



**ZUELLIG FAMILY
FOUNDATION**

Annual Report 2015

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VISION:

To be a catalyst for the achievement of better health outcomes for the poor by strengthening leadership and governance, with primary focus on rural communities and secondarily, urban poor communities, in the Philippines

MISSION:

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

GOALS:

1. All trained local health leaders have improved bridging leadership competencies.
2. All trained local health leaders are able to strengthen local health systems with equitable and sustainable community-driven arrangements for better health outcomes.
3. Lessons learnt and evidences are disseminated to advocate for equitable policies in public health and governance.
4. Partnerships with government and other stakeholders are formed to support and institutionalize leadership and local health system developments.



Bridges and Leaders

Alilem in Ilocos Sur occupies an interior upland area in the southern part of the province. Several hanging bridges dot the municipality to connect the village proper and town center to the different *sitios* (sub-villages). It had a high rate of home births and a low rate of skilled birth attendant (SBA) deliveries. To address these, Mayor Ruel Sumabat held dialogues with his municipal leaders so they could allot a higher budget for health. He personally visited villages to talk to his people. Winning support from internal and external partners, the local government has managed to hire additional midwives, build a halfway maternal shelter adjacent to its 4-in-1 PhilHealth-accredited facility, and establish emergency transport system in every village. Alilem's rate of facility-based deliveries increased from 72 percent in 2013 to 96 percent in 2015. Its SBA also increased in the same period from 75 percent to 96 percent. It recorded no maternal death from 2013 to 2015.

2015 SNAPSHOTS

640

NUMBER OF CITIES AND
MUNICIPALITIES WITH
ZFF HEALTH CHANGE MODEL:

33

PARTNER
PROVINCES

11

LUZON

6

VISAYAS

16

MINDANAO

35M

POPULATION OF
CITIES AND MUNICIPALITIES

37

COMPLETED FACILITIES
IN 28 MUNICIPALITIES

3

ONGOING CONSTRUCTION
IN 3 MUNICIPALITIES

12

ACADEMIC
PARTNERS

223

FACULTY
TRAINED

242

DEPARTMENT
OF HEALTH
DEVELOPMENT
MANAGEMENT
OFFICERS
TRAINED

MESSAGE FROM THE BOARD OF TRUSTEES



David Zuellig • Esperanza I. Cabral, M.D. • Daniel Zuellig • Washington Z. SyCip • Roberto R. Romulo, Chairman

Closing a cycle, increasing national influence

The year 2015 was very significant to us in the Zuellig Family Foundation. This was the year we marked the end of our first three-year operational cycle, during which we wanted to employ our strategy, the ZFF “Health Change Model” (HCM) in 300 local government units (LGUs). At 640 LGUs, we ended the cycle with 340 more. In fact, even our 10-year plan (2013-2022) target of 485 was exceeded.

This year also marked the end of the Millennium Development Goals. While numbers have yet to be finalized, the general consensus was that our country failed to hit the maternal mortality ratio (MMR) target.

Since we piloted our Health Change Model in 2009, we used MMR as basis to measure our success because it was a good indicator of how well the primary healthcare system was functioning. And it proved difficult to reduce nationally. Our trustee, Dr. Manuel Dayrit, had said that for over two decades, the country’s MMR figures have been flat with mean values falling between 110 and 130. He based this on the compiled data of the World Health Organization Global Health Observatory.

While the country’s failure to bring down its MMR to the ideal is unfortunate, we are confident the country will show marked improvements in the coming years.

BRIGHTER PROSPECTS AHEAD FOR HEALTH

We have seen our health leadership and governance training turn mayors into health champions. They collaborated with different stakeholders, harmonized differences, initiated health system reforms, and introduced health innovations.

In our LGUs where we saw mayors and municipal health officers (MHOs) strengthen ownership of their people’s health outcomes, health information systems improved. As a result, pregnant women are being tracked to make sure the LGUs know who needs natal checks; who is about to deliver; who needs hospital care; and who needs added support to reach healthcare facilities. Fewer mothers fall through the cracks.

Local chief executives have better appreciation of Philippine Health Insurance Corp. (PhilHealth). They are making the necessary investments to have their facilities PhilHealth-accredited to receive



Ernesto D. Garilao, President • Manuel M. Dayrit, M.D. • Francisco R. Billano • Kasigod V. Jamias, Treasurer • Reiner W. Gloor

capitation and reimbursements. Patients, especially PhilHealth members, are assured of receiving quality healthcare services for free. This is because accreditation requires standards in health personnel and health facilities. In our 72 prototype LGUs, where we piloted our Health Change Model, 46 have at least three accreditations: primary care, maternity care, and tuberculosis.

As a result of these developments, we have seen a growing number of our prototype LGUs reporting zero maternal death. In 2015, 43 LGUs had no maternal death, up from 37 LGUs in 2014 (see *Chart 1 on page 4*).

Success in our prototype LGUs prompted us to recognize in November 2015 some of the LGUs for sustained improvements in health outcomes. Some mayors and MHOs also received recognition for showing exemplary health leadership. Winning the top honors was the municipality of Tinambac, Camarines Sur. In the latter part of this report, you will know why it deserved the award.

We also found success beyond our prototype LGUs with the help of our partners, the United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), United Nations

Children's Fund (UNICEF), MSD for Mothers, and the Department of Health (DOH).

You will find in this report the stories of leadership transformations across the different levels of the health system: regional, provincial and municipal. After undergoing the "bridging leadership" process of ownership, co-ownership and co-creation, these leaders have become fully accountable for the health of their people.

We have regional leaders who made sure more mayors and MHOs receive the DOH-ZFF leadership and governance training so they, too, would know how a change within themselves can drive improvements in complex systems like health. We have provincial leaders whose support led to much-needed reforms in hospitals, where most maternal deaths occurred. We have mayors who have banded together to strengthen the health service delivery network in their areas.

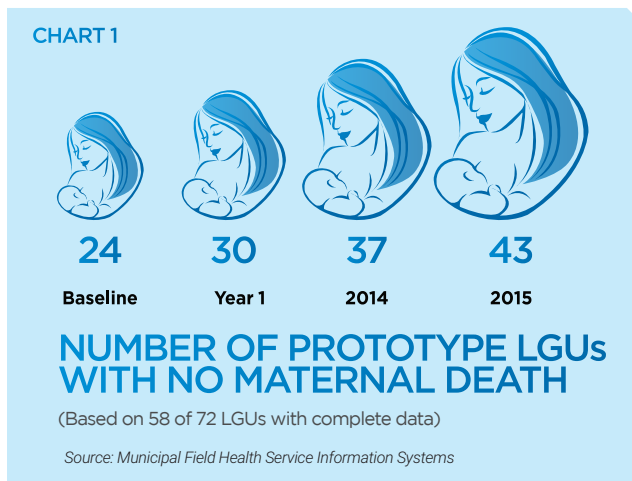
Their stories here are but a small fraction of all the heartwarming stories we have known, heard and witnessed.

STICKING TO OUR APPROACH AMID MORE CHALLENGES

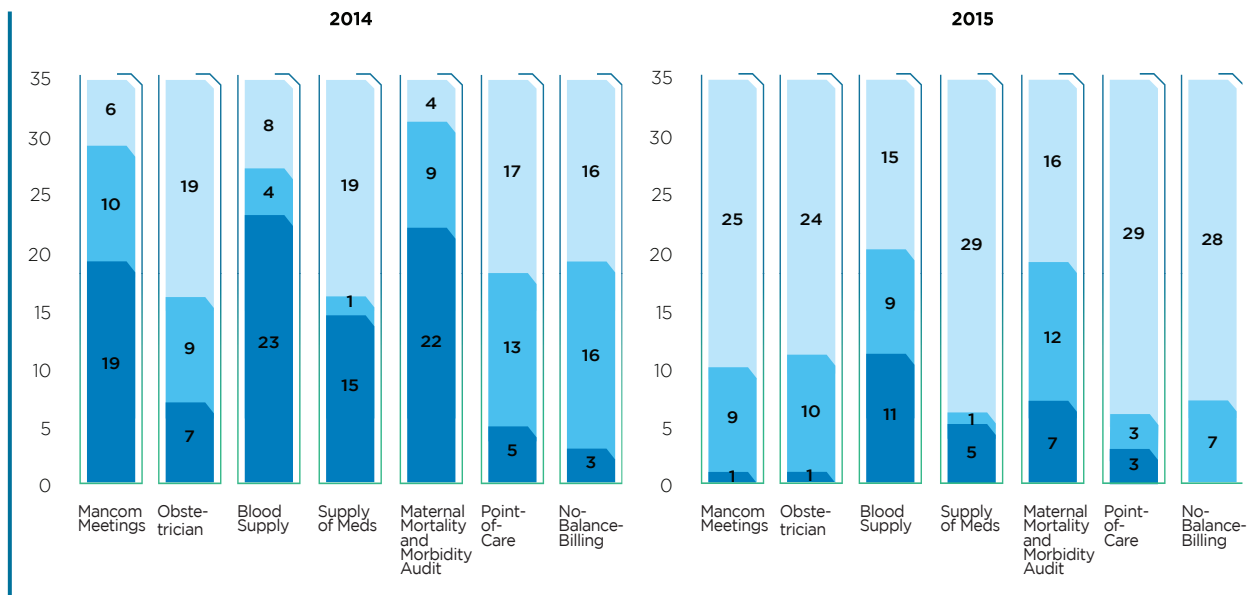
It is these transformations that encourage us to continue developing leaders who will bridge divides so health inequities will be reduced. While we still primarily focus on rural municipalities, we will also work in selected cities. Our partnerships enabled us to work with city governments. And we expect increasing health disparities with the growing movement of people to urban areas.

In 2014, a pattern emerged in our partner LGUs. Most maternal deaths were occurring in hospitals over which our mayors no longer had authority over. We then began working with the provincial health leaders. With our DOH partnership, our intervention got a boost from the regional offices. Reforms were focused on seven factors, including having an obstetrician and blood supply at all times. We are happy to note that most of the 35 hospitals we monitored in 33 provinces have made significant strides in all seven areas (see Charts 2 and 3).

We know the same issues exist and persist in other provinces so, among our next steps is to help our partner LGUs build a strong health service delivery network. This network will ensure patients get properly referred to higher level of care, whether between barangay and municipal health, or municipal and provincial. At any level, the receiving facility will be prepared to adequately handle the patient. Ideally, this network will also involve private health facilities.



CHARTS 2 AND 3. 2014 AND 2015 SCORECARD OF 35 HOSPITALS IN ZFF'S 33 PROVINCES



To address hospital challenges that contribute to maternal deaths, reforms were focused on seven critical factors. These include the need for the 24/7 availability of an obstetrician and safe blood supply. The chart shows the number of hospitals that **have met the targets** under each critical indicator, **still need improvements**, and **have yet to make improvements**.



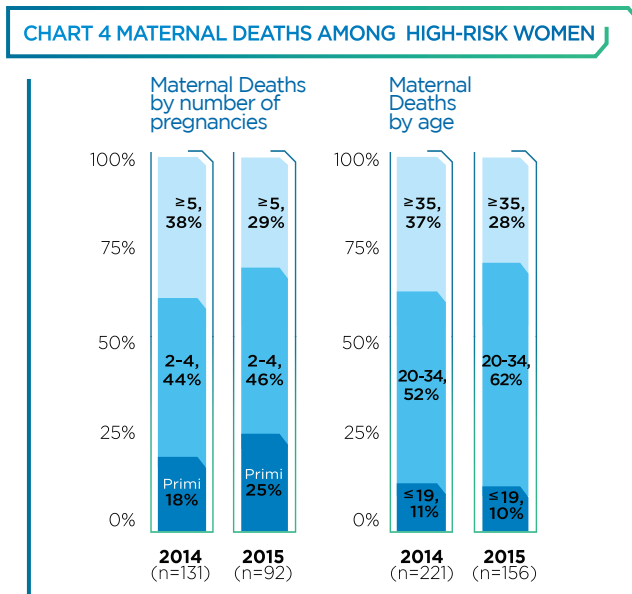
Source: Data from chiefs of hospitals

REPRODUCTIVE HEALTH AMONG YOUNG AND OLD

Another growing concern is death among high-risk women. These are women aged 19 and below, over 35 years, or those who have had five or more children (see Chart 4). We agree we need a strengthened reproductive health and family planning (RHFP) program. In many of our areas, increasing teenage pregnancies is also alarming. With our partners like the DOH, USAID, UNFPA and Commission on Population, we will continue to help our LGUs build a functional system to improve RHFP program implementation that will include the education of our youth. We need to have families that are informed of their choices and the youth know of the consequences of early parenthood.

SHARING LESSONS LEARNED

Expect us to also share more of what we have learned to stakeholders and the general public. We will do these through the distribution of research and learning materials. We will also hold conferences and discussions to promote our health advocacies. These will be available to anyone interested. We have always maintained an open policy on our training materials and knowledge products. The better it is to have more stakeholders armed with information and skills to improve health. And thus, as we continue implementing our strategy, it is incumbent upon us at the Foundation to keep improving our training programs and develop new ones to meet emerging challenges.



Source: Maternal death reviews of ZFF's partner local government units

WE ARE GRATEFUL

As we forge ahead, this time to help the nation meet its Sustainable Development Goals on health, let us first acknowledge the people and groups that made it possible for our Health Change Model to work and flourish.

Our management and staff have accomplished what we knew would be a daunting task. They had to work with hundreds of leaders, handhold them as transitions were being made in their agencies or areas, regularly keep tabs of progress and challenges, and continually create and co-create solutions to make sure our interventions work.

We are very grateful for all they have done, for clinging to their ideals and values, and for not giving up when our journey got tough.

