Greetings from Nepal

New year greetings card sent to the Editor by Mrs Krishneswori Pradhan from Katmandu, Nepal; Mrs Pradhan has sent similar cards to all members of the Committee. We send her our warm thanks and our best wishes.

Dear friends,

Here is the first QNT for 2006, number 63, and already the thirteenth in the new format, which we hope that you like. We count on each and every one of you to help us improve the contents. When talking about “constructive” criticisms we just mean they help us to give you a better newsletter. We hope that you find the articles on WHO history of interest, and we would welcome more of your comments for the “Readers’ Corner”.

Once again we request you to send us stories, memories and other articles; we would like the newsletter to stimulate a dialogue among former WHO staff.

D.C.

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Association of Former WHO Staff
Health Insurance

All of you have received from Health Insurance a leaflet summarizing present rules and benefits. We thought it useful to reproduce the main benefits.

**Services reimbursed at the rate of 80% include**:  
Reimbursable Medicaments (*medical prescription required*)  
Physicians and Specialists  
Radiology (*medical prescription required*)  
Laboratory examinations (*medical prescription required*)  
Ambulance in an emergency to the nearest hospital  
Hospital expenses excluding cost of accommodation

- **Subject to maximum daily rates**  
  Hospitalization *private or public hospital (accommodation)*  
  European countries *(except Switzerland)* USD 500  
  Switzerland *(details on request from HQ - e.g. CHF 580 in 2005)*  
  Rest of world *(details on request from regional office)*  
  **Long-term nursing care** *prior approval of HQ Surveillance Committee + medical report every 6 months* USD 80

- **Subject to time limits**  
  Convalescence after hospitalization *(after 15 days: medical report + approval)* 15 days

- **Subject to maximum authorized ceilings**  
  Optical: glasses/contact lenses every 2 years max. USD 400  
  Optical: new lenses *provided change dioptre of at least 0.25 within 2 years of last reimbursement* max. USD 300  
  Refractive eye surgery: *per eye during whole period of participation (specific conditions apply)* max. USD 2000  
  Dental benefits: *annually + unused portion of available credit from previous 2 years* max. USD 1500  
  Psychotherapy: *every 5 years (medical prescription required)* max. USD 6000  
  Hearing aids: *per ear every 5 years (medical prescription required)* max. USD 1500  
  Physiotherapist/Osteopath/Chiropractor: *every 2 years (medical prescription required) beyond this a medical report is required* max. USD 30 sessions

**Services reimbursed at the rate of 100%***  
- **Preventive measures** *(medical prescription required)***  
  Mammography every 2 years *after age 40* max. USD 200  
  Gynaecological check-up every 2 years max. USD 100  
  PSA *(prostate specific antigen) every year after age 50* max. USD 50  
  Consultation with a dietitian *per consultation: up to 10 consultations if BMI >30* max. USD 40  
  Colonoscopy every 5 years *after age 50* max. USD 600  
  Medical check-up every 2 years for retirees and their dependants *(except children)* max. USD 300  
  HIV test *annually (including pre-test and post-test counselling)* max. USD 100

- **Hospitalization in a 4-bed room in a public hospital**

**Non-reimbursable services include:**  
Some medicaments***  
Thalassotherapy/thermal cure/etiopathy  
Natural or alternative medicine *(e.g. phytotherapy/naturopathy)*  
Repatriation costs, rescue costs, funeral expenses

* All benefits are subject to the conditions set out in the SHI Rules
** 80% reimbursement for costs in excess of these amounts.
*** For any question, please contact SHI.
Age-related Macular Degeneration

Age-related macular degeneration (AMD) is the principal cause of blindness in people over 50 years of age in industrialized countries where it represents a major public health problem. This condition only affects the macula, the central and most sensitive area of the retina, which is used to process objects e.g. words, images, faces, colours.

Factors that trigger of this condition are little understood.

Factors that favour its development seem to be genetic predisposition, age, exposure to sunlight and other factors such as smoking.

