Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people


There’s nothing like a good snooze... (see page 8)
Unusual pictures

After the accident...

Have a good sleep!

Mind your head!

What a fine boat!

I am so thirsty

Highway interchange, Atlanta

(see other pictures in the French version)
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**EDITORIAL**

We note with pleasure that our new column “Points of View” has stimulated several replies and that another article also prompted a reaction. We congratulate those readers who reacted. Continue! It appears that they find our newsletter interesting and this really encourages us in producing what we would like to be YOUR newsletter.

This is election year for our Executive Committee. As you know, only life members and annual members who have paid their 2010 subscriptions are entitled to vote. We really hope that many of you will vote. Counting of votes will take place on 21 October.

Vaccination against seasonal influenza in Geneva: after the interruption last year due to the controversy surrounding the influenza A H1N1, we are resuming vaccination against seasonal influenza this year. The vaccine used will include that for the virus H1N1 in one single shot. Sessions will take place on 12 and 19 October in the mornings from 08:30 to 12:30 and afternoons from 13:30 to 16:30. Vaccinations will take place in the hall next to the Medical Service on the lower ground level.

We strongly hope that vaccination sessions based on the Geneva model will take place in the regions.

**DC**

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**Important contacts:**

AFSM: see on page 1

Health Insurance (SHI): + 41 (0)22 791 18 18; in case of absence, please leave a message; someone will call back.

Or email to: insurance@who.int

Pensions: +41 (0) 22 928 88 00 ;

email : jspfgva@unog.ch for Geneva

or unjspf@un.org for New York

AFSM office manned on Tuesday and Wednesday from 9.30 to 12.30.

Otherwise: please leave a message; someone will call back.
Our health insurance

Staff Health Insurance report for the year 2009

The WHO Staff Health Insurance (SHI) Report for the year 2009 contains interesting information on the SHI Fund. Incidentally, this was the fiftieth year of operation of the scheme. Overall, the financial results were good in spite of the effects of the global financial turmoil which continued to impact the return on investments during the first half of the year.

There was a net overall operational surplus (i.e. contributions received exceeded claims paid) of US$11.2 million (after a deduction of 25% of active contributions earmarked for retired staff). This was in sharp contrast to the situation in 2008 when an operational deficit of almost US$ 2 million was reported. This significant improvement was mainly due to the 10% increase in the rate of contributions effective March 2009. Further increases in contributions (2% per year) were agreed for 2010 and 2011. These increases in contribution rates which were recommended at the SHI Joint Meeting in 2008 and subsequently approved by the Director-General were necessary to meet projected claims. It should however be noted that the retired staff category showed a deficit of US$ 6.6 million. This was much less than the corresponding deficit in 2008 of US$ 13.4 million, mainly due to the increase in contributions in 2009. As the deficit for this category is to be expected, a special reserve has been established and continues to be maintained (article 470.2 of the SHI Rules).

At the end of 2009, the balance of the Fund stood at over US$ 450 million which represented an increase of almost 22% from the balance at the end of 2008. The major part of this reserve is required to meet expected future costs of retired staff and as a reserve to settle outstanding claims in accordance with articles 470.1 and 470.2 respectively of the SHI Rules. These SHI funds are invested (under the guidance of an Advisory Investment Committee) with the aim of ensuring that the levels of actual and expected returns, as well as the level of investment risk, are appropriate for the SHI Fund. As indicated in the Report, the long-term funds are managed by external fund managers who invest primarily in government and corporate bonds, and to a small extent in equities.

The number of persons insured stood at 35,550 in 2009 (including fixed-term staff, retired staff and eligible family members). As far as paying members are concerned, the ratio of active members to retired members and survivors has moved from 2.3 in 1993 to 1.9 in 2009. As shown in the Report, just under half of insured active staff work in areas where the cost of health care is high.

The work of the secretariat has steadily grown over the last ten years as revealed by the total number of claims settled (HQ and regions combined) which increased by 55.6% between 2000 and 2009.

As readers in the Geneva area are no doubt aware, agreements have been established with selected health care providers in the area. As confirmed in the Report, all agreements with hospitals and private clinics were renewed at the end of 2009 for the period 2010-2011 and “Clinique des Grangettes” was added to the list. This network of providers offers discounts for their services and fixed prices for some surgical procedures. Further details can be obtained from the SHI secretariat.

Ann Van Hulle

DELAYS IN REIMBURSEMENT OF STAFF HEALTH INSURANCE CLAIMS

At its meeting on 25 August 2010, the Headquarters Surveillance Committee (HSC) was informed that a number of factors had contributed to long delays (up to 8 weeks) in the reimbursement of Staff Health Insurance claims. The HSC mandated its chairman to write to the Director-General to request that she use all means at her disposal to rectify this situation.

Marjory Dam
Our pensions

2010 Session of the Pension Board

The 2010 session of the Pension Board took place from 15 to 23 July in London. Retirees were represented by observers from the Federation of Associations of Former International Civil Servants (FAFICS). The FAFICS observer delegation included Roger Eggleston, former WHO staff member and current president of the Association of Former International Civil Servants (AFICS) – Geneva. The summary below is based on his report published by AFICS.

Retirees will be happy to learn that the Secretary/CEO of the Board stated in his closing remarks that the Pension Fund is a secure place we can count on. In support of this conclusion there was good news about investment and cash flow.

