CATHOLICS CAN SUPPORT THE RH BILL IN GOOD CONSCIENCE
(Position paper on the Reproductive Health Bill by individual faculty* of the Ateneo de Manila University)

(Note: The opinions expressed in this paper are solely those of the authors and do not necessarily reflect the views of other faculty. Neither do they represent the official position of the Ateneo de Manila University nor the Society of Jesus.)

We, individual faculty of the Ateneo de Manila University, call for the immediate passage of House Bill 5043 on "Reproductive Health and Population Development" (hereafter RH Bill) in Congress. After examining it in the light of Philippine social realities, and informed by our Christian faith, we have reached the conclusion that our country urgently needs a comprehensive and integrated policy on reproductive health and population development, as provided by the RH Bill. We also believe that the provisions of the bill adhere to core principles of Catholic social teaching: the sanctity of human life, the dignity of the human person, the preferential option for the poor and vulnerable, integral human development, human rights, and the primacy of conscience.

Catholic social theology since Vatican II has evolved, on the one hand, from the emphasis on order, social cohesiveness, the acceptance of some inequality, and obedience to authority—to the recognition, on the other, of the centrality of the human person, and the concomitant need for human freedom, equality, and participation (*Pacem in Terris* 1963, *Octogesima Adveniens* 1971). In the same way that Vatican II was a council for *aggiornamento* (renewal) for the universal Church, so too did the 1991 Second Plenary Council of the Philippines (PCP-II) aim at the renewal of the Church in the Philippines. After a month of collectively studying and praying to discern the "signs of the times," PCP-II declared: "As we approach the year 2000, Christ bids this community—ourselves, the laity, religious and clergy of the Catholic Church in the Philippines—to be a Church of the Poor" (PCP-II Acts, no. 96).

As Catholics and Filipinos, we share the hope and mission of building a Church of the Poor. We are thus deeply disturbed and saddened by calls made by some members of the Catholic Church to reject a proposed legislation that promises to improve the wellbeing of Filipino families, especially the lives of women, children, adolescents, and the poor. Being a "Church of the Poor" urges us to be with and listen to the poor, so that their "joys and hopes... griefs and anxieties" become ours as well (*Gaudium et Spes* 1965, no. 1). We therefore ask those who denounce the RH Bill as "pro-abortion," "anti-life," "anti-women," "anti-poor," and "immoral" to consider the economic and social conditions of our people, as borne out by empirical evidence, and to recognize that the bill is, in fact, "pro-life," "pro-women," and "pro-poor."

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The Realities of Women and Their Children

No woman should die giving life. Yet, in the Philippines, 10 women die every 24 hours from almost entirely preventable causes related to pregnancy and childbirth (POPCOM 2000). Our maternal mortality rate continues to be staggeringly high, at 162 maternal deaths for every 100,000 live births (National Statistics Office (NSO), 2006 Family Planning Survey (FPS)). More lives would certainly be saved if all women had access to good prenatal, delivery, and postpartum care.

The reality, however, is that 3 out of 10 Filipino women do not have the recommended number of prenatal care visits (at least 4); and 6 out of 10 women still deliver at home, where they rarely have access to a skilled birth attendant, or to quality obstetric services in case complications arise (NSO and ORC Macro 2004, 2003 National Demographic and Health Survey (NDHS)). Moreover, because a woman's life and wellbeing are inextricably linked to that of her child's, it is not surprising that the country's infant mortality and under-five mortality ratios remain also worrisome: for every 1,000 live births, 24 children die before they reach the age of one, and 32 children die before they reach the age of five (NSO, 2006 FPS).

Aside from poor maternal care, our alarming maternal mortality rate also stems from the high incidence of induced abortions. The silence on this topic shrouds the tragedy of many Filipino women who have resorted to it in desperation. An estimated 473,400 women had induced abortions in 2000, translating to an abortion rate of 27 abortions per 1,000 women aged 14-44, and an abortion ratio of 18 abortions per 100 pregnancies (Juarez, Cabigon, Singh and Hussain 2005). Abortion not only terminates the life of an unborn child but also imperils the life of the mother, especially if performed in unsafe clandestine clinics by untrained personnel, or induced by the woman herself, as is the case of poor women who cannot afford a surgical abortion, or the services of a traditional practitioner (*hilot*). Of the nearly half a million women who had abortions in 2000, 79,000, or 17 percent, wound up in hospitals as a result of abortion complications (ibid.). Induced abortions accounted for 12 percent of all maternal deaths in the Philippines in 1994 (ibid.), and is the fourth leading cause of maternal deaths.

