The new year has been marked by the catastrophic event in Asia which also has generated an unprecedented wave of sympathetic solidarity among all peoples. This natural disaster is supplementary to those created by man – wars, genocides, famines, etc. – as well as those man can alleviate – AIDS, malaria, etc.

As our colleague, Dr. Jacques Hamon points out in a letter (reproduced in the Readers’ Corner) the deaths caused by the latter are roughly equivalent to 83 recent Asian Tsunamis…

The new Executive committee of the Association, elected in October 2004, has started its work. It wishes to share two welcome news for the retired.

First, the Health Insurance has finally abolished the decreasing scale of reimbursement for long term nursing services as long as it is called for by a medical certificate every six months (see details on p. 3). This is only a first step towards improving reimbursements for long term care especially in view of the favourable actuarial state of the finances of the Health Insurance.

The other welcome news is the decision of the UN General Assembly to gradually eliminate the 1.5% initial deduction from the cost of living (COL) adjustments instituted some years ago to address the then actuarial deficit. Hopefully, pensioners will see the incorporation of 0.5% of withheld COL increases on 1 April 2005 (see under Pensions p. 3).

D. Cohen

Murder of a WHO staff member

Particularly sad news is the murder of Lisa Véron, who worked first at HQ, then for the Regional office in Harare in the Stop TB programme since August 2004. She died on 10 January 2005 following a murderous assault and WHO is assisting in the inquiry into her murder.

The Committee extends heartfelt condolences to her family and her colleagues.
The disaster of the Tsunami has been reported as unprecedented both by its extent and the international response. WHO (SEARO, HQ, country offices), along with national and international partners, have made a huge and timely response. After the first emergency phase, our Organization has given priority to the surveillance of epidemics, equitable access to care, water and sanitation, mental health and the distribution channels for medical supplies. The coordination among national and international partners and the need to address long-term reconstruction needs remains of overriding concern.

In the next months and years to come, WHO should support local and national authorities in making the best use, and keeping control, of the external resources. This is possible only if WHO maintains a round the clock involvement – a fact that has been acknowledged by the Director General – Dr. Jong-wok Lee – and the Regional Director – Dr. Samlee Pliangbangchang. Mr Roger Fontana – President of the AFSM, Geneva, has assured the President of AFSM, New Delhi – Dr. H S Dhillon – and the Regional Director of all our support.

For further details, please access www.who.int

The WHO Voluntary Emergency Relief Fund (VERF) acknowledges with gratitude the many generous contributions received from former WHO staff for Tsunami relief (Maryvonne Grisetti, treasurer of VERF)

Free opinion: The international response to the Tsunami

As international civil servants, we are very happy to see the unprecedented generosity of the international community towards the victims of the disaster which has affected the countries around the Indian Ocean. Without delving into its causes, we would like to examine some implications of this response.

Will not the hundreds of millions of dollars received by the big humanitarian NGO’s overwhelm their operational capacity? Will they not be tempted to go beyond their mandate and assume a wider role for which they are ill-prepared technically and even more important politically? Once the emergency is over, and having to show the donors that their money will be well-spent, can they accept that reconstruction and development must be directed by national authorities with – if necessary - the support of the United Nations in the spirit of full national sovereignty?

In recent years governmental aid for development has been progressively replaced by humanitarian aid with high visibility – probably more for visibility than for real needs. For the Tsunami, the governmental pledges had an aura of auction – who can give more! One wonders what this will lead to.

Even the media has actively and directly sought contributions while there are numerous examples of major disasters which have not had the requisite media attention. Will not the TV watchers be more and more convinced that only those events with high media attention merit their generosity? It is for these reasons that “Doctors without Borders” (Médecins Sans Frontières) very early refused to accept further contributions from the public for this disaster – a fact well understood in many of the donor countries. Also this was an occasion to underline that NGO’s must respect the wishes of the contributors regarding the purpose of their donations even if there are other programmes lacking funding.

Dr Jean-Paul Menu jpmenu@attglobal.net

Comments from our readers are welcome
ew Year brings in better benefits under the staff health insurance

Amendments to the Staff Health Insurance rules, in particular affecting benefits for temporary staff and for those who require long-term nursing care, have been approved by the Director-General. Revisions to the Staff Health Insurance Rules are effective as of 1 January 2005 with no increase in the premium rate.