The market value of investments as at 31 December 2009 was some USD 36.7 billion, an increase from USD 31.1 billion at 31 December 2008. By the time the Board met in July, the market value of investments was still around USD 36 billion; there remained, however, considerable volatility in the financial markets.

There was also good news in terms of cash flow. Contributions from participants in the Fund in the year ending 31 December 2009 just exceeded expenditures on beneficiaries - by a very small margin of some USD 10 million out of the annual expenditures of USD 1.92 billion.

The results of the 31 December 2009 actuarial valuation showed an actuarial deficit of 0.38% of pensionable remuneration. The Committee of Actuaries confirmed that this was nothing to be worried about. It results from the incorporation into the calculation of the 2007 UN mortality tables – showing that the United Nations population is living much longer – and the losses in investment performance in the two years since the previous actuarial valuation.

Although, given the upheavals in the financial markets, the results of the actuarial valuation did not come as a surprise; it did affect the Board’s thinking on any changes or improvements in the design of the Pension Plan. Thus, the proposals put forward by the Working Group on Plan Design (established by the Board to provide specific proposals that could help guide the Board over the next several years) were all put on hold until the financial situation allowed further consideration.

Among the proposals put forward by the Working Group were:

- increase the retirement age to 65;
- improve withdrawal settlements for staff with less than 5 years service;
- eliminate negative cost-of-living adjustments from the pension adjustment system;
- restore, over time, the 2 percent accumulation rate;
- reduce the eligibility period for participation in the Fund from 6 months to 60 days;
- introduce four amendments to the provisions governing divorced spouses (Article 35bis of the Regulations);
- review the early retirement reduction factors;
- study enhancing the scope and flexibility of administering the Emergency Fund;
- eliminate the 0.5% reduction in the first cost-of-living adjustment due after retirement;
- introduce cost of living adjustments for deferred retirement benefits as of age 50.

The most heated discussions at the Board concerned the Working Group’s proposal to increase the retirement age to 65. The Participants (and the retirees) and the vast majority of the representatives of the Governing Bodies seemed to support the suggestion that the retirement age be increased; the representatives of the Executive Heads were, however, much less enthusiastic. What was clear, or appeared to be clear to almost all those present was that the retirement age - and the mandatory age of separation - will increase. The only real questions are when and how. The International Civil Service Commission is scheduled to review the matter in spring 2011.

Marjory Dam
Cancer of the colon and colonoscopy

Colon cancer is the third cause of deaths from cancer in Western Europe, North America and Australia (after lung and prostate cancers in men and breast and lung in women). Its incidence increases steadily with age (average age at diagnosis: 70 years). (Global incidence in 2000: 1 million cases of colon cancer and 0.5 million deaths). The primary lesion is generally a polyp, which is the target of the screening.

Risk factors
- Diet rich in animal fats, poor in vegetables: heavy consumption of red meat
- Existence of polyps in the colon: benign tumours that can develop into cancers at a later stage. 80% of colorectal cancers develop from a benign tumour.
- Genetic factor
- Family history of colorectal cancer
- Inflammatory diseases of the digestive tube, Crohn’s disease, haemorrhagic rectocolitis.
- Tobacco
- Sedentarism

The location and size of the tumour do not always permit the anus to be retained. A colostomy (creation of an artificial anus) is then envisaged.

Chemotherapy may be associated with surgery.

Prevention, screening:
Food plays an important role in the prevention of cancer of the colon: green vegetables particularly broccoli and cabbage, rich in fibre and antioxidants are advised for their protective effects.
Physical exercise is also very important. Early detection improves prospects.

Investigation for traces of blood:
The Hemoccult II® test enables abnormal, microscopic bleeding to be detected. A systematic examination during health checks from 50 years of age is strongly advised as the incidence of colon cancer increases rapidly with age.
This test consists of removing, on 3 consecutive days, using a small spatula, a small sample of faeces and placing it on a pastille containing a reactive product. These samples are sent to a laboratory for examination for microscopic quantities of blood. In the case of bleeding a colonoscopy must be undertaken.

The colonoscopy (or coloscopy) is normally advised in patients with a family history of colon cancer, or polyps in the colon, or a positive Hemoccult test. Removal of the polyps during the colonoscopy will avoid their evolution into cancer.

What is colonoscopy?
A colonoscopy is an examination of the colon (large intestine) using an endoscope (flexible tube with a camera at the end).
Colonoscopy

which enables the inside of the colon to be examined and samples to be taken for analysis using a microscope. Thus any polyps detected can be removed or destroyed to prevent cancer developing.

What is the procedure?
A colonoscopy is usually performed in hospital or in the gastroenterologist’s clinic. The examination, performed under sedation, lasts about half an hour, but strict preparation is necessary:
three to four days before: diet without residues: i.e white bread, meat or fish, no vegetables or fruit (the physician explains the exact diet to follow); the evening prior to the examination, the intestine is purged (unpleasant procedure, explained in detail by the physician, which consists of drinking a laxative solution with 3 litres of water). No further food or drink must be absorbed before the examination.

Complications
are rare. Removal of a polyp may occasionally be complicated by a perforation (0.4%), or haemorrhage (2%), requiring a transfusion or surgery. These complications may sometimes arise several days after the examination. In the event of unusual abdominal pain, loss of blood by the anus or high temperature, the physician concerned or the hospital emergency services should be contacted.