We thank our program and resource partners* for trusting our strategy can make a difference in local health leadership and systems. In particular, we acknowledge former Health Secretary Enrique Ona. He saw value in our Health Change Model and was actively involved in the discussions that led to the DOH-ZFF partnership program. His call to support this joint initiative led to our partnerships with USAID and UNICEF.



Left to right: Former Health Secretary Enrique Ona, ZFF chairman Roberto Romulo, ZFF president Ernesto Garilao and ZFF trustee Daniel Zuellig

We are grateful for our partners' knowledge, expertise and oversight. These strengthened our capacities, improved our internal systems, and prepared us to meet more challenges ahead.

And as we thank our current partners for working with us, we will continue to seek those who share our vision of achieving better health outcomes for the poor through leadership and governance strengthening.

We hope, like us, many more individuals and groups will be inspired to continue taking part in our efforts to find and develop leaders who put their people's interests before their own, and maximize their capacities to improve the lives of their constituents.

*PROGRAM PARTNERS 162 to 52 Coalition • Association of Foundations • Commission on Population • Department of Health • Kristian G. Jebson Foundation • League of Corporate Foundations • Manila Observatory • Medicines Transparency Alliance Philippines • MSD for Mothers • Tabang Visayas • United Nations Children's Fund • United Nations Population Fund • United States Agency for International Development • University Of Makati • University of Sydney School of Public Health • Zamboanga Alliance

*RESOURCE PARTNERS B. Braun Medical Supplies Inc. • CARD-MRI • Center for Community Transformation • Consuelo Foundation • East West Seed Foundation Inc. • Jollibee Foundation • Metro Drug • Netsuite.org • Panasonic HQ for Solar Lantern Project • Peace And Equity Foundation • Pfizer Philippines • PHAPCares Foundation • Philippine Nurses Association of America • ROK Water • Solar Energy Foundation Philippines • Synergeia • US - Philippines Society • Vitamin Angels • Wireless Access for Health • Zuellig Pharma

PARTNERSHIP: IT'S ABOUT ADDING VALUE TO EACH OTHER

When Zuellig Family Foundation (ZFF) was just starting in 2008, it had originally set its sights on just having 50 rural municipalities undergo its strategic intervention. But its success in its initial sets of municipalities gave ZFF the confidence its approach was worth expanding and replicating.

Doing so required program partners that shared ZFF's vision for the health of the Filipino poor. Fortunately, partners found merit in what it does.

What ZFF does for the health of the poor

And what does ZFF primarily do? It provides training aimed at transforming mayors into responsive leaders addressing the health needs of their people. To know if leaders are being transformed, ZFF checks on them and the developments in their areas as shown by their health indicators and specific targets outlined in the roadmaps ZFF supplies. The Foundation also coaches them in between their training modules.

What ZFF does to help reduce health inequities in the country is neither easy nor easy to grasp for some. How can training in health leadership and governance produce better health outcomes? Health leadership and governance is actually one of the six building blocks of a health system identified by the World Health Organization (WHO). Focus on this block is very important especially since health is devolved to local government units (LGUs), whose mayors are often not well-versed in health systems and have limited resources to use for different socioeconomic concerns.

In ZFF, the bridging leadership framework is used for its training, while measuring progress in the LGU is seen through a technical roadmap containing pre-defined targets under each of these building blocks: leadership and governance, financing, health information system, access to medicines, personnel, and service delivery. The roadmap tells ZFF where its leaders need more help, and this is where coaches can be very helpful.

Program partners

It was in 2012 when ZFF forged its first partnership with a multilateral development agency. The **United Nations Population Fund (UNFPA)** partnered with ZFF to bring its health leadership and governance program in their nine priority provinces and municipalities. The partnership also led ZFF to introduce and strengthen its interventions on **reproductive health and family planning**.

In 2013, the **MSD for Mothers** came as a partner to improve the **health of mothers** in 20 **geographically isolated and disadvantaged areas** (GIDAs) in the provinces of Samar and Northern Samar.

ZFF also forged agreements with the **United Nations Children's Fund (UNICEF)** and the **United States Agency for International Development (USAID)**. Both partnerships allowed ZFF to work with city governments. The USAID partnership got ZFF to also incorporate **tuberculosis prevention and control** in its interventions. With UNICEF, LGUs were introduced to **evidence-based planning**, while Eastern Samar and Samar LGUs affected by super typhoon Haiyan (local name: Yolanda) underwent training to develop their respective **health system resiliency plans**.

Adding value to partners

These organizations have various existing health programs that primarily provide technical assistance to LGU health officials and workers. And these are mostly done at the provincial level. ZFF's engagement of municipal and barangay (village) leadership brings their interventions closer to the intended beneficiaries of their programs: the local communities.

ZFF's work in improving health leadership and governance of municipal mayors has also had the effect of creating favorable environments for the implementation of partners' programs.

ZFF partners also get better understanding about different local development contexts. This is through



ZFF's knowledge of its partner LGUs' prevailing local political, economic and social conditions, and leadership commitment.

And since ZFF looks into the entire health systems of its LGUs, it has been able to flag health issues, like tuberculosis, which its partners could address through their existing relevant interventions.

The Foundation's openness to learn and innovate has also allowed its partners to explore opportunities that are strategic to their respective program interventions. ZFF has integrated its partners' program focus to its own leadership and governance program. And the resulting interventions have been piloted in urbanizing cities, GIDAs and conflict areas of the Autonomous Region in Muslim Mindanao.

ZFF has been providing all these to its partners while also ensuring it adheres to the agreements with them. And it is ZFF's ability to work well with its partners, the Department of Health and the local governments that give them more confidence in the Foundation.

UNFPA, a pioneering partner of ZFF, has asked the Foundation's help for its program with the Commission on Population, Bangsamoro Development Agency and the DOH National Implementation Team. ZFF is tasked to provide assistance in costed implementation planning, leadership module development and implementation, and human resource training and development.

The Foundation believes in the effectiveness of its approach and has actively sought partners to join its pursuit for better health outcomes. Making these partnerships work, however, is much more difficult than getting partners. That is why ZFF carefully studies partnership propositions as it evaluates its own capacities. The Foundation makes sure that in joining forces, its partnership intervention will lead to desired results, while also enriching each other's strategic approaches. ▣

DOH-ZFF initiative spurs increase of health champions

Zuellig Family Foundation (ZFF) had a major breakthrough in 2013. A partnership with the Department of Health (DOH) was forged in May that year. This bolstered ZFF's vision of improving health outcomes of the Filipino poor by strengthening health leadership and governance of the country's local leaders.

With the deal, the ZFF Health Change Model got introduced to hundreds of mayors from priority local government units (LGUs) identified by the National Anti-Poverty Commission. Originally, there were 609 priority LGUs, but after assessments done by DOH regional offices, other LGUs were included in the program as well.

The partnership program, called the "Health Leadership and Governance Program" or HLGP, involves not just the training of mayors and municipal health officers (MHOs), but also of DOH regional directors (RDs) and officers, academic partners' faculty, governors, provincial health officers (PHOs), and chiefs of hospitals. Even barangay (village) leaders get trained through the "Barangay Health Leadership and Management Program."

Given the number of LGUs involved, academic partners had to be invited to run the training program for mayors and MHOs. There are 12 academic partners* catering to different regions. Called the "Municipal Leadership and Governance Program" (MLGP), participants undergo two training modules and practicum. A colloquium marks the successful completion of the program. During this event, mayors narrate their leadership journeys and show the results of their transformations through improvements in the six building blocks of their local health systems.

Before giving the MLGP, faculty members undergo ZFF's "Health Leadership and Management Program," which is the same program given to DOH development management officers (DMOs).

*Ateneo de Davao University, Ateneo de Naga University, Ateneo de Zamboanga University, Benguet State University, Cebu Normal University, Davao Medical School Foundation, Development Academy of the Philippines, Siliman University, University of the Philippines (UP) Manila College of Public Health, UP Palo School of Health Sciences, UP Visayas, and Xavier University



Duty-bound to coach mayors in their assigned areas, DMOs are taught about bridging leadership as well as given training of trainers and training of coaches programs.

When ZFF was looking at maternal death reports in its LGUs, it found a significant number of cases occurring in public hospitals, which are either run by the provincial government or the DOH. As a result, ZFF's program intervention for provinces centered on improving hospital systems (*see page 4 for related information*). The "Provincial Leadership and Governance Program" (PLGP) is given to governors, PHOs and chiefs of hospitals. Primarily involving executive coaching sessions, ZFF has invited health experts to guide provincial leaders. Some DOH RDs are also coaches to the leaders.

It has been through the direct and active participation of DOH officials that ZFF learned important technical inputs and insights to make its strategy more relevant to LGUs. Thus, more than just the breadth in terms of number of LGUs, the DOH partnership gave ZFF a depth in its interventions.

In the succeeding pages, stories of transformations illustrate what ZFF and its partners have done, and how ZFF's approach turned local leaders into health champions, who ensure there would be improvements in the health of their people. ▀



Region 1 **ILOCOS**

CHANGE IN LEADERSHIP APPROACH BRINGS CHANGE IN HEALTH OUTCOMES

Ownership is not an issue, but if health reforms must be instituted and sustained, you need co-ownership and co-creation. Admittedly, Department of Health (DOH) regional director Dr. Myrna Cabotaje found the last two challenging.

“Ownership is easy, but not co-ownership. If I’m the mayor, I need the ‘buy-in’ of my whole community. The same with being in the DOH, I need my staff and the LGUs (local government units) supporting me. That is a very big challenge,” Cabotaje said.

But Cabotaje took on the challenge. When the DOH-Zuellig Family Foundation partnership program—the “Health

Leadership and Governance Program” (HLGP)—began, change became imminent.

The DOH regional office’s strategy shifted from being programmatic to systematic.

“In systems thinking, you start with what you have to do to get the ‘buy-in’ of people concerned. They are used to focusing only on service delivery and doing things piecemeal,” Cabotaje said of the 149 DOH employees in her region. Known for her strictness, Cabotaje shifted from being authoritarian to practicing bridging leadership. She had to, so she could guide her team effectively.



In a region where rural municipalities can get cut off from the world by natural disasters, health regional director Dr. Myrna Cabotaje (left), shown with Health Leadership and Governance Program coordinator Hazel Fabon, can now count on a growing number of mayors who share her accountability to overcome all health challenges.

Now she asks, "Does my staff in the DOH know that this is where we're going, and we need to get there together? Now, I sit down with my team and ask, 'What can we do?' I don't just force the issue. That is the paradigm shift."

Hazel Fabon, nurse and HLGP coordinator for Region 1, has seen and experienced this shift in strategy herself. While she found it very challenging, she also saw that it was very effective.

"With this strategy, you must be ready to make changes every now and then, especially when something is no longer working. Unlike other DOH programs, which are simply downloaded to the LGUs with a set of specific instructions to

be done, this time, the HLGP deals with a whole system that is complex, so you cannot say for sure that you will be doing the same things for the coming years," said Fabon, who has been with the DOH for 13 years.

It was this system that helped Region 1 organize its health data and allowed the LGUs, whose leaders finished the program, meet the health-related Millennium Development Goals in 2015: reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases.


Mayors and municipal health officers of 16 LGUs have bought into the new strategy. They completed the Municipal Leadership and Governance Program (MLGP), which is the training component under the HLGP.

Where these graduates come from—Dumalneg in Ilocos Norte; San Ildefonso, Sugpon, Quirino, Alilem, Gregorio del Pilar and Candon in Ilocos Sur; Burgos and San Gabriel in La Union; and Basista, Laoac and Sual in Pangasinan—no infant has died since 2012 and no mother has died from childbirth in 2015. Most of them have also met the global target for the reduction of under-5 malnutrition rate and malaria cases.

The LGUs that completed the program received P470,000 from the DOH Region 1 office to help with their operating expenses.

“What we’ve seen is a deepened accountability among the leaders because of the HLGP. It’s no longer just words. They are now accountable for what they’ve committed and they really want to improve the health of their constituencies,” Cabotaje said.

Cabotaje said the bridging leadership training was instrumental in ending the blame game between the provincial health offices and the provincial hospitals. Local health facilities and DOH-run hospitals no longer pointed at each other as the cause of maternal or infant deaths, and instead focused on co-creating solutions like cutting the delays in the referral system.

“That has been my problem initially—it was hard to encourage people to co-own the problem. Sometimes, they think it’s just my problem. But now it’s easier to talk to the local leaders, especially those who went through HLGP,” Cabotaje said. 



Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGPA ^A	Other ZFF programs
125	17	2

	Region 1 Health Indicators ^B		
	2013	2014	2015
MATERNAL DEATH CASES	2	0	1
Facility-Based Delivery (%)	97	99	100
Skilled Birth Attendant (%)	99	99	100

^A HLGP: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGP with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms

Region 3 CENTRAL LUZON

BRIDGING LEADERSHIP AND RELATIONSHIP CAPITAL IMPROVE REGION'S HEALTH

Regional director Dr. Leonita Gorgolon knows her numbers well.

"I have 21 congressmen, 7 governors, and 130 mayors," said the Department of Health (DOH) director for Region 3. "I've met 90 percent of them, and half of them are my friends."

While other regional heads would have memorized a different set of numbers—maternal deaths, infant mortality—Gorgolon learned the quickest way to a large region's heart is through its politicians.

Yes, she has those statistics, too, but not being a local—she is from the Caraga region in Mindanao—she realized no one in Central Luzon would take up the cause for maternal and child health if they did not even know their DOH director.

So Gorgolon socialized purposefully: calling on mayors for their health requests, congratulating governors whose provinces won awards, visiting Rural Health Units on weekends, and meeting her staff regularly.

"I make it a point to be with the local leaders, to relate with them. You must have a personal touch. If you're honest and sincere, they will know. This is a prime region, and political leaders are very aggressive here. You must be diplomatic and know your boundaries. It's part of the strategy," Gorgolon said.

