

A Position Paper on the Reproductive Health Bills

Ang Kapatiran Party

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(Revision 07)

Introduction

The Ang Kapatiran Party, a registered national political party, is releasing this Position Paper which summarizes a number of objections to the proposed "reproductive health" (RH) bills that are currently pending in Congress.

A number of have been filed at the House of Representatives. These include House Bill 96, known as the "Reproductive Health and Population and Development Act of 2010," filed by Rep. Edcel C. Lagman. This new bill is a rewritten version of the draconian HB 5043, which did not pass in the last Congress despite the underhanded and deceptive tactics of its authors and foreign-funded proponents.

Other bills on "reproductive health" filed in the 15th Congress include HB101 by Rep Janette Garin of Iloilo, HB513 by Rep. Bag-Ao of the AKBAYAN Party-List, and HB1160 by Rep. Rodolfo Biazon of Muntinlupa.

These bills were consolidated into a single one called "An Act Providing for a Comprehensive Policy on Responsible Parenthood, Reproductive Health and Population and Development." This new version was approved by the House Committee on Population and Family Relations on January 31, 2011. On February 16, 2001, it was also approved (with amendments) by the House Committee on Rules and Appropriations.

The new consolidated bill, as of February 2011, is numbered HB 4244. In late March 2011, just before Congress went into recess, Cong. Garin announced that a number of amendments would be made to HB 4244, presumably to entice more representatives to vote in favor of it.

In addition, a version has been filed at the Philippine Senate in the form of SB 2378 by Senator Miriam Defensor-Santiago.

The points covered in this paper are based on scientific evidence and legal arguments acceptable by persons from any religion. They do not, however, include all the many moral and religious arguments which can still be made against the proposed RH bill.

The so-called reproductive health (now being touted as "responsible parenthood") agenda is essentially repackaged population control and are a step in the direction of legalized abortion. Indeed, as this paper will show, the many RH bills in the past – as well as the present one – explicitly fund abortifacient contraceptives. They also have provisions that are undemocratic and violate the human and civil rights of Filipinos.

As a pro-life, pro-family, and pro-God organization, the Ang Kapatiran Party rejects the radical RH agenda as well as the bills that promote it. The party calls on all Filipinos to defend the sanctity of life, their rights, and our democracy by likewise rejecting the bill and to openly express their opposition to the radical RH agenda.

This paper was originally released in August 2010. This latest revision (revision 07) is was released in April 2011.

Objections to the proposed reproductive health bills

1 The bills fund abortifacient contraceptives in violation of the Constitution.

Previous versions of the bill explicitly fund the procurement and distribution of abortifacient contraceptives such as oral contraceptives, other hormonal contraceptives, and the IUD. Section 9 of the HB 96, for example, classifies hormonal contraceptives, intrauterine devices, and injectables as “essential medicines,” includes them as part of the National Drug Formulary, and subsidizes their procurement.

HB 4244 no longer specifies any artificial contraceptives. It does, however, contain the following provisions:

Section 7, Access to Family Planning, states:

All accredited health facilities shall provide a full range of modern family planning methods, except in specialty hospitals which may render such services on optional basis. ..

Section 10, Family Planning Supplies as Essential Medicines, states:

Products and supplies for modern family planning methods shall be part of the National Drug Formulary and the same shall be included in the regular purchase of essential medicines and supplies of all national and local hospitals and other government health units.

What are these family planning methods and their supplies?

Section 4, Definition of terms, states:

Family Planning refers to a program which enables couples, individuals and women to decide freely and responsibly the number and spacing of their children, acquire relevant information on reproductive health care, services and supplies and have access to a full range of safe, legal, affordable, effective natural and modern methods of limiting and spacing pregnancy;

And:

Reproductive Health Care refers to the access to a full range of methods, facilities, services and supplies that contribute to reproductive health and well-being by preventing and solving reproductive health-related problems. . . The elements of reproductive health care include:

(1) family planning information and services;

“Modern methods” of family planning are explicitly differentiated from natural methods, so these are obviously involve the use of artificial contraceptives, such as the IUD, hormonal contraceptive pills, injectables, and implantables, and maybe even so-called “emergency contraceptives.”

Such contraceptives, however, have been shown to cause early-term abortions by preventing the implantation and development of the fertilized egg – which is already a newly-conceived human being – in the womb.

One such study, “Postfertilization Effects of Oral Contraceptives and Their Relationship to Informed Consent,” came to the following conclusion:

"It seems likely that for perfect use of COCs, postfertilization mechanisms would be likely to have a small but not negligible role. For POPs, COCs with lower doses of estrogen, and imperfect use of any OCs, postfertilization effects are likely to have an increased role. In any case, the medical literature does not support the hypothesis that postfertilization effects of OCs do not exist."¹

Scientific studies show that IUDs are also abortifacient. Stanford and Mikolajczyk found that:

"“There are many potential mechanisms of action for the intrauterine device (IUD), which vary by type of IUD (inert, copper, or hormonal). This paper reviews the evidence for each potential mechanism of action. On the basis of available data for fertilization rates and clinical pregnancy rates, the relative contribution of mechanisms acting before or after fertilization were quantitatively estimated. These estimates indicate that, although prefertilization effects are more prominent for the copper IUD, both prefertilization and postfertilization mechanisms of action contribute significantly to the effectiveness of all types of intrauterine devices.”²

CVS/Pharmacy (<http://www.cvs.com>), described the functions of IUDs in the following manner:

"IUDs are thought to prevent pregnancy by making the womb 'unfriendly' to sperm and eggs. Sperm is either killed, or kept from reaching and fertilizing an egg. An IUD also may keep a fertilized egg from attaching to the womb and growing into a baby."³

The promotion and use of abortifacients is clearly against the Philippine Constitution which protects the unborn from conception. Article 2, Section 12 of the Philippine Constitution, on the other hand, states:

"The State recognizes the sanctity of family life and shall protect and strengthen the family as a basic autonomous social institution. It shall equally protect the life of the mother and the life of the unborn from conception. The natural and primary right and duty of parents in the rearing of the youth for civic efficiency and the development of moral character shall receive the support of the Government.”

Medical science has long considered conception to occur at fertilization. The online Merck Manual for Healthcare Professionals, for example, clearly equates conception with fertilization of the female egg cell by the male sperm cell. The terms are actually used synonymously:

“For conception (fertilization), a live sperm must unite with an ovum in a fallopian tube with normally functioning epithelium. Conception occurs just after ovulation, about 14 days after a menstrual period...”⁴

It is significant to note that the Philippine Medical Association agrees that human life begins at fertilization and has warned the Department of Health about the possible existence of abortifacient contraceptives in its roster of family planning paraphernalia.⁵

1 Walter L. Larimore, MD; Joseph B. Stanford, MD, MSPH, “Postfertilization Effects of Oral Contraceptives and Their Relationship to Informed Consent,” *Arch Fam Med*. 2000;9:126-133. (Abstract and full paper at <http://archfami.ama-assn.org/cgi/content/full/9/2/126>).

