any household in the weeks before their death, but it ensured that the type of overestimation that concerns Apfelroth did not occur.

Before publication, the article was critically reviewed by many leading authorities in statistics and public health and their suggestions were incorporated into the paper. The death toll estimated by our study is indeed imprecise, and those interested in international law and historical records should not be content with our study. We encourage Apfelroth and others to improve on our efforts. In the interim, we feel this study, as well as the only other published sample survey we know of on the subject,1 point to violence from the Coalition Forces as the main cause of death and remind us that the number of Iraqi deaths is certainly many times higher than reported by passive surveillance methods or in press accounts.

We declare that we have no conflict of interest.

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Les Roberts and collaborators' compared mortality figures before and after the invasion of Iraq in 2003. A 2.5-fold increase in the risk of death, mainly due to the extremely violent situation in Fallujah, was revealed. Even after the Fallujah outlier was removed from the analyses and the measured increase in infant mortality halved (to account for a possible, though unlikely, recall bias regarding infant deaths), the risk of violent death still soared by 37% after the war set off. When all data were analysed, the increase reached 58%. Coalition Forces may have targeted suspect fighters, but civilians were most frequently killed. The figure for the whole country (100 000 excess deaths since the coalition invaded Iraq) is regarded by Roberts and colleagues as an underestimate.

In January, 2003, two open letters to the Prime Minister of the UK were published in leading medical journals.2,3 More than 500 signatories from the London School of Hygiene and Tropical Medicine (LSHTM) warned about the public-health implications of war on Iraq. Based on estimates anticipating 50000 to 250000 deaths, they expressed their opposition to military intervention. Their views can now be contrasted with actual facts. The UN and WHO were badly right in their warnings, and the political leaders of the Coalition Forces wrong in their choice of military action. The claimed legality of their decision is at least dubious; its legitimacy is implausible.

The effects of the invasion on public health and humanitarian aspects other than direct mortality figures await scientific scrutiny. Reports about the physical and psychological suffering of other victims (the injured; the refugees; a deprived population enduring shortages of food, safe water, medical care and supplies, sanitation, shelter, personal safety, and mental-emotional stability; the soldiers; the tortured and humiliated prisoners; those kidnapped by terrorists—in summary, all those whose rights are violated plus their families) will appear in due course. They should be compulsory reading for all those who keep promoting collective violence.

Finally, Roberts and colleagues highlight how their results were achieved with modest funding and lots of nerve and commitment, making a brilliant case against those who (clearly trying to avoid accountability) hide behind claims that valid mortality data cannot be obtained in war environments. I declare that I have no conflict of interest.

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Does medicine have a moral message?

Referring to your publication of Les Roberts and colleagues’ paper on mortality in Iraq before and after the 2003 invasion,1 an article in the UK’s Observer newspaper on Nov 7, 2004,2 asks whether The Lancet is becoming politicised. This raises some of the most fundamental issues implicit, but rarely explicit, in the medical profession.

Most of us enter the profession—whether in clinical practice, or, like me, in research—with mixed motives: job security, social approval, intellectual curiosity. But there can be few so hard-boiled that they do not also have it somewhere in their minds that they can do good for their fellow men. A pity then if, in the struggle to stay afloat in the ever-deeper quagmire of bureaucracy and in the adrenalin spurs of the rat race, this once altruism is totally forgotten.

In my research into the immigration of the Russian Jews to Leeds, UK, I encountered the Lancets of the
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1880s. They were full of descriptions of the terrible conditions of the immigrants, their health, their sanitation, the adulteration of food for profit, the pollution of the air and the rivers. No journal could be more concerned, involved, or political.

There was a message in this—a message both practical and moral. Poverty and disease lead to crime, prostitution, and degradation. They degrade our environment. But they cannot be contained in the slums, they seep over into the privileged sectors of society. The cesspit of deprivation must be dealt with at source. How much more so in the global village of the 21st century.

We need to know how much destruction we have done in Iraq and in Afghanistan, not only because we are responsible but also because its effects cannot be contained there. They will—as we are seeing so clearly—come to visit us here.

The UK’s Foreign Secretary questions the figure of 98,000 dead. I suppose he would like it to be less. I suppose he would like it to be combatants not civilians. I suppose he would like it to be caused by Iraqi insurgents not by invading troops. Very well then. No, I declare that I have no conflict of interest.

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2 Doward J. Why I was right on the 100,000 dead. Observer Nov 7, 2004.

International aid, partnership, and child survival

Richard Horton’s Comment (Dec 11, p 2071) calls for a strategic change in UNICEF’s work and argues that “a pre-occupation with rights ignores the fact that children will have no opportunity for development at all unless they survive . . . The most fundamental right of all is the right to survive.” In 1990, Maurice King argued the opposite, claiming that in ecologically unsustainable communities “such desustaining measures as oral rehydration should not be introduced as a public health measure, since it increases the man-years of human misery, ultimately from starvation.” Some anthropologists expressed similar worries about prolonging the suffering of poor children while attempting to save their lives through international aid interventions. For UNICEF, the 1980s was the decade of child survival, followed by the decade of children’s rights. Interestingly, the 1990s was the decade when reduction of child deaths slowed down and aid fatigue was widespread.

One characteristic of aid organisations is their shifting priorities. The following account of our experience serves as an example. We came to Guinea-Bissau for the first time in 1982, 8 years after independence, and the atmosphere was optimistic. One of us (GG) was a doctor within the maternal-and-child health services in the capital Bissau, where Maurice King’s book on primary childcare was indispensable. The other (JE) was engaged in teaching the first cohort of laboratory students at the National Public Health Laboratory (LNPS), inaugurated 3 years earlier with support from the Swedish International Development Authority (Sida).

But already there were ongoing discussions about withdrawal of the support for this embryo public-health institution. The health problems were macroscopic rather than microscopic, some argued. The integrated rural development project, administered from what later proudly became called Olof Palme Centre, was the new exciting approach with “popular participation” and “empowerment” as the keywords for success. These were the early days of structural adjustment, and health care and education were regarded as unproductive sectors. Consequently, consultants were still busy discussing withdrawal of support to LNSP when we left the country in 1985.

We returned to Guinea-Bissau in 1993 to work within regional health services and to do research on maternal reactions to child death. With the ravaging HIV/AIDS epidemic, LNSP had become an example of a successful Sida project. Nonetheless, withdrawal of support was even now on the agenda as it was assumed to be unsustainable and aid dependency was feared. Consultants were still busy, this time closing the once so promising integrated rural development project. That approach was already out of fashion—as was the country itself. Good governance, ownership, dialogue, and partnership were some of the buzz-