Twentieth anniversary of WHO: at the World Health Assembly the Regions were represented by young girls in national costume who offered a flower to each delegate: also shown are Drs Candau and Dorolle, Director-General and Deputy Director-General.
The Directors-Generals since the beginnings of WHO

Dr Brock Chisholm (1948-1953)  
Dr Marcolino Candau (1953-1973)  
Dr Halfdan Mahler (1973-1988)

Dr Hiroshi Nakajima (1988-1998)  
Dr Gro Harlem Bruntland (1998-2003)

Dr LEE Jong-wook (2003-2005)  
Dr Margaret Chan (2006 -)
EDITORIAL

On the occasion of WHO’s 60th anniversary, this issue of QNT – No. 73 – is mainly devoted to the Organization’s early days: a 1976 interview with Dr Pierre Dorolle, former Deputy Director-General; an article by Dr Jo Asvall, former Director of the Regional Office for Europe; the speech given by Dr Halfdan Mahler, former Director-General, to the last World Health Assembly; a letter from Dr Frank Gutteridge, Legal Adviser from WHO’s earliest days and finally an article on Dr Martha Eliot, the only woman among the founders of WHO.

These articles all relate events and impressions which also reflect WHO’s first steps and evolution.

We would welcome articles from you, and particularly from our former colleagues in the regions, regarding your memories of WHO and your «WHO lives». Such articles would be welcome not only this year but at any time in the future.

The Committee has decided to make our annual reception in December a special event this year to celebrate the 60th anniversary: there will be talks, music, etc.

Between now and then the elections will have taken place, and there will be a new Executive Committee.

As has been the case for the last four years, free flu vaccination will be organized at WHO HQ this autumn for the retirees living in and around Geneva.

This issue will have reached you a little late. This is because new administrative procedures and budgetary restrictions at WHO mean that the Association must now assume the production costs; we shall keep you informed of any new development.

However, we shall now be obliged to send the QNT to paid-up members only, i.e. either life members or annual members who have paid their dues for the current year. So we strongly recommend that those of you who have not yet become members, or who have not yet paid their contribution, do so as soon as possible if they want to continue receiving the newsletter.

Many thanks.
The only woman to sign the founding document of the World Health Organization was Dr Martha May Eliot (April 7, 1891-February 14, 1978). Born in Dorchester, Massachusetts, Eliot graduated from Radcliffe College and, after being denied entrance to Harvard Medical School because it did not admit women, she received medical degrees from Johns Hopkins.

As early as her second year of medical school, Dr. Eliot was interested in public health. Her first important research—community studies of rickets in New Haven, Connecticut, and Puerto Rico—explored issues at the heart of social medicine.

For many years she was active in international health work. She was a member of a group of experts appointed by the Health Organization of the League of Nations to study methods of assessing the state of nutrition in infants and adolescents. During World War II Eliot was sent to England to study the impact of defense activities on children in Britain, observing the evacuation of city children to stay with families living in the countryside and publishing her report Civil Defense Measures for the Protection of Children in 1942.

Participating in UNRAA, UNICEF and in WHO as a US delegate, she was influential in bringing about the establishment, at the First World Health Assembly, of maternal and child health work as a priority programme for WHO. She joined WHO in 1949 as Assistant Director-General, Department of Operations. When she resigned her position as ADG in 1951 (to be replaced by Dr Marcolino Candau) Dr Chisholm paid her tribute: “During the two years that Dr Eliot has been with WHO she has given herself unstintingly and unreservedly to the work of helping to bring about better health for the peoples of the world. To this great cause she has brought a singleness of purpose and a whole-hearted devotion, which are unique. Those of us who know her best and have had the privilege of working with her have been filled over and over again with a sense of deep admiration for her indefatigable energy and her boundless enthusiasm. From the very beginning Dr Eliot has been and, although she is leaving us now, she will continue to be a source of real inspiration to all of us”.

During the next twenty years, Dr Eliot returned to WHO and UNICEF as a consultant; she served for more than thirty years as chief of the US Children’s Bureau and then as Professor of Maternal and Child Health at Harvard University’s School of Public Health. Dr. Eliot’s service to public health earned her many honours, created new opportunities for generation of women physicians to follow, and contributed to the cause of health for all in particular for the world’s mothers and children.
Dr Pierre Dorolle was Deputy Director-General of WHO from 1950 to 1973. As part of an early WHO Library programme to record recollections of prominent figures in international health, he talked with Mrs Erica Campanella and Dr Norman Howard-Jones on 21 September 1976. In the interview, Dorolle spoke about his participation in international health activities with the League of Nations between 1937 and 1950. In particular he refers here to the League at its Eastern Bureau, Singapore and the Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene, Bandung, Indonesia, in 1937.

"The [Eastern] Bureau played a very important role in receiving and distributing epidemiological information. It also played the role of epidemiological surveyor when necessary. In particular, I remember a request that the Bureau had addressed at the end of 1936 to Indochina because of its proximity to the Chinese island of Hainan where – through a series of translations from Chinese into English and then from English into French – we understood that there had been a number of suspected cases of yellow fever. It was evidently extremely serious information that greatly concerned Geneva and Singapore, and they requested the French to act as soon as possible. That was easy, given the proximity of Hanoi to Hainan. Bacteriologists from the Pasteur Institute in Hanoi went immediately to Hainan where they found that they were simply cases of viral hepatitis. There were cases with fever and jaundice, but in the transmission from Hainan the words yellow and fever were put together, and created an emergency for the Bureau."

Everything had to be prepared long in advance.

The League of Nations did only a few things, but those they did extremely carefully and completely. "In those days, the majority of people travelled by boat, as did the post. We would never send anything by post or by air as it would have cost far too much.

Everything they did demanded travel. For example, travel of a member of the League secretariat to Indochina took three weeks, and the same for return!"

"The Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene was in fact the forerunner of what has been discussed these last few years at WHO on the subject of the organization of primary health care and integrated health services – the model to adopt for health care in isolated rural areas…. It is extremely unfortunate that the Conference took place just before a great world catastrophe [World War II], so that its important conclusions were lost."

From 1937-1940, Dr Dorolle worked for the League of Nations in China as chief expert for technical cooperation.