2 Stanford JB, Mikolajczyk RT, “Mechanisms of action of intrauterine devices: update and estimation of postfertilization effects,” *American Journal of Obstetrics and Gynecology*, 2002 Dec;187(6):1699-708.

3 CVS/Pharmacy (<http://www.cvs.com>)

4 “Conception and Prenatal Development,” *The Merck Manual Online*, Merck Sharp & Dohme Corp., 2005. This section is available online at: <http://www.merckmanuals.com/professional/sec18/ch258/ch258a.html>. The Merck Manual Online is available at: <http://www.merckmanuals.com/professional/index.html>

5 ABS-CBN News, “Doctors warn DOH on contraceptives”, posted online at 12/11/2010 6:05 PM and updated

An abortifacient, however, causes the eventual destruction of the fertilized egg — of newly-conceived life. The RH bill, as stated earlier, promotes and funds such abortifacients. It therefore violates the Philippine Constitution.

Furthermore, the Filipino Family Survey (2009), conducted in December 2009 by the HB&A-ARO Research Group, found that 91% of Metro Manila residents agree that human and animal life start upon conception (when the sperm joins the egg), 98% would not ever consider aborting their unborn child still forming in the womb even if the pregnancy is unplanned, and 98% would not consider or condone aborting a baby even within the first three months. Of those aware of the pro-life provisions of Article 2, Section 12 of the Philippine Constitution, 87% agree with it.⁶

It may be argued that the abortifacient mechanism of some oral contraceptives has not been conclusively proven to occur in human beings, or that if it does occur then this occurrence is very rare. To the first argument we would reply that even if there really were any doubt that a contraceptive is abortifacient, the grave stakes involved (the death of a human being) means that the burden of proof is on those who would deny that these are abortifacients. In other words, they must prove that these contraceptives are in fact non-abortifacient. Until such a conclusive determination is achieved we must err on the side of caution and not place the lives of the unborn at risk.

To the second argument we reply that there is no medical necessity to birth control that justifies such a risk to the unborn child. Artificial and abortifacient methods of birth control are not necessary to preserve health; they are not therapeutic and pregnancy is not a disease. We also note that the imperative to avoid the questionable methods promoted by the RH bill becomes especially more compelling since there is a safe, modern, and effective alternative: Natural Family Planning.

2 Filipinos do not want an RH law.

The Filipino Family Survey mentioned earlier revealed that 92% of Metro Manila residents are against the passage of the controversial reproductive health (RH) bill once they know and understand its provisions. It was conducted from December 2-9, 2009, was conducted by HB&A International Research using the experienced field personnel of the Asian Research Organization (ARO), the Philippine affiliate of Gallup International. The poll has called into question claims of wide public support for the proposed measure made by its authors and supporters.

The claims of widespread support for a reproductive health law are also highly questionable as they are based on misleading surveys. Previous surveys by the pro-RH SWS asked questions such as whether the respondents favored family planning or believed in proper sex education, both of which are measures that even opponents of the bill, such as the Catholic Church, already support. Most respondents were almost totally unaware of the actual provisions of the bill in question.

Former Congressman Leonie Montemayor of the *Alyansang Bayanihan ng mga Magsasaka, Manggagawang-Bukid at Mangingisda* (ABA) noted that, "Earlier surveys were couched in very general terms and without first ensuring that the respondents had read or understood the contents [of the RH Bill]."

as of 12/12/2010 12:22 AM. Available online at: <http://www.abs-cbnnews.com/nation/12/11/10/doctors-warn-doh-contraceptives>

⁶ HB&A-ARO Research Group, "Filipino Family Survey," conducted December 2009, made public January 2010. The results of the study can be downloaded at <http://prolife.org.ph/home/uploads/Filipino%20Family%20Survey%20v.2.1-1-1.ppt>.

RH proponent and SWS president, Mahar Mangahas, acknowledged in his column in the Philippine Daily Inquirer that the previous SWS surveys made no mention of the penal provisions of the previous RH Bill (and which were still in House versions of the RH bills when these surveys were taken).⁷

3 Contraceptives often do not prevent unplanned pregnancy and may actually increase them.

Numerous studies have shown that the increased availability and usage of contraceptives does not necessarily reduce unplanned pregnancies and abortion. In fact, contraceptives often increase them.

For example, in the United States, 89% of sexually active women of reproductive age "at risk" of becoming pregnant use contraception, and 98% have used it in their lifetime, according to the Alan Guttmacher Institute.⁸ In addition, with typical use, 9% of women using oral contraceptives (OC) will become pregnant within one year,⁹ as will 15% of women whose partners use condoms.¹⁰ Forty-eight percent of women with unintended pregnancies were using contraception in the month they became pregnant.¹¹

Other studies show that greater access to contraception does not reduce unintended pregnancy. These include:

- Peter Arcidiacono (2005) found that among teens, "increasing access to contraception may actually increase long run pregnancy rates even though short run pregnancy rates fall. On the other hand, policies that decrease access to contraception, and hence sexual activity, are likely to lower pregnancy rates in the long run."¹²
- David Paton (2002) in a study of 16 regions of the U.K. over a 14-year period, found no increase in pregnancies or abortions in underage English girls despite reduced access to contraception, and no decrease in underage pregnancies or abortions overall from greater access to contraception. He found "no evidence" that "the provision of family planning reduces either underage conception or abortion rates."¹³
- Lawrence Finer (2007) in "Trends in Premarital Sex in the United States, 1954-2003," found that the increase in premarital sex amongst a group of teens turning 15 during the years 1964-1973 "may be partly due to increased availability of effective contraception (in particular, the pill), which made it less likely that sex would lead to pregnancy."¹⁴

7 Mahar Mangahas, "Business groups work for RH compromise," Philippine Daily Inquirer, November 20, 2009.

8 Boonstra H et al., *Abortion in Women's Lives*, New York: Guttmacher Institute, 2006, available online at <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>, pp. 6-7.

9 Conforth, Tracee, "Contraceptive Effectiveness," available online at <http://womenshealth.about.com/cs/birthcontrol/a/effectivenessbc.htm>.