The degeneration of the light sensitive cells results in blurred vision, barely noticeable in the beginning. Near vision rapidly becomes difficult, the affected person thus cannot read or write but has good peripheral vision and can move about and remain autonomous in the home. The lesions gradually increase in size, creating a blind spot (scotome).

There are two forms of AMD:
- The dry form, where macular atrophy is observed.
- The wet form (exudative) where macula is destroyed by neo-vessels.

In the dry form, which represents 80% of cases, deposits (drusen) on the retina lead little by little to the destruction of the macula cells, causing gradual vision loss. This condition develops slowly.

In the wet form (exudative), representing about 20% of cases, abnormal growth of blood vessels behind the macula, and particularly under the fovea, (the central area of the macula where the cells responsible for greatest visual acuity are concentrated) causes oedema and bleeding which alter vision and lead ultimately to the destruction of the macula cells. These neovascular disturbances result in the distorted vision of which those affected complain.

Exudative AMD is particularly serious because the drop in visual acuity is rapid and significant and blindness can develop suddenly (within a few weeks to two years). In sixty-percent of persons suffering from exudative AMD the second eye will be affected within five years.

Detection: early warning signs are the impression of a lack of light, then distortion of lines both vertical and horizontal.

From time to time try reading with one eye only: should the line of words appear to waver the beginnings of AMD must be suspected.

Treatment: For the moment there is no treatment for dry AMD. In the wet form, an intravenous injection of *Visudyne®* renders the neo-vessels opaque and they are then destroyed by dynamic phototherapy (a type of laser). This enables the condition to be halted or delayed. As with other problems, the quicker action is taken the better the results.

*Dr David Cohen*

*Photos Fédération française des handicapés visuels de France*
Avian Influenza
(continued, but not concluded)

Avian influenza continues to take its toll among wild and domestic birds. There have also been some more human victims, in particular, children in the east of Turkey who were in direct and relatively continuous contact with infected chickens. Then a cat, which had probably eaten an infected bird, was found dead on an island in Northern Germany. Epizootic is spreading: in Africa, in France, near Geneva...

What are the perspectives for the battle to combat this disease if, as is feared, the H5N1 virus manages to adapt itself to humans? Besides the massive culling of bird stock to stop propagation of the virus, several other types of research are ongoing.

New vaccine technology

Many laboratories, notably in Europe and North America, are trying to develop techniques which raise the immune response -- intradermal vaccines, adjuvants-- which would require vaccine doses that are greatly inferior to those used presently for the prevention of seasonal influenza. In addition, new techniques for cell culture are being tried to produce large quantities of vaccinal virus. Other teams are looking at vaccines consisting of vaccinal DNA adsorbed on gold particles; these vaccines could be stored for a long time without refrigeration and would, therefore, be much easier to distribute widely. Other researchers are experimenting with vaccines which would target the viral constituents existing in all the types and strains of influenza viruses that are likely to elicit immune responses.

Anti-viral drugs

Two drugs which are active against viruses, influenza among others, are currently available: oseltamivir (Tamiflu®) and zanamivir (Relenza®); many governments have acquired significant stocks of these products to combat the expected pandemic. Some new molecules are being studied; these would use other mechanisms than those targeted by existing drugs to fight against these viruses, addressing the problem of the probable appearance of resistant strains. Clinical trials are underway or are foreseen in the near future.

All of this research is difficult, full of dead ends. There will be no tangible results for many months.

The race has begun. Let us hope that we win, not the virus.

Dr Samy Kossovsky

Sources: « Scientific American » – Institut Pasteur, Paris

Part of drugs sent to Atjeh after the Tsunami need to be destroyed

Anyone intending to donate drugs should read this article

According to a study carried out jointly by the NGO Pharmacists without Borders (PSF) and WHO, a large part of the 4000 metric tons of drugs sent after the Tsunami to the Indonesian province of Atjeh (2 million inhabitants) need to be quickly destroyed. 60% of those drugs donated by 140 donors (101 Indonesian organizations and 39 foreign governments) are not in conformity with the WHO list of essential drugs. 70% are labelled in a language unknown to Indonesian health personnel. Furthermore, according to PSF, 600 tons of expired drugs have to be destroyed without delay at an estimated cost of € 2.4 million...

