Counting and accountability

The Lancet's Who Counts? Series (Nov 3–24)¹ brings an important issue to greater attention and focus. Our organisation, Human Rights Watch, works to uphold the principle of government accountability, and an important part of this is to ensure that individuals—citizens and others within a state's borders—are officially recognised and counted.

The most widely adopted international human rights treaty in history, the 1989 Convention on the Rights of the Child, outlines governments' obligations to provide birth registration.² Human Rights Watch's documentation of government denials of civil registration, especially concerning refugees, migrants, and minority groups,^{3,4} highlights the need to ensure the implementation of this right. Concerning women's and children's rights, discriminatory laws and customary practice can violate property and educational rights; standardising and regulating birth and marriage registration can help to bolster these rights.⁵ It is also crucial that governments, with assistance from international organisations, improve their ability to register and count deaths during conflict. Documenting such deaths is essential if we are to succeed in bringing to justice the perpetrators of violations of international human rights and humanitarian law. Documentation will also help in seeking improved practice by warring parties as well as humanitarian agencies and those charged with protecting and saving lives.

Any new international body created with the mandate to improve civil registration efforts must be guided as much by human rights principles as by public health and demography concerns.

We declare that we have no conflict of interest.

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Richard Horton¹ and the Who Counts? team are correct. Registering births and deaths is crucial to informing policymaking and planning health systems. Although this is a problem of particular seriousness in Africa and southeast Asia, there are substantial gaps in knowledge in developed countries such as England with respect to the effect of policy on the health of vulnerable migrant groups.

In 2004, a large and heterogeneous group including victims of trafficking, undocumented migrants, failed asylum seekers unable to safely travel home, and failed asylum seekers awaiting deportation lost the right to freely access most National Health Service (NHS) hospitals. Worryingly, the government has stated its desire to extend these rules into primary care.² With a government review of access to NHS services by "overseas visitors" expected soon, there is concern that such a change might be imminent.³

Applications recently made, under freedom of information legislation, to two hospital trusts in Bristol and London revealed that neither trust keeps a record of deaths in the population identified as not being eligible for free hospital care. With worrying case studies of the effect of the regulations governing secondary care accumulating,⁴ the only health

impact assessment of the primary-care proposals recommending against charging,⁵ and a dearth of information on health outcomes, moving forward with these proposals now would be reckless.

We are actively involved in campaigns to increase migrants' entitlement to health care with the student organisation Global Health Advocacy Project.

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Day or night blood pressures for prognosis

José Boggia and colleagues' paper (Oct 6, p 1219)¹ and Stéphane Laurent's associated Comment (p 1192)² address the pros and cons of night or daytime blood pressures in prognosis. They are discussing risk. Not discussed is whether patients really want their "risk" assessed with relatively cumbersome, still expensive, and certainly disruptive testing over a 24-h cycle. Even if new and mass-produced technology reduces the cost substantially, the 24-h technique and its analysis remain way out of reach for the global population burden that

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high blood pressure now represents. New guidelines acknowledge global risk assessment rather than single factors, even one as central as blood pressure.

Laurent and colleagues and ourselves pioneered the prognostic usefulness of non-invasive yet direct assessment of arterial structure and function or "stiffness" by use of aortic pulse-wave velocity.^{3,4} This simple (if for now still relatively expensive) method is a powerful index of prognosis in all 12 studies reported so far, independent of blood pressure.⁵ All other classic risk factors, including age, smoking, blood lipids, diabetes, etc, also act on the large-vessel walls, as does peripheral resistance from small vessels, so aortic pulse-wave velocity probably represents an integrated estimate of risk, not just that from a single factor.^{2,3}

Measures of arterial stiffness taken at one time point with good reproducibility surely represent a potentially better use of resources than day or night pressures alone or together. That hypothesis holds even if aortic pulse-wave velocity has not yet been studied for effects of treatment.

I declare that I have no conflict of interest.

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We agree with José Boggia and colleagues¹ that the monitoring of 24-h ambulatory blood pressure when presented as a night-to-day ratio is a more perceptive predictor of cardiovascular outcome than conventional measurement. However, we have some concerns.

First, mercury-based, auscultatory, and auditory measurements of blood pressure are not comparable.² Additionally, different antihypertensives have different effects on mortality: angiotensin-converting-enzyme inhibitors and angiotensin-receptor blockers can modify cardiovascular risks independently of their effects on blood pressure.³ Because the use of these medications and health-care provisions vary widely across the different countries of the study population, this might have created a discrepancy in mortality from hypertension.

Second, among those with hypertension, diabetic and non-diabetic patients are not differentiated. This is very important because these two subgroups will have different clinical outcomes even for the same level of blood pressure.⁴ Moreover, for the same level of blood pressure and body-mass index, cardiovascular event rates and outcomes will be different for different sexes and races, and this point has not been discussed at all. These points require more emphasis for the prognostic accuracy of blood-pressure analysis and to strengthen the guidelines.