10 *Ibid.*

11 Boonstra H et al., *Abortion in Women's Lives*, New York: Guttmacher Institute, 2006, available online at <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>, p. 7

12 Peter Arcidiacono et al, "Habit Persistence and Teen Sex: Could Increased Access to Contraception have Unintended Consequences for Teen Pregnancies?" (Oct. 3, 2005), p.29, available at <http://www.econ.duke.edu/~psarcidi/addicted13.pdf>.

13 David Paton, "The Economics of Family Planning and Underage Conceptions," *Journal of Health Economics*, 21.2 (March 2002): 207-225; abstract available at <http://www.sciencedirect.com/science/article/B6V8K-4537PJR-3/2/7b0ac0ed4b84065fae3119e1663e50bc>.

14 Lawrence Finer, "Trends in Premarital Sex in the United States, 1954-2003," *Public Health Reports*, Volume 122 (January-February 2007): pp. 77-78. The study can be found at

- Douglas Kirby (1999) concluded: "Most studies that have been conducted during the past 20 years have indicated that improving access to contraception did not significantly increase contraceptive use or decrease teen pregnancy."¹⁵
- Akerlof, Yellen, and Katz (1996) argue that a phenomenon they call "reproductive technology shock," caused by contraception, birth control, and legal abortion, changed the relationships between men and women, and led to an increase in out-of-wedlock births. Women that did not resort to these methods were at a disadvantage and biological fathers increasingly rejected the idea of paternal obligation.¹⁶

4 *Since contraceptives will not reduce unplanned pregnancy, they will not reduce abortion rates either and may increase them.*

As shown in the previous section, contraceptive usage can actually increase the incidence of unplanned pregnancy, and consequently, demand for abortion. In addition, studies in democratic countries that do not have historically very high abortion rates and where fertility is healthy or still dropping – exactly the situation in the Philippines – reveal that contraception does not necessarily lower abortion rates.

The Guttmacher Institute notes that in the United States, 54% of women seeking abortions were using contraception in the month they became pregnant.¹⁷ In Sweden, K. Edgardh found that despite free abortions, free contraceptive counseling, low cost condoms and oral contraceptives, and over-the-counter emergency contraception (EC), Swedish teen abortion rates rose to 22.5 per thousand from 17 per thousand between 1995 and 2001.¹⁸

Pro-RH groups have often cited studies that they claim prove that contraception will lower abortion rates. But much of this data is from countries that had abnormally high abortion rates to begin with, or countries that have very low, constant fertility. These conditions do not exist in the Philippines

The republics of the former Soviet Union and the Russian Federation are examples of countries that have historically very high abortion rates as a result of abortion being used as a birth control method, as well as government coercion or encouragement to abort.

The Guttmacher Institute's own study in 2003 showed simultaneous increases both abortion rates and contraceptive use in the United States, Cuba, Denmark, Netherlands, Singapore, and South Korea. The study also claimed, however, that abortion rates went down after fertility on some of those countries had reached very low levels and became constant, particularly in South Korea. Critics note, however, that in the United States, lowered abortion rates were also due to state laws restricting access to abortion.

Michael New Ph.D., (Feb. 2007), for example, found that pro-life legislation such as laws requiring parental involvement in the abortion decision, requiring informed consent, imposing Medicaid funding

<http://www.guttmacher.org/pubs/journals/2007/01/29/PRH-Vol-122-Finer.pdf>.

15 Douglas Kirby, "Reflections on Two Decades of Research on Teen Sexual Behavior and Pregnancy," *Journal of School Health* 69.3 (March 1999).

16 Akerlof, G.A., Yellen, J.L. and M.L. Katz "An Analysis of Out-of-Wedlock Child-bearing in the United States." *Quarterly Journal of Economics*, Vol. 111, No. 2 (May, 1996), pp. 277-317.

17 Jones RK, Darroch JE and Henshaw SK, Contraceptive use among U.S. women having abortions in 2000–2001, *Perspectives on Sexual and Reproductive Health*, 2002, 34(6):294–303; available online at http://www.guttmacher.org/pubs/fb_induced_abortion.pdf.

18 Edgardh, K. et al. Adolescent Sexual Health in Sweden, *Sex Trans Inf* 78 (2002): 352-6, available at <http://sti.bmjournals.com/cgi/content/full/78/5/352>.

restrictions, and banning partial-birth abortion, reduces minors' abortion rates. Parental involvement state laws resulted in a 30.5% decline, and Medicaid funding restrictions which result in a 23% decline.¹⁹ In an earlier (2006) study, Dr. New also found that after states passed and enforced parental involvement laws, abortion rates among minors were reduced. When these laws were repealed, abortion rates rose, and dropped again when new parental involvement laws were again passed and enforced.²⁰

A study published in *Contraception* in January 2011, found that in Spain, while contraceptive usage increased some 30 percentage points, the abortion rate actually doubled. The study's abstract noted:

“During the study period, 1997 to 2007, the overall use of contraceptive methods increased from 49.1% to 79.9%. The most commonly used method was the condom (an increase from 21% to 38.8%), followed by the pill (an increase from 14.2% to 20.3%). Female sterilization and IUDs decreased slightly and were used by less than 5% of women in 2007. The elective abortion rate increased from 5.52 to 11.49 per 1000 women.”²¹

5 The contraceptive approach does not address the causes of maternal deaths related to pregnancy and childbirth.

The contraceptive approach taken by the HB 4244 (and in its previous versions) treats pregnancy as if it were a disease, and seeks to reduce maternal mortality simply by reducing childbirth. Instead of providing urgently needed health care, the approach mainly provides condoms and abortifacient contraceptives, and therefore ignores the real causes of maternal death while attacking a non-problem. Preventing pregnancy to lessen maternal deaths, however, is like preventing people from owning a vehicle to lessen vehicular deaths. This approach will only succeed in diverting scarce resources away from more urgent problems while encouraging even more promiscuity and – as people experience even more contraceptive failures – eventually greater demand for abortion.

Instead of providing contraceptives, with all their attendant health risks and costs, maternal deaths related to childbirth can be reduced by increasing access to health facilities and skilled birth attendants. According to the National Demographic and Health Survey 2008, only 44 percent of births occur in health facilities and only 62% of births are assisted by a health professional.²²

Instead of wasting scarce funds on contraceptives the government should increase access to basic health facilities and trained birth attendants. These measures will do more to lower maternal deaths than contraceptives.

19 M. New, "Analyzing the Effect of State Legislation on the Incidence of Abortion Among Minors," Heritage Foundation Data Analysis Report #07-01 (2007), available online at <http://www.heritage.org/Research/Family/CDA07-01.cfm>.

20 M. New, "Using Natural Experiments to Analyze the Impact of State Legislation on the Incidence of Abortion," Heritage Center for Data Analysis Report #06-01 (January 23, 2006); available at <http://www.heritage.org/Research/Family/cda06-01.cfm>.