Studies show that the majority of women who go for an abortion are married or in a consensual union (91%), the mother of three or more children (57%), and poor (68%) (Juarez, Cabigon, and Singh 2005). For these women, terminating a pregnancy is an anguished choice they make in the face of severe contraints. When women who had attempted an abortion were asked their reasons for doing so, their top three responses were: they could not afford the economic cost of raising another child (72%); their pregnancy occurred too soon after the last one (57%); and they already have enough children (54%). One in ten women (13%) who had attempted an abortion revealed that this was because her pregnancy resulted from forced sex (ibid.). Thus, for these women, *abortion has become a family planning method, in the absence of information on and access to any reliable means to prevent an unplanned and unwanted pregnancy*. The fact is, our women are having more children than they desire, as seen in the gap between desired fertility (2.5 children) and actual fertility (3.5 children), implying a significant unmet need for reproductive health services (NSO and ORC Macro 2004, 2003 NDHS)

The importance of family planning to the lives of women and their children cannot be emphasized enough. The United Nations Population Fund (UNFPA n.d.) asserts that women's access to effective contraception would avert 30 percent of maternal deaths, 90 percent of abortion-related deaths and disabilities, and 20 percent of child deaths. In the Philippines, however, women sorely lack adequate access to integrated reproductive health services. This stems mainly from an inconsistent national population policy which has always been dependent on the incumbent leader. For example, studies have pointed out that former President Fidel V. Ramos and then Health Secretary Juan Flavier showed strong support for family planning initiatives. In contrast, President Gloria Macapagal Arroyo appears to have an incoherent national population policy, because while she recognizes the need to reduce the country's population growth rate, on the one hand, she relegates the responsibility of crafting, funding, and implementing population and reproductive health programs to local government units (LGUs), on the other. Thus, we are witness to uneven reproductive health and family planning policies and programs across LGUs: Whereas Aurora and the Mountain province, and Davao, Marikina, and Quezon Cities have put in place commendable RH policies and programs, a metropolitan city like Manila teeming with informal settlers had banned modern artificial methods of family planning under the administration of Mayor Joselito Atienza.

From the foregoing, it is easy to understand why the contraceptive prevalence rate of the Philippines is only 50.6 percent (NSO, 2006 FPS). This means that only a little over half of married women use any family planning (FP) method, whether traditional FP (14.8%), modern natural or NFP (0.2%), or modern artificial FP (35.6%). And yet an overwhelming majority of Filipinos (92%) believe that it is important to manage fertility and plan their family, and most (89%) say that the government should provide budgetary support for modern artificial methods of family planning, including the pill, intra-uterine devices (IUDs), condoms, ligation, and vasectomy (Pulse Asia, 2007 Ulat ng Bayan survey on family planning). In another survey, the majority (55%) of respondents said that they are willing to pay for the family planning method of their choice (Social Weather Stations, 2004 survey on family planning).

The evidence is clear: Our women lack reproductive health care, including information on and access to family planning methods of their choice. Births that are too frequent and spaced too closely take a delibitating toll on their health, so that many of them die during pregnancy or at childbirth. Some of them, despairing over yet another pregnancy, seek an abortion, from which they also die—and along with them, their unborn child too.

<u>The sanctity of human life and the dignity of the human person</u>

The Catholic Church proclaims that every human person is created in the image and likeness of God, as well as redeemed by Christ. Therefore, each person's life and dignity is sacred and must be respected. "Every violation of the personal dignity of the human being cries out in vengeance to God and is an offense against the creator of the individual," according to *Christifideles Laici* (1988, no. 37). Indeed, we should measure every institution by whether it threatens or enhances the life and dignity of the human person—whether that individual is a woman agonizing over her ninth pregnancy, or an unborn child in a mother's womb.

The RH Bill as pro-life and pro-women

We support the RH Bill because it protects life and promotes the wellbeing of families, especially of women and their children. Contrary to what its detractors say, the RH Bill is not "pro-abortion," "anti-life," or "anti-women." With "respect for life" as one of its guiding principles (sec. 2), the bill unequivocally states that it does not seek to "change the law on abortion, as abortion remains a crime and is punishable" (sec. 3.m). It can be argued, in fact, that in guaranteeing information on and access to "medically-safe, legal, affordable and quality" natural and modern family planning methods (sec. 2), the bill seeks "to prevent unwanted, unplanned and mistimed pregnancies" (sec. 5.k)—the main cause of induced abortions.

