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

The WHO HQ campus by...2023

Attentive readers of our Quarterly News will have noticed (News from WHO in QN 95 and 99) that the construction of a brand new, low-energy, low-maintenance building has been approved together with the renovation of the main HQ building.

The winning project for the new building has just been selected out of a short list of 13 finalists (250 original entries) and has been presented to the Sixty-eighth World Health Assembly in May 2015. The lucky winners are the Swiss architects Berrel, Berrel and Kraütler.

(continued on page 3)

A message from the Director-General

"It gives me great pleasure to congratulate the Association of Former WHO Staff Members (AFSM) on the 100th issue of your Quarterly News magazine. I recognize the value of the magazine in communicating important news to you all around the world about WHO activities, staff health insurance and pension matters, health issues and events, and in sharing news from members. You have a dedicated team of volunteers to produce the magazine. One hundred issues of a quarterly magazine means 25 years of activity of your Association. I am convinced that the AFSM plays an important role for former staff, especially retirees, and for promoting the image of WHO. I wish you continuing success for the future."

With my best wishes on this special occasion.

Dr Margaret Chan, Director-General
A functional workplace for the long term

“The main aim of the renovation strategy is to restore the working conditions to a more acceptable level and strengthen the long-term efficiency of the entire headquarters site, making it more functional and effective for the work we do,” says Richard Preston, OSS Director at headquarters. “We have been maintaining, securing and equipping 10 buildings on the site, some of which were never intended to be permanent. This is neither cost-effective nor efficient, and is certainly not conducive for staff who regularly put in very long hours in their offices.”

The next milestones:
2015: further studies on specifications, cost analysis, including consultations with staff
2016: the WHA gives its go ahead
2019: new building completed and occupied by staff currently in the main building
2023: Main building totally refurbished; Sale of current L and M buildings.

This article and pictures are based on information kindly provided by Mr Basu Gautam, Internal Communications Officer, Office of the Director-General
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EDITORIAL

First of all, our sincere apologies for the late arrival of № 99. This was due to the fact that the Printing Department was changing all of its printers; however the journal did appear on time on our website...

We have now reached issue № 100 of our magazine. It has come a long way since its birth: started in 1989 (see on page 3 a copy of the trial issue), it has been continuously improved. Our late, much missed, colleague Peter Ozorio managed it brilliantly for the first 50 issues. I took over with the 51st issue. I very much hope that you are not disappointed by our editorial group which makes every effort to present articles which are varied and, we hope, interesting.

At the same time as the 100th issue of the journal, we are celebrating 25 years of our association (see next page the article by Alain Vessereau, co-founder and 1st President of AFSM). So now it has reached full maturity. We hope that you will continue to have confidence in the AFSM and that new recruits will join and expand the membership. The more we are, the stronger we are!

Unfortunately, although you may perhaps be pleased to read the journal and benefit from the services provided by the AFSM, there are presently no new candidates for the Executive Committee; but it is essential that new members become involved to ensure the future of the association......

I very much hope that our appeal will not be in vain.

DC

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: shihq@who.int
Pensions: +41(0)22 928 88 00;
Email: unjspf.gva@unjspf.org for Geneva
Or+1 212 963 6931 and unjspf@un.org for New York
AFSM office covered on Tuesday and Wednesday from 9:30 to 12:00
Otherwise, please leave a message: someone will call back

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We pay special tribute to the Printing, Distribution and Mailing Services.

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The opinions expressed in this magazine are those of the authors and not necessarily those of the Editorial Board.

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Send your contributions to:
David Cohen:
dacohen@sunrise.ch

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We had taken the plunge, pushed on by the need to take action. Those who had gone before us into their new life as a retiree had advised us how hard it could be to resolve, alone, unforeseen difficulties and even to know who to call on when needed. The drawbridge of retirement had been reached but for those of us who had played an active role in the Staff Association Committee, we did not want to just stand around with our arms folded! We dared to believe that we still had a lot to offer to help our retired colleagues both individually and collectively.

However, from the beginning we set criteria for the Association – it should not become a syndicate but should be structured around three equal principles – friendship, solidarity and efficiency – a motto for engraving on the wall of our office, if we had had one. We especially did not want an Association without a “soul” and the intention was not to let material and financial matters take over at the expense of social and cultural aspects.

It was on this basis that, on 19 June 1989, we sent out a call to join us. The responses were so rapid, so many and so enthusiastic that within a few weeks any doubt was unthinkable and we could confirm that the Association was created and that a provisional group had been set up to organize elections.

The Association could just have been an extension of the Staff Association, to which it was still provisionally attached for administrative and logistical reasons, but it was much more than that because the group was privileged to comprise not only as many G as P staff but also an Assistant Director-General (ADG) and a Director of Administration, both recently retired. Thus we had a rare example, perhaps unique, of a structure uniting for the common good and creating mutual respect between those who might have been on opposite sides in the past.

I can still see our faces like old children studiously bent over our first files, still empty, very surprised to find ourselves collaborating so closely after having shed the labels stuck to us not so long ago and which had placed us in such or such category.

Thus constituted, we thought the Association could move mountains. Even from the beginning the main preoccupations centred of course on pensions and health insurance.

With regard to pensions, they were reliant on the enormous machinery of the UN Joint Staff Pension Fund – we could not envisage how to take any action. However, the Association’s role became immediately apparent, judging by the amount of information and advice which could be exchanged about this complex system.

Health insurance offered more possibilities for action and impact in view of its specific character within the Organization. In just dealing with controlling the rules and their application within WHO, their definition and amendments have a direct impact on members and their families and it was necessary to be at the centre of this mechanism.

One of the first actions was therefore to reactivate the request that a retiree be one of the members designated to represent participants on the Health Insurance Surveillance Committee. This request had been dragging on for about 4-5 years and had been submitted for the first time while I was still working and was the Chairman of the Surveillance Committee. Repeatedly requested each year and having been turned down by the representatives of the Administration until finally the Committee accepted the presence of an “observer”. It was a definite step forward and from the end of 1989 the health insurance rules created a seat on the Surveillance Committee for a retiree with the same rights as the other members representing active staff or the administration. In order to fully understand the major progress thus made by our young Association, suffice it to say that in many other international organizations in Geneva and elsewhere, retirees do not even
have observer status in their health insurance committees. When the recent "revolution" happened in the health insurance governance, the fact that the representatives of retirees had collaborated effectively for more than 20 years in the management of the health insurance, explains that there was no hesitation in proposing to them to have elected retiree representatives in the new committees.

There are so many other things to say about what has paved the way for the Association today! However, it is impossible not to underline the irreplaceable and constant place of its journal – the Quarterly News and our celebration of its 100th issue. From the early days, even an essential communication role and it was entrusted to competent and enthusiastic colleagues. This has never been refuted and everyone will recognize that, during the past few years, the high standards we thought we had reached have been excelled. Thus, a quarter of a century later, we can look back with satisfaction on our Association which fills the role for which it was destined at the beginning. It remains faithful to its commitment to represent and protect the interests of its members and often plays an active role in groups and circles which work on social and cultural activities for retirees.

Alain Vessereau

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**On the lighter side**

**60th High School Reunion**

He was a widower and she was a widow.
They had known each other for a number of years being high school classmates and having attended class reunions in the past without fail.

This 60th anniversary of their class, the widower and the widow made a foursome with two other singles.

They had a wonderful evening, their spirits high.
The widower throwing admiring glances across the table. The widow smiling coyly back at him.

Finally, he picked up courage to ask her, "Will you marry me?"

After about six seconds of careful consideration, she answered, "Yes... yes I will!"

The evening ended on a happy note for the widower. But the next morning he was troubled.

Did she say "Yes" or did she say "No?"

He couldn't remember. Try as he would, he just could not recall. He went over the conversation of the previous evening, but his mind was blank.

He remembered asking the question but for the life of him could not recall her response. With fear and trepidation he picked up the phone and called her.

First, he explained that he couldn't remember as well as he used to. Then he reviewed the past evening.

As he gained a little more courage he then inquired of her. "When I asked if you would marry me, did you say “Yes” or did you say “No?”"

"Why you silly man, I said ‘Yes. Yes I will.’ And I meant it with all my heart."

The widower was delighted. He felt his heart skip a beat.