Central Luzon, with its 12 million people and large urban centers, was originally not among the DOH's Health Leadership and Governance Program (HLGP) target areas because it was not poor, but Gorgolon, who underwent Zuellig Family Foundation's (ZFF) training on bridging leadership (BL) before HLGP was formed, could not let the local health leaders in the region miss out on the benefits of the leadership program.

"I knew how it could transform a leader as catalysts of change, especially politicians who think health is primarily the responsibility of the DOH."

She wrote the DOH central office and laid the groundwork for the HLGP even before her request to include Region 3 was approved. She reviewed the health indicators of the municipalities and started talking to prospective participants to the training component under HLGP: the Municipal Leadership and Governance Program (MLGP).

Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGPA	Other ZFF programs
130	25	1

	Region 3 Health Indicators ^B	
	2014	2015
MATERNAL DEATH CASES	13	15
Facility-Based Delivery (%)	94	96
Skilled Birth Attendant (%)	96	96



^A HLGP: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGP with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms



Region 3 CENTRAL LUZON

"I knew who needed help and who would participate. We tried to look into indicators and the personal conviction of each mayor, and their support for health because engaging the mayors isn't easy," Gorgolon said.

As of end 2015, 25 municipalities in the region are enrolled in MLGP. Two provinces—Aurora and Bataan—are being eyed for the provincial training.

"Credibility counts. Byword *na ngayon ang MLGP sa region*," Gorgolon said.

"RD Gorgolon was very active in evaluating our presentations, personally giving us inputs. She was able to give us direction," shared San Felipe, Zambales Mayor Carolyn

Fariñas, a lawyer who was thrust into politics when her husband, a former vice mayor, died.

San Felipe was hailed as one of the MLGP participants that exemplified a truly transformed relationship between the mayor and the municipal health officer, and increased health awareness among indigenous people, which comprised 12 percent of the town's population.


"Health used to be about medical missions and free medicines, but now, our health agenda is clear and our health targets are concrete," Fariñas said.

Dr. Gerard Madarang, DOH development management officer in San Felipe, was new in his assignment when he went through HLGP.



"I was not well-adapted at that time. Until our training, I did not know how to evaluate nor come up with scorecards. But now, I have a deeper understanding of budget, health worker's ratio and even mayors," Madarang said.

This early, Gorgolon is planning the next two batches of training and already has a calendar of HLGP activities until 2017. As for funding, she allocates the regional office's savings from the previous year, which amounted to P6 million in 2015, for the MLGP.

"It can be sustained. You just need commitment," she said of funding the MLGP in Region 3. 

She is a bridging leader who will not pass up the chance to create more bridging leaders out of the mayors in her region. Region 3 director Dr. Leonita Gorgolon (third from left) is shown with San Felipe, Zambales Mayor Carolyn Fariñas on her right during a visit to a village where Aetas live to check on the progress of maternal, child and reproductive health programs.



Region 11 **DAVAO**

REGIONAL HEALTH COALITION IS BRINGING DOWN MATERNAL AND INFANT DEATHS

Aiming for zero maternal and infant deaths may sound like a formidable task, but a Davao-based health coalition has cheerfully taken the first step in achieving this vision.

A brainchild of Department of Health (DOH) Region 11 director Dr. Abdullah Dumama Jr., “Team D Coalition” stands for Team Davao’s Direction, Drive, Dedication and Determination Coalition. It is composed of internal members from the DOH Regional Office 11 and external partners such as the Commission on Population (PopCom), Philippine Health Insurance Corp., the Armed Forces of the Philippines, Philippine National Police, obstetrician-gynecologist

consultants from the Southern Philippines Medical Center and Davao Regional Hospital, Zuellig Family Foundation, and media outfit ABS-CBN.

“I have been contemplating on the maternal and child health situation in our country recently, and it hurts me deeply to realize that there is still much to do,” Dumama said.

Dumama met with members of various sectors in the region in 2014, discussing the challenges of addressing the infant and maternal mortalities in the region and exchanging ideas on how to improve the health status of sexually active women of reproductive age.



Regional director Dr. Abdullah Dumama Jr. (second from left) is not alone in facing the uphill battle of preventing maternal deaths. Dr. Alicia Layug of Southern Philippines Medical Center and director Maduh Damsani of Commission on Population (third and fourth from left, respectively) are among the coalition members helping the regional office promote maternal and reproductive healthcare programs.

One of the DOH partners whom Dumama approached was Director Maduh Damsani of PopCom 11, who eventually coined a new fitting name for the group—Team D CHAMPS (Coalition of Health Advocates for Maternal and Infant Protection and Safety).

“When Dr. Dumama informed me of the initiative, I immediately told him that I was very interested in participating because it would also highlight PopCom’s own programs like teenage pregnancy and responsible parenthood,” Damsani said.

Another important coalition partner is ABS-CBN, represented by its public service officer for Mindanao, Waway Alcober*.

*Waway Alcober passed away on January 24, 2016.

Alcober said their organization’s primary asset and strength—information dissemination coupled with public service—was recognized by Dumama as vital in promoting the coalition’s advocacy.

“As public service officer, I knew the problem of maternal and infant mortality in the region existed because of various grievances we encountered in the station,” Alcober said.

Armed with its vision and battle cry *“Walang Nanay at Sanggol ang Mamamatay Dahil sa Panganganak,”* the coalition was launched in the different provinces and cities of Region 11 in January 2015. Local chief executives and stakeholders from the public and private sectors attended the launch, and adopted the coalition’s vision of zero mortality for mothers and infants.

Damsani emphasized the importance of putting up a “united front” during field visits conducted by the coalition. With a team of around 20 members from different sectors, local government and health leaders saw that the coalition was “very serious” in its mission.

“The coalition’s activities also provided an opportunity to assess health facilities and the capabilities of doctors, nurses, and midwives in conducting DOH and PopCom initiatives,” Damsani said.

For its part, ABS-CBN featured all launching events of the coalition and integrated the coalition’s goals and initiatives in its shows and programs.

“We shared information on what pregnant women should do, warned them on possible risks, and gave them options so they could have safe pregnancy and birth,” Alcober said.

Dumama said the coalition, in coordination with its partners, is continuously “gearing toward uplifting the knowledge, awareness and acceptance of the general populace, especially women of reproductive age, on the availability of maternal and child healthcare packages in the locality, and doing extensive efforts to entice them to patronize these goods and services.”

“The quest for achieving the elusive goal of reducing maternal mortality ratio and infant mortality rate may be over, thanks to the unrelenting devotion and passion of the people behind the Team D CHAMPS,” Dumama stressed. [f](#)

Total Local Government Units (LGUs)	LGUs with ZFF interventions
	HLGPA^A
49	33

Region 11 Health Indicators^B			
	2013	2014	2015^C
MATERNAL DEATH CASES	49	46	9
Facility-Based Delivery (%)	73	98	85
Skilled Birth Attendant (%)	78	85	88

^A HLGPA: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGPA with complete reports since 2013; partial-unofficial

^C First half 2015 data only

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms



Region 6 WESTERN VISAYAS

STRONG PROVINCIAL SUPPORT MEANS BETTER HEALTH FOR ALL

Iloilo Governor Arthur Defensor Sr. has been called the “champion of all bridging leaders”—and rightly so. Under his leadership, the provincial government of Iloilo has spent millions to improve its 12 hospitals through the Hospital Efficiency Assurance through Reform and Transformation (HEART) program.

HEART, according to Defensor, is dedicated to the less privileged. “We will do everything to upgrade the quality of our hospitals. I am committed to pour millions of investments to make these real hospitals for the poor.”

The program aims to improve hospital facilities and ensure Iloilo’s provincial hospital and 11 district hospitals are completely equipped.

“Our hospitals are now self-sufficient and earning,” Defensor said during the Iloilo Provincial Health Summit in November 2015.

He explained, “We were able to do this by improving and upgrading our facilities and equipment, using not only local funds but also foreign donations under our hospital enhancement program.”

Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGPA ^A	Other ZFF programs
133	47	2

As of July 2015, the hospitals registered a 77-percent increase in income or P240.2 million, compared to July 2014’s P136 million—an increase of P104.3 million over a 12-month period.

“We accomplished this through the strict implementation of the point-of-care program, and no-balance-billing policy, and the upgrading and enhancement of our facilities and services,” the governor said.

Region 6 Health Indicators ^B			
	2013	2014	2015
MATERNAL DEATH CASES	4	5	7
Facility-Based Delivery (%)	60	71	82
Skilled Birth Attendant (%)	73	85	82
Iloilo Health Indicators			
	2013	2014	2015
MATERNAL DEATH CASES	11	32	10^C
Facility-Based Delivery (%)	81	87	no data
Skilled Birth Attendant (%)	87	89	no data



^A HLGPA: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGPA with complete reports since 2013; partial-unofficial

^C First half 2015 data only

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms



Region 6 WESTERN VISAYAS

Defensor's concern for the health sector can be seen as early as 2010, when he created a new office to focus on hospital services.

Iloilo provincial health officer (PHO) Dr. Grace Trabado explained that under the "original structure," the provincial health office covered both the public health component and hospital management.

"But the governor wanted to make all the hospitals in our province at par with private ones, and he realized he could do this by creating a separate office to oversee hospital operations and policymaking," Trabado said.

While Trabado's office currently provides technical assistance and support to the province's Rural Health Units, the newly created Hospital Management Office (HMO) zeroes in on hospital reforms.

"We converted the hospitals into an economic enterprise in mid-2011, improving both the facilities and the services at the same time," provincial administrator Dr. Raul Banias, who also heads the HMO, said.

The local health leaders' mission to improve the province's health sector was further enhanced by their participation in the Zuellig Family Foundation's Provincial Leadership and Governance Program (PLGP).



In a region where rural municipalities can get cut off from the world by natural disasters, health regional director Dr. Myrna Cabotaje (left), shown with Health Leadership and Governance Program coordinator Hazel Fabon, can now count on a growing number of mayors who share her accountability to overcome all health challenges.

“We were just trying to improve our services in a general manner before,” Baniyas said, adding the ZFF gave them a clear policy direction and provided them with a detailed checklist on what a good hospital should be.

“Now we are aware of maternal deaths, and how these are caused by a variety of things: delayed referrals from the barangays, or the lack of blood and attending personnel upon the patient’s arrival at the hospital,” he disclosed.


The province has made physical improvement of the hospitals, opened more positions for specialists like OB-gynecologists and anesthesiologists, and began revamping the hospital culture to improve customer satisfaction.

Dr. Marlyn Convocar, DOH Region VI director, said through the DOH-ZFF’s Health Leadership and Governance Program,

the DOH continues to focus on local chief executives so they may effectively implement the major thrusts of the DOH *Kalusugang Pangkalahatan* (Universal Health Care).

So far, the Iloilo governor continues to make good on his promise to focus on the provision of quality health services to his constituents, especially the poor.

“By 2016, we will be establishing an office that will take charge of effectively implementing the initiative to efficiently address the needs of our barangays, and sustain what we have started,” Defensor said.

“I have always believed that good health is good politics, and my administration has been built on the strong foundation of universal access to essential health services,” he stressed. 



Region 5 **BICOL**

INTERNAL ASSESMENT LEADS TO SWIFT HOSPITAL REFORMS

In 2014, the biggest and most comprehensive hospital in the Bicol region posted the highest maternal deaths among the region's hospitals.

Dr. Rogelio Rivera, head of the Department of Health (DOH)-retained Bicol Regional Training and Teaching Hospital (BRTTH), used to say that their status as an end-referral hospital prevented them from saving the lives of mothers dying from pregnancy-related causes. The patients would end up dead on arrival at the BRTTH anyway, he reasoned out during two management committee meetings in 2014 wherein hospital maternal deaths were discussed.

This was before he saw the actual data on maternal deaths in his region.

This turning point happened in February 2015, when then-DOH regional director Dr. Gloria Balboa attended their first general assembly with the BRTTH staff and revealed the directions of the DOH Region 5 through a public narrative. Zuellig Family Foundation (ZFF) then presented the region's maternal death data, which BRTTH chief of medical and professional staff Dr. Salvacion Macinas helped gather.

The management team of Bicol Regional Training and Teaching Hospital, led by its chief Dr. Rogelio Rivera (not in photo), Dr. Salvacion Macinas (left) and Dr. Alma Rivera (second from left) was quick in implementing reforms after finding significant number of maternal death cases in the hospital.



Immediately after the assembly, Rivera and Balboa convened the OB-Gynecology (OB-Gyne) department to conduct a dialogue. This started the leadership journeys of Rivera, Macinas, and OB-Gyne department head Dr. Alma Bella Rivera.

Still new as OB-Gyne head, Dr. Alma Rivera was initially taken aback by the information, but rather than find excuses, she began analyzing the hospital's data and its existing systems.

For his part, the BRTTH chief attended ZFF's Provincial Leadership and Governance Program (PLGP) implementation review, where he presented the hospital's maternal death data analysis and finalized action plans with the hospital team.

He also participated in the dialogue initiated by the ZFF PLGP team, together with the Albay provincial health officer (PHO) and technical staff with the support of the DOH regional office, in March 2015. Dr. Rogelio Rivera, whose presence during the event surprised other participants, shared the BRTTH's challenges and focused on the congestion of the hospital's OB patients. He then asked the PHO and the provincial staff to help them address this challenge.

A few months later, the BRTTH headed a workshop on addressing maternal deaths with the local government units of Albay and Sorsogon. During the activity, the group identified solutions to major issues they faced: delay in decision to seek care, delay in reaching appropriate obstetric facility, poor referral system, and congestion in the hospital.