The RH Bill is also pro-life and pro-women because it aims to reduce our maternal mortality rate, currently so high (at 162 maternal deaths per 100,000 live births) that the government has admitted that it is unlikely to meet the Millennium Development Goal target of bringing it down by three-fourths (to 52 maternal deaths per 100,000 live births) by 2015 (NEDA and UNCT 2007). For example, section 6 of the bill enjoins every city and municipality to endeavor "to employ adequate number of midwives or other skilled attendants to achieve a minimum ratio of one (1) for every one hundred fifty (150) deliveries per year." Section 7 instructs each province and city to seek to establish, for every 500,000 population, "at least one (1) hospital for comprehensive emergency obstetric care and four (4) hospitals for basic emergency obstetric care." Section 8 mandates "all LGUs, national and local government hospitals, and other public health units [to] conduct maternal death review."

Moreover, the RH Bill's definition of "reproductive health care" goes beyond the provision of natural and modern family planning information and services, to include a wide array of other services (sec. 4.g). These include: maternal, infant, and child health and nutrition; promotion of breastfeeding; prevention of abortion and management of post-abortion complications; adolescent and youth health; sexual and reproductive health education for couples and the youth; prevention and management of HIV/AIDS and other sexually transmittable infections (STIs); treatment of breast and reproductive tract cancers and other gynecological conditions; fertility interventions; elimination of violence against women; and male involvement and participation in reproductive health. We therefore ask, *How then can the RH Bill be violative of human life and dignity?*

To reiterate, because reproductive health is central to women's overall health, fundamental aspects of women's wellbeing are compromised when reproductive health is ignored. The conditions under which choices are made are as important as the actual content of women's choices: the right to choose is meaningful only if women have real power to choose.

The Conditions of Poor Families

Poverty is a multi-faceted phenomenon caused by inter-related factors: the weak and boom-and-bust cycle of economic growth; inequities in the distribution of income and assets and in the access to social services; bad governance and corruption; the lack of priority accorded to agriculture including agrarian reform; the limited coverage of safety nets and targeted poverty reduction programs; and armed conflict. However, there is no question that poverty in the

Philippines is exacerbated by our rapid population growth (Alonzo *et al.* 2004, Pernia *et al.* 2008), which, at 2.04 percent, is one of the highest in Asia. A close association exists between our country's chronic poverty and rapid population growth, as the latter diminishes overall economic growth and blights the prospects of poverty reduction. Curbing our population growth rate is thus a requisite of sound economic policy and effective poverty reduction strategy, and needs to be undertaken with the same vigor we would exert in fighting corruption, improving governance, or redistributing resources.

Turning once again to the conditions of our people, surveys have established the strong association between household size and poverty incidence. Women aged 40-49 in the poorest quintile bear twice as many children, at six children per woman, compared to an average of three children for women in the richest quintile (NSO and ORC Macro 2004, 2003 NDHS). The same pattern is seen when one considers the woman's educational background: women aged 40-49 with no education (invariably because they are extremely poor) give birth to an average of 6.1 children, whereas women with college or higher education have three children on average (ibid.)

The sad fact is, whereas women in the richest quintile, who have three children on average, are able to achieve their desired number of children (2.7 children), the poorest do not. Women in the lowest quintile, who bear an average of six children, have at least two children more than their ideal number (3.5). The inability of women in the poorest quintile to achieve the number of children they want stems from their high unmet need for family planning, which, at 26.7 percent, is more than twice as high as the unmet need of women in the richest quintile, at 12.3 percent (ibid.).

In addition, studies have noted an inverse relationship between family size and household wellbeing. In particular, an increase in family size is accompanied by a decrease in per capita income, a decrease in per capita savings, and a decrease in per capita expenditures on education and health. Applying standard statistical techniques to indicators of household wellbeing in the 2002 Annual Poverty Indicators Survey (APIS), Orbeta (2005) notes that small families with four members enjoy twice as much income per capita, at P18,429 per annum, compared to large families with nine or more members, at P8,935. Annual savings per capita also declines from P2,950 for a four-member household, to P1,236 for a nine or more-member household.

Expenditures on education and health are good indicators of a family's investment on the wellbeing of its members. Based on the 2002 APIS, small households with four members spend 2 ½ times more on the education of each child in school, at P1,787 per student, compared to large households with nine or more members, where annual education expenditure per student is only P682. Similarly, four-member households spend nearly thrice as much on the health of each member, at P438, in contrast to nine or more-member households, where annual health expenditure per capita is only P150. These figures reveal that as household size increases, a family needs to spread its resources more thinly, thus investing less on the education and health of each member. This has deleterious consequences on human capital and income-earning potential (Orbeta 2005).

Moreover, as family size increases, school attendance of its members drops. The proportion of school-age members 6 to 24 years old who attend school declines from 67.9

percent for four-member households, to 65.6 percent for nine or more-member households (2002 APIS survey, cited in Orbeta 2005). The prevalence of child labor is also associated with household size. Working children's families tend to be larger (7-11 members) than those of nonworking children (2-5 members) (Del Rosario and Bonga 2000).

