The new Committee (2008-2010) sends you its best wishes for 2009
The recent Annual Reception was also the celebration of 60 years of WHO. All planning and events were arranged by Roger Fontana to whom we owe a deep gratitude. He single-handedly contacted and brought various artists together and arranged for the seating and the buffet. About 250 people attended the reception.

The celebration was scheduled for 5 pm and by 5.15 pm the attendees and the invitees were seated in the veranda of the cafeteria. It started with an address by Jo Asvall, previously Regional Director of EURO. He talked about the advent of Primary Health Care in 1978 in Alma-Ata (currently Almaty) and the role of WHO in spreading the “gospel” around the world. Although no one from the DG’s office could be present, we were fortunate in having the presence of Halfdan Mahler, our charismatic DG during one of the most exciting periods of WHO. Dr Asvall’s address was followed by a song by a group of five young interns in WHO and then a violin recital accompanied on the piano. This was followed by a group of gifted Swiss bagpipe players – all outfitted in kilts. They continued to perform even during and after people had served themselves.

One of the significant outcomes of retirement is the blurring of distinctions and hierarchy of staff as they all become equal. Many of the previously highly ranked staff, as well as the honorary Presidents of the Association, mingled with all others and there was general flow of conversation among all. The food was excellent and plentiful and the birthday cake was a masterpiece of the baker. We also owe our thanks to the caterer who did a marvellous job. All in all it was a significant success and people were seen to leave reluctantly.
**EDITORIAL**

This year, on the occasion of the 60th anniversary of the World Health Organization, our annual reception had a special air about it. As an introduction to the main proceedings, a speech was made by Dr Jo Asvall, followed by a musical interval.

The end of this year has also seen the holding of elections and the newly elected Committee taking up its duties for the next two years. Various functions have already been attributed to members who have begun work (see page 4). Our new President is Dev Ray and his message appears on page 5. Next year will be that of the General Assembly.

The Joint meeting of the Surveillance Committees of the Health Insurance was held from 6-10 October (see page 6 for a brief report). A working group is to meet during 2009 to review the entire insurance scheme. We will, of course, keep you informed.

Vaccination against influenza was again carried out free of charge at WHO/HQ for retired staff residing in and around Geneva. This is the fourth consecutive year that this has taken place (see page 7).

Contrary to what was announced in QNT No. 73, our publication will continue to be printed at no cost to AFSM. We are, of course, very relieved and grateful to the Administration.

However, we are maintaining the decision to distribute the QNT only to life members and those members who are up-to-date with their annual subscription in order to reduce costs. We strongly encourage, therefore, those of you who have not yet paid their dues to quickly do so.

Many thanks.
AOMS : New Committee 2008 -2010

The results of the election of the New Committee held on 21 October 2008 were as follows:
Number of envelopes received: 443; Invalid ballots 26; Valid ballots 417
David Cohen: 352 votes; Yves Beigbeder: 322 ; Marjory Dam :318 ; Roger Fontana : 313;
Dev Ray: 306; Jean-Paul Menu: 298; Carole Modis: 286;
Samy Kossovsky: 285; Averil Foster: 277; Roberto Masironi: 254;
Jean-Jacques Guilbert: 253; Bunty Muller: 234; Stanislaw Orzeszyna : 222 ;
Anne Yamada-Vetsch : 191 ; Pamela Hindle : 131.

Roger Fontana, nominated Honorary President, resigned; Stanislaw Orzeszyna was elected; Anne Yamada and Pamela Hindle were coopted.
The four honorary presidents (Alain Vessereau, Stanislas Flache, Rajindar Pal and Roger Fontana) participate in the Committee meetings, without the right to vote.

Responsibilities list:

President : Dev Ray  
Vice-presidents Carole Modis, Roberto Masironi  
Treasurer : Jean-Paul Menu ; Vice-treasurer : Anne Yamada

Main activities and responsible members  
(as of January 2009)

Health insurance representatives: David Cohen, Marjory Dam
Pensions committee representatives: Marjory Dam, Bunty Muller
Representatives to AAFI/AFICS: Dev Ray, Stan Flache, Roger Fontana
Relations with Geneva state and city: Stan Flache, Roger Fontana
Relations with the Regions: Samy Kossovsky
Relations with the WHO Staff Association: Dev Ray, Roger Fontana
Relations with the WHO Staff Counsellor: Jean-Jacques Guilbert, Carole Modis
Informatics and website: Carole Modis, Anne Yamada
Administration of the AFSM members' database: Anne Yamada
QNT Newsletter: Editor David Cohen