In China, the League of Nations had a number of specific programmes. One of them was an anti-malaria campaign, which became of vital importance to China after its encirclement by the Japanese, who had cut all the roads to the exterior. There was only the little mountain railway and road towards French Indochina, which was later called the Burma Road…. We had established there an anti-malaria project to protect workers on the road and also the many people who had to travel on the road. It also introduced something that was a pioneer effort, namely collaboration between a League of Nations team and a bilateral aid team. China had requested aid directly from the United States in the field of malaria. The US Surgeon General responded to this request by creating a team headed by Dr Lewis Williams…. Well, as you know, the United States was not a member of the League of Nations. It asked the League for its agreement to provide American bilateral aid to China. It was the world upside down compared with what you see today.

Like today’s United Nations peacekeepers, League officials often had dangerous working conditions.
We lived under war conditions. I had a car, and it was often machine-gunned by little Japanese planes.... All our travel was difficult and dangerous. We had to carry our own petrol. At one time, I believe that the petrol for China came from Alma Ata, and three quarters of our supply was used up on the long journey. We lived in very difficult conditions, but once again I’m certain that we provided the basis for the proposal to create a specialised health institution in the United Nations. It is interesting that, at the United Nations Conference on International Organizations San Francisco, in 1946, China was one of the two countries that requested the creation of an international specialised health organization; [Brazil was the other country].

Howard-Jones asks about Dorolle’s role on joining WHO in 1950 as Deputy Director-General.

When I arrived in WHO, [in 1950] our Director-General had no personal experience of field programmes but a very wide national experience. One of the reasons that I found myself by chance becoming Deputy Director-General is because he found himself face-to-face with someone who was complementary to him – with French language and also field experience in the Far East. I found Dr Chisholm a very agreeable man with a very broad outlook. There were all sorts of little internal problems to settle. The increase of WHO was beginning at that moment, and little by little I was able to develop myself into a theoretician. We are all inevitably theoreticians. It’s a good thing, and it’s fortunate that there were constant renewals through people coming in who brought a vast field experience with them. I think of people like Dr Emilio Pampana and Dr Lucien Bernard.

Dr Dorolle is an example of some of the dedicated, courageous, and exacting individuals who founded and developed WHO. Many former WHO staff remember him with fondness and abiding respect.

A Reminder

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It has been a great pleasure to meet many of you at the Global Health Histories lunchtime seminars series. There are just three more before the end of 2008.

Place: WHO Library Meeting Room
Time: 12:30pm

2 October 2008: The fruits of a new internationalism: South Asian governments, the WHO and global smallpox eradication
Speaker: Dr. Sanjoy Bhattacharya, The Wellcome Trust Centre for the History of Medicine at UCL, UK

20 November 2008: The rise of the global health consultant: The life and times of Brian Abel-Smith (1926-1996)
Speaker: Dr. Sally Sheard, Liverpool University, UK

Speaker: Dr. Lynette Schumaker, Manchester University, UK, and Dr. Virginia Bond, London School of Hygiene and Tropical Medicine and the ZAMBART Project, University of Zambia

For additional information, please see the web site at: http://www.who.int/global_health_histories
WHO at 60 – Health and more

By Jo Asvall, MD, MPH, WHO Regional Director Emeritus, Europe

WHO is more than just a technical arm of the United Nations system – it is a beautiful vision and instrument to create a better future for Mankind. This vision was not a pipe dream; it was the work of persons with profound public health knowledge, extensive experience, strong social and ethical views and impressive practical know-how. Those persons had lived through the terrible cataclysm of World War II and wanted to marshal global resources and catalyze peoples’ energy for a better future through healthy and just societies.

This dream was enshrined in the WHO Constitution, which still today is the heart of WHO and as up-to-date as ever. Stating that the health of all peoples is fundamental to peace and security and that health is one of the fundamental rights of every human being, it gives the organization an extremely strong mandate: WHO shall act as the directing and co-ordinating authority on international health work.

The scope of WHO’s work during those 60 years to fulfill its mandate is vast, and time permits me only to highlight a few elements – which means that very many essential ones will be left out, for which I apologize.

World War II killed some 50 million people, leaving huge destruction, untold suffering and widespread disease in its wake. Right after its creation WHO threw itself into a global Tuberculosis control campaign, developing a systematic approach to public health. That approach subsequently became the hallmark of all its later programmes: A thorough Situation analysis (using Prevalence surveys) on which to build the whole programme; a strong Prevention component (using BCG vaccinations); appropriate Care (Domiciliary drug treatment) and Technology (X-Ray equipment improvement) and Research (Epidemiological, operational etc.). Having thus established its modus operandi and world-wide operational basis, WHO’s “global Parliament” – the World Health Assembly (WHA) - in 1955 launched the biggest attack ever on a global health scourge. The Malaria Eradication program had a very strong foundation: A global political and scientific consensus; a scientifically solid strategy; huge, ample resources; excellent planning and management, and thorough training of staff at all levels. When 10 years later a growing DDT resistance in the Anopheles mosquito and post-eradication surveillance problems led the WHA to cancel the eradication attempt, huge results had been achieved. 674 million people in 35 countries had been freed from Malaria; in 76 countries (with 277 million people) eradication efforts were in preparation; and only in 37 endemic countries (with 87 million people) were there no plans yet. Furthermore, the value of the fundamental public health understanding and operational experience that the programme had given to more than a hundred thousand people around the world is difficult to overestimate. A superbly managed programme of global reach the Malaria Eradication attempt was a right initiative at a right time and it gave WHO a strong international image.

The 1960s brought freedom to the colonies world wide and a tremendous joy and optimism to their newly independent peoples. Providing youngsters in the newly independent nations with a “developed country” level education and channelling enough development funds to the new nations was felt to be the straight forward solution to health problems of the developing world.

At the same time medical research and technological developments made big breakthroughs, bearing the promise of an improved health service as the major solution for the world’s health problems and leading WHO to expand its reach in the scientific field.

Spurred by the Malaria eradication effort the WHA decided to take on another very serious global health problem. The Smallpox eradication operations started well, but then stalled to some extent, leading WHO to undertake a thorough review of its operational procedures. This was successful, and in 1977 a major milestone in WHO’s history was reached when the last wild Smallpox focus was extinguished. This amazing success was due, above all, to superb leadership – in the field, at programme level and from the WHO top.

While the disease specific initiatives of WHO had brought a lot of success, they did not explore to the full extent WHO’s constitutional mandate of global leadership. Furthermore, in the beginning of the 1970s it became clear that the development theory of the 1960s was insufficient, as the new health resources were spent on new hospitals in the capitals, while nothing happened for the masses in the rural areas.