In summary, poor households typically have more children than they aspired to have, as a result of a high unmet need for family planning. A large family size strains a poor family's capacity to earn, save, and provide education and health care for its members. This diminishes children's human capital and income-earning potential, and explains why poverty tends to be transmitted and perpetuated from one generation to the next.

The preferential option for the poor and integral human development

Scripture teaches us that God has a special concern for the poor and vulnerable. Similarly, the Church calls on all of us, followers of Christ, who was himself poor, to take on this *preferential option for the poor and vulnerable*. This is eloquently expressed in the Dogmatic Constitution of the Church, *Lumen Gentium* (1964): "Just as Christ carried out the work of redemption in poverty and oppression, so the Church is called to follow the same path.... [T]he Church encompasses with her love all those who are afflicted by human misery and she recognizes in those who are poor and who suffer, the image of her poor and suffering founder. She does all in her power to relieve their need and in them she strives to serve Christ" (no. 8).

Embracing the preferential option for the poor asks us to look at the world from the perspective of the poor, and create conditions for them to be heard, defended against injustices, and provided opportunities for their empowerment and attainment of the fullness of human life. An interrelated principle of Catholic social teaching is that of *integral human development*, which asserts that the whole person, and every person in society, must be allowed to develop to his or her full potential. As Pope Paul VI says in *Populorum Progressio* (1967): "Development cannot be limited to mere economic growth. In order to be authentic, it must be complete: integral, that is, it has to promote the good of every man and of the whole man" (no. 14). This is imperative because "[i]n God's plan, every man is born to seek fulfillment.... At birth, a human being possesses certain aptitudes and abilities in germinal form, and these qualities are to be cultivated so they may bear fruit" (no. 15).

The RH Bill as pro-poor

We therefore support the RH Bill because we believe that it will help the poor develop and expand their capabilities, so as to lead more worthwhile lives befitting their dignity and destiny as human beings. It is unconscionable that while the richest in our society are able to attain the number of children that they desire and can support, the poorest, on the other hand, are left struggling to break the chain of intergenerational poverty caused partly by a large family size that impairs their capacity to feed, educate, and take care of their children.

The RH Bill has a number of provisions that are explicitly pro-poor, such as section 11 mandating each Congressional District to undertake the "acquisition, operation and maintenance" of "a van to be known as the Mobile Health Care Service (MHCS) to deliver care,

goods and services to its constituents, *more particularly to the poor and needy* [italics ours], as well as disseminate knowledge and information on reproductive health." However, we would like to focus our attention on the pro-poor benefits offered by section 1, which states that "[t]he State... guarantees universal access to medically-safe, legal, affordable, and quality reproductive health care services, methods, devices, supplies and relevant information thereon *even as it prioritizes the needs of women and children, among other underprivileged sectors* [italics ours]."

In relation to the above, section 8 of the RH bill defines *contraceptives as essential medicines*, in recognition that family planning reduces the incidence of maternal and infant mortality. By placing "hormonal contraceptives, intrauterine devices, injectables and other allied reproductive health products and supplies" under the category of "essential medicines and supplies," they shall thus be included in the regular purchase of essential medicines and supplies of all national and local hospitals and other government health units. Moreover, section 9 of the bill guarantees *hospital-based family planning* for contraceptive methods requiring hospital services. These include tubal ligation, vasectomy, and intrauterine device insertion, which shall be made available in all national and local government hospitals. For "indigent patients," these services "shall be fully covered by PhilHealth insurance and/or government financial assistance."

Treating contraceptives as essential medicines and guaranteeing hospital-based family planning will make family planning products, supplies, and procedures available at all national and local government hospitals. This is a decidedly pro-poor measure, in view of the fact that the majority (58.1%) of Filipinos who use modern artificial family planning methods rely on the government for their supply of contraceptives (NSO, 2006 FPS). Thus, by expanding Filipinos' access to the family planning method (whether modern NFP or modern artificial FP, "with no bias for either") that is best suited to their needs and personal convictions, the RH Bill has the real potential to make safe and reliable family planning available to all Filipinos, and not only to the 50.6 percent practicing it in one way or another (ibid.). This becomes more important in light of the government's acknowledgment that it has a "low probability" of meeting the Millennium Development Goal target of raising the country's contraceptive prevalence rate from 50.6 percent in 2006 to 80 percent in 2015 (NEDA and UNCT 2007).

To recapitulate, the RH Bill does not only safeguard life by seeking to avert abortions and maternal and infant deaths. It also promotes *quality of life*, by enabling couples, especially the poor, to bring into the world only the number of children they believe they can care for and nurture to become healthy and productive members of our society.