PSF deplors that in crises with extensive media coverage, drug donations during the early stage of the emergency are often useless and create an additional public health problem. (abstract from an article published in Le Monde, 28 December 2005)

This situation is well known to professionals dealing with emergencies. For instance, in Bosnia Herzegovina, 1992-1996, 17 000 tons of inappropriate drugs had to be destroyed at the cost of USD 34 million. In Kosovo, 1999, 50% of drugs received had to be disposed of. Following the earthquake in Armenia in 1988, 50 staff spent six months to sort 5000 tons of drugs and rejected 60% of them. And so on...

It is understandable that well meaning members of the public who watch TV reports of a disaster take the initiative to collect and send donations in kind. At the same time, stricken countries cannot refuse donations that are already on the spot. Prevention is the only way. Ideally, the authorities in charge ought to advise potential donors of the type of aid they need and how to send it.

For examples, interested readers will find guidelines prepared by WHO and other organisations on the site www.who.int: Guidelines for drug donations, WHO/EDM/PAR/99.4.

Yves Beigbeder and Jean-Paul Menu
WHO’s Global Framework Convention on Tobacco Control

“Tobacco is the leading preventable cause of death in the world, killing nearly 5 million people every year. If current trends continue, this toll will double by 2020. Developing countries will suffer the highest burden with 70% of the deaths”, the WHO Director-General recently said.

Tobacco mortality and morbidity have been estimated to cause an annual global net loss of US$ 200 billion in health-care costs and lost productivity. Against this dark background WHO has been leading, since the early 1970s, an uphill worldwide struggle against the spread of the tobacco pandemic. Happily, after much hesitation, governments have finally understood the danger of tobacco smoking to the health and the economy of their countries. The process started with World Health Assembly resolution WHA 49.17 of May 1996. After numerous negotiating meetings of representatives of all WHO member states, the Framework Convention on Tobacco Control (FCTC) was unanimously adopted on 21 May 2003. History was made, as for the first time in its 55 years of existence WHO applied article 19 of its Constitution which reads: “The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization”.

The Convention has provisions that set forth international minimum standards on tobacco-related issues such as advertising, promotion and sponsorship, taxation and price measures, packaging and labeling, illicit tobacco trade and protection of non-smokers, especially children, from exposure to smoke. These provisions are designed to guide governments, which are free to legislate at higher thresholds if desired.

Following adoption, FCTC required ratification by only 40 governments to enter into force and become a legally binding document. The good news is that, at present, as many as 115 governments have ratified it, thus signifying how important FCTC really is. FCTC is now a law and, according to WHO, “the world has an evidence-based tool to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke”.

Roberto Masironi, former Coordinator, WHO Tobacco or Health Programme, President, European Medical Association on Smoking or Health;

A controversial issue: WHO Policy on Non-Recruitment of Smokers

As specified in the WHO website, “Smokers and other tobacco users will not be recruited by WHO as from 1 December 2005. This policy should be seen in the context of the Organization’s credibility in promoting the principle of a tobacco-free environment.” This policy has given rise to innumerable arguments in Globalink¹. Many Globalinkers felt the move was appropriate to promote the right image of WHO which fights against smoking and cannot therefore condone it “in house”. In their view, the policy could serve as an example to other health agencies, and perhaps give a signal to other UN agencies as well. On the other hand, many others, legal agents or journalists felt that this drastic measure was too extreme and discriminatory, and that it would have been enough to prohibit smoking on the premises without interfering with private attitudes. Whoever may be right or wrong, the policy is now in place. (Details available in www.who.int)

