Mandatory drug tests in prisons

EDITOR,—The recent report on Styal prison by the Inspectorate of Prisons highlights the problem of women who start to inject drugs during incarceration, calls for quantitative research on illicit drug taking, and recommends a "clinical model" of drug reduction.¹ The Home Office's response is in stark contrast: it is to introduce mandatory drug tests at the prison.² Prisoners from whom a urine sample is required need not be chosen randomly, refusal to provide a sample breaches prison rules and is punishable, and samples are attributable.

Mandatory testing, also dubbed a "war on drugs,"³ has been publicised on television and radio by Derek Lewis, the chief of the prison service, as a means of gathering information. As scientists, we have sought to distance "willing anonymous salivary HIV" surveillance in prisons (in which saliva is taken anonymously from volunteers) from the war on drugs.^{4,5} Our proved method has had the willing cooperation of prisoners and prison staff, is anonymous, is designed to avoid deductive disclosure about who is infected, yet estimates how many prisoners are infected and the prevalence of behaviours conferring a risk of HIV infection. It has led to better understanding of the prevalence of HIV infection in Scottish prisons than in England.⁴

The war on drugs policy is subject only to non-randomised, uncontrolled evaluation in eight prisons. English prisoners may now be reluctant to take part in planned willing anonymous salivary HIV studies, their cooperation jeopardised by the contemporaneous control initiative and the research incoherently linked with it.⁵ Obfuscation of the different aims of mandatory drug testing is a denial both of scientific method and that prisoners' health care matters.

The supposed informational objective of mandatory testing—estimating what proportion of inmates took cannabis in the previous fortnight (which is not a health care concern) or injected heroin in the previous three days (which is a major health care concern)—would be better served by obtaining non-attributable urine samples (to minimise the switching of samples) from randomly selected inmates. Those with heroin in their urine have not necessarily injected it: the information gleaned is inadequate to be used to prioritise treatment for injectors. What is worse is that mandatory attributable testing may result in inmates who previously took only oral or inhaled drugs converting to injecting drugs because injecting results in a shorter urinary half life. Crucially,

professional codes of conduct make it unethical, even if legal, for health care workers to obtain, and researchers to analyse, samples taken against a subject's wishes.

The current disjointed policy—mandatory drug tests and the home secretary's long deferred decision on harm reduction measures versus the inspectorate's clinical model of drug reduction¹ and the willing anonymous testing HIV surveillance funded by the Department of Health—poses unacceptable risks to prisoners' health and public health. These risks are of hepatitis B, which is of long standing; of hepatitis C, which is unquantified; and of HIV infection, which is undocumented in England. Action regarding health care in prisons will follow only the collection of valid scientific data establishing the scale and seriousness of problems.

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The WHO

Pay and conditions of service have been eroded

EDITOR,—Fiona Godlee's articles describe the serious loss of morale in the World Health Organisation.¹ Until recently I was a member of the WHO's staff and also general secretary of the UN Federation of International Civil Servants Associations. For years staff throughout the UN have suffered erosion of their conditions of service and cutbacks in funding, which have made it increasingly difficult to deliver the programmes they are expected—even mandated—to carry out. The WHO's salaries are now years behind those for equivalent posts in the United States' federal civil service (on which they are theoretically based), which are themselves far behind those in other international bodies, such as the World Bank and the European Union. Base pay for professional staff in the WHO has remained virtually stagnant for the past 15 years, and career appointments for senior staff have been replaced by two year contracts, with the possibility of a renewable five year contract after four years. Over two fifths of professional staff serve for less than five years. Pensions provided by the UN have eroded faster than those elsewhere.

Of course, pay is not everything, and many professionals join the WHO and other UN agencies because of idealism. But I doubt whether comparable staff in either Britain or the United States would have stood for a similar deterioration in pay and conditions of service. For the past 10

years qualified applicants from government service in the United States, Europe, and Japan have had to take a cut in salary on joining the WHO. Physicians and scientists from the private sector have no incentive to join.