The Situation of Our Youth

As parents and guardians of our 15.1 million youth aged 15-24 (Ericta 2003), our greatest challenge is to provide them a safe and nurturing environment where they can study and learn, forge friendships, develop their innate talents, and be guided into responsible citizenship. It might therefore cause us some shock and sadness to know that our youth are increasingly becoming involved in sexual risk-taking behavior. This includes premarital sex and unprotected sex, which may result in unintended pregnancy, or in contracting HIV-AIDS and other sexually transmitted diseases (STDs).

Comparing data from the Young Adult Fertility and Sexuality surveys of 1994 (YAFSS 2) and 2002 (YAFSS 3) involving youth aged 15-24 reveals that the prevalence of premarital sexual activity increased by 5.6 percentage points, from 17.8 percent in 1994 to 23.4 percent in 2002. Even more dramatic was the change over time among youth who said that they have friends who have engaged in premarital sex. In 1994, only 42.5 percent of the youth claimed that they have sexually-experienced unmarried friends. Eight years later in 2002, more than half (53.8%) reported having such friends (Marquez and Galban 2004, citing the University of the Philippines Population Institute (UPPI) and the Demographic Research and Development Foundation (DRDF), 1994 YAFSS 2 and 2002 YAFSS 3).

The 2002 YAFS survey also shows that 11.8 percent of the youth had their first sexual encounter within the ages of 15 to 19, compared to only 8.1 percent in 1994 (Raymundo and Cruz 2003, citing the 1994 YAFSS 2 and 2002 YAFSS 3). Moreover, the average age for the first sexual encounter of the youth declined from 18 years in 1994, to 17.5 years in 2002. Thus, it appears that more of our youth are getting initated into sex at increasingly younger ages.

What is particularly worrisome is how the majority of our youth who have had premarital sex did not intend to do so during their first sexual encounter. Of the youth who have had premarital sex, only 43 percent wanted their first sexual experience to happen. The rest of the 57 percent either said that they did not plan for their sexual encounter to occur but went along with it anyway (55%), or revealed that their first sexual experience happened against their will, which is tantamount to rape (2%) (POPCOM and UNFPA 2003, citing the 2002 YAFSS 3). Because the first premarital sex act is usually unplanned, it is typically unprotected. Nearly four in five (79%) youth who have had premarital sex did not use a contraceptive during their first sexual experience, compared to only one in five (21%) who did. Comparatively, protection was higher among the males (27.5%) than the females (14.8%), rendering the latter extremely vulnerable to unplanned pregnancy (Raymundo and Cruz 2003, citing the 2002 YAFSS 3).

Even more alarming is how the youth continue to fail to use any form of contraception in their subsequent sexual encounters. Of the sexually-active unmarried youth, three in four (75.1%) did not have any protection during their most recent premarital sex act, as against only one in four (24.9%) who did (Raymundo and Cruz 2003, citing the 2002 YAFSS 3). The reasons mentioned by the youth in 2002 for not using contraceptives, in declining order of importance, are: lack of knowledge on contraception; the belief that contraception is either wrong (against one's religion) or dangerous to one's health; objection of the partner; and the view that sex is not fun with contraception. And yet when female respondents who had already engaged in sex were asked in the 1994 YAFS survey if they were willing and prepared to become parents, an overwhelming 94 percent of them said that they were not (POPCOM 2002, citing the 1994 YAFSS 2).

From the foregoing, it is apparent that much of our youth's risky sexual behavior stems from their lack of knowledge on sex. Although 70 percent of our youth are aware that a woman could get pregnant only after she begins menstruation, the vast majority (80%) of young females do not know the fertile period of their menstrual cycle. Close to half of our youth are unaware that it is possible for a woman to get pregnant after only one sexual encounter (POPCOM and UNFPA 2003). In addition, our youth have many misconceptions about HIV-AIDS and sexually

transmitted diseases (STDs), such as: AIDS is curable (72.7%); AIDS is a punishment from God meted on people who had sex outside of marriage (35.1%); and AIDS is contracted only by those who have multiple sex partners (27.8%) (Laguna 2004, citing the 2002 YAFSS 3).

Our youth's increased sexual activity, notwithstanding their insufficient understanding of reproductive health and their sexual rights and responsibilities, can lead to adverse outcomes, such as unwanted pregnancy and contracting sexually transmitted diseases. The life script of a female who had early sex is invariably written as a plot of early marriage, aborted schooling, curtailed work opportunities, frequent pregnancies, and sometimes separation, abortions, and even early death. The 2003 National Demographic and Health Survey reveals that 26 percent of young women aged 15-24 years have begun childbearing, of whom 8 percent are teenagers aged 15-19 years. Many pregnancies among females in the 15-24 age bracket are unintended, resulting in abortions for some. Based on a 2004 nationwide survey of married and unmarried women aged 15-49, 46 percent of abortion attempts occur among young women, of which 30 percent are attempted by women aged 20-24, and 16 percent by teenagers aged 15-19 (Juarez, Cabigon, and Singh 2005).