21 José Luis Dueñas, Iñaki Lete, Rafael Bermejo, Agnès Arbat, Ezequiel Pérez-Campos, Javier Martínez-Salmeán, Isabel Serrano, José Luis Doval, Carme Coll. Trends in the use of contraceptive methods and voluntary interruption of pregnancy in the Spanish population during 1997–2007. *Contraception* - January 2011 (Vol. 83, Issue 1, Pages 82-87, DOI: 10.1016/j.contraception.2010.05.010). The study's abstract is available at: <http://www.contraceptionjournal.org/article/S0010-7824%2810%2900327-6/abstract>

22 National Demographic and Health Survey 2008, National Statistics Office (NSO), December 2008, Manila, Philippines (available online at http://philippines.usaid.gov/resources/key_documents/NDHS_2008.pdf).

Former senator Kit Tatad expressed the same idea in his article, "Revised: The Truth and Half-Truths About Reproductive Health," notes that "...experience has shown (as in Gattaran, Cagayan and Sorsogon, Sorsogon) that the incidence of maternal death arising from such complications could be fully mitigated and brought down to zero simply by providing adequate basic and emergency obstetrics care and skilled medical personnel and services."²³

The Philippines has to deal with many other true killer diseases such as heart and vascular diseases, pneumonia, tuberculosis, cancer, and diabetes. The government does not provide free medicines and medical treatment for these because it cannot afford to do so. Why then should it waste money on contraceptives which do not treat any real disease? Pregnancy is not a disease.

6 *The contraceptive approach does not address the real causes of infant mortality*

If we accept the assertion that infants and children have a greater probability of dying if they are born to mothers who are too young or too old, if they are born after a short birth interval, or if they are of high birth order, all these concerns can be safely addressed through modern Natural Family Planning, making contraception unnecessary.

Contraceptive methods introduce adverse medical side-effects and as such should not be a preferred method to effect a reduction in infant mortality. Modern Natural Family Planning methods, in contrast, are completely safe and can be easily used to effect birth spacing and avoid early or late pregnancies. Infant mortality can also be significantly reduced using the same means as reducing maternal mortality, namely increasing access to health facilities and skilled health attendants.

7 *The bills will exacerbate the suffering of rape victims by encouraging them to commit the crime of abortion using abortifacients.*

Rape is a terrible ordeal and victims deserve compassion, justice, and assistance. Many women who become pregnant often resort to abortion, compounding their suffering with the additional burden of guilt that comes with murdering their own children. The RH bill's proposed solution, however, making available so-called "emergency contraception," or EC, is also a form of abortion, and does not address the root causes of rape.

Many of the bill's proponents will often cite the WHO, saying that EC does not interrupt pregnancy and are therefore not a method of abortion; but this is only clever semantics, since the WHO has redefined pregnancy as beginning when the fertilized egg has implanted in the uterus. This definition is entirely different from the concept used by the Philippine Constitution, which mandates that the unborn be protected from conception. Medical science is also nearly unanimous in defining conception as beginning at fertilization, not at implantation.

Furthermore, studies have shown that increased access to EC does not reduce unintended pregnancies or abortions. An analysis by Raymond, Trussell and Polis of 23 studies published between 1998 and 2006 measured the effect of increased access to EC on its actual use, unintended pregnancy, and abortion. None of the 23 found a reduction in unintended pregnancies or abortions following increased access to EC.²⁴

23 Francisco Tatad, "Revised: The Truth and Half-Truths About Reproductive Health," <http://franciscotatad.blogspot.com/2008/09/truth-and-half-truths-about.html>.

24 E. Raymond et al., "Population Effect of Increased Access to Emergency Contraceptive Pills," *Obstetrics &*

Studies have also found the following:

- Sixteen months after 18,000 sexually active women in a health district in Scotland were each given five packets of EC, researchers concluded: "No effect on abortion rates was demonstrated with advance provision of EC. The results of this study suggest that wide-spread distribution of advanced supplies of EC through health services may not be an effective way to reduce the incidence of unintended pregnancy in the UK."²⁵
- In a San Francisco Bay area study of over 2,000 women randomly assigned to three groups each with varying access to EC, 7-8% of women in each group were pregnant in only six months. Over 80% of the women were also using another form of contraception. The study concluded: "We did not observe a difference in pregnancy rates in women with either pharmacy access or advance provision [of EC]; ... Previous studies also failed to show significant differences in pregnancy or abortion rates among women with advance provisions of EC."²⁶
- "Another commonly held view for which there is no documented evidence is that improving knowledge about and access to Emergency Contraception will reduce the number of teenage pregnancies. ... Experience of use so far does not give any evidence of effectiveness. Prescribing rates of the morning-after pill have multiplied steadily in Scotland while there has been no observed decline in the rate of teenage pregnancies or abortions."²⁷
- "Despite the fact that emergency contraceptive pills (ECP) have become easily available across the country during recent years, abortion numbers continue to rise in Sweden, especially in the young age groups (<25)."²⁸
- Pharmacies were allowed to dispense EC without a prescription from February 1998 to June 1999 through the Washington State Pilot Project. Pregnancy and abortion rates in Washington state initially dropped and then increased slightly the following year. Between 1996 and 2000, however, the decline in Washington state (at 3%) was actually smaller than the decline in the abortion rate nationally (which was 5%).²⁹

A study published in the *Journal of Health Economics* in February 2011 also found that providing free EC over the counter did not reduce the number of teenage pregnancies in the U.K. between 1998 and 2004, and may in fact be associated with a rise in sexually-transmitted diseases (STIs). Professor David Paton, one of the authors of the study, commented on his findings:

Gynecology 109 (2007): 181-8.

25 A. Glasier et al., "Advanced Provision of Emergency Contraception does not Reduce Abortion Rates," *Contraception* 69.5 (May 2004): 361-6, available online at <http://www.cwfa.org/images/content/scotland0905.pdf>.

26 T. Raine et al., "Direct Access to Emergency Contraception through Pharmacies and Effect on Unintended Pregnancy and STIs," *Journal of the American Medical Association* 293 (2005): 54-62, available online at <http://www.dph.sf.ca.us/sfcityclinic/providers/Directaccesscontraception.pdf>.

27 A. Williams, "The Morning After Pill," *Scottish Council of Human Bioethics* (Nov. 2005) (www.schb.org.uk, click on "Publications" then "Sexual Health").

28 T. Tyden et al., "No reduced number of abortions despite easily available emergency contraceptive pills," *Lakartidningen* 99.47 (2002): 4730-2, 4735 (abstract online at www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12523048&dopt=Citation; visited Feb. 16, 2007).

