Trusts lack the skills to implement Darzi reforms, say MPs

Zosia Kmietowicz LONDON

Primary care trusts in England lack the analytical, planning, and management skills needed to successfully implement the reforms of the NHS recommended by the health minister Ara Darzi, says a cross party group of MPs.

In its report on Lord Darzi’s next stage review, the House of Commons Health Committee says that the quality of leadership in the NHS must improve. Many doctors are put off becoming senior managers and need more training and support to take on management responsibilities. Better use must also be made of the NHS graduate management scheme to help develop better managers, say the MPs.

The final report of Lord Darzi’s next stage review was published at the end of June last year (BMJ 2008;337:a642). Its main emphasis was on improving the quality of care in the NHS through better measurement and financial incentives.

But the MPs are doubtful that the plans can be delivered at the pace the government hopes. Their report says, “We have concerns about the implementation of the report, which will be the responsibility of PCTs [primary care trusts], because we doubt that most PCTs are currently capable of doing the task successfully.”

“As we have noted in a series of inquiries, PCT commissioning is too often poor. In particular, PCTs lack analytical and planning skills and the quality of their management is very variable. This reflects on the whole of the NHS: as one witness told us, ‘The NHS does not afford PCT commissioning sufficient status.’ We consider this to be striking and depressing.”

The MPs say they are “not convinced” that the world class commissioning programme launched by the government to address weaknesses in commissioning will do much to improve the situation.

First Report of Session 2008-09 on the NHS Next Stage Review can be seen at www.parliament.uk/healthcom.

Cite this as: BMJ 2009;338:b111

UN reports big increase in civilian casualties in Gaza

John Zarocostas GENEVA

The situation is horrific and getting worse by the hour for civilians trapped in Israel’s military onslaught in the Gaza strip, senior UN officials have said. With the number of casualties, especially women and children, rising sharply, they have called on the international community to take effective action to stop the attacks.

John Ging, director of operations in Gaza for the UN Relief and Works Agency for Palestine Refugees in the Near East, said on 13 January, “The horrific consequences of this conflict . . . still continue. People are still being killed [and] injured. The destruction is going on, and it continues to go on day by day.”

Mr Ging said that the numbers of casualties are difficult to establish or verify, but he said that the Palestinian Ministry of Health and human rights organisations on the ground have reported that more than 900 people have been killed, among them 292 children and 85 women.

In neighbouring southern Israel four civilians have been killed and 250 have been wounded as a result of rockets fired by Hamas militants.

Mr Ging said that more than 4250 people in Gaza have been injured, including 1497 children and 626 women. “From a human perspective,” he said, “every time I visit the hospital I come away hugely distressed because the injuries are horrific. Even those that are alive and injured, their lives are destroyed. [There are] so many multiple amputees and so many other horrific injuries.”

Dorothea Krimitas, a spokeswoman for the International Committee of the Red Cross, said that surgical staff in the field have reported many people coming in with multiple injuries, and she added that “they had to perform many amputations.”

Paul Garwood, spokesman for the World Health Organization, said that WHO “remains extremely concerned” about the increasing number of casualties and about the damage to health facilities. Distributing medical supplies in the strip was extremely difficult because of the insecurity and the inability of many staff to get to work, he added.

Cite this as: BMJ 2009;338:b137
Older US women are less likely than men to get kidney transplants

Janice Hopkins Tanne NEW YORK

Women in the United States with end stage renal disease are just as likely as men to receive kidney transplants—but only until the age of 45. Older women and women with comorbidities are less likely to receive transplants than men of the same age or men with similar comorbidities, a new study shows, despite the fact that they have a similar or better survival benefit from a transplant.

Dorry Segev, director of clinical research for transplant surgery at Johns Hopkins University in Baltimore, Maryland, and colleagues reported their study in the Journal of the American Society of Nephrology (doi:10.1681/ASN.2008060591).

They reviewed 563 197 patients with end stage kidney disease, of whom 81 301 (14.4%) joined the deceased donor waiting list and 9359 (1.7%) received a transplant from a living donor without ever joining the waiting list. Of those who never had access to a transplant 49.6% remained on dialysis until the end of the study and 50.4% died.

