THE FRIENDLY CARE FOUNDATION, INC. OF THE PHILIPPINES: LESSONS FROM THE PROFAMILIA OF COLOMBIA

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INTRODUCTION

Still quite young and only turning 53 in October 2008, Dr. Alberto Romualdez Jr., the Vice Chairman of the Friendly Care Foundation, Inc., was already mulling over the possibility of relinquishing his Board of Trustee position to another doctor who is willing to take over his multifaceted responsibilities in the organization.

Dr. Romualdez Jr. is thinking of focusing on his specialized practice in physiology-membrane biophysics and immunology. However, to do this, he has to bring to completion the grandiose blueprint for the Friendly Care system patterned after the Pro-Familia of Colombia.

Dr. Romualdez Jr. is fully aware that the success of Pro Familia is slowly being replicated by Friendly Care but something must be done to fast track the process which took Pro Familia more than forty (40) years to accomplish.

The Early Stages of Pro-Familia

The population of any country is its principal resource base and the source of its identity and vitality. Populations are usually accounted for in terms of a nation's performance as a distinct political-economy. Human populations are seen as having direct influence and profound impact on the capacity of nations to create and share wealth among its members, on the way this capacity is organized and structured, and the manner by which the same institutional capacity is protected and enhanced through time. Population management is traditionally viewed as government's responsibility. In full as well as aspiring democracies today, however, private citizens, corporate entities and other non-government organizations (NGOs) are in the forefront of undertaking population management programs now referred to as 'family planning and reproductive health' services.

This was the experience of a group of Colombian nationals who established the Asociacion Pro bienestar de la Familia Colombiana in 1965, commonly referred to as Pro-Familia (PFC).

The Profamilia Colombia

PFC was set up as a private non-profit organization[1] offering family planning information and services to low income families.[2] Like most beginning organizations, PFC started small with its first service delivery outlet located in a physician's clinic in Bogota.[3] Yet, it could not be said that PFC started entirely from scratch or in a vacuum. Prior to PFC's establishment, enabling forces favoring birth control[4] already existed and exerted a growing influence on the population management landscape of Colombia. These forces are both internal and external and contributed to Colombia's dramatic fertility decline starting in the mid-1960s even before PFC itself existed.[5]

Internal enabling forces for population control in Colombia included a compact but active group of medical professionals who banded together to form the *Colombian Association of Medical Schools,* (ASCOFAME). In the mid-1960s, ASCOFAME provided institutional support for the delivery of the first family planning services in Colombia, along with "the first demographic research and program evaluation studies".[6]

ASCOFAME got support from a host of external enabling forces with strong interest in, and hence equally strong advocacies for, population control. These forces included a number of private organizations in the United States of America (U.S.) such as the Ford Foundation, the Rockefeller Foundation and the Population Council. It also included many U.S. universities that provided extensive training that "produced a cadre of well trained, committed Colombian professionals" that consisted of sociologists, economists, anthropologists, lawyers, communications experts, and many physicians and nurses…"[7] The most significant enabling force for Colombia and for a host of other developing countries, however, is a U.S. government agency – the US Agency for International Development (USAID) – whose support for Colombian population control also began in the mid-1960s.

The PFC itself obtained technical and/or funding assistance from external sponsors. Two years after it was established, PFC got affiliated with the "*International Federation for Family Planning*" (IPPF)[8], an active birth control and pro-choice NGO that was established in Bombay, India in 1952 but operated from the United Kingdom.[9] PFC, for a time, became IPPF's representative in its Western Hemisphere Region. Eventually, PFC obtained financial and technical support from the USAID itself.

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[1] Profamilia website: www.profamilia.org.co

[2] Jesus Amadeo, Dov Chernichovsky and Gabriel Ojeda, "The Profamilia Family Planning Program – Colombia: An Economic Perspective", Population and Human Resources Department, The World Bank, August 1991. p.8

[3] Amadeo, Chernichovsky and Ojeda, 1991. p.8

[4] The population control methods and services favored by these forces include abortion and the use of artificial means of preventing conception or the birth of children, which are opposed by institutions such as the Roman Catholic Church.

[5] Web article 'Population Trend', 1988, www.country-data.com/cgi-bin/query/r-3017.html This article argues that factors other than population control programs such as that offered by PFC produced the notable fertility decline in Colombia. It asserts, however, the PFC's services successfully kept this country's population growth rate down through time.

[6] Judith Seltzer and Fernando Gomez, "Family Planning and Population Programs in Colombia: 1965 to 1997", POPTECH Report No.97-114-062, May 1998, pp.xii-xiv

[7] Seltzer and Gomez, 1998 pp.xii.xiv

[8] Profamilia website: www.profamilia.org.co

[9] The IPPF is a highly devolved global NGO whose aim is to promote sexual and reproductive health and to advocate the right of individuals to make their own choices in family planning. It has 149 members to date and operates in 189 countries distributed into six regions. http://en.wikipedia.org/wiki/IPPF

Then came Friendly Care…

Friendly Care Foundation, Inc. (FCFI) was established in 1999 in the Philippines, as a "business entity with social goals"[10]. It is a non-stock NGO designed to provide "high quality and affordable family planning and other reproductive health services as well as family health care to low and lower-middle income Filipino families."[11] It is a response to the Philippine Government's challenge that the private sector should take "concrete action to the unmet family planning needs of a large segment of the [Philippine] population."[12]

Its founder Lizzie Eder Zobel, wife of the distinguished Jaime Zobel de Ayala, was cited in the cover story of the publication *Town & Country,* as follows …

> *Upon seeing the Philippines for the first time in 1986, she (Lizzie Zobel) says, "I made a commitment to myself that I would find a life here and that life would be very meaningful and very happy." Indeed, Zobel has made meaning not only to her life, but also to the lives of many others through the foundations she has set up. A commitment to education and family planning has seen the rise of the Museo Pambata, the non-profit organization Sa Aklat Sisikat, and the* ***Friendly Care Foundation****, all of which allow her to be a part of the change she hopes will live to see.*

Dr. Romualdez Jr. recalled that when he took over the reins of leadership as President of Friendly Care Foundation, Inc., following his stint as Health Department Secretary during the incumbency of then President Joseph Estrada, he really made an effort rehashing and ingraining in his mind the rationale for drawing on the experiences of Pro Familia, which were obviously the model used in running the affairs of FCFI. He surmised that Ms. Lizzie Zobel, being a Colombian national, had first hand knowledge of the successful family planning strategy and reproductive health benefits brought on by Pro-Familia to the families in Colombia, which she would like to spread to the Philippines.

There were other similarities and disparities that Dr. Romualdez Jr. could think of as regards the situations in the two countries which did not impede the Friendly Care Foundation, Inc. from emulating the successes of Pro Familia.

To begin with, both the Philippines and Colombia are developing countries, (Exhibit A: Comparative Geographic Features and Physical/Natural Endowments of Colombia and the Philippines) and inevitably, both the PFC and the PCFI have become immersed in the socio-cultural and political-economic dynamics of the nation-states they operate in. As regards population, although there is a big difference between the total population size of Colombia and the Philippines, both countries have relatively young population bases (Exhibit B: Demographic Features of Colombia and the Philippines). Likewise, both countries have almost the same infant mortality rate, literacy and life expectancy at birth. The point of divergence is in the total fertility rate where the Philippines exhibits TFR considered high by population control proponents.

A comparison of the two countries' socio-economic profiles highlights other crucial differences (Exhibit C: Socio-Economic Profiles of Colombia and the Philippines). Although Colombia and

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[10] Pilar Ramos-Jimenez, Mely D. Silverio and Desiree C. U. Garganian, "Potential Friendly Care Franchise/Business Partner Clinic Operators: Their Social Entrepreneurial Characteristics", 2001
[11] Jimenez, Silverio and Garganian, 2001, p.1
[12] Jimenez, Silverio and Garganian, 2001, p.1

the Philippines have identical GDP rates, their GDP per capita is set apart in view of their wide difference in total population. The higher per capita GDP of Colombia can be used as argument that lower total population and slower population growth rates have beneficial effect on a country's economic performance. Comparison of the remaining parameters provides a more complete picture of the relative performances of Colombia and the Philippines. The former's labor force, for instance, is almost 50% of its small total population, while that of the latter is only a third of its larger population base indicating greater economic development potential.

The significantly lower unemployment rate of the Philippines indicates that its labor force is more fully engaged in economic activity compared to that of Colombia. Both countries have serious high poverty profiles, with the Philippines faring better despite its larger population base. However, the historically based socio-political profiles of the two countries further show that they had other serious concerns aside from population. (Exhibits D: Historical and Socio-Political Issues & Exhibit E: Chronology of Public Order Issues/Concerns). The two nation-states' youth[13] would explain not only their dynamism but also the confusion and their "touch and go" approach to fitting into the post-cold war world order.