In 1973 Halldor Palsson was appointed Director General, and through his inspirational and enlightened leadership a unique global movement in health – Health for All (HFA) – was created. This

\[1\] Andrej Stampar, Karl Evang and Brock Chisholm were particularly strong and influential leaders among them.
took the organization back to its origins and ushered in a fascinating period that has left its imprint on WHO and the world until today.

From its start as a WHA resolution in 1977, HFA got its global launch through the 1978 Alma Ata Primary Health Care (PHC) conference – the most influential public health conference ever. Stating that PHC is the most important part of any health care system and is at the heart of the HFA, the Alma Ata Declaration became the lever that inspired all of WHO’s programmes and a large number of its Member States world wide to undertake fundamental reviews of health development and align their own policies and programmes with the HFA ideas. Thus, the HFA policy created a truly global movement in health. Building on inspirational ethical values and up-to-date public health science, this movement also managed to embrace and inspire the “developed” countries, linking WHO’s programmes logically to those of its Member States in a cohesive and mutually supportive manner. However, during the second half of the 1990s WHO Headquarters quietly let the HFA drop, while it continued in several regions and in many countries.

During the 1980s 2 infectious diseases got particular attention: HIV/AIDS and Poliomyelitis: As HIV/AIDS emerged in the beginning of the decade, both its prevention and its care strategies posed formidable operational and ethical problems – but problems that were well suited for the HFA approach. Through the charismatic leadership of Dr. Jonathan Mann and others WHO developed a very strong multidisciplinary AIDS/HIV program, which gave results and strengthened WHO’s global leadership – until WHO’s program was severely weakened by the creation of UNAIDS.

When WHO adopted the Polio Eradication programme at the end of the 1980s, it took on a task that turned out to be a particularly vexing one. While by the end of the 1990s eradication had been achieved in 3 of WHO’s 6 regions - as well as in most countries of the remaining 3 – the last 10 years have not brought the final victory hoped for (although recent developments are now rekindling that hope).

In the second half of the 1990s WHO’s groundbreaking Tobacco Convention initiative explored with success a tool (legally binding conventions) of WHO’s Constitution that had hitherto not been given the attention it deserves. Through that process WHO’s long fight against the smoking habit has gained new importance and created effective strategic openings. Since the start of the 21st century the recent HQ initiatives to revive the PHC strategy is of great importance, as is the increased focus on the health consequences of the climate change.

Many lessons can be drawn from the above – and from the many other important WHO initiatives not mentioned here. Clearly, the eradication initiatives have been important, both for their health impact and for their value in enhancing public health management capacities world-wide. Great contributions have been made by WHO in many areas of health services development, health promotion and environmental health protection. Most fascinating, however, has been the HFA experience – and most frustrating has been to see HQ throwing that one out of the window. WHO’s 2 roles of scientific development and of assistance to individual countries are essential, but without a unifying and visionary policy framework the efforts often become piecemeal, uncoordinated and without a clear and coherent focus. With the WHA and RC supporting HFA in hand it was easy to gain access to the top political, managerial and professional leadership in countries and to extend WHO’s help in improving their national health policies and programmemes – an issue of great importance. Until WHO reclaims that third role of being the keeper of the World’s Health Policy, its Constitutional mandate will not be fulfilled!

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2 In the European Region e.g. the Regional Committee (RC) adopted the first European HFA policy framework – “a blend of today’s realities and tomorrow’s dreams” – in 1980. The RC expanded it greatly in 1984, adopting time-limited targets, strategies to reach them, target specific indicators to measure progress in individual countries and in the region as a whole, and a regional Action Plan that included predetermined dates for periodic evaluations and updating. Such updates occurred in 1991 and 1998; in 2005 the RC confirmed the 1998 version as still valid.

3 The American Region in particular continued to give PHC a strong priority.
Dr Halfdan Mahler, Former Director-General of WHO

Distinguished audience,

My remarks will focus on "Why Alma-Ata in 1978 and Whither the Health for All Vision and Primary Health Care Strategy".

Milan Kundera wrote in one of his books: "The struggle against human oppression is the struggle between memory and forgetfulness." So allow me to remind all of us today, of the transcendental beauty and significance of the definition of health in WHO’s Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

This definition is immediately followed by: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Most importantly, the very first constitutional function of WHO reads: "To act as the directing and coordinating authority on international health work." Please do note that the Constitution says "the" and not "a" directing and coordinating authority.

To make real progress we must, therefore, stop seeing the world through our medically tainted glasses. Discoveries on the multi-factorial causation of disease have, for a long time, called attention to the association between health problems of great importance to man and social, economic and other environmental factors. Yet, considering the tremendous political, social, technical and economic implications of such a multidimensional awareness of health problems I still find most of today’s so-called health professions very conventional, indeed.

It is, therefore, high time that we realize, in concept and in practice, that knowledge of a strategy of initiating social change is as potent a tool in promoting health, as knowledge of medical technology. Primary health care is indeed conditioned by its holistic framework and as such, may use different expressions. For example, in some countries health management has to be considered along with such things as producing more or better food, improving irrigation, marketing products, etc. It is not that people consider health services as unimportant, but there are things like getting food, or a piece of land, or house or an accessible source of water which are more of a life and death nature and must, in the wisdom of the people, come first to make other things meaningful. We have rarely considered these needs as falling within our expressed policies for health development and therefore, we risk being restricted, unilateral and ineffective in our action.

Again, I am afraid that conventional or medical wisdom has done very little to provide scientific and political credibility to the alleged importance of individual,
family and community participation in health promotion.

These concerns, to which I have just alluded prompted an organizational study on "Methods of promoting the development of basic health services" by WHO's Executive Board in 1973 in which it is bluntly stated that:

"There appears to be widespread dissatisfaction of population about their health services for varying reasons. Such dissatisfaction occurs in the developed as well as in the Third World. The causes can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness on the part of the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professionals but which is not what is most wanted by the consumer".

It was this organizational study by WHO's Executive Board that led to the decision by WHO in co-sponsorship with UNICEF to convene "The International Conference on Primary Health Care" in the city of Alma-Ata in 1978. Let me then repeat with awe and admiration, the consensus concept of primary health care as contained in the Declaration of Alma-Ata 1978:

"Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part, both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

"It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

Let me also quote from the Declaration of Alma-Ata, that primary health care includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. In my opinion, an admirable summation of key priorities.