Classical colonoscopy and virtual colonoscopy

Virtual colonoscopy (scanner) is a recent addition to classical colonoscopy. Thanks to their speed and level of resolution, the latest models of X-ray scanners make it possible to undertake this type of investigation, which does not require insertion of a fibroscope, the colon simply being inflated through the anal insufflation of gaseous CO₂.
The investigation is extremely quick (about 15 minutes overall). It also allows visualization of all intra-abdominal structures (liver, kidneys, spleen, retroperitoneum, bladder, prostate/ovaries...), as in a classical abdominal scan.

Virtual colonoscopy requires the same cleansing preparation as classical colonoscopy. Results are interpreted on a computer outlet: it is possible to simulate an endoscopy, to “unwind” and “open” the colon (virtual dissection); polyps, even small ones can be identified and analysed using computer-assisted diagnostic software.

There are however limits to virtual colonoscopy. If it detects a polyp (30% to 40% of people present them), resection and histological analysis will require classical colonoscopy; the identification of “flat” precancerous tumours is difficult with this technique. Virtual colonoscopy also subjects the patient to a moderate dose of radiation.

It does not allow recourse to experimental techniques that can differentiate between lesions that require ablation and others.

For all these reasons, it cannot replace classical colonoscopy and its use remains limited to small-risk cases that cannot or will not submit to a classical colonoscopy.

Staff Health Insurance Policy
Within the framework of its prevention policy, our insurance fully covers a colonoscopy every 5 years as from age 50, for a standard cost currently set at USD 600. Extra costs are reimbursed at 80%.
(Staff Health Insurance, Manual II.7 Annex A, Appendix E: Preventive Measures)

Dr David Cohen

For more information:
MedicineNet.com; eMedicine.com. Colonoscopy;
www.prevention.ch/lecancerducolon.htm; www.doctissimo.fr/html/.../cancer_colon.htm; and many other sites.
Seven hours sleep, no more, no less?

A research team from the West Virginia University School of Medicine (USA) conducted a cross-sectional study of 30,397 American adults to research a possible association between sleep duration and the presence of cardiovascular diseases. Compared with a sleep duration of 7 hours, the team found both shorter and longer sleep durations to be independently associated with myocardial infarction, angina, and stroke. They conclude that the results suggest that sleep duration may be an important marker of such diseases.

The authors indicate that the results were independent of age, sex, race-ethnicity, smoking, alcohol intake, body mass index, physical activity, diabetes mellitus, hypertension, and depression.

Commenting on the results, Dr Anoop Shankar, who led the study, explained that rest has a direct effect on patients’ health. “Our study findings suggest that abnormal sleep duration adversely affects cardiovascular health, Sleep disturbances may be a risk factor for cardiovascular disease even among apparently healthy subjects”.

According to the French daily Le Monde dated 4 August 2010, Professor Yvan Touitou, Chronobiologist from the Paris-based Rothschild Foundation, welcomed this study but warned that personal behavioural patterns should also be taken into account. “Some people need a lot of sleep while others do not. Some are more awake in the morning, others in the evening. This does not mean that they are at a higher risk”.

So, let us continue to sleep soundly and according to our personal preference.

J-P Menu

Sabanayagam C; Shankar A. Sleep duration and cardiovascular disease: results from the National Health Interview Survey. SLEEP 2010; 33(8):1037-1042.

Sleeping like a baby
Highlights of the main public health events over the past few months

• WHO collaborated with the South African Department of Health in providing health advisories for the 2010 FIFA World Cup and to help ensure that the event was safe from public health risks.

• In June, WHO drew attention to the need to improve the rational use of medicines. Over 50% of all medicines are prescribed, dispensed or sold inappropriately, and 50% of all patients fail to take medicines correctly. WHO continues to provide guidance to countries and delivers training programmes.

• Also in June, an online tool called GLOBOCAN 2008 was launched by WHO’s International Agency for Research on Cancer. This interactive tool can produce maps and graphics of cancer cases occurring globally. It has shown that developing countries account for 63% of all cancer deaths and 56% of new cases.

• On 29 June, WHO launched the Global Network of Age-Friendly Cities as part of a broader response to the rapid ageing of populations. The Network aims to help cities create urban environments that allow older people to remain active and healthy participants in society. Many cities have formally applied to join the Network, the first being New York.

• In July, WHO and the International Olympic Committee signed a Memorandum of Understanding which sets out ways in which both can join forces to promote healthy lifestyles, prevent childhood obesity, encourage physical activity and sports, and reduce tobacco consumption worldwide. Physical inactivity is ranked as the 4th leading risk factor for all deaths globally, contributing to 1.9 million deaths each year.

• Also in July, WHO staff participated in the biennial International AIDS Conference which brings together some 25 000 participants. The theme of AIDS 2010 “Rights here, right now” emphasizes that promoting and protecting human rights are needed for a successful response to HIV. AIDS 2010 coincides with a major effort to achieve universal access to HIV prevention and treatment by the end of this year.

• WHO has been coordinating the response of health partners and supporting the Pakistani authorities by sending staff, medicines and related health supplies. Medicines for close to two million people have been delivered and thousands of people have been treated for water-borne diseases, such as diarrhoea, skin infections, acute respiratory illnesses and malaria. Vaccination campaigns have begun and dozens of mobile clinics have been sent to treat survivors.

• WHO is supporting the Ministry of Public Health of Afghanistan to launch a new drive to better prepare its health sector.