Then she continued: "And I am so glad you called because I couldn't remember who asked me!"
25 years and 100 issues

1989 was an auspicious year,
Both on the global scene and locally here
At WHO, when the AFSM was set up for you,
And the pilot Quarterly News was first issued too.

Seven founding fathers\(^1\) formed the interim team,
Working so hard to realize their dream,
Elections soon followed, with prestigious candidates,
And the first twelve\(^2\) were chosen, who opened the gates
To services wide, with information, advice,
Defending interests through a collective voice.

Two interim group members still help, do their share,
They are Alain Vessereau and Yves Beigbeder,
We thank them most warmly for all they have done,
And hope they can continue for years still to come.

As time went on, AFSM membership gained stride
To over 1000 members in more than 80 countries worldwide.
The vast support network is impressive in size,
And can be called upon as needed to help and advise.

Core issues are constant – health insurance and pension,
In comparison, other topics are hardly worth mention!
Keeping abreast of events and sharing information,
Your Committee does its best on every occasion.

Its main means of course is the Quarterly News
To impart points of interest and seek readers’ views.
One hundred editions is no mean feat,
Under just two chief editors, both have been great,
Peter Ozorio led the team for the first fifty,
Then David Cohen took over, with layout so nifty!
A big tribute to both is due with emotion,
For all their hard work and unfailing devotion.

So, here’s to further success in years still to come
For the AFSM, Quarterly News, and hopefully some
Young retirees will join us and take on a share
Of our services to members – we’ll continue to care!

Sue Block Tyrrell

\(^1\) Alain Vessereau, Robert Munteanu, Rajindar Pal, Yves Beigbeder, Gérard Dazin, Warren Furth and Thomas Strasser
\(^2\) Alain Vessereau, Robert Munteanu, Rajindar Pal, Robert Chapou, Margaret Baker, Yves Beigbeder, Gérard Dazin, Georges Esatoglu, Carlo Fedele, Stan Flache, Thomas Strasser and Vitorino Pinto
Messages from our colleagues from here and there

On the occasion of the 25th anniversary of our Association of former staff of WHO, I would like, on behalf of retired colleagues of the WHO African Region, to thank all those who had the idea to set up this platform which constitutes a continuous thread, linking the memory of the former and the experience of the younger staff in the service of the Organization. This fragile thread, in this sense precious, is above all a source of vitality and solidarity as we follow our solitary paths.

We would also like to acknowledge all the efforts that AFSM has made and continues to make to encourage all of the Regions to set up their associations of former staff. The strong support that you provide is much appreciated. It is now the occasion to thank and also congratulate the committee for this very altruistic assistance. We are convinced that this year will see the birth of the association of former WHO/AFRO staff, celebrating the maturity of the AFSM.

Happy birthday.

For the former staff of AFRO
Dr Kalula Kalambay

Greetings from WPRO, Manila. As AFSM-Geneva commemorates its 25th anniversary, AFSM-Manila is now on its second year of existence since it was organized on 16 May 2013. We thank our colleagues in Geneva for the support to our association, as well as their quick dissemination of information concerning retirees and defending their interest on pension and after-service health insurance. Governed by a volunteer set of Executive Committee members our association is in touch and interacts with our colleagues through a Facebook fan page @WHO/WPRO Former Staff Members currently with 100+ members or @AFSM-Manila. We have a Liaison Officer with AFICS Philippines and the AFSM President is an ex-officio member of their Executive Committee. At least once a year we organize a Christmas party and the last one in December 2014 was followed by a town hall meeting with BFO's presentation about SHI. The idea is to bring retirees in WPRO together through this event, our appreciation to ex. RD Dr S.T. Han who is always present in this party. We are inviting all former WPRO Staff Members to join us to see and interact with our former colleagues or like us and post to our FB fan page. With no deadlines to meet and with a good pension, retirement is a good and sweet life. For & in behalf of AFSM Manila,

Romy Murillo, President

How amazing that AFSM is in the process of preparing the 100th issue of the 'Quarterly News'? What an admirable achievement.

It is a privilege working with so many intelligent and friendly people at AFSM in Geneva; their assistance is always welcome when in doubt.

Relationships with various individuals with whom I am in regular contact are excellent, particularly Sue Block Tyrrell, David Cohen, Jean-Paul Menu and Ann Van Hulle..I could, of course, mention other Committee members, but there is not enough space!

My congratulations to AFSM on its 25th anniversary, and to all Committee members who work so hard on behalf of all former WHO staff.

Jill Conway-Fell

Reminder: Don't forget our General Assembly and annual reception will take place this year on the same day: Thursday 8 October.
Messages from our colleagues from here and there

the years your association has aided in bringing former staff in other Regions together. And the Quarterly News has served as a beacon of light and information informing us about important matters that might affect WHO current and/or former staff members.

AFSM PAHO has often looked to you for guidance and information. We have shared our ideas and concerns and, in the process, we have together established a foundation of friendship, collaboration, and trust that has benefitted us all.

Dr. German Perdomo has now assumed the Presidency of AFSM PAHO and joins me in looking forward to continuing, and perhaps even strengthening, our alliance. We both send our very best wishes to AFSM Geneva for many more productive years in the time ahead.

On behalf of the AFSM PAHO Board:
Nancy Berinstein, former AFSM PAHO President, German Perdomo, President AFSM PAHO

Staff Health Insurance - Its history and development

As the QNT celebrates issuance of its 100th edition, it is opportune to mark the 55th anniversary of the WHO Staff Health Insurance Fund by looking back on its growth and development since its inception in 1960.

Prior to the establishment of the WHO Staff Health Insurance (SHI) on 1 January 1960, WHO HQ staff (together with ITU) were insured in the ILO health insurance. It is interesting to note that the proposal to create a WHO health insurance was agreed by participants by means of a referendum before being endorsed by the Director-General.

The dynamics were very different at that time. There were some 6,800 insured staff and dependants but only 11 retired staff. It was easy to balance the books with a young, healthy insured population. The SHI sailed along nicely developing its rules and enhancing the benefits offered up to the late 1980’s. By that time, the number of insured active staff and dependants was near to 20,000 while the retired staff population was around 4,000 and expected to increase further over time.

I joined the Insurance Unit at that time when the Fund was facing enormous challenges. This coincided with the moment when Alain Vessereau1 became Chairman of the SHI HQ Surveillance Committee. He was instrumental in the Committee’s proposal to the Director-General to convene the first joint meeting of health insurance and staff committees so that important decisions could be taken for the future of the Fund. Experience up to then had shown that it was difficult if not impossible sometimes to reach a consensus by correspondence when 14 committees in total were involved (12 regional and 2 HQ). Having the key players meet face to face meant that they had a better understanding of important issues requiring decisions. In preparation for this meeting, an actuarial study was requested and the results were a wake-up call for the Insurance. It was clear that if decisive measures were not taken, the Insurance could not be sustained as the retired staff population grew. As their contributions were based on their pensions with higher per-capita claims compared to their active staff counterparts, a resulting deficit was inevitable. The ratio of active to retired staff at that time was 2.6 active to 1 retiree (by comparison, the current ratio is 1.8 active to 1 retiree).

The implementation as from 1990 of a number of measures aimed at correcting the actuarial deficit identified in the actuarial study. These included special contributions from the Organization and an in

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1 Founding member of the AFSM and Honorary Chairman of the AFSM Executive Committee
increase in contributions from all staff spread over several years. The split of contributions between Organization and staff changed from the 40/60 sharing to a one third (staff) and two thirds (Organization) sharing. Mechanisms to finance deficits of active and retired staff were also put in place. Today, we still reap the benefit of those measures.

In the years that followed, the Fund’s reserves grew considerably. This meant that there were sufficient funds to cover the shortfall for retired staff whose claims exceeded contributions as from 1995. That shortfall or deficit now exceeds US $15 million whereas the Fund’s reserves amount to some US $707 million.

So, as the Fund has reserves, one may ask why we need to be concerned about a deficit for retired staff. The main reason is that the number of retired staff is expected to grow significantly whilst the number of active staff is projected to remain stable. Medical cost inflation is another factor which will impact claims. This means that the future deficit or “unfunded liability” will increase over time. The insured population today is nearing 37,000 of which retired staff and their dependants represent over 8,000. With these considerations in mind, an annual increase in contributions was implemented since 2012. The situation is closely monitored to evaluate the impact and to recommend adjustments when appropriate.