29 J. Gardner et al., "Increasing Access to Emergency Contraception Through Community Pharmacies: Lessons from Washington State," *Family Planning Perspectives* 33 (2001): 172-5, available online at <http://www.guttmacher.org/pubs/journals/3317201.html>.

"Our study illustrates how government interventions can sometimes lead to unfortunate unintended consequences. The fact that STI diagnoses increased in areas with EBC schemes will raise questions over whether these schemes represent the best use of public money."³⁰

8 Contraceptives will not decrease the incidence of STDs and may actually increase it

A number of studies have linked increased access to contraceptives to an increase in STDs. These include:

- Tyden's study in Sweden mentioned earlier also found that between 1995 and 2001, Chlamydia infections rose 50% overall in Sweden and 60% among the young.³¹
- In a 2003 study, David Paton found that between 1999 and 2001, with improved access to family planning clinics in the United Kingdom (teen visits rose over 23%), the number of sexually active teens rose almost 20%, and STD rates rose 15.8%.³²
- A. Williams noted that "In Scotland there has been a doubling of the rates of Herpes and [Gonorrhoea] and a four-fold increase in Chlamydia in the past ten years (1993-2003)," despite a three-fold increase in the use of EC and greatly increased access to contraception.³³

9 Condom programs will not lower the incidence in AIDS/HIV cases and may in fact increase it

In 2004, Dr. Rene Josef Bullecer, Director of AIDS-Free Philippines and Executive Director of Human Life International (HLI) Visayas-Mindanao, observed that:

"The discrepancy in the infection rates between the two countries, Thailand with severe condom- oriented programs and the Philippines without, has continued and only grown wider. As of August 2003 there were 899,000 HIV/AIDS cases documented in Thailand and approximately 125,000 deaths attributed to the disease. These numbers are many times those projected by the WHO (60,000-80,000 cases) in 1991.

These numbers contrast sharply with those of the Philippines where, as of September 30, 2003, there were 1,946 AIDS cases resulting in 260 deaths. This is only a mere fraction of the number of cases (80,000-90,000) that the WHO projected would be reached by 2000."³⁴

30 University of Nottingham (2011, February 2). "Morning after pill linked to increase in sexually transmitted diseases, UK study shows." *ScienceDaily*. Retrieved February 18, 2011, from <http://www.sciencedaily.com/releases/2011/01/110131133121.htm>.

The study's abstract is available at: <http://dx.doi.org/10.1016/j.jhealeco.2010.12.004>

31 T. Tyden et al., "No reduced number of abortions despite easily available emergency contraceptive pills," *Lakartidningen* 99.47 (2002): 4730-2, 4735 (abstract at www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12523048&dopt=Citation).

32 David Paton, "Random Behavior or Rational Choice? Family Planning, Teenage Pregnancy and STIs," (Nov.2003), available online at www.swan.ac.uk/economics/res2004/program/papers/Paton.pdf.

33 A. Williams, "The Morning After Pill," Scottish Council on Human Bioethics (Nov. 2005).

34 Rene Josef Bullecer, "Telling the Truth: AIDS Rates for Thailand and the Philippines," cited in "Family values versus Safe Sex," Population Research Institute, PRI Review, 29 November, 1999, available online at <http://www.pop.org/00000000207/family-values-vs-safe-sex>.

The huge discrepancy continues, with Thailand having 610,000 [low estimate: 410 000; high estimate: 880,000] people living with HIV and death according to the UNAIDS/WHO. In contrast, the Philippines has only 8,300 [low: 6,000; high: 11,000] persons living with HIV. The numbers are even more striking considering that the Philippines has a much larger population than Thailand.³⁵

There is also more evidence from other countries that questions the effectiveness of condoms in the fight against HIV/AIDS. A study in Uganda by Kajubi *et al.* (2005) concluded that condoms were not effective at lowering HIV infections:

"In this study, gains in condom use seem to have been offset by increases in the number of sex partners. Prevention interventions in generalized epidemics need to promote all aspects of sexual risk reduction to slow HIV transmission."³⁶

Dr Edward Green, former Director of the Harvard AIDS Prevention Research Project, in his book *Rethinking AIDS Prevention: Learning from Successes in Developing Countries*, contested the efficacy of condoms and HIV counseling and testing, the preferred prevention strategies of Western donor nations and the U.N. Green said:

"The largely medical solutions funded by major donors have had little impact in Africa, the continent hardest hit by AIDS. Instead, relatively simple, low-cost behavioral change programs--stressing increased monogamy and delayed sexual activity for young people--have made the greatest headway in fighting or preventing the disease's spread. Ugandans pioneered these simple, sustainable interventions and achieved significant results."³⁷

Tim Allen and Suzette Heald, in a comparison of AIDS policy in Uganda and Botswana published in 2004, also noted:

"Promotion of condoms at an early stage proved to be counter-productive in Botswana, whereas the lack of condom promotion during the 1980s and early 1990s contributed to the relative success of behaviour change strategies in Uganda."³⁸

In a UNAIDS-sponsored study published in *PLoS Medicine* on February 2008, Daniel Halperin, *et al.*, noted that behavioral change was the major factor causing a decline in HIV infections in Zimbabwe:

"The behavioral changes associated with HIV reduction—mainly reductions in extramarital, commercial, and casual sexual relations, and associated reductions in partner concurrency—appear to have been stimulated primarily by increased awareness of AIDS deaths and secondarily by the country's economic deterioration. These changes were probably aided by prevention programs utilizing both mass media and church-based, workplace-based, and other inter-personal communication activities."³⁹

35 UNAIDS/WHO Epidemiological Fact Sheets on HIV and AIDS, 2008 Update: Core data on epidemiology and response, UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, December 2008.

36 Kajubi, et al., "Increasing Condom Use Without Reducing HIV Risk: Results of a Controlled Community Trial in Uganda," *Journal of Acquired Immune Deficiency Syndrome*, Volume 40, Number 1, September 1 2005, abstract available at <http://journals.lww.com/jaids/pages/articleviewer.aspx?year=2005&issue=09010&article=00013&type=abstract>

37 Edward Green, *Rethinking AIDS Prevention: Learning from Successes in Developing Countries*, (2003).

38 Tim Allen and Suzette Heald, "HIV/AIDS Policy in Africa: What has Worked in Uganda and what has Failed in Botswana?", *Journal of International Development*, November 2004, Volume 16, Issue 8, pp. 1141-1154.