The WHO Staff Health Insurance will cover pre-existing illnesses such as HIV/AIDS, cancer, heart disease, and others, for all temporary staff from the first day of service. Furthermore, after three months of service under the partial Insurance plan (Appendix C) and regardless of the length of their following appointment, temporary staff will be eligible with their family members for full insurance, under paragraph 50, and will be able to continue to be covered provided there is no interruption in participation. This rule does not apply, however, to consultants and temporary staff with daily contracts.

Another significant change is that long-term care will be reimbursed at the constant rate of 80% and no longer at a decreasing rate. The maximum basis for reimbursement per day is maintained at USD 80. The rule will now be worded as follow (changes in bold):

210 Reimbursement may be claimed for the cost of the following services, whether provided in a hospital or elsewhere, …
210.7 Domiciliary or institutional nursing services (provided by persons recognized or authorized to provide such services by the competent authorities) prescribed by the responsible physician or medical specialist when the patient is suffering from:
(a) an acute condition;
(b) a chronic disease, including a geriatric condition, approved in advance by the Headquarters Surveillance Committee in consultation with the relevant regional surveillance committee, at 80% of the cost of the nursing services only, subject to a maximum amount of US$ 80 per day, regardless of the duration of the condition and subject to presentation of a medical report to the relevant staff physician every six months.

Other benefits have also been increased or improved. Details of these changes will be or have already been provided to you by mail.

These recommendations were made at the sixth Joint Meeting on the Staff Health Insurance held in October 2004 in Geneva. A joint meeting of Surveillance Committees from Headquarters and the regions, with representation from the administration, serving and retired staff, meets once every three years to consider proposed modifications to the rules and practices of the Insurance. The recommendations of the Joint Meeting were forwarded to the Director General for consideration mid-November.

Claude HENNETIER
Head Staff Insurance / Acting Secretary of the WHO HQ Surveillance Committee

In his written response to the questions asked by the AAFI/AFICS Committee, Mr. Bernard Cochemé, CEO/UNSJPFS states (14 October 2004): “…on the basis of its discussions, the Board decided to:

(a) recommend a phased approach to the elimination of the 1.5 per cent reduction in the first CPI adjustments due under the TIT (Pension Adjustment System to benefits in award;
(b) recommend, as a first step, to reduce the reduction rate from 1.5 per cent to 1.0 percent, with effect from 1 April 2005;
(c) recommend, also with effect from 1 April 2005, that a 0.5 per cent increase be applied on the occasion of the next adjustments to the benefits in payment to existing retirees and beneficiaries who already have had the 1.5 per cent reduction applied to their benefits; and
(d) address in 2006, subject to a favourable actuarial valuation as at 31 December 2005, the possible total elimination of the balance of the 1.5 per cent reduction and, on an equal footing, the possible elimination of the limitation on the right to restoration based on the length of the prior service..”.

The retirees should see this improvement on their pension sheet of April.
First aid for heart attacks- How to survive a heart attack when alone?

Let's say it's 6:15 p.m. and you are driving home (alone of course) after an unusually hard day on the job. You're really tired, upset, and suddenly you start experiencing severe pain in your chest that starts to radiate out into your arm and up into your jaw. You are only about five miles from the hospital nearest your home; unfortunately, you don't know if you'll be able to make it that far. What can you do? You've been trained in Cardiopulmonary Resuscitation (CPR) but the guy that taught the course neglected to tell you how to perform it on yourself (People recently trained in first-aid, please note!).

Without help, the person whose heart stops beating properly and who begins to feel faint, has only about 10 seconds left before losing consciousness. However, these victims can help themselves by coughing repeatedly and very vigorously. A deep breath should be taken before each cough, and the cough must be deep and prolonged, as when producing sputum from inside the chest. A breath and a cough should be repeated about every two seconds without let up until help arrives, or until the heart is felt to be beating normally again. Deep breaths get oxygen into the lungs and coughing movements squeeze the heart and keep the blood circulating. The squeezing pressure on the heart also helps to regain normal rhythm. In this way, heart attack victims can get to phone and, between breaths, call for help. (Since many people are alone when they suffer a heart attack, this article seemed in order). Here are possible signs of heart attack:

- Fullness, pressure, heaviness, squeezing in mid-chest lasting more than just a few minutes.
- Pain in the arms, shoulders, neck, stomach, lower abdomen, or back.
- Sweating, nausea, vomiting, dizziness, shortness of breath, or difficulty in breathing.
- Cool and/or clammy skin, palpitations, paleness

(Courtesy: Health Cares, newsletter of Rochester General Hospital)

Short news

Iodine deficiency

The number of countries where iodine deficiency is a public health problem has halved over the past decade, according to a WHO report (DeBenoist, B. Iodine status worldwide, WHO, 2004). The main strategy - universal salt iodization - has been successful. However, 54 countries are still iodine-deficient.

