



## Where conflict's medical consequences remain unchanged [letter]

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## Where conflict's medical consequences remain unchanged

In the aftermath of the 2003 war in Iraq, much attention was focused on state reconstruction and development efforts. However, many remote areas were excluded from these developments, leaving thousands of Iraqis without access to essential health care to this day.

The explanation for this situation can be found in the conditions that affected the development of health provision during and after the conflict. Substantial and ongoing security constraints prevented humanitarian actors from accessing and properly assessing the medical needs in many parts of Iraq. Aid was mainly limited to the provision of supplies and training from abroad, without direct population contact and the ability to provide prompt and targeted adjustment to the support.<sup>1,2</sup>

With an estimated population of half a million people, Hawijah district of Kirkuk Governorate is a vivid example of where the medical consequences of the conflict continue. As a result of the well documented exodus of Iraqi medical doctors fleeing the country's violence,<sup>3</sup> and by the much less described internal migration of professionals towards safer areas within Iraq, it is extremely difficult to find Iraqi medical doctors willing to work in Hawijah, because they fear for their security. Rural primary health-care centres continue to report shortages of medical personnel, drugs, and services. Basic components of hospital medical care, including infection control and nursing skills, are sorely lacking and still in need of external support. The 116-bed district hospital remains without adequate human resource capacity to sustain the availability of emergency surgical services 24 h per day. With more than 3300 consultations in September and October, 2012 (Médecins Sans Frontières [MSF], unpublished data),

the hospital's busy emergency room remains highly dependent on three newly graduated doctors, often working alone since senior professionals are scarce. After almost 3 years of continuous support, MSF staff are still responsible for half of the hospital's anaesthetic procedures.

This situation in remote areas is not often portrayed in the media or medical literature, but MSF is witness to the struggle faced by health services in Hawijah to provide adequate care to the population. Development and state-building efforts need to reach every citizen, and to do so much more attention needs to be given to remote areas where the reality for Iraqis has not substantially improved over the past 10 years.

We declare that we have no conflicts of interest.

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- 1 Burkle F. Measuring humanitarian assistance in conflicts. *Lancet* 2008; **371**: 189–90.
- 2 Humanitarian Policy Group. Humanitarian action in Iraq: putting the pieces together. March 2008. <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/1716.pdf> (accessed Dec 13, 2012).
- 3 Webster P. Iraq's health system yet to heal from ravages of war. *Lancet* 2011; **378**: 863–66.

## Screening for type 2 diabetes and population mortality over 10 years

The study by Rebecca Simmons and colleagues (Nov 17, p 1741)<sup>1</sup> is interpreted as showing little or no mortality benefit from screening for type 2 diabetes mellitus in general practices in eastern England. In our view the results should be treated with caution because they depend on low patient numbers and notoriously unreliable death certification as a means of identifying cause of death.

The findings contrast with our own data on a large district population of patients with type 2 diabetes in the

northwest of England. We followed up almost 15 000 patients over an 8-year period using a district-wide diabetes register encompassing both primary and secondary care. Our findings indicate a falling mortality rate in type 2 diabetes.<sup>2</sup>

Simmons and colleagues recruited a large number of individuals in the screening and control practices, but a relatively small number of patients with diabetes was followed up. The intraclass correlation coefficient, which can only be indirectly estimated owing to the confounding effects in the two paired clusters, is unreliable. It is also possible to overestimate the stability of a trial of less than 40 clusters owing to the probability of large standard errors.<sup>3</sup>

Furthermore, the validity of permutation tests becomes unreliable since there are imbalances in the cohort cluster size and consequently distortion in the paired matching results.<sup>4</sup> The assumptions of the Cox proportional hazard modelling, which tests the mortality risks in the screened and controlled cohorts, is normally based on error variations in the cohort groups and not within matched pairs.<sup>5</sup>

Finally, Simmons and colleagues have not revealed whether there were adjustments for other covariates in the all-cause mortality in both cohorts. We suggest that Simmons and colleagues present their hazard ratios alongside a measure of time such as median time to death in comparison with the screened and controlled cohorts.

We declare that we have no conflicts of interest.

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- 1 Simmons RK, Echouffo-Tceugui JB, Sharp SJ, et al. Screening for type 2 diabetes and population mortality over 10 years (ADDITION-Cambridge): a cluster-randomised controlled trial. *Lancet* 2012; **380**: 1741–48.



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