QNT Editorial board: Yves Beigbeder, Averil Foster, Jean-Jacques Guilbert,
Samy Kossovsky, Jean-Paul Menu, Carole Modis, Dev Ray, Rosemary Villars (ex- Executive Committee member )

Oral History: Carole Modis
Remembering the Past: Jean-Jacques Guilbert
Social and cultural activities: Samy Kossovsky
Legal questions and statutes: Yves Beigbeder
Travels: David Cohen

Permanencies:
See on page 8
In November 2008, it was time to change the Chairperson of the Association of Former WHO Staff Members (AFSM).

According to the Statutes, an incumbent can continue in the same office for a maximum of two consecutive terms and hence Roger Fontana had to step down. A victim was duly found and thus I am in his place. However, it is an uneven succession since Roger devoted almost all his waking time to the Association – he was here nearly every day from 9am to 3 pm and pursued various other related activities at other times. Unfortunately, my commitment will be much less for which I apologize in advance.

Although AFSM has done remarkably well in defending the interests of former staff through its efforts to improve Staff Health Insurance and maintain Pension benefits - it has limited weight in the matter - it has not been so successful in “strengthening links with WHO as an institution”. When I was “forcibly” retired at the age of 60, I was ready to continue and hoped that some of my own “perceived skills” would continue to be used by WHO. As time went on, I realized that a distance develops fairly quickly between the Organization as an institution and former staff until one faces the fact that perhaps our “perceived skills” are not that much in demand except for some in Administration called in to step in for certain tasks that must be done.

Retirement can be seen as a separation – and one has to get used to it. We tried to elicit the views of retirees as to how they would like to be involved in the work of the Organization but we got very few responses to a questionnaire we circulated a few years ago. Maybe apathy sets in or we feel somewhat cut off from the mainstream and after some time cease to follow the programmes of the WHO. But some aspects have been resuscitated though two projects - Oral History project, personal interviews, and Remembering the Past, e-mail interviews, of retired staff regarding their years at WHO.

The second aspect is to bring people together socially. The annual receptions are big successes and it is heart warming to see our ever dwindling old friends and many new ones. But again, the questionnaire did not obtain much response to the need to get together more frequently perhaps for lunches or coffees. Rosemary Bell ran a monthly coffee morning for many years but attendance gradually dwindled. Many of the retirees are well integrated in the communities in which they live – while many others are probably often left alone. As one gets older, physical connections with our countries of origin also weaken.

We shall again try again to see if we can promote some social activities to bring people together – if they want to. Is it needed – we do not know. AFSM has been built up by many and will continue to provide a focus where retirees can meet occasionally or provide a forum for exchange of views.
Health Insurance: what is new?

As you were previously informed, the Headquarters and Regional Surveillance Committees of the Staff Health Insurance jointly met in Geneva from 6-10 October.

This joint meeting – the seventh – discussed many subjects, but particularly contributions and benefits. All problems were touched upon.

The main decisions were:

1. 10 per cent increase in contributions, from 1.5 to 1.65 per cent from 1 January 2009. Then 2 per cent in 2010 and 2011. An actuarial study will thereafter be undertaken (once every three years).

2. Various adjustments in benefits:
   - Long-term care – maximum increased from USD 80 to USD 100 a day.
   - Psychotherapy – increased from USD 6 000 to USD 10 000 over a period of five years.
   - Glasses and contact lenses – maximum USD 250 per year, with the possibility of drawing upon the unused benefit of the previous two years.
   - Hearing aids – increased from USD 1 500 to USD 1 800.

3. To convene a working group to revise the entire Staff Health Insurance Scheme. Subjects for discussion will be:
   - long-term care: to establish a general policy
   - representation of regional retirees
   - and numerous other subjects covering administration, finance, etc.

D.C.

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Pensions

With the recent meltdown of the world’s banking system, and looming recession, many retirees are justifiably worried about our pensions. However, the UN Pension Fund is in a somewhat favourable position due to the following facts:

1. UN pensions are benefit based and not contribution based – i.e. the amount of pension depends on the last years of pay (or pensionable remuneration) and service and not on how much contribution one made. Thus, the amount of pension will not fluctuate (except for some exchange rate problems).