Framework Convention on Tobacco Control

By December 2004, the Convention, adopted by the World Health Assembly on 21 May 2003, has been signed by 168 countries and ratified by 48. It enters into force on 27 February 2005.

(from WHO press releases)

A retinal implant microchip to treat macular degeneration?

Thirty million people worldwide are afflicted with age-related macular degeneration and retinitis pigmentosa, two potentially blinding eye diseases. Clinical trial results published this past April confirmed that a microchip developed by Optobionics that is implanted under the retina resulted in significant visual improvement with virtually no adverse side effects. The chip, thinner than a human hair, emits electrochemical impulses to stimulate the remaining healthy retinal cells. It derives its power from light entering the eye and reaching 5,000 micro photodiodes, which allows the chip to function free of wires or batteries. The operation lasts about two hours...

(Excerpted from Scientific American, December 2004)
Advance directives are oral or written instructions regarding your medical care preferences. Your family and medical professionals will turn to these directives if you lose the capacity to make your own health care decisions or you sustain an injury that renders you unable to express your wishes. Any competent individual age 18 or older may prepare an advance directive.

Advance directives primarily take one of two forms:

**Living will.** This written, legal document spells out the types of medical treatments and life-sustaining measures you do and don't want, such as mechanical respiration and tube feeding. In some states the living will may be known by a different name, such as health care declaration or health care directive.

**Medical power of attorney (POA).** Also called a durable power of attorney for health care, this legal document designates an individual to make medical decisions on your behalf in the event you’re unable to do so. The person you designate is known as a health care agent or proxy. The medical POA is different from the POA who authorizes someone to make financial transactions for you.....

In determining your wishes, think about your values, such as the importance to you of independence and self-sufficiency and what you feel would make your life not worth living. Is the treatment lifesaving or life-sustaining? Does that make a difference to you?

Treatments to consider include:

**Resuscitation.** Restarts the heart when it has stopped beating (cardiac death). Determine if and when you would want to be resuscitated by cardiopulmonary resuscitation (CPR) or by a device that delivers an electric shock to stimulate the heart.....

**Mechanical ventilation.** Takes over your breathing if you’re unable to do so. Consider if, when and for how long you would want to be placed on a mechanical ventilator. Would it matter what your prognosis was or if your condition was improving

**Nutritional and hydration assistance.** Supplies the body with nutrients and fluids intravenously or via a tube in the stomach. Decide if, when and for how long you would want to be fed in this manner. Would it matter what your prognosis was or if your condition was improving?

**Hemodialysis.** Removes waste from your blood and manages fluid levels if your kidneys no longer function. Determine if, when and for how long you would want to receive this treatment. Would it matter whether the treatment would be permanent rather than temporary?

**Treatments in the end stages of life.** Examples include but are not limited to antibiotics, pain medication and mechanical ventilation. Would you want to receive these as comfort (palliative) care if your prognosis was that it would only delay imminent death?

Also determine whether you’d like to donate your organs for transplantation or your body for scientific study.....It's important to put everything in writing....You may want to consult an attorney concerning this process.....Once you have filled out the forms, give copies to your doctor, your surrogate decision maker and perhaps other family members. Periodically review the forms.

Abstracted from the web site of the Mayo Foundation for Medical Education and Research (MFMER). All rights reserved. [http://www.MayoClinic.com](http://www.MayoClinic.com)

Other useful web sites: [http://cis.nci.nih.gov](http://cis.nci.nih.gov)
[www.peopleslawyer.net/willform.html](http://www.peopleslawyer.net/willform.html)

(for an example of Advance directives, see Dr Jean-Jacques Guilbert's article on page 5 of the French side).
History -- It is Important!

Q staff, young and older, as well as many visitors filled the WHO Executive Board Room on 26 January 2005 from 12:00 to 13:30 to attend a seminar on the "The Role of WHO in the History of Global Health" which highlighted the historical relevance of primary health care since 1978, and the transition from PHC to global health. Several departments at WHO sponsored the seminar: KMS Global Health Histories, Knowledge Communities and Strategy, Library and Information Networks for Knowledge, Staff Development and Learning, and Records and Archives.

