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Journal Interview, 7

In this occasional series we record the views and experiences of a number of people who have specially contributed to the evolution of ideas in the Journal's field of interest.

Conversation with Joy Moser

Joy Moser worked for the World Health Organisation from 1950–1982, and during that time carried major responsibility for its work on drinking problems.

B.J.A. What led you to work with WHO?

J.M. I came to Geneva in 1950 in response to an advertisement in *The Times* for an editor at WHO. I had to edit books, articles, all kinds of things and found it fascinating work from which I learned a great deal. After a year I got into a newly-formed Information section.

B.J.A. What was your background before WHO?

J.M. A mixed background in nutrition, education, languages and then, just before coming to WHO, two years as an abstractor, preparing summaries of publications from all over the world for a dairy science abstracts journal.

B.J.A. Why then Geneva?

J.M. Well, as with so many people who come to Geneva, to WHO, there was the great hope that one's work might be doing some good in the world, though certainly editing seemed rather a far cry from that ambition. I must say too that I was very keen on the international idea. Maybe historically patriotism was a useful concept in raising the level of concern for people's welfare beyond the confines of family and clan: but as communications were making the world smaller, more people were becoming interested in the welfare of other countries beyond their own. My love of languages probably pushed me in that direction too. I had tried earlier to get into the Food and Agriculture Organisation in Rome, but there were no posts available.

B.J.A. What happened next in your WHO career?

J.M. After my second year it was discovered that the information post was actually being paid out of the funds of the Mental Health Unit, as it was then called, under Dr Hargreaves. I was appointed as an assistant in that Unit which meant that instead of doing odd jobs for people in a number of sections I would be trying to help just one section with bibliographic research, writing a few articles, helping to prepare meetings. The Mental Health Unit at that time was Dr Hargreaves, a secretary, and nobody else until I joined. WHO was housed in the Palais des Nations. I found working with Dr Hargreaves personally very rewarding. He was in charge of Mental Health from 1948–1955. He had the habit of just letting people do what they wanted until he saw whether they were any good at anything, and I enjoyed that thoroughly. He was preparing a project on the hospitalisation of mental patients for an Expert Committee meeting. He asked me to collect material on the relevant legislation, which was published: very dry stuff it seems now. Much more fascinating was to help with four meetings on the Psychobiological Development of the Child, with people like Piaget, Margaret Mead and Grey Walter, who met for the first time in Geneva but continued for years afterwards to work together.

B.J.A. It sounds as if you were even by then a natural taker-on of problems, be it dairy produce, mental health legislation or child development.

J.M. I found it fun to be learning all the time I was working. Of course I made many mistakes but I get terribly bored if I have to work along just one line. I like to start off on new things.

B.J.A. Can you tell us something about Dr Hargreaves's impact on the Mental Health Unit?

J.M. He had a tremendous impact. When it came to an Expert Committee, he had a great capacity for picking brilliant people, very different in personality, who could nevertheless get on together, and then he would sit down, dictate for three hours to his secretary, and there would be the report. If you go back to the first report on Mental Health you will see in it an outline for almost everything we have ever done since.

B.J.A. When did your work first touch on alcoholism?

J.M. Well, actually, it was with Dr Hargreaves, who was very keen that some sensible things should be done about alcohol problems. He therefore employed Professor Jellinek and I was asked to work with him. Jellinek was a Consultant at WHO from 1950 to 1957 (Geneva, the Americas, and the European Office).

B.J.A. Have you any idea why with all else that WHO had to deal with Dr Hargreaves thought it was worthwhile to spend hard money on employing Jellinek?

J.M. He believed that alcoholism was tremendously widespread, very much misunderstood, and that there were possibilities of diminishing the extent of the problem. Jellinek was a memorable personality, a fascinating person, very strange, brilliant sometimes and childish at other times.

He had travelled widely. Originally he came from Czechoslovakia, I believe, and was related to Mercedes Benz. He bought large areas of forest in Brazil, hoping that one day they would make a road through it and he would become a multi-millionaire. But he died too early for that. He wrote a lot of verse, which was often highly amusing. He never appeared to be working hard but he produced a great deal. Although we pretend nowadays that speaking of the public health aspect of alcohol problems is something very new, in fact if you go back to the old reports you will find that this perspective was discussed even during Jellinek's time at WHO.

