

Obama and global health

What will the Presidency mean for the world's most vulnerable?

Review by **Steve Fouch**

CMF Head of Allied Professions Ministries

Barack Obama's inauguration as US President has largely been seen around the world as positive, but what will it mean for global health? Two major breaks with previous policy have gone almost unnoticed.

The first was the forced resignation¹ of Ambassador Mark Dybul, the controversial head of Bush's \$48 billion President's Emergency Plan for AIDS Relief (PEPFAR)² the day after Obama's inauguration. The second came when Obama overturned the Mexico City Protocol,³ which prevents US aid to overseas organisations providing or discussing abortion-related services.

PEPFAR has always courted controversy:⁴ for pumping billions into programmes for just one disease, for promoting abstinence-only prevention, for not funding family planning services, for being bilateral when it is argued funds are better funnelled through the multilateral Global Fund for AIDS, TB & Malaria,⁵ and for being seen as

driven by a conservative Christian agenda.⁶ But PEPFAR has been far more effective than credited: it got 2.1 million people in 15 countries onto antiretroviral therapy, distributed 2.2 billion condoms (countering the charge prevention's focus was abstinence-only), and gave access to anti-HIV therapy to prevent mother-to-child infection to 1.2 million women. Only 7.4% of its budget went to abstinence-only programmes.⁷

Obama will honour the December 2008 PEPFAR act to pump nearly \$50 billion extra into HIV prevention, care and treatment over five years. More of that money will probably now go to family planning services that will undoubtedly save lives.⁸ That some of those services will promote and provide abortion causes concern.

The world will watch Obama with interest. If he can live up to and exceed Bush's legacy in the developing world,

it will be good news for many. But uncertainties remain about the other forces that may move his hand less helpfully. Let us uphold him and all leaders⁹ in prayer.

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Coroners and Justice Bill

Hijack attempt underway

Review by **Peter Saunders**

CMF General Secretary

In recent months and as part of a concerted campaign, assisted dying has constantly been in the media spotlight through the Debbie Purdy case (seeking immunity for her husband from prosecution should he accompany her to commit suicide abroad), Craig Ewart's *SKY Real Lives* documentary (covering his death at the Dignitas suicide facility in Zurich), the BBC drama on the January 2006 suicide of Bath GP Anne Turner, and the double suicide of Peter and Penny Duff.¹ While British deaths at Dignitas remain small (100 in five years or 1 in 30,000 British deaths) these high profile 'hard cases', it is claimed, call for a change in the law.

Since the defeat of Lord Joffe's *Assisted Dying for the Terminally Ill Bill* in May 2006 the pro-euthanasia lobby have been regrouping for another assault on Westminster. It is now clear that this will come via the *Coroners and Justice Bill*.^{2,3} The Bill was introduced into the House of Commons on 14 January 2009, was debated at Second Reading on 26 January, has been since scrutinised by a committee of MPs, and will have its Report Stage and

Third Reading in late March, thereafter passing to the House of Lords.

This complex government Bill actually contains nothing about assisted dying, but rather has provisions to tighten up the Suicide Act 1961 in the wake of the Bridgend suicides.⁴ We expect though that from Commons Report stage on there will be repeated attempts to hijack it to legalise assisted suicide.

This has been made explicit by former Health Minister Lord Warner,⁵ by *Dignity in Dying* CEO Sarah Wootton in a letter to *The Times*,⁶ by David Winnick MP in an Early Day Motion (EDM 230) signed by over 100 MPs, by Liberal Democrat MP David Howarth in speeches to Parliament, and through *Dignity in Dying* running a grassroots campaign.

To legalise assisted dying, especially at a time of economic crisis, would inevitably place pressure on vulnerable people to choose to end their lives for fear of being a financial or emotional burden upon others.

The Prime Minister twice in December 2008 expressed his opposition to any change in the law to allow assisted dying,⁷

and there appears to be no government intention to do so. However, the price of freedom is eternal vigilance, and the voices of Christian doctors in writing and speaking to MPs, educating churches and colleagues, and commenting in the media will be essential in safeguarding the law and in promoting better care for those who are terminally or chronically ill.

