news reviews

Unsafe sex

Why STI rates continue to rise

Review by **Trevor Stammers**
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Public Health England (PHE) has released figures showing the highest annual levels of sexually transmitted infections (STIs).[1] There were 448,422 recorded hospital clinic diagnoses – a rise of 5% from 2011, with under-25s experiencing the highest rates. Chlamydia accounted for 46% of the total diagnoses. The rise in gonorrhoea diagnoses of 21% is a particular cause for concern as it will fuel the problem of antibiotic resistance highlighted earlier this year.[2]

Dr Gwenda Hughes, head of STI surveillance for PHE, said 'Too many people are continuing to have unsafe sex'.

If by 'unsafe sex' Dr Hughes meant sex with a partner you have only just met, then this makes good sense. If Hughes merely equates 'unsafe sex' with 'sex without a condom' which is how most of her audience will understand it, then this is not such sound advice. Sex with a condom may be safer than sex without one, but a lot depends on the sexual partner too and the sexual activity involved. Both taboo subjects, it seems, for PHE.

Such coyness wrecks lives. Spin about the rather modest effectiveness of condoms for many non-HIV STIs continues to be the norm in literature. The latest edition of the Faculty of Sexual and Reproductive Health Guidance on Barrier Methods for Contraception and STI Prevention (August 2012)[3] is typical of the blithe reassurances proffered on the flimsiest of evidence. For example, page 7 asserts 'the two most rigorously designed studies provided evidence to support a reduced risk of syphilis transmission with consistent use of male condoms'.[4] What the guidance fails to say is that the single reference given reviews twelve studies and the only one showing a statistically significant reduced transmission of syphilis was in a sample of Bolivian sex-workers[5] – hardly a comparable risk-group to UK population.

Until young people understand that mutual virginity before marriage, and faithfulness within it, is the only way to enjoy truly safe sex, STI rates will continue to increase.

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Hunger: not part of God's plan

Global malnutrition is becoming an epidemic

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

It is sobering that in the 21st Century we still face a malnutrition epidemic affecting millions. In 2011, according to recently published figures in *The Lancet*,[1] 3.1 million under-fives died from under-nutrition – 45% of total child deaths. This is improving, but much too slowly. However, the impact goes wider; malnutrition in adolescent girls affects the health of their children (and grandchildren) born years later, while malnutrition during pregnancy has an even more dramatic impact. Malnutrition in the first two years of life leads to permanent physical and mental stunting of children, increases their vulnerability to obesity and non-communicable diseases, and reduces job and educational opportunities in later life. Under-nutrition today causes health and economic problems for the next two generations at least.

A staggering 165 million children are affected by malnutrition. This is a global health problem of crisis proportions. The causes are complex – land controlled by vested interests driving off subsistence farmers, labour exploitation, financial austerity measures, fluctuations in global commodity prices (exacerbated by agricultural subsidies in the developed world) – the list goes on. The structure of global trade and food production is forcing many into hunger, often in areas where local food production is more than adequate to meet the need. The problem is systemic injustice, not a lack of food.[2]

The recent hunger summit in London (ahead of the G8) and the accompanying 'Big IF' rally in Hyde Park[3] aimed to galvanise global political commitment to make the policy changes necessary to end this kind of hunger. Critics commented that the rally and campaign did not address all the causative issues, and that the campaign and government policy seem very much in accord.[4] More seriously, it looks as if some of the measures being put forward (especially tax transparency) are being ably resisted by many governments with the help of big business lobby groups.[5]

The Scriptures remind us that hunger is not a part of God's plan for humanity – there will be no hunger in the new creation.[6] We are urged to feed the hungry, and to allow our surplus to meet the deficit of others.[7] However more than just caring, we are also enjoined to stand up for justice.[8] We will be picking up the pieces of these malnutrition-induced health crises all over the world for years to come. There can be no doubt that this cannot be allowed to continue; we need to continue to lobby for real action as well as to care for those affected.[9]

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Assisted suicide

Renewed pressure to change the law must be resisted

Review by **Peter Saunders**
CMF Chief Executive

The relentless pressure to legalise assisted suicide and euthanasia continues unabated in Britain. The Court of Appeal hearing of two cases of locked-in syndrome (Nicklinson and 'Martin') on 13-16 May was joined by a third appellant Paul Lamb, a 57 year old man with quadriplegia, who has taken Tony Nicklinson's place after the latter died last year.[1]

Nicklinson's widow argued that her husband being denied an 'assisted death' interfered with her right to a private life under the European Convention on Human Rights article 8. Lamb similarly used article 8 arguments but also argued that the legal principle of 'necessity' should allow a doctor to end his life without fear of prosecution for murder.