B.J.A. What was Jellinek's task at WHO?

J.M. His task was to develop international work on alcohol and alcoholism. He started by helping to organise several meetings which were reported in the Technical Report series. The first [1] dealt with general and theoretical questions, particularly the classification of alcoholism and excessive drinking. The second [2] was concerned more with the treatment and rehabilitation of alcoholics, and with statistics and epidemiological inquiries on alcoholism and alcohol consumption. Jellinek's famous summary of phases of alcoholism was reproduced here. He also ran several regional seminars which did much to raise the level of scientific interest in these topics. I helped him to search for material on the alcohol situation in many countries of the world and he prepared an inquiry that was sent to a number of experts. An unfinished book on the responses was later published by the Addiction Research Foundation. A further aspect of this work was provision of advice to governments — mostly in the European and American regions. I believe that while he was with us he was already writing his famous book 'The Disease Concept of Alcoholism'.

B.J.A. What happened to the WHO programme when Jellinek left?

J.M. There was no continuation of his work for several years because the person who replaced Dr Hargreaves was not keen on this line of development.

B.J.A. I am trying to see the shape of the story up to the point you have taken us. It looks as if Hargreaves's vision had got alcohol problems on the agenda, WHO had then done the orthodox thing and called in a consultant, got some papers written and organised some meetings. But then they just let alcoholism slip from sight?

J.M. In a sense. But the budget in WHO is terribly limited and one of WHO's objectives is to interest governments in specific problems within health programmes. You can't keep banging governments over the head with the same problem and unless they themselves show that they wish to do something about a particular topic there is not too much point in WHO continually saying 'Now what are you doing about this?' So I don't think it was necessarily a bad thing that there was a break.

B.J.A. And after the hiatus, what next?

J.M. Well, the next thing was the arrival of Dr Pieter Baan as Chief of the Mental Health Unit. During his first days he said to me 'Well, I have been told I have to make an international mental health programme — what would you do if you were in my place?' Just off the cuff I said the first thing I would do would be to try to get somebody representing mental health in each of the regions. When I first came to WHO there was only one region represented by a separate office, and that was the European Office which was based in Geneva. But after some years there was a lot of talk about decentralisation. We gradually got our six regional offices and one of them had a psychiatrist. Baan then asked me what I was particularly interested in and what I would like to work on, and I said, well, alcohol and drug problems, about which I didn't know very much but would like to learn more, mental retardation and suicide prevention. They all seemed pretty important and hadn't been tackled too much, and I thought they should receive keener governmental attention. Baan came from Holland. He was trained as a psychiatrist and as a criminologist.

B.J.A. So under the Baan regime the alcohol initiatives were able to get going again?

J.M. One of the first things we did was to meet some of the people who were active in the alcohol field. Since they were almost on our doorstep we first met Archer Tongue and people from his organisation (ICAA) — we hadn't met Eva Tongue by then. I had the great privilege of attending some of the ICAA meetings. This was an excellent way to get to know people in a number of countries and to learn something about their work. At the time it seemed to me that most of the work at this period was rather pathetic attempts at treatment of alcoholism. Just before Dr Baan arrived I also had the marvellous opportunity of going to the United States for a year to take a Masters in Public Health at Columbia University. For part of the time I joined a small group of psychiatrists studying public health and administrative aspects of psychiatric services. This involved getting to know something of the New York 'underworld', including the alcohol and drug scene. During the course we had to write a thesis and I thought, well, with some knowledge of nutrition and some knowledge of psychology of education, there weren't many subjects I could tackle, but alcoholism might be an interesting field. Then I really began to read up everything I could find on drinking problems.

B.J.A. So your interests in alcoholism were very much developing?

J.M. Yes. Dr Baan put me more or less in charge of the WHO mental health work on alcoholism and drugs under his guidance because at that time the WHO drug work was mainly to do with drugs and not with people. Baan was very keen to take into account the person who was using the drugs rather more than WHO had been doing up to then. And he agreed that I should go on with the work on suicide and mental retardation. But it was impossible at that time to concentrate too much attention on any one topic, because the mental health programme was rapidly expanding. I was involved for instance also in Dr Lebedev's work on biological psychiatry and Dr Lin's activities concerning the classification, diagnosis and epidemiology of mental disorders. I also had the exciting experience of taking part in our three travelling seminars on psychiatric services organised in the U.S.S.R. (1965, 67 and 70) where a good percentage of the participants were from the developing world. By the third seminar there was considerable exchange of experience and a start to planning improved national services.