Are you ready to address yourselves seriously to the existing gap between the health "haves" and the health "have-nots" and to adopt concrete measures to reduce it?

Are you ready to ensure the proper planning and implementation of primary health care in coordinated efforts with other relevant sectors, in order to promote health as an indispensable contribution to the improvement of the quality of life of every individual, family and community as part of overall socioeconomic development?

Are you ready to make preferential allocations of health resources to the social periphery as an absolute priority?

Are you ready to mobilize and enlighten individuals, families and communities in order to ensure their full identification with primary health care, their participation in its planning and management and their contribution to its application?

Are you ready to introduce the reforms required to ensure the availability of relevant human resources and technology, sufficient to cover the whole country with primary health care within the next two decades at a cost you can afford?

Are you ready to introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care as the overriding health priority?
Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care?

Are you ready to make unequivocal commitments to adopt primary health care and to mobilize international solidarity to attain the objective of health for all?

Alma-Ata was, in my biased opinion, one of the rare occasions where a sublime consensus between the haves and the have-nots in local and global health emerged in the spirit of a famous definition of consensus: "I am not trying to convince my adversaries that they are wrong, quite to the contrary, I am trying to unite with them, but at a higher level of insight."

The Alma-Ata primary health care consensus also reflects a famous truism: "The Health Universe is only complete for those who see it in a complete light, it remains fragmented for those who see it in fragmented light!" In conclusion, my personal view is that the Alma-Ata primary health care consensus has had major inspirational and operational impacts in many countries having a critical mass of political and professional leadership combined with adequate human and financial resources to test its adaptability and applicability within the local realities through a heavy dose of systems and operations research.

Mind you, it is much easier to be rational, audacious and innovative when you are rich! But, please, let us not forget that the inspirational energies and the evidence base came from the developing countries themselves; be they governmental or non-governmental sources.

For a majority of these countries, financial support from so-called donors was essential to carry out a broad array of studies, in appropriate technology, human resources development, infra-structure development, social participation, financing etc. in order to integrate the Alma-Ata vision into heavily constrained local contexts.

Most donors, after an initial outburst of enthusiasm quickly lost interest or distorted the very essence of the Alma-Ata Health for All Vision and Primary Health Care Strategy under the ominous name of selective primary health care which broadly reflected the biases of national and international donors and not the needs and demands of developing countries.

But in spite of these brutal impediments many developing countries have shown, before and after the Alma-Ata happening, courageous adhesion to its health message of equity in local and global health. Civil society movements have also been prime shakers and movers in these admirable efforts.

And so, being an inveterate optimist I do believe that the struggle between memory and forgetfulness can be won in favour of the Alma-Ata Health for All Vision and its related Primary Health Care Strategy. Let us not forget that visionaries have been the realists in human progression. And so, distinguished audience, let us use the complete light generated by WHO's Constitution and the Alma-Ata Health for All Vision and Primary Health Care Strategy to guide us along the bumpy, local and global health development road.

Thank you.

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This new project was started on August 6 by the sending of an e-mail to 226 AFSM members (outside the Geneva area). They were asked if they would accept to tap their memory about their own WHO experience through extensive exchanges by e-mail of carefully-structured written "interviews" based on a list of "suggested questions and themes". Within 24 hours 20 positive replies were received and another 12 followed since. Detailed instructions were sent by return to each respondent. We have already received a first draft from two of them. The final text of the "interviews" will be transferred to the WHO Archives.

We also were able to correct an unfortunate oversight thanks to a message saying "My husband died several years ago and is therefore unable to participate". Effectively we had thoughtlessly "forgotten" the spouses. An adapted list of suggested questions was immediately prepared - a spouse has already volunteered to participate.

Whatever your status, it is your participation which is important. If ready to participate please let me know (guilbertjj@yahoo.fr) NB: Over 45 e-mail addresses were reported as having "permanent errors" Please be kind enough to inform Ann Yamada (annyamada@jgmai.com) in case of a modification of your e-mail address by checking the one indicated in the AFSM "2007 Directory" list of members. Thank you.
I came to Geneva in the spring of 1948, 60 years ago. I travelled by train through war-torn France having changed in Paris to take the night sleeper. Geneva was a much smaller city at that time but it was striking to come from a former war zone to a place of peace with no obvious signs of destruction (the outskirts of Geneva had been bombed in error) and hardly any rationing.

This was to the Interim Commission of WHO - Although the Constitution had come into force on April 7, the organization proper did not come into being until 31 August 1948, when at the first World Health Assembly all the activities of the Commission were taken over by WHO.

We were housed in the Palais des Nations as a rather unwelcome tenant and a small extension was built at the western end of the complex for this purpose. I think that WHO was the only UN agency at the time not having its own headquarters building.

Nevertheless, after the hell and horror of war it did seem to be a wonderful thing to be engaged in United Nations activities and I remember the enthusiasm of the early staff, eager to get on with the creation of a new international health organisation and helping to reconstruct the world. We were all of 60 individuals at the beginning. I began as a PI at the age of 27 and finished as a Director – I imagine that this would probably be impossible in the UN system today.

Despite the auspicious beginnings, problems soon began to loom. Finances were restricted, there were legal difficulties over an acceptance of the Constitution linked to a right of withdrawal and the question whether this would be of general application, a matter which as far as I know has never been resolved, regional arguments, political problems and rumours of war. Together with these was the question of relations with UNICEF, WHO being the only Specialized Agency in the UN System finding itself with another organisation created almost simultaneously to deal with matters of public health, maternal and child health being a function of WHO under Article 2(1) of the Constitution. This caused some heart searching in the World Health Assembly until an accommodation was reached with UNICEF.

In the then legal office we dealt with a variety of subjects: constitutional interpretation, rules applying to the governing bodies, treaty making, agreements and contracts, institutional programming issues, examples being the creation of the International Agency for Research on Cancer in Lyons or the Onchocerciasis control programme in Africa, personnel and financial problems, staff disputes, etc.

We were also pressed to deal with various hot potatoes that nobody else wanted to touch, such as human rights. Thus, a missive from the Secretary-General of the UN that had been festering on someone's desk for a month or so would arrive on a Friday afternoon covered with urgent slips and signatures in varied coloured inks passing the buck and asking for a full report to be prepared by the following Monday. For some reason we also had to deal with messages received from the mentally disturbed or other frenzied individuals claiming that WHO had in some way done them wrong or seeking help from us.