Moreover, because early pregnancies are high-risk cases, many young women and adolescents die in pregnancy, at birth, or shortly after birth. Young women including teenage mothers accounted for 25.4 percent of the total 1,833 maternal deaths reported in 2004, of which 18.4 percent were deaths of young mothers aged 20-24; 6.6 percent, adolescent mothers 15-19 years old; and 0.4 percent, teenage mothers under 15 (NSO 2004). In addition, almost a third, or 30.4 percent, of the total 10,351 fetal deaths recorded in 2005 were experienced by young women 24 years old and below, of whom 22.8 percent were aged 20-24, 7.6 percent were 15-19 years old, and 0.01 percent were under 15 (NSO 2005).

From whom should our young people learn about reproductive health, sexuality, and responsible sexual behavior? Socialization agents such as the family, peer group, church, religion and the media are crucial to the youth's development, as they impart the values and norms of behavior acceptable to one's society. However, officials of the Catholic Church have strongly opposed the inclusion of sex education in the curriculum of public schools, arguing that doing so would arouse young people's curiosity about sex, encourage them to try premarital sex, and promote their promiscuity.

It is important to note that as early as 1972, the Department of Education, Culture and Sports (DECS) already had a module for sex education in elementary and high school called Population Education (POPED). Over the years, this module has been revised to adapt to changing times. However, in 2006, Catholic bishops assailed the introduction of a new module on adolescent reproductive health being developed by the Department of Education (DepEd), causing the Arroyo administration to back off from its trial run of the revised RH module. The Catholic Church has consistently maintained that the instruction of sex and sexuality to children should be the primary responsibility of the family, and of parents, in particular.

While it would certainly be ideal for families and parents to be their children's most important source of information on sex and sexuality, this is hardly the case. Studies show that children are not very comfortable talking to their parents about it—and vice versa. Based on the

2002 Young Adult Fertility and Sexuality survey, only 15.7 percent of the youth aged 15-24 freely talk about sex at home with their family (Marquez and Galban 2004, citing the 2002 YAFSS 3). And if sex is even discussed by parents with their children, it is usually to admonish the latter not to do "it." However, young people need to raise their questions and feelings about sex and their sexuality. If they are ill at ease doing this with their parents or other family members, they then turn to their peers, who are not the most reliable sources of information on sex, even as a considerable number of them engage in it. In addition, the youth seek information on sex from the media, which has been described as young people's "surrogate parents." The 2002 YAFS survey reveals that the youth learn about sex from pornographic materials. The majority (55%) of the youth have viewed x-rated films, whereas 39 percent have accessed pornographic reading materials (POPCOM and UNFPA 2003, citing the 2002 YAFSS 3).

In sum, although our youth are having their sexual debut at increasingly younger ages, they do so bereft of sufficient knowledge on reproductive health, particularly the consequences of early and unprotected sex. Curious and eager to know more about sex, they seek information from unreliable sources like their peers and pornographic materials, unable as they are to get that from socialization agents like their family or school. Worse, some of them learn about sex from actual experience, without fully knowing how one could get pregnant or contract sexually-transmitted diseases. Access to accurate and appropriate information and services on many aspects of sexual behavior, reproductive health, and sexuality is thus needed by our adolescents and youth, in light of increasingly risky sexual behavior among a significant number of them.

The right to be informed

Recent Catholic social theology has recognized the centrality of the human person, and, relatedly, has declared the "identification and proclamation of human rights [as] one of the most significant attempts to respond effectively to the inescapable demands of human dignity" (*Dignitatis Humanae* 1965, no. 1). Pope John XXIII, in *Pacem in Terris* (1963), was the first to articulate a set of human rights, foremost of which is the "right to bodily integrity and to the means necessary for the proper development of life, particularlly food, clothing, shelter, medical care, rest, and, finally, the necessary social services" (no. 11).

One human right that has received abundant attention in Catholic social teachings is the *right to be informed and to form opinions*. The Second Vatican Council and the popes since Pope John XXIII have all stressed this right to information as essential for the individual and for society in general. In *Pacem in Terris* (1963), Pope John XXIII says, "[Man] has a right to freedom in investigating the truth" (no. 12). Similar to *Pacem in Terris*, the Second Vatican Council, in its document, *Gaudium et Spes* (1965), identifies a set of rights as necessary for a truly human life, including "the right to education... to appropriate information, to activity in accord with the upright norm of one's own conscience... and to rightful freedom even in matters religious" (no. 26). Pope John Paul II, in *Centesimus Annus* (1991), likewise calls attention to "the right to develop one's intelligence and freedom in seeking and knowing the truth" (no. 47).