The researchers compared men's and women's relative risks of receiving a transplant, stratified by age group and the presence of common comorbidities. Women aged 18 to 45 had the same access to a transplant as men did (relative risk 1.01 (95% confidence interval 0.99 to 1.02). But the authors wrote: “With increasing age, access to transplantation for women declined dramatically, reaching a relative risk of 0.41 [0.34 to 0.5] for those who were older than 75 years, despite equivalent survival benefits from transplantation between women in all age subgroups.”

Dr Segev said, “Transplantation has significant survival benefits for many patients. In every age group that we looked at, women had the same or better survival benefits than men.” It did not make medical sense to exclude older women, he said, as they were likely to do as well as men of the same age with similar comorbidities who were being referred for transplantation.

Cite this as: BMJ 2009;338:b98

Health crisis in Zimbabwe requires urgent action

Peter Moszynski LONDON

The collapse of Zimbabwe's formerly world class health care system is a “man-made disaster,” says an emergency report from the US-based charity Physicians for Human Rights. It says that life expectancy at birth in the country has plummeted over the past 20 years, from 60 to 36, and it warns that the situation continues to deteriorate, as the country no longer has any functioning public hospitals.

In the report’s preface Mary Robinson, former UN human rights commissioner, Richard Goldstone, former UN chief prosecutor for Rwanda and Yugoslavia, and Archbishop Desmond Tutu say: “The Mugabe regime has used any means at its disposal, including politicizing the health sector, to maintain its hold on power. Instead of fulfilling its obligation to progressively realize the right to health for the people of Zimbabwe, the Government has taken the country backwards, which has enabled the destruction of health, water, and sanitation—all with fatal consequences.”

The charity sent a delegation to Zimbabwe last month to investigate the collapse of the country’s healthcare systems. It concluded that the “health and nutritional status of Zimbabwe’s people has acutely worsened this past year due to a cholera epidemic, high maternal mortality, malnutrition, HIV/AIDS, tuberculosis, and anthrax.”

Frank Donaghue, chief executive of Physicians for Human Rights, said that although his team entered the country legally and was transparent about its purpose of conducting a health assessment, the team members had to go into hiding and secretly flee the country overland after state media announced their arrests.

Mr Donaghue believes that these actions
Zimbabwe is man-made and intervention from all UN states

were “a desperate attempt by Robert Mugabe to conceal the appalling situation of his country’s people and to prevent the world from knowing how his government’s malignant policies have led to the destruction of infrastructure, widespread disease, torture, and death.”

The report points out that the continuing cholera epidemic “is an outcome of the health system’s collapse, and of the failure of the state to maintain safe water and sanitation.” It concludes that “this disaster is man-made, was likely preventable, and has become a regional issue since the spread of cholera to neighboring states.”

The report further claims that “the health crisis in Zimbabwe is a direct outcome of the violation of a number of human rights, including the right to participate in government and in free elections and the right to a standard of living adequate for one’s health and well being, including food, medical care, and necessary social services.”

The researchers maintain that “a causal chain runs from Mugabe’s economic policies, to Zimbabwe’s economic collapse, food insecurity and malnutrition, and the current outbreaks of infectious disease.

“These policies include the land seizures in 2000, a failed monetary policy and currency devaluations, and a cap on bank withdrawals.”

The preface’s authors describe the report as “yet another wake-up call to Zimbabwe’s neighbors and all UN member states for urgent intervention to save lives and prevent more deaths. These findings add to the growing evidence that Robert Mugabe and his regime may well be guilty of crimes against humanity.”

Health in Ruins: A Man-Made Disaster in Zimbabwe is available at www.phrusa.org.

Cite this as: BMJ 2009;338:b100

Children in central Africa have access to few essential drugs

Roger Dobson ABERGAVENNY

The availability of essential drugs for children in central Africa is poor, a new study shows. In only three of 14 countries surveyed were more than 50% of the drugs that are considered essential—as indicated by national lists and standard treatment guidelines—available from central medical stores.