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Authors' reply

In reply to Nihar Pandey and colleagues' comments, we would like to underscore that we analysed data from individual patients. This allowed us to account for confounders, such as cohort and antihypertensive drug treatment at enrolment. Additionally, we did sensitivity analyses in treated and untreated participants separately. We admit that we could not adjust for antihypertensive treatment as a time-dependent covariate because information on the use of blood-pressure-lowering drugs during follow-up was only available for the Belgian cohort. Furthermore, we used only monitors that had passed validation against conventional auscultatory blood-pressure readings. With the exception of the auscultatory recordings in 1221 Swedish men (16.4%), all ambulatory measurements were oscillometric. We obtained confirmatory results after exclusion of the Swedish cohort and in women and men.

We concur with Pandey and colleagues that the night-to-day ratio is a perceptive predictor of cardiovascular outcome. For total mortality, the fully adjusted hazard ratios associated with a 1 SD increase in the systolic night-to-day ratio were 1.11 (95% CI 1.05–1.18) in 6915 non-diabetic patients and 1.18 (1.01–1.38) in 543 diabetic patients. For all cardiovascular events, the corresponding hazard ratios were 1.06 (0.99–1.13) and 0.99 (0.85–1.15), respectively, again confirming the consistency of our results.

In reply to Kennedy Cruickshank's comments, we acknowledged the concept of the global cardiovascular risk by adjusting our hazard ratios for multiple risk factors and by

implementing sensitivity analyses stratified for major risk factors. We agree that aortic pulse-wave velocity is an independent and informative risk factor.¹ However, measurement of this variable requires special equipment and trained observers, which makes the technique more expensive and globally less accessible than recording the ambulatory blood pressure.

For this very reason, we developed the ambulatory arterial stiffness index (AASI).^{2,3} AASI reflects the dynamic relation between systolic and diastolic blood pressure during the whole day, which depends on various haemodynamic mechanisms, including arterial stiffness. AASI can be easily calculated from individual ambulatory blood-pressure recordings. In our hands, AASI correlates with several measures of arterial stiffness, including aortic pulse-wave velocity, the central and peripheral pulse pressures, and the systolic augmentation index.² AASI is a strong and independent predictor of stroke, especially in younger individuals.³⁻⁵

We assessed the independent contributions of aortic pulse-wave velocity and AASI to the stratification of cardiovascular risk in our Danish cohort.⁵ In multivariate-adjusted Cox regression models including both indexes, AASI (standardised hazard ratio 1.68, $p=0.01$) but not aortic pulse-wave velocity (0.91, $p=0.62$) predicted stroke, whereas the opposite was true for the composite of all cardiovascular events (aortic pulse-wave velocity 1.15, $p=0.03$; AASI 1.04, $p=0.68$).⁵

These findings support our main conclusion that recording the ambulatory blood pressure during the whole day should become routine in the work-up of hypertensive patients in all settings where resources allow its implementation.

We declare that we have no conflict of interest.

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“Packing” therapy for autism

I am writing to correct a number of serious inaccuracies in Laura Spinney's World Report (Aug 25, p 645)¹ entitled “Therapy for autistic children causes outcry in France”.

It is not the case that Pierre Delion recently “gave a course on the technique [of packing] at the Tavistock Clinic”. He was invited to give a 1-h talk on a subject of his choosing to the autism clinical research workshop, as part of an ongoing programme of guest speakers that helps us to keep abreast of varied developments abroad. Packing forms no part of our work with children with autism.

I did not say that there were “currently no effective treatments for autism”, but that no randomised controlled trials had as yet been completed, although this is being addressed for various interventions at several specialist centres in the UK and Europe. Treatments that foster

the child's capacity to relate can be very beneficial: these include the child psychotherapy offered by the autism service at the Tavistock. It is important to take account of family preference and to support the parents.

The statement that “one psycho-analytic theory holds... [that] children [with autism need to]... dismantle the defensive behaviours they developed at an early age, to protect themselves from a dysfunctional relationship with their mother” creates the erroneous impression that present-day psycho-analytic workers subscribe to such a theory, or believe that autism is a consequence of inadequate parenting. This is not true, as many, including myself, have repeatedly written.^{2,3}

I declare that I have no conflict of interest.

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Insecticide-treated bednets and child survival in rural Kenya

Greg Fegan and colleagues (Sept 22, p 1035)¹ seem to show that the recent upward leap in coverage of Kenyan children with insecticide-treated nets (ITNs) has had the hoped-for effect of reducing child mortality. However, the average reduction in mortality of 44% among net users compared with non-users is of only borderline significance (95% CI 4–67, $p=0.04$).

Fegan and colleagues consider various possible sources of bias, but they make no mention of the fact that their samples of families with children with or without ITNs were self-selected (as in earlier work in Tanzania²). It seems likely that the

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