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LAURENCE VERCAMMEN
rédactrice en chef adjointe / Deputy editor-in-chief

LA COMPÉTENCE ET L'ENGAGEMENT

Cette édition spéciale consacrée à l'Organisation mondiale de la Santé (OMS), présente une OMS dynamique et engagée au travers de l'action d'un personnel compétent et motivé.

Dans un esprit de transparence et de dialogue, l'interview croisée du Directeur général et du Président de l'Association du Personnel en page 5 présente leurs points de vue sur la vision de l'Organisation, son futur et les actions à mener.

L'OMS suscite un enthousiasme croissant du public, que ce soit au travers de son action au siège ou grâce à son intervention dans les domaines des systèmes de santé, et de la recherche en santé publique qui visent à atteindre les Objectifs du Millénaire. Certains progrès ont été réalisés grâce à son personnel, ses partenaires et les pays impliqués dans ces mêmes actions. C'est ainsi que l'Assemblée mondiale de la Santé en

mai dernier a adopté une résolution pour le lancement d'un plan ambitieux visant une éradication définitive et durable de la polio d'ici six ans. Nous savons aussi que 20 millions de vies ont été sauvées depuis 1995 au travers du département Halte à la Tuberculose. Nous explorerons également en page 12 les mécanismes qu'emploie l'OMS dans ses interactions et sa collaboration avec ses partenaires dans la préparation et la gestion de crises sanitaires mondiales, tel que le virus de la grippe aviaire A(H1N1). D'autres actions menées au siège, et dans les six régions auraient pu être citées, nous n'en avons retenu que quelques-unes.

Cette édition témoigne de l'engagement quotidien de chaque membre du personnel de l'OMS de par le monde à atteindre l'objectif de l'Organisation: «...amener tous les peuples au niveau de santé le plus élevé possible». ■

COMPETENCE AND COMMITMENT

This special issue mostly dedicated to the World Health Organization (WHO) presents a dynamic and committed Organization thanks to the actions of its competent and motivated staff.

In a spirit of transparency and dialogue, the parallel interviews of the Director-General and the President of the Staff Association on page 5 provide their points of view on the vision of the Organization, its future and the work to be done.

There is public growing enthusiasm for WHO, whether for its action at headquarters, its intervention in health systems, or in public health research aiming to achieve the Millennium Development Goals. Thanks to its staff members, partners and the countries involved in the same actions, significant progress has been achieved. As a result, the

World Health Assembly adopted a resolution last May to launch an ambitious six-year plan to eradicate polio and secure a lasting polio-free world. We also learned that 20 million lives have been saved since 1995 thanks to the Global Tuberculosis Programme. On page 12, WHO's preparedness mechanisms to manage together with its partners world health pandemics, such as the avian influenza A(H1N1) will be explored. We could have mentioned many more actions undertaken by our colleagues at headquarters or in the six regions, but we will only focus on a few of them.

This special WHO issue shows the dedication of each staff member worldwide who works every day to meet the Organization's objective: "the attainment by all peoples of the highest possible level of health". ■

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ONE ORGANIZATION, TWO PERSPECTIVES

INTERVIEW WITH

DIRECTOR-GENERAL OF WHO
Dr. MARGARET CHAN



Christopher Black, WHO

PRESIDENT OF WHO STAFF ASSOCIATION
Mr. LAHOUARI BELGHARBI



Ivan Babovic, WHO

LAURENCE VERCAMMEN, WHO

WHO, in its 12th General Programme of Work, has set priorities to address the “Health-related Millennium Development Goals”, in particular unfinished and future challenges. These include accelerating the achievement of the current health-related Goals up to and beyond 2015. Why has it not been possible to achieve all of the MDGs?

M.C. We can all be thrilled by the progress that followed commitment to the health-related MDGs. Those goals focused on development efforts and stimulated considerable innovation and resource flows.

Health, especially of the poor, benefitted enormously. We have progressed well on reducing child mortality and we have significantly increased the number of people receiving treatment for HIV/AIDS, TB and malaria. But the job is far from done. Progress towards the eight MDGs has been uneven not only among regions and countries, but also between population groups within countries. People living in poverty or in rural areas remain at an unfair disadvantage. Achievement of the MDGs is affected by less aid money overall, with the poorest countries most adversely affected. This is why we will continue to focus on the health-related MDGs well beyond 2015.

L.B. The original aim of the MDGs is to promote development through improving social and economic conditions in the world’s poorest countries and all these goals have specific stated targets and dates for achieving them. It is true there was some debate and certain criticisms raised about the lack of analysis, justification of the chosen objectives, the measurements and uneven progress towards reaching the goals. However, the UN conducted a wide and thorough consultation among Member States through the Millennium Forum, which brought together representatives of over 1,000 non-governmental and civil society organizations from more than 100 countries. The Forum met in May 2000 to

conclude a two-year consultation process covering issues such as poverty eradication, environmental protection, human rights and protection of the vulnerable. Regarding health matters, the World Health Organization (WHO), since 2000, had been able to lead efforts with several partners and Member States to reduce significantly the morbidity and mortality for several vaccine preventable diseases. Poliomyelitis eradication, measles elimination and access to HIV/AIDS, TB and Malaria recent examples are well known to the public in developed and developing countries. To elaborate further, good progress in achieving these goals was due to high immunization coverage reached and sustained, as well as accessibility and affordability to HIV, TB and Malaria treatment in the poorest affected countries. This being said, we are cognizant of the fact that some countries are not yet on track. A UN conference was organized in September 2010 to review progress and that concluded with the adoption of a global action plan to achieve the eight anti-poverty goals by their 2015 target date. There were also new commitments on women's and children's health, and new initiatives in the worldwide battle against poverty, hunger, and disease. These are areas where WHO is also strongly engaged and has translated them into the newly adopted Global Programme of Work (GPW) for the period 2014-2019. This then indicates that WHO will work beyond the 2015 target as needed to achieve these goals. The WHO staff and the WHO Staff Associations are also committed to help the Organization to meet these goals.

In view of the fact that staff numbers are projected to decrease (mainly through retirement), funds continue to be limited and Member States are eager to see the results of the tight reform agenda: how can the Organization maintain the same level of service that it provides at present?

M.C. I launched a reform process to make WHO more transparent, accountable, efficient and effective. The reform will position WHO to better address the increasingly complex health challenges in the 21st century, despite having limited human and financial resources. By establishing clear pri-

orities and adopting better management and governance practices, WHO can improve its service to the global health community, and, ultimately, protect health and save lives.

At the same time we need to secure adequate funds to allow core activities to stay operational to protect people's health. In June 2013 we initiated a financing dialogue with our Member States with the aim of fully financing our work for the next two years. We are on the right path to operate with impact.

In order to deliver on our commitments we need to ensure that our staff has the right skills. As staff retires over the coming years we are looking for new profiles to deal with emerging health challenges. A systematic review is now taking place of all positions that become vacant to determine whether they should be abolished, filled, or amended and filled. We expect to have a greater impact despite a potential decline in numbers of staff.

L.B. The WHO Staff Association in headquarters (HQ) has drawn the Director-General's attention to the potential negative impact of staff reduction on the quality of services that the Organization is expected to deliver. Translating a reduction of 937 filled fixed term and temporary posts by the end of 2012 implicitly requires staff to do more with less resources. It is true that the WHO had a policy to reduce the number of temporary staff from 5091 (58% of the total workforce in 2002) to 789 at the end of 2012 (10.8%). However in 2013, Management revisited the appointment policy and it was decided that the Organization could not sustain an appointment policy involving long-term liabilities. Therefore it was decided to have greater flexibility to recruit the new workforce. Moreover, the current WHO Human Resources projection indicates that 983 staff are due to retire during the next five years, and the number will reach 2114 staff over the next 10 years. Best management practices have shown that during major reorganization most institutions need a strategic succession planning and talent management strategy to overcome potential risks (lower quality of services, demotivation, lower performance, etc.). The WHO HQ Staff Association recommended to the Director-General to develop such a plan and are hopeful that our recommenda-

tions will be considered. We also anticipate that if such a plan is not developed and implemented soon, the Organization will encounter difficulties to sustain institutional memory and retain talent. Cumulatively, these will definitively negatively impact the intended output of the reform agenda and the quality of services provided by the Organization.

One goal of WHO reform is the development of a flexible and versatile workforce. What are the main features of the new workforce model that the Organization would like to promote?

M.C. The Organization is carefully examining what it needs to deliver and when, and is ensuring adequate staffing to support programme delivery. A flexible and versatile workforce is a workforce that can be adjusted and deployed quickly according to the changing needs of the Organization.

L.B. We had discussions with the Organization's management about the development of a WHO workforce model. Unfortunately, we have been informed there is no need to pursue such a model that was based on core and non-core staff including type of function, projects and activities. Moreover, our Human Resources Department confirms that there is no career development strategy within WHO, which frankly makes it difficult to develop a motivated workforce. Nevertheless, our understanding from the current discussions and recent practices in the Organization suggest that the model promoted by management places emphasis on: a) minimizing its liability to long term staff - that is, by reducing the number of staff with fixed term contracts and reducing staff's chance of eligibility to long term contracts, b) increasing non-staff contracts (e.g. relying more and more on consultants, agreement for performance of work contracts, etc.) who do not benefit from our internal justice system and c) redeployment of staff through functional rotation and mobility.

During reorganizations and reforms that may affect staffing conditions and jobs, there is a potential risk of conflict between employees and



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employers. At the same time, there is a need to promote and maintain a respectful workplace. What policies have you put in place to maintain the concept of a respectful workplace?

M.C. The Organization does not tolerate disrespectful behaviour from any party, without regard to the source of conflict. There are established channels for communication between employees and employers for prevention and resolution of conflicts. We are training managers to communicate better and have meaningful dialogue with staff. An Ombudsperson acts as a neutral arbitrator in inter-personal conflict in the workplace. The staff associations of WHO play an important role advocating for and supporting respect for staff in all instances. We have a code of ethical behavior and policy against harassment. And the Organization also makes sure that all staff members have access to more formal internal justice processes. These policies have proved to be essential for the promotion and maintenance of a respectful workplace.