The governance of the Insurance has also evolved over time. From the beginning, HQ and each regional office had their own surveillance committee which took decisions on individual cases and also made recommendations on rule changes and practices in the light of experience. In 2012, the Director-General agreed to the establishment of two new global committees. Both committees have members representing Administration, staff and retired staff of HQ and of the regional offices. Members representing retired staff are elected by retired staff at large. The first such global elections took place in 2011 and there will be further elections this year for a four-year term of office.

The Global Standing Committee (GSC) (which at the moment replaces the HQ Surveillance Committee) takes decisions on individual cases and makes recommendations on amendments to the Insurance Rules and practices in the light of its experience. The idea of incorporating regional surveillance committees into the GSC was to be examined at a later date. A Global Oversight Committee was established at the same time to oversee the SHI and to advise the Director-General on its management and operations. I believe it is fair to say that both committees have functioned effectively since their inception. Many active and retired staff representatives in the regions and HQ have devoted enormous time and effort over the years to the work of SHI Committees and this is still true to this day. Indeed, many of these representatives have frequently said how much they enjoy the Committee work even if it is demanding in terms of their time.

We are fortunate to have our own independent health insurance which has evolved over time and that significant steps have been taken to address the challenges. The SHI compares favourably to other UN organizations’ health insurances and we need to safeguard that. It is difficult to foresee what lies ahead as there are many variables involved in projections (staff numbers, salaries, medical and general cost inflation etc.). Consequently, close monitoring is required. The governance structure in place ensures a proper consultative process before changes are proposed or decided upon. I believe that it is important to have a consolidated approach towards change. The overall situation of benefits and contributions should be examined when necessary rather than cutting a benefit here or there to achieve some savings. Above all, the principles of equity and solidarity on which the SHI was founded should be respected when contemplating any rule changes.

We have a common goal in ensuring that the Fund remains financially sustainable and that it can continue to meet our aspirations in terms of the benefits it provides.

Ann Van Hulle-Colbert
Our health

Deafness in seniors

The hearing acuity declines from 25 years, but remains long undetected (subclinical).

Our sensory organ of hearing, the ear, comprises three main parts:

- **The external ear**: the entry to the ear, the auricle, which captures the auditory vibrations in order to transmit them to the ear drum, via the auditory canal.

- **The middle ear**: a cavity lined by a membrane (ear drum) which communicates with the pharynx via the Eustachian tube. It contains the chain of 3 small bones (ossicles) which are the smallest bones in the human body. The middle ear functions as an amplifier which transmits sound waves from the ear drum to the internal ear, passing along the chain of ossicles.

- **The internal ear** or labyrinth consists of the central vestibule, the semicircular canals, and the cochlea which has contains the sensory cells that transform the vibrations into nerve stimuli transmitted by the auditory nerve to the brain where the message is decoded and interpreted.

  - Although each of the ears is equipped with its own hearing apparatus, it is the correct functioning of both ears simultaneously that allows, in the presence of several sources of sound, to localise the sounds: this is stereoaoustics, very useful in noisy surroundings. It ensures two essential functions: the appreciation of direction which allows the source of sound to be identified, and the sense of depth which allows the distance from the sound to be sensed. Thus, the brain is able to determine whether the sound comes from in front or behind, and from left or right, and whether it comes from nearby or far away.

**Presbycusis** is a loss of hearing acuity associated with ageing. Ageing of the internal ear varies between individuals; it is linked to genetic factors and can be aggravated by other factors including local (chronic otitis...), general (metabolic, vascular...) or environmental factors (trauma due to noise...).

Presbycusis affects the sensory cells (ciliated cells) which undergo degeneration more at the base of the cochlea (high pitched sounds) than at the top (low pitched sounds). For this reason the auditory threshold is raised (the intensity of the sound must be increased for it to be heard), and an alteration in comprehension of speech may occur: “I hear but I don’t understand”.

**Clinical signs**

This form of deafness is bilateral and symmetric, mainly affecting the higher frequency sounds. This deafness may sometimes be accompanied by tinnitus (buzzing, whistling) and problems with balance.

The first signs usually appear between 60 and 65 years of age. Three stages can be distinguished:

- **Pre-clinical phase**
  Loss of discernment amid background noise. The person is embarrassed during conversations in groups (family meals, restaurant) and in meetings or where there is background music...
  The audiogram (Fig.2) shows the normal thresholds for low frequency sounds up to a frequency of 2000, with an inconstant loss of high frequency sounds of less than 30 dB.

- **Social awareness phase**
  The hearing impairment is evident also to others, the patient having to ask speakers to repeat or raise the voice. This develops when the hearing loss reaches 30dB at frequency 2000. 

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1. The cochlea is a hollow organ snail-shaped, filled with a fluid called endolymph. Located at the inner ear, the cochlea is the last step of the integration of sound before the hearing nerve.
Deafness (continued)

Specialist care is necessary.

Isolation phase
The affecter person who is untreated ceases to communicate. This may be followed by the development of a depressive syndrome.

Diagnosis
On ENT examination the ear drums are normal. The tonal audiogram shows a deafness of perception which is bilateral and symmetric, affecting the upper more than the lower frequencies.

The vocal audiometry shows the importance of difficulties in understanding speech and provides an indication of the likely results that will be obtained with hearing aids.

The differential diagnosis may involve a lack of recognition of any associated condition:
- Plugs of wax, or perforation of the ear drums, or chronic otitis.
- A deafness of transmission can be due to a blockage or an interruption in the chain of ossicles. It can also be mixed, with both types of deafness present.
- If the deafness of perception is asymmetric, it is necessary to examine for the presence of a neurinoma (benign tumour) of the acoustic nerve.

Treatment

a) Hearing aids
This should be proposed when the loss of hearing exceeds 30dB as from frequency 2000. In general, this apparatus should be prescribed as soon as possible without delaying until the effects of nerve degeneration appear.

The hearing aid amplifies the intensity of the sound heard by the patient but does not always lead to better understanding because of impaired discrimination. The choice and adjustment of the hearing aid must be done by an expert in audioprothesis. Tests must be carried out before purchase. It needs to be understood that hearing aids for presbycusis patients are often difficult to prepare and they may not be successful.

b) Speech therapy
Prescription of speech therapy sessions provides an introduction to, or improvement of, lip reading which is often very helpful.

In addition advice about preventing a worsening of the situation, particularly the prevention of auditory trauma and an annual assessment of hearing, are routinely recommended.

Other forms of deafness associated with ageing

1) Chronic otitis
Perforations of the ear drum (following suppurating chronic otitis) need to be treated up to an advanced age, because they prevent the function of the auditory system.

Cholesteatoma (erosion of the structure of the middle ear), although progressing less rapidly than in young persons, is treated according to the same protocol.

2) Otosclerosis (hereditary condition affecting the middle ear) is diagnosed and treated in the same ways as for otosclerosis in young persons.

Surgical treatment can be carried out at an advanced age and under local anaesthesia.

3) Other causes of deafness in elderly persons
All other causes of deafness can occur in the elderly:
- Traumatic deafness following a fracture of the labyrinth or a blow to the labyrinth without fracture.
- Deafness due to auditory trauma: affecting those who practice noisy forms of do-it-yourself activities, shooting, hunting etc… suffer traumatic deafness which aggravates the effects of Surgical treatment ageing.
- Deafness of toxic, infectious or vascular origin, or due to Ménière’s disease, does not pose any problems that differ from those in younger persons.
- Sudden unilateral deafness is treated as in younger persons.

The management of all of these forms of deafness usually requires the use of hearing aids.

Surgical treatment can be carried out until an advanced age: placement of electrodes on the cochlea with batteries attached outside the ear, followed by a course of speech therapy.

Hopes for a distant future: as fish and poultry constantly renew their dead ciliated (sensory) cells, research is investigating the mechanisms involved, in the hope of a human application?!!

Dr David Cohen
During a recent visit to WHO, I was asked for an article for the QNT.