I believe that some of WHO's past and present problems have arisen from the relative status of public health within government structures. As an example of this I remember a
TV news programme referring to a government minister's move to the health department as "slipping all the way down to health". Hardly very complimentary. Brock Chisholm in his time complained that he was the worst remunerated executive head in the UN system and had to put up with lay meddling in health matters when a UN commission deleted medical training and mental health from the draft UN Convention on economic, social and cultural rights. Despite their importance, these remain outside of Article 12 of the Convention to this day.

As an aside, a rather farcical incident that came to the eventual knowledge of the rank and file, like myself, was the discovery that at the height of rumours over the possibility of a third world war, a scheme had been concocted to evacuate those staff who were not military reservists to another neutral country somewhat removed from the potential battle zone on chartered civil airline planes in the event of an outbreak of fighting in Europe. I have no idea who dreamed up such a scheme. Whoever it was had little concept of modern war as all civilian aircraft would have been immediately grounded at the outbreak. In any case it seems doubtful that the Secretariat had the authority to do this; the matter was never reported to the governing bodies which would probably have rejected such a proposal. The matter came to our knowledge because the Headquarters Contract Review Committee was asked to decide on the disposal of time expired medical kits to accompany the aircraft, presumably to bandage us up when shot down or to succour those elderly staff with heart attacks. They were broken up and the viable contents distributed to the Regional Offices. Goodness knows what they did with them.

One matter which exercised me and others in the early days was the primitive state of communications. When telecommunications were in the hands of Post Offices it really was a performance, for example, to get in touch with a Regional Office or another sister organisation in another country. Messages were sent by mammoth telexes, requiring a dedicated operator and were punctuated with prolific "STOP" and "I REPEAT". Calls had to be booked in advance and there was no guarantee that one would not be cut off in mid-conversation, I recall at one Director General's morning meeting during a Health Assembly saying that it was easier to bring back a crippled spaceship from the moon then to ring WHO from the Palais des Nations. Personal computers had arrived in force shortly before I retired and I imagine that those old problems have long since gone away.

Considering the organization's programme, one must recall that WHO's two main predecessors, the League of Nations Health Organisation in Geneva and the International Public Health Office in Paris were under somewhat of a cloud at the time. The League organisation because of its failure to secure peace and the IPHO because of its rather static nature and its association with Vichy. WHO clearly did not want to become a bureaucratic convention making body and therefore followed the initiatives of the League or organisation and UNRRA in direct operations in the member countries. There was perhaps somewhat of a tendency at the outset to "blind them with science" and a lack of understanding that no programme could succeed unless the health administrations and authorities involved were in a position to continue the work after the international cooperation had ceased.

This came to be recognised in an important resolution adopted by the World Health Assembly in 1970 when the Assembly set out the most effective principles for the establishment and development of national health systems, including the proclamation of the responsibility of the State for the protection of the population, to be based on putting into effect a complex of economic and social measures which directly or indirectly promote the attainment of a nationwide system of health services based on a general national plan and local planning. This marked a far cry from the early days, when the Director General had been enjoined not pursue a policy of what was termed "socialised medicine" This was a precursor of "Health for All".

Since those days, WHO has greatly progressed, with major achievements such as smallpox eradication. Hardly a day goes by when WHO is not mentioned in news reports and I think that the organization must be the best known in any system and held in the highest regard. I am very happy to have served in those early days and to have helped in WHO'S creation and development.
A poem by Sue Block Tyrrell

Sue Block Tyrrell (TDR) has worked in the Organization for quite a few of its sixty years. In her spare time, she enjoys writing poems and lyrics for special occasions, including those celebrated by WHO - for example on the occasion of the departure of Dr D.A. Henderson, who led the smallpox eradication campaign in WHO, and for the occasional staff cabaret show at past WHO dances. « Sue has written various poems for special events in TDR where she works, and decided to put pen to paper on the celebration of sixty years of WHO.

Her poem highlights landmark achievements and considerable progress made by WHO and its many partners and collaborators over the past six decades. As WHO staff, we can look back on our history with gratitude and pride.

7 April 1948

Proved to be an auspicious date,
The WHO Constitution came into force
And WHO’s work began its course
To make health for all people a priority,
A right to absence of disease and infirmity.

Five Regional Offices began to grow,
Adding global coverage to existing PAHO,
Plus country offices all over the world
Where the WHO flag flutters high, unfurled.

First targets were infectious diseases, all too rife,
Bringing sickness and ending so many a life.
Early successes focused on yaws and TB,
Plus malaria control, no sign yet of HIV.
Disease eradication took on a role
And with smallpox WHO achieved that goal,
A huge contribution for humanity,
It took 21 years from dream to reality.
But the polio goal has yet to be won,
Despite the hard work and efforts done.

Many agencies/programmes were set up to mark
The spread of disease, IARC, EPI, TDR,
Global Programme on AIDS, RBM, Stop TB,
All striving for greater health security,
Assisted by GOARN to keep constant view
For deadly viruses like SARS, avian flu.
Today’s travel brings rapid disease from afar,
A good rationale to enforce IHR.
Non-communicable diseases are now on the rise,
Health needs good diet and regular exercise.
Tobacco control and road safety promotion
Were not liked by all, they caused a commotion.
Essential medicines are key where funding is tight,
Health for all makes our common future bright.

So many key areas are covered by WHO,
Further topics will come and bring programmes anew
Such as climate change issues, innovation, IP
Will bring new challengers to solve by the DG.

Seven DGs for the 60 years spanned,
Chisholm, Candau, Mahler, Nakajima, Brundtland,
On to JW Lee and now Margaret Chan
Have led to the current strategic health plan.
May your successes continue and show
The need to strive for global public health
And help each other to share in our common wealth
Six decades of work for which to be proud,
On this 60th birthday, to proclaim aloud
Many happy returns to you WHO.
Readers’ Corner

I should like to take this opportunity to congratulate our Committee on the progress made in the presentation of the Quarterly Newsletter. I imagine the daily efforts it entails for the Editorial Board and thank them most sincerely.

And I must refer to the considerable work that our Committee carries out for the benefit of the retired, with the support of the Management and the personnel. Warm thanks.

Jean Romain

Dear Friends

Unable to be a candidate for the 2008 elections, living as I do some 600 km from Geneva, I would like you to know how much I appreciate all you do in defending the retired staff of WHO. My thanks to you all.