Dr. Romualdez Jr. continued to play the profiles of Colombia and the Philippines in his mind, fully aware that the conditions and social processes depicted by the said profiles ultimately impact on the population that is served by family planning and reproductive health services providers such as the PFC and the FCFI. Admittedly, the said profiles only depict what happens inside the countries concerned. There are also decisions and policies made outside Colombia and the Philippines that equally affect their population policies.

In the case of FCFI, it was formed some 34 years after the creation of the PFC. This gap represents the experience base of the latter organization which could be made use of by the former as it develops its service mix through time. The relation between the two organizations is more than the mere similarity of their missions, for the FCFI was deliberately patterned after PFC. "The FCFI is the outcome of a number of visits made from November 1998 to January 1999 by government and non-government officials, representatives of the USAID cooperating agencies, and interested members of the private sector to Colombia and Mexico, where successful private family planning and health programs were observed."[14]

While modeled after the PFC, FCFI did not have a strong and organized institutional support such as that provided for PFC by ASCOFAME and ASCOFAME-generated mechanisms, but there are individuals and groups from both public and private sectors of the Philippines led by Lizzie Zobel who, sharing the same population control paradigm, have responded to the perceived need of the Philippines for more effective means to slow down the country's fertility rates.

Insofar as external enabling forces for population control in the Philippines are concerned, it is interesting to note that the list of bilateral and multilateral sponsors for family planning also included the USAID which has operated in the Philippines decades ahead of FCFI's establishment. Multilateral bodies such as United Nations Fund for Population Activities (UNFPA), World Health Organization (WHO), and the United Nations Fund for Children (UNICEF) provided one form of help or another to FCFI.

[13] This is insofar as Colombia's and the Philippines' being open-market democracies, as compared to established market-based democracies in Europe and the United States.
[14] Jimenez, Silverio and Garganian, 2001, p.1

Common Thread in Population Policy

The USAID represents the common thread that runs through the population control programs of Colombia and the Philippines. This becomes understandable viewed from the geopolitical and economic survival perspective of the United States (US).

Having emerged as the strongest political-economy after the two world wars and enmeshed in a Cold War with the international communist movement thereafter, the US was naturally concerned about sustainability of its capacity to create wealth and to uphold the democratic freedoms that underpin its projected identity before the rest of the world. Such sustainability depends on availability of raw materials and resources needed by its industries. Much of these raw materials and resources are located in other countries around the world but their availability is subject to socio-political vicissitudes that include the countries' population growth rate.

A coherent policy of outright intervention in population management of targeted countries may not have existed in the 1960s when the USAID started to support the PFC, and if it existed at all, the United States Government (USG) would have deemed prudent then to keep it under wraps. Eventually, in the 1990s, it was discovered that such a coherent policy did exist[15] in the form of the *National Security Study Memorandum No. 200: Implications of Worldwide Population Growth for U.S. Security and Overseas Interests* (NSSM 200) which was crafted and adopted as policy in the mid-1970s.

The memorandum listed thirteen developing countries considered of strategic importance to the US[16], and whose population growth may impact on the US's national security[17] as its uncontrolled growth "would tend to civil unrest and political instability."[18] Countries named in NSSM 200 are projected at the time of the study to constitute 47% of world population growth, and these included Colombia and the Philippines.[19]

US bashers would claim that the NSSM 200 is evidence of the USG's imperialist and hegemonic tendencies. However, a careful reading of the document has led Dr. Romualdez Jr. to think that the US was simply doing what any sovereign state with enough political power would do to ensure survival of its citizens within their chosen way of life in the midst of weak allies and unfriendly and threatening forces.
At the height of the Cold War, it would be easy to accuse the US of imposing its will upon weaker nations whose endowments could satisfy its industrial requirements. Today, when many of these nations have already experienced the hands-on rigors of balancing the needs of their consuming sectors as against those of their producing sectors, it has become easy to accept the observation that too much consuming population without equal or better production capabilities could indeed threaten the well being of the entire nation itself.

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[15] The NSSM 200 was a classified study commissioned by Sec. Henry Kissinger and was completed in December 1974. President Gerald Ford adopted it as official policy of the US in November 1995. Long held under wraps, the NSSM 200 was eventually declassified in the early 1990s and was obtained by researchers. http://en.wikipedia.org/wiki/National_Security_Study_Memorandum_200

[16] NSSM 200: Part II, Ch.2, Sect.A, No.2 – Geographic Priorities in U.S. Population Assistance, http://www.population-security.org/28-APP2.html

17 See NSSM 200: Part I, Ch.V – IMPLICATIONS OF POPULATION PRESSURES FOR NATIONAL SECURITY, http://www.population-security.org/28-APP1.html

[18] http://en.wikipedia.org/wiki/National_Security_Study_Memorandum_200

[19] Other countries listed in the NSSM 200 are: India, Bangladesh, Pakistan, Indonesia, Thailand, Turkey, Nigeria, Egypt, Ethiopia, Mexico and Brazil.

Common Geopolitical Pressure

For a better understanding of the US's population policy predilection, Dr. Romualdez Jr. took a closer look at a table which provided him an idea regarding the shifts in the population policy of the US. The Administrations concerned did not necessarily trumpet such changes publicly but simply put them in effect through alteration of items to support with funding and technical assistance through the USAID and related agencies. For the recipients of U.S. support on family planning programs in Colombia and the Philippines, these shifts also represent 'discontinuities' that impact on the overall effectiveness of their respective population management programs.

Table 1: U.S. Population Policy Shifts

Year	EVENT
1973	US Supreme Court legalizes abortion via Roe v. Wade ruling; Sen. Jesse Helms introduces amendments to Foreign Assistance Act prohibiting aid for abortion as a family planning method.
1974	Completion in December of the National Security Study Memorandum 200 (NSSM200) under the direction of Sec. Henry Kissinger. The study expresses US concerns over population growth in thirteen developing countries, attempting to quantify the risks therein such as civil unrest and political instability that could impact on these countries' economic development that would, in turn, impact on the development of certain US industries that depend on raw materials from the said countries. The thirteen countries projected by the study to create 47% of all world population growth are Bangladesh, Brazil, Colombia, Egypt, Ethiopia, India, Indonesia, Mexico, Nigeria, Pakistan, the Philippines, Thailand, Turkey.
1975	The NSSM 200 whose full title is '*National Security Study Memorandum 200: Implications of Worldwide Population Growth for U.S. Security and Overseas Interests'* was officially adopted as US policy by President Gerald Ford in November. The policy advocates the promotion of contraception and other population reduction measures. It also raises the question of whether U.S. should consider preferential allocation of surplus food supplies to states that are deemed constructive in use of population control measures. The report advises, "In these sensitive relations, however, it is important in style as well as substance to avoid the appearance of coercion."
1984	US Pres. Reagan introduces in the UN Population Conference in Mexico City, the so-called "global gag rule" which is a policy that bars foreign organizations that are recipients of US health-related aid from providing abortion services, counseling or advocacy even if they use non-US assistance for those activities.
1993	President Clinton reverses US' anti-abortion policy.
2001	Pres. Bush reinstates the anti-abortion policy signaling another turnabout in US position on family planning.

Source: 1. http://en.wikipedia.org/wiki/National_Security_Study_Memorandum_2002. Loder, Asjylyn, "Bush' Anti-Choice Policies Felt Around the World", Women's eNews, 1-20-2003, http://www.womensenews.org/article.cfm/dyn/aid/1189/context/archive

Thus, Republican President Reagan's incumbency led to pro-life policies while the assumption of Democratic President Clinton emphasized pro-choice policies. The policy pendulum swung back to pro-life with Republican President Bush. The policy shifts affected the grant of aid and assistance to Colombia, the Philippines and other targeted countries. With a major change in the fortunes of the Republican Party as a result of the U.S. war on Iraq, could another policy shift be expected in the aftermath of the 2008 U.S. Presidential elections?

Common Population Management Fiscalizer(s)

If there is one thing truly common to both PFC and FCFI, Dr. Romualdez thought it is the strong opposition of the Roman Catholic Church (RCC) to controversial population management and birth control methods in both predominantly Roman Catholic Colombia and the Philippines. It is opposition that is perceived as bordering fanaticism in tenacity by advocates of the more liberal population control approaches.