39 Halperin DT, Mugurungi O, Hallett TB, Muchini B, Campbell B, et al., (2011) A Surprising Prevention Success: Why Did the HIV Epidemic Decline in Zimbabwe? *PLoS Medicine* 8(2): e1000414. doi:10.1371/journal.pmed.1000414 , p. 2. The study is also available online at: <http://www.plosmedicine.org/article/info%3Adoi/10.1371/journal.pmed.1000414>

The paper also concluded:

One lesson emerging from this review is that in Zimbabwe, as elsewhere, partner reduction appears to have played a crucial role in reversing the HIV epidemic.⁴⁰

10 The RH bills are based on an erroneous analysis of population and family size as related to poverty

At one point in the campaign to pass the RH bills, their authors and proponents did not emphasize that the RH bills seek to address poverty through population control, assuming that poverty is caused by a large, growing population and large family size. In the 15th Congress, however, that claim has been revived and is being aggressively pushed as a justification for the passage of the bill.

The scientific evidence, however, does not support their contention.

Dr. Roberto de Vera, writing in his primer on the RH bill, noted that, "Population growth has little or no direct effect on per capita GDP growth. Thus there is no basis for a policy that aims to reduce population growth to raise per capita GDP growth."⁴¹ He then cited several studies to support his assertion:

Nobel prize winner Simon Kuznets's pioneering study contained in his 1966 book *Modern Economic Growth: Rate, Structure and Spread* (pp. 67-68) showed that "[n]o clear association appears to exist in the present sample of countries, or is likely to exist in other developed countries, between rates of growth of population and of product per capita."

Other studies have confirmed Kuznets's findings, showing no clear link between population growth and economic growth (or poverty). Here are the findings for five studies:

- (1) the 1992 Ross Levine and David Renelt study of the relationship between growth and its determinants found no significant effect of population growth on economic growth;
- (2) the 1994 Jeff King and Lant Pritchett study arrived at a similar finding where they allowed the effect of population on economic growth to vary according to the level of development and resource scarcity;
- (3) in a 1996 review of the population-growth-poverty relationship, Dennis Ahlburg points out that studies have shown population growth has little or no effect on poverty;
- (4) in a 2004 study examining the determinants of long-term growth, Gernot Doppelhoffer, Ronald Miller, and Xavier Sala-I-Martin, found that average annual population growth from 1960-1990 was not robustly correlated with economic growth;
- (5) the 2007 Eric Hanushek and Ludger Wommann study found that total fertility rates, which can be seen as an alternative measure of population growth, did not have a statistically significant association with economic growth.

40 Ibid.

41 Dr. Roberto de Vera, *A Primer on the proposed Reproductive Health, Responsible Parenthood, and Population Development Consolidated Bill*, dated September 11, 2008. This paper is available online at: <http://www.scribd.com/doc/21622530/Demographic-Economic-Historical-Evidence-vs-RH-Bill>

Similar conclusions have been arrived at by the US National Research Council in 1986 and in the UN Population Fund (UNFPA) Consultative Meeting of Economists in 1992.⁴²

In the same primer, Dr. de Vera also explained that:

"Large families are poor not because they are large but because most of the heads of these poor families have limited schooling which prevents them from getting good paying jobs. Moreover, a 1994 study shows that parents of poor families want the children they beget. These findings show that there is no basis for having a population management policy that raises economic growth to reduce poverty.⁴³

In its 2003 monograph entitled, "The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change," the RAND Corporation admitted that, in general, economists have realized that high population growth is not correlated with (or does not cause) poor economic performance:

Most economic analysis has examined the statistical correlation between population and economic growth and found little significant connection. Though countries with rapidly growing populations tend to have more slowly growing economies (see Figure 1.3), this negative correlation typically disappears (or even reverses direction) once other factors such as country size, openness to trade, educational attainment of the population, and the quality of civil and political institutions are taken into account. Figure 1.4 shows the portion of economic growth unexplained by these other factors. It shows that this "residual" growth bears little correlation to population growth rates. In other words, when controlling for other factors, there is little cross-country evidence that population growth impedes or promotes economic growth. This result seems to justify a third view: population neutralism.

The neutralist theory has been the dominant view since the mid-1980s (Bloom and Freeman, 1986). Although there are some variations within the neutralist school—with the NAS concluding in 1986 that "on balance ... slower population growth would be beneficial to economic development of most developing countries" (National Research Council, 1986; italics added), and many World Bank economists suggesting that in some countries bigger populations can boost economic growth—the overall tendency is to accord population issues a relatively minor place in the context of the wider policy environment.⁴⁴

Nicholas Eberstadt notes that the very idea of overpopulation is mis-defined, often being equated with the visible effects of poverty. This is to assume a causal relationship that is not supported by evidence.

Surprising as it may sound to those convinced that the world is beset by "overpopulation", the fact is that in our era, population density provides us with no information whatsoever for predicting a country's level of economic development or economic performance.

...

We could continue combing for demographic measures that might help to clarify the nature, and pinpoint the epicentres, of the population crisis that Al Gore, Jared Diamond and so many others envision. But as our exercise should already indicate, that would be a fruitless task. Additional demographic criteria will confront the same problem of obvious misidentification of

42 *Ibid.*

43 *Ibid.*

44 David E. Bloom, David Canning, Jaypee Sevilla. *The Demographic Dividend : A New Perspective on the Economic Consequences of Population Change* . RAND Corporation, 2003, ISBN 0-8330-2926-6, pp. 17-18.

presumptive regions suffering from “too many people” because demographic criteria cannot by themselves unambiguously describe “overpopulation”. This is a basic fact, recognised by every trained demographer. And that basic fact raises correspondingly basic questions about the concept of “overpopulation”.

The "population crisis" that advocates of "world population stabilisation" wish to resolve is impossible to define in demographic terms because it is a problem that has been mis-defined. In most people's minds, the notions of "overpopulation", "overcrowding", or "too many people" are associated with images of hungry children, unchecked disease, squalid living conditions, and awful slums. Those problems, sad to say, are all too real in the contemporary world – but the proper name for those conditions is human poverty. And the correspondence between human poverty and demographic trends, as we shall see in a moment, is by no means as causal and clear-cut as some would suppose.⁴⁵

In any case, it is apparent that fertility in the Philippines is fast declining and will soon be below replacement level even without population control measures. This was the conclusion of Fr. Gregory Gaston, formerly of the Pontifical Council for the Family at the Vatican, who wrote the following in an article published in 2007:

"The UN Population Division figures indicate that it is not an exaggeration to say that as early as now the Philippine Total Fertility Rate [children per woman] is already dangerously low. Whereas in the early 1970's the average Filipina had six children, today she has around three, and in another 20 years, only two. Shortly after 2020, or just fifteen years from now, the Philippine TFR will sink below its replacement level of around 2.29."⁴⁶

11 The RH bills are unduly coercive and violate freedom of speech, freedom of conscience, and freedom of religion

As of this writing, the authors of the Bill have announced that they will amend the legislation and delete Section 28 (e) of the proposed bill. This section lists the following as a prohibited act: “Any person who maliciously engages in disinformation about the intent or provisions of this Act.”

