did not resolve on stopping the drug. The Newcastle group includes data from the Committee on Safety of Medicines showing that cystitis and related symptoms are overrepresented among the British reports of adverse reaction to tiaprofenic acid compared with all other non-steroidal anti-inflammatory drugs.

Cystitis secondary to drugs other than cytotoxic drugs is an unusual problem. The cystitis associated with tiaprofenic acid seems likely to represent a direct toxic effect of the drug or its metabolites on the bladder. Tiaprofenic acid was being used for months or years in all the patients affected. Many of these patients were elderly, and their need for any long term treatment with a non-steroidal anti-inflammatory drug should be regularly reviewed. On present evidence long term treatment with tiaprofenic acid is potentially hazardous, and patients receiving this drug should be assessed for symptoms of cystitis, and if there are any the drug should be withdrawn.

The wider issue is whether a drug with such a potentially devastating effect should still be available, particularly when its indications for use are shared by many other agents without this particular toxic effect. This must be an issue for drug regulatory authorities to consider. Once again spontaneous reporting by doctors on yellow card forms in Britain has been invaluable in assessing the toxicity of a drug. Doctors should be encouraged to send in reports of adverse reaction even when unsure of a causal association.

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1 Smith A, Wright B. Benoxaprofen. *BMJ* 1982;285:459-60.
2 Phenylbutazone and oxyphenbutazone: time to call a halt. *Drug Ther Bull* 1984;22:5-6.
3 Bateman DN. NSAIDs: time to reevaluate drug toxicity. *Lancet* 1994;343:1051-2.
4 Brock PG, Jackson D. UK general practitioner experience of fenbrufen in elderly patients. *Eur J Rheumatol Inflamm* 1982;5:326-31.
5 Ahmed M, Davison ON. Severe cystitis associated with tiaprofenic acid. *BMJ* 1991;303:1376.
6 ADRAC. Update on tiaprofenic acid and urinary symptoms. *Australian Adverse Drug Reaction Bulletin* 1994;13:6.
7 Mayall FG, Blewitt RW, Staff WG. Tiaprofenic acid (Surgam) associated cystitis and ureteric obstruction. *BMJ* 1994;309:599-600.
8 Harrison WJ, Willis G, Neal DE. Adverse reactions to tiaprofenic acid (Surgam) can mimic interstitial cystitis. *BMJ* 1994;309:574.

The World Health Organisation in Africa

Too much politics, too little accountability

This month sees a crucial vote in international public health: the nomination of the World Health Organisation's next regional director for Africa. The appointment will affect how $850m of public money is spent and what happens to the health of 550 million of the world's poorest people.

Many people are unhappy with what has been achieved since the current regional director, Dr Lobe Monekosso, took office 10 years ago. His three phase development plan for Africa has remained on the shelf, and only just over half of the region's $136m budget for 1992-3 reached the region's 45 member states. The rest of the budget was spent at the regional office in Zaire, along with two thirds of the £112m donated for special programmes such as the AIDS and immunisation programmes.

Dr Monekosso has been unfortunate. Chronic difficulties caused by Africa's lack of infrastructure have been aggravated over the past year by civil unrest in Brazzaville, where the regional office is based. The office has been closed, and Dr Monekosso has had to decamp with some of his staff to his native Cameroon. The unrest prevented the WHO's auditors from evaluating biennial spending of $122m, assets of $20m, and liabilities of $21m,[1] and left Dr Monekosso unable to counter suggestions of poor management voiced by, among others, Zambian delegates in an outspoken attack at this year's World Health Assembly.

Dr Monekosso's main rival for the post of regional director is Dr Ebrahim Samba, director of the onchocerciasis control programme. Dr Samba, from the Gambia, took over the ailing programme in 1980 and has turned it into a success. Funded by the World Bank and executed by the WHO, the programme has already achieved its 1995 target of eliminating onchocerciasis as a public health problem. From its base in Ouagadougou in Burkino Faso it has cut the prevalence of infection in 11 west African countries from 95% in 1974 to less than 5% today. Aerial pesticide spraying has allowed resettlement of 25 million hectares of fertile river basin that had been abandoned because of infestation by blackfly. Donors' confidence has been maintained by clear results and tight financial management.

If the appointment of regional director was to be decided on a comparison of past performance Dr Monekosso would have reason to be worried. But it will be decided by the regional committee, which is made up of health ministers of the region's 45 member states, and observers say that, as in politics elsewhere, the sitting tenant will have the upper hand. According to a recent report, too much of regional directors' time is spent on regional politics.[2]

The fact that regional directors are answerable only to their regional committees and not to the WHO's governing body, the World Health Assembly, is increasingly seen as one of the WHO's major structural flaws. In theory the regional directors implement WHO policy. In practice they have complete autonomy within their domains, setting policy, appointing staff, and allocating resources.

Curtail regional directors' power

Observers say that, until recently, the regional directors' independence was tempered by the strong personality of the previous director general, Dr Halfden Mahler. His successor, Dr Hiroshi Nakajima, lacks his authority and communication skills. He is known to be in favour of limiting the regional directors' autonomy, and an internal United Nations report has now come to his aid.[3] It recommends that regional directors' powers should be curtailed and that they should be selected by the director general after consultation with the regional committees. The European region, whose director, Dr Jo Asvall, is also up for reselection this month, has gone one step further. A search group has been set up to look for potential candidates and to assess those put forward by member states.