L.B. The Organization is developing a policy to promote a respectful workplace, a joint effort between the Staff Association, the Human Resources Department and the Ombudsman's Office. There is also a code of conduct that promotes positive value and behavior respecting the UN Standards of conduct for international civil servants. Finally there is a policy to prevent and protect staff against harassment. We are also the only UN Organization that has developed a policy on occupational health and safety, however, it is not yet fully enforced and we hope we can speed up its implementation this year. We do believe that all internal issues that the Staff Association is working towards, such as applying all WHO standards recommended and published through its guidelines and values and the definition of health, should also be applied to its own staff. This has a lot to do with respect for staff and their health. Experience gained in this area shows that sometimes education in changing behavior needs routine and continuous strengthening specially for managers and during reorganization when we had experienced more complaints. Some staff have expressed a strong feeling of retaliation and may not be convinced about the Organiza-

tion's commitment to enforce and promote a respectful workplace. The WHO Staff Association in Geneva has recommended to the Director-General to reform the internal justice system to enable a speedy resolution of conflicts as well as to introduce a mediation mechanism that may help employees and employer to address conflicts peacefully. We have also kindly requested the management to revisit the work of the occupational health and safety committee, using and analyzing in-depth current information on sick leave, appeals and harassment statistics as well as addressing the relevant Joint Inspection Unit (JIU) report's recommendations in this area. We are currently working with the management to address both the internal justice system and to promote the concept of a respectful workplace.

In a recent speech, you referred to Universal Health Coverage as a process to change the way health care is financed and health systems are organized. How does WHO collaborate with other UN organizations to attain this objective and are there any joint initiatives?

M.C. I have expressed my personal commitment to universal coverage on many occasions. I regard universal coverage as the single most powerful concept that public health has to offer. It is the best way to cement the health gains made during the previous decade. It operationalizes the highest ethical principles of public health and is a powerful social equalizer and the ultimate expression of fairness.

An important development in global support for universal health coverage was the unanimous adoption of a resolution in the United Nations General Assembly, in December 2012, that emphasizes health as an essential element of international development. The resolution urges governments to move towards providing all people with access to affordable, quality health-care services and reaffirms WHO's leading role in supporting countries to respond to the challenges of implementing universal health coverage.

We are working with many partners on this. The Organization is, for example, a founding member of Providing for Health (P4H),

which is a global network for universal health coverage, promoting social protection in health. The network also includes the World Bank, ILO, African Development Bank, and the health/development agencies from the governments of Germany, France, Switzerland, Spain and the United States and provides advice and support to Member States. With financial support and technical engagement from the German, Swiss and British governments, WHO and the World Bank, for example, jointly organized a workshop on health finance strategy development for 13 African countries in June of this year.

An important milestone in our work will be the upcoming World Health Report 2013 that will focus specifically on how research can contribute to achieving universal health coverage.

L.B. The WHO staff have read the reform agenda and global programme of work endorsed by the World Health Assembly that underlined the six leadership priorities that will help the Organization to focus its work, one of which is "advancing Universal Health Coverage". All staff are concerned and well aware that this is becoming a high priority and they had been invited to contribute either individually or through their technical work to align their workplan and/or to propose a way to promote the concept by all means. So we are part of the initiative with many staff seeing that this is a platform, or umbrella, to unify our actions. We shall be contributing to it through our expertise, skills and experience.

Actions speak louder than words. Based on your experience, what are the actions you hope speak the loudest for the values of WHO?

M.C. The focus of all WHO's actions is the relief of preventable human misery. We work to better the health and lives of all people, but especially of the poorest and most vulnerable. It is people at the bottom who matter most.

The core values of our Organization and the reason why we were established are to work towards fairness and equity in people's access to health services. It is unacceptable that each year more than 100 mil-

lion people are pushed into poverty trying to pay for health services. Despite unprecedented levels of wealth in many countries the gap between the poor and the rich is growing wider. We cannot address public health risks unless we work towards this principle of equity in health.

I regard universal coverage as the single most powerful concept that the public health has to offer.

— Margaret Chan,
Director-General of WHO

Our job is to promote international cooperation to identify risks to and actions for protecting people's health. Therefore a lot of our work is based on bringing countries together, bringing sectors together and even bringing conflicting parties together for a higher goal – health for all. A few recent examples:

- Noncommunicable diseases and mental health are a challenge to all countries, rich and poor. Our technical expertise, our international cooperation and our value of health equity culminated in May when the World Health Assembly adopted a global action plan aimed at reducing deaths due to the four NCDs – cardiovascular diseases, diabetes, cancer and chronic lung disease – by 25% by 2025. We are now starting to help countries achieve this important goal.
- More than 100 million people in Africa became protected from epidemic meningitis by the new conjugate vaccine, developed in a project coordinated by WHO and PATH. In the ten countries that have introduced the vaccine cases of meningitis A have dropped dramatically. Recently published studies strongly suggest that epidemics that have ravaged the 26 countries in Africa's meningitis belt for more than a century can be brought to an end.
- The recent reductions in tuberculosis cases and deaths are impressive. A powerful new diagnostic tool for tuberculosis has been made more affordable by financial support from partners and is now being used in more than 70 countries. The first new anti-TB drug in 40 years received regulatory approval.
- For HIV, scientific breakthroughs, combined with more than a decade of operational experience in resource-constrained settings, are now being applied to provide better services to larger numbers of

people at lower costs. Nearly 10 million people, including the poorest countries, are now on antiretroviral therapy based on an idea initiated by WHO.

L.B. WHO Staff Association has already recommended to identify one of two main flags to promote the work of

WHO and I think we have been heard. One is the Universal Health Coverage mentioned

above and the other is the fight against non-communicable diseases across the life course. Both initiatives need that the Organization values the competencies and skills that it has among its staff and its networks of expertise. Concretely, universal health coverage promotes equity and the right to health, values and approaches that motivate our staff to produce excellent work. The burden of non-communicable diseases is greater in low- and middle-income countries, and again, our staff work hard to implement the global commitments of Member States in this area, for the benefit of people, young and old, around the world. ■

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A GROWING ENTHUSIASM FOR WHO



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Every year more than 3500 people from over 100 countries, come to the WHO Briefing Centre to find out more about major health issues affecting people around the world.

DORINE DA RE – VAN DER WAL, WHO

University and college students; public health specialists; health care professionals; diplomats; parliamentarians and researchers are amongst the stream of inquiring audiences who come to learn about the World Health Organization and its role in protecting people's health. Their fascination is for subjects such as avian flu, food safety, mental disorders, environmental health risks, new vaccines, child obesity, maternal mortality, HIV/AIDS, universal health coverage and many more.

Over 145 institutions and delegations came to the WHO headquarters in 2012, and the number is steadily rising. The majority of visiting groups are from universities and colleges and represent a broad spectrum of disciplines.

In some cases, they are in Geneva to visit all the UN entities and WHO is only one of their destinations. Others come exclusively to spend from one to five days in WHO as part of their academic or professional training. Either way, they come with their specific interests: some request in-depth briefings in technical areas related to their professional profile, while others need a broad overview about the work of WHO. For some, it is the first time ever that they

are exposed to the world of international work. Many of the visiting institutions have established visits to WHO as a regular feature in their trainings and curriculums.

The WHO Briefing Centre organizes technical briefings and interactive sessions tailored to meet the different needs and demands of each group (that can vary from 10 to 60 participants). Over 250 WHO staff members have participated in the briefings, in a variety of languages and on all possible topics.

The invited speakers are enthusiastic to interact with groups beyond their conventional audiences and are not afraid to be exposed to the inquisitive, often critical view of "outsiders". They make themselves available, regardless of their workload. Many speakers say that they find these interactions energizing, stimulating and highly rewarding and see it as an important way to engage key audiences in our public health efforts.

A visit of this kind can impact people's lives: through the interaction during the briefing sessions, highly motivated students have been able to obtain internship positions following their visit to WHO. Some, as a result of the engaging sessions, consider changing their study career. One regular visitor group – Sciences Po, France/Northwestern University, US – appreciated so much the richness and accessibility of the WHO library resources that they decided to give a US\$ 1000 donation to a small NGO in Bolivia. This provided the NGO with access to the "HINARI Programme", established by WHO and major publishers, enabling developing countries to gain access to one of the world's largest collections of biomedical and health literature.

The service that the Briefing Centre provides is a core activity that shares the latest public health information with current and future health practitioners and decision makers. It is about involving the Organization with diverse groups of partners and audiences, demonstrating a capacity to be transparent

about and responsive to the interest of those who come and visit us. ■

For more information please contact:

Dorine Da Re – van der Wal, WHO Briefing Centre

Email: dared@who.int

"After the WHO visit, all of us are now equipped with WHO information and insight; it was an enriching experience that motivates us to further develop the health systems in our countries."

— Young international researchers from the Institute of Tropical Medicine, Belgium

"We have to be accessible if we want to access to people"

— WHO Speaker

"The students very much enjoyed the visit, and the speakers were excellent and engaging. At least one is now seriously considering a career in public health law"

— Widener School of Law, USA

"The group was impressed and touched by the presentation and the whole visit."

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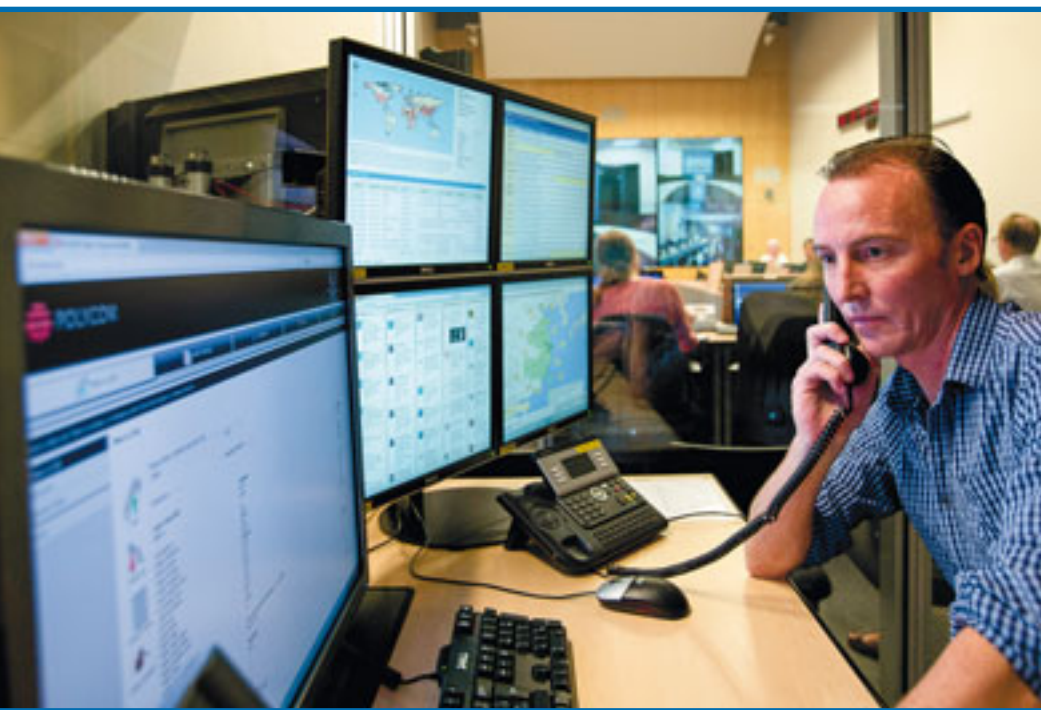


Photo: WHO

Emerging and re-emerging infectious diseases, such as HIV/AIDS, SARS, influenza A(H5N1) or pandemic influenza, have repeatedly demonstrated their ability to threaten the health security of countries.