This opposition has two outstanding features: first, it is grounded on long standing and time tested ideology[20], and second, it has the advantage of the RCC's institutional, leadership, and program continuity. The latter feature stands out vis-à-vis the stark discontinuities of the Colombian and Philippine political systems that are the source of the profound weaknesses of the two governments.

Yet, examination of the RCC's position on population management would show that opposition is directed not at population management per se, but toward population control approaches believed by the Church as threatening the very foundations upon which today's advanced civilizations are based – the dignity of human life, and the self-discipline that today's functioning democracies require from their citizens if their market systems are to operate efficiently and productively.

To advocates of liberal population control methods, the RCC's opposition would have appeared unreasonable and may have generated a lot of frustration especially in countries where birth rates as well as the number of families falling below the poverty threshold are rapidly on the rise. This could have been the case for Colombia during the first half of the 20th century, as well as for the Philippines in the latter half of the same century.

Population control advocates and practitioners in both countries tackled the RCC in different ways. In Colombia, the practice appears to be a mix of approaches where the state avoided frontal confrontation by putting off as far as possible the crafting of formal population management policies that could spark outright confrontation with the Church. Civil society groups, on the other hand, particularly NGOs and professional groups aligned with liberal birth control philosophy kept up pressure through time using specific cases of perceived violations of the rights of women and girls as events would allow.

Population dynamics in the Philippines pursued a different tack. As early as the mid-1960s, population management policies have already been formally put forward by the state. The policies, however, have been regarded as too watered down and instances of accommodation to the position of the RCC. Although the Philippine government professes an understanding of the need for population management for economic management reasons, today it is an active advocate of natural family planning. It appears that no civil society group or NGO in the Philippines has as yet offered an effective counter-balance to the RCC position on population control.

It is probably the value-basis of the RCC's consistent fiscalizing of the two countries' population management thrusts that prevents the Colombian and Philippine governments from completely and unilaterally ignoring Church position on family planning and birth control. The Arroyo Administration of the Philippines, for instance, has espoused and actively advocates for the

[20] Conservative Roman Catholics would say that opposition to abortion and artificial birth control methods is 'faith-based'.

modern natural family planning approach without necessary clamping down on, or deemphasizing other methods.

Finally, the RCC's insistence on respecting nature's way as far as population growth is concerned now appears to be vindicated by a phenomenon that increasingly alarms both developed and developing countries worldwide – the so-called 'population implosion' or depopulation of countries now feared as harbinger of economic dislocation for the affected nations and the entire world.

Internal Context of the PFC's and FCFI's Mission

Both the PFC and FCFI's vision and mission statements offer affordable family planning and reproductive health services to clients who belong to the less privileged classes of society. The two organizations' mission is inevitably aligned to an ideology that recognizes the reality of close interdependence among open-market democracies and the need for resource-rich countries supplying the raw materials for advanced industrialized nations to stay economically fit.

The above-mentioned ideology and belief system form enabling as well as contending forces that shape the decisions of PFC and FCFI as they pursue their mission through time. From the stand point of liberal population control philosophy, the PFC's mission execution is a resounding success as the said organization has demonstrated flexibility and skill in delivering the services it is expected to deliver to Colombian society. The same success cannot yet be attributed to FCFI as it has just begun providing its services.

PFC's Mission Execution

Essential startup activities dominated PFC's first five years after its establishment in 1965. Major steps during this period consisted of getting affiliated in 1967 with an international NGO – the IPPF – with capability to provide technical assistance as well as funding. It will be noted that the IPPF obtained part of the funds it shares with its affiliates from the USAID itself. By 1969, PFC launched its first family planning campaign.

The activist streak of PFC emerged in the 1970s. For the first time in Colombia, vasectomy was offered in 1970[21]. Actual distribution of contraceptives and the offering of vasectomy services began in 1971. The following year, PFC launched its female sterilization program which turned out to be much more successful than the its vasectomy program[22].

In 1973, PFC conducted the earliest procedures for laparoscopy, a way of viewing the state of the ovaries and related organs in female patients. In 1976, PFC launched its first Mobile Sterilization Program. By 1979, PFC was conducting familiarization and training programs on sterilization for medical doctors and service providers in the Colombian health sector.
In the last years of the 1970s, PFC also conducted surveys to learn more about its market. One survey project launched in 1978 lasted till 1983. These survey activities reveal the determination of PFC to professionalize its services through application of scientific methods even in the marketing aspect of its business.

[21] Williams, Ojeda & Trias, 'An Evaluation of Profamilia's Female Sterilization Program in Colombia', *Association of Voluntary Surgical Contraception,* New York, NY 10168, 1986
[22] Williams, Ojeda & Trias, 1986

The 1980s is a period of operational contrasts for PFC. It is during this period that it has begun to reap the first fruits of its efforts from the late 1960s to the 1970s. In 1984, for instance, PFC's 28 clinics nationwide is said to account for around 65% of total family planning in Colombia. [Riding] Nonetheless, government hospitals and private medical practitioner have started by this time to be more active in family planning and reproductive health services delivery. By this time, too, sterilization has become a most popular family planning method second only to the birth control pills. [Of the total patients availing of sterilization services, 97% are women[23].

Despite this apparent success in its unfolding mission execution, a major challenge arose by the middle of this decade that truly tested the mettle of PFC. During the UN Population Conference of 1984 in Mexico City, US President Ronald Reagan introduced what has become known since then as the 'global gag rule', a policy that prohibits recipients of US health-related aid from providing abortion as a reproductive health service[24].

This turnaround from a major supporter of liberal population management policy was at that time, part of an emerging conservatism in US politics, propped by the growing strength of Christian fundamentalism [Evangelicalism] that has found common cause with the fierce stand of the RCC against artificial birth control methods.

New York Times contributor Alan Riding describes PFC's reaction as one of being "stunned by [the] US change of policy that threatens significant cuts to its foreign funding"[25]. PFC's reaction becomes understandable when viewed from the fact that the US, through the USAID, has always been a strong and steady proponent of liberal population control policy. The establishment of PFC itself is a product of this policy.

Riding estimates that about one-third of PFC's budget of US$7 million comes from the IPPF which, in turn receives about one-fourth of its US$48 million annual budget from the USAID. In reaction, PFC founder Dr. Tamayo said that PFC "could lose US$600,000 a year if Washington carries out its new policy[26]." He added that PFC may have to cut back on its surgery programs in sterilization.

This setback notwithstanding, PFC's momentum in the 1980s appears unhampered as it proceeded with mission execution.

Table 2 shows these various activities.

[23] Alan Riding, "Battleground in Colombia" NYTimes; http://query.nytimes.com/gst/fullpage.html?res=9F02E0DA1038F936A3575AC0A962948260&sec=health&spon=&pagewanted=print]
[24] Asjylyn Loder , "Bush' Anti-Choice Policies Felt Around the World", Women's eNews, 1-20-2003 http://www.womensenews.org/article.cfm/dyn/aid/1189/context/archive
[25] Riding, 1984
[26] Riding, 1984

Table 2: PFC's Mission Execution Activities

Year	ACTIVITY
1985	PFC launched its experimental male clinics; collaborated with the Association for Voluntary Surgical Contraception for a survey of factors that influence decisions to be sterilized; by 1995, eight male clinics already in operation since PFC's Male Reproductive Health program started[27].
1986	PFC launched the "Juridical Consultations Program for Families", a new reproductive health service addressing needs of families
1987	PFC launched its information campaign for the prevention of HIV/AIDS.
1990	• PFC established its 'Program for Colombian Youth' or the 'Profamilia Youth Program' which aims to provide specialized sexual and reproductive health services to Colombian youth with a guarantee to privacy of clients. • PFC and its founder given recognition for outstanding performance. The PFC was awarded the "Encuesta Nacional de Demografia y Salud" for its contribution to Colombian health and demographic stability[28] while Dr. Fernando Tamayo Ogliartri was given the Boyaca Cross.
1994	PFC initiated its emergency contraceptive services complete with its own information campaign
1995	PFC created a 'Gender Office' to advocate for gender equality and women's rights in Colombia[29]/also intended to conduct researches and execute strategies that promote the rights of women for reproductive health; thus the PFC was invited by the Colombian government to join its national delegation at the 1995 Conference for Women in Beijing, China.
1996	PFC launched a new program that addressed menopause as part of its reproductive health service mix
1998	• PFC launched the 'International Training Program' (SUR-SUR) for Latin America and the Caribbean region serving as a model for efficient family planning and reproductive health services delivery; it also started its Sexual and Reproductive Health Program intended for Colombians displaced by social unrest and violence. • PFC and its founder received recognition from major institutions -- the 'Alejandro Angel Escobar Foundation' for Excellence in Solidarity Work, while Don Fernando Tamayo was given the "Guillermo Leon Valencia Peace Award" by the Colombian Red Cross. • PFC received the "People's Award" from the UN; one of the many public and private awards that the organization received in recognition of its outstanding contributions to population control.
2000	PFC initiated a study on the impact of armed conflict on women[30] and also registered its emergency contraceptive drug 'Postinor-2' with the National Institute for Vigilance on Drugs and Food[31]. PFC skillfully and successfully used the issue of gender based violence generated by Colombian social unrest in pushing for the emergency contraceptive pill (ECP) Postinor-2, against the objections of the church[32].
2001	PFC completed its study on internally displaced women which concluded that one in five displaced woman becomes a victim of sexual violence[33], the results of which were published in 2002 under the "In Depth Study" section of the Encuesta Nacional de Demographia y Salud (ENDS) -2000.
2003	PFC expanded its reproductive health services to include the Profamilia Fertility Program, offering modern techniques for assisted pregnancy; PFC had also become more active in helping out the internally displaced victims of social unrest in Colombia.
2006	PFC was able to establish 35 centers in 29 cities in Colombia[34].