• On 10 August, the Director-General announced that the H1N1 influenza virus had moved into the post-pandemic period but recognized that localized outbreaks of various magnitudes are likely to continue. WHO continuously monitors the influenza situation, especially currently in the Southern Hemisphere. Weekly updates can be found on the WHO web site.

• On 12 August, the International Year of Youth began, underscoring the fact that health is a human right and an integral part of youth development. Over 1.8 million young people die each year and an even larger number engage in behaviours that jeopardize not only their current health, but often their health for years to come. Some of the main health issues are: early pregnancy and childbirth, HIV, malnutrition, mental health, tobacco use, harmful use of alcohol, violence, road traffic accidents, drug abuse and loud music levels.

(cont'd on page 16)
Universal old age pensions?

From time to time we publish in our Quarterly News articles abstracted from the website of HelpAge International, an NGO whose mission is to “work with partners to ensure that people everywhere understand how much older people contribute to society and that they must enjoy their right to health care, social services and economic and physical security”. We are sure that you share their vision of a world where all older people can lead a dignified and active life, whilst benefiting from health and physical protection. HelpAge drew attention to a recent report by the World Bank* that endorses universal minimum pensions.

Over 340 million older people lack regular income today and this will rise to 1.5 billion people by 2050. In developing countries, most of them will have spent their life in heavy manual and agricultural labour activities that they cannot sustain in old age. Introducing universal pensions has transformed the lives of older people and their families in countries in Latin America such as Brazil, Bolivia and Chile.

Universal social pensions are regular cash payments paid to older citizens by governments. Unlike contributory pensions, they do not require any previous contributions from the recipients. Many governments recognize that it is an effective and practical way to alleviate the poverty of older people and their households. Until recently, the World Bank, as one of the most influential voices on pensions, believed that poor older people should be covered within a catch-all safety net for the whole population. The study, however, suggests the contrary, arguing that “alleviating poverty in old age requires a different approach from other age groups”.

Old age poverty

The report highlights the lack of existing international data on old age poverty and the challenges involved in measuring it. A detailed analysis of each age group would be required but the authors were able to confirm that the poverty rate of older people is higher than the overall poverty rate.

Universal versus means-tested social pensions

In considering the advantages and disadvantages of both approaches, the report suggests that an unconditional (universal) pension has a number of advantages: it is administratively simpler, it implies less disincentives to work and save and it carries less social stigma. It is however more costly. The study concludes that “a priori, an unconditional pension would cost more than a conditional (means-tested) one but would be more attractive”.

Poverty impact

The report succinctly analyses some of the benefits of universal pensions. It uses a number of scenarios to simulate their impact. Setting, for instance, the daily transfer at USD 2.5 (double the international poverty line) to everyone over age 60 would reduce considerably old age poverty.

The study concludes that the cost of universal pensions is “far from negligible but it is reasonable” and that the final choice will depend on financial feasibility and mainly on political support. Above all, the authors argue that the benefits which come with universality justify the extra investment. For more information, please visit www.helpage.org/news.

JP Menu

* Universal minimum old age pensions: impact on poverty and fiscal cost in 18 Latin American countries, Jean-Jacques Delthier, Pierre Pestieau et Rabia Ali
The European sky for autumn 2010

The brightest thing in the night sky at the moment (apart from the Moon of course) is the planet Jupiter. This rises in the east in the early evening, and by mid evening it is about a third of the way from the horizon to the zenith. Look at it with binoculars or a small telescope and you will be able to spot up to four of its major moons, like little stars strung out on either side of it.

Jupiter is in a rather barren area of sky at the moment, between Aquarius and Pisces, but directly above it you can find the quite large pattern known as the Square of Pegasus. This is a good signpost to other constellations. It shares its top left star with Andromeda, which has two other bright stars in a widely spaced line to the east. Beyond this is Perseus. Above the easternmost star of Andromeda lies the W-shape of Cassiopeia, virtually overhead in autumn.

Look above the middle of the three bright stars of Andromeda for two fainter stars. Just to the right of the second of these is the famous Andromeda Galaxy. You can pick it out with binoculars or even the naked eye.

Later in the autumn, or later at night, over to the east you will see the beautiful star cluster of the Pleiades rising (also known as the Seven Sisters). Below this is the V-shape of another, less spectacular, cluster, the Hyades, with the noticeably red star Aldebaran at one top of the V. This cluster marks the head of Taurus, the Bull, with Aldebaran as its angry eye.

For a monthly star map, and more handy hints on stargazing, go to the Society for Popular Astronomy website: http://www.popastro.com/youngstargazers/thismonth.html.

Article kindly provided by the British Society for Popular Astronomy

We welcome comments from readers on whether you find such astronomy articles of interest. We also repeat our request for information from our readers in other parts of the world for information on what can be seen in your skies, including the Southern Hemisphere.

if you would like to admire some of the stunning photographs taken by the Hubble telescope, you may wish to access http://mail.google.com/a/sunrise.ch/images/ppt.gif

Events in Geneva

1st October: International Day of Older Persons (see page ).

12 and 19 October: vaccination against influenza in front of Medical Service in Headquarters.