DR. KEIJI FUKUDA¹

Health security is threatened when these agents cause disease that is often severe and unexpected, subsequently resulting in social anxiety and economically damaging actions, such as changes in food-related behaviors, decreased travel and tourism and trade embargoes. Moreover, such diseases raise complex ethical, social and economic questions. These fast-moving events also highlight the need to disseminate critical information quickly and broadly through multiple media forums. Because such emergency events can be so disruptive and because levels of preparedness and response can directly affect the health and livelihood of countries, health security is one of five priority areas of work of WHO. In this context, health security can be viewed as a broad and cross-cutting approach to

protecting countries and their communities against a broad range of emergencies, ranging from natural disasters, to environmental and food-related hazards to pandemic and epidemic infectious diseases.

Recently, two new viral infections caused by the Middle East respiratory syndrome coronavirus (MERS-CoV) and the avian influenza A(H7N9) virus have been the focus of much global concern. MERS-CoV was first detected in the Middle East in 2012 and H7N9 in China in 2013. Although these viruses are not related to each other, their emergence and activity have been closely monitored because both can cause severe illness, both have demonstrated limited person-to-person transmission, and both may have the potential for significant international spread. Their emergence, presumably

from different animal species, underscores the close and complex relationship between people and animals.

The emergence of new infectious agents posing a potential global threat is a long standing challenge that has grown more complex over time due, in large part, to globalization and changing social expectations. To help address such events, WHO Member States have developed and adopted two separate but complementary instruments: the International Health Regulations (IHR) and the Pandemic Influenza Preparedness (PIP) Framework.

The IHR are a legally binding international instrument with 196 States Parties, including all WHO Member States. Their purpose is to provide the international community with a global framework to prevent and respond to the international spread of disease while avoiding unnecessary interference with international travel, transport and trade. The IHR include rights and obligations for States (and mandated functions for WHO) including detection, surveillance and response for almost any internationally transmissible disease risks; notification and verification to WHO of events and risks; rules on the application of appropriate health measures to international travellers, trade and transportation; requirements for sanitary conditions and services at international ports, airports and ground crossings; and development of minimum national public health capacities for surveillance, assessment, response and reporting for a broad range of risks – throughout the territories of all States Parties.

The current IHR came into force for all WHO Member States in 2007. Although the large majority of the provisions of the IHR, including those for the identification, assessment and reporting of public health events and risks, are being implemented worldwide on a daily basis, the first comprehensive global test of the Regulations, including

the special mechanisms for a serious, truly worldwide threat, was the 2009 influenza A(H1N1) pandemic.

The PIP Framework is an international arrangement, adopted in 2011 by the World Health Assembly, that brings together the 194 WHO Member States, industry, other key stakeholders and WHO in implementing a coordinated, global approach to strengthening preparations and response for pandemic influenza. The impetus for developing the PIP Framework was the need to increase equity and fairness in the access to affordable pandemic influenza vaccines, antiviral drugs, diagnostics by developing countries, while at the same time ensuring that influenza viruses continued to be shared for global alert, risk assessment and urgent development of pandemic vaccines.

When potentially important events are detected, including a wide range of disasters and hazards, WHO employs its Emergency Response Framework to organize and coordinate activities internally. During such events, WHO also works routinely with the UN and other key technical partners, including through the Global Outbreak Alert and Response Network (GOARN). GOARN is a technical collaboration of institutions and networks, organized by WHO, that makes global expertise and technical resources available to affected countries. Such assistance can aid in rapidly identifying, investigating, confirming and responding to important outbreaks. GOARN is a critical operation that links, coordinates and efficiently provides global expertise and skills. It also functions as a mechanism to keep major technical organizations informed about outbreaks.

When outbreaks of global or regional importance occur, such as those caused by MERS-CoV and H7N9, WHO's global activities are coordinated through the Strategic Health Operations Centre (SHOC) located at WHO's headquarters. The SHOC is the global nerve centre of WHO's global emergency response, and provides a single point of coordination to manage acute public health events, including infectious disease outbreaks, chemical and radiation emergencies and natural disasters. It is the hub of WHO's global alert and response

operations, coordinating support to field operations and facilitating incoming and outgoing information and activities undertaken in collaboration with Member States, technical partners and other emergency operating centres.

The SHOC is now being used to support monitoring and response to both MERS-CoV and H7N9. Although it is unclear how these two disease outbreaks will unfold, given their importance and potential magnitude WHO will maintain a high level of vigilance until their future course is better understood. ■

More information is available at:
www.who.int/csr/don/en/index.html

¹ Dr. Keiji Fukuda is the Assistant Director-General, Health Security and Environment since September 2010. He was Special Adviser on Pandemic Influenza to the Director-General from October 2009 to August 2010. Prior to that, he was the Assistant Director-General for Health Security and Environment ad interim. In 2005, he came to WHO as a Scientist in the Global Influenza Programme



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Strates: Marco Del Carlo, Johan Persson, Nigel Bander, 2007; Louis Vincent, Luis Castilla; Thomas Aum, Marco Borgogni, Diego Reggiani, John Hogg

WHO VIDEO CHECKLIST



How many movies can you name that feature the World Health Organization in some way or the other?

CHRISTOPHER BAILEY, WHO

Many of us remember the film crew for *Contagion* who shot a scene at the number 8 bus stop in front of the headquarters building a few years ago. Marion Cotillard played the intrepid WHO technical officer who travels to the Far East to investigate a mysterious outbreak, only to get herself kidnapped as part of a high-stakes game of international intrigue. Clearly, she did not take the field security training that we are obliged to take before missions.

But are we experiencing an upsurge in this mini-genre of WHO films? It seems so. Consider the evidence:

Call for action on zombiism?

In *World War Z* which is infecting box offices globally at the moment, Brad Pitt plays an international health officer (read UN investigator) desperately trying to find a cure for the mass zombiism (Acquired Post-mortem Involuntary Muscular Animation Syndrome, or APMIMAS) which is sweeping

the planet with apocalyptic results. The film also mentions a "secret WHO research facility" in Wales, United Kingdom, that develops a zombie-repellant vaccine! Given the global numbers, should we make the reduction of zombies worldwide a WHO programmatic priority?

Judging from the selection of Brad Pitt and Marion Cotillard for the roles of international health officers in these films, we can only conclude that the UN Core Competencies have expanded the selection process to include good looks and an impeccable fashion sense, as these staff members were certainly well appointed. And by the way, what is the ICD-10 (international classification of diseases) code for zombiism?

On the theme of beautiful, yet kidnapped, WHO technical officers, who can forget Penelope Cruz in the movie *Sahara*, based on the Clive Cussler novel of the same name? The Cussler hero Dirk Pitt (no relation to

Brad) protects Cruz, and the smallpox samples she has stolen, from the clutches of an evil dictator who intends to use them to devastate global populations.

Disaster movie response team

If Clive Cussler seems too much like literature for you, perhaps Jean-Claude Van Damme's classic *Derailed* is better fare. In this, a beautiful yet kidnapped WHO technical officer is carrying a deadly bio-weapon on a cross-country train. Her only protection is the 'Muscles from Brussels' who, after killing most of the terrorists and a few innocent bystanders, completes the job by destroying the train (hence the title). Don't ask why he didn't destroy the train in the beginning to save some effort, but then again it would have been a very short movie.

If all of this sounds familiar, it is because it is. It is a nearly identical plot to *The Cassandra Crossing*, a disaster both in and outside

of the box office, starring Sophia Lauren, Burt Lancaster, Ava Gardner, a young Martin Sheen as her kept man, Richard Harris, O.J. Simpson and Lee Strasberg... In fact, it might be shorter to list who is NOT in the movie.

The right stop for health

Aside from the inspiration for Van Damme, it is most notable for the beginning credits sequence in which an aerial camera slowly swoops down from the clouds over the Alps, across Lake Geneva and over the Palais des Nations, to zoom into the International Labour Organization, which is identified by the movie as the International Health Organization (this is clearly before the days of GPS).

In the first scene, sick patients are rushed in on stretchers into WHO, past country-specific operating rooms and armed guards for immediate emergency medical treatment.

For a darker theme, there is the "based-on-a-true-story" *L'Adversaire* starring Daniel Auteuil as a man posing as a WHO employee who eventually murders his family. In the days before heightened premises security, he would come into the headquarters building, check out WHO library books, and leave them around his home to reinforce his fiction of working at WHO. This film at least filmed on location scenes in the right building, but still couldn't resist clothing WHO staff in long white laboratory coats.

For the most subtle mention of WHO in a movie, the award goes to *Guess Who's Coming to Dinner*. When Spencer Tracey is reviewing Sidney Poitier's background, it is mentioned that Poitier's character worked at WHO for three years.

Another novel character

And on the literary scene, currently at the top of the bestseller list is Dan Brown's latest novel (and undoubtedly eventual movie) *Inferno* which includes a fictional character based on a female Director-Gen-

eral of WHO, another beautiful technical officer who gets kidnapped.

The films which feature WHO run the gamut in quality and subject matter, but do have a few interesting aspects in common. Increasingly over the years, when screenwriters want to explore global health themes, WHO becomes the symbol of public health, a trusted authority which

the world turns to for authentic knowledge and information, and for salvation. And especially to its extremely attractive staff who sometimes have the unfortunate tendency to get kidnapped.

Click on www.youtube.com/watch?v=t6_JHm6rz50 to have a glimpse of a film featuring WHO. ■



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A BLUE BOX THAT COULD SAVE LIVES



Photo: WHO

GAUTAM BASU & CATHERINE ROCH

WHO's Blue trunk library project: providing health information to remote areas

The Blue Trunk Library (BTL) was originally developed 15 years ago for installation in district health centres in Africa. Currently it is in use in all continents, to provide up-to-date medical and health information to users in health centres and hospitals with low-or no internet connectivity. Each trunk, or library, is catalogued according to major health topics and contains over 100 books on medicine and public health.

The first Blue Trunk was sent to Guinea-Conakry in 1998. As of 31 December 2012, 2281 blue trunks with more than 300,000

books and journals have been sent to 90 countries, and 570 health staff trained in their use. In addition, orders have already been received this year to ship trunks to Bhutan, Cuba, Indonesia, Honduras and Tanzania. The Blue trunk libraries are available in 5 languages: Arabic, English, French, Spanish and Portuguese.

Edith Certain, a librarian, who retired recently from WHO, virtually single-handedly set up the first trunk. "The metal trunk was thought up to keep the books intact during transportation, and the first trunk was coloured blue. The colour caught on, and the library got its name," she recalled. Their durable construction and small size make them a versatile tool in disseminating information and improving health systems through local or district health centres. They also serve as great teaching tools in schools of nursing.