On July 7, 2015, the BRTTH leadership scored a major victory through the finalization of the hospital policy on referral to the BRTTH's OB department. This was disseminated to all concerned Rural Health Units in Albay and Sorsogon.


The policy ensured only complicated cases were brought to BRTTH. An earlier analysis made by Dr. Alma Rivera on admissions showed significant number of normal deliveries that should have been handled in primary healthcare facilities. With the new referral system in place, BRTTH could devote their resources to those who need them more.



"I was not able to recognize this problem as our problem before. But now, we have accepted the challenge and realized we can do something about it," Rogelio Rivera said.

For his part, Albay PHO Dr. Nathaniel Rempillo acknowledged the roles of mayors.

"We recognize the indispensable role of the local chief executives (LCEs) in all these efforts," Rempillo said, adding that ZFF's training programs have enabled local leaders to give their full support to the health sector.

"The LCEs are now aware that public health goes beyond the conduct of medical missions, and they are likewise able to acknowledge the role of hospitals in the community and the preventive side of healthcare," he stressed. 

Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGP ^A	Other ZFF programs
114	56	10

	Region 5 Health Indicators ^B		
	2013	2014	2015
MATERNAL DEATH CASES	51	82	93
Facility-Based Delivery (%)	81	81	no data
Skilled Birth Attendant (%)	86	84	85

^A HLGP: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGP with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms

Region 9 ZAMBOANGA PENINSULA

ONLINE COACHING IMPROVES HOSPITAL MATERNAL DEATH MANAGEMENT SYSTEM

When the Zuellig Family Foundation (ZFF) first invited Dr. Reynaldo Joson to coach government hospitals in the Zamboanga Peninsula on maternal death control, he immediately thought of a structured curriculum that would enable him to measure his service output.

“I could have done the traditional way of coaching without a structured curriculum, i.e., just go to the government hospitals every month and ask them what their problems are and advise them on what to do, but I didn’t. I wanted more than that,” Joson said.

The doctor was invited in February 2015 to serve as a consultant for the ZFF-initiated, United States Agency for International Development (USAID)-funded project on the reduction of maternal mortality ratio in Zamboanga del Sur Medical Center, Zamboanga del Norte Medical Center, and Zamboanga Sibugay Provincial Hospital (ZSPH). In May 2015, the Zamboanga City Medical Center (ZCMC) was added to the consultancy project, this time with United Nations Children’s Fund (UNICEF) funding the initiative.

Joson then added the online coaching component called “Online Collaborative and Interactive Learning on Maternal Death Control Management System” (OCIL-MDCMS).

The online collaborative and interactive learning program utilized the internet to allow both Joson and the hospital personnel to brainstorm and discuss issues on maternal death control.

As deliverables, Joson’s OCIL-MDCMS required participants to do a case study on the “Maternal Death Control Management System” in their hospitals, construct a website that contains their manual of operations on MDCMS, and pass the “Online Learning Cum Evaluation Test Exercise” (OLETE).

Soon, ZSPH would receive the prestigious Asian Hospital Management Award (HSMA) in September 2015 for using this method. The HSMA gives recognition to hospitals in Asia that implement best practices.

ZSPH’s Community Hospital Improvement Award commended “the implementation of an Online Collaborative and Interactive Learning to create a structured, comprehensive and sustainable design and development plan on maternal death control management system.”

Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGPA	Other ZFF programs
72	43	3

	Region 9 Health Indicators ^B		
	2013	2014	2015
MATERNAL DEATH CASES	26	42	21
Facility-Based Delivery (%)	68	83	87
Skilled Birth Attendant (%)	74	84	87

^A HLGPA: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGPA with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms





Region 9 ZAMBOANGA PENINSULA

Dr. Arthur Luspo, ZSPH chief of hospital, said the MDCMS aimed to improve the maternal healthcare service through the creation of task forces composed of personnel directly or indirectly involved in the pregnant mother's well-being.

The MDCMS team's members should include a representative from obstetric (OB)-gynecology department as head; nurses from emergency, labor-delivery or operating rooms, and the OB ward or floor; and representatives from other departments including medical records, laboratory and finance.

"This is important because the whole hospital is able to see and realize that taking care of a pregnant woman is not the monopoly of the doctor or the nurse," Luspo stressed.

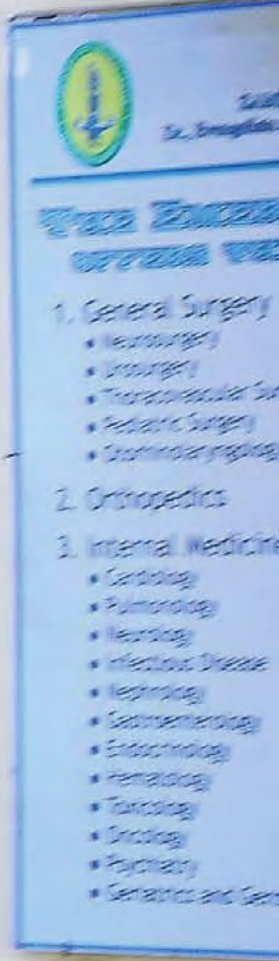
While maternal deaths did not significantly drop between 2014 and 2015 in the hospital, the causes have changed.

"In 2014, some of the cases involved the lack of blood supply or the lack of doctors in our hospital," Luspo said. "But last year, we determined most of the deaths were late referrals from other hospitals."

Dr. Soraya Abubakar, Zamboanga City Medical Center (ZCMC) chief of clinics, echoed a similar pattern: no dramatic decrease in maternal deaths at the ZCMC—23 deaths in 2014 to 20 deaths in 2015—but the cases of mothers dying 48 hours after arriving at the hospital decreased significantly: from 13 in 2014, it dropped to three in 2015.

EMERGENCY

EMERGENCY ENTRANCE

- 
- A blue sign with a logo at the top and a list of medical services. The list is organized into three numbered categories: 1. General Surgery, 2. Orthopedics, and 3. Internal Medicine. Each category has several sub-items listed below it.
- 1. General Surgery
 - Neurosurgery
 - Urology
 - Thoracic/vascular surgery
 - Pediatric Surgery
 - Gynecological surgery
 - 2. Orthopedics
 - 3. Internal Medicine
 - Cardiology
 - Pulmonology
 - Nephrology
 - Infectious Disease
 - Nephrology
 - Geriatrics
 - Endocrinology
 - Hematology
 - Toxicology
 - Oncology
 - Psychiatry
 - Geriatrics and Gerontology

“This means more patients being brought to our hospital are in their terminal stages—cases we could not do much about,” Abubakar said. Like ZSPH’s Luspo, Abubakar stressed the importance of addressing hospital referral system.

“We need a program to interconnect the different Zamboanga Peninsula hospitals because we are the end-referral hospital,” Abubakar said, explaining that ZCMC currently accepts patients from all provinces in the region.

For his part, Joson said that while the MDCMS program is still in the early stages of development, he is positive that with the comprehensive strategies formulated and fully implemented in the next two to three years, the maternal death ratio in each hospital will decline. [f](#)

As an end-referral hospital in the entire Zamboanga Peninsula, the Zamboanga City Medical Center (ZCMC) receives a lot of patients in their terminal stages. While death is imminent in most of the cases, an online system to control maternal deaths introduced in ZCMC and other provincial hospitals in the peninsula, allowed hospital officials to trace gaps in their systems and work cooperatively to address them.



Region 12 **SOCCSKSARGEN**

THE POOR NEED NOT PAY IN PRIVATE HOSPITALS

In five local government units (LGUs) in Sultan Kudarat, a province in the southwestern part of Mindanao, the rich and the poor can go to the same private hospital. They will get the same treatment, see the same doctor and recover in the same facility. The only difference is that the poor patient will be discharged without paying a single centavo.

This is possible because of the public-private partnership between five LGUs in the inter-local health zone (ILHZ) and seven hospitals in the province. Comprising Sultan Kudarat's health zone are Bagumbayan, Isulan, Tacurong, Esperanza and Senator Ninoy Aquino. Collectively known as BITES, it has

been chaired since 2007 by Bagumbayan Mayor Bernardita Bito-onon. Mayors and municipal health officers (MHOs) of all five have completed the Zuellig Family Foundation's Municipal Leadership and Governance Program (MLGP).

"The quality of health services the rich can afford must also be made available to the poor," said Mayor Lina Montilla of Tacurong City.

While the ILHZ has existed prior to the MLGP, the local chief executives' training in the ownership, co-ownership and co-creation concepts of leadership and governance has



changed the manner of their involvement in the health zone, Dr. Mercedes Manansala, the provincial Department of Health officer (PDOHO) in Sultan Kudarat, noted.

“The mayors used to send their municipal health officers to ILHZ meetings, but now they themselves come and discuss their concerns with the referral hospitals. What’s better, the solutions come from them as well. They think of how to make things easier for their constituents,” Manansala said.

One of the health solutions being strictly implemented by the BITES ILHZ is the no-balance-billing (NBB) policy for poor patients, even in private facilities.

Like other poor residents, this mother from Bagumbayan receives healthcare services for free even in private hospitals. This is thanks to the agreements forged by the inter-local health zone of Bagumbayan, Isulan, Tacurong, Esperanza and Senator Ninoy Aquino in Sultan Kudarat. In photo are (from left) development management officer Lorelie Resmundo, Bagumbayan Mayor Bernardita Bitonon, Sandig Medical Clinic and Hospital director Dr. Marilie Lechonsito, Tacurong City Mayor Lina Montilla, and provincial Department of Health officer Dr. Mercedes Manansala.

Under this co-created initiative, the LGUs inked partnership agreements with five private facilities in the province: Sandig Medical Clinic and Hospital, Quijano Clinic and Hospital, Tomboc-Salayong Hospital, Dr. Domingo Tamondong Memorial Hospital, and Galinato Family Clinic and Hospital. They also have two government partner hospitals: Sultan Kudarat Provincial Hospital and Senator Ninoy Aquino Hospital.

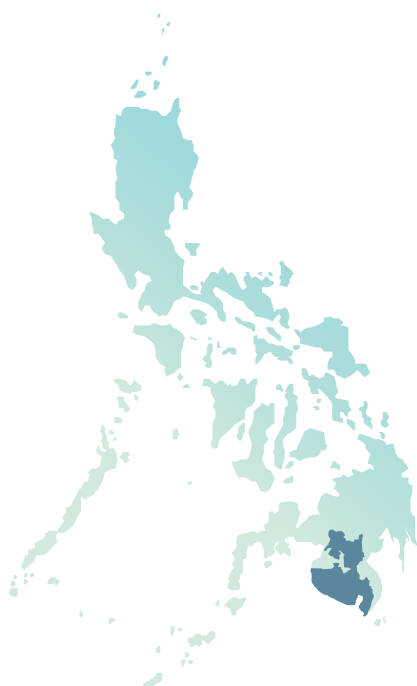
The NBB policy covers BITES-sponsored Philippine Health Insurance Corp. (PhilHealth) members and their beneficiaries, and indigents identified and referred by the local governments.

Lorelie Resmundo, DOH development management officer who coordinates with Bagumbayan and Isulan for the ILHZ, said the initiative is intended to address mothers' fears of incurring high costs when they opt for facility deliveries.

To avail of free hospitalization, the patients must present their referral slips from the mayors or MHOs. The color-coded referral slips indicate the amount to be covered by the LGU, based on the health officer's assessment of the case. The usual coverage from the LGU is P3,000 per patient, on top of the PhilHealth benefits, but it can go higher, depending on the patient's need.

The receiving hospitals then bill the LGUs for services provided to the patient.

Every year, each of the five LGUs put in P100,000, and when the fund reaches half, concerned LGUs are alerted for replenishment.



According to Manansala, the NBB policy has been crucial in reducing maternal and infant mortalities in Sultan Kudarat because it removed the pressure to produce money for hospitalization.

Even the blood needed by the poor patients for transfusion is courtesy of the local governments. The BITES LGUs either find ways to stock up on blood at the Philippine Red Cross (PRC) or pay for the blood bags consumed.

Manansala said since most previous deaths were due to lack of blood supply, an agreement has been put in place for the PRC to give blood to those with referral slips.

“Our people are really clamoring for health and social services, and we will respond by continuing to provide them with these,” Montilla said, who added, “The local government has to find a way to answer the needs of the indigent, because they have nowhere else to run to.”

Total Local Government Units (LGUs)	LGUs with ZFF interventions
	HLGPA ^A
50	38

Region 12 Health Indicators ^B			
	2013	2014	2015
MATERNAL DEATH CASES	43	35	37
Facility-Based Delivery (%)	78	82	91
BITES inter-local health zone, Sultan Kudarat Health Indicators			
	2013	2014	2015
MATERNAL DEATH CASES	5	3	4
Facility-Based Delivery (%)	92	94	95

^A HLGPA: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGPA with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms

Region 4B MIMAROPA

LEADERS ACT TO ADDRESS HEALTH CHALLENGES IN PARADISE

She was with the Southern Tagalog region of the Department of Health (DOH) when the region was divided into Region 4A or Calabarzon (Cavite, Laguna, Batangas, Rizal, Quezon) and 4B or Mimaropa (Occidental and Oriental Mindoro, Marinduque, Romblon, Palawan). Made to choose between the two, Batangas native Anna Birtha “Baj” Datinguinoo chose Mimaropa.

Baj knew the region’s geography posed several challenges, particularly access to healthcare services. But she admits the beauty of the provinces is oftentimes enough to inspire her to forge ahead and conquer the challenges.

Palawan is a very good example of a beautiful place facing serious health challenges. Baj said this is because of the province’s considerable size, various indigenous peoples’ communities and insufficient number of health workforce.