1. Globalink is a computer network managed by the International Union against Cancer (UICC). It uses Internet to provide tobacco-related news bulletins, electronic conferences, databases and directories.
For information: http://www.uicc.ch/glob/gtap.html.
History matters

WHO staff under fire

In July 1956, President Nasser of Egypt announced plans to nationalize the Suez Canal. By September, the military and political situation in Egypt was very unstable. At that time Ronnie Peters was working as the administrative assistant to Dr Aly Tewfik Shousha, the first Director of the WHO Regional Office for the Eastern Mediterranean (EMRO), located in the old Egyptian quarantine office in Alexandria.

Ronnie typed the highly confidential, four stage plan to respond to the crisis which began with a state of alert and ended with the evacuation of the EMRO staff from Alexandria.

On 1 November 1956, the order for evacuation came from the UN Secretary-General Dag Hammarskjold. It was announced that not only internationals would be taken but also locally recruited staff and dependents who wanted to leave. Some people had to make agonizing decisions whether to stay or to leave with the one piece of baggage allowed.

The last few hectic hours were filled with putting papers in order, making lists and issuing travel documents between blackouts. In the early morning, Dr Shousha said a determinedly cheerful goodbye to his staff, watching them leave for the port in a line of taxis, flanked by the custodial staff on the running boards. He stayed behind to negotiate for the release of one of the EMRO secretaries who was being held by the Egyptian authorities.

Once the quay was reached, men, women and many children and babies were loaded on to three US Navy troopships amid the intermittent firing of anti-aircraft guns as nearby airfield installations were bombed. Ronnie’s group was put on board the USS Chilton; on deck was a long table with a sign from the marines that said “We heard you were coming, so we baked a cake.”

On reaching Suda Bay, Crete, the 2000 evacuees were transferred in lighters to the troop ship, “General Alexander Patch.” They were told they were “in the Navy now” and asked to volunteer for dishwashing and other duties. WHO nurses took over the nursery where they cared for 15 babies all less than nine months old.

Four days after leaving Alexandria, the contingent arrived at Naples at 7 o’clock in the morning where they were greeted by a US Navy band, as well as by press photographers, movie cameras and Red Cross and UN officials.

In Rome, EMRO staff boarded a train for Geneva to be greeted at Cornavin train station by their WHO headquarters colleagues. EMRO staff worked from offices in the Palais des Nations until early February 1957 when most of them returned to Alexandria. During the crisis, EMRO projects on tuberculosis, trachoma, environmental sanitation and maternal and child health, to name a few, were carried out with a minimum of interruption.

Carole Modis

We are very grateful to Ronnie Peters for telling us about this remarkable chapter in her long and interesting WHO career. The photos are from slides she took during the events in 1956.

Photos: Left: Top: Boarding the troopship Bottom: Approaching the destroyer
Right: Top: Arriving to Naples Bottom: Reg Renaut on the train.
On the lighter side

**Plague or Cholera?**

The phone rings and the lady of the house answers, "Hello.
"Mrs. Ward, please."
"Speaking."
"Mrs. Ward, this is Doctor Jones at the Medical Testing Laboratory. When your doctor sent your husband's biopsy to the lab yesterday, a biopsy from another Mr. Ward arrived as well, and we are now uncertain which one is your husband's.
Frankly the results are either bad or terrible."
"What do you mean?" Mrs. Ward asks nervously.
"Well, one of the specimens tested positive for Alzheimer's and the other one tested positive for AIDS. We can't tell which your husband's is."
"That's dreadful! Can't you do the test again?" questioned Mrs. Ward.
"Normally we can, but Medicare will only pay for these expensive tests one time."
"Well, what am I supposed to do now?"
"The people at Medicare recommend that you drop your husband off somewhere in the middle of town. If he finds his way home, don't sleep with him."