How did the idea of a Blue Trunk Library germinate?

Many medical libraries in developing countries suffer from a shortage of medical books and journals, due to funding constraints. The few books or journals available are often outdated and hence of little use but they do have readers. The thirst for knowledge is very real. The situation is even gloomier in rural hospitals, where updated information is rare. Those medical libraries which do have some information often lack the means

of disseminating the information: limited paper for photocopying, unreliable postal services, or inadequate personnel.

Studies into this issue by WHO a decade ago showed that improving community health services depends to a great extent on updating the knowledge of health personnel, especially rural health workers. WHO's manuals are a treasure trove for district health centres, but they happen to reach only a few lucky institutions or individuals. Many district and rural health workers rarely have access to expensive books. In these remote areas, providing electronic publications is not an option due to lack of electricity or internet connectivity.

It was in such a backdrop that the BTL was conceived. In every trunk priority is given to practical manuals (especially those by WHO) offering easily accessible solutions to medical, public health and management problems. Differing levels of education among district medical staff is also taken into account: the same topic is addressed in different publications from different points of view – of the physician, nurse, nursing auxiliary or health worker. The collection, which has been deliberately kept small, is not exhaustive; books on topics not covered by WHO's publishing programme are purchased and added to the collection. Other suitable local material available at district level can be added.



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How are Blue Trunk Libraries funded?

Each trunk is sold for US\$ 2000, this allows for the cost of the WHO and non-WHO publications that each library contains to be covered, as well as the staff time involved in the selection, management and dispatch of the publications and libraries. The program depends on these sales as it receives no other form of support and has been sustainably financed in this manner for the 15 years that the project has been running. Use of BTLs in countries is monitored by the WHO country office with support from the WHO Representative. Ministries of health and a variety of other organizations – including the World Bank, European Union, UNDP, UNICEF and UN Missions – have bought BTLs for donation to various countries. Bilateral aid agencies and national governments have also pooled funds, as have var-

ious NGOs such as Solidarité Protestante, Entraide Médicale Internationale and Save the Children Fund, all of which have included the BTLs in their own health centre projects. A significant number of BTLs have also been funded by the Offices of WHO Representatives.

WHO interns and visiting medical students have also made a significant contribution to raising funds for BTLs through innovative measures such as bake sales, musical concerts and sale of coupons. Musical instruments have also been sold to pay for a BTL. Some trunks are also donated by individuals.

The BTL project makes it possible to establish a network to disseminate medical and health information that reaches out be-

yond academic and university circles. The distribution of publications and documents is often the weak link in the best-intended development projects. The success of the Blue Trunks was possible because they defined a target, the health districts, chose the right publications for the target, and had workable and sturdy mode of distribution to peripheral health centres, thanks to the metal trunk. ■

For more information on the Blue Trunk Library, click on: www.who.int/kms/initiatives/bluetrunk/en/



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A 'GARDEN OF EDEN' AT HEADQUARTERS



TEXT AND PHOTOS GAUTAM BASU, WHO

A garden designed along the lines of a 12th-century royal treaty on garden arrangements (*Suku-tei-ki*), replete with pagoda and pool. A gift from an emperor designed meticulously to traditional landscaping concepts by a septuagenarian architect flying 10,000 miles for the task. A rejuvenating patch of green designed to incorporate architectural principles to induce peace and calm. And inaugurated with all the trappings of formal pageant including a traditional tea ceremony. This is the story of a fascinating spot inside the WHO headquarters campus.

As you walk down to the cafeteria in the Main Building, you will notice the Japanese Garden (*Jardin japonais*) on your right, now iridescent with flowers in summer, a gift to WHO made 50 years ago by the Emperor and people of Japan.

The story begins with a pledge at the Nineteenth World Health Assembly in

1966, the year WHO moved into its current headquarters. The Japanese delegate, Dr. Tatebayashi, pledged on behalf of his government to present a traditional garden to beautify the new headquarters campus.

After the gift was accepted formally by WHO in January 1968, the Permanent Delegation of Japan to the International Organizations in Geneva soon donated the first installment of cash for this donation in kind. Then Director-General, Dr. M.G. Candau said: "I am sure the Japanese-style garden will be a very effective addition to the building."

We now fast-forward to 13 October 1971. On this date, Mr. Hideo Kitahara, Ambassador of the Japanese Permanent Delegation in Geneva, announced "the honour of donating the garden to WHO". What followed three days later, the handover ceremony, was a colourful pageant by itself. But even more colourful perhaps was the story of the garden's construction.

According to documents in the WHO Archives, the garden was designed by Professor Jiro Asano, "an expert in landscape gardening". In view of the specialized work involved, "a strong opinion (in Japan) was in favour of engaging a Japanese firm to carry out the work". The principal architect, Katsua Saito, was nearly 75 years old when he flew in to personally supervise the finer details.

The 900-sq. metre garden incorporated elements of trees, stones and water, thus representing all facets of nature. Five rocks weighing about 13 tonnes were placed in the *tonseki* fashion, reflecting the mythical symbol of the authority of a chief performing an act of benevolence for his people.

The pagoda in one corner has five levels, denoting the five stages in the life of the Buddha. The murmur of water in the tiny pool denotes the movement of the waves of the ocean. The tiny island on it has a rock in *Yukimidoro* style, which translates to, and is in the shape of, "a woman who looks at the snow with a flowery hat". And there is more.

Water is an intrinsic part of all gardens, indicative of its fundamental importance to human life. Water conducted by bamboo shoots falls drop by drop in the garden re-



flecting the concept of *tsukubai*, the Japanese philosophy of ablution. At the western corner are two small square plots of black and white stone, intertwining to reflect the variations of yin and yang, the interconnected balancing dualities of nature.

Traditional schools of Japanese art were incorporated in every feature. For example, the lantern is made in the *Rakugan* (duck) style from Kyoto, and the quaint wooden bridge in the style of *yatsu-kashi*. The stone basin reflects an intrinsic feature of all tea ceremonies dating from Zen Buddhist times of the 16th century.

The highlight of the formal yet cheerful handover ceremony on 16 October 1971 was a traditional Japanese tea ceremony. The formal event was planned to be held at the foot of the exterior stairway to the EB Room in the open, “weather permitting”. The weather gods did smile, and 20 distinguished guests, including Dr. M.C. Candau, then Director of Administration, John Armstrong, and about a dozen delegates from Japan, attended.

The programme was documented in meticulous detail, even stating who would hand over the ribbon and scissors to the wife of the Japanese Ambassador for that key photographic moment. The guests assembled before the Brazilian painting, and “made a tour of the garden exiting from the passerelle by the EB stairway”.

This was followed by the tea ceremony (*cha-no-yu*), wherein tea was prepared by a “Japanese tea mistress, Mme Iwashita”. The memos for the event had an interesting detail: “Those wishing Western-style tea will be served in the Executive Board lounge”. Details such as the chinaware required and

even who would wash up after the ceremony were also listed and can be read at the WHO Archives.

For those interested in the more prosaic details: the Japanese Garden was constructed by the Japan Association for Beautification of Environment with a panel of six leading garden-designers from that country. The period of construction was 10 August to

10 October 1971. The cost: 30 million yen. Half of this was sponsored by the Japanese Ministry of Health and Welfare and the Japan Medical Association.

And yes, like everything else in life, this project too saw a cost escalation entailed by “supplementary works undertaken in May-June 1972”. The extra amount: 7389 Swiss francs, not to mention 45 centimes. ■

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RESEARCH TO CONTROL INFECTIOUS DISEASES OF POVERTY A UN APPROACH



Photo: WHO

TDR, the Special Programme for Research and Training in Tropical Diseases, will be celebrating its 40th anniversary in 2014.

JOHN REEDER, DIRECTOR, UNICEF/UNDP/ WORLD BANK/WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES, WHO

It was set up in the mid-70s as a global, UN-sponsored research effort to tackle some of the world's most neglected diseases. It has been based at the World Health Organization in a unique co-sponsoring ar-

angement with UNDP and the World Bank as additional founding co-sponsors, and UNICEF coming on board in 2003.

At the time of its establishment, there was no international framework for coordination of research to support infectious disease control, particularly in the developing world. Moreover, apart from their vote at the World Health Assembly, developing countries had little say in research priorities. TDR's design reflected an emerging philosophy – that disadvantaged populations, when properly enabled, would be capable of driving a “bottom-up” development process, rather than passively awaiting “trickle-down” benefits. An innovative board arrangement was created that opened decision-making processes to equal participation by both donors and recipients, effectively breaking down those distinctions and creating a new partnership paradigm where representatives from disease endemic countries had a major role in determining TDR's strategic direction. This group is called the Joint Coordinating Board, which is an independent body comprising donors and participating countries that oversees the financial and administrative elements of the Programme. Complementing this is the Scientific and Technical Advisory Committee, which provides independent scientific review and verification of progress. This model has stood the test of time, and has been copied by other international organizations since then.

TDR began with two interdependent objectives of developing improved tools for the

control of tropical diseases and strengthening the research capability of affected countries themselves. The impact of this bold new approach that integrates UN and other international bodies has been considerable.

Attacking the diseases of a generation

TDR has supported more than 9000 research and development projects involving more than 7000 scientists in 146 countries, mostly in the developing world. The Programme initiated new treatments for leprosy, malaria, visceral leishmaniasis, human African trypanosomiasis and onchocerciasis. It supported the concept of sequencing the genome for the malaria vector, *Anopheles gambiae* and the trypanosomatid parasites responsible for sleeping sickness, Chagas disease and leishmaniasis. It also led some of the first efforts to promote genetic research into the development of modified mosquitoes to control malaria, now being tested in field conditions.

More than 4 000 research capacity strengthening projects in over 80 countries have fostered and strengthened the capacity of over 200 institutions. More than 1 500 scientists worldwide have received training, and an additional 5 000 young scientists “nested” their graduate training within other TDR grant formats.

A new strategy to improve access to healthcare for all

Today, TDR is embarking on a new strategy that builds on this vast experience and network of TDR “alumni.” Many of

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the Programme's grantees are now leaders of research organizations and fostering a new generation of scientists and leaders for today's issues. Climate change, large-scale migration, urbanization, irrigation and globalization are changing the patterns of infectious disease and vector-borne disease transmission. Some diseases, such as tuberculosis and dengue, are resurgent, and others are newly emerging, like the novel coronavirus. Since TDR's founding, new product development partnerships have been set up outside the UN system (many initiated by TDR) to focus on drug development for malaria and neglected tropical diseases, and to develop diagnostic tests. New drugs are available for use and there are even more in the pipeline, but today the problem is one of access. Millions of people live where health systems, including supplies and health workers, are limited. How do they receive these new treatments that can save lives and reduce disability?