2 December: Annual reception of AFSM at the Cafeteria in Headquarters.

May or June: AFSM annual travel. Details will be sent soon.
Copyright / Copyleft / Copywrong

Recently, I don’t know why, my attention was drawn to a text in fine print concerning copyright at the bottom of the verso of the cover page of a publication in the series “Technical Reports of WHO” (TRS). It read “This publication does not necessarily represent the decisions or the official policy of WHO”. A few lines later, I also read “this information is published without warranty of any kind either expressed or implied” on the part of WHO. But the presence of the WHO emblem (logo) seemed to confer an official blessing.

My long experience in WHO helped me to understand how difficult it was for the Legal Services (LEG) of the Organization to give opinions and recommendations in what were sometimes delicate political situations.

However, it is difficult for me not to point out that the texts suggested by LEG in the area of copyright\(^1\), which is a domain less affected by the concerns of the day, sometimes lack clarity and may understandably perplex ordinary mortals\(^2\) in terms of “well, this document does, however, seem to be of an official nature”. This can also put the Publications service in an embarrassing situation faced with questions from those reading, or acquiring texts published by WHO.

One could also remark “it even has the “logo” of WHO”. Indeed, according to the rules of WHO\(^3\) this emblem constitutes its official seal and its use implies that WHO endorses the documents on which it appears. In fact this “logo” always appears on the covers of reports of WHO Expert Committees like the one mentioned above. In fact this logo always appears on the covers of reports of WHO Expert Committees like the one mentioned above.

If this reassuring WHO logo appears in a corner to the left or right of the cover page, in the upper part one can read “This report expresses the collective views of a group of international experts and not necessarily the decisions or official policy adopted by the World Health Organization”. The subtlety of this “necessarily” will surely not escape you.

In the event that an elderly reader is unable to read the fine print on the cover page of the standard recommendation, care has been taken to repeat it on the verso for commendable security concerns.

Would it be preferable not to consider this clause as “standard” and to decide on a case by case basis whether to include it or not?

In fact, as you know from press reports regarding the recent “flu pandemic” one can never be too careful as regards the opinions of an “expert” even when “appointed” by the Director General\(^4\).

\(^{1}\) In accordance with Article 4.12 of the Rules governing panels and committees of experts, Basic documents, OMS 47th edition, 2009
\(^{2}\) I was told that fortunately ordinary people don’t usually read this type of information
\(^{3}\) For information regarding the use of the logo/WHO emblem, consult the site http://www.who.int/about/licensing/emblem/fr/index.html
\(^{4}\) Any person possessing qualifications and/or experience relevant and useful to the activities of the Organization (Basic Documents 3.I, page 105) “appointed by the Director General” (*1.4*)

J-J Guilbert
Points of view (Cont’d)

RED: We are pleased to see that our readers are reacting to this column and are sending us their points of view. Please continue to write to us!

J-J Guilbert has lately been rather vocal in criticizing the actions of “those in charge of WHO”. Now, apparently, he is having misgivings and seeks reassurance by inviting other former staff “to exchange a few ideas about the loyalty that we…owe to our Organization.” Here is one response to his invitation.

I trust we all feel loyal to WHO (though our loyalty to “those in charge” may at times have been subject to certain strains) and support its constitutional objectives; but few of us, I think, feel a need for soul-searching on the subject. Could it be that Dr Guilbert takes himself, and the part we oldies can aspire to play in shaping the Organization’s policies, a mite too seriously?

As regards the substance of his strictures, there were bound to be widely conflicting estimates of how serious the H1N1 pandemic would prove. Had things gone differently everyone might be praising WHO for its foresight. The allegation that “scientists who drew up key WHO guidelines” were in the pay of drug companies was inevitable, but that doesn’t make it true. Indeed, Dr Guilbert himself says that WHO has “refuted”, i.e. disproved it (but I suspect that he is making the common error of using “refute” to mean “deny”).

No doubt a lot more mud will be slung before the full facts emerge. Let’s wait for them.

John Fraser

The Quarterly review arrives and it is immediately read with interest--- even the French bit to make sure I don’t forget my second language. Reading the article by JJ Guilbert brought forward an issue that has concerned me for some time, namely: “field workers”.

Don’t we have any anymore? If so, how do the “out of town issues in health get improved? After all WHO’s goals are health for ALL the population.

My 25 years with WHO taught me that it was not only formal training programmes for nurses and midwives in towns, universities, etc., but also training programmes for traditional birth attendants and proper training albeit sub professional for their successors, which was just as important if not more so.

And how do you get trained health workers out of the towns and into the countryside where health problems are most acute? What, if anything, is happening in the field? How many rural training programmes exist and are they increasing in number and improving in quality? What proportion of qualified health workers work in the countryside? From what I gather from once colleagues who are now working voluntarily in the field, maternal and child health isn’t a major priority anymore—and can’t be, if there is no international help where the problem lies. Can we have a report on “the outback and its health issues at some stage please?

Joan Bentley

* RED: The best we could do is to ask the relevant services to carry out such a report.
I read with interest the article in QNT 80 entitled “Our ‘loyalty’ to WHO”.

I wondered whether I was a “former WHO staff member” or an “ex-WHO staff member”. I concluded, like the author, that I do not owe blind loyalty to the Organization, but my sentiments of belonging should push me to continue to collaborate constructively.

My 26 years of experience in WHO (1954-1980) covered all the Regions and Headquarters. I have “lived through” problems similar to the recent pseudo epidemic of the (H1N1)A virus without WHO causing a global psychosis of a major health crisis – harmful for both the national and international economy.