[27] http://www.kit.nl/exchange/html/1995_4_colombia_male_family_pl.asp
[28] PFC received this recognition again in 1995.
[29] http://www.profamilia.org.co/003_social/social.htm
[30] Veronica Vadía Morgenstern, "New Rights, Old Wrongs: Colombia has eased some abortion restrictions—but displaced women still suffer" http://msmagazine.com/winter2007/newrights.asp
[31] Laura E. Asturias, Ed.: Aricle from *Latin American Consortium for Emergency Contraception Newsletter,* Vol.1, No.1 – October 2002, p.10
[32] Asturias, 2002
[33] Morgenstern, 2007

In 1989, however, almost two decades and a half after PFC was established, a study confirms that unsafe abortion continues in Colombia. Stamping out unsafe abortion was the original rationale put forth to justify a more aggressive and liberal application of birth control by organizations like the PFC. A study by Guttmacher puts the annual number of abortions performed in Colombia at 288,400 -- a rate of 33.7 per 1,000 women or an average of 1.2 abortions per Colombian woman. The study estimates that 57,680 of these abortions were unsafe[35].

The 1990s had been a busy decade for PFC, its services more and more addressed to clients coming from extraordinary circumstances and desperate situations in Colombia. While this period saw the flowering of PFC services, Colombian society reeled from the social malaise that gripped the nation over the past ten years. The victory of Bill Clinton as US President in 1992 was a boon to the PFC as he eventually reversed US' anti-abortion policy in 1993.

By the year 1999, meanwhile, some 23,000 people have reportedly been killed by leftist guerillas, right-wing paramilitaries, drug traffickers and common criminals. Moreover, violence has created more than 100,000 refugees while two million Colombians are said to have fled the country[36].
By the year 2000, estimates of displaced Colombians run at 1.5 million. Of these, 58% are said to be women, hence the spike in abortions that reached an estimated annual average of 350,000 out of an estimated 605,000 annual pregnancies[37]. The year 2000 could also be considered a time the PFC 'has arrived' as an institution of distinction among the international community of birth control and reproductive health services providers. Its President, Ms. Angela Gomez de Mogollon was elected this year as President of the IPPF to which PFC has become the second largest affiliate worldwide[38].

The election of George W. Bush as US President became a setback to proponents of liberal birth control in Colombia. In 2001, Pres. Bush reinstated US' anti-abortion policy once again putting a squeeze in the flow of funding for artificial methods of birth control. This must have been an issue of grave concern for PFC considering that by this time, the US provides more than half of PFC's annual budget[39].

Significantly, the PFC's emergency contraceptive pill (ECP) was successfully registered with the Colombian Ministry of Health Standards which has already included ECPs as part of the country's family planning program. PFC members championed people's access to ECPs, pursuing this tack by building networks and alliances with the media, medical associations, women's groups and the youth. The support of these groups helped secure the ECP as an integral component and option in Colombia's family planning program[40]. This allowed PFC to start distributing the ECP Postinor-2.

By 2004, an estimated 75% of Colombian couples practice family planning and 65% of this is serviced by PFC. This measure of success in PFC's mission execution is somehow set in contrast against the unfolding social tragedy of Colombia as a whole and which was described by the UN humanitarian coordinator early in the year as the worst humanitarian crisis in the Western

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[34] http://www.profamilia.org.co/003_social/06vincularse.htm
[35] http://www.guttmacher.org/pubs/ib12.html
[36] http://www.infoplease.com/ipa/A0107419.html
[37] http://www.kit.nl/exchange/html/2000_2_addressing_reproductive.asp
[38] Morgenstern, 2007
[39] Loder , 2003 http://www.womensenews.org/article.cfm/dyn/aid/1189/context/archive
[40] PFC article at info@profamilia.org.co

Hemisphere[41]. Toward the end of 2004, the New York Times updated UN's report on the crisis by announcing that nearly three million Colombians live as internally displaced persons whose plight has changed the face of Bogota and other cities by establishing neighborhoods in their periphery[42]. The internally displaced women of Colombia are the primary market of PFC's emergency contraceptive pills.

By 2005, the effect of conservative pressure on population control efforts in Colombia was reflected in the reaction of lawyer and pro-choice activist Monica Roa who accused PFC of bowing to the US relative to abortion. Roa alleged that Colombia's abortion campaign was being undermined by the Bush Administration whose policy is to ban overseas aid for groups that support abortion[43].

Nonetheless, the advocacy efforts of liberal population control sector appears to be gaining the upper hand as Colombia's Constitutional Court in 2006 allowed abortion in cases where the life of the mother is in danger, when she had been a victim of rape, or when the fetus would not survive outside the womb[44]. PFC placed the Court's ruling within the context of the plight of internally displaced women around 20% of who fall victim to sexual abuse and become infected with HIV/AIDS[45].

By 2006, also, PFC had 35 centers in 29 cities in Colombia, an indication of its continuing growth through time[46].

In 2007, Colombia's first legal abortion took place on a pregnant 11-year old girl who was raped by her stepfather[47]. PFC considers this a victory for the liberal, pro-choice position it has come to uphold through its lifetime. This position has become reinforced through PFC's constant interaction with other social forces of opposing views and its exposure to the realities and tragedies of life in Colombia. On the overall, it can be said that PFC has accomplished its mission with the help of other institutions and organizations aligned to its position. It accomplished its mission principally through persistence, timing and skill in taking advantage of major social conditions and events that could bolster its advocacy and advance its services.

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[41] The UN Humanitarian Coordinator reports that Colombia's drug wars have driven more than two million people from their homes, several Indian tribes are threatened with extinction, the government is mired in debt and reluctant to divert military funds to aid uprooted people escaping the fighting or forced off their land by cocaine traffickers. Because of this, Colombia now houses the third-largest displaced population in the world. Displaced people flooding into cities are ripe for recruitment into guerilla, paramilitary or drug gangs. – Foreign Desk, Reuters, "Crisis Facing Colombians is Called Worst in Hemisphere", May 11, 2004, Late Edition – Final; Section A, Page 8, Column 6.

[42] Juan Forero, "Colombia's 3 Million Refugees, Hidden in Plain Sight", Week in Review Desk – NYT, September 12, 2004, Late Edition – Final; Section 4, Page 6, Column 1; http://select.nytimes.com/gst/abstract.html?res=FA0613FA39540C718DDDA00894DC404482&n=Top%2fReference%2fTimes%20Topics%2fSubjects%2fI%2fImmigration%20and%20Refugees

[43] "Colombia's abortion campaign under attack", internet article posted 14 October 2005, at http://www.peopleandplanet.net/doc.php?id=2560

[44] Ludwig De Braeckeleer, "Colombian Hospitals Defy Abortion Ruling Court" Published 2006-09-08 13:45 (KST) http://english.ohmynews.com/articleview/article_view.asp?menu=c10400&no=315868&rel_no=1

[45] Morgenstern, 2007

[46] http://www.profamilia.org.co/003_social/06vincularse.htm

[47] Morgenstern, 2007

FCFI's Mission Execution.

Since FCFI was patterned after PFC, Dr. Romualdez Jr. would expect that the growth trajectory of the former would be like that of the latter. In fact, one could probably expect more from the FCFI considering it was established at a period when management science is more developed. Indeed the organizers of FCFI appeared to have carefully studied its service delivery setup and with assistance from USAID's Commercial Marketing Strategies (CMS) Program examined business models such as medical services franchising for possible adoption.