The RH Bill as supportive of the youth's right to information

Being educators, we are in favor of the RH Bill's intent to offer "age-appropriate reproductive health education" to our children and youth. We affirm that this is key to providing young people the information and values they would need, not only to take care of their reproductive and sexual health, but also to arrive at sound and responsible decisions regarding their sexuality, sexual behavior, and family life, whether now or in the future.

In asserting the need for reproductive health education in schools, we are not negating the primary role of parents in educating their children on sex. We believe that families should provide the environment where children can raise their questions, feelings, and needs regarding sex. However, we also recognize that such discussions, in reality, rarely happen, with only, at best, one in five of the youth (15.7%) saying that they can talk about sex at home (2002 YAFSS 3). Given this, reproductive health education in schools becomes all the more imperative.

We share neither the view nor the fear that discussing sex in schools will make adolescents prurient and promiscuous. Rather, we trust that our youth have the capacity to make intelligent and value-driven choices regarding their sexuality and sexual behavior. As teachers, we believe that knowledge is empowering, and thus uphold our youth's right to information and education on sex and reproductive health. We would like to empower them to make responsible decisions now and in the future, first by providing them correct and sufficient information on reproductive and sexual health, and second, by helping them identify, articulate, and deal with their issues and sentiments regarding sex and their sexuality.

An examination of section 12 of the RH Bill shows that reproductive health education, as envisioned, will promote values espoused by Philippine society in general, and Catholicism, in particular. "Responsible sexuality" (sec. 12.i.) and "abstinence before marriage" (sec. 12.g)—and not sexual promiscuity—will be encouraged, even as RH education seeks to create opportunities for young people to air out their "attitudes, beliefs and values on sexual development, sexual behavior and sexual health" (sec. 12.c). Respect for the sanctity of life will be stressed by the RH education's "proscription [against abortion]" and lessons on the "hazards of abortion" (sec. 12.d). "Responsible parenthood" (sec. 12.e), another key Filipino value, will likewise be emphasized, through, among others, discussions on the "use and application of natural family planning methods to promote reproductive health, achieve desired family size and prevent unwanted, unplanned and mistimed pregnancies" (sec. 12.f).

And who can argue against the need to instill in our children the value of "reproductive health care" (sec. 12.b), or the importance of their "reproductive health and sexual rights" (sec. 12.a)? Will our youth not benefit from being taught about the "prevention and treatment of HIV/AIDS and other STIs/STDs, prostate cancer, breast cancer, cervical cancer and other gynecological disorders" (sec. 12.h)? Will our young women not become more prepared for motherhood as a result of being educated on "maternal, peri-natal and post-natal education, care and services" (sec. 12.j)? And in case we are worried that our children in elementary school will be taught sex lessons beyond the grasp of their tender minds, we can lay our fears to rest. The RH Bill provides for "age-appropriate reproductive health education" starting from Grade Five up to Fourth Year High School, to be taught by "adequately trained teachers." This implies that

preteeners will study only such topics as the parts of the reproductive system, and proper hygiene and care of one's body.

In sum, we believe that by upholding our youth's right to information and education on reproductive health, we are contributing to their development into adults who will exercise their reproductive health and sexual rights, and plan their future families, with great responsibility. We close with this reassuring quote from the United Nations Population Fund: "It has been repeatedly shown that sex education leads to responsible behaviour, higher levels of abstinence, later initiation of sexuality, higher use of contraception, and fewer sexual partners. These good effects are even greater when the parents can talk honestly with their children as well" (UNFPA 2008).

A Call of Conscience: Catholics in Support of the RH Bill

After studying the provisions of House Bill 5043 in the light of the realities of Filipino women, poor families, and our youth, we, individual faculty of the Ateneo de Manila University, speaking for ourselves and not for the University, have come to conclude that the Philippines urgently needs a national policy on reproductive health and population development. We therefore strongly support the RH Bill's immediate passage in Congress.

We further believe that it is possible for Catholics like ourselves to support HB 5043 in good conscience, even as we recognize, with some anguish, that our view contradicts the position held by some of our fellow Catholics, including our bishops. We are aware that they have denounced it as "pro-abortion," "anti-life," "anti-women," "anti-poor," and "immoral." However, our reason, informed by our faith, has led us to believe and say otherwise.