I had an immediate inspiration: to write about Dr. Emilio Pampana and his famous Malaria Advisory Teams, ingenious creations, that checked the results of his anti malarial campaigns. These led to the eradication of malaria in Taiwan and many other countries, where post eradication surveillance was effective and spraying of insecticides were conscientiously carried out. Unfortunately, resistance to antimalarial drugs by protozoa and by vectors to insecticides quickly followed. The method was criticized as it became known that insecticides were polluting and toxic, which put an end to Dr. Pampana’s breviary, this beautiful book now forgotten, that I bought when he retired. Then came the VBC (Vector Biology Control), which subsequently and brilliantly dealt with diseases transmitted by insects, some of which appeared during its existence.

I participated as an entomologist, in three of these teams; Iran in 1956, with Dr. Julian Zulueta; Taiwan, with Dr. Farinaud; and the Philippines in 1957, this time with Dr. Issaris. I left the "teams" to devote myself to Ethiopia. During the first three expeditions, a Greek entomology technician, Kyriacos Thymakis and an Italian hematology technician, Pasquale Caprari, accompanied us and we were enlightened by their great skills. Our exploits there were recounted in detail in my modest collection of entomological memoirs (2006) and I will not repeat them here. However, we had some incredible adventures during our quest to eradicate our inaccessible grail. One dramatic adventure was the typhoon Agnes in the Philippines, which blocked us for more than a week, while bridges and roads were destroyed around us and more than 500 people were drowned in a village a few kilometres from our hotel. We barely escaped, but that was part of the risks in our race to eradication. Other colleagues participated at the same time in other Advisory Teams in Afghanistan, Thailand, Mauritius, where eradication was going well, and again elsewhere on the blue planet. We were then hopeful that eradication would remain a thing possible. We praised the safety and efficacy of DDT and, in the alternative, other similar organochlorines, carbamates or organophosphorus. They had not yet discovered pyrethroids and nicotinoids nor the famous abate. We still had not heard of chromosomal translocations, male sterility, or the Bacillus thuringiensis, in other words the genetic and biological control. One of my good colleagues, a professor at the University of San Jose, USA, had even made a bet to swallow a kilo of DDT, to show its safety. It stayed a bet and, fortunately for him, he never carried out his "insecticidivore" project. They had not yet thought of treated nets which met with great success much later. Our expeditions took place a long time ago, during the mid 50's, when Dr. Candau was Director-General and Miss Grace Meyer chaired the briefing of our entire team and all the Organization's staff. There was then the Special Funds for malaria and the fierce fight using methods now abandoned. Biological control was then in its infancy but put away indefinitely. At the time we believed in DDT and obtained very good results especially on islands and isolated areas, until the day when nature resisted and insecticides were regarded as potentially dangerous.

In Iran, we broke out in cold sweats as we did not have immediate access to our equipment. In Taiwan, we found a small pocket of Anopheles minimus raging in the mountains and which infected the wood cutters. In the Philippines, we were testing in turns during the night the resistance of Anopheles by capturing the insect on the back and the sides of the sleeping carabao (buffalo) regretting mosquito traps from the Rockefeller Foundation, which had us so saved many lives, but who all disappeared. In Tehran, we fabricated a Busvine a stress test, with glass tubes. WHO later produced these wonderful plastic tests, which were even used by FAO for herbivorous insects. We had a lot of work and, at that time, random tests Swaroop were the ultra modern. The eradication, while easy in Taiwan, Mauritius, Réunion, Corsica, Sardinia, Jamaica, remained difficult if not impossible in European countries, such as Italy and Greece and in Central America and in Ethiopia, given the contamination with untreated neighboring regions. But there again the sprayed areas were still very protected. Strict surveillance was necessary, otherwise the infection resumed and malaria reappeared everywhere, even on the islands. There were amazing events. There were always reintroductions, forgotten cases. And that was the end of Dr Pampana's beautiful dream and the Malaria Eradication Advisory Teams.

What were the actual results of this teamwork? First, good evaluations of the level of malaria
control by using the strategy available at the time. The goal was almost reached in a few places like Taiwan. Elsewhere, almost, but far from what was expected. Sometimes accidental discoveries were made, as in Afghanistan, the action of ophtalmotropes butterflies on mammals, as later on birds or even in reptiles. Parenthetically, I would never see them in the buffalo’s eyes in the Philippines. We sometimes discovered new species of Anopheles.

Work was a daily routine and hardly allowed us to move away from conventional research. Dr. Pampana was at the end of his term violently criticizes, but, as they say, dogs bark and the traveler passes. The stakes were worth it and we could then attempt everything, even when it was working and while the toxicity of insecticides was not then fully understood. A great adventure for those who participated and survived it. The others had the glory of having contributed to a time when comfort and safety were not always present. It was in the old days, as the song says, in the world of dreams, but we all believed in it.

Pierre Jolivet.

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On the lighter side

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A young graduate in Nuremberg

worked at the Nuremberg War Crimes Trial as an assistant to my uncle Henri Donnedieu de Vabres, the French judge, from March to August 1946.

The judge needed some help and he called on two nephews in succession to Nuremberg. I was the second one, a recent law graduate (the French licence en droit) aged 22. I was asked to summarize French verbatim records of the hearings, delivered daily in four languages, on seven defendants. They included Hans Frank, originally a lawyer, the Governor-General of Poland, the “Butcher of Poland”. I wrote a short article in the French weekly Réforme (25 May 1946) on his unique guilty plea of 18 April 1946: a converted Catholic, he said that he was possessed by a deep sense of guilt. Baldur von Schirach, the Nazi youth leader, but also the Vienna Gauleiter, was another of my “clients” entrusted to me by my uncle in view of my (then) strong interests in scouting. In his testimony in May 1946, he said that he was always tolerant. He learned about the gas chambers and massive exterminations only in 1944. He concluded: “Hitler is a murderer. Auschwitz must mark the end of racism. It is a shame in the German history”.

My summaries were dictated to French secretaries, older than me, who wondered whether I was up to the job. My work was in the back office but I was allowed occasionally to be present on important occasions during a Tribunal’s session.

This was my first job.

The trial was set in a destroyed Nuremberg, where only the restored Tribunal looked like an oasis of order and justice. Coming from a France not yet recovered from its defeat, German occupation and restrictions, the Tribunal set in the American zone of Germany was to me a place of luxury of all goods we still missed in my country. French participation in the trial suffered from the lack of adequate financial resources, available documentation and the shortage of qualified jurists: the French judges had almost no legal staff and the French prosecution staff was meagre in comparison with US and British delegations. Transportation from Paris to Nuremberg was provided by the US military, and British cars took the French judges on excursions.

There was a contrast between the dramatic solemnity of the trial sternly and ably led by its British President, Sir Geoffrey Lawrence, the rows of the defendants, former powerful Nazi leaders, the smooth American operational efficiency, and the offer of evening distractions and week-end tours. Among the gifted interpreters who initiated the new “simultaneous interpretation” technique, I remember the Russian interpreter who forgot his stuttering when he spoke to the microphone.

I was lodged in a requisitioned house in the near suburbs of Nuremberg together with Donnedieu and Robert Falco, his alternate judge and their wives. Donnedieu was a former professor of criminal law and an eminent specialist in international law. His lack of judicial experience was somewhat compensated by his expertise in international criminal matters and Falco’s long experience as a magistrate in the Cour de Cassation. He had been expelled from the Court by the Pétain regime as a Jew in December 1940. Falco, at the preliminary London negotiations and Donnedieu during the pre-judgment deliberations challenged the validity of a “crime against peace” under international law and raised objections to the concept of conspiracy both charges initiated and strongly maintained by Robert Jackson and included in the Nuremberg Charter.

My uncle knew German but no English which hampere any professional or social familiarity with his American and British colleagues. Falco and his wife knew good English. We were driven each day to the Tribunal under the protection of two US military bodyguards.

Hermann Goering, although thinner and deprived of his flamboyant uniforms, was the leader in the dock and faced the charges of Robert Jackson in April 1946 with aplomb and a better insider knowledge of Nazi facts. Rudolf Hess looked absent except to reject the jurisdiction of the Tribunal and deny, like all defendants,
any guilt. The generals and admirals maintained their dignity. One of the most impressive testimonies also in April 1946 was that of Rudolf Hess, who had been Commandant of the Auschwitz extermination camp from May 1940 to December 1943, as a damning witness for Kaltenbrunner. Hoess declared calmly having personally sent to death in gas chamber close to two million person (present estimates are 1.1 million detainees’ deaths). He was told that this was to prevent the Jews from annihilating the German people. He also gave details on the Nazi medical experiments.