“If the availability of these essential medicines for children is as poor as is suggested by the results of this study, we have a lot to do to understand what is happening in the supply systems for medicines in these countries before we can improve them,” say the authors, from the World Health Organization and the University of Newcastle, Australia (Bulletin of the World Health Organisation, www.who.int/entity/bulletin/volumes/87/08/053645.pdf).

The authors looked at the availability and cost of the drugs in Cameroon, Chad, the Republic of the Congo, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Mali, Nigeria, Rwanda, Senegal, Uganda, Tanzania, and Zambia. Surveys were carried out in 12 public and private sector drug outlets in each capital city.

The survey covered 17 different drugs in 20 dosage forms. These were identified as essential by an expert group of clinicians and pharmacists.

In only three countries were more than half of the drugs available from central medical stores (range 15% to 75%). Availability in stores of non-governmental organisations ranged from 10% to 65%, but the overall percentage tended to be higher in teaching hospitals.

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of qualified doctors decided to abandon clinical medicine and go into other professions.

Many doctors also emigrated. Recent statistics show that by 2007 about 16 000 German doctors had left the country, many of them (4200) to practise in Britain.

Furthermore, doctors became less inclined to set up their own practices or to take over a practice because of the high financial risks and long working hours.

At a press conference in October 2007 the German Medical Association and the National Association of Statutory Health Insurance Physicians warned that several rural areas did not have enough GPs, gynaecologists, ophthalmologists, neurologists, and dermatologists and that patients were having to wait several months for an appointment or travel to neighbouring towns. “In 2012 we expect a deficit of about 41 000 doctors,” Andreas Köhler, head of the national association, told the press conference.

However, Marco Dethlefsen, spokesman for the Association of Statutory Health Insurance Physicians in the largely rural state of Schleswig-Holstein, said that lifting the age limit would not fix the problem but only postpone it until many older practitioners retired.

His colleague Jochen Hansen, chief hospital anaesthetist in Schleswig-Holstein, warned that doctors should not carry on just for financial reasons if they were not physically fit.

Cite this as: BMJ 2009;338:b97
UK radiation workers have lower than normal death rate

Susan Mayor LONDON

Radiation workers’ risk of developing a range of cancers rises with increasing exposure to ionising radiation, a UK study has found. The study confirms previous findings but also shows that this group benefits from a “healthy worker effect,” with a lower overall death rate than in the general population.

The study looked at cancer incidence and mortality in 174,541 people in the National Registry for Radiation Workers, which was set up in 1976 to assess the effects of protracted exposure to low dose radiation in the workplace. They include workers at nuclear power stations, people working with atomic weapons and medical isotopes, and researchers working with radioactive materials.

The latest results show that the incidence and mortality from leukaemia (apart from chronic lymphocytic leukaemia) and all other malignant neoplasms apart from leukaemia (that is, solid cancers) rose significantly with an increasing dose of radiation exposure (British Journal of Cancer 2009;100:206-12).

The evidence of an increase in the incidence of malignancies overall with rising radiation dose was strong ($P=0.02$ on a one sided test). The excess relative risk rose by 28% with each unit of radiation dose (1 sievert (Sv)). The average lifetime exposure of the registry participants was 25 mSv, which was assessed from personal dose meters measuring penetrating radiation at the body surface.

The leukaemia subtype showing the strongest association with radiation exposure was chronic myeloid leukaemia, a finding seen previously in survivors of atomic bomb explosions and cancer patients treated with radiation.

The study also found a trend to increasing incidence of myeloma and rectal cancer with radiation dose, although the numbers of cases were small.

The study found that overall mortality was slightly lower in radiation workers, whose standardised mortality ratio (standardised to 100 in the general population) was 81. The mortality ratio for all malignant neoplasms combined was also lower, at 84.

This “healthy worker effect,” in which workers of any kind are likely to be healthier than the population as a whole, has been seen previously in studies of other occupational groups.