B.J.A. What was the alcoholism world like at that time?

J.M. It was a strange world with a peculiar population, tremendously varied, ranging from highly scientifically-minded people to others who seemed quite obviously cranks even to a person pretty ignorant about the subject. There were many who wanted to treat alcoholics but at that time very little consideration was being given to possibilities of preventing alcohol problems, and little thought to alleviating the impacts on the family.

B.J.A. Would it be right to say that in the '60s a WHO 'programme' essentially meant meetings and preparing reports, at least so far as something like drinking problems was concerned?

J.M. Yes, but if you put it so baldly I think you miss the reason for having the meetings and preparing the reports. These activities were not just to inform people but also to get people together so that they could think more about what could be done in their own situation, using and adapting the experience from very many different countries. Moreover, an important meeting was considered not just as an isolated event, but as the culmination of a considerable amount of advice and preliminary activity by many people and preparations that would take more than a year to complete. An example would be the Expert Committee on Services for the Prevention and Treatment of Dependence on Alcohol and other Drugs [3]. It was fascinating to be closely involved in the planning of this meeting, held in 1965.

B.J.A. Had anyone at that time any vision of national policies, thinking at policy level?

J.M. I am sure there were such people but I didn't know much about them in the early '60s. Perhaps in Scandinavia [4] and in Canada, more at a Provincial level. This vision must have been behind some of Jellinek's work too. But in the late '60s the first steps were taken in planning WHO work on national responses to alcohol and drug problems, and this was a basis for much of the later developments on national policies. By 1968, for activities concerning alcohol and drugs I was apportioned an annual budget equivalent to a month of consultant salary. On this frail foundation I recklessly decided to organise a new kind of seminar where the participants, selected by their governments, would be expected to present carefully prepared reviews of the national situation related to alcohol and drug problems. A week would be spent in each of three host countries willing to organise field visits

and discussions on their attempts to deal with these problems. Finally, the participants would review the seminar and discuss how the experience could be adapted for use in their own countries. There would be no reading of long papers! Griffith Edwards enthusiastically joined in the planning and introduced many novel ways of sharing experiences. Thanks to the collaboration and hospitality of the host countries (Netherlands, Poland and U.K.-England) and the tremendous input of the consultants and their colleagues, it was possible to hold the seminar in 1971. Dr Cameron, Chief of the Drug Dependence Unit, joined in the organisation of the seminar. This experiment aroused such interest that a similar seminar was held in 1972 in Sweden, Yugoslavia and Switzerland. Altogether administrators and psychiatrists from 33 countries attended these meetings.

B.J.A. Was the enthusiasm generated by these seminars just allowed to die down, or was there some continuity?

J.M. There was definitely some follow-up within the 33 countries that had participated. This was perhaps helped by preparing a publication [5] on the work and requesting the participants to suggest amendments to the early drafts. In the Regional Offices, too, there were important follow-up activities, especially in the Americas and in Europe, whose mental health staff had been involved in the seminars.

B.J.A. When this decade of laying the groundwork had been achieved, in the '70s you moved into rather different activities?

J.M. Yes, I gradually began concentrating more and more on alcohol problems, though in the early '70s I had the privilege, thanks to Dr Lambo's initiative, of being able to visit a number of countries to see something of mental health services in general, particularly in the developing world, and to discuss the planning of these services with governmental authorities. Maybe people were less afraid of me as a non-expert than they might have been of a highly-qualified psychiatrist who knew a lot about his own field and was convinced that the way psychiatric services were run in his own country was the best approach. My report on travel in nine African countries was discussed in draft with the Director of the Regional Office for Africa, Dr Quenum, and used for developing the Region's mental health programmes. I suppose some of the ideas came from my public health training. The report contained suggestions on an alternative training for psychiatrists that might prepare them better to work with communities, to train less highly-qualified health workers for more effective diagnosis and care of mental illness and to organise mental health services that were more dependent on community links. The use of psychiatrists to do more than care for the individual patient seemed essential in countries where in some cases there was only one trained psychiatrist for a million or more of the population. This experience helped me to organise an Expert Committee meeting on Mental Health Services in Developing Countries, held in 1974. The running of the meeting was most ably taken over by Dr Harding, who had joined WHO a month previously. He made use of my paper 'Development of basic mental health services: an operational research proposal' to work out an excellent project on strategies for extending mental health care, carried out in several developing countries.

