# LETTERS

## 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 incorrectly linked with it.[3] 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 reduction[1] 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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1 HM Inspectorate of Prisons. *Report of an unannounced short inspection of HM Prison and Young Offender Institution Styal.* London: Home Office, 1995.
2 HM Prison Service. *Mandatory drug tests to be introduced at Styal HM Prison and Young Offender Institution for Women.* London: HM Prison Service, 1995. (Press release.)
3 Connor S. Thousands of prisoners face HIV screening. *Independent* 1995;Jan 29.
4 Connor S. Drug tests "threaten AIDS virus study." *Independent* 1995;Feb 3.
5 Bird AG, Gore SM. Inside methodology: HIV surveillance in prisons. *AIDS* 1994;8:1345-6.

**Advice to authors**

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

## 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