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Like a virgin?

The details prove that social factors encouraging virginity do show benefit

Review by **Trevor Stammers**
CMF Chairman, GP, and Lecturer

The Chief Medical Officer advocates total abstinence from alcohol for under-15s,¹ but encouraging abstinence from underage sex is usually ridiculed. No surprise therefore that misleading headlines about a new study² on US virginity pledges were universally along the lines of 'Virginity pledge ineffective against teen sex despite government funding'.³ The study showed those who made an abstinence pledge were just as likely to have had sex at age 21 as those who had not pledged, and were less likely to have used condoms at first intercourse.

Recently however, the RAND Corporation found that virginity pledges did delay sexual intercourse and did *not* decrease condom use.⁴ Why then the differing findings? As so often, it all depends on the sampling. The RAND study included those as young as 12 and examined sexual experience 1-3 years later, whereas Rosenbaum only sampled over-15s and examined their sexual experience 5 years later when aged 21-23. Both studies carried out propensity score matching⁵ to try and eliminate variables other than pledging. This meant that both

pledging and non-pledging samples were matched, eg, for religiosity.

Perhaps it is not surprising then that, at 21-23, Rosenbaum's pledgers and matched non-pledgers did not differ in premarital sex, sexually transmitted diseases, anal and oral sex variables, since they all came from similar home backgrounds whether they pledged or not. What went largely unreported, however, was that *both* Rosenbaum groups demonstrated less teen pregnancy; fewer friends who used drugs; less premarital vaginal sex than US teenagers overall; and that the average age of first intercourse for both groups was 21 against the US average of 17.⁶

The Rosenbaum study then actually shows common factors in both matched groups that delay first intercourse by around four years, confirming many studies showing religion, family structure⁷ and parental attitudes to sex⁸ have a major influence on age of first coitus with no evidence of increased harm. STI rates were not statistically different at 5% level, even though they reported far less condom use. In fact the chlamydia rates were over 40% lower in the pledging group. For

Rosenbaum to conclude that 'virginity pledge programmes do not prepare pledgers to protect their health if they have sex' and for the UK media to propagate it, is yet another case of the blind leading the blind.⁹

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End of life care in Scotland

Comprehensive palliative provision or physician assistance to die?

Review by **Andrew Fergusson**
CMF Head of Communications

CMF has about 450 doctor and 100 student members in Scotland, and since devolution of health policy, they have had to face some different challenges. At the time of writing, two Members of the Scottish Parliament are reviewing results of their radically different consultations on end of life care.

Margo MacDonald MSP has Parkinson's disease and supports assisted dying. In December 2008 she sought views on her proposed End of Life Choices (Scotland) Bill.¹ CMF is now mainly opposing euthanasia through its membership of the Care Not Killing Alliance² which brings together disability and human rights organisations, healthcare and palliative care groups, and faith-based organisations to promote palliative care, prevent weakening or change of the law, and influence public opinion. Their robust response³ criticises the consultation's

lack of clarity (does it advocate euthanasia or physician assisted suicide or both?) and its lack of detail, particularly about 'safeguards'. CMF Scotland's submission⁴ develops some specifically Christian arguments and amplifies medical and public policy concerns. MacDonald needs 18 MSP signatures to have any chance of her proposed Bill being debated in the Scottish Parliament.

Meanwhile, Roseanna Cunningham MSP has been consulting⁵ on a proposal to make needs-based palliative care uniformly available across Scotland. She 'highlights the uneven access to palliative care in Scotland' and 'aims to place a statutory duty on health boards in Scotland to provide high-quality palliative care to those who need it'.

This edition of *Triple Helix* features⁶ some of the conclusions of an innovative primary care research group in Edinburgh developing palliative care which is accessible for people with all life-threatening illnesses, is delivered

in the community, and explores spiritual distress at the end of life. There are characteristic trajectories of physical decline at the end of life which also have a spiritual dimension, and this understanding allows spiritual support to be planned and delivered to patients and their carers to relieve distress and help in the search for meaning and purpose. CMF supports care, not killing.

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