Cite this as: BMJ 2009;338:b64

Milburn is to lead body to widen entry to medical training

Adrian O'Dowd LONDON

The former health secretary Alan Milburn has been chosen to head a new commission for social mobility that will aim to widen access to people from all backgrounds to professions such as medicine.

The need to widen the field for future doctors was underlined in a report commissioned by the Liberal Democrat party and published on 12 January by the children’s charity Barnardo’s. It showed that a child’s socioeconomic group was more likely to become doctors.

Mr Milburn will chair a panel of representatives from the professions to bring forward proposals on what more can be done. Issues the panel will consider include:

- Financial obstacles to entry to and progression in the professions and ways to overcome them, such as scholarships
- The role of work experience as an entry route into the professions and in particular unpaid internships
- Recruitment practices, and
- Action to encourage new applicants and those seeking promotion.

The government’s drive to improve social mobility was outlined in a white paper published online by the Cabinet Office on 13 January (www.hm.gov.uk/newopportunities/download.aspx).

Part of Mr Milburn’s task will be to ensure that professions such as medicine, the law, the civil service, the armed forces, and the media recruit more young people from poorer backgrounds.

The BMA supports the commission’s intentions and said last year in a report called A Need for Change that the medical workforce should be more representative of the diverse society it serves.

Louise McMenemy, a member of the executive of the BMAs medical students committee, said that inequalities in the education system meant that people from poorer backgrounds were less likely to become doctors.

She said, “If you look at the number of students that come from the lowest socioeconomic groups in comparison with higher socioeconomic groups, the percentages are vastly different. There’s not one single reason for that. It’s not just the case that people are in a lower socioeconomic group: it can be to do with schooling or aspiration.”

Ms McMenemy, a fourth year medical student in Guy’s, King’s and St Thomas’ School of Medicine, London, said that some universities already had initiatives to widen access for students, such as extended six year courses. A Need for Change is at www.bma.org.uk.

The Barnardo’s report is available by e-mailing info@socialmobilitycommission.org.

Cite this as: BMJ 2009;338:b116

London PCTs lose

Lynn Eaton LONDON

A new recommended formula for funding primary care trusts in England seems to threaten health services in several London boroughs. The new formula has been adjusted to account for overfunding in some boroughs at present, given relative levels of healthcare need among their populations.

The recommendations, for funding in 2009-10 and 2010-11, come from the Department of Health’s advisory committee on funding primary care trusts in England. The formula aims to reflect more accurately the differences in need between areas.

But a leading health economist, John Appleby, chief economist at the healthcare think tank the King’s Fund, says that the formula will not make much difference in tackling the apparent overfunding of some London primary care trusts.

Cite this as: BMJ 2009;338:b61
out in proposed formula for funding health care

such as Richmond and Twickenham, Kensington and Chelsea, and Westminster.

“It is a sophisticated formula,” he said. But the decision whether or not to bring a primary care trust’s funding into line with its actual target was a political one, he explained. “The government will never take anything away but will only give a smaller percentage increase.”

The government has allocated a total of £164bn to primary care trusts in England over the two years 2009-10 and 2010-11, giving the trusts control over 80% of the NHS revenue budget and allowing them to tailor healthcare services to meet the needs of local patients. In 1996-7 health authorities, which were then responsible for most of primary care purchasing, controlled 72% of the total revenue spend.

This funding includes an average increase of 5.5% for each year. Some trusts will gain slightly more—such as Bassetlaw, which gets a 17.1% increase over the two year period—while others, including many in London, will see an increase of only 10.6%.

But by the end of 2011 Richmond and Twickenham’s allocation will be 23.4% above what it ought, in theory, to receive under the new funding formula, putting it in top place in terms of being above target. Westminster is close behind, at 20.8% above target. Kensington and Chelsea will be third at 20.6% above target. The top 10 trusts in England are all in London.