The province accounted for 65 percent of maternal deaths in Mimaropa in 2014 based on DOH data. Reducing maternal mortality ratio of Palawan would actually enable the region to meet the Millennium Development Goal target of 52. So Palawan municipalities, identified as having medium- to high-risk maternal health index, were given priority enrollment to the training program under the Health Leadership and Governance Program (HLGP), of which Baj is the coordinator.

Among the first into the program was El Nido, world famous for its pristine beaches, clear waters and diverse ecosystem. In 2014, three maternal deaths occurred in this “paradise.” El Nido municipal health officer (MHO) Dr. Cesar Rivera had been aware of their problems even before taking the program. But since the training he and Mayor Edna Gacot-Lim attended, reforms immediately followed.

Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGPA	Other ZFF programs
73	26	6

	Region 4B Health Indicators ^B		
	2013	2014	2015
MATERNAL DEATH CASES	21	23	17
Facility-Based Delivery (%)	73	77	87
Skilled Birth Attendant (%)	73	79	88
Palawan Health Indicators			
	2013	2014	2015
MATERNAL DEATH CASES	25	30	30
Facility-Based Delivery (%)	93	no data	73
Skilled Birth Attendant (%)	94	no data	74



^A HLGP: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGP with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms



Region 4B MIMAROPA

“We implemented pregnancy-tracking initiatives to monitor mothers and discourage home deliveries,” Rivera said, adding that facility-based deliveries in the municipality have increased to almost 76 percent from below 40 percent. There was no maternal death in 2015.

In its adjacent town of Taytay, health system reforms began after Mayor Romy Salvame realized the importance of health in the progress of his municipality. Maternal deaths dropped to one in 2015 from five the year before.

The two towns also reactivated their inter-local health zone to improve service delivery network that includes the Northern Palawan Provincial Hospital (NPPH), the end-referral hospital of the two.

Fortunately, changes have also begun in NPPH after its leaders took part in the Zuellig Family Foundation’s Provincial Leadership and Governance Program.

“Before the Zuellig Family Foundation provided us with assistance, the hospital had a very weak management. There was a lack of personnel, no supplies, and no functional ambulance,” NPPH administrative officer Zenaida Nolsol said.

The hospital has been focusing on its free ride for patients so they can save P300 in transportation costs. There is also a maternal halfway shelter, where mothers, especially from distant villages, can stay temporarily when their due dates draw near.

Addressing its hospital issues has also positively impacted income. The hospital’s goal is to be self-sustaining by end-2015; income-generating by end-2016; and generating 25 percent net profit annually from 2017 to 2020.

There is also a vision to elevate it to a “Level 2, ecotourism hospital” that will have its own operating room and cater to both locals and tourists.



Alongside these reform programs in the municipalities and hospital is the significant support the DOH regional office has been providing. It mobilized resources for leadership workshops and conduct of multi-stakeholder activities like “Buntis (pregnant women’s) Congress.” It also deployed midwives in hard-to-reach areas, provided sea ambulance for patients referred to hospitals, and gave scholarships to potential medical technicians.

For Baj, mayors’ growing appreciation for and understanding of health system will sustain the gains in health. As a regular presence in HLGP training activities and in mayors’ offices and municipal health offices for conflict resolutions and consultations, Baj mused, “(The LCEs) are now more supportive in terms of health. Hopefully, the time would come when MHOs would depend less on us and more on the local government.”

With several pristine beaches and rock formations, El Nido in Palawan is undoubtedly a beautiful place. Its natural characteristics, however, also make access to healthcare a challenge for patients, especially poor mothers. But Health Leadership and Governance coordinator Anna Birtha Datinguinoo (right) is hopeful more mayors will become active health allies as they learn about their important roles in local health systems.



Region 8 **EASTERN VISAYAS**

TRAGEDY TAUGHT THEM, RESILIENCY PREPARES THEM

Turning her back on a lucrative career as a surgeon to follow her passion for public health, Dr. Marian Isiderio, the Eastern Samar provincial health officer (PHO), has no complaints about the four- to five-hour travel she must endure each time she needs to reach her office in Borongan from her home in Tacloban City.

Isiderio has embraced her role as PHO amid all the challenges, which have become a way of life in the province, where poverty is prevalent, maternal mortality ratio is high, and typhoons are common, including the strongest typhoon ever recorded, super typhoon Haiyan (local name: Yolanda).

Isiderio has faced all these challenges with her longtime ally, provincial Department of Health officer (PDOHO) Dr. Jean Marie Egargo. This strong partnership, coupled with a training program of the Zuellig Family Foundation (ZFF), can be cited as reasons no disease outbreak occurred in the province in the weeks and months after Haiyan.

“We have always recognized the importance of each of our roles,” Isiderio stressed. She corrected the misconception that the main role of DOH development management officers (DMOs), who are supervised by Egargo, is solely “to collect data and reports.”



Super typhoon Haiyan (local name: Yolanda) destroyed lives and properties. But it also brought lessons in responsiveness and resiliency. Now health leaders like provincial health officer Dr. Marian Isiderio (right) and provincial Department of Health (DOH) officer Dr. Jean Marie Egargo (left) are more confident they can overcome any health challenge that may come their way.

"This is definitely not true for us, because we have numerous partnerships which could not have succeeded without the help of the other," Isiderio said.

One fruit of this partnership is the activation of the "Surveillance in Post Extreme Emergencies and Disasters" or SPEED, a special reporting system that ensured the immediate detection of diseases in Haiyan-ravaged communities.

Since there were no functioning phone lines and signals in the aftermath of Haiyan, the provincial health office had a

motorcycle-riding messenger collect written reports from Rural Health Units (RHUs) placed in drop boxes in all LGUs, and then deliver them to designated operation centers. Reports are checked then DMOs visit affected areas for verification and assessment of patients' needs.

"We were also able to activate this system during typhoon Ruby the following year," Egargo said, stressing their learnings during the program's first run made it easier for them to deal with another typhoon.

Aside from each other, the two health leaders gained more allies among mayors and municipal health officers (MHOs) who have taken the Municipal Leadership and Governance Program, under an initiative by ZFF and United Nations Population Fund. The two doctors acknowledged the importance of this program, which enabled mayors and MHOs of Haiyan-ravaged municipalities to better deal with the aftermath.

“The lessons I learned on ownership, co-ownership and co-creation helped me prepare for and manage the aftermath of Yolanda,” Salcedo Mayor Melchor Mergal said. All of Salcedo’s 41 barangays were severely affected by the typhoon, with its RHU and five of its seven Barangay Health Stations totally destroyed.

Mergal added, “I took it as a test of my commitment and I was not discouraged; instead, Dr. Socorro Campo (Salcedo Municipal Health Officer) and I worked double time to restore what was lost.”

The mayor also saw the super typhoon as “more of an opportunity rather than a disaster.” He quickly gained the trust and confidence of the DOH, government, non-government and international organizations, and local stakeholders—all of whom would become important partners in Salcedo’s rehabilitation and recovery.



Salcedo likewise became part of the Resilient Local Health System Project, a one-year joint initiative of ZFF with the United Nations Children’s Fund that began in October 2014, aimed at enabling 12 Samar partner LGUs of ZFF to improve their preemptive response and recovery from disasters.

“We were devastated by Yolanda but it helped us improve our capacities,” Mergal said. Between December 2013 and July 2014, Salcedo had no maternal death, posted 100-percent facility-based deliveries and 100-percent pre- and post-natal visits.

Egargo and Isiderio could not agree more. “Yolanda is the best teacher,” they echoed.

Total Local Government Units (LGUs)	LGUs with ZFF interventions	
	HLGPA ^A	Other ZFF programs
143	37	22

Region 8 Health Indicators ^B			
	2013	2014	2015
MATERNAL DEATH CASES	4	3	5
Facility-Based Delivery (%)	86	no data	95
Skilled Birth Attendant (%)	89	no data	96
Eastern Samar Health Indicators			
	2013	2014	2015
MATERNAL DEATH CASES	8	8	9
Facility-Based Delivery (%)	81	88	91
Skilled Birth Attendant (%)	85	86	92

^A HLGPA: Health Leadership and Governance Program

^B Includes only cities and municipalities under HLGPA with complete reports since 2013; partial-unofficial

Sources: Field Health Service Information Systems, Bureau of Local Health Systems Development-issued forms

ZFF HEALTH CHANGE MODEL: AN APPROACH WORTH UPSCALING

When and how did the Zuellig Family Foundation (ZFF) start the implementation of its Health Change Model approach?

The strategy was conceived in 2008 after a review of the Philippine health system showed significant inequities between the health of the rural poor and the urban rich. The challenging situation was echoed by President Benigno Aquino III when, in July 2010, he said many Filipinos die without ever seeing a doctor.

To address this, ZFF created an approach to make mayors and their municipal health officers bridging leaders whose values will move them to take greater accountability for the health of their people; encourage them to work with various stakeholders; and harmonize differences so they work toward common health goals.

Under its Community Health Partnership Program (CHPP), ZFF piloted its strategy in its first cohort of municipalities in 2009. The cohort consisted of nine rural towns: Santa Fe in Nueva Ecija, Dingalan in Aurora, Padre Burgos in Quezon, Dao in Capiz, Bacolod in Lanao del Norte, and the Maguindanao towns of Datu Paglas, Gen. S.K. Pendatun, Paglat, and Sultan sa Barongis. The two-year CHPP included training, practicum and grants for health facilities and equipment.

From nine, ZFF's prototype municipalities numbered 72 by end-2015. And they were grouped into three: the poor, the geographically isolated and disadvantaged areas (GIDAs), and the Autonomous Region in Muslim Mindanao (ARMM).

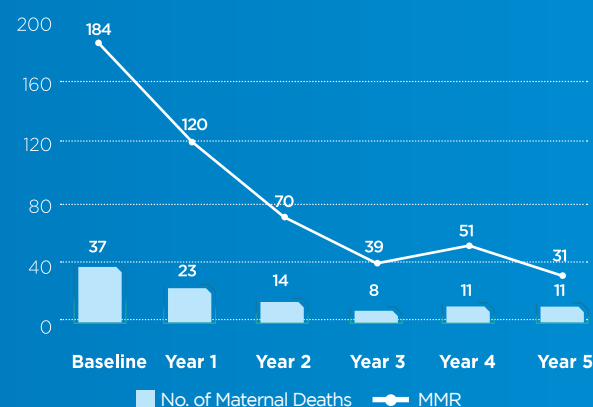
Working in these municipalities afforded ZFF the opportunity to strengthen its strategy because it learned what worked, what did not, what else needed to be done, and how things are supposed to be done.

Health leaders of the prototype local government units (LGUs) also proved ZFF's approach works. Their improved health indicators support this. Of particular interest to ZFF is maternal mortality ratio (MMR), or the number of maternal deaths over live births multiplied by a hundred thousand. The country has found difficulty in bringing this number down. Since it is also a good measure of how well the primary healthcare system is working, ZFF closely monitors this.

In a study commissioned by ZFF^A, decrease in the MMR of municipalities that have been with ZFF for at least five years was found statistically significant beginning Year 2 (see *Chart 1*).

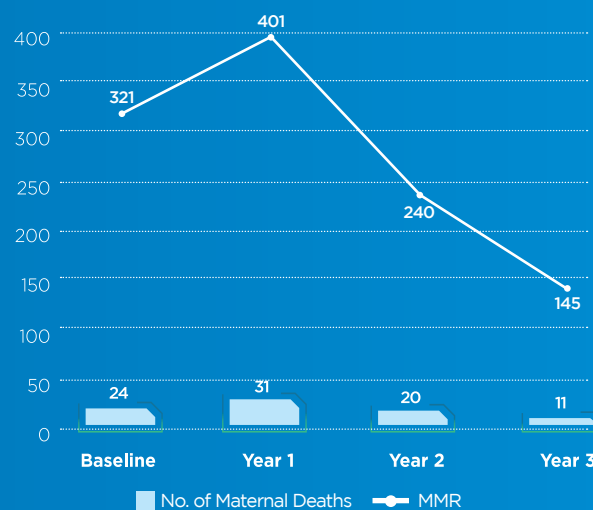
Considering the more challenging conditions in GIDAs, a look into their MMR also showed a considerable decline, though it was statistically significant at Year 3 (see *Chart 2*).

CHART 1. MMR AND MATERNAL DEATHS OF COHORTS 1 TO 3



There are 29 municipalities that have been with the ZFF for at least five years. These belong to Cohorts 1, 2 and 3, which include municipalities from the Autonomous Region in Muslim Mindanao. The decline in their collective maternal mortality ratio was found statistically significant at Year 2, that is, after two years of introducing the program.

CHART 2. MMR AND MATERNAL DEATHS IN GEOGRAPHICALLY ISOLATED AND DISADVANTAGED AREAS



Geographically isolated and disadvantaged areas are characterized as hard-to-reach areas where poverty is prevalent and security threats may be present. In these challenging areas, ZFF expected difficulty in improving health indicators. Turned out, though maternal mortality ratio remained high in these areas, the decline was statistically significant at Year 3.

^ASarol, Jesus Jr., PhD and Nemuel Fajutagana, M.D. "Impact Evaluation of the Zuellig Family Foundation's Community Health Partnership Program on Leadership, Governance, Health Systems and Maternal and Child Mortality in Municipalities in Cohorts 1, 2 and 3."

“Upscaling the Health Change Model on the national level will surely enhance our ongoing KP (Kalusugang Pangkalahatan – Universal Health Care) Hi-5 initiatives.”

Janette Loreto-Garin
Secretary, Department of Health



While the health leadership and governance training alone may not have been the sole reason MMRs declined, ZFF knows this: after training, mayors and their health teams acted more quickly on their health issues. They created health programs and innovations that are worth replicating in more areas.

During ZFF's first "National Health Leaders Conference" (HELECON) in November 2015, Health Secretary Janette Loreto-Garin acknowledged the Foundation's strategy.