Through the International Labour Organisation the UN has promulgated a set of enlightened rules for protecting employees, but it has failed to apply them to its own civil servants. At least for professional staff, the director general of the WHO has direct control over hiring and firing. In fact, he and the six regional directors have long had the freedom to operate much as medieval barons, with potentially absolute powers and arbitrary control over their staff. Although the WHO's staff have the right to form staff associations (but not unions), staff have no legal right to negotiate their terms and conditions of service. These are set by interagency administrative bodies, which may listen to staff representatives but are under no legal obligation to pay attention to what they say. Furthermore, if the director general does not like what the body says he or she can ignore it, pleading budgetary constraints or whatever.

Staff in the WHO and throughout the UN should be given the rights enjoyed by workers in every civilised nation: the right to organise, to negotiate their terms and conditions of service, to protect themselves against arbitrary relocation or dismissal, and to protect whistleblowers who report irregularities. The WHO should restore career employment and bring pay scales and the mandatory retirement age into line with the best in the international civil service. This would remove competition related to salary among international agencies and attract the greatest talent, even perhaps from the private sector.

This will be possible only if the WHO's member states reverse their policy of cutting the organisation's budget, arbitrarily withholding their assessed contributions, and voting for further reductions in UN pensions. They must wake up to the reality that, in response to their legitimate concerns over efficacy, cutbacks in the WHO's core professional staff have now exceeded the limits of cost effectiveness and may already have passed the point of no return.

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1 Godlee F. WHO in crisis. *BMJ* 1994;309:1424-8. (26 November.)

Non-government organisations should be catalysts for change

EDITOR,—Fiona Godlee's articles on the World Health Organisation fairly describe an institution in disarray.¹ WHO has become outdated and sclerosed and desperately needs to be revitalised if it is to provide health leadership for the modern world. In fact, except in its inner sanctum and in some ministries of health, there is widespread agreement about the need for major reform. Yet unless some action is taken soon the current leadership will continue and urgently needed institutional overhaul will be postponed.

Who should be responsible for catalysing and carrying forward the reform? In the past, middle level health officials from many countries have

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agonised about the future of the WHO yet the high officials with a voice (ministers of health) have often been silent. In 1992-3 the futile effort to replace the current director general symbolised the failure of reform: the campaign was rapidly reduced to one of nationalist geopolitics, opposition was steamrollered, health issues were ignored, and leadership capability became irrelevant.

Yet, while the WHO is an organisation of member states, its future cannot be left exclusively to governments. Firstly, this is because governments may be too tied to the benefits of its status quo (or their own) to create the necessary alliance of industrialised and developing governments that would alone be capable of insisting on reform. Secondly, health is increasingly appropriately being influenced and advanced by communities and non-government agencies, so that the catalyst for reform may need to come from outside official circles. Non-government organisations can announce, boldly and clearly, when the emperor has no clothes. They are not less threatened by reprisal. They can also do what governments have not done: inform the global public about world health and threats to its wellbeing. In this manner, the WHO will become increasingly accountable, for the first time beyond tight official circles, for what it does and does not do.

The campaign for reform must be positive, based on a clear and articulated vision of health in the modern world. What might a revitalised WHO look like? Beyond important administrative and procedural reform (for example, to prevent incestuous financial relationships and to limit arbitrary actions and other abuses of power by staff), the WHO must undergo both a short term and long term structural and conceptual realignment. Policies must be centralised; the ability to act in concert with a wider range of national and international partners must be decentralised. A creative approach in a world vastly different from that in the late 1940s will require both a renewed commitment to the organisation's central values, including health for all, and a substantial broadening of disciplinary skill.

The WHO's revitalisation could be jump started by a conference on the renewal of the WHO organised by non-government organisations; governments could follow once the pressure for reform had become irresistible and its inevitability apparent. Like any organisation that has lost its sense of purpose and its contact with the real problems for which it was created, the WHO is now much more vulnerable and ready for dramatic change than it may initially seem.

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1 Godlee G. WHO in crisis. *BMJ* 1994;309:1424-8. (26 November.)

The WHO was in favour of social security

EDITOR,—In her article discussing whether the World Health Organisation is losing its influence Fiona Godlee comments on its report on medical aspects of social security.¹ I was the officer responsible for this and wish to clarify matters. Contrary to Godlee's comment, the report did not "[come] down against health insurance." Quite the opposite: it spoke strongly in favour of social insurance for medical care, stating: "The Social Security system is obviously a key social measure in making available medical care to the people of a nation." The World Medical Association, which at that time was dominated largely by the American Medical Association, indeed criticised the WHO for its favourable stance toward social security, attacking it for involving itself in "political" issues.

