Who should be doing what in international health: a confusion of mandates in the United Nations?

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Since 1945 at least five United Nations organisations have become substantially involved in international health activities. This has led to considerable confusion among policy makers, scholars, and UN staff over their distinct and appropriate mandates. Interviews with staff and a historical analysis have shown that while formal mandates have been complementary, effective mandates have led to an unclear delineation of activities. The processes of translating formal into effective mandates have been influenced by the decentralised nature of the UN, lack of a master plan for its activities, the considerable growth in the policy agenda, and the shift towards a multisectoral approach to health. The identification of each organisation's comparative advantage, at both the global and country levels, is one way of understanding what each organisation does best and perhaps should be doing. There is a need for improved mechanisms to define effective mandates, taking into account comparative advantages, if the mandates of UN organisations are appropriate to meet future challenges in international health.

There has been much recent reflection on and criticism of the World Health Organisation (WHO) and its role in international health.[1] What much of this criticism has failed to acknowledge is that the WHO is no longer the only major player in this field and that many of the other players have ceased to regard the WHO as the captain of the team.

Much has changed in the UN during the past 50 years. In 1948 the WHO was created as the UN specialised agency in health. Five decades on international health has become crowded with other organisations—notably, the UN Children's Fund, Unicef; the World Bank; the UN Population Fund, UNFPA; and the UN Development Programme, UNDP. All four have active roles in international health but may also at times duplicate activities, compete instead of cooperate, and even promote contradictory policies and interventions. For the countries in which they are working this can be both confusing and wasteful.

The international health policy programme at the London School of Hygiene and Tropical Medicine is examining the mandates of the above organisations as part of a study of the UN and the health sector. The study is exploring how the mandates of these organisations have been defined, how these have changed over time, and the extent to which they are complementary or overlapping. The research uses unstructured interviews with UN staff and national policy makers in developed and developing countries, and historical analysis of official documents.

UN health related organisations

World Health Organisation
World Bank
UN Children's Fund (Unicef)
UN Population Fund (UNFPA)
UN Development Programme (UNDP)

UN Educational, Scientific and Cultural Organisation (Unesco)
Food and Agricultural Organisation (FAO)
World Food Programme
UN High Commissioner for Refugees
International Labour Organisation
UN Environment Programme
UN Fund for Drug Abuse Control

What is a mandate?

A mandate or mission of an organisation can be defined in two ways. A formal mandate is an agreed statement of the organisation's overall purpose or raison d'être, usually encapsulated in a constitution, charter, or articles of agreement. This formalised statement is usually worded in broad terms but may specify certain functions for the organisation to carry out in a particular subject or sectoral area. An effective mandate refers to how formal mandates have been interpreted over time as the purpose and functions of the organisation become operationalised into more concrete and specific activities. This process is generally carried out by those who implement activities, either at headquarters or regional or country levels. Although an effective mandate may be found in part within policy documents describing organisational operations, its interpretive nature means that it is defined in an unstructured and evolutionary manner according to prevailing policy actors, contexts, and processes.[2]

The problem, which many critics of the UN system raise, is that the formal mandates of the UN organisations working in the health sector have become so broadly interpreted that their respective roles are now confused. This, it is argued, has contributed to global, regional, or country level activities which suffer from poor coordination, overlap, and duplication of effort. To begin to assess the extent to which this is true there is a need to clarify what we understand by the mandates of WHO, Unicef, UNFPA, UNDP, and the World

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Definitions

Types of mandates:

Formal mandate—An agreed statement of an organisation's overall purpose or raison d'etre, usually encapsulated in a constitution, charter, or articles of agreement

Effective mandate—The actual activities of an organisation as its formal mandate has been interpreted and operationalised over time

Types of UN organisations:

Peacekeeping force—A specially organised contingent set up to deal with international conflicts through such activities as preserving ceasefires, monitoring elections, and creating buffer zones. Examples include the UN Transitional Authority in Cambodia (UNTAC)

Specialised agency—Organisations affiliated to the UN with autonomous constitutions, member states, governing bodies, and financing mechanisms which operate independently of the UN General Assembly. Examples include WHO and the World Bank

Funds and programmes—Organisations set up under, and accountable to, the UN General Assembly generally to deal with a specific issue. Governing bodies have more limited representation and activities are financed largely from voluntary contributions. Examples include Unicef, UNFPA, and UNDP

Bank. In short, what precisely are each of these organisations supposed to be doing and what are they actually doing?