**My enlarging circle of "...ists" and"...icians"!**

Who said life after retirement is not exciting? As I grow old, I find life could be really exciting with exploring different medical specialists!
When I retired, I had only the general physician to look after my health. Now I have many others to take care of me, and their list is expanding!
A few years after retirement, I was referred to an ophthalmologist; she continues to advise me. Shortly thereafter I was advised to consult a cardiologist whom I visit at least once a quarter!
Once when I was in a foreign country, I consulted inadvertently an internist who promptly referred me to an oncologist who strongly suggested that I should consult a haematologist on my return home! Yes, I did consult a haematologist after returning home. Luckily for me, the "flow chart" stopped there though I was advised that I should see the haematologist once in two months.
Apart from these episodes, I had to consult a neurologist—normally his consultation starts about 7 p.m. and goes on until midnight even. (In the city where I live, it is quite common for physicians, etc. to follow these hours. Interestingly though the letter-heads say "Consultation by appointment", the appointment time is observed more in breach. One may have an appointment for 8 p.m., but you will be able to talk to the doctor around 11 ‘o clock!)
In between, I met an orthopaedician—he was quite a taciturn individual who answered questions with grunts only. He charged me not only for an X-ray, but an "X-ray exposure" as well, whatever that may mean. As a matter of fact, I feel that it should be I who should be charging for X-ray exposure. He successfully palmed off a couple of unnecessary (at least for me) accessories!
Oh yes, I also met a therapeutics—he was the only one who kept his appointment time.
In between these consultations and visits, lucidly I have been able to continue with my self-assigned tasks and hobbies.
I have yet to meet a dentist, a geriatrician (they are very few here). Are there any more "...gists" and "...icians"? Most probably, all these will end with the services of a mortician! (sent by J.P Perumal, formerly SEARO and EMRO)

**Humour in the fifties at United Nations**

From UN Special, April 1953

His application form says: “Bilingual from birth”

**Do you know how the word "GOLF" originated?**

Many years ago in Scotland, a new game was invented. It was ruled “Gentlemen Only. Ladies Forbidden”...and thus the word GOLF entered into the English language.
The rule about "Gentlemen Only...Ladies Forbidden" actually originated from the venerable St Andrew's Golf Course in Scotland - the cradle of golfing civilisation.
Congratulations
To the President, Mr Fontana and to the AFSM Committee
12 January 2006
Greetings to you and I wish you a very Happy New Year 2006 with my sincere wishes for health, happiness and success in all your projects and activities. I appreciate very much receiving the issues of the Quarterly News, and I always read them with pleasure, in particular the special issue on the General Assembly. I want to thank you very sincerely for your devotion, accessibility and also for the work taken on by all the members of the AFSM Committee.
With my cordial greetings,
Georgina Cohen-Sajnovic
ED: Thank you, Mrs Cohen, for your warm encouragement.

About Jill Forman
Dear Editor,
I thought that the memorial piece on Jill Forman-QNT62, p 17 was perfectly written by Bernadette Rivett - she caught the mood totally correctly; would you please forward this message to her that I appreciated her piece - unfortunately I don’t have her address, but am most grateful to her for her understanding. Jill was a great WHO servant but did not, in my opinion, receive the recognition she deserved.
Bernadette has gone a long way in putting this right.
Yours,
Dr A. Davis, Formerly, Director, Parasitic Diseases Programme, WHO.
ED: Thank you, Dr Davis for your message.