"The Health Change Model has proven to be a catalyst in harnessing the energies, talents, and commitment of local chief executives, MHOs and community leaders in improving the health outcomes of our constituents. Upscaling the Health Change Model on the national level will surely enhance our ongoing KP (*Kalusugang Pangkalahatan* – Universal Health Care) Hi-5 initiatives."

In the same event, the Foundation also recognized its mayors and MHOs who have displayed outstanding leadership qualities to drive health system reforms in their areas. Prototype municipalities that recorded no maternal death for at least five years were also recognized.

Finally, one municipality from among the 72 was chosen to receive ZFF's first "Excellence Award for Leadership in Public Health." In choosing, ZFF looked into their health systems, health indicators, and the bridging leadership competencies of the health leaders. Winning the award was the town of Tinambac in Camarines Sur.



COMMITMENT to HEALTH

This Declaration is a reaffirmation of the different aspirations and goals of the different sectors of the Philippine society, particularly those at the grassroots level. These are expressed with deepest confidence and assurance of the services to society's peripheries and achieve better health outcomes.

We declare that health is a basic right of every Filipino, and it promotes human dignity. It is the foremost duty of health leaders, elected or otherwise, to ensure access to quality healthcare. We envision a society where all Filipinos are healthy, and able to realize their full potentials. We call upon PhilHealth to affirm and protect, and that all structures be put in place to guarantee human rights.

We declare that every Filipino has a responsibility in building a health system. We call upon the nation's leaders to provide the means, resources, and participation of every Filipino in the process. We call upon health leaders to engage in collaborative efforts, the achievement of which will be science-based and evidence-based. We call upon health leaders to uphold the principles of transparency and accountability through an inclusive process of dialogue to ensure the best interests of the Filipino people.

We declare and affirm our commitment to building a health system that is equitable, efficient, and sustainable. We envision health systems that are people-centered, community-based, and evidence-based. We call upon health leaders to ensure that health services are accessible, affordable, and of high quality. We call upon health leaders to ensure that health services are accessible, affordable, and of high quality.

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Like many rural municipalities, Tinambac also struggled with high incidences of maternal and infant deaths. It also had residents living in hard-to-reach villages. However, its mayor and doctors were committed to uplift the lives of their people. With ZFF providing a systemic way to address their challenges, the health leaders managed to overcome their pressing health issues. Along the way, they also managed to expand stakeholder involvement in their health issues.

Having the likes of Tinambac and its leaders is what makes ZFF hopeful and eager to continue the work of transforming local health leaders.

Tinambac, Camarines Sur was chosen as recipient of ZFF's first "Excellence Award for Leadership" during the National Health Leaders Conference in November 2015. Receiving the award were Mayor Ruel Velarde and Dr. Francisco Severo IV (third and fourth from left, respectively). Looking on are (from left) ZFF chairman Roberto Romulo, ZFF trustee Daniel Zuellig, ZFF president Ernesto Garilao and Nico Zuellig Form.

WHOLE COMMUNITY COMES TOGETHER FOR MOTHERS' AND BABIES' HEALTH

TINAMBAC, CAMARINES SUR



What's a priest or a *habal-habal* (motorcycle taxi) driver got to do with the health of a mother and child? A lot, at least in the small town of Tinambac, Camarines Sur.

In this municipality of more than 65,000 residents, ordinary townsfolk share in the daunting task of keeping every mother and baby alive and healthy, especially those in the remotest coastal and upland villages.

Midwives regularly make the rounds in villages to conduct checkups and immunizations, *habal-habal* drivers are on call to give mothers in labor a ride to the nearest health facility,

and priests preach the importance of family planning during Sunday masses.

Tinambac might be lacking in sophisticated and cutting-edge facilities and equipment but it has made great leaps in curbing maternal deaths to zero in the last couple of years by fostering this innovative synergy.

"I learned that providing better health for the mothers and children is not just the job of the mayor, the barangay official or the health personnel. Forging partnerships, creating more partners are important to achieve this goal," said Tinambac Mayor Ruel Velarde.



Mayor Ruel Velarde (second from left) knows how much influence the Church has on his constituents. So armed with data, he met with priests to make his case on family planning and teenage pregnancies. Now, he has the support of priests for his reproductive health and responsible parenthood programs.

The first-class municipality nestled northeast of Camarines Sur was accorded in November 2015 the first Zuellig Family Foundation (ZFF) “Excellence Award for Leadership in Public Health” for instituting health reforms to help make significant cuts in the national figures on maternal and infant mortalities.

In 2013, Tinambac brought down the number of maternal deaths to one and finally to zero in the two succeeding years despite the geographical isolation of majority of its 44 barangays (villages).

Velarde said his wake-up call was in 2011 when his town encountered critical setbacks in its health programs punctuated with the death of nine mothers at birth and 11 infants before they reached a month old.

For a town with a population of less than 100,000, the figures were quite alarming as the country struggled to meet the Millennium Development Goal target on maternal mortality at 52 women per 100,000 live births by the end of 2015.

Department of Health records showed that as of the first nine months of 2015, 539 maternal deaths had been recorded, a 57-percent reduction from the numbers culled in 2012. But Health Secretary Janette Loreto-Garin said the country still failed to meet the 2015 targets.

With his municipal health officer (MHO), rural health physician and members of the local health board, Velarde initiated health innovations—some of which have been replicated in other areas—when he trained under ZFF’s Community Health Partnership Program in 2012.

The program tasks mayors and MHOs to improve health indicators in their jurisdictions using a roadmap with the World Health Organization’s six building blocks of health system alongside a two-year, four-module leadership training.

Armed with new leadership skills, Velarde forged a “breakthrough alliance” with the Archdiocese of Caceres and local parishes, which tapped priests to help the municipal government in advocating for responsible parenthood and safe, planned and wanted pregnancies.

The unlikely partnership yielded positive results because the men of cloth were still highly revered as God’s messengers in his town, said Velarde.

“If we just let the local leaders do all the talking, people may not listen and reject the message, especially when they feel that it will contradict their beliefs and traditions,” he said, adding that it also helped that the town has the most number of parishes, seven, under the archdiocese.

The national government and the Catholic Church have been divided over the reproductive health law, which gave Filipino couples access to a wide range of birth-control methods, particularly artificial ones.

“Priests are still effective communicators in our municipality. Our people still believe that the message priests deliver is the word of God, so they obey,” said the chief executive.

The priests in his town assist in teaching couples the calendar method, a form of natural family planning method that tracks the woman’s menstrual cycles to estimate the time of ovulation, said Velarde. “The health experts handle the scientific commodities of family planning,” he added.

Engaging the priests also became convenient in communicating ignored programs and activities like free prenatal and postnatal checkups for mothers and vaccination schedules for babies, he pointed out.

At times, Velarde said he would join the priest in front before the mass was concluded to make the announcements himself or lecture about the calendar method. Velarde himself is well-versed in the calendar method. “My wife and I used this technique in spacing all our children,” he disclosed.

In the previous years, Tinambac had a dismal rate of facility-based deliveries. Pregnant women would rather give birth in their homes with the assistance of a *hilot* (traditional birth attendant) and laboring mothers delayed admission to hospitals.

One of the major causes of maternal and neonatal deaths in the town is the failure of pregnant mothers about to give birth or with an emergency medical situation to get immediate help. Others who do not have enough money to pay for transportation opt to give birth in their homes, he said.

To address these obstacles, the municipal government passed the safe birthing ordinance, which imposes harsher sanctions to hardheaded hilots and couples who seek their assistance rather than get professional medical care.

Velarde also gave hilots a more stable and lucrative job to discourage them from assisting in home-based deliveries. The young ones were employed as barangay health workers, who assisted midwives in their barangay chores, while older ones worked as herbal gardeners.

Due to the distance of coastal and upland villages to the town’s health facilities—two Rural Health Units and a municipal hospital—Velarde organized a crew of habal-habal drivers in each of the 44 barangays under the *Kasurog* Program to ensure every pregnant woman in labor reaches the hospital on time.

The habal-habal drivers were given uniforms and IDs and a record book that identified all the pregnant women in their own villages as well as the women’s addresses and due dates. After bringing the mothers, drivers can collect payment from the local government.



“The record book is regularly updated by the municipal health office. It gives the drivers an idea when they should bring these mothers to the nearest health facility,” he said.

A more permanent solution came when a halfway maternal home was constructed in 2013, providing a temporary sanctuary to pregnant women while awaiting their due date so they will no longer need to travel from far-flung villages.

Now serving his last term, Velarde is set to step down in June 2016 but he is convinced the municipality has worked harder in the last two years to strengthen the town’s health system that involved all the sectors.

“We have institutionalized our programs, so even without me, there will be continuity. The principle of supply and demand will also come in. The people already know what the municipal government owes them so they will continue to demand better services from whoever will lead the municipal government,” he said.

Habal-habal (motorcycle taxi) drivers play a crucial role in making sure babies are born safely. These drivers bring pregnant women to the nearest health facility when they become due. Payment for this service is provided by the local government so mothers and their families need not worry about the extra costs.

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FINANCIAL HIGHLIGHTS

THE ZUELLIG FAMILY FOUNDATION
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE

	December 31	
	2015	2014
ASSETS		
Current Assets		
Cash and cash equivalents (Note 4)	P74,572,068	P109,787,043
Receivables (Note 5)	8,245,261	3,758,173
Prepayments and other current assets	957,522	745,853
Total Current Assets	83,774,851	114,291,069
Noncurrent Assets		
Property and equipment (Note 6)	7,421,998	10,184,021
Retirement asset (Note 10)	–	231,351
Total Noncurrent Assets	7,421,998	10,415,372
TOTAL ASSETS	P91,196,849	P124,706,441
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables (Note 7)	P35,940,588	P41,181,674
Due to a related party (Note 8)	432,383	439,669
Total Current Liabilities	36,372,971	41,621,343
Noncurrent Liability		
Retirement liability (Note 10)	7,427,536	–
Total Liabilities	43,800,507	41,621,343
Fund Balance	47,396,342	83,085,098
TOTAL LIABILITIES AND FUND BALANCE	P91,196,849	P124,706,441

The complete audited financial statement report and accompanying notes to financial statements can be found in the CD.

THE ZUELLIG FAMILY FOUNDATION
 (A Nonstock, Nonprofit Corporation)
 STATEMENTS OF REVENUES, EXPENSES AND FUND BALANCE

	Years Ended December 31	
	2015	2014
REVENUES		
Donations (Note 8)	₱175,043,072	₱176,314,216
Interest (Note 4)	395,468	654,010
Others	104	6,990
	175,438,644	176,975,216
EXPENSES (Note 9)		
Professional fees	65,537,815	40,599,041
Trainings and seminars	54,363,566	27,021,404
Transportation and travel	32,981,746	25,256,227
Salaries, wages and other benefits	25,438,920	19,943,887
Utilities (Note 8)	10,283,281	6,827,570
Retirement costs (Note 10)	7,658,887	593,572
Depreciation and amortization (Note 6)	4,625,821	5,362,994
Materials and supplies	3,409,519	4,214,626
Donations and contributions	3,046,369	28,171,263
Representation and entertainment	1,466,329	1,558,952
Infrastructure projects	637,015	17,307,124
Unrealized foreign exchange losses	31,192	66,300
Others	1,646,940	1,157,177
	211,127,400	178,080,137
DEFICIENCY OF REVENUES OVER EXPENSES	(35,688,756)	(1,104,921)
FUND BALANCE AT BEGINNING OF YEAR	83,085,098	84,190,019
FUND BALANCE AT END OF YEAR	₱47,396,342	₱83,085,098

The complete audited financial statement report and accompanying notes to financial statements can be found in the CD.

THE ZUELLIG FAMILY FOUNDATION
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF CASH FLOWS

	Years Ended December 31	
	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES		
Deficiency of revenues over expenses	(P35,688,756)	(P1,104,921)
Adjustments for:		
Depreciation and amortization (Notes 6 and 9)	4,625,821	5,362,994
Interest income (Note 4)	(395,468)	(654,010)
Retirement costs (Note 10)	7,658,887	593,572
Unrealized foreign exchange losses	31,192	66,300
Revenues (expenses) before working capital changes	(23,768,324)	4,263,935
Increase in:		
Receivables	(4,487,088)	(3,521,542)
Prepaid and other current assets	(211,669)	(127,615)
Increase (decrease) in:		
Accrued expenses and other payables	(5,241,086)	11,818,521
Deferred revenue	–	(18,355,451)
Due to a related party	(7,286)	376,324
Net cash used in operations	(33,715,453)	(5,545,828)
Interest received	395,468	654,010
Net cash used in operating activities	(33,319,985)	(4,891,818)
CASH FLOWS FROM INVESTING ACTIVITIES		
Additions to property and equipment (Note 6)	(1,863,798)	(4,717,117)
Proceeds from sale of property and equipment	–	1
Net cash used in investing activities	(1,863,798)	(4,717,116)
NET DECREASE IN CASH AND CASH EQUIVALENTS	(35,183,783)	(9,608,934)
EFFECT OF FOREIGN EXCHANGE RATE		
CHANGES ON CASH AND CASH EQUIVALENTS	(31,192)	(66,300)
CASH AND CASH EQUIVALENTS		
AT BEGINNING OF YEAR	109,787,043	119,462,277
CASH AND CASH EQUIVALENTS		
AT END OF YEAR (Note 4)	P74,572,068	P109,787,043

The complete audited financial statement report and accompanying notes to financial statements can be found in the CD.

2015 ZUELLIG FAMILY FOUNDATION ANNUAL REPORT
Corporate Communications - Zuellig Family Foundation
Concept and Design: Studio 5 Designs, Inc.
Photography: Revoli Cortez, Ray Leyesa, Richard Visco
Text: Georgina Ortiz-Fabreag, Blanche Fernandez, Jo Morelos



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 2015 audited financial statements are contained in the CD. The Report may also be downloaded from our website, www.zuelligfoundation.org.



