From the beginning, the Foundation’s mission was simple – be a catalyst for improved health outcomes of the poor [SLIDE 1].

That the Zuellig family’s focus on health is not surprising, since the family is knowledgeable about the health sector. At that time, the prospects of meeting the country’s Millennium Development Goal targets particularly in the area of maternal and child health were slim.
The late Alberto Romualdez, former DOH Secretary and ZFF trustee, enjoined the Foundation to look at the health of the poor if it wants to address inequities in the health system that lead to poor outcomes.

The family is focused on the rural poor, as poverty in the Philippines is largely homogenous in rural areas, and access to public health services is dire especially among the very poor and marginalized.

Most of us in this room are very aware of the great lengths that the rural poor has to go through to reach basic health and social services. It was for these families, that Zuellig family felt that that Foundation could give most impact to.

Guided by the Zuellig family values, the Foundation operationalized its public health mission beginning in 2008, paying attention to rural areas and focusing on health outcomes of the poor. The work, therefore, is not only strategic, but has added value to the Philippine health system.

Suggestions were given. One was to put up community clinics, but this was not sustainable, unless one wanted to do it forever. The recommendation was to work with local governments, since health is a devolved function.

But in 2008, working with local governments is not a preferred option. It was counter intuitive, but it was strategic. It had risks, but it can be mitigated.

But above all it was done before by mayors, like the late Sonia Lorenzo of San Isidro, Nueva Ecija, who provided access to good health facilities and services for most of her constituents, especially the poorest of the poor; or by Municipal Health Officers like that of Gattaran, Cagayan Province, who kept maternal deaths at zero for ten straight years, from 1998 to 2008.

Other researches offered good practices. When all these were put together, it gave a total picture that emphasized the value of political leadership and community participation on pro-poor health programs and services.

This body of experience on responsive leadership and wealth of good practices on health systems reforms were then translated to a Theory of Change – the ZFF Health Change Model [SLIDE 2], which states that to have better health outcomes, the community, especially the poor, must have access to health services, made possible by a responsive health system, which in turn was transformed by committed local leadership.
This was not an unknown concept, but its operationalization is a relatively unexplored territory.

The Foundation’s foray into public health was focused on municipal health system where its experience and learnings can be used, replicated and mainstreamed.

The first intervention was to improve the health services where the poor go – the rural health units of local government. This meant working with municipal mayors and his or her health leadership team (SLIDE 3), who after the devolution of health services in 1992, were now responsible for promotive and preventive health.
To train the mayors and his health leadership team, the Foundation designed the Health Leaders for the Poor program, which equipped the mayor with an understanding of the inequities in his health system, and what needs to be done to reduce such inequities.

At the same time, the program allowed him to bring together his internal bureaucracy as well as his external stakeholders to co-own the shared vision and response, and come up with new institutional arrangements to bring in equity in the system.

Built around the Bridging Leadership process, the development framework is heavily influenced by the writings of Nobel Laureate Amartya Sen and the use of Theory U as technology for social change.

From 2009 to 2013, the Foundation tested this Model in 72 municipalities in 9 cohorts of various combinations.

The focus was on maternal health. The results showed that the two year intervention approach, consisting of four 5-day face to face modular training sessions with 6-month practicum periods in between, where the mayor and his leadership team improve the health can in fact bring about better health outcomes.

Our work with municipalities yielded several results [SLIDE 4].
One, mayors can become champions for health.

Two, they need an easy-to-understand and measurable scorecard with clear corresponding leadership acts from them to improve their health systems.

And, number three, mayors and their teams need mentoring and coaching in transforming their health systems. Our work with mayors have proven that local mayors and their teams have to be integrators of the health system, and improving their leadership skills and competencies allows them to innovate.

Our initial cohort of municipalities showed us that in working on system-sensitive indicators such as maternal health, maternal deaths can be in fact be brought down by early tracking, providing complete pre- and post-natal care, ensuring facility-based deliveries, and providing access to family planning services. And for mothers with high risk pregnancies, there should be access to referral facilities for critical obstetric care.

These are not innovations that we credit to our interventions. But rather these are acts of leadership that mayors did, as integrators of the health system.