Working with national governments and WHO country, regional and headquarter offices, TDR is expanding its portfolio of research that focuses on system bottlenecks. There is an exciting range of questions being addressed: Can trained community health workers diagnose the causes of fever and treat uncomplicated diseases like malaria and pneumonia? Can public health officers be trained to use the country's health data to find solutions that reduce the rise of multidrug- and extensively drug-resistant tuberculosis? What is the impact of environmental and climate change on diseases of poverty?

This work is being done through new training models for public health workers and researchers in low- and middle-income countries. There is a new motto in the TDR office – no research without capacity building and no capacity building without research. The commitment to sustainable research capacity remains, what has changed

is the way this is being done. In 40 years, a strong cadre of institutions and research leaders has developed, in part due to TDR support. This group, the TDR alumni, is preparing the next generation of scientists, and TDR is helping with customized support and mentorship.

In the end, TDR is about partnership and collaboration – among UN agencies, among donors and recipients, among researchers and policy-makers. Its mission has stood the test of time, and the Programme has continued innovating and changing to meet the needs of the most vulnerable people. It has made a great difference in many people's lives, and it is already working with next generation. ■



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WHO'S CORNER



LE 10 SEPTEMBRE: PARLONS-EN!

LAURENCE VERCAMMEN, WHO

Chaque année près d'un million de personnes décèdent en mettant fin à leurs jours. Avec un décès toutes les 40 secondes et 20 tentatives pour un suicide, l'Organisation mondiale de la Santé (OMS) considère le suicide comme un problème de santé publique, comme en témoigne la journée mondiale de prévention du suicide le 10 septembre. Le but primordial de cette journée est de susciter une prise de conscience et un engagement pouvant déboucher sur des actions en faveur de la prévention du suicide.

A cet effet, l'OMS et l'Association internationale de la Prévention du Suicide (IASP) co-sponsorisent la journée mondiale 2013. La liste des actions et activités menées dans le monde est disponible sur leur site (www.iasp.info) qui vous renvoie également vers les centres d'appels de prévention sur tous les continents.

Il est statistiquement prouvé que les méthodes de prévention du suicide réduisent considérablement le taux de passages à l'acte. Rappelons que le suicide est un acte complexe dans lequel des facteurs culturels, sociaux, et environnementaux interviennent. La prévention requiert une approche multisectorielle et globale car elle ne relève pas uniquement du domaine de la santé mais appelle plusieurs acteurs à jouer un rôle déterminant dans la prévention. Ainsi, des actions préventives et efficaces peuvent être menées conjointement dans les domaines de l'éducation, du travail, de la politique, des médias, de la justice, de la religion, et de la police. Ne sous-estimons pas le rôle que chacun de nous peut jouer en étant simplement attentif envers son voi-

sin, son collègue, ses enfants, etc.

En matière de prévention, l'OMS recommande de restreindre l'accès aux moyens d'auto-agression, comme l'accès à des substances toxiques, et aux armes à feu. Elle recommande également le traitement approprié de la dépression, et de la dépendance à certaines substances.

Prévenir le suicide passe également par le dialogue.

Etre à l'écoute et attentif à son entourage permet souvent d'éviter le pire.

On reconnaît une personne potentiellement suicidaire lors de changements significatifs de comportement, lorsqu'elle a modifié ses habitudes dans tous les domaines de sa vie, qu'elle annule des rendez-vous, ne mange plus, ne va plus travailler, est au bord des larmes. Dans ce genre de cas, il est recommandé d'entamer le dialogue afin de vérifier jusqu'où la personne est prête à aller. Si nous sommes parfois démunis face à la détresse des gens, il existe des centres de prévention dans le monde, comme le Centre d'Etude et de Prévention du Suicide (CEPS) à Genève.

«La vie est un mystère qu'il faut vivre, et non un problème à résoudre»

— M.K. Gandhi

Le suicide ou la tentative de suicide touche toutes les couches de la population et n'est pas une fatalité. Dans le courant de sa vie, M.K. Gandhi, le principal leader du mouvement de l'indépendance en Inde, a vécu des épreuves qui l'ont fortement marqué. Il a vécu plusieurs épisodes de dépression dont l'un l'a poussé à faire une tentative de suicide. Il a toujours parlé de sa dépression de façon tout à fait ouverte et franche ce qui l'a aidé à surmonter son état.

Le suicide est le dernier maillon du désespoir mais n'est pas une fatalité. Il n'est pas la seule issue au mal être. Alors parlons-en! ■

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CEPS website: ceps.hug-ge.ch

Si vous souhaitez réagir à cet article, veuillez envoyer un email à vercammenl@who.int

Il est FAUX de penser que:

- ceux qui parlent de leur suicide ne le font que pour attirer l'attention
- ceux qui se suicident ont de graves troubles mentaux
- ceux qui veulent vraiment mourir ne se ratent pas
- le suicide est un choix personnel, il ne faut pas intervenir
- le suicide est imprévisible, aucune prévention n'est efficace
- le suicide est héréditaire
- parler du suicide peut inciter au suicide



GLOBAL TB PROGRAMME

TUBERCULOSIS: ONE OF THE GREATEST KILLERS!

Dr. MARIO RAVIGLIONE, WHO PHOTO, WHO

Over the past two decades, significant progress has been made by the World Health Organization (WHO), countries and other partners in the fight against Tuberculosis (TB). Between 1995 and 2011, 51 million people were successfully treated for TB using the WHO strategy, saving an estimated 20 million lives.

Despite this progress, TB remains one of the leading causes of death worldwide. In 2011, some 1.4 million people died of TB and 8.7 million people fell ill with this disease. This makes TB close to HIV/AIDS as the greatest killer worldwide due to a single infectious agent. In recent years, the emergence of multi-drug resistant TB (MDR-TB) has increased the urgency of combating this epidemic.

The WHO Global TB Programme is leading the global response to this epidemic by promoting universal access to TB prevention, care and control, guiding the global response to threats through norms and standards, supporting Member States, monitoring the burden and response, and introducing innovation. As a result, country efforts, strengthened with WHO support, have advanced the fight against this deadly disease.

Thanks to the effective implementation in most settings of the WHO strategy, the Millennium Development Goal (MDG) target to halt and reverse the TB epidemic by 2015 has already been achieved.

New cases of TB have been falling since the mid-2000s, although too slowly to allow elimination soon. Between 2005 and 2011, the implementation of the WHO-recommended collaborative TB/HIV activities has resulted in an estimated 1.3 million lives saved globally.

The roll-out of Xpert MTB/RIF, a rapid molecular test that can diagnose TB and drug resistance within 100 minutes has been impressive.

Between its endorsement by WHO in December 2010 and today, 3.1 million tests had been purchased by 88 low- and middle-income countries. This is one of the most successful transfers of new technology to high-burden countries ever seen. Further, for the first time in over 40 years, a new TB drug – bedaquiline – is available for the treatment of MDR-TB, and was granted accelerated approval by the United States Food and Drug Administration in December 2012. WHO issued interim guidance on the safe use of Bedaquiline to treat MDR-TB in June 2013.

However all this global progress remains fragile without increased investment in the fight against TB. WHO and the Global Fund have identified a gap of US\$ 1.6 billion in annual international support for tackling TB

in 118 low and middle-income countries on top of an estimated US\$ 3.2 billion that could be provided by the government of high-burden countries themselves. Closing this gap could enable full treatment for 17 million TB and multidrug-resistant TB patients and save six million lives between 2014 and 2016. In addition to the gap in international financing for the critical implementation interventions above, WHO and partners estimate that there is a US\$ 1.3 billion annual gap for TB research and

development during the period 2014-2016, including clinical trials for new TB drugs, diagnostics and vaccines.

Let's take up the challenge: join forces and work together to reach a total eradication! ■

Visit the website: www.who.int/tb

If you have comments about this article please send an email to vercammenl@who.int



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WITH 99% OF THE WAY THERE AFTER 25 YEARS, WORLD HEALTH ASSEMBLY ADOPTS AMBITIOUS PLAN TO SECURE LASTING POLIO-FREE WORLD



Photo: WHO

25 years after adopting a resolution for the worldwide eradication of polio, this year the World Health Assembly (WHA) launched an ambitious six-year plan to end all polio disease.

Dr. BRUCE AYLWARD¹

The new 'polio endgame' plan is based on new knowledge, innovative tools and lessons learned. The aim? To secure a lasting polio-free world – and to continue to strengthen health systems long after the disease is gone.

In 1988, the World Health Assembly (WHA) adopted a resolution to achieve an ambitious goal. To rid the world of an ancient and devastating scourge – the crippling disease of polio. At the time, polio paralysed more than 350,000 children for life every year, all over the world. This year, fewer than 200 cases have been reported worldwide.

A concerted effort known as the Global Polio Eradication Initiative (GPEI) – spear-

headed by national governments, the World Health Organization (WHO), Rotary International, the US Centers for Disease Control and Prevention (CDC) and UNICEF – reduced the incidence of this disease by a staggering 99%. Going door to door and vaccinating every child in the world, this collection of more than 20 million volunteers, communities, governments, donors, religious and civic leaders has nearly wiped out this disease. In 2011, India – long regarded as the technically most challenging place from where to eradicate polio – became polio-free. Today, only three countries remain which have never stopped polio: Nigeria, Pakistan and Afghanistan.

But failure to finish the disease in the re-

maining endemic areas means it will come back, with a vengeance. This year, the world is battling a dangerous new outbreak in the Horn of Africa following a virus importation, in Somalia and refugee camps in Kenya. Over the past six months, poliovirus has also been detected in the sewage systems of Egypt and Israel – thankfully, no cases have occurred. We know that if eradication is not completed, within ten years, we could see 200,000 new cases every single year, and poliovirus rampant all over the world.

This May, the 194 ministers of health at WHA adopted an ambitious new plan to end all polio disease within six years. It is a truly global plan, affecting all countries, and its implementation will ensure that not only is polio eradicated, but that it stays eradicated! New insights and lessons learned from the past 25 years have informed it, ensuring that strategic approaches are more effective than ever. And, crucially, plans are being put in place to ensure the vast infrastructure to eradicate polio will continue to help strengthen broader public health systems, long after polio is gone.

The new Polio Eradication and Endgame Strategic Plan 2013-2018 – stopping the virus in the remaining endemic areas

Endemic polio is at its lowest levels ever, with the fewest number of cases reported from the fewest districts. One of the two remaining types of poliovirus has not been detected anywhere since November. The prospects have never looked better.

But deadly new challenges have arisen: frontline health workers have been attacked and killed delivering polio vaccine in Pakistan and Afghanistan. Their courage is heroic. Just recently, a vaccinator in Pakistan told me: "I am not afraid for myself. I am afraid for the children who might be paralysed if they are not vaccinated." It is an admirable attitude, but frontline health workers should not and must not have to

work under such conditions. Attacks on health workers are unacceptable, and governments and communities are doing more than ever to ensure their safety.

