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

2 Cohen JM. *Building sustainable public sector managerial, professional, and technical capacity: a framework for analysis and intervention*. Harvard: Harvard Institute for International Development, 1993. (Discussion paper 473.)

3 Trostle J. Research capacity building in international health: definitions, evaluations, and strategies for success. *Soc Sci Med* 1992;35:1321-4.

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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1 Godlee F. WHO's special programmes: undermining from above. *BMJ* 1995;310:178-82. (21 January.)

2 Progress towards eliminating leprosy as a public health problem. Part 1. *Wkly Epidemiol Rec* 1994;69:145-52.

3 Progress towards the elimination of leprosy as a public health problem. *Wkly Epidemiol Rec* 1993;68:181-6.

4 Crawford CL. Controlling leprosy. *BMJ* 1992;305:774-5.

5 Crawford CL. In spectacular retreat. *BMJ* 1990;300:261.