As I travelled around, I certainly tried to look at anything that I could discover to do with alcohol problems. I must say that in most of the developing world I didn't find too much interest in trying to deal with these issues, although some people would make sweeping statements about the enormous extent of the problem or the fact that there wasn't a problem in their country at all.

B.J.A. Did people at WHO in those days actually talk about an 'alcoholism programme'?

J.M. Well, I would say that the first long-term plan on alcohol-related problems was prepared in 1975. By that time the Mental Health Unit had grown into a Division under Dr Norman Sartorius as Director. He suggested a restructuring without separate Units (such as the recently coalesced Drug Dependence and Alcoholism Unit) but where staff members would have main responsibility for specific projects and also collaborate in others. The plan for alcohol problems was found acceptable but practically no regular budget funds were forthcoming. It was therefore most timely that the Director of NIAAA (National Institute on Alcohol Abuse and Alcoholism, U.S.A.) came to see Dr Lambo, now the Deputy Director General of WHO, and suggested that NIAAA would be happy to provide some funds for WHO to work on alcohol problems in a bigger way, if only we could put forward some suggestions for suitable work. This approach by NIAAA followed WHO's invitation to that Institute to participate in the 1971 seminar.

B.J.A. The fact that NIAAA offered money precipitated WHO into a different style of programme?

J.M. To some extent, yes. It precipitated the development

of a few important projects which we hoped might serve not exactly as models, but as a useful basis for further development.

The first NIAAA-assisted project concerned disabilities related to alcohol use, and this was partly selected by NIAAA because they considered that the findings of such a study would be useful to them in the U.S.A. Luckily we had excellent consultants who felt that the funds available and the interest of the topic could enable us to produce something which would be of use for a much larger number of countries than just one — a more suitable task for WHO. Actually a WHO Expert Committee had already in 1950 [6] pointed to the need for a commonly accepted terminology concerning dependence on alcohol and other adverse effects of drinking. Attempts to achieve this aim were continued at several Expert Committee meetings and seminars. More recently though WHO had become increasingly interested in defining and measuring disability instead of concentrating on diseases. It was argued that such an approach would help to focus attention not only on possibilities of prevention or limitation of functional incapacity, but also on the need to reduce the consequences of the disability for the individual, the family and society in general. WHO therefore gladly accepted NIAAA's offer of financial and technical assistance for a WHO project that aimed at increasing international agreement on criteria for identifying and classifying disabilities related to alcohol consumption. Between 1973 and 1975 a steering group prepared and discussed extensive reviews of the state of knowledge on these matters. All this material was synthesised by Dr Edwards and the complete documentation was submitted to a wider group of investigators from various parts of the world. This group's final report was published together with several of the working papers [7].

One result of this project was that the term 'alcohol dependence syndrome' described in the report, was accepted for the ninth revision of the ICD. Moreover this project seems to have promoted considerably increased recognition that it is not enough to focus on treatment of the person with this syndrome (the 'alcoholic'). Many other disabilities related to alcohol consumption are likely to be of greater public health significance because they are so prevalent and have such an impact on society. Actually the term 'alcohol-related disabilities' did not become very widely accepted, but the alternative term employed in the project — alcohol-related problems' — soon came into very general use. At the same time, interest was growing in the need to develop more effective ways of preventing or limiting the impact of alcohol-related problems.

B.J.A. Was WHO able to do anything further about promoting this interest?

J.M. Yes, indeed. Again, thanks to NIAAA, funds became available for two further projects, one on the prevention of alcohol-related problems and the other on community response to alcohol-related problems.

B.J.A. Were these projects carried out in the same way as the previous one?

J.M. No, but they both relied very much on the findings of the disabilities project and they both involved the collaboration of governments and of a variety of experts in the alcohol field. The experience acquired in the two seminars was also valuable here.

B.J.A. Would you describe the two projects briefly?