A Department of Health spokesman would not be drawn on whether or whether the actual targets would be implemented. He said, “We remain committed to bringing PCTs [primary care trusts] to their target allocations as soon as is practicable. “At the start of 2009-10 the most under-target PCT will be 10.6% below its target allocation. By the end of 2010-11 it will be only 6.2% below target,” he said.

See Observations, p 139.

The Report of the Advisory Committee on Resource Allocations is available at www.dh.gov.uk.

Cite this as: BMJ 2009;338:b115

Ethnicity influences breast cancer risk, stage at diagnosis, and treatment but not survival

Roger Dobson ABERGAVENNY

A woman’s risk of getting breast cancer, the stage at which it is diagnosed, and the treatment she gets all vary with ethnic background, a new UK study has found.

But the researchers found, after adjusting fully for age, level of socioeconomic deprivation, stage of disease, and treatment received, that survival from breast cancer did not vary significantly (British Journal of Cancer doi:10.1038/sj.bjc.6604852).

The researchers, from King’s College London, analysed data on 35 631 women who received a diagnosis of breast cancer in southeast England between 1998 and 2003. The ethnic groups they looked at were white, Indian, Pakistani, Bangladeshi, black Caribbean, black African, and Chinese.

They found that white women had the highest age standardised incidence of breast cancer and Bangladeshi women had the lowest. Incidence rate ratios calculated with that among white women as the baseline were all significantly lower: Indian 0.68 (95% confidence interval 0.64 to 0.73), Pakistani 0.59 (0.51 to 0.69), Bangladeshi 0.23 (0.20 to 0.26), black Caribbean 0.80 (0.74 to 0.86), black African 0.66 (0.59 to 0.74), and Chinese 0.54 (0.47 to 0.63).

Their analysis also showed that the differences in incidence between white women and the other ethnic groups increased with age group, a pattern most evident in Bangladeshi, black Caribbean, black African, and Chinese women.

White women were the most likely to have a stage recorded at diagnosis (73% of this group) and Bangladeshi women the least likely (55%). After patients whose stage was unknown were excluded, the study found that Pakistani women were the most likely to be given a diagnosis of metastatic disease (17%).

Black African women were less likely than white women to have a record of surgery for cancer (63% versus 72%; P<0.003) and hormone therapy (32% versus 54%; P<0.001) and more likely to receive chemotherapy (38% versus 29%; P=0.001). Pakistani women were less likely than white women to receive radiotherapy (27% versus 36%; P=0.043) and hormone therapy (41% versus 54%; P=0.014), whereas black Caribbean women were less likely than white women to receive hormone therapy (39% versus 54%; P<0.001).

Cite this as: BMJ 2009;338:b91

The differences in incidence between white women and other ethnic groups increased with age group

BMJ | 17 JANUARY 2009 | VOLUME 338

131
First UK baby free of BRCA1 is born: The first baby in the UK to have preimplantation genetic diagnosis for the BRCA1 mutation, which is linked to breast cancer, has been born. Women with this mutation have an 80% chance of developing breast cancer and a 60% chance of developing ovarian cancer in their lifetime.

Burma begins polio vaccination of children: Burma, with financial backing from Unicef and the World Health Organization, is to vaccinate more than seven million children against polio. The country was declared free of polio in 2003, but it re-emerged in 2006. The programme, being carried out in January and February, will cost at least $5m (£3.4m; €3.7m).

Trust has made “huge strides” in infection control: Maidstone and Tunbridge Wells NHS Trust has substantially improved its infection control since an investigation by the Healthcare Commission in 2007 identified serious failings, the watchdog says. The trust reported its lowest rate of \textit{Clostridium difficile} infection in three years, for January to March 2008. However, more nursing staff are needed, and learning from complaints and incidents needs to improve.

Complaint from Roy Meadow is rejected: The Press Complaints Commission has rejected a complaint from Roy Meadow about an article in the \textit{Times}, which referred to him as having “gone beyond his remit” when he acted as an expert witness in the cases of Angela Cannings and Sally Clark and submitted statistics based evidence even though he was not a statistician.