2. The total contributions received from serving staff is almost equal to the total benefits paid to retirees (around 1.65 billion USD annually) – thus the cashflow does not yet depend on the market or need not be derived from dividends and interests.

3. The assets of the Fund have periodically gone up and down but have yielded an average of 4.4% annually (which is very good) net of inflation as contrasted to 3.5% yield assumed in actuarial valuation (which is a comparison of the income from assets and contributions with the total future liabilities).

4. The assets of the Fund are diversified – 56% in equities, 33% in bonds, 5% in real estate and 6% in short term investments or cash. Geographically, 38% of the assets are invested in North America, 33% in Europe and 38% in rest of the world. Such a diversification makes the Fund less subject to volatility in the market.

5. The governance structure requires a periodic actuarial valuation and an Investment Committee consisting of eminent financial experts from around the world to advise on investments. The last actuarial valuation in Dec 2007 showed a surplus of 0.49% (i.e. a reduction of 0.49% in contribution would not affect the future liabilities of the Fund).

6. Even then, the assets of the Fund have had a dramatic fall from a high of 42 billion USD in June 2008 to 28 billion USD in October. One, however, expects that the value will go back up within two years or so.

7. Thus, there is no cause for alarm but the situation needs to continue to be monitored. (See also CEO’s letter on the website www.unjspf.org)
Health

Road Safety: blind spot (Mariotte)

In the 17th century, while dissecting a human eye, the French physician Edme Mariotte discovered a blind spot in the retina where the optic nerve is attached to the ocular globe. He suspected that as there were no photo receptive cells, light did not stimulate that area and that, as a result each eye possessed a blind spot, a small area of the field of vision where it is blind. He demonstrated this with the following:

Close your left eye and look at the cross, just the cross, and approach to about 30 cm. You will no longer see the round dot. If you can still see it move nearer or further away and there will be a place where you can no longer see it.

Similarly, close the right eye and focus on the round dot and only the dot, approach to about 30 cm and at a certain spot you will no longer see the cross... If you can still see it, try moving closer or further away.

Thus, when both eyes look in the same direction there is no problem, because the two blind spots are not superimposed one on the other. What you cannot see with one eye, you can see with the other. However, when only one eye is looking in a certain direction, in the countryside for instance, it can miss something.

Danger on the road

The most common example is an accident at a crossroad. The conductor is waiting at a stop, ready to drive off. At that moment he is hit by a car he has not seen. This is because the driver did not really turn his head and look with both eyes on both sides. If a vehicle is in the blind spot, the brain fills the blind spot with a piece of road or countryside. Two-wheel vehicles and pedestrians are the most frequent victims of this type of accident. But the risk inherent in the blind spot can also apply to larger vehicles like cars or lorries. To avoid the danger is simple. Turn your head when you look so that both eyes see and, preferably, do it more than once!

For the diagram: cornea, retina, vitreous, optic nerve, pupil, macular, crystalline, sclerotic (white of the eye) choroid

Source: dictionnaire.doctissimo.fr/definition-tache-aveugle.htm

NB: Don’t forget anyway to consult your ophthalmologist once a year!

A computer for older persons?

An idea of the Japanese electronics giant Fujitsu: to offer seniors a laptop easy to use. For example, for better identification, keyboard most used keys are of different colours. On the other hand, to be more visible, the characters are bigger than the usual traditional alphanumeric ones. A button "assistance" facilitates the use of the computer and brings up tutorials for learning. Finally, following the manufacturer’s studies, a menu offers direct access to the applications most used by seniors (e-mail, surfing the net, etc.).
Health

A vaccine against malaria soon?

This is the encouraging conclusion that can be drawn from an article published on the website of the New England Journal of Medicine on Monday 8 December.

This experimental vaccine (RTS.S), developed by the firm GlaxoSmithKline (GSK), has been tested in three studies carried out in Kenya and Tanzania on 894 children aged from one to 4 years, then on children from 5 to 17 months, in association with a more immunogenic adjuvant (AS01E).

Developed in Belgium at the end of the 1980s, this vaccine was first tested on volunteer American soldiers in the context of collaboration with the Walter Reed Research Institute. A first study conducted in Mozambique had enabled its efficacy to be evaluated on new born babies directly exposed to the risk of malaria. The results confirmed that the vaccine met all the conditions that would allow it to be used in the field. The main study was undertaken in Tanzania on 340 babies under 12 months of age. The RTS.S/AS02 was given jointly with paediatric vaccines recommended by WHO. The study showed 65% effectiveness against malaria in newborns followed for a period of six months.