The initial results of the Health Change Model opened an opportunity for scaling up. In late 2013 then DOH Secretary Dr. Enrique Ona, challenged the Foundation to transfer the approach to DOH and work with priority municipalities of the National Anti-Poverty Commission (NAPC) [SLIDE 5].
Moving the perimeter from 72 municipalities to more than a thousand nationwide required a leap of faith, but it was a rare window of opportunity not always given to a private family foundation.

But it came with risks, mainly because the intended innovation is coming from the outside, a private NGO, and pushed by a politically appointed Secretary, whose tenure is dependent on the pleasure of the President.

But it was an opportunity not to be missed, and as our experience with working with LGUs showed, the risks can be mitigated.

For this scaling up, we had a program partnership with DOH – the Health Leadership and Governance Program. To reduce the risks, we ensured that the innovation is internally owned.

We ensured all partnership policies, systems, procedures were co-created with the DOH. There is nothing in the program that was unilaterally insisted by ZFF. Further, ZFF covered all its program operating costs in this program including training costs of academic partner trainers.

This partnership has three major elements [SLIDE 6]:

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**Developing Strategic Partnerships**

*Key to mainstreaming:*

*Ensuring innovation is internally owned, rather than externally imposed.*
1. Transfer the technology by enhancing the leadership and governance capability needed to operationalize the Model, and use a systems approach with Bridging Leadership as the platform to participating regional offices, requiring the training, coaching, and mentoring of regional directors as well as those of selected regional staff;

2. Build the capacity of regional academic partners through training, coaching, and mentoring to be able to effectively provide training and other interventions to their municipal leadership teams; and

3. Provide DOH resources, funding and otherwise, to facilitate the responsiveness of local health systems to the needs of the poor (SLIDE 7).
Building upon the results of our interventions in local governments, the Foundation engaged other partners to further expand the reach of the Health Change Model and adopt the technology to achieve better outcomes in response to specific challenges.

Partnerships [SLIDE 8] is critical to the Foundation given our intention to work within a “collective impact” approach, leveraging our resources and engaging partners.
Engaging partners for ZFF provides opportunities for the organization to improve its processes, access to additional resources, maximize existing resources, build networks, and promote greater understanding and innovations to our work.

Our work with the UNFPA, for example, enabled the Foundation to work with provincial governors with specific focus on family planning, which later became a key element of the Provincial Leadership and Governance Program.

Our work with the UNICEF facilitated our engagement with cities and inequities in urban areas, where our learning and insight will move into our emerging partnerships with highly urbanized cities under the City Leadership and Governance Program especially in addressing urban poor health inequities and increasing teenage pregnancies.

Our engagement with MSD for Mothers (MSD) to address maternal health challenges in Geographically Isolated and Disadvantaged Areas (GIDA) on the other hand, became the basis for our continuing work with GIDA communities in Region 8, where our experience can be part of the GIDA strategy of the DOH.
Our work with USAID encouraged us to work on issues such as family planning, tuberculosis, and resilient service delivery networks. It also pushed us to collaborate with the DOH for the institutionalization of the HLGP.

The Foundation’s partnership with the US-Philippine Society in the Yolanda relief effort enabled us to work on the resilience of health systems in Samar and is now being used in the health resiliency model for mainstreaming in our training modules.

Our current work with the Kristian Gerhard Jebsen Foundation looks at the serious problem of malnutrition and stunting, and has implications on addressing the stunting issue across the country. When the proof of concept is validated, the approach and strategies can be diffused to provinces whose governors are willing to use it.

In 2016, in response to the Philippine Health Agenda, we started working with provincial governors and DOH regional directors. The Philippine Health Agenda promoted universal health care, service delivery network and continuity of care for the three burden of diseases. Implicit in this agenda is that the poor will have better access to health services.

We again saw this as a window of opportunity for a provincial governor (SLIDE 9) to exercise leadership in the integration of curative and preventive care. While he exercises direct supervision over his hospitals, he has to use his political influence to align the goals and objectives of the municipal health systems as the basis for the overall provincial health goals and objectives.
This is required if the service delivery network is to be effective, especially in addressing the poor of the province.

However, this new governor’s role requires guidance, as well as support from the DOH regional office, especially the RD and the PDOHO who will coach and guide the governor and his provincial health team toward this direction (SLIDE 10).