'Martin' also argued under article 8 asking the Director of Public Prosecutions (DPP), the Solicitor's Regulatory Authority and the General Medical Council to make clear in advance the extent to which solicitors and doctors could assist his suicide.

The judgment is still awaited at the time of writing but if any of these appeals are successful the case will go back to the High Court for consideration of more detailed evidence.

Lord Falconer introduced his new 'assisted dying bill' into the House of Lords on 15 May with a second reading (debate stage) expected to take place in October.[2] It seeks to legalise assisted suicide (but not euthanasia) for mentally competent adults with less than six months to live and uses a 'two doctors' signature' model similar to the Abortion Act 1967. The aim is to medicalise assisted suicide, making it a standard healthcare option.

Margo MacDonald MSP has published the results of her new consultation aimed at legalising assisted suicide in Scotland and has obtained the necessary 18 signatures that she requires to take a bill forward. She has announced that she plans to introduce it into the Scottish Parliament in the summer.

Alongside these moves, the Royal College of General Practitioners (RCGP) is consulting its members about whether it should abandon its long opposition to a change in the law and adopt a neutral stance.[3] The inquiry closes on 9 October.

The voices of three key groups – doctors, disabled people and faith communities – will be crucial in countering the encroachment of this culture of death. In particular, Christian doctors, as key advocates for those who are sick or disabled, will continue to have a huge role to play.

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The NHS number

Time for private abortion providers to be accountable

Review by **Philippa Taylor**
CMF Head of Public Policy

A Government consultation on the collection of national statistics on abortion may seem like a dry and uncontroversial topic. However, it has provided CMF with an opportunity to highlight an issue that has received very little publicity but which we believe is vitally important.[1]

In England and Wales, many abortions are not properly recorded on women's health records. This means there is no record of them for future medical treatment and care, nor is it possible for linkage research to be carried out on the outcomes of abortion for these women.

With over 200,000 abortions per year, this data is necessary to test the UK evidence of sequelae from abortion.

The problem arises because many abortions commissioned *outside* of the NHS are undertaken without use of the NHS personal number. The NHS number is an administrative identifier, used to match patients to their medical records.[2] The commissioned providers of abortion in England (mainly BPAS and Marie Stopes) are not routinely required to record the patient's NHS number, thus subsequent women's health events cannot easily be linked back to the abortion, and longitudinal research is almost impossible.

Outcomes of abortion and possible side effects (eg possible subsequent premature birth, mental health problems, infertility or other trauma) cannot easily be tracked in England. This puts England behind much of Europe regarding this evidence, including behind Scotland. In Scotland abortions are largely undertaken within the NHS, so good record linkage is available.

In 1991 the NHS funded 9,197 abortions carried out by the *private sector* – just 10% of private sector abortions. By 2010 the NHS funded 111,775 abortions carried out by the private sector – 93% of all abortions carried out by the private sector.[3]

By 2010 more NHS commissioned abortions were carried out in the private sector than within the NHS in England and Wales (59%).[4] Hence the problem with data collection, as the NHS number is not routinely recorded for the large numbers of private sector abortions.

It could be argued that women undergoing abortion require complete confidentiality and privacy protection, and might be identified through the collection of data via the NHS number. However, all good epidemiological longitudinal research is confidential, which would include research on the outcomes of abortion linkage with the female health record.

Routine record keeping of the NHS number for every abortion should be put in place. The problem is, while we may have the means to do so, there is little political will while publicly-funded private abortion providers enjoy a stranglehold over the abortion industry.[5]

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