Similar results having been observed in Kenya, a Phase III study, indispensable before the vaccine can be marketed, will be launched in 2009. This work is carried out in the framework of a partnership established in 2001 between GSK and « the initiative for a vaccine against malaria » developed thanks to an initial grant from the Foundation Bill and Melinda Gates.

Dr David Cohen

Vaccination against Influenza

It has now become a tradition – every October in Geneva – retirees of WHO and their spouses can be vaccinated free of charge against influenza. Vaccination this year took place on 13 and 20 October, morning and afternoon.

More people were vaccinated than previously – no less than 251 – conscious of the necessity to be protected against this illness which can be serious and even fatal if pulmonary complications occur, particularly in the elderly and children. It is also a social occasion for former staff to meet and chat over a coffee.

Our grateful thanks go to the medical service, particularly to the nursing staff, who undertook the vaccinations in addition to their normal duties.

DC

Permanencies in Office 4141: every Tuesday and Wednesday from 9:30 to 12:30; other days, answering machine
Interns at WHO: meeting with Dr Chan

2008, Geneva — Every year hundreds of young people come from all over the world to spend weeks or months working as interns at WHO. For them, it is an opportunity "to be at the centre of global public health issues", to learn from the experts, and to be able to take their knowledge back and apply it in their own countries.

Director-General Dr Margaret Chan recently met with a group of interns to talk about the "WHO experience" and to answer their questions. They discussed the current economic crisis and how this is affecting funds for health; the role of women in health and leadership positions; the way in which people see the world and how many of the problems in the world are related to health. She stressed the importance of having an open mind, of always being respectful to diverse cultures, how important it is to be passionate about work and life, but also to be patient, and to wait to say things at the right moment.

Our Committee has helped on several occasions these interns, young men and women, who spend some time at WHO finishing their studies, to find accommodation, sort out administrative details and to get settled in Geneva.

We wish them all a successful stay at WHO.

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Corrigendum

In the article titled “Remembering the past” (QNT 73, page 11), an error was made in Anne Yamada’s e-mail address: you should read anne.yamada@gmail.com, and not annyamada@gmail.com as written by error.

We strongly apologise.
International Day for older persons and developing countries


It's certainly a nice idea. Trouble is, I'm not sure the 100 million older people living on less than $1 a day feel particularly recognised right now. As they struggle to survive in the face of discrimination, marginalisation and a lack of economic and physical security, they probably feel pretty invisible.

Unfortunately, this is reflected in current international development policy. Initiatives such as the Millennium Development Goals focus largely on women and children, while global responses to HIV and AIDS target younger generations.

Older people are nowhere to be seen. Until this changes, the situation of older people living in poverty will continue to deteriorate.

The irony is that older people are the missing link in development. They are the backbone of society in many developing countries and play a vital role in supporting families and communities.

It's older people who facilitate the economic growth fuelled by migration of younger generations to urban areas - staying behind to look after homes and children. It's older people, caring for the sick and the orphaned, who are at the frontline of the battle against HIV and AIDS. And it's older people who, without access to pensions, work long into old age to feed extended families.

Imagine what could be achieved then, if older people were not only recognised in international development policy but actively supported, if they were seen as a resource, rather than a burden on society.

Let's take poverty reduction. Around one in 12 people in developing countries is over the age of 60. Can any poverty reduction strategy be truly effective without including this significant proportion of the population? Access to social security is absolutely vital to lifting older people out of poverty.

Social pensions, where they exist in developing countries, have proved extremely successful in this regard, with the benefits going beyond older people themselves. For those supporting extended families, particularly orphans of AIDS, a pension provides financial resources which can help ensure healthcare and an education for the next generation.

Pensions can also help to mitigate the impact of sudden shocks like rising food prices, and stimulate local economies.

Targeting older people with income generation activities has a similar effect. Most older people want to work, to retain independence, dignity and security in old age. Yet all too often they are sidelined in income-generating projects, written-off as a risky investment.

Where older people have been given access to these initiatives, their business skill quickly becomes clear; they invest the money in farming or a business to create long-term income security.

And what about HIV and AIDS? Currently, several of the indicators used by UNAIDS to monitor the impact of the pandemic don't even include people over the age of 50. This fails to recognise older people both as a group at risk of infection (yes, the over-50s do have sex!) and their invaluable role as carers.