The internal report's recommendations will be discussed at the next assembly, but most observers doubt that the WHO will succeed in implementing them across all six regions. They think it highly unlikely that the Pan

American Health Organisation, which acts as the WHO's regional office for the Americas, will relinquish its independence. It predates the WHO and agreed to act as the WHO's regional office only on condition that it maintained its autonomy. Other regions will be able to use the American stand to resist coming into line. Since many members of the regional committees attend the assembly there is small chance, say diplomats, that they will vote to reduce their own powers. Should they feel inclined to do so the regional directors will be on hand to remind them of their responsibilities.

Opposition to Dr Monekosso is growing in Africa. Next week we will know whether this has proved enough to unseat him. Regardless of the result of the regional committee meeting in Brazzaville, the time has come for a thorough review of the effectiveness of the WHO in Africa. This would help to reassure those who question the WHO's ability to manage its decentralised democracy and so reduce the ammunition of treasury officials in donor countries waiting to withdraw their funds. The WHO needs to reform its selection procedures and make its regional directors more answerable to the World Health Assembly; in this way it will eliminate the existing potential for too much power combining with too little accountability.

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1 World Health Organisation. *Financial report and audited financial statements for the financial period 1 January 1992-31 December 1993 and report of the external auditor to the World Health Assembly.* Geneva: WHO, 1994.
2 Danida. *Effectiveness of multilateral agencies at country level: WHO in Kenya, Nepal, Sudan and Thailand.* Copenhagen: Ministry of Foreign Affairs, 1991.
3 Daes EIA, Daoundy A. Decentralisation of organisations within the United Nations system. Part III. The World Health Organisation. Report of the joint inspection unit. *General assembly official records, 48th session. Supplement No 34.* New York: UN, 1994. (A/48/34.)

Cairo conference

Health in the shadow of the population pyramid

See personal view on p 614

Next week's United Nations conference in Cairo on population and development will evoke some hand wringing about the inability of governments to act quickly enough to avert demographic and environmental crises. Gloomy predictions have been made since at least the time of Malthus, who at the end of the 18th century foresaw geometric increases in population outstripping arithmetic increases in food production.[1] Largely because of unforeseen technological advances in agriculture, major disaster has not occurred—although current per capita production trends are not reassuring.[2] So, as life expectancies edge up in most populations, sceptics might ask if there is any new reason for concern over today's rapid population growth.

Yes, there is a reason—and it has clear implications for public health. Today there is a new type of writing on the wall; it concerns the worldwide environmental impact of the size of the human population, energy intensive technology, and consumerism. Globally, we are now seeing anthropogenic changes in atmospheric composition, the degradation of fertile lands and ocean fisheries, the depletion of fresh water, an accelerating loss of biodiversity, and the social and ecological problems of massive urbanisation.[3] Part of this global environmental change reflects pressures from population growth—particularly in those "developing" countries where widespread poverty persists, embedded in the structural inequities between First and Third Worlds. In future, per capita consumption levels will increase in those burgeoning populations, thus supplementing the environmental impacts of today's overconsuming rich countries. Early last century there were fewer than one billion of us, of whom about 5% lived in cities. This decade there will be over six billion, of whom one half will live in cities. Many of those will live in poverty on the fringes of Third World cities, where already 100 million homeless children eke out a desperate existence.[4,5]

There are many ways by which these demographic-environmental trends, if translated into climatic change, regional food shortages, and weakened ecosystems, would adversely affect human health.[2,3,6,7] True, the scale, the time frame, the ecological context, and, often, the unpredictability of these effects pose challenges to scientists and policymakers.[8] But, overall, there could hardly be a more fundamental reason for concern over population growth than its impact on the global systems that support health and life.

Will the Cairo conference address the public health dimension? Regrettably, the World Health Organisation is likely to take a minimalist line, concentrating on "reproductive health" (focused on family planning that is accessible and health promoting for women and families). In addressing the larger, population oriented issue of reduction in fertility, international agencies such as the WHO are all too easily hamstrung by member states that, because of religious orthodoxy or Third World indignation at perceived First World presumption, oppose concerted international action. Yet it is crucial that health scientists and agencies address the wider impacts of population growth on health.

On its own, child saving aid may not be enough

This year's Unicef report on the world's children discusses the "poverty-population-environment spiral".[9] Population pressures damage the carrying capacity of local environments, especially in poor countries disconnected from the mainstream world economy. Nevertheless, Unicef dislikes the argument that by saving children's lives the piecemeal transfer of Western public health and medical knowhow (sanitation, vaccination, control of vectors, micronutrient supplementation) and oral rehydration, can exacerbate population growth. Yet the dilemma is that continuing this asymmetric childsaving "aid," unaccompanied by substantial aid to help mobilise the social and economic resources needed to reduce fertility, may delay the demographic transition in poor countries and potentiate future public health disasters.[10]

Optimists point to recent reductions in fertility. Even in recalcitrant corners of sub-Saharan Africa, average family sizes have halved.[9,11] Pessimists say that this is too little too