FCFI was created and started operating at a period when Philippine population growth rate has considerably declined. Just like in the case of PFC in Colombia, forces of modernization have already contributed to the Philippines' 2.36% fertility rate by the end of the 1990s. Despite this decline, the said rate is still above the standard replacement rate and needs to be brought down further.

Dr. Romualdez could very well relate to the difficulties encountered by FCFI during the early stages of its mission execution. In its very young existence, FCFI went through a tough socio-political environment and at a time of adjustments in the strategy of its major sponsor. Although the Philippine government has provided policy guidance on population matters as early as the 1970s, such guidance has not been consistent through administrations. What remained consistent were the population management practices that through the years appear to be skewed in favor of pro-life advocacies.

Through its own researches in 1998, USAID and partner multilateral organizations have determined the inefficiencies in the distribution of family planning services via the government. The agency thereby resolved to channel population management aid as much as possible through the private sector. The creation and operation of the FCFI is an important aspect of this strategy.

FCFI's establishment in1999 also happened toward the end of the term of the liberal President Clinton's Administration in the U.S. The assumption of the Ultra-Conservative Bush Administration led to another shift in emphasis that meant adjustments to USAID's means and mode of support for population management in the Philippines.

FCFI appears to be adapting to this tough environment. By 2007, it announced a range of family planning products that are not only competitively priced but also have been proven effective in their application. Listed below are the services normally offered at any of the six existing Friendly Care Clinics:

I. Primary Services

A. Primary Care Physician - Family Medicine, Internal Medicine
B. Pediatric Medicine - General Pediatrics
C. Obstetrics & Gynecology - General Obstetrics & Gynecology

II. Specialty Services

A. Cardiology
B. Dental Services
C. Dermatology
D. Diabetology

E. Pediatrics – Allergology, Neurology
F. Obstetrics & Gynecology – Reproductive Endocrinology and Infertility
G. Ophthalmology
H. Otorhinolaryngology (ENT)
I. Surgery - General Surgery, Bilateral Tubal Ligation and No-Scalpel Vasectomy
J. Urology

III. Laboratory and Diagnostic Services

A. Clinical Pathology and Laboratory Packages
B. X-ray
C. Ultrasound (including Thyroid, Breast, Scrotal ultrasound)
D. Cardiac Services – Electrocardiography, 2D Echo
E. Drug Test

IV. Examination Packages

A. Annual Physical Exam
B. Pre-employment Exam
C. Corporate Packages
D. Executive Check-up

To enable the clinics to carry out these services, Friendly Care has a total of 171 accredited doctors assigned in all 6 clinics (Exhibit F: List of Friendly Care Doctors and their Specializations). Table 3 shows the products as well as other non-family planning services being offered in their outlets.

Table 3: FCFI Products and Services as of 2007

FriendlyCare Bilateral Tubal Ligation (BTL)	Permanent method of contraception for women; 99-99.5% safe and effective; Reimbursible for PhilHealth members; Done on out-patient basis
FriendlyCare No-Scalpel Vasectomy (NSV)	Permanent method of contraception for men; 99-99.5% safe and effective; Reimbursible for PhilHealth members; Done on out-patient basis
FriendlyCare IUD (Intra-Uterine Device)	Eight to ten (8-10) years of protection for women; 98% safe and effective; Insertion reimbursible for PhilHealth members
FriendlyCare Injectables (DMPA)	Three (3) months temporary protection for women; 99.6% safe and effective, especially if injection is given regularly every three months
FriendlyCare Pills	One (1) month temporary protection for women; 99.6% safe and effective, especially when taken everyday
FriendlyCare Condoms	Temporary method of contraception for men; Easy and convenient to use; Helps prevent sexually-transmitted diseases
FriendlyCare Cycle Beads	Natural method of contraception for women; 95% effective when used properly; New, simple and easy to learn
ExeCheck	An out-patient comprehensive Executive Check-up
FriendlyCard	Classic - P 980 Health Plus – P1,600 Baby – P 1,400 Kids – P 1,200
Adult Vaccination	Flu vaccine Hepa B Pneumonia (Pneumococcal) Typhoid (Typhim)

Source: http://www.friendlycare.com.ph/family_planning.htm

The inclusion of the Friendly Care Cycle Beads in FCFI's product/service mix would appear to be an accommodation to the powerful influence of the RCC and the commitment of the Arroyo Administration to natural family planning as main mode of population management. Nonetheless, its offering of artificial methods sets it at loggerheads with the RCC and official government policy. What adds to the challenge of survival for FCFI is the socio-economic condition of the Philippines which at this point in time is reaching a critical juncture in its democratic transition.

The impact of FCFI's products and services was immediately recognized and appreciated. In 2001, it received the "Child Friendly Firm Award" from the Cebu Chamber of Commerce and Industry (CCCI) in collaboration with the Employers Confederation of the Philippines (ECOP)[48]. FCFI received several similar awards in subsequent years, much like the PFC of Colombia. At the same time, Friendly Care clinics have been endorsed by the Department of Tourism as ambulatory clinics where *balikbayans*, foreigners and other tourists are encouraged to avail of their outpatient health services. Moreover, Friendly Care clinics can already conduct the medical examination of overseas workers (landbased) by virtue of the accreditation given by the Department of Health (DOH) and POEA.

Indeed, FCFI's startup years were an uphill struggle inasmuch as it had to grapple with certain difficulties as it attempts to execute its mission amidst the challenges of the first few years of its first decade. Table 4 shows that the number of clinics or service outlets directly operated by the FCFI peaked at ten in 2003, but then declined progressively in the following years becoming six in 2007.[49]

Table 4: FCFI Clinics and Clients through the years

YEAR	NUMBER OF CLINICS	NUMBER OF CLIENTS SERVED
2000	**1**	**22,000**
2002	**2**	**100,000**
2003	**10**	**200,000**
2005	**7**	**152,466**
2007	**6**	**N.A.**

Sources: USAID Brochure, USAID Office of Population, Health and Nutrition, April 2003, p.5; USAID Brochure, USAID Mission in the Philippines, Manila, September 2005, p.1; FCFI website: http://www.friendlycare.com.ph/

The apparent decline in outlets could simply be part of a process of consolidation, as FCFI readjusts to the vicissitudes of its market. (Exhibit G: Location of 6 Friendly Care Outlets in the Philippines).

[48] Philippine Information Agency (PIA) Newsletter, 2006

[49] Still in its start-up phase, it is also possible that the FCFI is merely adjusting to the vicissitudes of its unpredictable market.

Despite the odds, to include a poverty incidence of 26.9 % in 2006[50], a moribund oligarchy-controlled political system that prevents the Philippines from joining the ranks of young Asian tiger economies, and given the increasing cost of health care,[51] FCFI as private sector conduit for family planning services was given the thumbs up by several HMOs, and companies/ corporations which avail of its services, to include the following: AXA Life, Ayala Life, Cocolife, Caritas Health Shield, EA Phils, Inc., Fortune Care, Health Maintenance Inc., John Hancock, Manulife Philippines, Pramerica Financial, Value Care, New York Life, Prulife UK, Medicard, IMS Wealthcare.

Because the FCFI's experience as family planning service provider is relatively much less (in terms of years) than that of PFC, and in view of the fact that Colombia's situation is qualitatively different from that of the Philippines' despite some historical similarities, Dr. Romualdez Jr. realized he needed to dig deeper and to act fast in order to draw and replicate useful lessons from PFC's performance.

New Trends and Challenges to FCFI Mission Execution

Through the coming years, the FCFI will need to hone its ability to adapt to and cope with its internal and external environments. This is to enable it to face an entirely new 21st century demographic scenario in an international setting where nations and their economies have become interdependent and mutually interactive. This very interdependence also influences the local economy and, ultimately, the operations of FCFI. The forces and patterns to look out for include the following:

> **'Depopulation' or 'Population Implosion'**. In the late 1980s and early 1990s, developed countries started attaining the 'replacement rate' in their national fertility[52]. Some developing countries followed suit. As the trend toward declining population growth rates continued, countries started reporting 'sub-replacement rates' raising the specter of depopulation or 'population implosion'. Alongside these trends in the same countries were reports on ageing populations and the consequential concern regarding the quality of the future work force and its capability to support an ageing society through time.
>
> These trends are generally attributed to (1) better health and hygiene practices that lead to longer lives for most people, (2) women's decision to postpone child bearing as a result of better education and ability to hold careers outside the home, and (3) the success of birth control programs. Whatever the actual reasons for the apparently irreversible decline of population as well as its inevitable ageing, both developed and developing countries are now looking at the situation with much concern.[53]

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[50] This represents a 2.5% growth from the poverty incidence of 24.4 in 2003, but still lower than the 27.5% incidence of 2000. Source: National Statistical Coordination Board. http://www.nscb.gov.ph/pressreleases/2008/FINAL%20-%20rav%20presentation,%205mar08.pdf

[51] Its targeted low-income clientele would now find it more difficult to avail of FCFI products and services whose prices will have to reflect inflationary forces in the market.