The first occasion occurred in January 1976. An epidemic associated with a new virus - A/NewJersey/76 (Hsw1 N1) affected about 500 soldiers in Fort Dix (New Jersey). President Gerald Ford decided to vaccinate the whole US population. This vaccination campaign was carried out as soon as the vaccine became available. The campaign was quickly abandoned when it was realized that the local epidemic did not seem to spread as the swine virus did not lead to human to human transmission. The disadvantages outweighed the advantages.

Dr Halfdan Mahler, with his vast experience in the field and at Headquarters, was Director-General at the time. He considered it wise to call on an international group of experts to examine the situation. Although they had recently recommended rigorous “high level surveillance and preparedness”, the experts prevented the Organization from advocating measures harmful for the world economy.

The second occasion occurred in May of the following year, with the appearance in China of influenza outbreaks associated with a new virus A (H1N1) which was not of animal origin. The outbreak spread rapidly to the whole population in the form of clinically benign influenza – as the outbreak in 2009. We merely decided to introduce the new virus into the composition of the seasonal influenza vaccine. Since that time, this vaccine is a triple vaccine (H3N2) A and B and (H1N1) A.

The decision taken on 29 April 2009 to move the alert level from phase 4 to phase 5 was taken “on the basis of data showing human to human transmission in at least two countries of one Region” (Weekly Epidemiological Record No. 20 dated 15 May 2009). At the same time, in this Region (AMRO), the mortality rates in the United States of America and Canada showed that the infections due to the new virus (H1N1)A were clinically benign. In view of the fact that the other Regions were not showing the same rapid propagation as in America, it would seem that the decision by WHO Headquarters was taken in the absence of adequate international coordination. The consequences were heavy for the economy of countries which trusted the Organization by ordering excessive quantities of vaccine to launch vaccination campaigns for their entire populations. Schools had to be closed as well as other communities.

These excessive measures have tarnished the reputation of WHO.

I am sorry to think that these measures are a consequence of the lack of communication and especially of the coordination which currently exists, on the one hand among the Regional Offices, and on the other hand, since the upheaval in 1998 of the organigram, among the different divisions (“clusters”) of the Organization’s Headquarters.

Dr Pierre Delon
Readers’ Corner (Contd)

A response to the article by Rajinder Pal on malaria

...I was very interested to read...in QNT 80... your summary of the article “Short-circuiting malaria”, which appeared in Newsweek 10 April 2010...

All ideas mentioned in the article were our dream while working in the field of malaria control... If they can be realised, it would be huge contribution to the malaria control programme.

In addition to the ideas of the article, I am thinking of others also. For example, another tool that could detect:

1) Age of the vector mosquitoes without dissection
2) Identification of species complex
3) Easy collection and sampling of the outdoor resting mosquitoes (exophilic vectors)
4) A new repellent that people would welcome because it was easy to apply, had long lasting effectiveness (at least 4 hours) and reasonably priced.
5) Also some genetic methods of mosquito control.
6) I came up with these ideas because of my long field experience and the difficulties I face.

By the way, I sent copy of your article to several Japanese colleagues who are interested in malaria.

They appreciated it very much and they are looking forward to the realisation of the ideas...

...All best wishes.

Dr Jun Akiyama.

UN International Day of Older Persons, 1 October

A 20th celebration of this day took place at the United Nations, Geneva, with the following objectives:

1. To address the current state of the Global Ageing Agenda and Strategies at the United Nations: Millennium Development Goals 2010 review, the 2011 UN High-Level Segment of ECOSOC on Education and the UN Human Rights development on extreme poverty.

2. To identify innovative initiatives which are advancing the Global Agenda on Ageing and the UN Madrid International Plan of Action on Ageing 2002.

3. To emphasize the need for anchoring ageing further into the UN activities: analyzing current strengths and weaknesses as well as opportunities for the future.

Panel members representing the UN voice, the voice of a government and the voice of the nongovernmental organizations spoke under the overall theme of “Long Life Development for Older Persons: How are we advancing with UN Global Strategies?”

Sue Block Tyrrell

Reserve the date!

Thursday 2 December 2010: our annual reception at the Cafeteria in Geneva Headquarters
• At the end of August, WHO drew attention to the problem of lethal falls which are the second cause of accidental deaths worldwide. Adults over the age of 65 years are at the greatest risk of fatal falls.

• With only five years left until the 2015 deadline to achieve the Millennium Development Goals (MDGs), the UN Secretary-General called a summit from 20-22 September to accelerate progress towards the MDGs. Health is key to the achievement of all the MDGs. WHO’s work helps countries to improve maternal, child and newborn health; to combat AIDS, TB and malaria; and to improve people’s access to safe food, clean water, sanitation and essential medicines. On 22 September an interagency Global Strategy for Women’s and Children’s Health was launched which strives to provide universal access to care for all women and children. The strategy received pledges totaling more than USD 40 billion.

• 26 September is World Heart Day. Cardiovascular diseases are the world’s largest killers, claiming 17.1 million lives a year. Risk factors for heart disease and stroke include raised blood pressure, cholesterol and glucose levels, smoking, inadequate intake of fruit and vegetables, overweight, obesity and physical inactivity. In partnership with WHO, the World Heart Federation organized awareness events in more than 100 countries.

• 14 October is World Sight Day which focuses global attention on blindness, visual impairment and rehabilitation of the visually impaired. It is the main advocacy event for the prevention of blindness and for “Vision 2020: The Right to Sight”, a global effort created by WHO and the International Agency for the Prevention of Blindness.