Formal versus effective mandates: the five UN organisations

The WHO was created during a period of lofty international idealism; its overall objective was defined as "the attainment by all peoples of the highest possible level of health," with health being a "state of complete physical, mental and social well-being."[3] Accompanying this broad and ambitious purpose were 22 specific functions on the kind of work the WHO would be involved in but still stated in broad and flexible terms. During the postwar period this broadly defined formal mandate was not expected to be problematic. The WHO was anticipated to be and remain the lead UN organisation in the health sector and "to act as the directing and co-ordinating authority on international health work." Thus, it was expected that the WHO would be responsible for supporting or carrying out a comprehensive range of health activities.

During its first 30 years the WHO's effective mandate focused on two main activities: providing scientific and technical advice and setting international normative standards. It has never sought to be involved on a large scale with the delivery of national health services, except to support such global campaigns as the eradication of malaria and smallpox. Since the 1970s, with the launch of such policies as Health For All, primary health care, and the code on the marketing of breast milk substitutes, the WHO has taken on the role of advocating change in health policy. Some critics believe that this expansion of the WHO's role, not only within health policy but into broader areas of social policy, has wrongly led the organisation into politically controversial areas. Many believe that its contribution should remain information based, providing the technical knowledge and means to pursue health activities.

The first organisation with which there was potential for overlap was Unicef, created in 1946 (two years before the WHO) initially as a temporary organisation to assist "children and adolescents" after 1945. Health was recognised as an important part of this assistance, and Unicef was given the task of utilising its resources "for child health purposes generally."[4] When the WHO came on to the scene two years later it was accepted that coordination on health matters was needed. This led to the creation of the WHO/Unicef joint committee on health policy, with the WHO, importantly, designated as the lead health organisation.

While formally created as a fund Unicef has been actively operational in a range of high profile areas such as emergency relief and mass immunisation campaigns. During the UN's earliest years this was not a problem with so much to be done in relief and rehabilitation. When Unicef graduated from being a temporary "emergency fund" to a permanent development oriented organisation in the 1950s, however, the question of respective mandates began to be raised. Not only was there potential overlap with the WHO but distinctions began to be needed, for example, from the UN High Commissioner for Refugees (UNHCR), World Food Programme, and UNDP. In the meantime, Unicef staff continued to pride themselves on being in the business of "doing," focusing the bulk of organisational resources at field level to support targeted interventions. From the late 1970s, under the leadership of the late James Grant, Unicef also developed a stronger advocacy role, jointly supporting the Alma Ata Declaration on primary health care and Bamako initiative with the WHO, hosting the World Summit for Children in 1989, and pushing for the adoption of the 20/20 initiative at the 1995 World Summit for Social Development. The 20/20 initiative calls for 20% of public expenditure in low income countries and 20% of official assistance to be spent on basic social needs. By the late 1980s, Unicef's effective mandate had also broadened to include the welfare of youth and women, with spending on health increasing by over 120% during the 1980s.[5]

The World Bank's formal mandate in health is perhaps the least immediately obvious among UN organisations. The formal mandates of the two (of four) most relevant arms of the World Bank Group, the International Bank for Reconstruction and Development and the International Development Association, are contained in their articles of agreement, drawn up in 1944 and 1960, respectively, and periodically amended. The International Bank for Reconstruction and Development's formal mandate is to provide financial capital to assist in the reconstruction and development of member states. The International Development Association is intended "to promote economic development, increase productivity and thus raise standards of living in the less-developed areas of the world"[6] through soft loans to governments.

