placebo-treated patients, were 42 - 61% less likely to have significant arterial calcification (as measured by computed tomography).[2] These publications are in stark contrast to earlier publications by the same investigators that implied HT as a cause of CAD, without taking into account that this did not apply to the typical patient, who initiates HT at the age of 50 - 59 years.[3]

Dr Rapeport further falsely assumes that SAMS promotes the use of HT for the prevention of CAD, even though it is not included in the list of approved indications in the revised guidelines. We maintain our position that if the only aim of treatment is protection against CAD, HT is an inappropriate choice in view of other proven methods. However, it is important to be able to assure the patient in the age group 50 - 59 years, who starts HT for the control of vasomotor symptoms or the prevention or treatment of osteoporosis, not only that HT will not cause CAD, but that protection can be expected. This also needs to be taken into account when deciding on termination of treatment.

We stand by our statement that the initiation of HT for the indications as provided is safe for the patient in the age group 50 - 59 years and that the small risk of any complication can be further reduced by using the lowest effective dose.

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'Opi-phobia' among doctors leads to unnecessary suffering

To the Editor: Francois Venter and Chris Bateman are to be commended on this piece.[1] Basic training of South African doctors and nurses in palliative care has been poor. Therefore few have raised their voices to improve palliative care, despite the great need for it in a developing country where many patients present with far advanced disease. This applies particularly to people with HIV because of denial and stigma.

An important step towards the development of good general palliative care in Australia and the UK has been the formation of departments of palliative care in teaching hospitals, through which all students must rotate during their training. I suggest that pharmacology students also have a short rotation. With the enormous need for such care, it seems an urgent priority to establish such departments in all our teaching hospitals. These should also bring past graduates up to speed in this discipline.

Another serious public sector hospital problem is the lack of effective links between district hospitals and community structures offering home-based care. Too often, medical staff end up saying to patients, 'There is nothing more that we can do for you', because the doctor has decided cure is not possible. In most cases, no thought is given to linking patients to community carers, or to empowering the carers with medications to reduce the suffering of their last days. No help in controlling symptoms is provided to home-based carers who appeal to district clinics when the scheduled drugs needed are not available to clinic staff. This has two effects. Firstly, hospital staff are never really confronted with the patient's palliative care needs, so they never grow in that expertise. Secondly, there is an assumption that palliative care in HIV is simple (which it is not), just as the rest of the medical care of people with HIV is difficult and requires considerable experience and expertise.

A solution to this problem could be the development of palliative care facilities in every district hospital, staffed by medical and nursing staff who are part of the training team of home-based carers in the district. They could assess the patient's palliative needs, access the necessary medications, and link the patient and family to a designated carer, or non-governmental organisation. They should also identify patients with HIV wrongly consigned to terminal care when they have a manageable infectious condition. Such a facility could have regular follow-up clinics in each of the district clinics, and be empowered to carry and dispense the necessary scheduled drugs. This should be a high-priority project for co-operation between district health services and the medical staff of every district hospital, including those in metropolitan centres serving rural communities.

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1. 'Opi-phobia' among doctors leads to unnecessary suffering [Izindaba]. *S Afr Med J* 2007; 97: 399-406.

Achieving the Millennium Development Goals in sub-Saharan Africa

To the Editor: The UN has released a mid-term report on progress towards achieving the Millennium Development Goals (MDG), eight pro-poor goals contained in the Millennium Declaration of 2000, to be achieved by 2015.[1] It paints a gloomy picture of health in sub-Saharan Africa. Child mortality rates declined globally, but the improvement was uneven, with sub-Saharan Africa recording the highest rate and the slowest pace of progress. In 1990 and 2005 in sub-Saharan Africa, 185 and 166 children respectively died, mainly from preventable causes, before their 5th birthday for

every 1 000 live births, a mere 10% reduction in 16 years. The corresponding figures for North Africa were 88 and 35 (i.e. 60% reduction). In addition, a woman's lifetime risk of dying during pregnancy and childbirth was 1 in 16 in sub-Saharan Africa; compared with 1 in 3 800 in the developed world. Most maternal deaths in sub-Saharan Africa resulted from maternal haemorrhage, hypertensive disorders of pregnancy, sepsis, abortion, and obstructed labour.[2,3] Most of these deaths could have been prevented through appropriate reproductive health services before, during and after pregnancy, and through life-saving interventions when complications occur.[4,5]

Sub-Saharan Africa can increase its pace towards achieving health MDG if efforts to prevent death and disability are tailored to local conditions, given that the causes of death and disability vary considerably.[2,3,6] Choice of health interventions and policies should be based on solid scientific evidence, and, where it is lacking, we must invest in research.[7] Such well-informed selection and implementation of effective health care interventions and policies requires close collaboration between policy-makers and researchers.

The SUPPORT (SUPporting Policy-relevant Reviews and Trials) Collaboration is an example of cooperative partnership between researchers and policy-makers in low- and middle-income countries, which started in October 2006. SUPPORT (www.support-collaboration.org) involves partner institutions in sub-Saharan Africa, Latin America, Europe and North America, and aims to improve the use of reliable research evidence in decisions on maternal and child health, and to help fill in the gaps where there is a lack of rigorous evidence. The partner institutions (including the Medical Research Council of South Africa) are preparing summaries of current best evidence on the effectiveness of relevant interventions in a way that is easily accessible to decision makers, developing tools to support access to and use of research evidence to inform policy decisions, supporting the conduct of pragmatic trials of interventions when reliable evidence is lacking, and exploring appropriate ways to disseminate these tools and provide support for the appropriate use of research evidence. The structured summaries will be available by December 2007 and SUPPORT partners conducted a policy-maker workshop in Rosario (Argentina) in November 2006 and have planned others in Harare (Zimbabwe) and Cape Town (South Africa) in September and November 2007 respectively. Workshops comprise interactive presentations and small group sessions during which policy-makers develop skills on how to frame a health problem, identify a systematic review or trial that addresses the problem, and assess the quality and local applicability of the systematic review or trial. Each workshop is planned and facilitated by both policy-makers and researchers, ends with an evaluation, and empowers policy-makers to become informed users of research-based evidence. This knowledge-translation project provides a model of how multi-national collaborations can be configured and how efficiencies can be gained from cross-continental linkages.

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Why no autopsies on marathon deaths?

To the Editor: The July 2007 *SAMJ* featured a report on the deaths of two Comrades Marathon runners.[1] I agree with Mayosi of Groote Schuur Hospital that postmortem examinations should be performed on such cases to establish the cause of death with certainty, in so far as it is possible, because of implications for the surviving next of kin.

We expected that the Forensic Pathology Services in Durban would receive these cases, but neither was referred. Both deaths can be considered unexpected and unexplained sudden deaths, since there are no clear clinical diagnoses (owing to very short survival of only one of them) and both individuals were relatively young. However, the decision to request an autopsy is the duty of the clinician responsible for the patient. It is likely that both these deaths were considered and registered as natural deaths.

There is capacity for diagnostic autopsy examinations on sudden unexpected deaths mainly in the academic *forensic pathology* centres. Where the source of the case is not a public establishment, there is little provision in the academic anatomical pathology unit served by that establishment (now under the National Health Laboratory Service) for a diagnostic autopsy. In these cases, one was declared dead in the medical