• At this time of the year, the Regional Committees meet: AFRO – 30 August to 3 September in Malabo, Equatorial Guinea; AMRO – 27 September to 1 October in Washington DC, USA; EMRO – 3 to 6 October in Cairo, Egypt; EURO – 13 to 16 September in Moscow, Russian Federation; SEARO – 7 to 10 September in Bangkok, Thailand; and WPRO – 11 to 15 October in Putrajaya, Malaysia.

Sue Block Tyrrell

New members

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

New Life Members:
Alpha Oumar BARRY, Maria DWEGGAH, Dorothy KLINGER, Luz MAGPANTAY, Jean YAN Cheng Man-Lock RAY,

New Annual Members:
Dorothy C. HALL

Conversion from Annual Member to Life Member:
Pierre BELOT
### On the lighter side

**Self derision** (From the American Association of Retired People)

#### Questions and Answers from AARP Forum

| Q: Where can single men over the age of 60 find younger women who are interested in them? | A: Try a bookstore, under Fiction. |
| Q: How can you increase the heart rate of your over-60 year-old husband? | A: Tell him you’re pregnant. |
| Q: How can you avoid that terrible curse of the elderly wrinkles? | A: Take off your glasses. |
| Q: Why should 60-plus year old people use valet parking? | A: Valets don’t forget where they park your car. |
| Q: Is it common for 60-plus year olds to have problems with short term memory storage? | A: Storing memory is not a problem, retrieving it is the problem. |
| Q: As people age, do they sleep more soundly? | A: Yes, but usually in the afternoon. |
| Q: Where should 60-plus year olds look for eye glasses? | A: On their foreheads. |
| Q: What is the most common remark made by 60-plus year olds when they enter antique stores? | A: "Gosh, I remember these!"

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**A few quotations from Winston Churchill:**

*History will be kind to me for I intend to write it.*

When Field Marshall Viscount Montgomery said to him: "I neither drink nor smoke and am a hundred percent fit", Churchill’s reply was: "I drink and smoke and I am two hundred percent fit."

Lady Nancy Astor: “Winston, if you were my husband, I'd poison your tea”. Churchill: “Nancy, if I were your husband, I’d drink it”.

To Lord Chamberlain after he signed the treaty with Hitler in Munich "You were given the choice between war and dishonour. You chose dishonour and you will have war."

“No comment is a splendid expression. I am using it again and again”.

“I may be drunk, Miss, but in the morning I will be sober and you will still be ugly”.

“It has been said that democracy is the worst form of government except all the others that have been tried”.

“I am ready to meet my Maker. Whether my Maker is prepared for the ordeal of meeting me is another matter.”
In memoriam

John E. Morgan (1933-2010) passed away in Geneva on 18th June 2010

John was born in Hobart, Tasmania in September 1933. Having excelled in mathematics at school, he worked for Price Waterhouse Accountants in Sydney until he was recruited by WHO for a post in SEARO in 1962. In 1967, he was transferred to Geneva for a couple of years until he was reassigned to EMRO. 1975 saw him back in Geneva where he progressed through the post of Chief IPC to become Chief Accountant.

After his retirement in 1995, he continued to work part-time at WHO for several years, but he was starting to have some health problems culminating in a heart transplant on 22 July 1999. He recovered well and led as full a life as he could for ten more years. John was respected for his professionalism, knowledge, attention to detail and his commitment to the Organization. He was also a very sociable person and kept contact with his many friends throughout the world.

John was a proud Tasmanian and he was also a great Royalist. He had many and varied interests, including golf and philately and a great love of trains and aircraft. His knowledge of 20th century military history was encyclopaedic and he served the Swiss branch of the Royal Air Force Association as treasurer for 8 years.

It was commonly known that John was not always easy to get on with, being stubborn and often short-tempered. Despite all that, he was a big-hearted and caring man with a great sense of humour who was devoted to his family and friends. He is survived by three children and five grandchildren.

Richard Saynor

Marc Louis Bazin, former World Bank economist who succeeded Dr Pierre Ziegler as second Director of the Onchocerciasis Control Programme in the Volta River Basin area in the mid 1970s died in Haiti on 16 June.

Marc Bazin was generally credited with consolidating the OCP structures and strengthening its international dimension. One of his former colleagues said “he was probably the best boss I ever had. He had the rare capability of being able to listen to his advisors and letting his technical people get on with the job without interference”.

It was during the severe drought of the early 1970s that Robert MacNamara (then head of the World Bank) was introduced to the human and economic consequences resulting from onchocerciasis, or ‘river blindness’, during a visit to West Africa. He delegated Marc Bazin to assess possible Bank involvement in the planned oncho programme. Bazin recommended that the Bank take on the role of mobilizing and administering resources.

After leaving OCP, Marc Bazin was assigned by the Bank to set up a Development Bank in Haiti during the era of Jean Claude (Baby Doc) Duvalier. In 1982, the Bank, pushed by the US, demanded that in return for further assistance Bazin be appointed Minister of Finance and Economy. His efforts to attack corruption earned him the nickname of “Mr Clean”, attempts on his life and, finally, dismissal from office. In 1990 he made a bid for the presidency, but his appeal to the educated elite could not match the populist appeal of the Catholic priest Jean Bertrand Aristide. In 1992, at the insistence of the US government of President George H.W. Bush, he was installed as Prime Minister to bring order to the chaos created by the overthrow of President Aristide by a military junta. A year later a new US President, Bill Clinton, decided that Haiti should have fresh elections and a new government was formed under Aristide who was returned to power. Until his death Marc Bazin remained active in local affairs, most recently providing support to the current Prime Minister, Jean Max Bellerive, and to the reconstruction efforts.