As Naim writes, however, "even though the purposes of the ....bank are often stated in official documents, the expectations and the behaviour of the different groups with influence over their policies frequently tend to reflect very different assumptions about these fundamental purposes."[7] Hence, as development paradigms in the World Bank have shifted from rapid industrialisation in the 1950s and 1960s, to poverty reduction in the 1970s, to structural adjustment in the 1980s, and back to poverty alleviation in the 1990s, so too has the effective mandate guiding its activities. It has been the emphasis on poverty in particular that has brought health into the bank's perceived remit. While lending for population activities began in the late 1960s and for health as a component of agricultural and other projects in the 1970s, financing health projects specifically was not provided until 1980 with the creation of the population, health, and nutrition department. Under President Robert McNamara, the bank recognised that more resources were needed for "basic needs" as an investment in "human capital." Thus, between

1981 and 1990, annual loan disbursements for health (excluding population and nutrition) rose from about US$33 million to US$263 million. By the year 2000 disbursements are expected to exceed US$1 billion. To provide such loans and credits the bank has built up health expertise among its own staff. This has been accompanied by a more vocal role in the development of health policy, marked by the publication of the 1993 *World Development Report: Investing in Health*. With "social sector lending" accounting for 15% of all bank lending by the mid-1990s, the World Bank has become the largest single source of financing (loans) for health.

The UN Development Programme was established in 1965 as a general fund for development activities and has become the world's largest multilateral source of grant funding for development cooperation.[8] The formal mandate of the programme also gives it responsibility for coordinating all UN development assistance at the country level through a network of resident representatives. While this role has been ineffectively carried out, in large part due to an unwillingness of other UN organisations to be coordinated, there have been renewed efforts in recent years to strengthen this responsibility (for example, country strategy notes). It is in the translation of these two functions, funding for development and coordination at country level, into concrete activities which has brought the programme's effective mandate to overlap potentially with other UN organisations. The development programme's activities in health derive from the organisation's holistic approach to development, which includes assistance to national governments to meet basic social needs. At the global level the programme has been a cosponsor with other UN organisations of programmes on tropical disease research, human reproduction, and HIV/AIDS. Despite being a relatively small financial player with a health sector budget in 1990 of only US$14 million[5] the organisation focused its limited resources on building up in house skills and operational capacity in these health areas.

The UN Population Fund was set up in 1969, the same year the World Bank began lending for population activities, to have "a leading role in the UN in promoting population programmes."[9] Interestingly, a new UN organisation was created for population because both the WHO and Unicef were initially reluctant to become more actively involved in this politically sensitive field. While the WHO saw its effective mandate in population as limited to medical research on human reproduction, and Unicef saw its mandate as maternal and child health (providing contraceptives only if requested by governments), supporters of a more active and broader UN programme on population saw the need for a separate organisation. Hence, the UNFPA was created to channel funding to national governments, non-governmental organisations, and other UN organisations. As a fund, but unlike Unicef, the population fund has not strayed far from this channelling function. Working largely through "executing agencies," its effective mandate has remained supportive (for example, technical support) rather than operational (for example, service delivery). As discussed below, with a new emphasis on "reproductive health," a broader interpretation of the population fund's formal mandate is currently being debated.

To summarise, all five UN organisations started with broadly stated formal mandates which, when adopted, were not expected to be problematic in their operationalisation (table 1). It has been in the process of translating formal into effective mandates, however, that debates have arisen over interpretation. How this process has been carried out has been influenced by various factors, both internal and external to the organisations themselves.