A VISIT TO WHO HQ GENEVA IN LATE JANUARY 2006
In late January 2006, for important family reasons, I visited Geneva for the first time in about 10 years since my retirement from WHO in 1992 and my return to my home country, the U.K.
Whilst I was in Geneva, I decided to visit WHO HQ to settle an outstanding matter about my subscription to the AOMS.
I much appreciated meeting Mr. Fontana again who made me most welcome in three languages. Other former WHO staff members that I met in the AOMS office were also very kind; of course, the majority of my contemporaries are long gone from WHO and form part of the Diaspora of WHO retirees around the world.
However, one very personal touch was a former colleague Julia (formerly of MAL/TDR - unfortunately I forget her married name) who heard my voice in the corridor and immediately shouted "I know that voice" and came out of her office to meet me. Touching, indeed.
A former WHO staff member commented to me that the only word he had found to express his feeling at leaving WHO after many years of service was 'poignant'. Just so: my own WHO service was over 33 years.
I have always strongly supported the idea of the AOMS from its inception during the time I was a member of the Staff Association Committee. Although it has to be said that my experience post-retirement is that of WHO Staff who departed from Geneva after their retirement - let's call them 'Outlanders' - have felt a little left out of things compared with their Geneva and Haute Savoie based colleagues who can just 'pop in' and join in the various social functions and events that the AOMS promotes. Mind you, I wouldn't trade my mini-paradise à l’Anglaise on the South Wales coast for the now very busy and congested City of Geneva and its environs.
Perhaps a page, or even half a page, of the Quarterly News, could be routinely devoted to the 'Outlanders', concentrating on things that are of most interest to them and eliciting their contributions. I know there are 'Outlanders' who do correspond with QN, myself included. Maybe with a little encouragement more could be persuaded to do so.
Finally, I would like to mention a couple of additional, but relevant points.
Firstly, I would like to state how much I was encouraged to hear from Mr Fontana and his colleagues of the interest shown in its activities by the Director General, and the most helpful level of support given by the Administration. Excellent.
Secondly, as an 'Outlander' I would like to say how much we appreciate the regular arrival of our monthly pension payments in our nominated banks. From Day 1 I have not had any problem whatsoever. However, we UK pensioners do worry what effect the arrival of our monthly pension payments in our nominated banks. From Day 1 I have not had any problem whatsoever. However, we UK pensioners do worry what effect the UK’s joining the EURO currency might be, and it would be good to be kept up-to-date on how the UN Pension payments would be integrated with Pound/Dollar should that possibility arise. Of course, BAFUNCS keeps us informed of what they learn, but it would be nice to hear from the horse's mouth via the QN.
And last but not least, I must give full acknowledgement to the excellent service given by the WHO Staff Health Insurance Chief and her staff. It is true that the reimbursement process is a bit slow, but when one appreciates the size of the system and the difficulties in applying it across the globe it seems unseemly to cavil. Wishing the AOMS and all my former and present WHO colleagues the best of health, good fortune and success in their endeavours across the world. WHO was never more important.
Dr David Payne (formerly MAL/TDR)
1 Of course we would be delighted to receive more contributions from ‘inlanders’ as well as ‘outlanders’.
As for the UK’s joining the EURO currency, for the moment, it does not seem to be a problem.
Who will pay for the elephants, Dr Brown?

Dr Arthur Brown hopes that his recently published autobiography "A Public Health Odyssey or Prevention is Better than Cure and much cheaper"* will inform and entertain his readers by bringing to life real people and their doings in another time in remote countries—the human side of work in the field during the first twenty-five years of the World Health Organization.

The book is dedicated to "those who, unsung, labour to lessen mankind's burden of disease in the face of ignorance, poverty, corruption, greed and war."

In a recent interview Arthur told us: “The reason I got interested in preventive medicine goes back to a single afternoon in 1941 when I was still a medical student. During a training session, we were taken to a boy who had diphtheria. He had had a tracheotomy, and our tutor stressed that there were occasions when dealing with an obstructed airway had to be done immediately. He described how to do it on a kitchen table with a teaspoon and a pen knife. After the session, we talked to two Canadian doctors who had come to see some cases of diphtheria because there were no more in Canada. They explained that an immunisation campaign had cleared it up. It struck me then that what we really needed was an immunisation campaign rather than learning what we can do with a pen knife and a spoon. And that is why the book is called Prevention is better than cure—and a lot cheaper.