I remember a visit of Raphael Lemkin, the Polish lawyer, to our house. He was promoting his concept of genocide and tried to have it mentioned in the judgment. He failed, but the Genocide Convention was adopted by the UN General Assembly on 9 December 1948.

I left Nuremberg in August 1946. The four judges and their alternates had started their deliberations in June, before the end of the public proceedings. The trial, which started on 18 October 1945, ended on 1 October 1946. Donnedieu and Falco gave me a precious testimonial that I had performed my duties to their entire satisfaction.

I then went to Indiana University in Bloomington on a two-year scholarship, where I completed requirements for a Master’s degree in Education and Psychology, leaving the Nuremberg trial well behind. I then engaged in a long career in UN organizations, the Food and Agriculture Organization of the UN in Rome, and the World Health Organization in Africa, Denmark, Alexandria, New Delhi and Geneva.

I was a Personnel Officer, and finally Assistant Chief of Personnel in WHO at Geneva. My work involved legal duties.

I returned to the Nuremberg trial when I started giving courses on international organization to universities in North America and in Europe, besides my WHO work and after my retirement. Part of my courses concerned international justice and Nuremberg came back in the picture. The creation of international criminal tribunals in the 1990s – the Former Yugoslavia, Rwanda, Sierra Leone, Cambodia, Lebanon – and the establishment of the International Criminal Court in 2002 renewed my interest in the fight against the impunity of major leaders. I published five books on international criminal justice and tribunals between 1999 and 2011.

The Nuremberg and the Tokyo Tribunals were later criticized as “Victors’ Justice”. Their jurisdiction and judgments were also deemed to be based on charges not in force when the alleged crimes were committed. In Nuremberg, the German lawyers used the *tu quoque* argument: they denounced the Soviet aggressions against Finland and Poland (crimes against peace) and the Katyn massacre, and the British and American mass bombing of German cities.

On the positive side, Nuremberg is credited as a major juridical and judicial precedent in international law: for the first time, high level political and military leaders were held responsible for crimes committed in their name or in the name of their government. Individual responsibility replaced the ineffective state responsibility. A civilized, punctilious, judicial process replaced raw vengeance and summary executions. Donnedieu wrote in 1947 that although Nuremberg was human justice, incomplete justice, a relative justice was better than no justice. For him, the Nuremberg judgment ratified the supremacy of international law over national law. It also affirmed the primacy of conscience over the exigencies of discipline.

The Nuremberg Charter, the new definition of international crimes, the Tribunal’s procedures and jurisprudence have served as essential precedents for the creation and functioning of the later international criminal tribunals and of the International Criminal Court. It opened international law to individuals, previously reserved to states: individuals had obligations under international law. The Universal Declaration of Human Rights, adopted in 1948, affirmed that they also had rights.

In spite of its limitations and failings, international criminal justice remains as a necessary instrument to fight against the impunity of criminal leaders.

Yves Beigbeder

Reminder : Don’t forget our General Assembly and annual reception will take place this year on the same day: Thursday 8 October.
Tobacco kills up to half of its users, which means nearly 6 million people each year, i.e. approximately one death every 6 seconds, accounting for one in 10 adult deaths. Unless urgent action is taken, the worldwide annual death toll could rise to more than eight million by 2030. Incidentally, this writer (RM) remembers the “good old times” of the early 70s when WHO used to warn that, unless action was taken, the death toll would amount to (… just…my italics) one million per year, i.e. one death every 13 seconds! At the time these figures were appallingly small, now they are worse. Nearly 80% of the world’s smokers live in low- and middle-income countries.

More than five million of those yearly deaths are the result of direct tobacco use while more than 600 000 are the result of non-smokers being exposed to second-hand smoke. This is the smoke that fills restaurants, offices or other enclosed spaces when people burn tobacco products such as cigarettes, bidis and water pipes. There are more than 4000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 50 are known to cause cancer. Like active smoking, also second-hand smoke causes serious cardiovascular and respiratory diseases, including coronary heart disease and lung cancer. In pregnant women, it would cause low birth weight. Every person should be allowed to breathe smoke-free air.

From the above it results evident that in spite of all health-oriented efforts, the tobacco epidemic has become one of the biggest public health threats the world has ever faced. Because there is a lag of several decades between when people start using tobacco and when their health suffers, the adverse health effects are not perceived by the smokers as being impending.

Among smokers who are aware of the dangers of tobacco, most want to quit. Counselling and medication can more than double the chance that a smoker who tries to quit will succeed. Another and most cost-effective way to reduce tobacco consumption especially among young people and poor people is the increase in tobacco taxes. It has been proved that a tax that increases tobacco prices by 10% will decrease tobacco consumption by about 4-5%. Smoking restriction laws do protect the health of non-smokers, are popular, do not harm business and encourage smokers to quit.

WHO is committed to fighting the global tobacco epidemic. The WHO Framework Convention on Tobacco Control (FCTC) entered into force in February 2005. Since then, it has become one of the most widely embraced treaties in the history of the United Nations with 180 Member States being parties of it. All the above is very beautiful: WHO is finally engaged in a strong fight against tobacco, backed by numerous staff and a substantial amount of money. But it has not always been like this. Let us go back remembering the many difficulties that a pioneer anti-tobacco programme in WHO had to face. Over great many years WHO was hesitant to oppose tobacco as too many member states had huge financial interests in the crop, including growing, manufacturing, taxation, employment etc. It was “health against wealth”.

The whole thing started with an EB resolution in January 1970 (EB45.R9) on “Limitation of Smoking” which requested WHO to ascertain the risk to health due to tobacco smoking. The resolution passed just by chance. It had not been planned. It had been proposed by the great old man against tobacco, the late UK Chief Medical Officer Sir George Godber, who succeeded to convince two other delegations who just happened to sit alphabetically on his right side and on the left, by the same letter, “U”: Uganda and Uruguay. Other “Sir” later came on to help WHO fighting tobacco, namely Sir John Reed and Sir Richard Peto who first enunciated tobacco-related mortality data in various countries, a big novelty at the time. This writer (RM) was in the Division of NCD (Noncommunicable Diseases) and was asked to take up, together with his duties on Cardiovascular Diseases, the smoking-and-health problem, but no money, no staff, no programme name either. WHO’s attitude at the time wasn’t much of an enthusiastic anti-smoking beginning for what nowadays WHO itself accuses to be the worst man-made epidemic. It was not of much help either in contrasting Philip Morris, BAT and other “big tobacco” powers. The UN, UNCTAD, ILO and FAO were all in favour of tobacco. Now they are all no-smoking. Smokers’ position was not: it was useless for health bodies to shake the death rattle, “…we’ve got to die of something anyway…” was the smokers’ attitude. Smoking...
was just considered as a personal habit, not an "addiction". WHO did not consider it in its ICD of Diseases until the 10th edition, applied in member states in 1994, i.e. 24 years after the passing of the first resolution, under rubric F17 "mental and behavioural disorders due to the use of tobacco".

In his 1984 book "The Smoke Ring" the BBC journalist Peter Taylor reported that the WHO Programme and Budget 1984-85 "...after lengthy discussions on a programme on smoking-and-health the consensus was to maintain activities at a low level...on a part-time basis" so that "...the WHO was beginning to adopt a more objective neutral position". Just think: WHO being neutral against tobacco!

Finally, on World Health Day 7 April 1988, on the occasion of the 40th anniversary of the founding of WHO, the Organization officially changed attitude by declaring itself as a "No-Smoking" working area. The DG at the time, Dr. Halfdan Mahler, gave the signal by breaking an ashtray at a symbolic ceremony in front of a total HQ staff gathering. No more ashtrays in WHO since.

Luckily two member states provided some soft money to hire a documentalist (our present-day AFSM colleague Laura Ciaffei) and financially cover occasional meetings and short-term consultants for a few years.