This provision is overly broad and “disinformation” could (and most probably will) be construed as prohibiting the expression of objections to the law when passed, such as what we are presently doing. This provision is obviously going to be used to suppress dissent, and is an undue restriction of freedom of speech. It has no place in any of the laws of a democratic nation.

Another announced amendment will be the deletion of section 21, which mandates that employers must provide family planning services (or information on where to obtain these), presumably including abortifacient contraceptives, to their employees. Employers, therefore, are not given any choice despite the fact that distribution of these abortifacients and contraceptives may be against their conscience. This section is said to be a reiteration of existing law and therefore not necessary.

There has been no announcement, on the other hand, that Section 28 (a), numbers 1 and 3, will be deleted. These provisions require any private or public healthcare provider to provide correct information on “reproductive health” programs and services, as well as provide health care services.

45 Nicholas Eberstadt, "Too many people?", International Policy Press, July 2007, pp. 6-7. Available online at: http://www.aei.org/docLib/20070712_Too_Many_People.pdf

46 Rev. Fr. Gregory D. Gaston, STD, "World Population Collapse: Lessons for the Philippines," in *Familia et Vita*, vol. XII (2007) no. 2, pp. 84-113, paragraph no. 22.

In section 10 (Family Planning Supplies as Essential Medicines) of HB 4244, however, mandates that “products and supplies for modern family planning methods shall be part of the National Drug Formulary.” Section 4 (Definition of Terms) includes as a family planning method so-called “modern methods of limiting and spacing pregnancy,” a euphemism for artificial and abortifacient contraceptives.

If health care providers refuse to perform certain services so on religious grounds – presumably because these are morally objectionable to them, as in the case of Catholic doctors requested to dispense abortifacient contraceptives – they must still refer those who want to use such devices or methods to another person who will dispense them. Conscientious objectors are thereby required to cooperate in acts they believe to be wrong, and if they refuse, they are punished with penalties ranging from one to six months imprisonment and a fine of P10,000-P50,000, as specified in Section 29 of the proposed bill. This bill therefore eliminates any choice for conscientious objectors and makes no room for their legitimate concerns.

Critics of the bill – and even erstwhile supporters – have not missed this controversial point and have expressed objections to this and other penal provisions in previous versions of RH bills. Former finance secretary Roberto de Ocampo, for example wrote the following in the *Philippine Daily Inquirer*:

“...the present draft bill contains punitive provisions that are tantamount to an affront to civil liberties and smack of religious persecution. Just read the section mandating private sector employees and private health practitioners to actively promote artificial birth control methods and distribute devices whether or not their conscience and religious convictions agree with the practice. Combine that with the section imposing penalties of imprisonment or fines or both if they don’t follow or are deemed guilty of “perceived violations” and tell me that the bill does not encroach on basic civil rights. Tell me that the bill does not unfairly force a person into a moral dilemma, a State-induced struggle of conscience. This is not education, it’s coercion. This is not choice, it’s threat.”⁴⁷

An analysis of HB 4244 by Sean Murphy of the Protection of Conscience Project likewise states (emphasis added):

Section 28(3) contains the only provisions for accommodation of freedom of conscience or religion. Many of the procedures and services identified in the bills are morally controversial, but this section does not allow religious or ethical objections to any of them. [Comments 35, 36] Instead, it allows health care workers and institutions to claim an exemption only if they assert that they have refused to provide health care or information because of a patient's marital status, gender, sexual orientation, age, religion, personal circumstances, or nature of work. **In other words, the bill offers accommodation only to those willing to face denunciation for unjust discrimination.**

Conscientious objection normally occurs because a health care worker is unwilling to be morally complicit what he believes to be in a wrongful act, not because of a personal characteristic of the patient. A physician who, for moral reasons, refuses to perform contraceptive sterilization does so because he believes it to be wrong, not because his patient is a man or woman. **Thus, the accommodation permitted by the bill would be worthless in most of the cases in which it would be needed.**

47 Roberto de Ocampo, “Kill ‘Bill’?”, *Philippine Daily Inquirer*, November 27, 2009. The article can be viewed online at <http://opinion.inquirer.net/inquireropinion/columns/view/20091127-238839/Kill-Bill>.

Even if a personal characteristic is related to an objection (as in the case of refusing contraceptives to an unmarried patient), the objection is not to the patient. Instead, the objector seeks to avoid vicarious moral responsibility for something done by the patient (extra-marital sex). An objector willing to risk public obloquy and prosecution might claim an exemption in such a case, but would then be required to refer the patient to a willing colleague. **However, referral and other forms of facilitation also raise the problem of complicity, and objectors may find the requirement unacceptable.**

Thus, the exercise of freedom of conscience is made impossible or ridiculous, and exposes those who claim the exemption to prosecution for human rights violations. It is not clear whether this part of the bill has been deliberately constructed as an obstacle to conscientious objection, or has simply been badly drafted.⁴⁸

Also disturbing is the claim of “reproductive rights” or “reproductive health care” as a human right, as Murphy explains:

For if it really were a "human right" to be given contraceptives or contraceptive sterilization, it would follow that anyone who refused to provide them would be guilty of a human rights violation. Moreover, it is contrary to sound public policy to permit violations of *authentic* human rights based on appeals to religious or conscientious convictions. We do not, for example, admit a defence of religious freedom in cases of racial discrimination, nor do we accommodate racial prejudices. Thus, the general claim of rights made in the first sections of the bills would, if accepted, leave no principled basis upon which to exempt any health care institution or health care worker from a requirement to provide contraception, contraceptive sterilization, or even potentially embryocidal or abortifacient drugs and devices.⁴⁹

Murphy also notes that, if passed, the RH law's recognition of such rights could have serious implications for conscientious objectors:

Note that one of the requirements for accreditation by the Philippine Health Insurance Corporation is "recognition of the rights of patients." Thus, the declaration of rights in the RH Bill would enable PhilHealth to deny accreditation to any health care facility that refused to comply with the Act for reasons of conscience.⁵⁰

It is clear then that the RH bill's provisions eviscerate conscience protections and be used to coerce persons to implement morally questionable policies.

12 Values-neutral sex education involving instruction in contraceptive methods will not reduce unplanned pregnancies or encourage responsible sexual behavior.

