whether the world will allow deliberate gender restrictions to erase decades of maternal health gains. The global maternal mortality ratio has fallen by nearly 33% since 2000,[6] proving that progress is possible even in resource-limited settings. Afghanistan's recent improvements came when women could study, work, and serve their communities. The regression we are witnessing now is not cultural destiny. It is a man-made public health disaster born of decisions to exclude women from education and work.

As clinicians, we must be clear: restricting female health workers is not tradition. It is a policy with a measurable death toll. The message must be simple, powerful, and impossible to ignore: let Afghan women train, work, and lead in health care and beyond. The health of mothers, the survival of newborns, and the wellbeing of entire communities depend on it.

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Health safeguards under the UN's reimposition of sanctions on Iran

On Sept 28, 2025, the UN Security Council snapback under Resolution 2231 reinstated multilateral sanctions on Iran related to insufficient compliance in international oversight of its nuclear programme.[1] This Correspondence does not take a position on the UN Security Council decision to reimpose multilateral sanctions. We focus on the implications of these geopolitical decisions for Iran's population, against the backdrop of devastating impacts on at-risk populations under previous sanctions.

The human toll of the sanctions imposed against Iran to deter it from continuing its nuclear programme is considerable. The pre-2015 UN sanctions architecture, consolidated by Resolution 1929, encompassed nuclear and missile restrictions, arms embargoes, transport inspections, and financial limitations.[2] Although humanitarian exemptions existed, no dedicated mechanism was mandated to verify their effectiveness or safeguard health outcomes. The UN Security Council-mandated sanctions disrupted medicine imports, with price spikes of up to 300% for some antiepileptic drugs, considerable reductions in market availability for 13 of 26 essential non-communicable disease medicines, and more than 6 million patients with non-communicable diseases foregoing high-quality treatment.[3] A cross-national analysis reported an average reduction in life expectancy of around 1·2–1·4 years under UN sanctions, with women disproportionately affected.[4] The UN Special Rapporteur's 2022 country report on unilateral coercive measures documents barriers to medicines and medical equipment in Iran, arising from sanctions and over-compliance with them. Despite exemptions, restrictions in finance and trade have undermined the delivery of lifesaving treatments. Prices have increased, patients have rationed care, procurement has been delayed, and counterfeit or expired drugs have surfaced, causing disproportionate harm to at-risk groups.[5]

Notably, the UN Sanctions Committee and subsequent panel of experts prioritised technical enforcement and compliance for uranium enrichment levels; their reporting contained no systematic assessment of access to medicines, medical equipment, or broader health effects for Iran's population, illustrating a persistent institutional blind spot within the UN.[6] To safeguard population health under sanctions and address the liability gap, a coherent framework is needed that (1) ensures that humanitarian exemptions and payment channels operate effectively; (2) addresses over-compliance as a potential discriminatory practice, with liabilities for blocking access to essential medicines and health services; (3) monitors availability and affordability of essential medicines and equipment, and procurement performance and access for at-risk groups; (4) should include indicators on financial protection, food security, and national preparedness so that countries can cope with emergencies alongside sanctions, ensuring effective response when shocks coincide, as in the COVID-19 pandemic; and (5) assigns oversight to a technical panel mandated to apply proportionality and right-to-health tests and recommend action. Policy makers should conduct ex-ante health effect assessments and pair exemptions with practical enforcement mechanisms for payments, banking, and procurement. Without such safeguards, restrictions risk exacerbating health issues, particularly for at-risk

populations. Therefore, robust global instruments are needed to uphold proportionality and the right to health.

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Striving for free health education in Greece after a financial crisis

Generations of medical students and trainee doctors in Greece have benefited from free education in public institutions, from textbooks to clinical training and doctoral degrees. Tuition fees have been restricted to specific postgraduate programmes.[1] However, this free education is often subsidised by students themselves via unpaid overtime, uncompensated clinical rotations, voluntary research, and out-of-pocket expenses for conferences and external courses.

Recent changes call for the reassessment of affordability for the roughly 1500 students admitted annually to public medical schools.[2] English-language programmes and newly licensed private schools have added over 100 students, competing for limited teaching halls, laboratories, and clinical placements.[3] Residents meanwhile face escalating out-of-pocket costs for continuing education—registrations, memberships, and European board examinations—consuming up to 10% of a gross annual income of about €24 000 (before taxes).[4]

In other EU member states, stronger support is offered: students in Germany[5] may receive financial compensation during clinical rotations, while French students[6] in their final years receive stipends for hospital duties. Such measures reduce financial pressure and help retain physicians. In Greece, however, free education translates into hidden costs and unequal opportunities compared with European peers.

In an era of persistent inflation, expenses are often compensated for by family resources, personal savings, or sponsorships from pharmaceutical and device companies. Although presented as corporate social responsibility, such support risks blurring professional independence. The burden is tangible: one young doctor was obliged to work night shifts as a barwoman to fund postgraduate studies, highlighting how personal sacrifice substitutes for institutional support (personal communication with ASP).

Furthermore, resident salaries remain stagnant despite rising living costs in urban centres. Medical graduates wait an average of 3 years, sometimes up to 10 years, before starting residency, often undertaking unrelated employment. Greece has Europe's highest physician-to-patient ratio (65·8:10 000), fuelling competition in the private sector.[7] Meanwhile, the increase in tuition-based master's programmes risks aggravating access disparities; most PhDs rely on limited public funding or case-specific competitive funding, complemented by impartial support from endowments and the dedication of local academics and clinicians.

Safeguarding free training for young doctors is an urgent priority. Revenues from English-language and private programmes could be earmarked for stipends covering residency expenses. Transparent regulation of sponsorship and tax exemptions for training costs would further reduce inequities.

Access to free medical education is not only fair for trainees, but a prerequisite for safety and equity for patients whose care depends on well-prepared professionals. Sustaining this principle requires institutional commitment and social engagement in Greece, and in every country aspiring to train the next generation of doctors without financial barriers.

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