Calls to NHS Direct over Christmas were up 16% on last year: NHS Direct answered 255 562 calls between 20 December and 1 January this year, up from 221 225 in the same period last year. The busiest day was Saturday 27 December, when the service answered 29179 calls, then Boxing Day, with 26130 calls. The early outbreaks of colds, flu, and the winter vomiting bug were partly responsible for the higher demand.

Measles cases rise in England and Wales: A total of 1217 cases of measles were reported in England and Wales to the end of November 2008, exceeding the total of 990 reported for the whole of 2007. Most recent cases (74%) were concentrated in the North West, South East and West Midlands NHS regions.

An anaesthetist’s life working on the Congolese front line

\textbf{Brigitte Breuillac MÉDECINS SANS FRONTIÈRES}

For Paul Kanulambi Walelu, dealing with gunshot wounds, open fractures and emergency caesarean sections is all in a day’s work. Or, quite often, all in a night’s work. For as well as working seven days a week, Mr Walelu, an anaesthetic nurse, works every other night, for the medical aid organisation Médecins Sans Frontières at the busy Rutshuru Hospital in North Kivu, the war-torn province on the eastern border of the Democratic Republic of Congo.

It is Mr Walelu who in October last year helped the British surgeon David Nott in a forequarter amputation on a 16 year old boy who was close to death (BMJ\textit{2008;337:a2958, 10 Dec}). Mr Nott made headlines across the world for carrying out the operation with the help of instructions sent by text message.

Mr Walelu is nonchalant about what he describes as the “very intense” pace of work at Rutshuru Hospital. The two surgical theatres deal only with emergencies, and their workload can multiply 10-fold when fighting in the region intensifies, he says.

“We operate on an average of 350 patients a month for a wide range of surgeries. We do laparotomies following typhoid perforations, peritonitis, or traumas. When there are gunshot victims we often find ourselves with abdominal wounds and open fractures on upper and lower limbs. We also perform a lot of caesarean sections and other obstetric emergencies,” says Mr Walelu.

“Usually we see about 15 gunshot injuries every month. But in just one day in October, when the fighting and violence intensified, we saw 40 wounded people in two hours.”

The two surgical teams at Rutshuru generally operate with three Congolese anaesthetists (two nurses and one doctor) and two surgeons (one Congolese and one foreign).

“We sometimes happen to have three surgeons, like in October, but this is rare,” says Mr Walelu. “Occasionally we have an obstetrician gynaecologist. We work seven days a week, are on duty every other night, and get two weeks off every three months.”

Mr Walelu studied anaesthetic nursing in Kinshasa and has more than 13 years’ professional experience, the last two years at Rutshuru for Médecins Sans Frontières.

The operating theatres in the hospital are very well equipped, he says. “For the anaesthesia we have an oxygen concentrator in each theatre, an anaesthetic machine with a halothane vaporiser and a ventilator, a multifunction monitor (oxygen saturation, pulse, heart rate monitor, blood pressure, spirometer, and ECG [electrocardiogram]). And also—which is rare in DRC [the Democratic Republic of Congo]—we have two syringe drivers. Also, the hospital has a blood bank, and we have, on average, three units of blood available for each operation.”

Médecins Sans Frontières is BMJ’s Christmas appeal charity. See www.msf.org.uk/bmjappeal.aspx.

\textbf{Cite this as: BMJ \textit{2009;338:b101}}

Poor nations’ health systems must be boosted

\textbf{John Zarocostas GENEVA}

Health systems in poor countries, especially in Africa and south Asia, need to be substantially strengthened to improve care of the newborn and to reduce mortality in women during pregnancy and childbirth, a Unicef report says. “Every year more than half a million women die as a result of pregnancy or childbirth complications, including about 70000 girls and young women aged 15 to 19,” said Ann Veneman, Unicef’s executive director.

“Since 1990, complications related to pregnancy and childbirth have killed an estimated 10 million women,” she said.

The report says that most maternal and neonatal deaths can be averted through interventions that have been proved to work.