Arthur trained to be a doctor in the 1940s, before serving with the Dutch Navy on the North Atlantic convoys during World War Two. After the War, he worked in the Budapest office for the United Nations Relief and Rehabilitation Administration. He participated in the WHO Interim Commission as a WHO Liaison Officer for Hungary. In 1953, he joined WHO and became the WHO Area representative for Cambodia, Laos, and Vietnam. He was the WHO Deputy Chief of Mission during the UN intervention in Congo Zaire, WHO Representative in Ethiopia and Regional Advisor for programme development in Turkey and Bulgaria before becoming Assistant Director of Health Services at EMRO until his retirement in 1974.

Arthur concludes, “For some of its pioneers in the field, WHO was a church as much as an employer. When we began, we were just a handful of people. We were proud to serve, proud to voice the concern for global suffering that the World Health Organization epitomized, and convinced that some of the major causes of human suffering could be reduced, if not eradicated. I believed in WHO—that it was really necessary. And now I’m at the end of my days nearly, and I still believe in it.”

To find out who paid for the elephants, read this book and you will take a remarkable journey filled with letters, photos, humour, love and wisdom. It is an inspiration, and, most important, great fun to read. Carole Modis

* Copies can be ordered from Dr Arthur Brown 2 Belvedere Place, Leopold Road, Newmarket Road, Nowich, Norfolk NR4 7PP, UK or: browne1917@yahoo.com
In memoriam

Dr Abdel Kader Mbaye began his career in 1950 when he finished at the African School of Medicine and Pharmacy of Dakar; in 1963, he graduated from the Faculty of Medicine and Pharmacy at Bordeaux.

A distinguished career in public health took him to Cameroun (1951-1953) and Côte d’Ivoire (1954-1959), before he returned to his native Senegal in 1963. After taking a diploma in occupational medicine and a certification in merchant marine medicine, specializing in tropical medicine and in hygiene and sanitary work, he held several posts in public administration in Senegal such as Chief Medical Officer of Sanitary Services for the Port of Dakar and the Regions of the River and of Sine-Saloum.

In 1971, he joined the World Health Organization as a medical epidemiologist and participated in Zaire in the global Smallpox Eradication Campaign until 1973. From 1974 to 1975, he was the WHO representative to the governments of the Central African Republic and Chad. In 1975, he was designated WHO Representative for Togo where he stayed until his retirement in 1983.

Dr Abdel Kader Mbaye passed away on the 20 of June 2005 in his ninetieth year as discreetly as he lived. Those who knew him remember his conscientious and meticulous way of working, his openness of mind, his great capacity for listening, and his remarkable gift for friendship. May he rest in peace.

By Dr Khadidiatou Mbay, daughter of Dr. A.K. Mbaye, currently WHO Representative in Conakry. (This text was send to us by Dr Jacques Pierre Ziegler, who added: “I had the privilege of working with Dr Mbaye in the Congo for the Smallpox Eradication Campaign. I think that it was thanks to men like him that the Campaign was finally successful”.

List of Deceased

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A story of AFSM

The beginnings of the Association of former WHO staff (AFSM) date back to 1989. For some time, retired staff had felt the need to find a way to maintain or re-establish relations which had been formed with colleagues during active service at WHO.

At the end of 1989 some of the retirees took the initiative to send to all WHO former staff a letter of intent proposing the creation of an association. The responses from former staff in many countries were so numerous and so enthusiastic that a Section of Former WHO Staff was established under the auspices of the WHO Staff Association in Geneva. Indeed AFSM has maintained close links with the WHO Staff Association to this day.

An Executive Committee was immediately constituted; its membership consisted of former general service and professional staff as well as a former Director and even an Assistant Director General. This composition indicated how differences in position disappear as WHO former staff come together in a community of shared interests—whatever they may be.

Objectives of the Association

From its inception, the Association of Former WHO Staff (AFSM) decided upon three fundamental objectives:

Friendship to preserve the companionship, the fraternity which had developed in the course of shared work and challenges

Solidarity because, more often than one can imagine, people find themselves in difficulties which can be relieved by the actions of others

Efficiency because when the provisions made to retired staff for their pensions or health insurance are jeopardized. it is important to raise a collective voice to ensure the welfare of all

Today

The Association of Former WHO Staff (AFSM) has become a totally autonomous association which has a recognized place in the heart of the Organization.