As a result, the agency which is leading countries in their response to HIV and AIDS has no data on how it is affecting older people. Without this, older people are excluded in policy and programming responses, and the overall strategy remains flawed.

So, including older people in development policy is crucial if there is to be real progress on some of the world's biggest issues. This isn't just common sense though, it's essential if we are to effectively prepare for what, after climate change, is the next big challenge of our times.

The world's population is ageing fast. By 2050, one in five people will be over the age of 60, with the fastest growth in developing countries. Unless the international community starts supporting older people now, we'll be unable to harness their massive social and economic potential for the future.

According to the U.N., this is a day when age should be celebrated, when older people's contribution to society should be recognised and applauded.
1 December—UN AIDS Day: A reflection

Twenty years ago in the offices of the World Health Organization in Geneva, there was a dawning realisation that a new pandemic was about to be unleashed.

Earlier years had seen the eradication of smallpox – one of the greatest scourges of mankind, TB was treatable, polio immunisation was proving successful, mosquito control programmes had reduced malaria infections, “Health For All By The Year 2000” had been the rallying cry from the Alma Ata Conference in 1978. Surely, we were seriously getting to grips with one of those Horsemen of the Apocalypse?

But in the US there were growing reports of “mystery illnesses” and increases in rare diseases and opportunistic infections such as Kaposi’s Sarcoma and PCP (pneumocystis carinii pneumonia) that seemed to target immunocompromised homosexual men: the so-called Gay Related immune deficiency (GRID).

By the mid 80s came reports from Africa of a wasting disease (Slim) amongst promiscuous heterosexuals, and PCP infections in needle sharing heterosexual drug users were reported in the West. It seemed that there was a new virus threatening the world, and that its management, control and eradication, and the treatment of the resulting disease, was not just a medico-scientific problem but a social and political one as well. Look through the news headlines on AIDS in the 1980s and what do you find? -Homophobia, conspiracy theories, biological warfare fears, racial and religious bigotry. Governments and societies were in denial: “There is no AIDS in our country because we do not have homosexuality ...” “Prostitution is illegal here so there are no sex workers...” “People here do not inject drugs...”

HIV positive people were discriminated against in schools, bars, shops and even hospitals, some governments wanted travel restrictions introduced, there was panic in insurance companies, commercial organisations, airlines.

The WHO Global Programme on AIDS was established in 1987 to coordinate efforts to survey and monitor the disease, provide a platform for informed scientific debate on viral research and treatment, and to provide a consensus approach to the public health information and education programmes which would revolutionize attitudes not so much towards sexually transmitted disease as toward sexual mores, not just towards intravenous drug abuse but the social context of drug use, not towards prostitution but the hypocrisy which society adopts to it and the utter social exclusion of sex workers. As the Programme’s documentation officer, I was one of the initial team members privi-

UNAIDS is now the programme responsible for coordinating the efforts and resources of UN agencies, reflecting in many ways Dr Mann’s initial response to the epidemic: that this is more than a health issue, it is about the whole of humanity; and tackling it requires just that – humanity.

Peter Hoare, now at Intute health and life science website www.intute.ac.uk
Because “good health is a fundamental resource for social and economic development,” as well as an inalienable right, Partnerships in Health is dedicated to building critical health knowledge and skills through health education and training of the primary care providers. In partnership with the countries of South East Europe and Central Asia, FPH assists local institutions to build their capacity and achieve sustainable improvements in the quality of basic and essential health services.

Our strategy is to work with local partners in the design, implementation, and institutionalization of programmes that support and are tailored to national and local health reform efforts and improve health promotion, prevention and clinical care in a sustainable manner. Our ultimate goal is to build local capabilities of institutions and individuals -- including those managed by and serving the more vulnerable groups -- to achieve better control over their health and a better quality of life.

Current FPH Programmes include

- regional HIV and AIDS prevention programme
- a reproductive health programme for adolescents and care.
- prevention

and a multi-disciplinary programme for diabetes

An invitation to join us—given our limited technical and financial resources, we can offer professionals with health and social sciences background great opportunities to become involved in sustainable health development activities. We are also seeking individuals who can assist us with fund-raising, marketing, website maintenance, and administrative tasks. We are located in the village of Céligny, with train and bus connections to Geneva, Nyon or Lausanne and ample parking.