[52] Replacement fertility is the total fertility rate where women will have an average of exactly one daughter over their lifetimes. This means women have just enough babies to replace themselves. This rate is pegged at 2.1 births per woman for industrialized countries, but ranges between 2.5 and 3.3 in developing countries where there's higher mortality rate. [http://en.wikipedia.org/wiki/Total_fertility_rate]

[53] The issue of ageing and declining population has become a serious concern as even the UN itself and leading think tanks in developed countries have expended manhours to understand and address the phenomenon. An example of a major think tank showing concern for this issue is the RAND Corporation

Economic Upside of Population Growth. The Philippines has recently been 'reaping' some benefits from the contributions of overseas Filipino workers to the local economy. Table 5 shows the growth of these contributions since 1997.

Table 5: OFW Remittances1997-2006 (in thousand US Dollars)

FOR THE PERIOD	TOTAL	LANDBASED	SEABASED
1ST SEMESTER 2006	5,958,866	5,027,704	931,162
2005	10,689,005	9,019,647	1,669,358
2004	8,550,371	7,085,441	1,464,930
2003	7,578,458	6,280,235	1,298,223
2002	6,886,156	5,686,973	1,199,183
2001	6,031,271	4,937,922	1,093,349
2000	6,050,450	5,123,773	926,677
1999	6,794,550	5,948,341	846,209
1998	4,925,989	4,651,440	274,549
1997	5,741,835	5,484,223	257,612

Source: POEA website http://www.poea.gov.ph/stats/remittance_1997_2006.html

This initially unintended yet progressively expanding economic windfall would not have been possible or sustainable in a Philippines with rapidly declining population. Though unwelcome to traditional political-economists, these trends cannot be ignored by serious development planners especially those who understand and appreciate the double edged nature of globalization today.

A New Look at the "RCC Opposition"

Although the FCFI has already taken steps to 'accommodate' the strong advocacy of the RCC against artificial birth control methods, it may be useful to understand the attitude underpinning the said 'opposition' as expressed in the decisions of the 'influenced' politicians. First, it seems too easy to pin the blame for the current fertility performance of the Philippines on the 'pressure' of the RCC as well as on 'lack of political will' of politicians and their constituents in countering the said 'pressure'. Such perspective could conveniently overlook the possible reality that certain leaders of society – whether in the Business, Civil Society or State sectors – could have strong personal moral but non-religious – convictions about the propriety of the use of artificial birth control methods, including abortion.

Second, it may be useful also to heed some aspect of the RCC's advocacy, that may actually reflect the convictions of Filipino leaders and their constituents. For these leaders, the promotion of 'convenience, ease of use and effectiveness' of artificial birth control methods and products could actually go against the code of personal discipline that underpins civic discipline, the decline of which leads to a weak State that is unable to protect its citizens from rapacious vested interests.

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whose European branch produced in 2004 a monograph titled "Low Fertility and Population Ageing – Causes, Consequences and Policy Options", for the European Commission.

Third, the RCC's warning about the consequences of unfettered use of artificial population control methods and products seems to have already emerged and have now become the concern of leaders from both developed and developing nations as mentioned in the above-section on "Depopulation or Population Implosion".
Tapping his pen on his palm as he was wont to do while in deep thought, Dr. Romualdez Jr. could only mumble … Honestly, Friendly Care still has a long way to go….

GUIDE QUESTIONS:

1. *How do you explain the low number of Friendly Care Clinics nationwide despite the comparatively high number of medical practitioners presently affiliated with Friendly Care?*
2. *With the variety of services offered by Friendly Care clinics and the fact that it is being tapped by a number of HMOS and other companies for the health care requirements of their staff, do you foresee the foundation expanding the number of clinics?*
3. *What other best practices of Pro Familia should Friendly Care further emulate?*
4. *With the new Reproductive Health Act gaining ground, what should be the next moves of Friendly Care?*
5. *What is the greatest organizational problem of Dr. Romualdez in turning over the leadership of Friendly Care?*
6. *In terms of number of clients served, Friendly Care seems to be moving ahead, what are its other concerns?*
7. *Based on Pro-Familia experience, how should Friendly Care address the continuing opposition from the Catholic Church to artificial family planning methods?*
8. *Aside from DOH and POEA, what other agencies should provide support to Friendly Care?*

Exhibit A: Geographic Features, & Physical/Natural Endowments

Except for natural resources and natural hazards, most other features are vastly different, sometimes in a paradoxical way. For instance, Colombia's land area is almost three times that of the Philippines, but its population base is only half that of the latter.

	Colombia	Philippines
National Name	Republica de Colombia	Republika ng Pilipinas
Location	Northern South America	Southeastern Asia
Land Area	Total: 1,138,910 sq km Land: 1,038,700 sq km Water: 100,210 sq km Note: includes Isla de Malpelo, Roncador Cay, & Serrana Bank	Total: 300,000 sq km Land: 298,170 sq km Water: 1,830 sq km
Terrain	Flat coastal lowlands, central highlands, high Andes mountains, eastern lowland plains	Mostly mountains with narrow and extensive coastal lowlands
Coastline	3,208 km	36,289 km
Natural Hazards	Highlands subject to volcanic eruptions; occasional earthquakes; periodic droughts	Astride typhoon belt, usually affected by 15 and struck by five to six cyclonic storms per year; landslides; active volcanoes destructive earthquakes; tsunamis
Natural Resources	Petroleum, natural gas, coal, iron ore, nickel, gold, copper, emeralds, hydropower	Timber, petroleum, nickel, cobalt, silver, gold, salt, copper
Land Use	Arable land: 2.01% Permanent crops: 1.37% Others: 96.62%	Arable land: 19.00% Permanent crops: 16.67% Others: 64.33%
Irrigated land	15,500 sq km (2003)	9,000 sq km (2003)
Population	44,379,598 (July 2007 est.)	91,077,287 (July 2007 est.)

Source: Index Mundi, http://www.indexmundi.com/philippines/demographics_profile.html, and http://www.indexmundi.com/colombia/demographics_profile.html

Exhibit B: Demographic features of Colombia and the Philippines

	Colombia	Philippines
Population	44,090,118 (May 2008 Official Colombian Population clock)	88,574,614 (Aug 2007 Official NSO Census results)
Age Structure	0-14 yrs: 29.8% 15-64 yrs: 64.8% 65 yrs + : 5.4% (2007)	0-14 yrs: 34.5% 15-64 yrs: 61.3% 65 yrs + : 4.1% (2007)
Median Age	Total: 26.6 Male: 25.6 Female: 27.5 (2007)	Total: 22.7 Male: 22.2 Female: 23.3 (2007)
Birth rate	20.16 births/1,000 population (2007)	24.48 births/1,000 population (2007)
Death rate	5.54 deaths/1,000 population (2007)	5.36 deaths/1,000 population (2007)
Population Growth rate	1.433% (2007)	1.764% (2007)
Total Fertility rate	2.51 children born/woman (2007)	3.05 children born/woman (2007)
Infant Mortality rate (deaths per 1,000 live birth)	Total: 20.13 Male: 23.86 Female: 16.28 (2007)	Total: 22.12 Male: 24.85 Female: 19.25 (2007)
Literacy rate (Definition: age 15+ can read and write)	Total population: 92.8% Male: 92.9% Female: 92.7% (2004)	Total population: 92.6% Male: 92.5% Female: 92.7% (2004)
Life Expectancy at Birth	Total population: 72.27 years Male: 68.44 years Female: 76.24 years (2007)	Total population: 70.51 years Male: 67.61 years Female: 73.55 years (2007)

Source: Index Mundi, http://www.indexmundi.com/philippines/demographics_profile.html, and http://www.indexmundi.com/colombia/demographics_profile.html

Exhibit C: Socio-Economic Profiles of Colombia and the Philippines

	Colombia	Philippines
GDP Real Growth rate	5.4%	5.4%
GDP per Capita	$8,400	$5,000
Labor Force	20,810,000	35,790,000
Unemployment rate	11.1%	7.9%
Population below Poverty Line	49.2%	40%