Its Executive Committee is composed of twelve members, each elected for two years. In addition, a General Assembly is held every two years, giving members a regular opportunity to express their opinions on how activities are conducted; on alternate years, elections are held.

A newsletter, "Quarterly News" is published every three months, open to contributions from all.

AFSM participates on an equal basis with the representatives of the Director-General and the personnel on the Health Insurance Surveillance Committee and the WHO Pension Committee; in each of these committees, AFSM has a member and an alternate.

The Association participates in the work of the Association of Former International Civil Servants (AFICS)—five members of the AFSM Executive Committee have a seat on the AFICS Committee.

In addition, AFSM maintains close and regular relations with the WHO Staff Association in Geneva and with the WHO administrative services which give the Association considerable and much-appreciated assistance.

Finally, another of the concerns of AFSM is to help promote and support the associations of former WHO staff in the regions, and to give them any assistance they may need from WHO headquarters whether it be for individual cases or to the associations as a whole.

Alain Vessereau

Distinction

Our colleague Dr William Gunn has just been designated honoris causa by the College of Surgery in Dublin in recognition of his research on primary essential surgery during natural disasters and major crises. In addition to this honor, he has already received the honoris causa doctorate from the Universities of Palermo and Prague. Our warm congratulations to Dr Gunn.
News from the Committee

Donation from AFSM in favour of Kashmir earthquake victims

Following the decision of the General Assembly, the Committee sent a donation of CHF 5000 to the NGO Médecins sans frontières, to help the victims of the recent earthquake in Kashmir. Below are extracts of the acknowledgement from MSF.

Geneva, 19 January 2006

Dear Members of the Association for Former WHO Staff,

On behalf of all of us at “Médecins sans Frontières”, I wish to thank you from the bottom of our hearts for your generosity. Your gift of 5000 Swiss francs has been duly received and forwarded, according to your instructions, to our emergency mission in Pakistan.

Three months after the earthquake which devastated Pakistani Kashmir and the neighboring province of the Northwest Frontier, here is some news about our activities there. Thousands of wounded persons still need care. Many of them, who were operated on immediately after the earthquake in precarious conditions, suffer from complications. Some others must remain hospitalized and in some cases undergo another surgical intervention. To take care of them, MSF opened on 21 November a hospital in Mansehra. This structure of more than 1,000 m² and with a 120 bed capacity is installed under nine inflatable tents. It comprises four operating theatres, an emergency room and an intensive care service. In addition, MSF has installed in the city of Mansehra several medical villages in order to house patients with their families—patients who no longer need to be hospitalized but still need regular medical follow up and cannot return to their own villages.

Letter from the President

This year, as mandated by our statutes, we will be carrying out an important process—that of electing the members of the Executive Committee for 2006-2008 which will enter into force on 7 November 2006.

The current Committee would welcome a larger number of women candidates for election to the next Committee. Do you have ideas or suggestions to help us to accomplish this objective? Please let us have your comments.

In the QNT no. 64 (the one for June) we will devote an article to outlining the obligations and responsibilities of all the members of the Executive Committee of the AFSM.

In addition, we remind you that item five of our statutes states that all members of the Association who are up-to-date with their dues and who live in and around Geneva are eligible for election to the Executive Committee.

Thank-you for taking some time to give some thought to the future of our Association.

Roger Fontana

We wish to thank all those who collaborated on this issue with articles and/or translations (Editorial Board: Yves Beigbeder, Samy Kossovsky, Jean-Paul Menu, Carole Modis, Dev Ray, Rosemary Villars. Article, translations, Editorial coordination and layout: David Cohen).

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The opinions expressed in this newsletter are not necessarily those of the editor.