Between 1975 and 1991 this small programme (with a small "p" not a capital "P" as I was told by HPC, the Headquarters Programme Committee) nevertheless produced at least 35 pioneer reports from WHO Expert Committees and other meetings, seminars in developing countries, guidelines on smoking surveys and statistics, chemical composition of smoke, anti-smoking legislation, etc. Of particular interest were the 1984-85 reports on smoking in aircraft, in taxi and ground transport, in schools and by teachers, smoking by health professionals and in hospitals, at a time when smoking was allowed practically everywhere. Only one handful of hospitals in Australia, New Zealand and the US declared to restrict smoking in their premises. These writers remember when they tried to promote the idea of no-smoking in the Geneva University Hospital (HUG). For several years their repeated approaches were simply ignored, as practically all health and non-health professionals physicians and nurses were openly smoking. In the major hospital of Rome, RM even saw a doctor smoking and letting ashes drop over the electrocardiogram electrodes of a cardiac patient. Unthinkable now.

IATA and the UN/ICAO, the air transport associations, did attend WHO meetings on smoking but where unconvinced as to the possibility to limit smoking onboard. At the most they set aside 3 seat rows for non-smokers. RM could not speak against smoking in China as at the time the top man in the country was a heavy smoker. He could only say that smoking was a risk factor, among several others, for cardiovascular diseases.

But this is history of pioneer times. Things have drastically changed for the better under the last two DGs. Smoking is now forbidden in all hospitals, in all public ground transportation including taxis, in all schools, and in all aircraft. WHO has established a powerful programme on Tobacco Free Initiative (TFI) under whose aegis the WHO Framework Convention on Tobacco Control (FCTC) was launched in 2003. We are finally on the right track. Details on the present TFI antitobacco programme are in <WHO.int/health topics/tobacco>.

To conclude, RM would like to recall two things that he is proud of as they are still operational in WHO. One is the yearly World No-Tobacco Day, launched on 31 May 1988 and still being celebrated in many countries after 27 years. The first year’s theme was “Smoking or Health, the Choice is Yours". This year’s theme was “Stop Illicit Trade of Tobacco Products!".

The second thing dates from as far back as the early 1980s, when RM assisted a young lady doctor initiate a smoking-related study of lung patients in a hospital in Rio de Janeiro. Brazil was at the time 100% in favour of tobacco, with tobacco “one of the fastest growing tobacco markets anywhere" as Peter Taylor’s book says, and “a tobacco man’s dream". The hospital director wasn’t enthusiastic but did not oppose the idea. Now the former young lady doctor has become the Director of WHO/TFI: Dr Vera Luiza da Costa e Silva.

Ad majora, Vera!

Roberto Masironi and Laura Ciaffei
Former WHO Staff are sporty!

London Marathon

Many headquarters colleagues will remember the group of lunch-time runners who would put us all to shame as they ran out the door for their jog and returned looking almost just as fresh in time for an afternoon of work. Several of them – the “WHO Marathoners” – ran a marathon each year and in doing so raised large sums of money for bodies such as Handicap International, Asian orphanages and African hospitals. Philip Jenkins was one of that group and, since his retirement, Philip has remained very active. Last December he began training for the London Marathon, running every second day, come rain or shine. Philip’s fundraising target for the Multiple Sclerosis Society was initially GBP 2000 and, thanks to generous donations from friends and former colleagues, he surpassed that amount, rising more than GBP 2700. On Sunday 26 April, Philip achieved his goal and crossed the finishing line at 15 h 33, having run every step of those 42 km and 195 m. He recalls that the first half seemed easy, but he relied on the enthusiastic crowd to keep him going for the last 10 km and on the music! His target was to finish within 5 hours and he managed it with 3 mins and 40 seconds to spare.

Philip was delighted to run with the likes of world record holder Paula Radcliffe, racing driver Jenson Button and Welsh rugby international Shane Williams (but miles behind all three). He overtook Olympic gold medallist (1968) David Hemery, nine rhino-costumed runners, one dressed as Big Ben and one wearing a bomb disposal suit, and was overtaken by a couple doing a 3-legged run!

Except for the fatigue, Philip reports that he had a wonderful time. Well done Philip! Do any of our other readers run marathons or half marathons or other races? Please share your stories with us.

Sue Block Tyrrell

Global Health Histories

Some readers may be aware of this project which was established within WHO headquarters and regional offices in late 2004. An important part of the project is a seminar series which is supported by the Wellcome Trust and co-hosted in Geneva and elsewhere by WHO and the University of York, United Kingdom. Seminars are held monthly and bring historians and scientists from around the world to discuss and debate with WHO topical issues in global health. Each event is broadcast live, people can listen to the talks, view the speakers’ powerpoint presentations and, if they wish, even pose questions to the presenters and other discussants.

The schedule of seminars in 2015 has been posted on the AFSM website – www.who.int/formerstaff/. The seminars are held in the WHO headquarters’ library room from 12.30 – 14.00 CET and are also broadcast via webinar. AFSM members around the world are welcome to register for a webinar, by contacting – GHHistories@who.int.

Sue Block Tyrrell
Celeste Jacinto (1959-2015), R.I.P.

Celeste Jacinto, one of our longest-serving and extremely popular colleagues in the Manila office, passed away on Saturday, 21 March.

Celeste, who was 56, succumbed to illness. Celeste had the enviable record of having served 3 regional directors in the Regional Office of the Western Pacific (WPRO) for more than 3 decades, said Dr Corinne Capuano, Director in the Office of the Regional Director in Manila, when breaking the news to colleagues in headquarters on Monday morning: "Celeste was one of our most admired and loved colleagues, not because she had been the assistant of 3 Regional Directors but mainly because she was a uniquely loving and caring person. She is part of these few people you meet in your life, who will positively mark it for-ever."

"Celeste was one of the most humble but still most well-known staff in the Organization. It is rather unique for a support staff. It is all due to her wonderful personality, constant high quality work and full dedication to WHO. She is a shining example of someone who has served WHO without fail for over 3 decades; those exemplary people who make WHO's work possible behind the scenes," were Dr Capuano's concluding words.  

Rebecca Agoncillo

Claude-Henri Vignes passed away on 30 March of this year. He served a total of 3 decades in the Legal Office, half of which as Legal Counsel, through often tumultuous times. He may well be remembered by many for his highly public role in guiding WHO through many difficult Health Assembly and Executive Board crises. In fact, he seemed to thrive during these parliamentary challenges. Particularly memorable was the 1989 Health Assembly

However, for us he will also be remembered for his unique blend of professional commitment, humour and enviable life balance. He took his work very seriously, always ensuring that everything was done to a high standard. Yet percolating underneath the lawyer’s professional veneer was a very funny, ironic sense of humour. In addition, more than anyone we know he achieved a remarkable balance between his professional and personal lives. While being extremely well-prepared in the Office, it seemed he was always skiing during winter weekends, sailing and playing tennis in the summer, and horseback riding in between. Until last year, Claude-Henri and his wife sailed by themselves every summer across the Mediterranean! Claude-Henri Vignes was born on 22 December 1930 in Marseilles. After obtaining his law degree at the University of Aix-en-Provence in 1953, his professional development showed the mix of practical and academic interests that will characterize his entire career. He was admitted to the Bar of Marseilles in 1954 and initially worked in private practice while also teaching as a Lecturer in Law and later Associate Professor at the Universities of Aix-en-Provence, Lyon, Geneva, Paris and Grenoble. He cultivated his academic interests throughout his career and was responsible for some publications that provided important insights into WHO and its governance, such as his article on the status of the Members of the Executive Board, and the monograph on WHO that he co-authored in 2004 with the current Legal Counsel, Gian Luca Burci.

He joined what then was the Legal Division of WHO in 1961 and was appointed Legal Counsel in 1978, a position he held with a brief interruption until December 1995. Among the professional landmarks that he was particularly proud of were his participation as WHO’s agent in the two advisory opinions that the International Court of Justice rendered at the request of the Health Assembly, in 1980 on the Agreement between WHO and Egypt for the hosting of EMRO; and in 1996 on the legality of the use by a State of nuclear weapons. Claude-Henri maintained his life-long commitment and support to WHO even after his retirement. He continued to provide advice to the Legal Office, for example during the revision of the International Health Regulations, and participated in the meetings of the Onchocerciasis Programme (APOC) for several years. Aside from his WHO career, he also had the distinction later in life of being appointed a Knight in the French Legion of Honour.