Introducing the speakers, Dr Ariel Pablos-Mendez, Director, Knowledge, Management and Sharing emphasized that history not only describes the past, it allows us to harvest its lessons and understand the forces that shape our choices and opportunities in the future; history provides us with meaning and inspiration.

Of special interest to all the attendees was the first speaker, Dr Halfdan Mahler, former Director-General of WHO and the father of primary health care. Those of us who served under Dr Mahler were moved to hear his familiar voice again in the EB room as he outlined his public health work in the tuberculosis campaigns in Ecuador and India, his service under Dr Candau at WHO and his appointment as Director-General in July 1973. He spoke about the inspirational energy resulting in the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. During the question and answer period, he observed that the most wonderful event during his career at WHO was the time of consensus reached by the representatives of 134 governments and 67 international organizations attending the Alma Ata Conference and how this agreement then resulted in a new, community-based approach to health care in countries.

The next speaker, Dr Marcos Cueto, University Cayetano Heredia, Peru, has written a book published by PAHO: El valor de la salud: historia de la Organización Panamericana de la Salud, 2004. Dr Cueto spoke about the origins of primary health care, outlining its background and context, the primary actors and its impact and legacies. Again he referred to the Alma Ata Conference as a watershed event and a worldwide sounding box.

Dr Elizabeth Fee, Chief, History of Medicine Division of the National Library of Medicine, USA as the final speaker, defined "international health" as concerned with activities across national borders, for example the control of epidemics. "Global health" addresses the health needs of people across the planet. She asked the question: "Is this meaningless jargon or is there a major shift in health care today from international health to global health." Outlining the history of the World Health Organization, she concluded that the movement toward the concept of global health could mean a restored leadership role of WHO as the unquestioned steward of the health of the world population.

A number of questions followed these inspiring and thought-provoking talks. It was a real pleasure to see the history of WHO taking center stage. We would like to hear from any of you out there who attended the Alma Ata Conference and who might have some particular memories or lessons for the future to share with us.

Carole Modis, cmodis@gmail.com

For further reading:

From the left side: Mr Thomson Prentice, Dr Halfdan Mahler, Dr Elizabeth Fee, Dr Ariel Pablos-Mendez, Dr Marcos Cueto
When I was asked to write a few sentences on the recent Executive board, I regretted that I had not followed the discussions better. The Governing Bodies hold a particular fascination for me since for about ten years in the mid eighties I was coordinating them. But then there was no special office of Governing Bodies nor staff exclusively allocated for those functions. People used to be detached during the meetings (which lasted about two and a half to three weeks) and would go back to their programmes after the meetings ended. My involvement was also long drawn – I was, at first, Assistant Secretary of Committee A (in those days there was only one Secretary and one Assistant) in the World Health Assembly for about five years, Secretary for four years, and Assistant Secretary to the Board for about seven years – all under Dr. Mahler. With the advent of Dr Nakajima, an Office of Governing Bodies was created – and I continued as Chief until 1993. In addition to Governing bodies, we also had to provide support to other meetings, coordinate the biennial programme-budget and co-ordinate the development of the general programmes of work. Since then, durations of the Board and the Assembly have been drastically reduced, Members in the Board now speak on behalf of their countries, and not in their individual capacities, and the incisiveness of discussions has gone down.

This particular Board saw a reversal in the drop in quality of discussions and many delegates were quite well prepared. To select one particular delegation, that of Thailand seems to have done a thorough preparation on every item on the agenda – as is usually the case of only the major contributing countries – but occasionally they could be a little prickly. The Chair – Dr. Gunnarsson of Iceland – had a nice touch and made members feel at ease. There were many technical subjects under review and, on the whole, they were well reviewed. The administrative issues were efficiently dealt with. Two NGO’s which had applied for official relations withdrew their applications. Since both of them were related to grocery or food manufacturers, one wonders what happened in the background and whether we are seeing a slight reversal of the all-encompassing public-private partnerships that has become the rallying cry of international organizations.