The nature of the beast—the UN hydra

The UN is afflicted by a profound organisational problem which sets it apart from nationally based institutions—it has no central brain and has many independent heads. The WHO and the World Bank are independent "specialised agencies" within the UN family, each with their own constitutions and governing bodies. Unicef, UNFPA, and UNDP are "funds" with a closer relationship to the UN general assembly but retaining separate governing councils and executive boards. In practice, this loose institutional map has allowed effective mandates to change as each organisation has deemed necessary. Yet without a "master plan" coordination of these mandates and resultant activities has remained poor. Furthermore, with the WHO's function as "the directing and co-ordinating authority on international health," the UNDP as coordinator of UN development assistance at country

Table 1—*The main UN organisations in the health sector*

UN organisation	Date founded	Formal mandate	Total annual budget	Amount spent on health, population, and nutrition	Relation to UN
WHO*	1948	To support "the attainment by all peoples of the highest possible level of health"	US$1·8 billion (1994-5)	US$1·8 billion (1994-5)	Specialised agency
World Bank†	1944	IBRD—to provide financial capital to assist in the reconstruction and development of member states	IBRD/IDA US$12 billion (1994)	US$1·22 billion (1994)	Specialised agency
		IDA—"to promote economic development, increase productivity and thus raise standards of living in the less-developed areas of the world"			
UNICEF‡	1946	To work "for the benefit of children and adolescents of countries which were the victims of aggression"	US$1 billion (1994)	US$250 million (1994)	Fund
UNFPA§	1969	To take "a leading role in the UN in promoting population programmes"	US$220 million (1993)	US$220 million (1993)	Fund
UNDP[15]	1965	To channel technical cooperation to developing countries, and to coordinate all UN technical assistance at the country level	US$920 million (1994)	US$64 million (1990)	Fund

*Figure represents proposed programme budget for 1994-5 biennium.[10]
†Total authorised lending for fiscal 1994.[11,12]
‡Figure does not include spending on water and sanitation or nutrition.[13]
§Figure represents spending on population activities only.[14]

level, and the UNFPA as taking a "leading role" in the UN system on population, the problem quickly becomes "too many cooks in the kitchen."

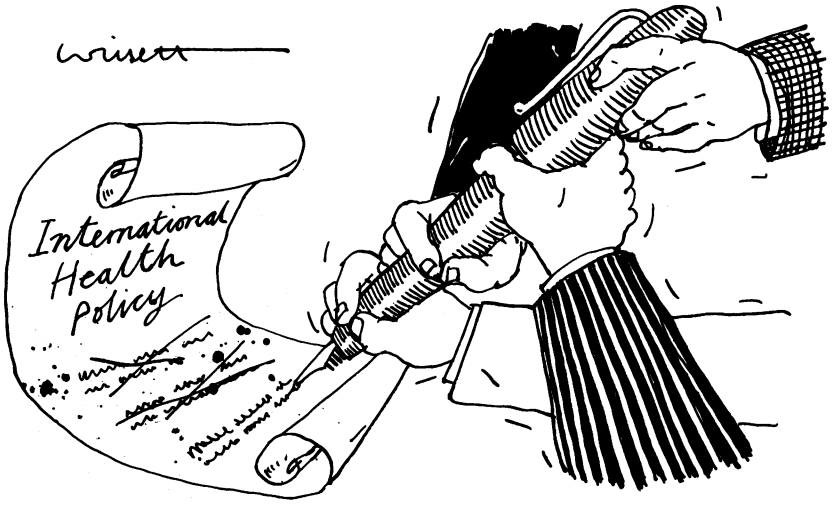
Middle aged spread

Institutions, like plants, grow into the space and resources available to support them. With the strengthening of multilateralism after 1945 has come increased reliance on international organisations like the UN. Yet, with so many organisations, each subject to prevailing political and economic demands such as cold war rivalries and north-south debates, it has grown in a somewhat ad hoc fashion into a complex collection of institutions. The 1960s and 1970s saw a multiplication of UN organisations concerned with developing countries. Since the late 1980s, 13 peacekeeping operations (more than the preceding 40 years) have been added to the UN's already long list of responsibilities.[16] In the mid-1990s many are seeking to prune the UN's overgrown policy agenda in the face of serious financial constraints.