Claude-Henri was a man bigger than life, and he remained that way until the last months of a long, intense, productive and happy life. He was good-looking, impeccably dressed, very sporty and debonair. He was a charming person with whom it was a pleasure to work. His professional commitment certainly has had a long-lasting positive influence on the way the Organization functions. He will certainly be missed.

Gian Luca Burci and Tom Topping
In memoriam

Bill Barton. It is with sadness that we announce the death at his home in Nairobi, on 15 April 2015, surrounded by his family, of Dr William L. (Bill) Barton, after a short illness. From a senior post in the London School of Hygiene and Tropical Medicine, Bill joined WHO in 1972 at Director level in the Division of Family Health. Shortly after his arrival, however, Dr Halfdan Mahler was appointed as Director General of WHO and put in motion some fundamental changes, one of which was to establish a programme of staff development and training with a view to helping all staff reach their maximum potential, and Bill was put in charge of this programme which he developed with great energy and imagination. Bill was also a highly talented comic amateur actor and his many performances with the Geneva English Drama Society will long be remembered. Our heartfelt sympathy and condolences go to his beloved wife, Libo, and to all his family Barton.

Bernadette Rivett

It is with great sadness that we learn of the death of Dr Ebba Mahler (1923-2015), wife of Dr Halfdan Mahler, past Director-General of WHO and life member of the AFSM. Medically qualified since 1946, Mrs Mahler, after various positions in Denmark, the USA and India, completed her career at the Geneva University Hospital and at Caritas at the age of 85. We offer our sincere condolences to Dr Mahler and his two children.

Bernadette Rivett

Vincenzo D’Inca passed away on 26 May. He was aged 89 years.

Dr LEE Jong-wook: Remembering him

This year is the 25th anniversary of our Association and 100th issue of our QNT. We thought it would be appropriate to remember one of our real well-wishers – Dr Lee. Dr Lee Served as Director General of WHO from May 2003 to his untimely death in May 2006. During this short time, he endeared himself to the staff and WHO’s friends outside.

Dr Lee was born in 1945 in Republic of Korea and studied medicine in Seoul National University. He joined WHO as a leprosy consultant in South Pacific in 1983 and moved to the Western Pacific Regional Office in 1986. After overseeing Polio eradication in WPRO, he moved to HQ in 1994 as Director of the Global Programme for Vaccines and immunization. In 1998 he joined the Cabinet of the then DG – Gro Brundtland - as Senior Policy Adviser. At that time, he often would drop in his friends’ offices and chat about various subjects. In 2000 he was appointed director of the Stop TB programme where he oversaw a global public-private partnership involving a large number of international partners.

He was appointed DG in May 2003 by the world Health Assembly. During the election in the Executive Board, many personalities – principally Regional directors – had stood as candidates. In the end, the election was between him and Peter Piot – the Belgian discoverer of Ebola virus. Dr Lee prevailed after two drawn votes.

Like Dr Mahler, he would drop in on various Programme offices to discuss issues of importance. He was also particularly friendly and helpful to our retirees’ association and would drop in on our General Assemblies without hesitation or notice. He not only addressed the retirees as friends but also made resources available to the Association.

We are grateful for all his support and friendliness. We still miss him.

Dev Ray
First Ministerial conference on Dementia: 16/17 March 2015

Dementia is a syndrome in which there is deterioration in memory, thinking, behaviour and ability to perform everyday activities.

Although dementia mainly affects older people, it is not a normal part of ageing. Consciousness is not affected. Dementia affects each person in a different way. There are many forms and causes – Alzheimer’s disease is the most common form and may contribute 60-70% of the cases. Other major forms include vascular dementia.

Signs and symptoms linked to dementia can be understood in three stages:

**Early stage** where the onset is gradual and is characterized by
- forgetfulness
- losing track of time
- becoming lost in familiar places

**Middle stage** is when the signs and symptoms become clearer:
- becoming forgetful of recent events and people’s names
- becoming lost at home
- having difficulty with communication
- needing help with personal care

**Late stage** is of near total dependence:
- becoming unaware of time and place
- having difficulty recognizing relatives and friends
- an increasing need for assisted self-care
- having difficulty walking.

Dementia is becoming a huge problem in the world. Currently it is estimated that more than 47 million people are living with dementia and 60% of those live in low or middle-income countries. As population ages, it is estimated that there will be around 150 million people with dementia in 2050. In 2010, the worldwide cost of dementia, mainly driven by social-care needs, was estimated to be US$ 604 billion and will soar to US$ 1.2 trillion by 2030.

Since dementia is related to ageing, it is useful to remember that about 3% of population 65-74 years of age suffer from dementia but the proportion goes up fast – 19% of those 75-84 and about one-half of those above the age of 85. There is no known cure nor of any medicine to prevent dementia. However the risk factors are high blood pressure, diabetes, smoking, obesity and lack of physical and mental activity.

WHO, with the support of Department of Health of the UK and the Organization for Economic Cooperation and Development (OECD), hosted the first Ministerial Conference on Global Action Against Dementia on 16 – 17 march. The conference was attended by a large number of experts from research, clinical and advocacy communities. The UK government has pledged US$ 100 million for pioneering a new Dementia discovery Fund. The participants adopted a Call for Action, which stated, inter alia:

- Dementia is not a natural consequence of ageing and the risk may be lowered by reducing cardiovascular risk factors
- Empowering full and active participation of people living with dementia, their caregivers and families is essential
- Overcoming stigma and discrimination based on human rights approach
- Devoting much greater resources to participatory and open research shared by all
- Promoting preventive actions and supporting the efforts of caregivers, families and health workers.

Many NGO’s are currently active e.g. Alzheimer’s disease International and world Dementia council. What is heartening was to see an intergenerational solidarity through the active support of the Global Young Leaders Network.

Much remains to be done but we the retirees have a double stake in helping in the processes – some of us will succumb to dementia and we also need to promote the call for action to combat this growing scourge. I would like to pay tribute to the organizers of the meeting for the participatory way it was conducted but also welcoming us warmly.

If only other programmes in WHO similarly welcomed us – those who have previously contributed to the work of WHO!!

*Dev Ray*
New AFSM members

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

New Life Members:
Modibo Dicko, Elena Nivaro

Conversion to life member:
Barry John Cooper Marie-Thérèse Brouland, Alison Porri Elena King
Anant Vijay

New Annual Member
Philip Jenkins

In the Geneva area

Nyon coffee group

A few AFSM members who live in the Nyon area join the group for the monthly coffee mornings at “Le Magot” café – see QNT 98, January 2015, for further details and dates. In past years, the group has been run by Bob Yazgi, ex UNHCR, but since 2015 Bob has handed over to Pauline Nicholls, ex WMO. In order to thank Bob for all his efforts, Pauline organized a lunch in his honour at the Croix Verte restaurant in Nyon, after the coffee date on Wednesday 6 May. Twenty of us attended, including three from WHO – Ray Cheng, Mary Kehri-Smyth and myself. If you live not far from Nyon, do come and join us – we are a real UN family of former staff.

Sue Block Tyrrell
BAFUNCS: The 38th Annual General Assembly and Reunion

The Maidstone Great Danes Hotel, Hollingbourne, Kent, 15-17 May 2015

In 2015 BAFUNCS held its Annual Reunion in Kent. It was a pleasant weekend and the weather was very kind to us this time. Attendance was around 80 participants. As usual participants arrived to a welcome with tea on Friday afternoon and the informal dinner on Friday evening. WHO's retirees were well represented with 13 ex staff members and 4 spouses. The meeting started on Saturday morning with the business part which was dealt with in record time. Mention was made of the recent unrest that surrounds the pension fund as a result of the non finalization of a memorandum concerning certain revisions in the fund management. However, the BAFUNCS pension expert alleviated any worries by explaining the situation, but did state that because of the disarray among UN officials a certain deterioration of client services may result.

It was unfortunate that the main speaker, who should have been Lyse Doucet, the BBC foreign correspondent, had been called away to Yemen two days before the meeting and hence a substitute speaker had to be found.