Source: Index Mundi, http://www.indexmundi.com/

Exhibit D: Historical and Socio-Political Issues

	Colombia	Philippines
Year of Independence	1824 – from Spain	1898 – from Spain 1946 – from U.S.A.
Form of Government	Republican	Republican
Political Development Issues	Political turbulence due to transition from a feudal to modern democratic nation-state	Political turbulence due to transition from a feudal to modern democratic nation-state
Governance Issues	Weak state institutions vis-à-vis politically active non-state actors	Weak state institutions vis-à-vis politically active non-state actors
Public Order Issues	Three radical leftist insurgencies; Ultra-rightist rebellion;	Communist insurgency; Separatism; Banditry/local terrorism; International terrorism.
Rule of Law Issues	Intrusive special interest groups; Active and organized narco-criminality;	Intrusive special interest groups; Destabilizing political blocs;

Exhibit E: Chronology of Public Order Issues/Concerns

	Colombia	Philippines
1960s	Marxist guerilla group organized: May 19th Movement (M-19), National Liberation Army (ELN), and the Revolutionary Armed Forces of Colombia (FARC)	Militant youth group 'Kabataang Makabayan' (KM) organized to oppose government policies. The Communist Party of the Philippines (CPP) came into being after splitting with the original Marxist oriented Partido Komunista ng Pilipinas (PKP). CPP's military arm, the Maoist oriented 'New Peoples Army' (NPA) was formed.
1970s	Colombia becomes an international center for illegal drug production and trafficking; at times, drug cartels virtually controlled the country.	Separatist Moro National Liberation Front (MNLF) established & launches bid to secede from the Philippines. Martial law declared.
1980s	Socio-political instability heightens as government attempts address security issues on several fronts.	EDSA 'People Power' removes dictator from power. Traditional politics restored. Series of ultra-rightist-led coup attempts threaten to topple the new government.
1990s	Numerous right-wing paramilitary groups formed by drug traffickers & landowners; paramilitary umbrella group formed: United Self-Defense Forces of Colombia (AUC). Some 23,000 people reported killed by leftist guerrillas, right-wing paramilitaries, drug traffickers, and common criminals. Violence has created more than 100,000 refugees while 2 million Colombians have fled the country.	Peace successfully negotiated with Rebel Soldiers and the MNLF. Disgruntled Muslim fighters split with MNLF to form the Moro Islamic Liberation Front (MILF) which continued efforts to secede Mindanao from the rest of the Philippines.
2000s	International Crisis Group publishes report on Colombia's humanitarian crisis offering recommendations. UN announces that Colombia's 39-year long drug war had created the worst humanitarian crisis in the Western Hemisphere. More than 2 million people have been forced to leave their homes; several Indian tribes are close to extinction; Colombia now houses the third largest displaced population in the world. Colombia is challenged by world bodies on its human rights record, pointing to alleged extrajudicial killings and disappearances of persons in the country.	Popularly elected President removed from power. Riots in an attempt to remove the newly installed President. Coup attempts and series of destabilizing moves by political blocs try to dislodge elected but unpopular President. International bodies challenge government's human rights record in view of alleged extra-judicial killings and forced disappearances of militants.

Exhibit F: FRIENDLY CARE ACCREDITED DOCTORS/DENTISTS:

NAME	SPECIALIZATION	LOCATION
CUESTA, Margarita G.	BTL Surgeon	Shaw
GARCIA, Luis R., Jr.	BTL/NSV Surgeon	Shaw
GUEVARRA, Abel P.	BTL/NSV Surgeon	Shaw
MAGLAYA, Hermie F.	BTL/ OB Gynecologist	Shaw
DE TORRES, Ma. Theresa U.	Cardiologist	Lagro / Shaw
ENTIENZA, Roy	Cardiologist	Cebu
HERNANDEZ, Arlynn M.	Cardiologist	Davao
RECIO, Alma	Cardiologist	Shaw
SINAY, Vincent R.	Cardiologist	Lagro
YANEZA, Liberty O.	Cardiologist	Masinag
ASOY, Felix R.	Dentist	Cebu
PONTI, Rene	Dentist	Shaw
VILLEGAS, Vicente	Dentist	Davao
AVIGUETERO, Maria Teresa D.	Dermatologist	Shaw
CEBRIAN, Portia N.	Dermatologist	Lagro
GALUTERA, Rainier D.	Dermatologist	Shaw / Masinag
SAAVEDRA, Maria Lorraine H.	Dermatologist	Masinag
STA. ANA, Maria Lourdes D.	Dermatologist	Cubao
TIO CUISON, Noemie F.	Dermatologist	Lagro
ORTIZ, Vicente G.	Diabetologist	Lagro
WEE, James H.	Diabetologist	Shaw
GUEVARRA, Dominic P.	ENT	Cubao
ANDAL, Deo Magno S.	ENT	Lagro
ACOSTA, Emilio Romel III G.	ENT	Masinag
ALCARAZ, Paul Jansen T.	ENT	Shaw
LOO, Michael	ENT	Shaw
AMISCUA, Rufino Nelson R.	Family Medicine	Davao
BAGUIA, Maria Imelda U.	Family Medicine	Cebu
BALAGOSA, Evangeline I.	Family Medicine	Cebu
BUNGAR, Romeo L.	Family Medicine	Cubao
BUYSER, Floripinas Jr.	Family Medicine	Cebu
CAINTO, Maria Rosellee C. (FM/IM)	Family Medicine	Metro Manila Clinics
CHING, Ishmael	Family Medicine	Metro Manila Clinics
DELOS REYES, Rubi Silangan M.	Family Medicine	Masinag
DIANALAN, Johaira L.	Family Medicine	Cubao
DIZON, Ma. Elena J.	Family Medicine	Metro Manila Clinics
DOCTOR, Marie Therese S.	Family Medicine	Metro Manila Clinics
ENTING VILLANUEVA, Innocencia	Family Medicine	Cebu
ESCOBAR, Perry Anthony G.	Family Medicine	Cubao
FONTANILLA, Ma. Regina C.	Family Medicine	Metro Manila Clinics
LLIMOSO, David V.	Family Medicine	Lagro
LOPEZ, Teresa M.	Family Medicine	Metro Manila Clinics
LOZADA, Marissa B.	Family Medicine	Cebu
MAMARADLO, Alma V.	Family Medicine	Lagro
MANGOROBAN, Ma. Lourdes S.	Family Medicine	Cebu
MATONDO, Cledale D.	Family Medicine	Cebu

NAME	SPECIALIZATION	LOCATION
MEDINA, Nimfa M.	Family Medicine	Lagro
MOJICA, Winlove P.	Family Medicine	Metro Manila Clinics
PALPAL-LATOC, Joy S.	Family Medicine	Masinag
PANGILINAN, Micheline Phoebe V.	Family Medicine	Davao
PEDROSO-GALLARDO, Irmachelle	Family Medicine	Cebu
PIOC, Jose Emmanuel Q.	Family Medicine	Masinag
REYES, Aleta Hope I.	Family Medicine	Shaw
REYES, Ma. Rosario E.	Family Medicine	Lagro
REYNES, Mary Ann C.	Family Medicine	Cebu
RIVERA, Marie Antonette	Family Medicine	Metro Manila Clinics
SAAVEDRA, Melvin Darl T.	Family Medicine	Davao
SALAMAT, Sonia S.	Family Medicine	Metro Manila Clinics
SANTOS, Joan R.	Family Medicine	Metro Manila Clinics
SEGURA, Jolly Peal	Family Medicine	Metro Manila Clinics
VALENCIA, Anton Guido F.	Family Medicine	Shaw / Cubao
VIOVICENTE, Alice Rona H.	Family Medicine	Shaw
CHAN, Anthony Jayvee V.	Family Medicine/ IM	Masinag
ENRIQUEZ, Danilo V.	Family Medicine/ IM	Shaw
ESTANISLAO, Joel	Family Medicine/ IM	Metro Manila Clinics
GRACILLA, Wilma E.	Family Medicine/ IM	Cubao
JACALAN, Tirso Jr.	Family Medicine/ IM	Cebu
RAMOS, Justiniano Ma. III	Family Medicine/ IM	Cubao
SALAZAR, Rommel T.	General Surgeon	Cubao
BUENO, Ma. Lourdes R.	IM-Gastroenthrologist	Cubao
HERNANDEZ, Katherine V.	Internal Medicine - Oncologist	Shaw
SANTOS, Edgar II B.	Internal Medicine	Shaw
BORGAILY, John Habib B.	Internal Medicine	Davao
CUBILLAN, Jerick	Internal Medicine	Shaw
TESORO, Anthony A.	Internal Medicine	Davao
AGUILAR, Angela S.	OB - Rep. Endo & Infertility	Shaw
PENOLIO, Vaneza Valentina L.	OB - Rep. Endo & Infertility	Cubao
ANDAL, Olivia P.	OB Gynecologist	Lagro
AGUSTIN, Louella P.	OB Gynecologist	Metro Manila Clinics
AGUSTIN, Sonia P.	OB Gynecologist	Davao
ALFORQUE, Marie Louise T.	OB Gynecologist	Cebu
ASOY, Janette T.	OB Gynecologist	Cebu
BRIONES, Judith A.	OB Gynecologist	Cubao
CASTRO, Eduvijes Anastacia M.	OB Gynecologist	Masinag
CONCEPCION, Genevieve C.	OB Gynecologist	Cebu
CORTEZ, Genevieve	OB Gynecologist	Cebu
DE VERA, Genevieve F.	OB Gynecologist	Metro Manila Clinics
DE VILLA, Helen R.	OB Gynecologist	Masinag
ELISES, Mae N.	OB Gynecologist	Cebu
FELIZARDO, Teresa Marie C.	OB Gynecologist	Lagro
JOSE, Vina Adora S.	OB Gynecologist	Shaw
LUY, Annabel A.	OB Gynecologist	Davao
ONG, Ma. Ethel B.	OB Gynecologist	Shaw