The various versions of the RH bills mandate several years of mandatory, “age-appropriate” sex education for young children. The training these children will receive will include family planning

48 Murphy, Sean, “Philippines 'RH Bill' of 2011: the shape of things to come?” The Protection of Conscience Project, Legal Commentaries April, 2011. Available online at: <http://www.consciencelaws.org/issues-legal/legal055.html>

49 Ibid.

50 Ibid.

methods (including contraceptives), population and development, and children's and women's rights. As harmless as these topics may sound, they are actually dangerous and counterproductive

The topic on family planning methods, for example, will include explicit training in the use of contraceptives as these are defined as being family planning methods. Many studies have shown that so-called comprehensive sex education programs that involves training in the use of contraceptives are ineffective in reducing unplanned pregnancies or irresponsible sexual behavior. In fact, such programs often increase the incidence of both.

In 2009, Meg Wiggins *et al.*, published research evaluating the effectiveness of the U.K.'s Young People's Development Programme (YPDP) in reducing teenage pregnancy, substance use, and other outcomes. The program involved giving teenagers sex education and advice about contraception. Of those in the program, 16 percent became pregnant, compared with just 6 percent in a comparison group. The study concluded that:

No evidence was found that the intervention was effective in delaying heterosexual experience or reducing pregnancies, drunkenness, or cannabis use. Some results suggested an adverse effect. Although methodological limitations may at least partly explain these findings, any further implementation of such interventions in the UK should be only within randomised trials.⁵¹

To be sure, the bills that have been filed at the Philippine Congress also include values formation, sexual abstinence, and proscription and hazards of abortion, but studies indicate that when these topics are taught along with contraceptive use and other value-neutral topics, they become ineffective, presumably because of the conflicting and confusing value messages that such education transmits to young students.

Scientific studies support this conclusion. John B. Jemmott III *et al.*, for example, compared the effectiveness of abstinence-only, safer-sex only, comprehensive sex education, to evaluate the efficacy of an abstinence-only intervention in preventing sexual involvement in young adolescents. The study, involving 682 African-American students in grades 6 and 7, found that students in the abstinence-only intervention had lower sexual activity even over time than those in the control group. The study concluded that:

“Theory-based abstinence-only interventions may have an important role in preventing adolescent sexual involvement.”⁵²

In addition, Stan Weed *et al.*, examined seventh graders in northern Virginia, and found that students who received abstinence education were half as likely as non-participants to initiate sexual activity one year after the program.⁵³

51 Meg Wiggins et al., "Health outcomes of youth development programme in England: prospective matched comparison study," *British Medical Journal*, July 2009, BMJ 2009;339:b2534, available online at http://www.bmj.com/cgi/content/full/339/jul07_2/b2534.

52 John B. Jemmott III PhD; Loretta S. Jemmott, PhD, RN; Geoffrey T. Fong, PhD, "Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months : A Randomized Controlled Trial With Young Adolescents ," *Archives of Pediatric and Adolescent Medicine*, 2010;164(2): pp. 152-159. Abstract available online at: <http://archpedi.ama-assn.org/cgi/content/abstract/164/2/152>.

53 Stan Weed et al., "An Abstinence Program's Impact on Cognitive Mediators and Sexual Initiation," *American Journal of Health Behavior*, Vol. 31, No. 1 (2008), pp. 60-73.

Recommendations

Rejecting the the so-called reproductive health bills is only a part of what must be done to protect and uphold the sanctity of human life. The Ang Kapatiran Party also proposes a number of measures that will promote and protect life, our families, our rights, and improve the quality of life in our nation.

1 *Clear and unambiguous legal definition on the beginning of life and punitive provisions to protect the unborn*

Although the Philippine Constitution mandates the protection of the unborn from conception, there is a need for further legislation to fully implement the Constitution's provisions. To eliminate any possible ambiguity, we recommend laws that explicitly define conception as beginning at fertilization, as well as explicitly define the unborn as legally recognized persons with human rights and dignity.

We note that such legislation has already been filed at the 15th Congress in the form of HB 13, the Protection Of The Unborn Child Act Of 2010, by Rep. Roilo Golez of Parañaque City. Its abstract states that the bill, “aims to remedy the oversight in the statutes by recognizing that the unborn has a basic right to life and by extending the mantle of legal recognition and protection to it by defining and clarifying the basic concepts and principle of fetal development.”⁵⁴

2 *Stricter laws against abortions and better enforcement of these laws*

Abortion is already a crime in the Philippines, but there is a need to further enhance the penal laws on this matter. We recommend stricter and more comprehensive enforcement of anti-abortion laws and increasing the punishment for abortion one degree higher than at present.

3 *Ban on abortifacient contraceptives*

Abortifacient contraceptives are already available in the Philippines and may be responsible for thousands of unrecorded deaths of unborn children. We recommend legislation that explicitly bans the sale and use of abortifacient contraceptives, as well as punishes those who engage in the traffic of such deadly substances and their accomplices.

4 *Warning labels on dangerous non-abortifacient contraceptives*

There are other non-abortifacient contraceptive methods (such as condoms) that nevertheless pose risks to those who rely on them because they are inherently prone to failure. If these cannot be removed from the market, then they should be required to carry labels warning users of the probability of failure, their unreliability, as well as any other possible side-effects and risks that they may pose to unsuspecting users.

5 *Chastity, values, and abstinence education*

Many social ills such as unplanned pregnancy, rape and incest are the result of the breakdown of public morals. This situation can be addressed by consistent and integrated education in chastity, moral

54 An Act Providing for the Safety and Protection of the Unborn Child and for Other Purposes. Summary and abstract available online at http://www.congress.gov.ph/legis/search/hist_show.php?save=0&journal=&switch=0&bill_no=HB00013&congress=15

values, abstinence from sex until marriage, and fidelity in marriage. Such education should be offered not only to students that are ready to receive it but to parents and married couples as well. No one, however, should be forced to receive such education against their conscience or their religious beliefs.

6 Natural Family Planning

There are certain situations where married couples can justify the use family planning. We recommend that the government undertake measures to promote the safest and most effective means to do so, namely modern Natural Family Planning (NFP) methods. NFP is the only method that has absolutely no adverse medical side-effects, is practically 100% effective when used correctly and properly, and does not violate moral or religious tenets of the nation's major religious groups.

About the Ang Kapatiran Party

The Ang Kapatiran Party (AKP) is an accredited national political party that espouses a pro-God, pro-life platform as an antidote to the traditional personality-based parties that have dominated and debased Philippine politics for decades

The party was founded by Reynaldo "Nandy" Pacheco in 2004 and was accredited as a national political by the Commission on Elections that same year. It participated in the 2007 and 2010 elections, fielding candidates for local and national positions.

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