J.M. The projects were run simultaneously and were interrelated. For the prevention project, the first stage was to collect and review information from the literature and from responses to an inquiry. On this basis a preliminary document was drafted and sent to the Regional Offices and to experts, with a request for amendments and additions. This process was repeated in two succeeding drafts before publication [8] so that a considerable number of interested persons became involved. During a second stage, an abbreviated form of the inquiry used for the 1971–72 travelling seminars was circulated to countries, together with any information already available in WHO. Gradually a collection was made of summaries of the information for 29 countries [9] Again the process of consultation, amendment and approval was used, in the hope that governments would make use of the data collected as their own material, rather than looking upon it as yet one more document compiled by an outsider. In fact the 1982 Technical Discussions showed that this had occurred. The drafts were also discussed at several meetings in the WHO Regions.

The project on Community Response to Alcohol-Related Problems was a much more ambitious endeavour. It was carried out as a research and action project, mainly in three countries where the governments welcomed the collaboration with WHO. It aimed to develop mechanisms for exploring how communities and nations as a whole respond to alcohol problems and how more appropriate responses might be developed. Firstly, how do you find out what these problems are and how extensive they are in a specific setting? What harm do they do to the individual and the community? And, what, if anything is being done to prevent such problems or to

limit their impact? An important objective of this project was to stimulate investigators to work with both a community and the national authorities while making use of the experience of other investigators working in settings where the situation was different.

B.J.A. Why were only three countries selected to participate in this project? And what were the criteria for selection?

J.M. Partly because of the exploratory nature of the task and its complexity, it was felt that working with more than three countries in the beginning would make the project unwieldy, and there were time, funding and staffing limitations. Criteria for selection were worked out at a preliminary meeting of a 'steering group' of consultants. They agreed that, if the project findings were to be useful to a wide range of countries disturbed by alcohol problems, the selection should include one country in the developing world, one industrialised country and one undergoing very rapid social and economic changes. In all cases the government of the proposed country should be willing and eager to be involved because of an expressed need to deal more appropriately with alcohol problems. In the event, Zambia, U.K. (Scotland) and Mexico collaborated in the work and in this way three different WHO regions were also represented.

B.J.A. In your opinion, was this a valuable project?

J.M. I think it was an extremely valuable project. Firstly, it showed that the complex research attempted can be carried out in very different situations. Of course a great deal was learnt about how some of the most sophisticated methods, for instance the epidemiological surveys and the data analysis, have to be modified. Then the idea of reporting back the research findings to the national authorities as a basis for discussion and further planning was well received and seemed to be particularly successful in Mexico. Involving the communities in the actual research and follow-up action was much more difficult, except in Scotland where something similar had been undertaken before this project started – it had been hoped that this might be a good model for the other countries. However, the attempt has perhaps underlined the fact that there is much still to be learnt about how to carry out research – and action derived from it – *with* a community rather than merely *on* a community.

The fact that the governments of each of the three collaborating countries agreed to host a final meeting to discuss the results of the project and to invite representatives of neighbouring countries, did much, I feel, to extend the impact of the project. Investigators in additional countries have used some of the research instruments devised for the project to carry out parts of the work and others may be assisted by the publications prepared [10, 11, 12].

B.J.A. So far as alcohol problems are concerned, does the world need WHO, could it get by if WHO pulled out from this area tomorrow?

J.M. Some countries might get on with these things if WHO pulled out. But I certainly have held very strong views that some kind of central agitation and central co-ordination of efforts, together with the establishment of a forum so that people can learn from each other, can have excellent results. It's difficult though – you can't set up a controlled experiment on that sort of issue.

B.J.A. Over these many years you have seen things develop. Do you have any feelings that governments are now really taking drinking problems any more seriously?

J.M. I think there has been a groundswell of change, and one of the reasons may have been that WHO did try to get people from many countries to collect information on what was happening in their own country and put it down in black and white and compare it with what other people were doing. I think this may have helped, but one can't be sure that any impetus will be carried through to action.

B.J.A. Can you give any examples of nations which are taking drinking problems more seriously?

J.M. Just at random I would mention Papua New Guinea – it does seem that the efforts of WHO and other people who have gone there have aroused the concern of the government. I'm not sure how far the recent work in France has been pushed a little further forward by WHO's programme. In Australia and New Zealand it looks as though the WHO efforts may have strengthened the hand of those who felt that the governments should take alcohol problems more seriously. In Mexico and in Zambia the results of the community response project were certainly taken very seriously by the governments. But I have been disappointed by the efforts in Africa in a way: I had hoped that what we had been trying to do there would have greater repercussions, though I suppose that in Africa the whole sweep of health problems is so huge that while you are dying of malnutrition you can't think too

much about alcohol problems — even though they may be linked. However, the WHO efforts there are continuing, partly in connection with a long-term project on the development of mental health programmes.