Robert Daspres

ED: Our thanks to these three readers: your appreciation encourages us to keep at it!

New members

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

Life members:

Mr Sora BHANDARY; Dr Mohammadou Kabir CHAM; Mrs Geneviève PINET; Dr Brian WILLIAMS.

Annual members:

Mrs Josseline BOISBELAUD; Mrs Elisabeth FELLER; Mrs Praxedes FONTANILLA; Mrs Gisela VOGEL.

Conversion from annual members to life members:

Mrs Raymonde BENE; Mr Giovanni CEREDA; Mrs Marguerite DE HALLER; Dr Marcus A. C. DOWLING; Mr Virgilio FEDRIZZI; Mr Jean GERMAIN; Mrs Margaret GRINLING; Dr Frank GUTTERIDGE; Dr Amara TOURÉ.

HELP WANTED

We are looking for a recently retired WHO staff member who worked on a WHO website using WebIt and who would be able to give us some time to help improve and revise the AFSM web site (http://www.who.int/formerstaff)? We can handle routine updates to the web site, but we would be grateful for help to add some new photos or graphics. If you can assist us, please contact Carole Modis at cmodis@gmail.com
One of the last secrets of the Mediterranean

This morning I woke up in “...a strange city that seemed to have been cast up in the valley one winter’s night like some prehistoric creature that was now clawing its way up the mountainside. Everything in the city was old and made of stone...”.

In the afternoon, I wandered through an archaeological site in an olive grove buzzing with cicadas—according to classical mythology it was founded by exiles from Troy. Later, I swam in an opal coloured sea with white beaches, and now, with a cold beer in hand, I watch the sun set on the wine-dark Ionian Sea. Can you guess where I am?

Most likely, your first thought was not the Republic of Albania or Shqipëria land of eagles. A part of Illyria in ancient times and later of the Roman Empire, Albania was ruled by the Byzantine Empire from 535 to 1204. An alliance of Albanian chiefs led by Skanderbeg failed to halt the advance of the Ottoman Turks, and the country remained under Turkish rule for more than four centuries, until it proclaimed its independence on Nov. 28, 1912.

A battlefield in World War I, Albania became a republic under a conservative Muslim landlord, King Zog. During World War II, first Italy then Germany occupied Albania until Communist guerrillas seized power in 1944. For the next forty years, Enver Hoxha coerced Albania to forge its individual version of the social state and become one of the most isolated, mysterious and economically underdeveloped countries in the world. Changes of government and civil unrest characterized the 1990’s. Today Albania seems to be slowly recovering from its turbulent and often tragic past as it enjoys a period of relative freedom, peace and renewal.

One of the first harbingers of this renaissance is tourism. Although, the roads are often rough and under construction and accommodations very basic, it is a privilege to visit this beautiful, ancient country and fascinating to witness how it is waking up to the twenty-first century.

Among the discoveries to be made in Albania are remarkable archeological sites such as Apollinia founded by Greek settlers in 600 BC and used under Roman rule by Julius Caesar in his campaign against Pompeii. Another marvel is Burtint, a microcosm of Mediterranean history representing the rise and fall of the great empires that dominated the region: Illyrian ruins, a Roman town and theatre, an early Christian baptistery and basilica. Situated in lovely wooded park by the sea, it is easy to imagine the arrival of Aeneas as recounted in Virgil’s epic poem or Lord Byron striding down the shaded paths in Albanian dress.

The first lines in this article refer to Gjirocastër with its stone medieval Ottoman-houses—200 of them are designated as historical monuments. Another of the delightful towns is Berat, the village of a thousand windows and innumerable narrow streets and courtyards.

Driving from the capital, Tirana, the mountains come dramatically down to the sea as the road winds down to Vlorë, Dërmj, Saranda and Durres. Along the way there is a stop to visit a hilltop monastery. A guardian comes forward with a bunch of keys and opens the wooden church doors revealing Byzantine frescos blazing on the walls. Last but not least, the local wine is inexpensive; there are tomato, cucumber and feta salads and fish to eat and the Albanian people are happy to see you. Hopefully Albania will be able to preserve its natural beauty while progressing towards a prosperous and peaceful future.

Carole Modis

1 The first line from Chronicles of Stone by Ismail Kadare, first published in Albanian in 1971 as Kronikë në gur

2 In his notes to Childe Harold’s Pilgrimage he wrote that the Albanians “struck me forcibly by their resemblance to the Highlanders of Scotland, in dress, figure and manner of living. Their very mountains seemed Caledonian with a kinder climate.”
**In memoriam**

**PROFESSOR AMBROSE WASUNNA**

*A message from Dr Steffen Groth, Director, Department of Essential Health Technologies, World Health Organization, Geneva, Switzerland:* On behalf of Professor Ambrose Wasunna's former colleagues and friends in the World Health Organization, I am honoured to pay tribute to a remarkable and much loved man.

Ambrose's involvement with WHO began as early as 1978 when he participated in an Expert Committee on Cancer Statistics and he joined WHO in 1986, following the first stage of his distinguished career in Kenya. In 1987, he was an active member of the Global Blood Safety Initiative, which was established as a collaborative endeavour between WHO, the Global Programme on AIDS, the International Federation of Red Cross and Red Crescent Societies, the World Federation of Hemophilia and the International Society of Blood Transfusion.

As Director of the Programme on Health Technologies, Ambrose worked closely with the incumbent Director of the new department of Blood Safety and Clinical Technology, who remembers him as a close friend and trusted colleague, who will be sadly missed. He played a key role in establishing a vibrant and forward-looking new programme to address the many areas of work that he recognised as being essential to the developing world.

Ambrose worked closely with the many colleagues and friends he made in his time in WHO. He was a deeply devoted Christian, which was reflected in his work and attitude in the complex environment of an international organization. He is also remembered with great affection by a number of professional organizations and institutions for which he was responsible in their roles as Organizations in Official Relations with WHO, none more so than the World Federation of Societies of Anaesthesiologists.

After retirement from his post as Divisional Director, Ambrose returned to the University of Nairobi to realize his dream of building a district hospital in Samburu.

Ambrose was greatly respected and loved by his former friends and colleagues in Geneva and beyond. He is remembered as much for his inimitable personal qualities as for his expertise as a clinical specialist and a manager. His tall, charismatic figure, always so elegant, was accompanied by an enthusiastic yet modest personality that captivated and animated others. Colleagues speak particularly of his warm smile and infectious, often mischievous, sense of humour. "He was a true gentleman", said one. Another spoke of how anyone needing surgery would feel so safe and confident in Ambrose's hands. We all agree that he was simply a lovely man.