Foundation PH Suisse – Partnerships in Health (FPH) is registered under Swiss Foundation law and is managed by a Swiss volunteer Board of Directors. The organization operates a small head office in the canton of Geneva, with technical and administrative staff. Additional technical and administrative and programme staff are located in five field offices in Albania, Bosnia and Herzegovina, Kosovo, the Kyrgyz Republic and Serbia, with a network of affiliated consultants in the Western Balkans, Central Asia, and other parts of the world.

For more information, look at our websites: www.partnershipsinhealth.ch and www.balkans-fight-hiv.org and contact Bettina Schwethelm at bsch@partnershipsinhealth.ch or the FPH office at contact@partnershipsinhealth.ch or 022 776 7887.

Porto, the Douro Valley and Salamanca, 7 nights

OPORTO-REGUA - VEGA DE TERON- FERRADOSA - PINHAO

Day 1: OPORTO. Welcome aboard river cruiser from 17h. Settling in and introduction to the crew followed by welcome drinks served in the lounge (according to the arrival of the different groups, welcome drinks and introduction to the crew might have to be postponed to day 3) then dinner on board, followed by an optional panoramic tour of Oporto by night.

Day 2: OPORTO (optional excursion to Braga). Buffet breakfast on board followed by optional excursion of Oporto with optional guided visit. Oporto is one of the oldest towns of Europe. Its centre classed as UNESCO World Heritage Site with its old quarters still intact, a maze of steep winding streets, arcades, and magnificent churches. But Oporto is, above all, all about Port wine. Amongst vineyards lost to sight along the Douro river, we visit Vila Nova de Gaia renowned for its famous Port wine. Lunch on board. Afternoon free or possibility of transfer by “rabello” to the town centre. Free time, leave for a visit of Oporto, magnificently situated at the mouth of the Douro, it climbs in steps on the river. Diner on board followed by a “Fado” evening.

Day 3: OPORTO – REGUA. Buffet breakfast on board. Free morning or optional excursion to Braga, known as “Portuguese Rome” thanks to its religious architecture of great quality. Return to ship for diner and enjoy the spectacular views from the water down to Regua. We go through the locks of Crestuma and Carrapatelo, the highest in Europe at 36 metres. Arrival at Regua about 20 h. Dinner on board followed by dancing or night excursion (individual) to Regua.

Day 4: REGUA – BARCA D’ALVA. Buffet breakfast on board and leave for optional excursion to Villa Real with its very varied religious architecture. Visit Manor de Solar de Mateus and walk around its gardens before rejoining the ship in Pinhão for lunch. Cruise continues through the steep, terraced, celebrated vineyards of Oporto planted to a height of 700 metres which then plunge into the river. We continue through the locks of Valeira and Pocinho and arrive at Barca d’Alva during the evening. Dinner is followed by a show with Flamenco dancers.


Day 6: VEGA DE TERON – FERRADOSA – PINHÃO. Early start and buffet breakfast on board. Return back through the locks at Pocinho and Valeira. Morning sail. Lunch. Arrive at Ferradosa at 14 h. Leave for optional excursion of the “wines of Porto” through the vineyards, stopping at a lookout in the heart of the vineyards followed by a wine tasting of Porto in a “Quinta”. Return on board at Pinhão at about 18 h. Free time to discover the old railway station with its magnificent “azulejos”. Dinner and gala evening on board.


Day 8: OPORTO. Buffet breakfast on board. Disembark. First flight return from Porto airport to your destination, after a week of Portuguese enchantment, the heart and eyes full of beautiful souvenirs. End of cruise.

Highlights: Discover Oporto, a city between vineyards and sea; Braga, the “Portuguese Rome”, Vila Real and the gardens of Solar de Mateus; Salamanca, dazzlingly beautiful; the vineyard road of Porto; Lamego, Episcopal city; Fado, Flamenco and folklore evening on board.

Included: Cruise with full board from dinner first evening to breakfast last day, accommodation in air conditioned double cabins with private facilities, entertainment, hostess assistance on board, welcome drink, gala, Flamenco, Fado and folklore evening on board and port taxes.

Not included: Drinks, insurance, flight, optional excursions (to be reserved and paid for on board or at the agency), transfers airport/port/airport, personal expenses.

Association des Anciens de l’OMS Page 13
Trip to Portugal (Contd)

Prices 2009:
Maximum price for less than 20 persons (we ought to be more than 20, so prices should be inferior):

Enrolment form

I am interested:

Name          First name
Number of persons
Address
Tél:
E-mail
Date, signature

Please reply by e-mail or by post; avoid the telephone.

