876,140**
Net Book Value	**₱1,944,747**	**₱5,325,815**	**₱444,811**	**₱3,114,526**	**₱10,829,899**

	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

7. Accrued Expenses and Other Payables

This account consists of:

	2013	2012
Accrued expenses	**₱28,111,439**	₱16,036,208
Due to government agencies	**1,230,257**	1,296,692
Other payables	**21,457**	2,041,671
	₱29,363,153	₱19,374,571

Accrued expenses pertain to payable to contractors, unpaid utilities, materials and supplies and professional fees. 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. Such amount was settled on January 29, 2013.

Accrued expenses, due to government agencies 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 (in millions)	Outstanding Balance	Terms	Conditions
Zuellig Group, Inc.	Donations (a)	**2013**	**₱104.4**	**₱–**	None	Unrestricted
		2012	119.9	–		
David Zuellig	Donations (b)	**2013**	**2.1**	**2.1**	None	Restricted
		2012	–	–		
Roberto R. Romulo	Donations (b)	**2013**	**1.1**	**1.1**	None	Restricted
		2012	0.1	0.1		
Christopher Zuellig	Donations (b)	**2013**	**1.1**	**1.1**	None	Restricted
		2012	–	–		
Thomas Zuellig	Donations (b)	**2013**	**1.1**	**1.1**	None	Restricted
		2012	–	–		
Daniel Zuellig	Donations (b)	**2013**	**1.1**	**1.1**	None	Restricted
		2012	–	–		
Stephanie Zuellig	Donations (b)	**2013**	**1.1**	**1.1**	None	Restricted
		2012	–	–		
Joan Zuellig	Donations (b)	**2013**	**0.3**	**0.3**	None	Restricted
		2012	–	–		
Zuellig Pharma Corporation (ZPC)	Donations (b)	**2013**	**0.7**	**0.7**	None	Restricted
		2012	0.5	–		
	Share in utilities (c)	**2013**	**0.6**	**0.1**	90 days upon receipt of billings; noninterest-bearing	Unsecured
		2012	0.7	0.3		

a. 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.

b. These donations are intended for the victims of Typhoon Haiyan in the Visayas areas. The donations were restricted and earmarked for relief and recovery operations. The amount, which will be utilized in 2014, is shown as part of "Deferred revenue" account in the 2013 statement of assets, liabilities and fund balance. The amount of deferred revenue in 2012 represents the donation received from Roberto R. Romulo (member of the BOT) that was earmarked for 2013 activities.

c. 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, 2013 and 2012 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 as at December 31, 2013 and 2012:

	2013		
	Project Expenses	**General and Administrative Expenses**	**Total**
Donations and contributions	**₱27,831,806**	**₱115,000**	**₱27,946,806**
Infrastructure	**23,254,801**	**–**	**23,254,801**
Professional fees	**17,597,881**	**4,397,535**	**21,995,416**
Trainings and seminars	**19,862,560**	**921,452**	**20,784,012**
Salaries, wages and other benefits	**9,461,127**	**6,318,836**	**15,779,963**
Transportation and travel	**14,271,417**	**1,463,464**	**15,734,881**
Depreciation and amortization (see Note 6)	**–**	**4,721,560**	**4,721,560**
Utilities (see Note 8)	**1,946,122**	**2,489,337**	**4,435,459**
Materials and supplies	**3,444,271**	**655,193**	**4,099,464**
Representation and entertainment	**1,132,361**	**373,470**	**1,505,831**
Others	**277,085**	**773,210**	**1,050,295**
	₱119,079,431	**₱22,229,057**	**₱141,308,488**

	2012		
	Project Expenses	General and Administrative Expenses	Total
Donations and contributions	₱23,277,978	₱20,000	₱23,297,978
Trainings and seminars	13,713,720	267,533	13,981,253
Salaries, wages and other benefits	6,818,836	6,405,687	13,224,523
Professional fees	7,274,750	4,984,225	12,258,975
Infrastructure projects	10,711,136	–	10,711,136
Transportation and travel	6,069,223	146,839	6,216,062
Depreciation and amortization (see Note 6)	–	4,049,831	4,049,831
Utilities (see Note 8)	1,462,342	1,248,539	2,710,881
Materials and supplies	1,873,795	183,367	2,057,162
Representation and entertainment	622,563	101,148	723,711
Unrealized foreign exchange losses	–	119,721	119,721
Others	176,165	436,512	612,677
	₱72,000,508	₱17,963,402	₱89,963,910

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.

Pregnancy Tracking System. To help establish improved health information system in municipalities through the installation and application of pregnancy tracking system, the Foundation rolled out Wireless Access for Health (WAC) in partner municipalities. This will improve health care delivery through the optimal use of information to provide a reliable health data transmission by health centers for faster decision-making and timely health intervention by decision makers in public health and rural health units.