NAME	SPECIALIZATION	LOCATION
QUIROGA, Maria Christina O.	OB Gynecologist	Shaw
SALAZAR, Clarissa D.	OB Gynecologist	Cubao
SALAZAR, Pearlie S.	OB Gynecologist	Cubao
SAMSON, Gloria M.	OB Gynecologist	Lagro
SANTOS, Melissa Jane M.	OB Gynecologist	Shaw
SUPAN, Stephanie H.	OB Gynecologist	Metro Manila Clinics
SUPLICO, Felice A.	OB Gynecologist	Metro Manila Clinics
TORRES, Romerico F.	OB Gynecologist	Metro Manila Clinics
UTITCO, Pia Marie V.	OB Gynecologist	Metro Manila Clinics
MACEDA, Florence F.	OB-Sonologist	Davao
CANSON, Jayson	Ophthalmologist	Shaw
FLORDELIZA, Raymond	Ophthalmologist	Shaw
LIM, Anthony Jude V.	Ophthalmologist	Lagro
MEJIA, Margarita N.	Ophthalmologist	Lagro
MUNOZ, Cirio M.	Ophthalmologist	Masinag
ABANILLA, Susan B.	Pathologist	Cebu
GRAGEDA, Oscar P.	Pathologist	Davao
TORRES, Reynaldo P.	Pathologist	Shaw
DE JESUS, Olivia G.	Pediatric Allergoligist	Shaw
ADRILLANA, Christian D.	Pediatrician	Lagro
ALANILLA-VIBAR, Ma. Lourdes	Pediatrician	Masinag
ALQUIZA, Glenn M.	Pediatrician	Metro Manila Clinics
ANINON, Nickson A.	Pediatrician	Cebu
ASPURIA, Mellinor A.	Pediatrician	Metro Manila Clinics
BAUTISTA, Ma. Marion	Pediatrician	Davao
BAUTISTA, Michelle Elaine C.	Pediatrician	Cubao
BOLIMA, Susan T.	Pediatrician	Shaw
BUENDIA, Maria Nieves S.	Pediatrician	Shaw
CAGUETE, Maria Fatima Q.	Pediatrician	Lagro
CHONGCO, Ma. Sonia S.	Pediatrician	Metro Manila Clinics
CRUZ, Mary Joan S.	Pediatrician	Lagro
CRUZ, Romillie E.	Pediatrician	Shaw
DE LA TRINIDAD, Rojessa	Pediatrician	Metro Manila Clinics
DIVIDINA, Sheila C.	Pediatrician	Metro Manila Clinics
FABON, Grace M.	Pediatrician	Lagro
GELAGA, James Winford	Pediatrician	Cebu
GOMEZ, Raisa L.	Pediatrician	Metro Manila Clinics
HASSAN, Maria Ana R.	Pediatrician	Shaw
LAYOS, Chonna P.	Pediatrician	Cebu
LEGAMIA, Ma. Victoria A.	Pediatrician	Davao
MANALILI, Anna Mae G.	Pediatrician	Metro Manila Clinics
MANGOBA, Hilario John R.	Pediatrician	Metro Manila Clinics
MASILLONES, Jemma B.	Pediatrician	Metro Manila Clinics
MENDOZA, Loretta S.	Pediatrician	Metro Manila Clinics
PANGUITO, Gladys Ann O.	Pediatrician	Masinag
PASIA, Shirley	Pediatrician	Davao
PEREZ, Catherine B.	Pediatrician	Metro Manila Clinics
RAMOS, Leilani	Pediatrician	Cubao

NAME	SPECIALIZATION	LOCATION
RICAFRENTE, Joy D.	Pediatrician	Metro Manila Clinics
ROQUE, Emerence Q.	Pediatrician	Metro Manila Clinics
SANTIAGO, Myra Perpetua V.	Pediatrician	Masinag
TAYAG, Vincent Davis A.	Pediatrician	Masinag
URBIZTONDO, Grace M.	Pediatrician	Metro Manila Clinics
URGEL, Virgil	Pediatrician	Cebu
LABAO, Romeo Jr., O.	Pulmunologist	Shaw
AZUCENA, Benedict Cesar I.	Pulmunologist	Shaw
ACOB, Florence B.	Radiologist/Sonologist	Metro Manila Clinics
BANEZ, Nerea P.	Radiologist/Sonologist	Shaw
CRUZ, Gemma Bessie J.	Radiologist/Sonologist	Shaw / Lagro
DE CASTRO, Ronald J.	Radiologist/Sonologist	Davao
JUDAN, Grethel D.	Radiologist/Sonologist	Metro Manila Clinics
LAYUGAN, John Anthony B.	Radiologist/Sonologist	Masinag
LAYUGAN, Sheiglah Ann S.	Radiologist/Sonologist	Cubao
MACEDA, Michael Sherwin P.	Radiologist/Sonologist	Davao
MEDALLE, Edwin Ray	Radiologist/Sonologist	Cebu
TUPAS, Romeo Jr., N.	Radiologist/Sonologist	Davao
ZABANAL, Zarah	Radiologist/Sonologist	Lagro
Tan, Cecile	Rehabilitation Medicine	Shaw
TAN, Gilbert L.	Rehabilitation Medicine	Shaw
ALBERTO, Enrique Luis Ma. B.	Surgeon	Masinag
CHENG, George B.	Surgeon	Masinag
NOLASCO, Jonathan C.	Surgeon	Shaw
RECTO, Restituto S.	Surgeon	Shaw
TRONCALES, Alfred D.	Surgeon	Masinag
CHUA, Jo Ben Mirasol	Surgeon / Urologist	Shaw
DIAZ, Michael J.	Urologist	Masinag
BUENO, Dominador M.	Urologist	Cubao
YRASTORZA, Samuel Vincent G.	Urologist	Lagro

Exhibit G: Location of Friendly Care Outlets

Headquarters / Shaw Branch
#710 Shaw Blvd., Mandaluyong City, Metro Manila
(063) (02) 722-2968 to 88
(063) (02) 722-2995 (fax)
fcfi@friendlycare.com.ph
view location map

Masinag, Antipolo Branch
G/F, Unit 4, Selicone Bldg, Brgy. Mayamot, Sumulong Highway,
Antipolo City (In front of Masinag Public Market)
(063) (02) 682-3015, 682-5181
(063) (02) 250-2385 (fax)
masinagisc@friendlycare.com.ph
view location map

Davao City Branch
Brokenshire Integrated Health Ministries, Inc. (BIHMI),
Madapo Hills, Davao City
(063) (082) 224-5150
(063) (082) 222-7970 (fax)
davaoasc@friendlycare.com.ph
view location map

Cebu City Branch
GMC Plaza Building, Legaspi Extension, Cebu City
(032) 254-7727, 255-3438, 255-3423
(032) 253-4170 (fax)
cebuasc@friendlycare.com.ph
view location map

Greater Lagro Branch
G/F Rm. 2, Bonanza Plaza, Quirino Hi-way,
Greater Lagro, Novaliches, Quezon City
(063) (02) 935-6919 to 20
(063) (02) 935-6918 (fax)
lagroisc@friendlycare.com.ph
view location map

Cubao Branch
2/F Metrolane Complex, P. Tuazon St., Cor. 20th Avenue,
Cubao, Quezon City
(063) (02) 421-1660, 421-1678 to 79
(063) (02) 421-1684 (fax)
fcfi_cubao@friendlycare.com.ph