The major issue in front of the Board was the review of the proposed Programme budget for 2006-2007. The proposal called for about a 9% increase in the regular budget – which, in old days, would have dismayed us. The discussion, as such, seemed to be quite constructive and only a few major contributors raised questions about the level of the budget. The discussions, however point to three major observations. Rule 97 of the Rules of Procedures of the Assembly explicitly state that the Assembly “shall adopt the budget .. for the next financial period after consideration of the DG’s budget estimates and the Board’s recommendations thereon;”. In our days, we used to have a formal report from the Board to the Assembly outlining its recommendations – a report considered “important”. There is no longer such a report – or any report at all. Apparently, this report has disappeared since about ten years – perplexing! The second observation is that the ADG in charge of Administration was at the table during the whole budget discussion – in early times he was there only when the budget level was considered. Third, a statement from the Secretariat was heard that the Board would be presenting its recommendations to the DG. The Constitutional provision of the DG being under the authority of the Board is probably also changing.

The above are some personal comments. In conclusion, the recent Board took place in the midst of snow storms and a very cold and windy spell which did not deter the delegates from participating actively.

Dev Ray devray@gmail.com
A citizen of Trinidad and Tobago, our life member Dr Fitzroy Gregory Joseph wrote to QNT in order to let us know about his present life, very active, in Trinidad. He wrote many books, including poetry, and has just published a biography of what he calls one of Trinidad’s icons in Community work:

“The life of Nesta Bonaparte Patrick. A truly Caribbean woman”

1Published by: The University of the West Indies school of Continuing studies, St Augustine, Trinidad & Tobago, 2004

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Fitzroy Gregory Joseph was born in Trinidad …

His tertiary professional education and training was in the USA, Europe and the United Kingdom. He is a medical doctor and a Public Health and Family Health Specialist. He worked in French and Belgian hospitals then went to Kenya to train doctors, midwives and nurses, and to open clinics in rural areas... He joined the World Health Organization (WHO) subsequently and was Family Health Adviser firstly to the Solomon Islands, Western Pacific, and then in the Regional Office of the WHO in Manila. He was then appointed Team Leader of the Inter-country Family Health Team in Africa, based in Cotonou, Republic of Benin. In addition, he was called to the Regional Office for Africa in Brazzaville, Republic of the Congo. “…to oversee the Family Health programmes of the Sub-Saharan countries.

In 1987 Dr. Joseph took early retirement from WHO but continued assignments as a consultant with WHO and other UN agencies. In 1989 he joined the Faculty of Medical Sciences, The University of the West Indies, Mount Hope, Trinidad as Senior Lecturer in the Community Health Section and retired in 1995.


Dr. Joseph is a lover of music generally, but particularly some types of classics, jazz, blues and Caribbean-Central South American music. Plants are part of his living world.

Self-help Group

The Self-help Group has been in existence for eleven years. Its principal aim was to provide a means for colleagues retired in the Geneva area to stay in touch through monthly meetings for coffee followed by lunch for those who wished to stay.

A list was drawn up and circulated of members of the Group who would be willing to receive calls for assistance from others (this was the “Self-help” bit).

Over the years, some 60 names are on the list of whom about a dozen come frequently to the coffee/lunches - this is, in fact, a good size for the Buffet de la Gare, our current meeting place. Other centrally placed restaurants do not welcome groups who arrive at around 11.00 and don't all stay for lunch!

The Group is very friendly and we have often received messages from those who come rarely, or not at all, but who are pleased to know that we exist. However, it is a fact that the idea of offering help to those who run into some problem has not really taken off. Of the cases we have had, all have contacted the organizers of the Group; no-one used the "network" set up.

Two things seem clear: retired staff seems to stay largely within their own age group and we see now the 70-80 year-olds. The older ones were mostly out of touch before we started, and the younger ones don't come "because I don't know anybody". The other thing is that the sort of people who come to meet others are not the ones who suddenly find themselves in need (except for bereavement), the sort of people who are alone in need are the sort of people who do not come out to meet former colleagues with whom they were not friendly while in service.

Margaret Baker and I very much hope that those who come for coffee/lunch will be encouraged to continue - it seems that they plan to - but this is not the method of helping those who fall by the wayside.

We both hope that the Executive Committee will organize social activities/outings, etc.. which might include a member of the EC going along to the coffee/lunches once a month. However, we do feel that some other method is needed to help the shyer people - it seems unlikely that none have problems. With this in mind, we urge the EC to collect information on EMS, private homes or residences where help is available for those needing some assistance while retaining their independence.