New members

We have pleasure in welcoming to the large AFSM family the following new members and we congratulate them on their decision.

Life members:
Ms Anne ALLEMAND; Dr Pie MASUMBUKO; Mr J. V. PERUMAL;
Ms Lynn SELLARO.

Annual members:
Pr Oumou Younoussa BAH-SOW; Mr. John WICKETT; Ms Annette CHANEL;
Dr Muhammad D.Z.A. KHAN; Ms NALLET.
It is a "text book" that should become a must for all categories of students (and former students) around the world. It is indeed a must for all citizens of the world with a conscience.

The author is a strong spokesman for human rights and solidarity. His 30 years of field experience of pervasive violence in the “world of the defenceless” is the basis for an impressive and rather terrifying description of children abuse and neglect, inhuman and degrading treatment.

It is an archaeological search in the depth of human evil behaviour leaving the reader with many disturbing questions about the avalanche of domestic and community violence an expression of force in a situation of inequality. It hurts to read that “Parents are the main group of perpetrators not only in poor families but also in affluent ones”.

The book is carefully researched via an extensive study of published scientific literature and combines history, science, statistics and personal observations with focus on children.

Supportive data shows that violence is extremely common in all cultures, societies, economic, social and religious strata.

- Three billion people are the traumatized victims of childhood sexual, physical, psychological forms of abuse.
- Over one billion as a consequence become disabled or meet a premature death.
- 5-10 million children (less than 5 years old), mainly girls, die annually because of intentional neglect or outright murder.
- 10 million abandoned children are in, often dilapidated, residential institutions.

After such a monstrous diagnosis the author is still able to say “Yet there should be hope”.

The aim is “Helping people, who have nothing to eat or who are afraid of being beaten up, in their struggle to get out of poverty instead of a globalization of power in the hands of the few and rich”.

It implies “To fight against corruption, cover-ups or inaction inside the judicial system, against the uncaring public attitude, against the non-compliance by Governments with their Human Rights obligations where many perpetrators escape justice” and to “Open the media to the realities they are now hiding”.

The author recommends “school education and massive public education campaigns for the practice of empathy, social and emotional skills, and basic knowledge about the causes and consequences of child violence”.

The expected role of World leaders is that if they do not take measures to “mobilize communities” and create “a positive social environment” then “the alternative will be to create more prisons for the perpetrators and more hospitals for the victims (...) avoiding to solve the root problems”.

The author provides a convincing description of a “Disability prevention programme” and a “Community-based rehabilitation strategy (CBR)”, both lauded by H. Mahler former Director General of WHO.

Such training programmes include “policies, planning, programme design, service delivery systems, quality/cost control methods and human rights”. The successful delivery of public care is related to the appropriate managerial training of the professionals (Alma-Ata, 1978).

The author says that “Such primary prevention is possible” but that it “will only be effective if major alterations in human behaviour and in the culture of our societies occur”. This is a very big “if” indeed. It will take a few generations to see real improvements. “Plus ça change, plus c’est la même chose”

J-J Guilbert
Vector and Rodent-borne Diseases in Europe and North America: distribution, public health burden and control


Norman Gratz, former Director of the Division of Vector Biology and Control at WHO headquarters, died in November 2005; his wife and numerous friends miss him profoundly.

Until the early part of the 20th century many vector and rodent borne infections were a serious public health problem in Europe and North America. Dr Gratz reviews the distribution of vector and rodent borne diseases in Europe, the USA and Canada. Their incidence and prevalence, their costs and hence their public health burden are detailed and their arthropod vector and rodent reservoir hosts are described. With such information, the individual clinician is more likely to have a degree of epidemiological suspicion that will lead to earlier diagnosis and correct treatment; equally, the public health authorities will have readily understood the measures necessary to control this group of infectious agents. This is an excellent reference book for use by public health workers.

Rajindar Pal

Remembering Norman Gratz

On 21 November it was three years ago that Norman Gratz passed away. On the occasion of Rajindar Pal's review of his last book, I was asked to write a few words of remembrance. I first met Norman late in his career, in September 1983 when I arrived in the Division of Vector Biology and Control in Geneva, to take up a position in the PEEM Secretariat. I was ushered into his office by his admin assistant, Rosemary Jimenez, and he welcomed me, cigar in hand, in a cloud of smoke. "You will enjoy working with Mr Chen Kuo, he is a decent man."