At the same time, in too many places children cannot be reached with polio and other lifesaving vaccines, because they live in areas affected by conflict. No matter where they live, children everywhere have the right to benefit from lifesaving health interventions.

As these challenges are overcome, the disease can quickly disappear from these remaining infected areas. Transmission of the virus will have been successfully interrupted globally at that point. It will be an unparalleled public health success. Work cannot stop there, however. A lasting polio-free world must be secured.

The new Polio Eradication and Endgame Strategic Plan 2013-2018 – making sure that polio does not come back and securing the effort's legacy

Eradicating polio is one thing – making sure it stays eradicated is another. Activities will need to be implemented to ensure this.

The use of all oral polio vaccines (OPV) will eventually need to be discontinued. On very rare occasions, the weakened vaccine-viruses contained in OPV can revert to a neurovirulent form, and cause outbreaks of the disease it is meant to prevent. This will require the introduction of an entirely new vaccine – inactivated polio vaccine (IPV) – in 125 countries across the world. It might seem paradoxical to introduce a new vaccine for a disease which will no longer exist. But it is a critical part of the polio endgame, as IPV will enable countries to maintain population immunity to polio, without the risk of vaccine-derived polio outbreaks.

That the last case of smallpox occurred as a result of a laboratory containment failure in Birmingham, United Kingdom, in 1978, one year after global eradication of smallpox, serves as an important reminder of the need for effective containment of any stocks of such viruses after eradication. For polio eradication, this means that all countries will have to implement clearly defined containment procedures for appropriate bio-handling of poliovirus stock in laboratories and vaccine manufacturing sites.

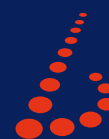
Implementation of these activities will go a long way to securing a lasting polio-free world. But perhaps one of the most important aspects of the new six-year plan is to secure the legacy of the global eradication effort. Time and again, the GPEI has proven its capacity to reach chronically unreached children with delivery of polio vaccine, other basic health services, all the while supporting surveillance and response for other vaccine-preventable diseases. The world must ensure that the essential polio functions are systematically transferred into existing health structures. Only in this way can it be assured that the vast assets, knowledge and systems built up by the polio eradication effort will continue to benefit broader public health systems, long after polio is gone.

The price-tag for achieving such a lasting polio-free world is US\$5.5 billion. However, over the next 20 years, a polio-free world will reap economic benefits amounting to an estimated US\$50 billion, most in developing countries. In April, global leaders at a Global Vaccine Summit in Abu Dhabi pledged US\$4 billion towards the new plan. These very generous pledges must now be converted to cash, and the remaining US\$1.5 billion urgently mobilized.

To succeed against polio requires the full engagement of all country governments to fully finance and implement the new plan. It needs the involvement of all of us as parents and members of our communities, to protect and vaccinate our children.

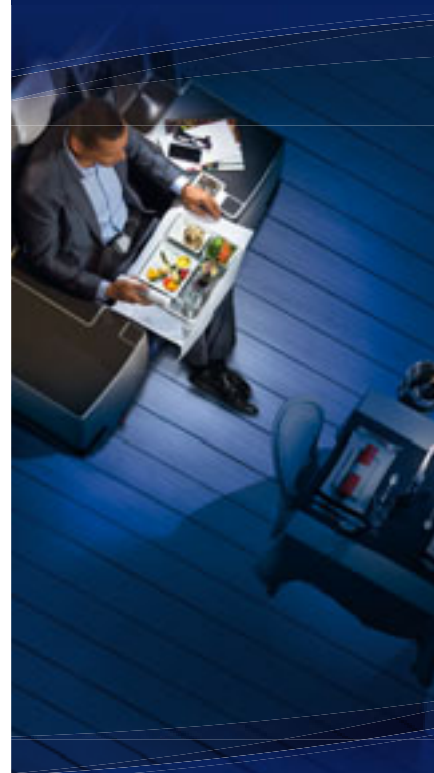
The polio endgame plan is ambitious. It is challenging. It is time-limited. And it is achievable. Together, as a global community, we can ensure that no child will ever again know the pain of polio paralysis. Please follow the global effort to eradicate polio and see how you can help at www.polioeradication.org. ■

¹ Dr. Bruce Aylward is the Assistant Director-General for Polio, Emergencies and Country Collaboration which brings together WHO's work in polio eradication, humanitarian response and country cooperation. Since 1998, Dr. Aylward has been responsible for the oversight and coordination of all polio eradication activities across WHO's Regional Offices and the Global Polio Eradication Initiative partnership.



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DANGEROUS SCULPTURES

BY JOSÉ TOLEDO ORDÓÑEZ

AT THE PALAIS DES NATIONS – JULY 18, 2013



José Toledo Ordóñez poses with two of his artworks at the entrance of Palais des Nations.

The *Dangerous Sculptures* exhibition by Guatemalan artist José Toledo Ordóñez (Pepo Toledo), opened last July 18 before a large crowd at the Palais des Nations, Geneva.

ANA REGINA TOLEDO

José Toledo Ordóñez is a Guatemalan sculptor, painter, movie producer, and art and literature promoter. This multifaceted profile has allowed him to expose his sculptures in 22 individual exhibitions, in places as prestigious as the José Luis Cuevas's Museum and Diego Rivera's Museum, both in

Mexico, the Art Gallery of the International Development Bank in Washington, D.C., and now at the Palais des Nations in Geneva. He has also unveiled 10 urban sculptures in Mexico, Costa Rica, and Guatemala.

Mr. David Chikvaidze, on behalf of Mr. Kassym-Jomart Tokayev, United Nations Under-Secretary-General, Director-General of the United Nations Office at Geneva, inaugurated the exhibition, thanking the artist for contributing with such unique artwork to the halls of the Palais des Nations. In his opening remarks, he said: "We are pleased to showcase these sculptures for the international community here in Geneva. The themes of respect for our natural environment, sustainability, and the quest for peace certainly resonate with the work of the United Nations – here in Geneva and around the world. In these sculptures we see a commitment to the preservation of nature and to promoting harmony with all humanity. Let us share this same commitment this evening, in our work for a better, safer, and more sustainable future."

The Ambassador of Guatemala, Carla Rodríguez Mancia, stated: "No better place could have been chosen for this premiere than the city of Geneva which is internationally known for its commitment to peace, security, and development, seat of the Office of the United Nations, a global message for a global city and a global word. Many have also approached me for an explanation on the title of the exhibition: *Dangerous Sculptures*. I can really assure you that the only danger that you might face while admiring these sculptures is the danger of changing your mind and your attitudes in a way that will surely contribute to a better world for all."

Finally, the artist quoted: "My message goes against the destruction of nature and the degradation of human relations in all senses: violence, war, injustice, and of course, the



Mr. David Chikvaïdze in representation of Mr. Kassym-Jomart Tokayev, United Nations Under-Secretary-General, Director-General of the United Nations Office at Geneva, Ambassador of Guatemala Carla Rodríguez Mancia, and the sculptor José Toledo Ordóñez. Mr. Chikvaïdze holds in his hand the project for the Angel of Peace sculpture.



Marlene Rommel Toledo, Ana Regina Toledo Ordóñez, the sculptor's sister, José Toledo Ordóñez, his wife Regina, and Karin Rommel.

destruction of art itself associated with truth and human values. Hence the name of this expo: *Dangerous Sculptures*, because truth hurts and the search of freedom threatens human race oppressors”.

The exhibit was scheduled to start on 18 July and continue through 14 August. Due to the success on the inauguration day, the United Nations cultural authorities decided to extend the end of the event for two more weeks, i.e. until 30 August.

In the end, the Guatemalan artist proposed his *Angel of Peace* sculpture to be installed in the gardens of the Palais des Nations, handing the project to Mr. David Chikvaïdze.

The next stop of the *Dangerous Sculptures* exhibition from Pepo Toledo will be held at La Maison de l'Amérique latine in Paris, on 9 October of this year. ■


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LIFE AND ART IN MOTION



Ralfonso "Ralf" Gschwend is a Swiss designer of large environmentally interactive, kinetic, light and sound sculptures. As a kinetic artist he has pushed the boundaries of traditional, static art forms to introduce visual experiences through the interaction with the environment such as wind, light and water.

LAURENCE VERCAMMEN
PHOTOS RALFONSO.COM LLC

He is an award winner of the Beijing City Sculpture Competition 2007 and a winner in the "Contest of Landscape Sculpture Designs for Beijing 2008 Olympic Games". His wind sculpture "Dance with the Wind" – 33 ft (10m) tall – was commissioned and

permanently installed at the Olympic Park in Beijing, the People's Republic of China (China) in 2008.

With his passion for Kinetic Art, he co-founded the Kinetic Art Organization (KAO) in 2001 with a German and a US fellow Kinetic Artist. Now, with more than

1000 members in over 60 countries KAO has become the largest kinetic art organization in the world. www.kinetic-art.org

Please tell us about what inspires you in your work?

My passion for this particular niche of sculptural art started very early. Even as a very young boy I was always fascinated with engineering, mechanics and design. From this fascination I started to design objects and sculptures that have a motion component. I am inspired by nature, by the shape and natural interaction of all the elements. So my sculptures gently move with the wind, the water, or when pushed by hand.

"The walls between art and engineering exist only in the mind."

— Theo Jansen

I believe that the art experience should be an active continuous exchange and discovery between art and viewer. So instead of a passive, static and one-sided viewing, I strongly believe it should be a dynamic interaction where the art and the viewer change, react and interact. With this quest for dynamic interaction and discovery, I now have started to design sculptures that can be viewed through social media – SMS, Internet, Smart Apps – locally and from all over the world. See as an example the EX STRATA sculpture in Beijing and the Netherlands at: www.youtube.com/watch?v=6OWX2_ksSwU

Who are your clients?

Clients for my large, site-specific public sculptures are mostly cities, such as our current UNION kinetic sculpture group project with the City of Orlando or Cities like Beijing, Zhengzhou, Wuhu, etc.

The second largest group of clients are developers of large, master planned developments, such as the Mass Transit Railway corporation (MTR) in China, Hong Kong Special Administrative Region or large cor-



porations, such as the RBI Holding in the Russian Federation, or the Royal Caribbean Cruise Line Corporation in the USA.

The third group of clients are Universities such as the Simons Center for Geometry

and Physics at Stony Brook in New York, the Tsinghua University in Beijing, or the University of Applied Sciences in the Netherlands (NHL) where we are now developing a new internet and smart phone interactive Light sculpture called EX STRATA

III that will connect with the EX STRATA at Tsinghua University.

Lastly, I am starting to design much smaller sculptures, in the 60 cm to 3 m range for a few private clients who have commissioned me to design site specific sculptures for their gardens or homes.