Since 1952 the American Medical Association (belatedly) has recognised the value of social security as a method of financing health services.

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1 Godlee F. WHO in retreat: is it losing its influence? *BMJ* 1994;309:1491-5. (3 December.)

Education at prestigious centres is valuable

EDITOR,—Several questions arising in Fiona Godlee's article on World Health Organisation fellowships need to be addressed.¹ These include the value of education at prestigious centres (of which the London School of Hygiene and Tropical Medicine is a leading example), the role of externally imposed objectives in education, and the WHO's priorities. Examination of the WHO may be justified, but the more general conclusions do not follow.

Both young students and professionals in mid-career come to prestigious centres because they obtain value for money. At the London School of Hygiene and Tropical Medicine one in five overseas students finance their own studies. The school enables students to build a one year course to complete a unique training related to their professional objectives. For established professionals this is a well proved mechanism for intellectual refurbishment and development. To obtain such programmes elsewhere requires infrastructural and academic investment.

Godlee discusses training objectives in terms of the WHO's objectives for the programme and the training needs of the country concerned. An equal component must be the needs and objectives of the students. Our students who were interviewed by Professor Stuart MacLeod commended their training for its relevance to research in the developing world. The students are professionals who are aware of the health agendas in their country. To imply that objectives should be imposed on them is to devalue their contribution to the development of objectives within the health agenda. The discredited model of training described in Godlee's article is not one that I recognise.

The number of overseas students educated each year at the London School of Hygiene and Tropical Medicine is greater than that on the total programme of Incen, the international clinical epidemiology network. This year students from 86 countries are studying at the school, and this provides an opportunity for them to put their country's problems in an international context. They become part of the wider international group of alumni of the school and can network among colleagues, sharing related experiences.

Our aim is to enhance the status of self sustaining critical thinkers, ensuring that they can maintain academic and managerial activity without needing to depend on northern institutions. The test is not the extent to which they are supported but the extent to which they can enable others to function.

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1 Godlee F. WHO fellowships—what do they achieve? *BMJ* 1995;310:110-2. (14 January.)

The tropical disease research programme has a coherent plan

EDITOR,—At times when reading Fiona Godlee's articles analysing the performance of the World Health Organisation I have had the feeling that journalistic enthusiasm for piercing criticism has

taken precedence over the need for constructive suggestion. A case in point is the article on WHO fellowships,¹ which refers to a report that I wrote in 1993 for the tropical disease research capacity strengthening programme.

In my report I underscored the difficulty in evaluating capacity building activities in the absence of a universally accepted definition of such activities.^{2,3} Capacity building may be targeted at organisations, organisational units such as institutions, or individual practitioners and scientists and should, if successful, enhance effective and efficient performance of tasks. In my report in 1993 I noted that the programme's goals and objectives as set out in the strategic plan were clear and that institutional performance could be evaluated; evaluation was more problematic, however, at the level of individual trainees because in many cases expectations had not been clearly delineated. I do not believe, as Godlee suggests, that the overall tropical disease research programme lacks a coherent plan.

The tropical disease research capacity strengthening programme is committed to self evaluation, strategic planning, and improvement. Indeed, my report was commissioned as part of that commitment. The programme is a good example of targeted capacity building and is highly successful within the limits imposed by the availability of funds. My comment on the current budget as a "drop in the ocean" should not be construed in any way as suggesting that the current funds are not well spent. In fact, I regret the inadequacy of support for training in research in this high priority field.

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New cases of leprosy are falling

EDITOR,—Fiona Godlee accepts the statement from the International Federation of Leprosy Associations that, "despite multidrug treatment, there has been no sign of a decline in the number of new cases."¹ In 1993, 590 933 new cases were detected.² This was a fall of some 60 000 from the previous year,³ even if some of this decline may have been due to the elimination of misdiagnosed cases.

When considering whether leprosy can be eradicated by multidrug treatment it would be more helpful if the decline in the number of new cases was used as the criterion rather than the fall in the prevalence of treated patients. New rates of lepromatous leprosy and leprosy in children should also be recorded.⁴

There is, of course, evidence of a decline in leprosy as a result of monotherapy with dapsone.⁵

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