Decency was an important value for Norman. So were professionalism, dedication and respect for colleagues. He was in many ways a Director of the old school, leading the Division with a level of benign dictatorship aimed to ensure Vector Biology and Control remained well-resourced. He managed to combine a broad technical grasp of insect and rodent-borne diseases with an instinct to attract donors to invest in it. Yet, after the demise of the malaria eradication programme, vector control was on the decline in WHO, and in 1990, three years after Norman's retirement, VBC was disestablished.

In his private life Norman enjoyed entertaining - a lot of this was work-related, usually lavish receptions for delegations during the then much longer- World Health Assemblies at his home in Commugny, but he also loved to single-handedly prepare meals for smaller groups of friends, who could indulge in a nice single-malt whiskey ("if you ask for water, I'll give you "Teachers" ) and a good meal accompanied by excellent wines. Meanwhile, his feline friends competed for his attention.

Norman really never retired - he continued to consult, advise and attend meetings, and it was only when he returned very tired from a trip to Uzbekistan that a medical check-up revealed an advanced malignancy. Remarkably, he spent the last 15 months of his life putting all his efforts into writing the book reviewed above - three weeks after completing it, he passed away.

It is a privilege to have worked with him, to have travelled with him and to have known him.

1 Panel of Experts on Environmental Management for Vector Control

Robert Bos, Scientist, Water, Sanitation, Hygiene and Health
On the lighter side

How to resolve the mid-life crises

After twenty-five years of marriage, a man looked at his wife and said to her: “Darling twenty-five years ago we had a tiny flat, an old car, lounged on the sofa whilst we looked at a ten inch black and white television BUT I slept with a twenty-five year old beautiful young blonde. Now we have a €500 000 house, a €50 000 BMW, a water bed, a 50 inch colour flat screen television, BUT I sleep with an old woman of 50.” His quick witted wife replied: “You only have to find a young twenty-five year old blonde and I will make sure that you will again find yourself in a tiny flat with an old car, lounging on a sofa watching a ten inch black and white television.”

Women are incredible!! They can cure men in mid-life crises in a flash!

*Quote of the Day*
"I believe that banking institutions are more dangerous to our liberties than standing armies. If the American people ever allow private banks to control the issue of their currency, first by inflation, then by deflation, the banks and corporations that will grow up around the banks will deprive the people of all property until their children wake-up homeless on the continent their fathers conquered"

Thomas Jefferson 1802

Next trips

Due to the success of previous travels, we have decided to undergo in 2009 two travels. The first one is scheduled for April in Portugal (see page 11), and the second will take place at the beginning of September in Croatia, starting from Zagreb or Ljubljana, to Dubrovnik, then by boat to Rijeka then to Slovenia back to Zagreb then to Geneva.

You can from now, without engagement, pre-enrol for this trip.

The dates will be: from 6 to 15 September or 5 to 14 October 2009 (the dates, details and price will come in the next issue (QNT 75).

Pre-enrolment

I am interested in the trip to Croatia
Name First name
Number of persons
I would prefer ☐ September ☐ October
Tel: E-mail
Date, signature

Send reply by e-mail or by post, not on the telephone
Joining AFSM – Updating membership

*This form is not for those who are already life members.*

*It is intended only for those who are not yet members, or are annual members.*

Are you still not a member of AFSM? Is it because you don’t like it or what it stands for? Let us know. Or, do you keep forgetting to join?

Hope you will become a life member – it costs 250 CHF – and you will never again have to remember to pay your dues. Or, you want to give it a try? Then join for a year at 25 CHF – and decide after a year. Fill in the form below and send us your payment.

- I am not yet a member and I want to join
  - as a life member
  - as an annual member

*(Please fill in the application form below)*

- I am already an annual member and I want
  - to convert into a life member
  - to pay my dues for the current year

Dues can be paid either in cash at the office or through a postal form (add 2 CHF for charges) for persons who live in Switzerland, or by bank transfer to the AFSM account number (+ bank charge, if any):

IBAN: CH 4100279279-D310-2973-1
SWIFT: UBSWCHZH80A

APPLICATION to JOIN

Name ........................................ First Name ........................................

Address:

Postal Code .......................... City........................... Country ..........................................................

Phone ......... Fax ......................... e-mail ............

Date of Birth ....................... Nationality ..........................................................

Date of separation from WHO ............................ Length of service with WHO ..............................

I should like to receive documentation in

□ English □ French

Date ............................................................................................................... Signature