B.J.A. How does one turn nations towards more serious interest? What are the strategems?

J.M. As I've said, I think one of the first things that has to be done is to get the government and its representatives involved with finding out what exactly is happening in the country itself. It is so easy for a country to say it has no alcohol problems or that it has vast alcohol problems. For instance, when I was in several West African countries I tried, in a naive way, to find people who would go with me to the Customs or to other relevant places and often they discovered for themselves something about the problem. I remember in Dakar someone phoning a colleague of his in Customs and to his astonishment he discovered how much alcohol was being imported and exported, and he realised that trade in alcohol was very much a part of the problem. And he said 'I can phone up somebody else who knows a lot about another aspect of the alcohol situation — the influence of growing Islamic faith in our country.' And this informant went on to say that there are certain tribes that never drink and other tribes, also Moslem, which still drink and sometimes drink very heavily. He said 'I have noticed the big change in young people — they are going to drink whatever happens, and they are drinking more and more, and I wonder how much this is to do with the increasing amount of alcohol available.' A little probing opens up these questions, these self-awarenesses, and that's perhaps a basic strategem for change.

B.J.A. Is it legitimate to try to persuade a nation which is wondering whether it can achieve economic solvency to tackle drinking problems, or is one just going to be laughed at if one says that somewhere early in the foundation of your State and your new economy you should take alcohol problems seriously?

J.M. If a country has got to the stage where it has developed a Health Ministry and a Ministry of Economics or whatever these Departments may be called, then they must have some mechanism for developing health programmes and economic programmes, and I think it is within these programmes that alcohol and alcohol problems should be taken on board. When funds became available in WHO to organise an Expert Committee Meeting on Problems Relating to Alcohol Consumption [13] I ensured that these questions came on the agenda. Under the chairmanship of Professor Kendell, the Committee made strong recommendations that governments should develop a national alcohol policy and should implement programmes for preventing and managing alcohol problems within a framework of general health and national development. During the meeting Committee members emphasised that in some areas undergoing rapid social and economic changes there is a particular danger of great increases in the availability of alcohol and consequently in the extent of alcohol problems. It was felt that these matters should receive urgent consideration by the national authorities concerned. Certainly when we had the Technical Discussions at the 1982 World Health Assembly there appeared to be tremendous interest in ensuring that alcohol problems were included for consideration in international health and development programmes.

B.J.A. Do you think that within the developing world, at a political level, there is any real likelihood of drinking problems being taken seriously?

J.M. Judging by the kinds of things that representatives of developing countries said during the Technical Discussions I believe that there are great possibilities of the topic being taken very seriously. But whether that concern will remain at a theoretical level or will be put into action is difficult to predict. One doesn't have to go to developing countries to see the conflict between the need to take action and the fact that by the sale of alcohol governments have a tremendous source of revenue. Here I wouldn't distinguish very much between developing and developed countries.

B.J.A. You have mentioned the Technical Discussions several times. Could you explain what these are?

J.M. Yes, these discussions have become part of the annual World Health Assembly, which brings together representatives of all the WHO Member States to advise on the WHO programme and budget. Each year a specific technical topic is selected by these representatives for concentrated discussion two or more years later at a special session lasting 1½ days. The topic 'Alcohol Consumption and Alcohol Problems' was selected in 1979 and the discussions were held in May, 1982. In order to sharpen the focus on action, it was decided to concentrate on the development of national alcohol policies and programmes.

I was asked to prepare for and organise these discussions and was able to use the occasion to draw together many of the threads of experience accumulated

over the years. The Member States were approached officially about a year beforehand and requested to comment on a brief background statement and inquiry and preliminary discussions were held in several of the Regional Offices, in some cases using information collected in previous WHO projects. Delegates from more than 100 countries, together with representatives of international organisations, participated in the Technical Discussions. The participants divided into six groups for very lively debate on why national alcohol policies are needed and what strategies might be adapted for use in different socio-cultural and economic situations. These alternatives were looked at in a context of national strategies for health. A review [14] based on these discussions has been prepared. It contains summaries of the responses from 57 countries on their situation concerning alcohol problems and policies for dealing with them.