John Skeldon who had been addressing the UN witness seminar on humanitarian issues which had been held a few days before the BAFUNCS reunion was found willing to deliver his talk on Migration also to our meeting and proved to be an excellent substitute. The title more precisely was: Development, Population and Migration: Myths, Realities and Illusions. Dr Skeldon who is a professor at the University of Sussex has worked for IOM on population issues. His talk stated that migration and development are intricately linked but that the relationship is very complex. He also stated that statistics do not show the fear of (im)migration which exists in many developed countries is justified. One major aspect is that the young adults that form the majority of immigrants are in the end contributing to development in their own countries through remittances and in their adopted places of residence through partaking in the economic process.

The Saturday afternoon was as usual devoted to the excursions. There was a choice of three: to Down House, where Darwin once resided; to Sissinghurst Gardens and Castle and the third one a walk through Rochester town. All three were much appreciated. I enjoyed Sissinghurst's beautiful gardens, the legacy of Vita Sackville West and Harold Nicolson. A very nice official dinner completed the day.

Sunday morning was devoted to the remainder of the business meeting and an address by Sir John Holmes, former British Ambassador to France and Under Secretary of the United Nations for humanitarian affairs. Sir John spoke on: UN neutrality ad delusion, showing that in severe humanitarian crises it is not possible for the UN to stay neutral as moral obligation will often force decisions to go one way or another. Keeping the balance is most important.

After the usual reading of the preamble to the UN charter, the meeting was closed by Sir Richard Jolly; the president, Edward Mortimer having had to leave earlier for another engagement.

Next year there will be Bournemouth, organized by WHO's June Hargreaves. The attached photograph shows only a few of the WHO participants as it was not possible in the time available to get everyone to line up.

Coby Sikkens
Highlights from the 68th World Health Assembly, 18–26 May 2015

Angela Merkel, Chancellor of the Federal Republic of Germany, addressed delegates on the first morning of the Assembly, affirming that “The WHO is the only international organization that has universal political legitimacy on global health issues”. She called for a new plan to deal with “catastrophes” like the recent Ebola outbreak and paid tribute to all those working to safeguard human health worldwide, urging them to “work together”. She pledged that under Germany’s presidency, the G7 would focus on fighting antimicrobial resistance and neglected tropical diseases: she emphasized the need for all countries to have strong health systems and highlighted the key role of health in sustainable development.

In the afternoon, the Director-General Dr Margaret Chan outlined her plans to create a single new WHO programme for health emergencies, uniting outbreak and emergency resources across the three levels of the Organization, stating “I have heard what the world expects from WHO, and we will deliver”. The new programme will be accountable to the DG and will have its own business rules and operational platforms: it will set up a new global health emergency workforce as well as strengthen its own core and surge capacity of trained emergency response staff. A USD 100 million contingency fund will be established and will run initially as a two-year pilot.

Under the presidency of Dr Shri Jagat Prakash Nadda of India, who pledged USD 1 million for the new fund on behalf of his Government, many technical issues were discussed, resolutions adopted and decisions taken, including on the following issues:

- Ebola: to provide WHO with the mandate to carry out structural reforms, establish a single unified emergency programme to prepare for rapid response to emergencies and disease outbreaks, and create the pilot contingency fund
- Polio eradication: recommitment to stop the disease and prepare for the phased withdrawal of oral polio vaccines
- International Health Regulations (IHR): notably the establishment of a new review committee to assess the effectiveness of the IHR in regard to the Ebola outbreak and to recommend steps to improve their functioning and effectiveness
- Adoption of a new global malaria strategy and targets for 2016-2030
- Addressing the health impacts of air pollution
- Strengthening care for epilepsy
- Adoption of a global action plan to tackle antimicrobial resistance, including antibiotic resistance
- Improving access to sustainable supplies of affordable vaccines
- Endorsement of the Rome Declaration on Nutrition and a Framework for Action across the health, food and agriculture sectors to address malnutrition
- Strengthening emergency and essential surgical care and anaesthesia
- Consensus on many parts of the draft framework of engagement with non-State actors
- Approval of the Programme Budget for 2016-2017 – USD 4384.9 million, an increase of USD 236 million over the 2014-2015 budget

Other key news

- In April, WHO established a new registration system – The Global Foreign Medical Teams Registry - to help build a global roster of foreign medical response teams ready to deploy for emergencies
- During World Immunization Week, 24-30 April, the WHO campaign focused on closing the immunization gap – one in five children worldwide is still missing out on vital immunization
- On 8 May, WHO published the new edition of its Model List of Essential Medicines
- On 11-12 May, WHO convened a Summit on Ebola Research and Development to develop a roadmap for coordinated R&D action for future epidemics
- On the occasion of World No Tobacco Day, celebrated on 31 May, WHO called upon Member States to sign the “Protocol to Eliminate the Illicit Trade in Tobacco Products” – one in every ten cigarettes, and many other tobacco products, consumed worldwide are illegal
- WHO has assisted with various other emergencies and disease outbreaks, notably coordinating medical relief in Nepal after the earthquakes, assisting with the response to the cyclone in Vanuatu, cholera in the United Republic of Tanzania, measles in Liberia, Middle East respiratory syndrome coronavirus (MERS-CoV) in Qatar, Republic of Korea and Saudi Arabia, and meningitis in Niger
- Currently, at WHO headquarters, there is a display of photographs paying tribute to the role of health workers during the Ebola outbreak: the photos were taken by Samuel Aranda who has spent the last 15 years documenting conflict, migration and social issues around the world
- See the separate article on page 2. concerning the new WHO headquarters’ building

Further information can be found on the WHO website – www.who.int

Sue Block Tyrrell
Astronomy

Night Sky for July – September 2015

The evening skies at the moment have no bright planets, unless you are in the southern hemisphere, in which case you will see Saturn well up in the west, not far from the red star Antares, marking the heart of the Scorpion. From the northern hemisphere it is low down and sets soon after the Sun.

So rather than finding planets, have a look for three less well-known but rather nice star patterns. Start by finding the bright star Altair, in mid sky, to the south in the northern hemisphere and to the north in the southern. It has a fainter star on either side of it, making a group of three which is easy to recognise.

A little way to the east of Altair and its companions is a small but attractive constellation, Delphinus, the Dolphin. Its stars are fairly faint so you may need binoculars. A diamond of stars marks the dolphin's head and, for once, the pattern looks like what it is meant to be.

Another of these, also quite faint, lies a similar distance to the north of Altair. This is Sagitta, the Arrow, and it is a very obvious arrow shape. To see the third pattern you will need binoculars even in a dark sky. Just to the west of Sagitta is a small but unmistakable group of stars known unofficially as the Coathanger. Once you see it, you will have no doubt why!

To find out more about astronomy, visit the Society for Popular Astronomy website, www.popastro.com.

Article kindly provided by the British Society for Popular Astronomy

Memoirs

“A JOURNEY TO REMEMBER “

Mr. Vitorino (Vic) Pinto dropped in some days back and kindly presented us with his book "A Journey to Remember", an offer to AFSM. With an attractive cover and over 450 pages, the book, takes us along his years of professional and leisure life, particularly with a strong input of his days with WHO.

The Chapter on WHO describes first his field assignments in Nigeria, followed by his years as Regional Adviser AFRO, in Brazzaville, and finally his work at WHO/HQ. He recalls with nostalgia his involvement in the Community Water Supply and Sanitation Unit during the seventies and part of the eighties, which he considers were the Golden Years of WHO, which was rightly acknowledged then as the Lead Agency in the field of Water and Sanitation.

The book describes at length the large WHO contribution to the development of Water and Sanitation worldwide not only through his regular staff at HQ, Regional Offices and the field, but also from the WHO/IBRD Cooperative Programme based at HQ at the time.

The book covers at length the Pre Investment Studies, a unique type of assistance to countries, where with funds provided by UNDP, and WHO designated as Executing Agency, projects were prepared for implementation by the World Bank. It talks about the Sector (Water Supply and Sanitation) Studies, Rapid Assessment Studies, etc. that culminated with the launching of the First International Drinking Water Supply and Sanitation Decade in November 1980.

Finally, the book also describes the many travels and visits to countries during his professional years and later after retirement. There is a single copy of the book for reference in the AFSM office, and those interested in having a copy may contact Mr. Pinto directly (address in the WHO/AFSM directory).