Son of a Haitian senator, Marc Bazin studied economics, law and sociology. An art and literature lover, he is remembered by former colleagues not only for his leadership and management skills, but also for his human qualities and his great sense of humour.

Rosemary Villars
In memoriam (cont’d)

Dr Joshua Cohen was born in Glasgow, Scotland, in 1924. After studies in Glasgow, London and Yale, he emigrated to Israel in December 1949, just married to his wife Nancy.

In 1947 he had been a doctor in camps for holocaust survivors in the South of France and in July he became doctor-in-charge of the famous Haganah-ship EXODUS 1947. He left the Israeli Army in December 1953 and worked as a director in Israeli hospitals. From 1956 to 1969 he was at the Ministry of Health in Jerusalem where he devised a hospital master plan for Israel. In this profession he was member of several committees and boards as well as Advisor to Ministers of Health, mainly in Africa.

In 1963 he became a consultant to WHO on the development of health systems. In 1969 he joined WHO, at Headquarters, and served for nearly 20 years in developing WHO’s policies and programmes for modern planning, organizational and managerial methods and information systems. As the Senior Health Policy Advisor to the then Director-General Dr H. T. Mahler, he has been the "architect" of implementing the concept of Primary Health Care. His vision "Health for All by the Year 2000" aimed at all the peoples of the world to reach a level of health that would allow them to lead a socially and economically productive life. He tried to make the world a better place through principles of equity, government responsibility and democratic participation - and he was successful in many negotiations involving Member States of WHO, industry and consumers’ organizations, especially regarding drugs and infant feeding. In the final years of his tenure he was instrumental in setting up the Global Programme on AIDS. To say it in short: Dr Joshua Cohen was of inestimable value to the World Health Organization as we know it today.

His rare sense of humour - be it in complex discussions or in sensitive human relations with colleagues - was not only helpful, but also facilitated difficult negotiations.

Dr. Cohen died on 6th July, 2010, in Jerusalem where he had lived for the last 20 years. He is survived by his wife, a son and a daughter and three grandchildren.

Ingar Brueggeman

Gennady Nikolaevich Souchkevitch passed away in Moscow on 6 July 2010.

Professor Souvhkevitch worked for WHO at the Medical Radiology Programme (1983-1988) and, then, as a Responsible Officer for Health consequences of the Chernobyl accident of the Environmental Health Department (1993-2002).

He was kind and a great friend and valuable colleague to all those throughout the world who were lucky to know and work with him. His contribution to relevant programmes was immense, being built on his deep understanding and feeling for the needs of the people and countries. He will be sadly missed by those who had the privilege to enjoy his friendship, his sense of humour, his devotion to work and standards he had set for himself.

Colleagues as well as friends from all over the world will remember him with great fondness and respect.

Victor Boulyjenkov
In memoriam (Cont’)

Raymond HUBINOIS, passed away on 14 August 2010, at the age of 85 years, surrounded by his family, near Paris

A father of two children, he was lucky to enjoy five grandchildren, and recently two great grandchildren. His retirement followed a rich and varied professional life, highlighted in particular by his work in Morocco and then at WHO, firstly in the Congo and later in Geneva. During the early years of his retirement, he carried out several long distance assignments for WHO, then enjoyed a well-deserved rest, spending his free time between Le Pecq in ‘les Yvelines’ and Menton in the maritime alps, a town of which he was particularly fond.

Unfortunately his retirement was tainted during the last seven years by the arrival of a long illness which he immediately confronted with courage and tenacity. During the past few months, it was thanks to the devoted and attentive care of his wife, his ‘favourite’ nurse, that he was able to stay at home, close to us all. He therefore had the chance to stay close to his wife, his children and his grandchildren, until the end.

His courage during the last few years, without ever complaining, and the extraordinary confidence he had in medicine throughout his ordeal and until his last breath, will remain as an example for his wife, children and grandchildren.”

Yves Beigbeder and Jean-Paul Menu attended his funeral. Yves spoke on behalf of the AFSM and in his own right as an old friend of the family.

Jan Atkins passed away on 9 June 2010

Jan was born on 15 September 1935. She was a wonderful English lady who worked tirelessly in TDR’s communications section from 1979 until 1994, when she left to return to England with her husband Geoff on his retirement. Jan always joked that she came to help TDR for just a couple of weeks and ended up staying some 15 years!! With her easy-going and kind personality, and sense of fun, she loved to help everyone and we all enjoyed working with her. She took great pride in promptly sending documents to scientists in the disease endemic countries to help their efforts and many wrote back to thank her for her help. All this started in the days before emails!

Jan is survived by her husband, her son and daughter, and five grandchildren of whom she was rightly very proud.

Lynda Pasini and Sue Block Tyrrell
Joining AFSM – Updating membership

**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?

We 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 .............................                                    ...
Date of separation from WHO ………………………………. Length of service with WHO ....................................................
I should like to receive documentation in □ English □ French
Date …………………………………………………………………………………………………………………….. Signature