In the health sector it is recognised that each UN organisation cannot do everything and that priorities must be set. At the World Health Assembly in May 1995 the need for the WHO to improve priority setting was one of the main criticisms levelled by the governments of the United States, Sweden, and Australia.[17] But the WHO is by no means alone in this regard. According to some critics, the World Bank faces the problem of "many expectations and definitions of the fundamental role of the bank" and "needs a more focused mission and a smaller number of operational priorities."[7] Other organisations have seen health sector aid as a "growth industry" at a time of shrinking multilateral aid budgets and thus a way of securing institutional survival. This has encouraged the definition of the "C" (children) in Unicef and the "P" (population) in UNFPA to become more broadly interpreted, incorporating into their remits such constituencies as girls, women, and families. With so many organisations chasing limited resources, institutional rivalry has encouraged UN organisations to define their effective mandates widely.

A multisectoral understanding of health: the case of reproductive health

The changing context within which the UN must work has been accompanied by changes in the way we think about health. Most scholars and practitioners now differentiate between relatively narrow, biomedical, and disease focused approaches and broader, multisectoral explanations of health. The WHO, for example, has moved over the past 50 years from a strong, disease orientation to a more horizontal approach to health. Definitions of development have also shifted during this period from an emphasis on economic growth and industrialisation to the intersectoral approach advocated by the UNDP.



While generally seen as a positive step towards recognising the complexities of health issues, the institutional effect has been greater difficulty in distinguishing mandates. The area of reproductive health is a good case in point. According to a joint letter of February 1991 by the heads of the WHO, Unicef, UNDP, and UNFPA to their staff on their respective organisational roles in maternal and child health and family planning, each organisation possessed "a complementary and supportive role":

"...in the field of health WHO is required to provide technical cooperation. Unicef has been identified as the lead agency for children within the UN dealing with all matters related to children and their needs. UNDP's primary objective is to support the efforts of the developing countries to accelerate their economic and social development. The responsibilities of UNFPA have been defined in terms of capacity building to respond to needs in population and family planning, awareness promotion of population problems, provision of assistance to developing countries at their request and in terms of playing a leading role in the UN system in promoting and coordinating population programmes."

The purpose of the letter was to encourage "more coordinated support to countries in this priority area," and to "decrease the incidence of multiple approaches."

This division of labour, however, has been thrown into confusion with the follow up to the International Conference on Population and Development (ICPD) held in 1994. Reproductive health has been defined in the conference's programme of action as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[18] This has a familiar ring because it is based on the working definition put forth by the WHO, and the organisation is fighting hard to maintain its role as "executing agency" for the WHO/UNFPA/UNDP/World Bank special programme for research, development and research training in human reproduction. Indeed, according to the WHO, its "mandate in reproductive health includes both normative and technical cooperation functions" and means "a lead role in defining policies, identifying research priorities and giving technical guidance, including setting norms and standards."[18] This poses a potential clash with the UNFPA, which has enjoyed a higher profile since the International Conference on Population and Development. Executive director Nafis Sadik has worked actively, some in the WHO say aggressively, to keep the momentum behind her organisation and to ensure that it leads the way on reproductive health.

Amid this global jostling, Unicef has remained strategically on the sidelines. In preparing for the conference Unicef identified "certain key areas" for Unicef action in the area of family planning: "enhancing the role of women, promoting safe motherhood and breast-feeding, supporting basic education and literacy, intensifying information, education and communication and providing appropriate support for family planning services."[19] Since the conference, Unicef's executive board has struggled to adopt a policy on reproductive health. Some interest groups, led by the Vatican, believe that Unicef should not be even peripherally involved in population. Others, including one UNFPA official, argue that Unicef's

current policies are "as if Cairo didn't even happen."

The shift towards multisectoral approaches to a range of health issues—notably, in reproductive health, HIV/AIDS, and environmental health—have pushed UN organisations to work more closely together. It has also made more apparent the fact that historical boundaries between different organisations have not been adapted accordingly. Furthermore, there may be no obvious lead organisation within the current UN system for each of these areas. Complex issue areas require different types of knowledge and technical skills, and the institutions created 50 years ago may not entirely fit all the tasks at hand today. The dilemma, as argued above, is that organisations cannot do everything. One way forward is a better understanding of what each organisation does best; in other words, their comparative advantage.