Thus, we developed two programs with the DOH: the Provincial Leadership and Governance Program Version 2, and the Bridging Leadership Fellowship Program for DOH Regional Directors.

These interventions are challenging because you see the two integrations: the first is between the provincial and the municipal health systems; and the next between the latter and the DOH regional support system. If the two integrations are done, then the local health system is better implemented toward better health outcomes. Our catalyst role is how to help make it happen.

COLLOQUIUM: REPORT OF RDs

Later on in the program, we will hear the RDs relate their experiences in leading their teams in institutionalizing the approach and the technology. By putting in the policy, additional manpower, and the needed resources for the program, the regions have achieved critical milestones in their institutionalization initiatives.
We hope that as the RDs move into the central offices as ASec or USec, as in the case of USec Cabotaje and ASec Dumama, they will continue to be champions and advocate local health leadership and governance as the platform for the implementation of public health programs.

**COLLOQUIUM: REPORT OF THE GOVERNORS**

In subsequent panels, we will also listen to their experiences in interacting with governors in pursuit of operationalizing the different components of the partnership at the provincial level, especially to improve performance of their hospitals and performance of rural health units; their leadership on setting up the service delivery network and the focus on the poor.

This symposium, in fact, hopes to highlight the achievements of governors who have decided to adopt the approach and use the technology to address their provincial health challenges.

Briefly, as these will be covered in the succeeding sessions for the rest of the day, PLGP Version 2 opened a new arena in the development of integrated provincial health systems. The experience shows the following key success factors in this engagement:

- A governor committed to good health outcomes and supported by competent staff;
- At the very least, governors are able to establish their core group, fix the provincial health system, and improve the rate of MCP-accredited RHUs;
- Started improving the service delivery systems, and focused on the poor.

Overall, as the program showed, it would take at least a year for the governors to fix their systems, which will be useful in the light of the Universal Healthcare bill that puts the provincial health system as the organizing system for public healthcare in the country.

What difference does 10 years make?

All in all, the Zuellig family has provided P800 million over the period. Collectively, the Foundation’s partners have spent around P400 million. For its partnership program with ZFF, the DOH has spent P800 over the last five years, on top of the Foundation’s own P150 million for the HLGPP alone.

As previously mentioned, over 600 municipalities have been exposed to the Health Change Model, as well some 23 provinces, since 2008. More than 400 DOH staff, including senior regional operations staff, together with around 54 faculty members from 13 academic institutions all over the country, have likewise been trained in BL.

What we can show for our work (SLIDE 11)
What have we learned?

- A public leadership and governance approach which can be shared with other interested sectors, through public programs that will be available starting next year.
- Partnership engagement with the DOH, especially at the regional levels, where direct operations work is essential;
- A network of academic partners that can diffuse and move the technologies and tools to other sectors;
- Engagement of other partners critical for the replication, mainstreaming, and expansion of coverage of the change model and its capacity building platforms.

All these are now part of the Zuellig Family’s legacy of giving back to the country of their birth. The giving back could have been, as mentioned by our Chairman, “Feel good initiatives with a scatter gun approach.” The giving back was operationalized by the Family Foundation with a focused vision and mission to be the catalyst of health outcomes for the poor. It is a foundation with a strategic goal with measurable results.

What it leaves behind are local chief executives with better commitment for public health leadership and governance in partnership with health institutions that care for the same. The continued partnership of these two groups, plus the participation of a stronger public voice for health will be critical in the sustainability of this approach.
In ending let me say my thanks:

- To the DOH, from the central office, especially the BLHSD, to the regional offices for co-owning and co-creating the journey with us to make Filipinos healthier.

- To our local chief executives – the mayors and governors and the health leadership teams for not giving up on making their scorecards green.

- To our other partners, for sharing resources and expertise to make our work mutually and beneficially better.

- To our ZFF staff past and present – for their continuing commitment for better health outcomes for the poor.

- To the Board of trustees for the guidance, presence, and insightful observations and critical questions.

- To the Zuellig family, especially to David and Daniel Zuellig, for their support to the foundation in pursuit of better health outcomes for the poor. And its faith and respect for its professional management and staff.

- And finally, to our Chairman, Amb. Roberto Romulo without whose wisdom and wicked wit, this will not be all possible. Thank you Bobby.

Thank you and good morning.