mic control should be agreed between patient and doctor. Although many elderly diabetic patients can be managed in primary care, closer liaison between general practitioners and hospital doctors is likely to be beneficial. In each locality or district, guidelines for managing diabetes should be agreed between interested parties, and these should be supported by adequate documentation, computerisation of information, and clinical audit. A simple mechanism should exist to ensure that elderly diabetic patients who require consultation with a consultant (for example, those with serious diabetic complications or those requiring insulin) receive it. Geriatricians can manage many elderly diabetic patients, especially those with increasing dependency and multiple medical problems, but they will require training in diabetes to do this well. Rather than setting up diabetic clinics for elderly patients it may be more appropriate for a geriatrician to join the diabetic team, allowing the concentration of resources and ready access to support services required for the care of elderly patients.

These strategies may help to meet the needs of this important sector of the diabetic population, but to be effective they must begin at an early stage of the disease and be adequately funded. It is hoped that the enthusiasm for implementing the St Vincent declaration, which recommends ways of reducing the substantial toll of complications such as amputation, renal failure, and blindness in the diabetic population,1 2 will also take on board the special problems of elderly diabetic patients.

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WH artyku the crossroads

Will it embrace the necessary reforms?

The World Health Organisation is at a turning point in its 45 year history. This week its 183 member states will decide whether its director general, Dr Hiroshi Nakajima, should continue in office for a second five year term despite allegations of mismanagement and clear signs of the organisation's fall in influence under his leadership. WHO is faced with growing challenges and falling funds: its overall budget fell by a tenth in real terms over the past 10 years. AIDS, environmental degradation, and the spread of smoking in the developing world are now added to old health problems—such as tuberculosis and malaria—that WHO has so far failed to solve. Despite a biennial budget of over $26m for malaria programmes the disease is still endemic in 93 countries and kills between 1·5 and 3 million people a year. Tuberculosis, once thought to be under control, now kills a similar number each year (p 1147).

The heady days of eliminating smallpox are over, and WHO's donors are becoming increasingly critical of the organisation. They criticise its fixation on medical technology—vaccines, drugs, and doctors—and its unwillingness to grapple with the practicalities of delivering health care. Critics would like to see a move away from medical and scientific experts, who make up nearly a fifth of WHO's staff of 4500, towards employing more economists and administrators. They believe that WHO should be helping to tackle the root cause of most disease—poverty—and doing more to improve the infrastructure of health care in the developing world.

WHO faces massive problems inherent in any large international bureaucracy. Run by UN civil servants its internal workings remain closed and cumbersome, and it escapes the moderating influence of public accountability and scrutiny from the international press. In addition, a system that must be seen to be achieving fair and balanced representation of all member states risks breeding committees high in make-weights. Political considerations are likely to take priority over finding the best person for the job.

Dr Nakajima's re-election in January by the organisation's executive board, against the unprecedented opposition of every major donor nation except Japan, was a prime example of national interests being put above the international good. According to Western diplomats, the Japanese government carried the vote by threatening to withdraw trade and aid agreements from poorer countries if their representatives on the executive board did not vote for Nakajima. The desire to uphold national pride is one explanation for Japan's unstinting support for a man whose first term in office was characterised, say his critics, by an autocratic style, poor communication, and numerous appointments of inappropriate people to the organisation's staff. As he is reaching retirement age he could easily have stood down gracefully. Even senior Japanese members of staff have joined the clamour for Nakajima's removal; one of them in a recent letter to Japan's foreign ministry used words such as "nightmare" and "catastrophe" to describe the likely outcome if he stays.

The past two months have seen further damaging allegations against him. Although the organisation's external auditor rejected allegations of corruption, it found that the number of contracts let to members of the executive board had doubled and their value trebled in the six months leading up to the election. Disappointed though Dr Nakajima's opponents are by the auditor's main conclusions they can still point to the shortcomings in management and disregard for the organisation's rules also highlighted in the report.

Dr Nakajima’s response to these criticisms has been to
institute organisational changes—but whether he will learn from the outcry against him is something that most Western countries are unwilling to wait to find out. Intensive lobbying has been going on since January to persuade Japan to withdraw Dr Nakajima’s candidacy. Failing that, Western diplomats hope to canvass support for a move against him at the meeting of the World Health Assembly in Geneva next week. A majority vote against Nakajima would effectively veto his re-election by turning it into a so-called “important issue”—one that needs a two thirds majority at the executive board rather than Nakajima’s simple 18 to 13 majority in January. Nakajima’s opponents are confident that they could carry a third of the votes at the executive board, but they are not so sure of reaching the necessary majority in the World Health Assembly.