Harnessing comparative advantages: a whole greater than the sum of its parts

One concept often put forward by policy makers in the current debate on UN reform is that of "comparative advantage." Comparative advantage is an economic concept which, applied to the UN system, holds that if each organisation were to specialise in what it does best the system and international health as a whole would be better off. The challenge is to identify precisely what each organisation best does and then, a more difficult task, to encourage each organisation to limit its activities accordingly. The research so far has found that each organisation has perceived strengths and weaknesses in relation to type and level of activity and some clear differences in the approaches and activities pursued.

The WHO's recognised strength lies in its biomedical knowledge, its scientific knowledge base, its surveillance and normative regulations, and its data collection. Most of these activities are carried out at the global level. There is no other organisation that produces such a range of scientific information and knowledge and which also has the potential to disseminate it worldwide. Its perceived weakness lies in its limited ability to apply this knowledge at country level. Representation of the WHO in countries generally consists of a single professional staff member who, armed with little power to make decisions and few resources, is responsible for overseeing a broad range of WHO initiatives.

Unicef can be seen as a mirror image of the WHO, focused heavily on country operations but largely relying on others (notably, the WHO) for scientific and technical skills. Because it is highly operational Unicef is often credited with "doing" more, and senior staff have been skilful in maintaining a visible presence in many parts of the developing world. Unicef's weakness, according to critics, relates to the sustainability of such activities once staff move on to the next campaign and given its vertical approach to health interventions. As an organisation concerned with health Unicef's formal constituency also remains limited to children and mothers, although some initiatives (for example, the Bamako initiative) can cover whole populations.

The UNDP and UNFPA have been less operational, relying instead on governments and executing agencies, because of their emphasis on "building capacity" within countries. Both the strength and weakness of the UNDP derive from the fact that it is a multisectoral organisation. This encourages a more interdisciplinary perspective on health than, say, the WHO with its biomedical approach, but it can also swamp health within a potential quagmire of "development." The UNFPA's strength lies in the extent to which its advocacy for family planning has been widely accepted. Its weakness, however, is its vulnerability to shifts in political opinion, particularly on issues such as abortion. Despite the consensus forged at the International Conference on Population and Development, the UNFPA's work still evokes greater controversy than, for example, Unicef's work for children.

The World Bank is increasingly perceived as a heavyweight in international health. Its strength clearly lies in its unrivalled financial resources, provided in the form of low interest loans and credits. In addition, the high quality of its staff has given the bank considerable intellectual credibility. As one staff member described, in reference to the research environment at headquarters, "it's like being in a university." Also, during an era of emphasis on cost effectiveness and allocative efficiency in the health sector, the economic knowledge of bank staff has been able to influence strongly debates on health financing reform. A weakness of the organisation is that most of this analytical skill is based at headquarters in Washington. This has led to a top down approach based on short term visits by bank missions to countries. Critics believe this "parachuting in" by bank staff gives inadequate depth of understanding to conditions in specific countries. Another organisational weakness that is often raised is that there are differing views on its foremost purpose, including the "bank-as-a-bank" model and the bank as a mechanism to transfer financial resources from richer to poorer countries. The former view gives primacy to economic goals and knowledge, a starting point that raises concern among many public health advocates.

Conclusion

The question of mandates lies at the heart of any efforts to reform the UN's role in international health. Without a clearer delineation of mandates—namely, the purpose and functions of each organisation—improvements to mechanisms of financing, implementation, and coordination will remain problematic. We have begun by returning to the formal mandates of each organisation to understand how and why changes have occurred to specific activities over time. This has helped to remind us of the original intentions of those who created these organisations and to distinguish those intentions from subsequent "wish lists."

It is widely recognised that the ability of organisations to interpret their formal mandates according to changes in such factors as policy contexts, technological innovation, and new health challenges is crucial. As the WHO director general Hiroshi Nakajima recently stated, "I do not think... WHO can be limited to one function only or to a standard model for carrying out its cooperation and programmes. These must vary with the health issues, the environments and partners involved."[20] The difficulty lies in the process by which this interpretation occurs. At present, given independent governing bodies and despite a number of coordinating mechanisms each UN organisation sets its own policy agenda. This has led to problems of priority setting, not only within individual organisations, but across the UN system.