Do you collaborate with other artists to make your art pieces or do you create them all from A to Z?

I would love to collaborate with other artists, students and scientists, especially if they come from different disciplines.

From conception to the engineering and the achievement of the prototype I work on my own. I make the small sculptures, however for the larger size sculptures, once my little prototype is fine-tuned, I commission different Chinese companies which I have been collaborating with for the past ten years. We collaborate in synergy and I am always happy to receive sug-

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gestions from my Chinese colleagues on my original plan.

In China, people are flexible, curious, show a genuine interest for any type of art and are always open to learn new methods of work. Once a piece of art is done, it is shipped to the client.

How long can the entire process take from the conception to the final touch?

I am an intuitive person and sometimes I visualize the concept immediately, sometimes it takes weeks or months to finalize it. There are still some projects that I have started years ago waiting for me to find the “missing” element and to be finalized.

What are your plans for the future?

For me, life is about movements and interactions. Art is a way of life. I am extremely fortunate as my art brings me to see amazing places around the world, meet wonderful people and make new friends.

I am constantly exploring different approaches and methods. As an artist my goal is to push the envelope of interactive and dynamic public art, whether with sculptures that connect universities and cities via interactive art or by creating visual and audio feedback loops between the art and the viewer.

In order to explore this “bleeding edge” in design, materials and opportunities, I have worked with students at various technical Universities, such as the Swiss Fed-

eral Institute of Technology (ETH) and the Ecole polytechnique fédérale de Lausanne (EPFL) in Switzerland, and currently with the University of Applied Sciences (NHL) in the Netherlands. I really would like to do much more interaction with students for my projects, as it is a wonderful learning experience allowing me to discover new techniques.

This year, during the month of November, I will teach the very first Kinetic Art class in China, at the Tsinghua University. I believe kinetic art can make a major contribution and positive difference in the education of young people, especially if the learning is multidisciplinary.

This will be a new challenging experience at a cultural, personal and professional level for me. Teaching is also about interaction and learning to adapt to different audiences.

I am also currently discussing with large urban developers for the benefits of a master-planned strategic public art implementation approach. Here our concept is, to provide an overall art plan for completely novel and interactive art experiences for the visitors, residents, tenants of their large developments. So this calls much more for an overall curatorial and art master planning approach than the design of a single piece. As president of the KAO, I know most of the artists around the world that do this kind of contemporary kinetic and interactive art, so it is a great pleasure to be able to help create a thematic and harmonious approach to the art pieces in a new city or mixed use development, rather than the piecemeal approach so often seen.

Where can one admire your work?

My sculptures have so far been exhibited or permanently installed in Switzerland, The Netherlands, the Russian Federation, China, Germany, the United Arab Emirates (UAE), France and the USA.

My recent exhibitions include: “Art in Motion” in the Netherlands; “Ralfonso Kinetic Art” in St. Petersburg, Russian Federation; “MomentuM”, Grounds for Sculpture in New Jersey, USA; the Changchun Interna-

tional Sculpture Park, China; the Inaugural Exhibition at Cuadro Gallery in Dubai, UAE, the Wuhu International Sculpture Park, China, etc.

Currently you can join us at the open air sculptures exhibition “Mouvement et Lumière” until 3 November 2013 at the “Centre d’art contemporain Frank Popper” in Marcigny, France.

As an artist you are also involved in a charity cause.

Yes, every year I create a sculpture and donate it to “The Sabrina Children’s Foundation” based in Geneva. The Foundation was created to provide support to children who suffer from cancer and their families through various initiatives. In 2010 the “Sabrina” sculpture was auctioned in Geneva for 24,000 Swiss francs, which I was really happy about. I am glad to work with charity causes, if I am asked.

Among all your work, what is your favorite piece?

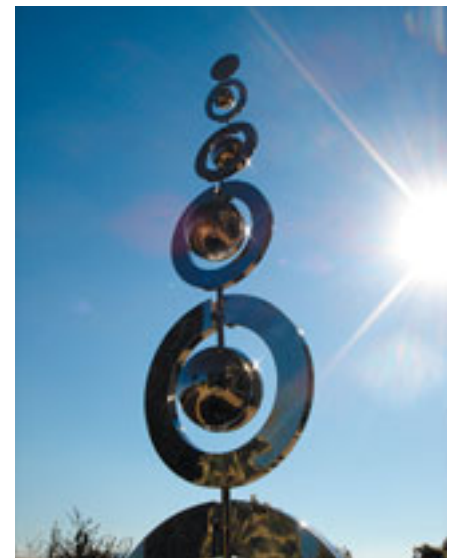
The next one! My life is a quest for discovery. It is art that takes me on a life-long journey leading me to new places, new friends and new opportunities. ■

For more information on kinetic art:

www.ralfonso.com

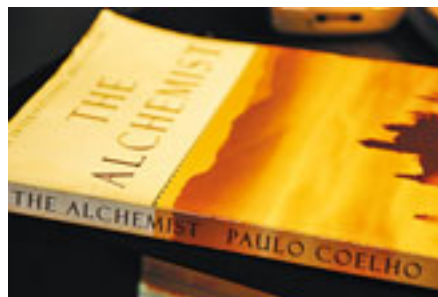
or see his Art in Action on YouTube at:

www.youtube.com/user/ralfonso1



THE ALCHEMIST

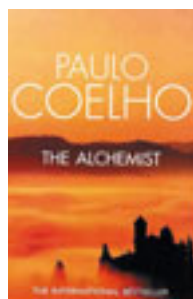
BY PAULO COELHO



"Remember that wherever your heart is, there you will find your treasure. You've got to find the treasure, so that everything you have learned along the way can make sense."

— Paulo Coelho, *The Alchemist*

NILOFAR BAWA



The Alchemist celebrated its 25th anniversary recently. It is listed as a New York Times best seller and among the top 100 most influential books in history.

Paulo Coelho tells the story of a young shepherd boy Santiago living with his sheep in an abandoned church in Andalusia. Although Santiago studies to become a priest, he decides to become a shepherd to travel and visit new places. Santiago discovers there is more to life than food and water, which distinguishes him from his sheep. He grows through experience and learns to listen to his Heart and heeds its warnings and advice. "My Heart is

afraid it will have to suffer." Tell your Heart that the fear of suffering is worse than the suffering itself."

When he dreams of a hidden treasure in the pyramids of Egypt, he sells his sheep and sets out in its search. By observing the signs and omens, he believes he will eventually fulfill his destiny and find his treasure.

On his journey, he meets a gypsy, an old man, a merchant, an Englishman and the Alchemist. He learns that when we truly want something, the whole universe conspires to help us achieve it. But it is also very important we must always know what we really want.

Santiago learns to speak the Language of the World which requires no words and by knowing this language one can understand the world. Santiago understands the mean-

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ing of 'Maktub' that everything is written and can be accessed by penetrating the Soul of the World. He accepts that all things are manifestations of only one thing. Every second of his search is an encounter with divinity.

At the oasis he meets the love of his life, Fatima, and accepts that he loves her because the entire universe conspired to help him find her. He could have happily settled down with Fatima but he believes he must find his treasure first or he would lose the treasure and never be happy in life. He believes in his love which to him is like the desert. The dunes change by the wind but the desert never changes and like the desert their love will never change.

To realize one's destiny is a person's only obligation. He knows that everyone on earth has a treasure that awaits him. Every search begins with a beginner's luck and every search ends with the victor's being severely tested.

Paulo Coelho brings forth the hidden mysteries of the world, where the hidden is manifested by the known. The Sacred expresses itself in simple things and eternity is hidden in a grain of sand. Miracles happen to those who believe in miracles. The Heart guides us if we learn to listen to it. Every element in nature evolves into something better.

Those immersed in the material world find it hard to believe in the unseen wonders and when told the Truth refuse it. Anyone trying to convince the world of the great treasures hidden within is seldom believed.

The Alchemist is a spiritual journey where the seen and the unseen worlds run parallel together. To understand one, one must know and believe in the other. As long as we believe in our personal legend, we can achieve our dreams. The only thing that makes it impossible is the fear of failure.

The end of the journey is a new beginning. Everyone has a treasure waiting for him. Once we reach our treasure and achieve our dreams we understand the meaning of life and all that took place along the way. ■

GAZ DE SCHISTE OÙ EN EST-ON?

Les hydrocarbures non-conventionnels, ou gaz et huiles de schiste, diffèrent du gaz naturel et du pétrole courants par leur localisation, au sein de roches profondes, peu poreuses et peu perméables.

Il n'est pas possible de les extraire par pompage et il faut fracturer le sous-sol, avec un mélange d'eau sous haute pression et d'additifs souvent toxiques, pour leur permettre de remonter.

JACQUES CAMBON

La migration, au travers des forages et des failles naturelles, du gaz produit et des substances chimiques injectées a provoqué aux Etats Unis des pollutions de l'eau et de l'air. Ce risque a conduit le parlement français à voter en juillet 2011, sous la pression de l'opinion publique, une loi interdisant la recherche et l'exploitation de ces hydrocarbures au moyen de la fracturation hydraulique.

Depuis, des voix discordantes sont venues jeter un certain trouble. L'intervention du Président de la République, affirmant le 14 juillet 2013: «Tant que je suis président, il n'y aura pas d'exploration de gaz de schiste», était censée clore le débat. Et pourtant, il n'en est rien!

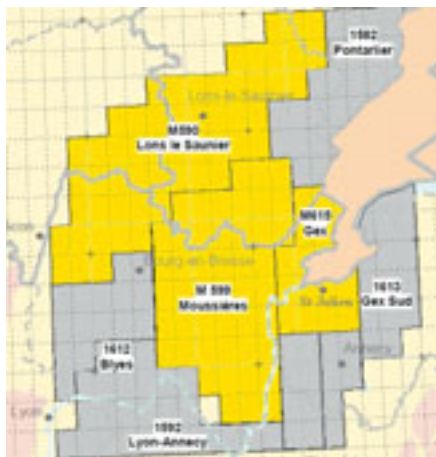
En effet les avis du Conseil Constitutionnel s'imposent même au Président de la République, et ce conseil a reçu le 12 juillet une «question prioritaire de constitutionnalité» d'une entreprise dont les permis de recherche ont été annulés. Il doit rendre son verdict, sans appel, dans les 3 mois. Le risque d'une abrogation de la loi est donc réel et un vide juridique s'ouvrirait devant les pétroliers dont les foreuses sont déjà en action dans le Bassin Parisien. Et leur lobbying intense pourrait bien compliquer l'adoption d'une éventuelle loi de substitution, quelle que soit la détermination du tout nouveau Ministre de l'Ecologie, Philippe Martin.