Behind the West’s lobbying against Nakajima are solid threats. None of WHO’s member states are threatening to resign as the United States and Britain did from Unesco over disagreements with its leadership in the 1980s. But they could reduce their voluntary contributions to WHO’s international programmes. At present these almost equal the organisation’s regular biennial budget of $750m and include major programmes on AIDS, immunisation, diarrhoea, and human reproduction.

Diplomats from the United States, WHO’s major donor, as well as from Denmark and Britain have made clear that their governments would consider withdrawing funds from these programmes if Dr Nakajima continues as director general. The other Scandinavian countries would be likely to follow Denmark’s lead. This would not mean an overall reduction in aid to the developing world as donors would transfer funds to other agencies such as the World Bank or to bilateral aid projects. But it would seriously damage coordinated international efforts. As most commentators acknowledge that the voluntary funded programmes are the most effective part of WHO, withdrawing funds would be a serious step.

Whatever happens in Geneva next week the damage to WHO is unlikely to be quickly reversed. If Nakajima remains WHO will be hampered by a director general who lacks the support of its major donors. If he is forced out by the assembly recriminations will continue long into the future, diminishing WHO’s effectiveness. And even if, against all the odds, the Japanese government withdraws Dr Nakajima’s nomination—the most damage limiting alternative—what of his replacement? Dr Mohammed Abdelmoumen, ex-deputy director general and Nakajima’s main opponent in January, had the support of the West, but few were convinced that he was the best person for the job.

Selecting candidates by internal promotion has shown itself to be flawed. The leadership net should be thrown beyond the confines of WHO to bring in new organisational talent free from political influence. The world needs a WHO that works, which means effective and disinterested leadership.

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**Universal named testing of pregnant women for HIV**

*Many benefits*

The British government’s decision to support the universal named HIV testing of pregnant women where appropriate is welcome.1 Current evidence points to the benefit of initiating treatment before the patient’s immune system is damaged irreversibly2 3; this will become more apparent with better antiviral treatment and prophylaxis. Furthermore, knowledge of their serological state allows patients to take measures to prevent them transmitting the infection sexually. During the antenatal period such knowledge enables a woman to make an informed decision about continuing with her pregnancy and, if she decides against termination, to take precautions to reduce the risk of transmitting infection to her child by avoiding breast feeding.4 Immediately after birth the infant can be monitored for HIV and, if infected, can benefit from the early treatment of HIV related diseases.

Against the benefits of testing have to be weighed its disadvantages, including cost, and obstetric units may have difficulty deciding whether to adopt universal testing. Accordingly, the scrutiny of available information about the extent of HIV infection among pregnant women in their area is vital so that an informed decision can be made. Britain’s extensive programme of unnamed anonymous HIV testing of neonatal metabolic screening cards and residual serum from blood samples taken routinely from women during pregnancy permits monitoring of the prevalence of HIV among the country’s pregnant women.5 6 By comparing the number of infections detected by this approach with the number of women who, at the time of their pregnancy, were known to have tested HIV positive the level of clinical ascertainment of infection can be determined. As well as knowing the size of the group with HIV infection undetected it is important to realise its proportions of high risk and low risk patients; if undetected cases are principally women with features suggesting high risk who have previously been offered and declined testing then implementing universal testing might have little extra impact. Consequently, unlinked anonymous studies, particularly among pregnant populations, should collect limited information on risk categories.8

Our current knowledge of HIV infection in Britain suggests that most obstetric centres would be justified in continuing with a policy of selective testing of high risk patients. Although it has been argued that targeting discriminates against vulnerable groups of women,9 we believe that such practice is pragmatic, especially in view of the health service’s financial constraints. Even so, where selective testing is performed the trend should be towards informing all women about the risks of HIV infection and the availability of HIV testing. All women, regardless of their risk, should be able to obtain such a test easily.

Some centres would benefit from a policy of universal testing. In parts of London and Scotland, where heterosexual transmission may be becoming the principal means of spread, selective testing will miss increasing numbers of cases. In inner London, for example, only about one in five pregnant women infected with HIV are known to be so by their obstetricians.9 10

Counselling raises several difficult issues. We believe that pre-test counselling should be incorporated into the antenatal programme without the need for a special HIV counsellor. This will be conditional, however, on obstetricians and midwives receiving proper training. As Holman et al have indicated, counselling entails not only HIV testing but also