Rosemary Bell
Dr. Sabih Djazzar passed away on 15 December 2004. His death was a great loss to his family, friends and former colleagues, and caused them much sorrow and pain. Sabih was a dedicated health worker. Having qualified as a physician from the Medical School, Damascus University in 1950, he started working for WHO in 1962, as a short-term consultant in EMRO, then as a staff member in 1965 until his retirement in 1985. The greatest part of his WHO career was spent in AFRO, inter alia as WR in the Congo, Brazzaville, Togo, and Niger, to give but some examples. His last few years of service were at HQ, at the then Division of Coordination. His services in AFRO were highly appreciated by the Member States in which he served, and he was awarded the title of “Officier de l’ordre de Mono” by the President of Togo, for his distinguished services in that country. Even after his retirement from WHO, Sabih continued to serve the cause of public health, working as a UN volunteer in Jamaica, Kuwait and the United Arab Emirates.

Sabih possessed many fine human qualities and a very high degree of loyalty towards his family, friends and the Organisation. He was always ready to provide help and advice, whenever asked, and he offered it with humility and sincerity. He had a great faith in his religion (Islam), but he was neither rigid nor radical in his religious approach. We used to have lunches with him, and he would happily advice about what wine to order, would smell it to assess its quality, but he never touched it.

He will be greatly missed by his family, friends and former colleagues. He is survived by his wife, two daughters and a son.

Sami Shuber

Dr. Djazzar, who had been a member of the 2000-2002 AFSM Committee, was much appreciated for his courtesy and loyalty. The Committee extends heartfelt condolences to his family and friends.

Eugène SERVAIS passed away on 20.09.2004 at the age of 80 years. He had joined WHO in 1949 until his retirement in 1982. He was employed in the Treasury Unit of Finance Section and, for most of his career, was the only citizen from the Grand-Duchy of Luxembourg.

"Oosh", as he was known to his friends, was a "fun" person. After World War II, most of which he had spent in a Belgian army unit in Great Britain, he served for a time in UNRRA, then he was recruited by WHO. In 1951, he married Grace Spencer, a fellow staff member.

He was full of laughter and good humour, making the Treasury Unit a most desirable place in which to work. Oosh became Chief of Treasury. He had seen the unit grow. In the latter years of his stewardship, it was turning over close to 500 million dollars p/a.

Eugene Servais was an asset to WHO: he "stretched" the Organization's liquid funds by astute professional and competitive placement and investment.

His passion was mountaineering. For more than 25 years he was a member of the Swiss Alpine Club’s Geneva section, where he planned and organized climbs as the "Chef de la Commission des Courses". There weren’t enough mountains for Oosh to climb in the Alps of Switzerland and neighbouring countries, so he made periodic expeditions farther afield, to conquer peaks in the Atlas range, the Andes, the Rockies and South Africa. He still found time each year to take a small group of office colleagues on a climbing week-end. He was still "fun-Oosh" at his best. Those trips were invigorating and sometimes exhausting, but always hilarious.

He is survived by Grace, his wife of 53 years, his children, Jackie and Frank, and his grandson Nicolai ("Kolya"). He will be sadly missed.

Tony Ingram
On the light side

An old advertising for wine aimed to car drivers, in the French road maps at the time when people did not know that « Drink or drive, you must choose »

Hopefully, things have changed.

A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it.

Max Planck, 1949
World Health Day

The slogan for World Health Day 2005

Make every mother and child count

reflects the reality that today, the health of women and children is not a high enough priority for many governments and the international community. WHO is pleased to announce healthy mothers and children as the theme for World Health Day 2005. This is also the subject of the World Health Report 2005, which will be launched on World Health Day, on 7 April 2005.

MESSAGES FOR WORLD HEALTH DAY 2005

Too many mothers and children are suffering and dying each year

Healthy mothers and children are the real wealth of societies

Millions of lives could be saved using knowledge we have today; the challenge is to transform this knowledge into action

In order to make a difference, we must all join forces and act. Together we can do it. Each one of us has a role to play. AFSM is an active participant in World Health Day.

(For details, please see the WHO website: http://www.who.int/world-health-day/2005/fr/index.html

Elections 2004 – Did you vote?

Voting is a high point in the life of AFSM as it represents a formal opportunity to demonstrate its members’ commitment to our Association.

We took advantage of the ballots received to provide you with statistical data on your voting behaviour!