He is survived by his wife, Marigold and 4 children, and grandchildren.

Charles GOOSENS

It was with great sadness that I learned of the death of Charles Goossens which occurred on 10 March 2008. We understood each other very well – Charles, always calm, balanced, with clear sound judgement – and we usually shared the same opinion. But I had not seen him during the past 5-10 years busy as we each were with our respective families and other activities.

I often called Charles « Carolus ; he had been selected as the Director General's messenger, a key post on the seventh floor of the main headquarters building. « God's messenger », as he was called could be found behind a large desk in a wide open space where he received the Director-General's visitors. In February 1988 I was designated to replace Charles temporarily during a brief absence. As the Director-General was absent, a long calm day stretched lay ahead of me and I amused myself by writing the following text, which happily I found was still in my possession:

*See next page*
In memoriam (contd)

Un plaisir, Carolus que de te remplacer.
Mais, à ton bureau, ce que l'on peut s'enrayer !
« L'ennui naquit, dit-on, de l'uniformité ».
C'est pour moi maintenant vérité révélée.
Chaque jour où, par Ciron, au septième dépêché,
Il me faut de longues heures sur mes fesses endurer !
Je grimpe, comme au théâtre, jusqu'à ce poulailler,
D'ailleurs, ne suis-je point dessous le pool, oyez
Ces vains bavardages et ces caquètements :
- « M'sieur Goossens n'est donc pas là ?
- Non, mais demain il sera là !
- Mon Dieu, il n'est pas malade pour le moins ?
- Nenni, ma mie, je crois qu'il vaque à Moëns »
- Son dos... ? N'est-il pas retenu par son dos ?
- Depuis son siège neuf, il l'a comme un sandow !
- À l'ennui, à l'uniformité, à ton ramage, à ton plumage, à ton joli nez,
- Que, de ce beau et vaste poulailler,
- Tu es, des vrais coqs, le plus recherché... !
Février 1988

1 The affectionate gallicisation of the name of our Chief « il Signore Cirone »;
2 the pool, the shorthand typing services in the official languages;
3 Charles lived in Prevessin Moens:
4 Like many former pilots, Charles suffered from back pain resulting from the « g »

Based on the above text, it could be thought that Charles was something of a Don Juan: nothing was further from the truth. I was astonished how many secretaries noticed Charles' absence and I drew it to his attention in this humoristic way.

Dr. George Shidrawi died on 17 July 2008 after a long struggle with stomach cancer.

Born in 1932, George graduated as a biologist from the American University of Beirut in 1953 and won a 2-year WHO fellowship to study Medical Entomology at the London School of Hygiene & Tropical Medicine. He obtained an M.Sc in 1955 and became a member of the Royal Society of Tropical Medicine & Hygiene and the Royal Entomological Society. George subsequently studied at CDC, Atlanta, with field training in Florida, Georgia and with the Tennessee Valley Authority.

Returning to Lebanon, he joined the Ministry of Health as Director of the Division of Insect and Rodent Control, and subsequently directed the Programme of Malaria Eradication when Lebanon became the first country in EMRO to eradicate malaria and one of its main vector species.

George was recruited by WHO in 1959 as Adviser (entomology) to the Malaria Eradication Campaign, Tunisia. He married his wife Odile in 1963 while on home leave from his second assignment in East Pakistan (now Bangladesh) and later that year joined the WHO inter-regional Malaria Field Research Project in Southern Uganda where his first two children were born. In 1965 George joined the other inter-regional team in Kankiya, Northern Nigeria to test the possibility of interrupting malaria transmission by combining insecticide spraying and mass drug administration moving, in 1969 and until its final evaluation, to the reformulated project in Garki, North of Kano.

In 1975 George became Regional Adviser for Vector Biology and Control in EMRO; and in 1986 he joined the Malaria Action Programme in Geneva, transformed in 1990 into the Division of Control of Tropical Diseases. He retired in Geneva in 1992, obtained a D.Sc. in 1994, and undertook numerous STC missions in Africa and Latin America.

George said the best period of his life had been in Dacca and Kankiya, places where life was reduced to real essentials. A born naturalist with a keen interest in biology, George thrived on field research. A patriarchal disciplinarian with his team, he was the first to follow required discipline, demanding but protective of his staff.

George could enliven any party and was a great dancer. He was a perfectionist not only in his work but in all he undertook, including golf. Always ready to help he served for two years on the Executive Committee of AFSM. George leaves a large vacuum in the hearts of all who knew him. Dr José Najera

Other deceases recently notified

Ms May RACINE;
Mrs Suzanne TESTUZ;
Mrs Isabella CORRIGAN: 20 August 2008;
Mr Michel REVERDIN: 11 September 2008.
On the lighter side

How to Give a Cat A Pill

1. Pick up cat and cradle it in the crook of your left arm as if holding a baby. Position right forefinger and thumb on either side of cat’s mouth and gently apply pressure to cheeks while holding pill in right hand. As cat opens mouth, pop pill into mouth. Allow cat to close mouth and swallow.

2. Retrieve pill from floor and cat from behind sofa. Cradle cat in left arm and repeat process.

3. Retrieve cat from bedroom, and throw soggy pill away.

4. Take new pill from foil wrap, cradle cat in left arm, holding rear paws tightly with left hand. Force jaws open and push pill to back of mouth with right forefinger. Hold mouth shut for a count of ten.

5. Retrieve pill from goldfish bowl and cat from top of wardrobe.

6. Wrap cat in large towel and get spouse to lie on cat with head just visible from below armpit. Put pill in end of drinking straw, force mouth open with pencil and blow down drinking straw.

7. Check label to make sure pill not harmful to humans, drink 1 beer to take taste away. Apply Band-Aid to spouse’s forearm and remove blood from carpet with cold water and soap.

8. Retrieve cat from neighbour’s shed. Get another pill. Open another beer. Place cat in cupboard, and close door onto neck, to leave head showing. Force mouth open with dessert spoon. Flick pill down throat with elastic band.


10. Call fire department to retrieve the damn cat from across the road. Apologize to neighbor who crashed into fence while swerving to avoid cat. Take last pill from foil wrap.