This research has found that while the formal mandates of WHO, Unicef, UNFPA, UNDP, and the World Bank are generally complementary, their effective mandates in some areas have increasingly overlapped over time. Along with the WHO, there are now at least five UN organisations with an established presence in health. This leads to several fundamental questions. Firstly, how can the process of defining effective mandates be better carried out to optimise the use of resources for international health? While there are formal mechanisms to encourage coordination, few, if any, are taken seriously as effective forums. Again this is due to the independence of UN organ-

Key messages

- The WHO is no longer the only major health player in the UN, with the UN Children's Fund (Unicef), the UN Population Fund (UNFPA), the UN Development Programme (UNDP), and the World Bank also carrying out health activities
- It is important to distinguish between formal and effective mandates
- While the formal mandates of each organisation are broadly complementary, their interpretation over time has led to confusion over who should be doing what
- Comparative advantages can be identified for each organisation, with distinct activities at global and country level
- There is a need for improved mechanisms to define effective mandates, taking into account comparative advantages, if the mandates of UN organisations are to best meet future challenges in international health

isations as well as the insecurity of their funding, thus encouraging competition rather than cooperation. A review of these mechanisms and, above all, the needed authority to bring organisations closer together is essential to better central planning.

Secondly, can the recognised strengths and weaknesses of each organisation lead to a better delineation of institutional boundaries? With limited resources no organisation can do everything and do it well. At a time of increasing demands on the UN, rationalisation of activities could allow a focus on what has been done best. To reach agreement on what comparative advantages exist there is an urgent need for multilevel research and broad consultation within and outside the organisations, notably with recipients of UN health activities. This needs to be followed by an ongoing process of high level negotiation among the organisations and all member states on a clearer division of labour facilitated by increased security of financial resources for implementation. This will need to go hand in hand with central planning described above to avoid fragmentation.

Finally, given a redefinition of responsibilities, do the formal mandates of each organisation remain appropriate for the coming century? This latter question is perhaps the most difficult because it forces us to ask what we want from the UN. It is now 50 years old, and the purposes and functions of its organisations were defined by a postwar policy agenda that had very different health challenges from those faced today. Formal mandates need to be reconsidered in the light of not only how their activities have changed but also anticipated needs in the coming decades. Separate initiatives have been taken in recent years to set future priorities.[21 22] What is needed is a joint review, similar to the International Health Conference of 1946 which led to the establishment of the WHO, of all formal mandates. These would, of course, be highly political discussions which would bring current "turf wars" to the surface. For this reason, they must also be as participatory as possible so that UN health activities can be placed under the closest scrutiny they have had for 50 years.

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MY MOST INFORMATIVE MISTAKE

School refusal

Some years ago a little girl was referred to me because she was refusing to go to school. Her mother had advanced cancer and three years before had been told that she would be dead in six months. Thanks to intensive treatment she had stayed alive, in pain and misery, longer than predicted. I thought her an unpleasant woman and was told she always had been, but that she used to show love for her daughter. At the moment she was bitchy with everyone, and I could clearly see how the little girl was rebelling by refusing school. But how could I say this to a dying woman?

I went home and after deciding that I was there to help the child not her mother I visited again, determined to bite the bullet. The mother was there, bald and covered in lumps, in her wheelchair, nagging as usual. And I could not do it. Instead I turned to the child and said, "Mummy would really like to have you stay at home with her, but she loves you so much that she tries to help you to go to school where it would be happier for you." To my utter amazement the expressions on the faces of the mother and child showed this to be true. The little girl came over and gave her mother a hug and went to school that afternoon.

The funny thing is that I knew all the time that blame seldom helps and it is unlikely that I would have criticised the mother even if she had not been dying. So how was it that I misled myself?—UNA FREESTON *is a consultant child psychiatrist in Canterbury*