We assert that RH Bill is pro-life, pro-women, pro-poor, pro-youth, and pro-informed choice. By giving couples, and especially women, information on and access to "medically-safe, legal, affordable and quality" family planning methods (whether modern natural or modern artificial), the RH Bill seeks to avert unwanted, unplanned, and mistimed pregnancies, which are the root cause of induced abortions. In that sense, the bill is not only *pro-life* but also *pro-women*, because it helps them to plan the number and spacing of their children, so as not to experience frequent and closely-spaced pregnancies that take a toll on their health and wellbeing. Moreover, the RH Bill seeks to improve maternal and infant health by enjoining cities and municipalities to provide an adequate number of skilled birth attendants as well as hospitals rendering comprehensive emergency obstetric care.

HB 5043 is *pro-poor* because it makes contraceptives (including those requiring hospital services) more accessible and cheaper for Filipinos, especially for the poorest 20 percent, who have the highest unmet need for family planning (26.7%), and 2.5 children more than they desire and are able to feed, clothe, and send to school. The bill is also *pro-youth*, because it seeks to provide our young people the information and values they would need in taking care of their reproductive health, and in making responsible decisions regarding their sexuality, sexual behavior, and future family life.

Furthermore, the RH Bill is *pro-informed choice*. In seeking to promote both modern natural and modern artificial methods of family planning (with "no bias for either"), HB 5043 recognizes that couples, especially women, have the right to choose the family planning method that they consider to be the safest and most effective for them, provided that these are legally permissible. Although natural family planning (NFP), which the Catholic Church promotes, offers many benefits, it is important to realize that pursuing an NFP-only population policy will be a disservice, if not a grave injustice, to women and couples for whom NFP simply cannot work. We are thinking of women who find it impossible to predict their infertile periods; or couples who see each other on an irregular basis; or women who are trapped in abusive relationships with men who demand sex anytime they want it. Why is it morally wrong for such women and couples—and even others not encompassed by the above situations—to use a modern artificial family planning method that has been pronounced safe and non-abortifacient by health authorities, if their discernment of their particular situation has led them to conclude that such a method will enable them to fulfill the demands of marital love and responsible parenthood?

At his trial, Thomas More stressed the sacredness of conscience when he said: "[I]n things touching conscience, every true and good subject is more bound to have respect to his said conscience and to his soul than to any other thing in all the world besides." Catholic social teachings similarly recognize the *primacy of the well-formed conscience* over wooden compliance to directives from political and religious authorities. *Gaudium et Spes* (1965) tells us: "In the depths of his conscience, man detects a law which he does not impose upon himself, but which holds him to obedience. Always summoning him to love good and avoid evil, the voice of conscience when necessary speaks to his heart: do this, shun that. For man has in his heart a law written by God; to obey it is the very dignity of man; according to it he will be judged" (no. 16).

We respect the consciences of our bishops when they promote natural family planning as the only moral means of contraception, in adherence to *Humanae Vitae* (1968), which teaches that married couples who want to control and space births should "take advantage of the natural cycles immanent in the reproductive system and engage in marital intercourse only during those times that are infertile" (no. 16). In turn, we ask our bishops to respect the one in three (35.6%) married Filipino women who, in their "most secret core and sanctuary" or conscience, have decided that their and their family's interests would best be served by using a modern artificial means of contraception. Is it not possible that these women and their spouses were obeying their well-informed and well-formed consciences when they opted to use an artificial contraceptive?

We therefore ask our bishops and fellow Catholics not to block the passage of HB 5043, which promotes women's and couples' access to the full range of safe, legal, and effective modern natural and modern artificial family planning methods, from which they can choose the one most suitable to their needs and personal and religious convictions. To campaign against the bill is to deny our people, especially our women, many other benefits, such as maternal and child health and nutrition; promotion of breastfeeding; adolescent and youth health; reproductive health education; prevention and management of gynecological conditions; and provision of information and services addressing the reproductive health needs of marginalized sectors, among others. In pursuit of the *common good*, or the "sum total of social conditions which allow people... to reach their fulfillment more fully and more easily" (*Gaudium et Spes* 1965, no. 26),

we call on the Catholic Church to let the RH Bill pass in Congress, and to consider forging a principled collaboration with the government in the promotion of natural family planning which *Humanae Vitae* deems morally acceptable, and in the formation of consciences with emphasis on the value of responsible sex and parenthood.

To our fellow Catholics who, in good conscience, have come to conclude, as we have, that we need a reproductive health law: we ask you to declare your support for HB 5043.

Finally, we call on our legislators in Congress and in the Senate to pass the RH Bill. Doing so upholds the constitutional right of spouses to found a family in accordance with their religious convictions; honors our commitments to international covenants; and promotes the reproductive health and reproductive rights of Filipinos, especially of those who are most marginalized on this issue—our women, poor families, and youth.

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