B.J.A. What is your sense of balance as to how driving and messianic one should be in dealing with a social problem like excessive drinking, as opposed to going slowly?

J.M. The messianic approach might do more harm than good, but trying to get people to look at what the problems really are and decide themselves whether they need to do anything about it is urgent. I don't think any nation is going to learn too much from guidelines based on knowledge of one particular country, but if the guidelines include some practical suggestions on how you start looking at your own national problem I would think that is where WHO might press.

B.J.A. Do you think that within WHO the proper place for an alcohol problems programme is Mental Health, or would you put alcohol elsewhere?

J.M. No, I don't think it should necessarily be within Mental Health. Maybe it would be wiser for it to have a separate identity and many more links with many other parts of WHO. But the complication there again is partly budgetary, because there would have to be a personnel structure which would enable such a programme to be pushed through the various channels, and you can't have such a top heavy complicated structure for every topic with which WHO is dealing. Personally, I always thought that drinking problems should come into Family Health, but then again it depends very much on the staff and structure of the particular Division.

B.J.A. Have you any strong views as to the extent to which drug and alcohol programmes should be combined within WHO?

J.M. My views have vacillated. Again, it's partly a question of the people who are running the programmes. What I have learnt from our experts has certainly persuaded me that there are many matters in common between alcohol and drug problems. There should at the least be a very close link between the two programmes. But there is already a vast store of experience in the alcohol field that is not necessarily all directly relevant to other drug problems. Unless WHO has at least one person knowledgable about the alcohol literature, about ongoing programmes, and about the wide variety of specialists in the field, the impetus of the international efforts so far is likely to die away, at a time when many of the problems are increasing.

B.J.A. If you were today telling a young person with a bibliographic background who had just arrived in Geneva regarding the distillate of those things you had learnt about international work and which don't go into reports, what would you say?

J.M. I think my experience has taught me that one has to be exceedingly open to learn all the time. One has to listen to people. It is also very necessary to try to see the particular topic one is working on within the perspective of a wide range of other problems. I have learnt too that the more one travels the more one sees differences in people's backgrounds, ways of speaking, hospitality, but also more and more the similiarities. You don't have to go to meet the highly placed people in far off countries with any fear but rather with humour and humility. I must admit that I myself have not always shown too much humility in headquarters but this was partly because I was very much concerned that programmes I was dealing with should find a place on the agenda of WHO. But in travelling around the world I have felt immediately at home whatever the scenery or whatever kind of people I have met. I was fascinated to realise that it was rather easy to talk to people. It's difficult for a young person who is travelling for the first time on WHO business to get this feeling that people everywhere are similar to oneself, that we are all going to make our mistakes, that we are not going to put all our eggs in one basket, that we are not just going to follow the dictates of a group of experts, but that on the other hand, interest in what people are trying to do can often lead them to do something a little more successfully.

B.J.A. What makes for success or for failure in international work? Are there any general principles as to

why some ideas become dusty reports while other efforts in small ways become effective?

J.M. Unless you are really going to involve people from the very beginning in any project, they are not going to take much interest in the outcome. All the time it's a matter of working with people, trial and error, and then you may get some success. Moreover, I don't know where you put the dividing line between success and failure. I think it's often a matter of a pendulum.

B.J.A. Was it unusual when you started at WHO to find a woman on this sort of international stage?

J.M. I don't think I have really noticed that as a problem. I have never been a feminist. I just consider that women have a lot to offer and men have a lot to offer. Certainly I remember several outstanding women in WHO in those early days and the Organisation has constantly tried to increase the percentage of women in senior posts.

B.J.A. Looking back on all these years of experience in Geneva, did you take the right job? Are you glad that you answered that advertisement in *The Times*?

J.M. I personally feel it has been a tremendous privilege to have worked in WHO. The experience has been fascinating, exciting, demanding and most rewarding. But I think the question ought to be put differently: Did WHO take the right person? Of course, I was not recruited initially by WHO to deal with alcoholism, but by the time I left there was pressure from many quarters for WHO to establish a long-term post specifically concerned with alcohol problems. I was happy to see that at least a first step had been taken and a two-year position created, with a competent person to run what has gradually become a programme on alcohol-related problems.

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