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)

Completed and complied with the requirements of the Global Reporting Initiative
G3.1 self declared application level A+

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www.zuelligfoundation.org



**ZUELLIG FAMILY
FOUNDATION**

Annual Report 2015

Audited Financial Statements



VISION:

To be a catalyst for the achievement of better health outcomes for the poor by strengthening leadership and governance, with primary focus on rural communities and secondarily, urban poor communities, in the Philippines

MISSION:

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

GOALS:

1. All trained local health leaders have improved bridging leadership competencies.
2. All trained local health leaders are able to strengthen local health systems with equitable and sustainable community-driven arrangements for better health outcomes.
3. Lessons learnt and evidences are disseminated to advocate for equitable policies in public health and governance.
4. Partnerships with government and other stakeholders are formed to support and institutionalize leadership and local health system developments.



Bridges and Leaders

Alilem in Ilocos Sur occupies an interior upland area in the southern part of the province. Several hanging bridges dot the municipality to connect the village proper and town center to the different *sitios* (sub-villages). It had a high rate of home births and a low rate of skilled birth attendant (SBA) deliveries. To address these, Mayor Ruel Sumabat held dialogues with his municipal leaders so they could allot a higher budget for health. He personally visited villages to talk to his people. Winning support from internal and external partners, the local government has managed to hire additional midwives, build a halfway maternal shelter adjacent to its 4-in-1 PhilHealth-accredited facility, and establish emergency transport system in every village. Alilem's rate of facility-based deliveries increased from 72 percent in 2013 to 96 percent in 2015. Its SBA also increased in the same period from 75 percent to 96 percent. It recorded no maternal death from 2013 to 2015.



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FINANCIAL HIGHLIGHTS

THE ZUELLIG FAMILY FOUNDATION
(A Nonstock, Nonprofit Corporation)
INDEPENDENT AUDITOR'S REPORT

The Board of Trustees
The Zuellig Family Foundation, Inc.

Report on the Financial Statements

We have audited the 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, 2015 and 2014, 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.

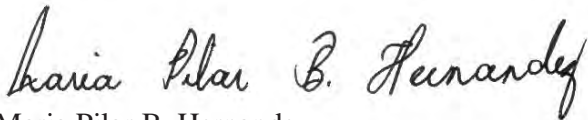
Opinion

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, 2015 and 2014, 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 No. 15-2010

Our audits were conducted for the purpose of forming and opinion in the basic financial statements taken as a whole. The supplementary information required under Revenue Regulations No. 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.



Maria Pilar B. Hernandez

Partner

CPA Certificate No. 105007

SEC Accreditation No. 1558-A (Group A),

April 14, 2016, valid until April 14, 2019

Tax Identification No. 214-318-972

BIR Accreditation No. 08-001998-116-2016,

February 15, 2016, valid until February 14, 2019

PTR No. 5321644, January 4, 2016, Makati City

April 29, 2016

FINANCIAL HIGHLIGHTS

THE ZUELLIG FAMILY FOUNDATION
 (A Nonstock, Nonprofit Corporation)
 STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE

	December 31	
	2015	2014
ASSETS		
Current Assets		
Cash and cash equivalents (Note 4)	P74,572,068	P109,787,043
Receivables (Note 5)	8,245,261	3,758,173
Prepayments and other current assets	957,522	745,853
Total Current Assets	83,774,851	114,291,069
Noncurrent Assets		
Property and equipment (Note 6)	7,421,998	10,184,021
Retirement asset (Note 10)	–	231,351
Total Noncurrent Assets	7,421,998	10,415,372
TOTAL ASSETS	P91,196,849	P124,706,441
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accrued expenses and other payables (Note 7)	P35,940,588	P41,181,674
Due to a related party (Note 8)	432,383	439,669
Total Current Liabilities	36,372,971	41,621,343
Noncurrent Liability		
Retirement liability (Note 10)	7,427,536	–
Total Liabilities	43,800,507	41,621,343
Fund Balance	47,396,342	83,085,098
TOTAL LIABILITIES AND FUND BALANCE	P91,196,849	P124,706,441

See accompanying Notes to Financial Statements.

THE ZUELLIG FAMILY FOUNDATION
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF REVENUES, EXPENSES AND FUND BALANCE

	Years Ended December 31	
	2015	2014
REVENUES		
Donations (Note 8)	₱175,043,072	₱176,314,216
Interest (Note 4)	395,468	654,010
Others	104	6,990
	175,438,644	176,975,216
EXPENSES (Note 9)		
Professional fees	65,537,815	40,599,041
Trainings and seminars	54,363,566	27,021,404
Transportation and travel	32,981,746	25,256,227
Salaries, wages and other benefits	25,438,920	19,943,887
Utilities (Note 8)	10,283,281	6,827,570
Retirement costs (Note 10)	7,658,887	593,572
Depreciation and amortization (Note 6)	4,625,821	5,362,994
Materials and supplies	3,409,519	4,214,626
Donations and contributions	3,046,369	28,171,263
Representation and entertainment	1,466,329	1,558,952
Infrastructure projects	637,015	17,307,124
Unrealized foreign exchange losses	31,192	66,300
Others	1,646,940	1,157,177
	211,127,400	178,080,137
DEFICIENCY OF REVENUES OVER EXPENSES	(35,688,756)	(1,104,921)
FUND BALANCE AT BEGINNING OF YEAR	83,085,098	84,190,019
FUND BALANCE AT END OF YEAR	₱47,396,342	₱83,085,098

See accompanying Notes to Financial Statements.

FINANCIAL HIGHLIGHTS

THE ZUELLIG FAMILY FOUNDATION
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF CASH FLOWS

	Years Ended December 31	
	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES		
Deficiency of revenues over expenses	(P35,688,756)	(P1,104,921)
Adjustments for:		
Depreciation and amortization (Notes 6 and 9)	4,625,821	5,362,994
Interest income (Note 4)	(395,468)	(654,010)
Retirement costs (Note 10)	7,658,887	593,572
Unrealized foreign exchange losses	31,192	66,300
Revenues (expenses) before working capital changes	(23,768,324)	4,263,935
Increase in:		
Receivables	(4,487,088)	(3,521,542)
Prepaid and other current assets	(211,669)	(127,615)
Increase (decrease) in:		
Accrued expenses and other payables	(5,241,086)	11,818,521
Deferred revenue	–	(18,355,451)
Due to a related party	(7,286)	376,324
Net cash used in operations	(33,715,453)	(5,545,828)
Interest received	395,468	654,010
Net cash used in operating activities	(33,319,985)	(4,891,818)
CASH FLOWS FROM INVESTING ACTIVITIES		
Additions to property and equipment (Note 6)	(1,863,798)	(4,717,117)
Proceeds from sale of property and equipment	–	1
Net cash used in investing activities	(1,863,798)	(4,717,116)
NET DECREASE IN CASH AND CASH EQUIVALENTS	(35,183,783)	(9,608,934)
EFFECT OF FOREIGN EXCHANGE RATE		
CHANGES ON CASH AND CASH EQUIVALENTS	(31,192)	(66,300)
CASH AND CASH EQUIVALENTS		
AT BEGINNING OF YEAR	109,787,043	119,462,277
CASH AND CASH EQUIVALENTS		
AT END OF YEAR (Note 4)	P74,572,068	P109,787,043

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 Km. 14, West Service Road cor Edison Ave., 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 20 and 18 regular employees in 2015 and 2014, respectively.

The Philippine Council for Non-Government Organization Certification (PCNC), on October 26, 2015 issued a certification for good governance and accountability for a period of five (5) years.

The Bureau of Internal Revenue (BIR) issued the Certificate of Registration for donee institution status that is valid until October 15, 2016 subject to extension until October 28, 2020 upon presentation of renewed Certificate of Registration from the Department of Social Welfare and Development (DSWD).

In accordance to the provision of Revenue Regulations (RR) No. 13-98 dated January 1, 1999, the donations received shall entitle the donor/s to full or limited deduction pursuant to Section 34(H)(I) or (2), and exemption from donor’s tax pursuant to Section 101(A)(3) of the National Internal Revenue Code of 1997.

Furthermore, the Foundation has filed with the BIR a revalidation of its tax exemption status. As of April 29, 2016, the Foundation is still waiting for BIR’s confirmation. Being a nonstock, nonprofit corporation, it is not subject to income tax under Section 30 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 29, 2016.

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).

FINANCIAL HIGHLIGHTS

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 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.

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.

Accrued expenses and other payable are recognized initially at the transaction price.

It is necessary to estimate the amount or timing of accruals, however, the uncertainty is generally much less than for provisions.

Financial Instruments

Classification

The following are basic financial instruments:

- Cash
- A debt instrument that satisfies specific criteria
- A commitment to receive a loan that cannot be settled net in cash, and when the commitment is executed, is expected to meet the conditions of a debt instrument above

FINANCIAL HIGHLIGHTS

- An investment in non-convertible preference shares and non-puttable ordinary shares or preference shares.

Other financial instruments would include instruments that are not within the scope of basic financial instruments.

Recognition

Basic and other financial instruments are recognized in the statement of financial position when the Foundation becomes a party to the contracts.

Initial Measurement of Financial Instruments

Basic financial instruments are measured at their transaction price including transactions costs.

If the contract constitutes a financing arrangement, it is measured at the present value of future payments discounted at a market rate of interest for a similar instrument (this is not applicable to assets and liabilities classified as current, unless they incorporate a finance arrangement).

If interest is not at a market rate, the fair value would be future payments discounted at a market rate of interest. Other financial instruments are initially measured at fair value, which is usually their transaction price. This will exclude transaction costs.

Subsequent Measurement

Investments in non-convertible preference shares and non-puttable ordinary, and preference shares that are publicly traded or their fair value can otherwise be reliably measured, are measured at fair value through profit or loss if a public market exists, otherwise at cost less impairment.

All other financial instruments are measured at fair value at reporting date. The only exception are equity instruments (and related contracts that would result in delivery of such instruments) that are not publicly traded and whose fair value cannot be reliably determined are measured at cost less impairment.

Impairment of Basic Financial Instruments

At each reporting date, an assessment is made as to whether there is objective evidence of a possible impairment. The impairment loss of basic financial instruments at amortized cost is the difference between carrying value and the revised cash flows discounted at the original effective interest rate.

The impairment of basic financial instruments at cost is the difference between the carrying value and best estimate of the amount that would be received if the asset was sold at the reporting date.

Reversal of impairment on basic financial instruments is permitted.

Impairment of Other Financial Instruments

Other financial instruments carried at cost are impaired on the same basis as basic financial instruments measured in the same manner.

Fair Value

The standard makes use of a fair value hierarchy. This is quoted prices in an active market, prices in recent transactions for the identical assets (adjusted if necessary), and use of a valuation technique (that reflects how the market would expect to price the asset and the inputs reasonably represent market expectations). Fair value, where there is no active market, is only considered

reliable if the variability in the range of fair values is not significant and the probabilities of various estimates can be reasonably assessed.

Derecognition

The Foundation derecognizes a financial asset when:

- The contractual rights to the cash flows from the financial asset expire or are settled,
- The Foundation transfers to another party substantially all of the risks and rewards of ownership of the financial asset, or
- The Foundation, despite having retained some significant risks and rewards of ownership, has transferred control of the asset to another party and the other party has the practical ability to sell the asset in its entirety to an unrelated third party.

The Foundation derecognizes a financial liability when extinguished.

Fund Balance

Fund balance includes all current and prior period results of operation as disclosed in the statement of revenues, expenses and fund balance.

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

FINANCIAL HIGHLIGHTS

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. When the Foundation expects reimbursement of some or all of the expenditure required to settle a provision, the entity recognizes a separate asset for the reimbursement only when it is virtually certain that reimbursement will be received when the obligation is settled.

The amount of the provision recognized is the best estimate of the consideration required to settle the present obligation at the statement of assets, liabilities and fund balance date, taking into account the risks and uncertainties surrounding the obligation. When a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows.

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.

Foreign Currency Transactions

Items included in the financial statements of the Foundations are measured using the currency of the primary economic environment in which the Foundation operates (the functional currency).

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Outstanding foreign currency denominated monetary assets and liabilities are translated at the exchange rate prevailing at statement of financial position date. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation of monetary assets and liabilities denominated in foreign currencies are recognized in the statement of revenues, expenses and fund balance.

Related Parties

Related party relationship exists when one party has the ability to control, directly, or indirectly through one or more intermediaries, the other party or exercise significant influence over the other party in making financial and operating decisions. Such relationship also exists between and/or among entities which are under common control with the reporting enterprise, or between, and/or among the reporting enterprise and its key management personnel, directors, or its stockholders. In considering each possible related party relationship, attention is directed to the substance of the relationship, and not merely the legal form.

Transactions between related parties are accounted for at arms' length prices or on terms similar to those offered to non-related entities in an economically comparable market.

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

The Foundation's financial statements prepared in accordance with PFRS for SMEs require management to make judgments and estimates that affect the amounts reported in the financial statements and related notes.

Judgments

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 in the next page.

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 2015 and 2014 amounted to ₱179.0 million and ₱155.1 million, respectively, while general and administrative expenses in 2015 and 2014 amounted to ₱32.1 million and ₱22.9 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 were no changes in estimated useful lives of property and equipment in 2015 and 2014.

The carrying value of property and equipment amounted to ₱7.4 million and ₱10.2 million as of December 31, 2015 and 2014, respectively (see Note 6).