Ballots were sent to the 779 paid up members (life and annual members). You were 366 (47%) to mail them back.

50% of the 440 members living around Geneva did vote, compared to 46% of the 339 members living in 59 different countries.

59% of the 563 life members voted but only 41% of annual members

Considering only those countries with more than 10 members, the United Kingdom held the record with 54% of voters, followed by France (50%) and USA (50%). Does that reflect ethical concerns or simply an efficient postal service?

While the Committee would have hoped for a higher voting rate, it notes with pleasure that being far away from Geneva is not necessarily a constraint to feeling part of the Association. The comparatively good response of members outside the Geneva area reinforces our commitment to consider their specific needs.

Whether you did vote or not, the Committee would be happy to receive your feedback on those results. This will be one way to improve the life of the Association.

jpmenu@attglobal.net
Our recent history was marked by two spectacular events, the attacks of 11 September 2002 against the United States, which prompted profound changes in US international politics, and the South-East Asian tsunami at the end of 2004, which resulted in a wave of extraordinary solidarity. Currently, nearly 83 million people die each year, more than a quarter of them prematurely, from easily avoidable or curable causes—nearly 21 million each year. With reference to the attacks of 11 September or the recent tsunami, these yearly premature deaths are equal to the impact of 83 tsunamis or 7,000 September 11 attacks—causing no reaction from anyone. Curious, isn’t it?

Jacques HAMON 4, impasse du Coteau, 74240 GAILLARD

ED.: Reactions to Dr Jacques Hamon’s commentary are welcome!

Mr President, Dear Colleagues,
First of all, allow me to send my best wishes to all for a very happy year—2005. I would like also to congratulate Roger Fontana on his election as President to the Association of Former Staff Members. The Association carries out remarkable work informing and defending the interests of retired WHO staff. In particular, the Quarterly Newsletter, which we receive regularly, merits our appreciation for its clarity and the quality of articles it contains.

Prof. Dr Michel Mercier, Belgium

Dear Ms. Foster,
Towards the end of each year, former WHO staff often remember their dear colleagues and the years they spent together serving the country members of their regions in the promotion of their health services to address the health needs of their people. Therefore, I and my family wish to seize this happy occasion to convey to our WHO/AFSM President, Dr. D. Cohen, and to the committee members of the AFSM NEWS, and to all the WHO retirees, especially my EMRO colleagues, where I have worked more than three decades, our sincere greetings and good wishes for a Merry X-Max wishing all good health, happiness and joy all through the coming New Year. HAPPY NEW YEAR.

Dr. K. Mneimne Former WHO/EMRO Regional Adviser (RA/EDH)

N.B: I have transferred the sum of USD 100 to the AFSM’s account as a contribution to support our AFSM Quarterly News.

Thank you very much to our readers, especially to Dr Mneimne; your appreciations touch us very warmly.

Information to retirees residing in Geneva and surroundings: Once a month (first Friday), former staff members meet at the Café de la Gare, Cornavin, around 11 a.m. to have coffee and/or lunch together. You are welcome.

Congratulations to all those who have contributed to this issue through their articles and/or translations (Editorial Board: Yves Beigbeder, Samy Kossovsky, Jean-Paul Menu, Carole Modis, Dev Ray, Rosemary Villars; Editing and layout: David Cohen), with a particular gratitude to the printing, distribution, and mailing services.

The views expressed in QNT are not necessarily those of AFSM
Readers are highly encouraged to dialog between themselves and with the Editorial Board, through the Readers’ Corner as well as articles.
Joining AFSM

Former staff not yet members who would like to continue to receive our newsletter and circulars, vote to elect our representatives, etc., should become members by filling in this form and send it to office 4141 (see address on top first page). Annual membership is 20 CHF and life membership 250 CHF (unchanged since the beginning of the association).

Dues can be given either in cash at the office or through postal form (add 2 CHF for charge) for persons who live in Switzerland, or by bank shift at the AFSM account number (+ bank charge, if any):
IBAN : CH 4100279279-D310-2973-1
SWIFT : UBSWCHZH80A

APPLICATION FORM

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Phone Fax ......................................................... e-mail .........................
Date of Birth .....................................................................................................
Nationality..........................................................................................................
Date of separation from WHO Length of service with WHO ......................
Function occupied on separation ........................................................................
I should like to receive documentation in □ English □ French
Date........................................................................................................ Signature