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 personal and community level, 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.

Health Leadership and Governance Program (HLGP). A joint initiative with the Department of Health (DOH) to strengthen the leadership and governance capabilities of the local chief executives and public health professionals to address the health system challenges. The program will bolster the capacities and commitments of regional and local health and other agencies, including the academe, to support local health systems. 609 local governments identified by the National Anti-Poverty Commission (NAPC) will receive leadership and governance program in ZFF accredited universities.

Also, the Foundation entered into a three-year partnership with the United States Agency for International Development (USAID) to implement the HLGP program. This aims to improve health outcomes on maternal and child health (MCH), family planning and reproductive health(FP/RH) and tuberculosis in 121 LGUs.

Strengthening Provincial and Municipal Champions in Health Program with UNFPA. 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.

Merck Sharp & Dohme-Merck for Mother Global Giving Program. The program aims to develop the health leadership and governance, strengthen the local health systems and improve community participation and health-seeking behavior of women and mothers living in the 21 municipalities that are classified as Geographically Isolated and Disadvantaged Areas (GIDAs) in the provinces of Samar.

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 2,607 pupils in public elementary schools in 13 municipalities are being served daily lunch while their parents are being educated on cooking, budgeting, health and nutrition.

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 initiated relief and recovery operations in affected municipalities of super typhoon Haiyan. Relief packs containing food, water and hygienic kits were distributed to households in municipalities of 20,121 families in the province of Capiz and Eastern Samar. Also, the Foundation conducted medical missions in Capiz and donated medicines to partner-municipalities in Samar provinces.

Out of the total donations received, ₱18.4 million will be utilized in 2014 for health and livelihood recovery programs in affected municipalities in Eastern Samar municipalities. This is shown as “Deferred Revenue” in the statement of assets, liabilities and fund balance.

The Foundation also distributed consumable and non-consumable kits for the victims of Typhoon Pablo and Zamboanga standoff.

Peace and Equity Fund. A research study to document the practices of social enterprises in the health sector, which will be used to formulate lending policies for social enterprise

PHAPCares and MeTA. A tripartite agreement with two groups for the development and conduct of a workshop on “Leadership, Governance and Transparency in Pharmaceutical Management for LGUs.”

Sydney Medical School-The University of Sydney Australia (SMS USYD). The Foundation accepted a two student interns in December 2013 as they worked for eight weeks on research protocols based on their topics.

10. **Retirement Costs**

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

The Foundation's retirement liability (asset) is based on an actuarial valuation as of December 31, 2013, as follows:

Present value of defined benefit obligation	₱4,693,333
Fair value of plan assets	(5,565,442)
Asset ceiling/limit	47,186
Retirement benefit plan asset	(₱824,923)

Retirement expense for the year ended December 31, 2013 consists of:

Current service cost	₱1,594,674
Interest cost	231,869
Actuarial gain	(1,593,445)
Past service cost:	
Non-vested	489,817
Vested	214,182
Changes in the effect of the asset ceiling	47,186
Total	984,283
Reversal of accrual of retirement costs	(984,283)
Retirement expense	₱–

Details of retirement benefit liability in 2013 are as follows:

Balance at beginning of year	₱11,571,103
Current service cost	1,594,674
Interest cost	231,869
Past service cost:	
Non-vested	489,817
Vested	214,182
Actuarial gain	(1,559,027)
Total	12,542,618
Reversal of accrual of retirement costs	(7,849,285)
Balance at end of year	₱4,693,333

Changes in the fair value of plan assets in 2013 are as follows:

Balance at beginning of year	₱–
Contribution made	5,531,024
Actuarial gain	34,418
Balance at end of year	₱5,565,442

Reconciliation of retirement liability (asset) in the 2013 statement of assets, liabilities and fund balance is as follows:

Balance at beginning of year	₱11,571,103
Actual contribution made	(5,531,024)
Reversal of accrual of retirement costs	(6,865,002)
Balance at end of year	(₱824,923)

The principal assumptions used in determining retirement benefits for the year ended December 31, 2013 are as follows:

Discount rate	5.72%
Expected return on plan assets	1.15%
Expected rate of salary increase	10.00%

11. Supplementary Information Required Under Revenue Regulations 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.

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	Amount
Business permit	98207837	January 16, 2013	₱17,711
Community tax certificate	00056318 and 14944667	January 16, 2013	2,005
Others	Various	various	14,496
			₱34,212

b. Withholding Taxes

Expanded withholding taxes	₱3,468,510
Withholding taxes on compensation and benefits	3,039,642
	₱6,508,152