FINANCIAL HIGHLIGHTS

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

No impairment losses were recognized for the years ended December 31, 2015 and 2014. The carrying value of property and equipment amounted to ₱7.4 million and ₱10.2 million as of December 31, 2015 and 2014, 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 include among others, discount rates, expected returns on plan assets and rates of compensation increase. While the Foundation believes that the assumptions are reasonable and appropriate, significant differences in the actual experience or significant changes in the assumption may materially affect the pension and other retirement obligations (see Note 10).

4. Cash and Cash Equivalents

This account consists of:

	2015	2014
Cash on hand and in banks	₱46,148,960	₱41,283,817
Short-term placements	28,423,108	68,503,226
	₱74,572,068	₱109,787,043

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 ₱0.4 million and ₱0.7 million in 2015 and 2014, respectively.

5. Receivables

This account consists of receivables from:

	2015	2014
Program Partners:		
United Nations Children's Emergency Fund (UNICEF)	₱7,566,225	₱3,247,399
United Nations Population Fund (UNFPA)	377,218	245,025
META	-	241,127
Advances to suppliers	99,340	-
Advances to officers and employees	58,497	8,006
Other receivables	143,981	16,616
	₱8,245,261	₱3,758,173

- 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:

	2015				Total
	Transportation Equipment	Office Equipment	Furniture and Fixtures	Office Improvements	
Cost					
Balance at beginning of year	₱5,631,140	₱12,524,632	₱2,828,216	₱8,028,168	₱29,012,156
Additions	–	853,946	370,902	638,950	1,863,798
Balance at end of year	5,631,140	13,378,578	3,199,118	8,667,118	30,875,954
Accumulated Depreciation and Amortization					
Balance at beginning of year	3,142,514	8,655,284	2,427,315	4,603,022	18,828,135
Depreciation and amortization (see Note 9)	806,397	1,883,707	191,533	1,744,184	4,625,821
Balance at end of year	3,948,911	10,538,991	2,618,848	6,347,206	23,453,956
Net Book Value	₱1,682,229	₱2,839,587	₱580,270	₱2,319,912	₱7,421,998

7. Accrued Expenses and Other Payables

This account consists of:

	2015	2014
Accrued expenses:		
Professional fee	₱15,466,921	₱7,864,849
Trainings and seminars	9,860,086	7,580,365
Payable to contractors	4,788,973	20,342,409
Others	3,035,849	3,048,592
Due to government agencies	1,949,102	1,756,919
Other payables	839,657	588,540
	₱35,940,588	₱41,181,674

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.

FINANCIAL HIGHLIGHTS

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	Outstanding Balance		Terms	Conditions
<i>(Amount in millions)</i>						
The Zuellig Group, Inc.	Donations (a)	2015 2014	₱100.0 100.0	₱- -	None	Unrestricted
Roberto R. Romulo	Donations (b)	2015 2014	0.01 0.50	- -	None	Restricted
Zuellig Pharma Corporation (ZPC)	Share in utilities (c)	2015 2014	0.9 0.7	0.4 0.4	90 days upon receipt of billings; noninterest-bearing	Unsecured

- 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.
- 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 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, 2015 and 2014 were recorded under “Due to a related party” account in the statements of assets, liabilities and fund balance.

Total compensation to key management personnel amounted to ₱15.1 million and ₱10.8 million in 2015 and 2014, respectively.

9. Expenses

The Foundation’s expenses consist of the following for the year ended December 31, 2015 and 2014:

	2015		Total
	Project Expenses	General and Administrative Expenses	
Professional fees	₱63,453,093	₱2,084,722	₱65,537,815
Trainings and seminars	52,804,372	1,559,194	54,363,566
Transportation and travel	32,561,279	420,467	32,981,746
Salaries, wages and other benefits	15,026,327	10,412,593	25,438,920
Utilities (Note 8)	7,348,801	2,934,480	10,283,281
Retirement costs (Note 10)	-	7,658,887	7,658,887
Depreciation and amortization (Note 6)	-	4,625,821	4,625,821
Materials and supplies	2,489,523	919,996	3,409,519
Donations and contributions	3,046,369	-	3,046,369
Representation and entertainment	1,011,336	454,993	1,466,329
Infrastructure projects	637,015	-	637,015
Others	600,724	1,077,408	1,678,132
	₱178,978,839	₱32,148,561	₱211,127,400

	2014		
	Project Expenses	General and Administrative Expenses	Total
Professional fees	₱36,914,073	₱3,684,968	₱40,599,041
Donations and contributions	28,171,263	–	28,171,263
Trainings and seminars	25,778,631	1,242,773	27,021,404
Transportation and travel	24,392,078	864,149	25,256,227
Salaries, wages and other benefits	13,063,982	6,879,905	19,943,887
Infrastructure projects	17,307,124	–	17,307,124
Utilities (Note 8)	4,303,864	2,523,706	6,827,570
Depreciation and amortization (Note 6)	–	5,362,994	5,362,994
Materials and supplies	3,522,940	691,686	4,214,626
Representation and entertainment	1,313,886	245,066	1,558,952
Retirement costs (Note 10)	–	593,572	593,572
Others	366,101	857,376	1,223,477
	₱155,133,942	₱22,946,195	₱178,080,137

General and administrative expenses represent 15% and 13% of the total expenses in 2015 and 2014, respectively.

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 toward 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 healthcare delivery by having reliable and up-to-date information that can be used for faster decision-making, data transmission, and timely interventions by health leaders and personnel in the rural health units and other health facilities.

FINANCIAL HIGHLIGHTS

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 fix their local health systems and reduce health inequities. 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 leadership formation program for local chief executives and municipal health officers intended to fix their local health systems such that better health outcomes for the poor are achieved.

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, determine relevant interventions to address health challenges, and attain provincial health targets. The program includes executive sessions and coaching program for governors and PHOs after each module.

Other interventions involved are assessment of public hospitals, and coaching and mentoring of hospital management teams; and *lakbay-aral* (learning journeys) for local chief executives and key health leaders.

Health Leadership and Management for the Poor (HLMP). A training program designed to improve the leadership and management capability of relevant health officials of the Department of Health and faculty members of academic partners.

Barangay Health Leadership and Management Workshop (BHLMW). The program trains barangay leaders in health systems improvement. The goal is to make barangay health systems more independent and empowered through leadership workshops. The training has led to the establishment of Barangay Health Boards (BHBs) that helped improved behaviors of pregnant women. The BHBs has also served as municipal LGUs' arm for policy implementation in the communities.

A technical training component is also included to address barangay health workers' lack of appropriate knowledge and skills in delivering maternal and obstetric healthcare services. The technical training includes: (1) Pregnancy Tracking System; (2) Danger Signs of Pregnancy; and (3) Referral system to RHUs.

Continuing Leadership for Health and Development (CLHDP). The aim of the program is to help alumni partner municipalities of the Foundation to sustain health reforms in their local health systems by expanding concerns to include social determinants of health such as education and livelihood. Aside from maternal and child healthcare, the program aims to further improve health systems to address nutrition, tuberculosis, and adolescent sexual and reproductive health.

Change Management Program (CMP). The program is aimed at creating urgency among regional directors (RDs) to steer his/her team in the direction that will ensure the success of the Health Leadership and Governance Program (HLGP). The training program for RDs is also aimed at ensuring within the regional office an acceptable new vision with the HLGP in the picture is developed.

Health Leadership and Governance Program (HLGP). A joint initiative with the Department of Health (DOH) to strengthen the leadership and governance capabilities of local chief executives and public health professionals to address health system challenges. The program improves capacities and commitments of the regional and local health leadership as well as other organizations, including the academe, to support local health systems development. There were 609 priority local government units identified by the National Anti-Poverty Commission (NAPC) for inclusion in the program when it was created in 2013.

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.

The United Nations Children Funds also responded to the DOH's call for HLGP support. The HLGP implementation in UNICEF areas varies per level of LGU engagement. UNICEF covers the costs of training and coaching of nine municipalities and six cities.

Resilient Health System. The 15-month engagement was completed in December with the project objective of enabling the 12 Yolanda Cohort LGU partners to draw-up their respective Health Emergency Preparedness Response and Recovery Plans (HEPRRP). This is another undertaking of ZFF, with funds from the United Nations Children's Fund and assistance from Manila Observatory.

Other than leadership and governance training, health leaders of the 12 LGUs were trained on Psychosocial Processing, Basic Health Emergency Management System and Evidence-based Planning Processes for a Health Emergency Preparedness, Response and Recovery Plan.

City Leadership and Governance Program (CLGP). The program is an enhancement of an existing Short Course on Urban Health Equity (SCUHE) developed by DOH Bureau of Local Health Systems Development (BLHSD) and the Development Academy of the Philippines (DAP), and implemented in partnership with the World Health Organization (WHO). Other partners involved in the rollout of the training are the DOH-ROs and city health officers (CHOs).

CLGP has been conducted in 20 cities in partnership with the USAID, UNICEF, and BLHSD.

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 health leadership and governance of mayors, municipal health officers and local leaders; strengthen the local health systems; and improve community participation and health-seeking behavior of women and mothers living in the 20 municipalities classified as geographically isolated and disadvantaged areas (GIDAs) in the provinces of Samar and Northern Samar.

FINANCIAL HIGHLIGHTS

c. Other Projects

Action Research and Policy Studies. The Foundation has been conducting action researches on policy environments to determine and address factors that would contribute to the success and sustainability of health programs the Foundation’s partner municipalities. ZFF formed the Research Advisory Board composed of experienced researchers, who provide technical inputs during the development and conduct of the research studies.

Community Disaster Response Programs. The Foundation conducted *Buntis Congress* in three Samar municipalities affected by Typhoon Nona (Melor) and distributed 670 maternal kits.

PHAP Cares 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”.

US-Philippines Society (with Montero Medical Missions Foundation). On-going construction of maternal homes in the Eastern Samar municipalities of Balangkayan, Gen. MacArthur, and Basey.

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 present value of the retirement liability and the related current service cost and past service cost were measured using the Projected Unit Credit Method.

The amounts included in the statements of assets, liabilities and fund balance are as follows:

	2015	2014
Present value of defined benefit obligation	₱13,154,559	₱5,441,553
Fair value of plan assets	(5,727,023)	(5,672,904)
Net retirement liability (asset)	₱7,427,536	(₱231,351)

Retirement expense for the years ended December 31, 2015 and 2014 consists of:

	2015	2014
Current service cost	₱2,768,246	₱1,594,674
Interest cost	258,474	222,756
Expected return	(107,218)	–
Actuarial loss (gain)	4,739,385	(1,666,489)
Past service cost	–	489,817
Changes in the effect of the asset ceiling	–	(47,186)
Retirement expense	₱7,658,887	₱593,572

Details of retirement benefit liability as of December 31, 2015 and 2014 consists of:

	2015	2014
Balance at beginning of year	₱5,441,553	₱4,693,333
Current service cost	2,768,246	1,594,674
Interest cost	258,474	222,756
Past service cost	–	489,817
Actuarial gain	4,686,286	(1,559,027)
Balance at end of year	₱13,154,559	₱5,441,553

Changes in the fair value of plan assets in 2015 and 2014 are as follows:

	2015	2014
Balance at beginning of year	₱5,672,904	₱5,565,442
Actuarial gain	(53,099)	107,462
Expected return	107,218	–
Balance at end of year	₱5,727,023	₱5,672,904

The allocation of the plan assets is shown below:

Cash and cash equivalents	0.2%
Investment in government securities	99.6%
Receivables	0.2%

The plan assets of the Foundation are maintained by a trustee bank.

The plan assets are composed of cash in banks, receivables - net of payables and investments in debt securities. Descriptions of each category are as follows:

- a. Cash and cash equivalents consists of savings deposits and special savings deposits.
- b. Investments in debt securities consist of investments in government bonds.
- c. Receivables - net of payables consist of interest receivables.

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

	2015	2014
Balance at beginning of year	(₱231,351)	(₱824,923)
Retirement expense	7,658,887	593,572
Balance at end of year	₱7,427,536	(₱231,351)

The principal assumptions used in determining retirement benefits for the years ended December 31, 2015 and 2014 are as follows:

	2015	2014
Discount rate	5.10%	4.75%
Expected return on plan assets	3.00%	1.89%
Expected rate of salary increase	10.00%	10.00%

11. Supplementary Information Required Under Revenue Regulations No. 15-2010

Exempt from Tax on Corporations

The Foundation being a nonstock and nonprofit charitable institution is exempted from taxation of corporation.

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

- a. The National Internal Revenue Code of 1997 also provided for the imposition of VAT on sales of goods and services. Accordingly, the Foundation's sales are exempt from output VAT while its importation and purchases from other VAT-registered individuals or corporations are exempt from input VAT.

- b. 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	0195884	January 20, 2015	₱20,608
Community tax certificate	00180861 and 03072206	January 14 and January 17, 2015	2,005
Barangay clearance	5866084	January 16, 2015	1,200
Others	Various	Various	11,003
			<u>₱34,816</u>

- c. Withholding Taxes

Expanded withholding taxes	₱6,388,899
Withholding taxes on compensation and benefits	5,265,063
	<u>₱11,653,962</u>

- d. Tax Assessments

The Foundation has no tax assessments as of December 31, 2015.

- e. Tax Cases

The Foundation has no outstanding tax cases in any other court bodies outside of the BIR as of December 31, 2015.

2015 ZUELLIG FAMILY FOUNDATION ANNUAL REPORT
Corporate Communications - Zuellig Family Foundation
Concept and Design: Studio 5 Designs, Inc.
Photography: Revoli Cortez, Ray Leyesa, Richard Visco
Text: Georgina Ortiz-Fabreag, Blanche Fernandez, Jo Morelos



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 2015 audited financial statements are contained in the CD. The Report may also be downloaded from our website, www.zuelligfoundation.org.



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)

Completed and complied with the requirements of the Global Reporting Initiative
G3.1 self declared application level A+

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