11. Tie the little ********‘s front paws to rear paws with garden twine and bind tightly to leg of dining table, find heavy-duty pruning gloves from shed. Push pill into mouth followed by large piece of fillet steak. Be rough about it. Hold head vertically and pour 2 pints of water down throat to wash pill down.

12. Consume remainder of scotch. Get spouse to drive you to the emergency room, sit quietly while doctor stitches fingers and forearm and removes pill remnants from right eye.

13. Arrange for RSPCA to collect mutant cat from hell and call local pet shop to see if they have any hamsters.

How To Give A Dog A Pill:

1. Wrap it in bacon.

2. Toss it in the air.

Only great minds can read this

This is weird, but interesting!

fi yuo cna raed tih, yuo hvae a sgrane mnid too
Cna yuo raed tih? Oly 55 plepoe out of 100 can.
i cdnuolt blveiee taht I cluod aulaclty uesdnatnrd waht I
was rdanieg. The phaonmneal pweor of the hmuan mnid,
aoccdrnig to a rscheearch at Cmabrigde Uinervtisy, it
dseno’t mtaetr in waht oerdr the ltteres in a wrod are, the
only iproamtnt tihng is taht the frsit and lsat ltteer be in
the rghit pclae. The rest can be a taotl mses and you can
still raed it whotuit a pboerlm. Tihs is bcuseae the huamn
mnid deos not raed erve

WIZARD OF ID

International Herald Tribune 20.12.2004
Violence and Health

Jean-Paul Darmsteter, former Public Information Officer in EURO and still a poet, published in 2007 “Violence et santé, le refus engagé d’une fatalité” (Violence and Health, the committed refusal of a fatality) at the Hôpitaux universitaires de Genève in co-edition with Médecine et Hygiène, to celebrate the tenth anniversary of the “Consultation interdisciplinaire de médecine et de prévention de la violence de Genève” (Geneva Interdisciplinary Consultation of medicine and prevention of violence).

The Consultation is open to all persons confronted with a situation of violence, whatever role they have in this situation. Its action is based on the following principles:
- acts of violence are unacceptable on the grounds of human rights;
- violence has an impact on physical, mental and social health, and has an economic cost;
- the person is considered in the context of his/her life, history, culture;
- the confidentiality of the meetings is guaranteed by the medical secret;
- the intervention aims at promoting the autonomy of the person.

The book includes studies and thoughts, collected by the author, that explain and justify the need to detect and look after victims of violence, and the major role of prevention.

The creation of the Consultation in 1997 predated the recommendations of WHO’s report “World Report on Violence and Health” published in 2002. While many countries only had a punitive approach to this problem, WHO had already adopted a resolution in 1996 which defined violence as a public health problem. According to the Organization, violence is one of the major causes of death and traumas in the world. It recommends setting up systematic and coordinated measures of prevention.

According to Professor Daniel Halpérin, founder and manager of the Consultation, medicine cannot elude the problem of violence: it must extend its action in this area, where social and legal elements interact with medical ones.

Yves Beigbeder

Communiqué

As indicated in the Editorial (page 3), the cost of producing the newsletter will in future be borne by AFSM, which will probably have to assume other costs till now absorbed by the Administration of WHO.

We shall be obliged to print fewer copies and to send them to paying members only. However, QNT will continue to be available to all retirees on our website http://who.int/formerstaff.

As regards information circulars, in order to keep costs low we would prefer to send them to members by e-mail where possible; of course those of you who do not have an e-mail address will continue to receive them by mail. So kindly check whether the e-mail address included in the Directory is valid and if not please send the current one. Those who have not so far indicated their e-mail address are kindly requested to send it to us at:

aoms@who.int.

Many thanks.
Announcements

Elections

As you are aware, there will be elections this year – 15 candidates have come forward for the 12 places on the Committee to be filled. The ballot counting will take place on 21 October and the new Committee will be in place on 11 November.

We hope that you will all vote!
We will keep you informed of the results.

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Vaccination against Influenza in Geneva

For the fourth consecutive year, two sessions of free flu vaccination for retirees and spouses, who are still insured under WHO staff health insurance, will be undertaken in October at WHO/HQ, in cooperation with the Medical Service, Health Insurance, and AFSM.

The first session will take place on Monday 13 October from 9:00 to 12:30, and 14:00 to 16:30 and the second one on Monday 20 October, from 9:00 to 12:30, and from 14:00 to 16:30.

The vaccinations will take place in the Hall in front of the Medical Service. You are invited to dress such a way that you can easily bare your arm.

You already received a circular describing the whole process. Please be kind enough to fill in and return the form attached, by e-mail or post, as soon as possible.

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Health Insurance

A joint meeting of the Health Insurance Surveillance Committees of HQ and the Regions will take place at Headquarters from 6 – 10 October; the purpose of this meeting, the 7th, is to review the current financial situation of the Fund, prospects for the coming years, any modifications and /or improvements needed and the consequent adjustment of the allowances and contributions, and to modify the rules accordingly.

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How can the AFSM Committee help you?

Dear Readers- do you know what the Committee can do to assist you?

Apart from this newsletter, which we hope you find interesting, we have organized, and will continue to do so, trips (cruises, tours, at very competitive prices) to Morocco, Bavaria, Andalucia, capitals of the North, and the Mediterranean, and visits to museums---which make up the cultural side of our activities. We also help with more basic matters:

- we assist members with health insurance, pensions, survivors entitlements, retirement homes, long -term health care, etc.

- Examples include helping resolve a question of non payment of retirement home expenses following the death of an insolvent retiree; finding a retirement home for another member while helping one of the family to obtain a residence permit, and assisting a widow who had not received the pension for her deceased husband for many months.

There is also the important rôle played by the Committee’s representative on the Health Insurance Surveillance Committee.

The purpose of this information is not to pat ourselves on the back. but to remind you of the ways in which we can help you, if needed.
Joining AFSM – Updating membership

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

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

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

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

(Please fill in the application form below)

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

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

APPLICATION to JOIN

Name ………………………….. First Name……………………………………………..
Address:
Postal Code …………………… City…………… Country…………………………………………………………..
Phone ………. Fax ………….. e-mail ………..
Date of Birth …………………… Nationality ………………………………………………………………..
Date of separation from WHO …………………………. Length of service with WHO ………………………
Function occupied on separation …………………………………………………………………………...
I should like to receive documentation in □ English □ French
Date ……………………………………………………………………………………………………… Signature