Essential services that are needed, it says, include better nutrition and safe water, sanitation, and hygiene facilities; adequate antenatal care; skilled assistance at delivery; basic and comprehensive emergency obstetric and newborn care; postnatal care; neonatal care; and integrated management of neonatal and childhood illnesses.

The report notes that severe infections often
Poor nations’ health systems must be boosted to improve maternal and newborn health, Unicef says

Health workers protest at unfair trial in Iran of two HIV and AIDS doctors

Peter Moszynski LONDON

The trial of two Iranian doctors on secret charges has caused a storm of protest from medical practitioners worldwide.

Arash Alaei and Kamiar Alaei, two brothers known internationally for their groundbreaking work as HIV and AIDS physicians, had been held without charge for more than six months before their appearance at Tehran’s Revolutionary Court at the end of December. They were summarily convicted of “communicating with an enemy government” and other as yet undisclosed charges and were still awaiting the verdict as the BMJ went to press.

The advocacy group Physicians for Human Rights says that the two were “denied fundamental requirements of due process,” because the prosecutor refused to disclose all the charges against them and denied their right to confront the charges and defend themselves. It says that the trial “also sends an ominous signal regarding the Iranian government’s crackdown on international scientific exchange.”

The two doctors have been held in Tehran’s notorious Evin Prison since late June 2008. On 31 December the Iranian state prosecutor tried the brothers on charges of communicating with an enemy. It also informed the court of additional, secret charges that the brothers’ attorney had no opportunity to refute, because the prosecutor did not disclose either the charges or the evidence on which they were based.

“Iran’s failure to reveal the nature of the secret charges against the doctors makes it impossible to determine if the charges have any factual basis,” Frank Donaghue, chief executive of Physicians for Human Rights, said. “To all appearances the arrest and now the trial of these two prominent and widely travelled AIDS doctors seem to be an effort to shut the door on medical and public health collaboration on global health crises . . . a policy that is dangerous for the wellbeing of the Iranian people and for global health.”

Mr Donaghue said that for the trial to be fair according to the standards of international human rights law “Iran must safeguard the doctors’ right to know the evidence against them and their right to confront and cross examine their accusers.”

He said, “A defendant’s right to hear and confront witnesses against him is a fundamental guarantee of life and liberty.”

Kamiar Alaei is a doctoral candidate at the State University of New York’s Albany School of Public Health. In 2007 he received a master of science degree in population and international health from the Harvard School of Public Health in Boston. Arash Alaei is the former director of international scientific exchange at the Iranian National Research Institute of Tuberculosis and Lung Disease.

Together the two brothers helped raise Iran to the forefront of innovative strategies to combat HIV and AIDS. Some of the methods they instituted domestically, such as harm reduction in prisons, have been adopted internationally.

More than 3100 doctors, nurses, and public health workers from more than 85 countries have signed an online petition demanding their release. Leading physicians and numerous organisations have also publicly called for the brothers’ release.

More information and the petition are available at www.IranFreeTheDocs.org.

Cite this as: BMJ 2009;338:b109

to improve maternal and newborn health, Unicef says

associated with unhygienic delivery practices and unsafe water and sanitation “accounted for 36% of neonatal deaths in 2000.”

Unicef and the World Health Organization recommend that all women have a minimum of four antenatal visits, which enable them to receive interventions such as tetanus immunisation, screening for and treatment of infections, and crucial information during pregnancy and delivery.

Most maternal deaths, says the report, are related to obstetric complications, including postpartum haemorrhage infections, eclampsia and prolonged or obstructed labour, and complications of abortion.

Most of these direct causes of maternal mortality, it says, “can be readily addressed if skilled health personnel are on hand and key drugs, equipment and referral facilities are available.”

From 2000 to 2007, the report says, skilled health workers attended 61% of all births in the developing world, but it adds that the regions with the lowest coverage—sub-Saharan Africa, with 45%, and South Asia, with 41%—also registered the highest maternal mortality.

It says that healthcare systems in many poor nations suffer from weak administration, low technical and logistical capacity, inadequate investment, and a lack of skilled healthcare personnel.

The report can be seen at www.unicef.org.

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