Une autre source d'inquiétude réside dans le texte de la loi, qui ne définit ni ce qu'est un hydrocarbure non-conventionnel ni en

quoi consiste la fracturation hydraulique. Alors certaines entreprises qui avaient posé des demandes de permis pour des hydrocarbures non-conventionnels ont simplement déclaré qu'elles ne cherchaient plus que du pétrole conventionnel, et ont ainsi vu ces permis confirmés! Et pour ajouter à la confusion, les arrêtés de rejet des demandes classées «gaz et/ou huile de schiste» par les services techniques de l'Etat s'empilent sur le bureau des ministres successifs sans jamais, ou presque, être signés.

Dans le Jura français, le permis de recherche «des Moussières» ne s'intéresse qu'au «pétrole conventionnel», affirme la société attributaire bien qu'un rapport interne, récemment divulgué dans la presse, démontre le contraire. Ce permis est arrivé à échéance et le ministère ne s'est pas encore prononcé sur la recevabilité de son renouvellement. La même société, qui d'ailleurs n'a jamais réalisé un seul forage où que ce soit, dispose aussi d'un permis de recherche en Suisse, à Noiraigue dans le Canton de Neuchâtel, où elle avance les mêmes arguments. Les communes concernées ont donné un avis défavorable, mais le lobbying continue à Berne.

En Suisse toujours, une autre société a réalisé en 2011 sous le Lac Léman, à Noville dans le canton de Vaud, un forage qui aurait identifié des ressources en gaz «serré», définition permettant de contourner le moratoire sur les gaz de schiste décrété par le Canton. Mais la technique d'extraction du gaz «serré» est la fracturation hydraulique, comme pour



Permis accordés en jaune; Demandes en instance en gris

L'exploitation de ces hydrocarbures amènerait de nouvelles quantités de gaz à effet de serre dans l'atmosphère.

Pour être complet il faut encore citer en France le permis de Gex, qui s'intéresse au secteur de Saint Julien en Genevois, les permis voisins de Lons-le-Saunier et de Pontarlier, ainsi que les demandes de Gex Sud, Blyes et Lyon-Anancy toujours en attente de décision du ministère.

La situation est donc loin d'être éclaircie et l'action des citoyens doit continuer. Outre les impacts locaux des forages sur les ressources en eau, la qualité de l'air ou les activités agricoles et touristiques, l'exploitation de ces hydrocarbures supplémentaires amènerait de nouvelles quantités de gaz à effet de serre dans l'atmosphère, en totale contradiction avec les objectifs de réduction

d'émissions préconisés par le Groupe d'experts intergouvernemental sur l'évolution du climat (GIEC) et retarderait les investissements dans les énergies renouvelables soutenus par le Programme des Nations Unies pour l'environnement.

Des collectifs existent dans toutes les régions de France concernées pour informer et mobiliser les citoyens, et le mouvement commence en Suisse, fortement relayé par des élus. L'association «Collectif non au gaz de Schiste Pays de Savoie et de l'Ain» agit sur 3 départements et au sein du «Réseau Rhône-Alpes» ainsi qu'avec la Fédération Rhône-Alpes des associations de protection de la Nature, membre de France Nature Environnement. ■

Pour en savoir plus, veuillez cliquer sur:
<http://collectif.ngds74.info>

le gaz de schiste et avec les mêmes risques. Le foreur souhaite réaliser de nouvelles explorations à Noville, et a également déposé une demande en France, juste de l'autre côté de la frontière: Cette demande de permis, dit «d'Abondance», serait irrecevable selon les services techniques régionaux, mais sans confirmation du ministère.

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LES RÉCRÉATIONS DE RÉGIS



**Au retour de vacances
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je voudrais vous parler
du goût.**

La semaine du goût se déroulera en Suisse du 12 au 22 septembre au cours de laquelle de nombreuses manifestations auront lieu. Prenez-en note.

De quel goût s'agit-il? Du «vrai»? De celui d'antan, de la cuisine de nos grand-mères, du repas mijoté avec amour ou de la poudre de Perlimpinpin que certains nouveaux «plâtriers et maçons» de la cuisine tendent à nous faire avaler sans modération, maniant allègrement publicités mensongères et appels ciblés à la ménagère?

Ce qui va suivre s'adresse à tous les amoureux de cuisine auxquels je demanderai de faire passer le message et également aux enfants qui, en goûtant le vrai, doivent sensibiliser leurs parents à cuisiner.

Je voudrais attirer votre attention sur l'importance du maintien de nos valeurs culinaires, de nos producteurs artisans des

métiers de bouche, qui donnent le meilleur d'eux-mêmes pour élaborer un produit noble de grande qualité sans qui, nous «les chefs et autres», ne pourrions nous exprimer correctement et vous offrir des mets du terroir de goût exceptionnels.

Le problème majeur n'est pas dans la multiplication des plats cuisinés dans les supermarchés, puisque nous avons le «libre choix d'acheter ou pas».

La grande distribution nous pousse à «ne plus cuisiner». C'est à nous d'engager le processus inverse en cuisinant simplement et fraîchement.

Notre santé passe par la cuisine. Une mère qui cuisine avec amour pour sa famille pense à la santé de ses proches. Le danger primordial actuel est «la perte du goût». Pensons à la transmission culinaire familiale et cuisinons maison. Cuisiner en famille,

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quelle belle idée de passe-temps. Goûter et déguster ce que l'on a fait, en savourer la satisfaction en ayant réfléchi à la confection. Je suis persuadé que c'est grâce aux enfants, en les éduquant culinairement que nous changerons les habitudes. Ils doivent connaître jeunes le goût du vrai, du produit artisanal et non le goût standardisé que l'on veut nous faire gober au travers des produits insipides de qualité médiocre.

Sincèrement, après mûre réflexion, la solution viendra de cette prise de conscience, de l'interprétation par les ENFANTS de la cuisine du goût. De ce fait, ils continueront à perpétuer les traditions que NOUS sommes allègrement en train de «laisser tomber».

Je vous remercie de m'avoir lu et de «mijoter tranquillement ces paroles».

Au mois prochain pour une nouvelle récréation que je vous assure plus réjouissante. Surprise...

Culinairement vôtre,
Chef Régis ■

MES ADRESSES DU MOIS

- LE CHAT NOIR, rue Beauséjour 27, 1003 LAUSANNE: Incontournable au niveau du goût, de la création, tout en restant dans un créneau traditionnel. Toujours parfait.
- PLANETE CAVIAR, rue Duchosal 7, 1207 GENEVE: Sa boutique-restaurant, sélection de vins où la diversité, le choix des produits et le goût sont inimitables.

MA RECETTE DU MOIS

Cailles aux raisins et raisiné, chou romanesco, purée de panais

Pour 4 personnes: 4 cailles désossées, 1 CAS d'huile d'arachide, 1 CAS de beurre, 3 cl d'armagnac, 1 grappe de raisin d'Italie, 2 C de raisiné.

Couper les bouquets de romanesco, les cuire un peu croquants à la vapeur et les lier avec 2 cuillers d'huile d'olive.

Cuire à l'eau salée 1 livre de panais, 1 pomme de terre bintje avec 1 verre de vin

blanc pendant 20 mn. Egoutter, lier avec 100 gr de beurre et 1 dl ½ de lait entier.

Peler les raisins et les mettre à macérer dans l'armagnac ½ heure avant de débiter la cuisson.

Faire revenir les cailles 5 mn aller-retour dans l'huile et le beurre chaud, les flamber avec un peu d'armagnac des raisins. Les couvrir et cuire 15 mn en les arrosant de temps en temps. Les réserver sur une assiette. Dégraisser la poêle, ajouter les raisins et le reste d'armagnac; laisser cuire un peu, ajouter le raisiné, faire mijoter 2 mn et ajouter s'il y a lieu, le jus des cailles reposées. Remettre les cailles dans la préparation.

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Journal de bord Yannick Gagneret: Sécurité ONU Genève. Episode II

Deuxième tentative

Cette année, nous sommes seulement deux alpinistes à tenter l'ascension du Lhotse sans oxygène. Le second, un alpiniste taïwanais, part pour le sommet trois jours avant moi.

Au moment de quitter à mon tour le camp de base, j'apprends que ce dernier est dé-cédé à 7900 m, probablement un œdème.

Lors du premier assaut, j'ai laissé énormément d'énergie. La cornée de mes yeux ainsi que trois doigts ont gelé pendant l'ascension, ce qui les rend plus sensibles et plus

vulnérables au froid. De plus, mon infection pulmonaire n'est toujours pas soignée, je tousse beaucoup.

Dès le départ du camp de base, je sens que les deux jours de repos n'ont pas suffi pour retrouver la forme. L'ascension s'annonce difficile.

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Je trouve la montée jusqu'au camp II (6400 m) très longue. J'arrive au camp en début d'après-midi et je me couche directement afin de récupérer en prévision de la montée au camp III (7400 m) le lendemain.

Le scénario est identique le lendemain, je mets presque dix heures pour atteindre le camp III et j'arrive épuisé. Heureusement, ma tente est déjà en place, j'avais mis deux heures pour l'installer lors de la première tentative. Je m'endors immédiatement et j'arrive à dormir deux heures, ce qui est exceptionnel à cette altitude.

Le lendemain, le 22 mai, je reçois le bulletin météo quotidien sur mon téléphone satellite. Le beau temps (pas de nuage et très peu de vent) est confirmé pour le 23 mai.

C'est ma dernière chance d'arriver au sommet du Lhotse, je suis motivé comme jamais. Je quitte ma tente le 22 mai à 19 h en espérant atteindre le sommet le lendemain dans la matinée. Il fait -30°C , mais la température risque de baisser pendant la nuit.

La première partie de l'ascension finale se passe très bien, j'arrive à conserver un rythme constant. Je suis parti très léger, mon sac à dos contient juste un thermos de thé, trois barres de céréales et une paire de gants de rechange.

Malgré la difficulté de l'effort, j'arrive à profiter d'un moment exceptionnel: je suis seul sur la paroi du Lhotse, face à l'Everest, la lune vient de se lever et illumine toute la vallée du Khumbu. Aucun bruit autour de moi, j'aperçois juste les lampes des alpinistes sur l'Everest. Je suis conscient de vivre un moment unique.

Je poursuis mon ascension. Mon seul point de repère est l'altimètre qui monte doucement: 7600 m, 7700 m, 7800 m. Je vois une tente installée sur un petit replat. Le corps de l'alpiniste taïwanais est allongé à l'intérieur, il sera descendu au camp de base quelques jours plus tard.

A 7900 m, j'arrive enfin à l'entrée du dernier couloir menant au sommet. Il s'agit d'un passage mixte (glace-rocher) très raide qui serpente entre les blocs rocheux et mène

au sommet. Je commence à ressentir la fatigue et je dois m'arrêter de plus en plus souvent pour reprendre mon souffle. Pour l'instant, je suis encore lucide mais ça ne va pas durer...

L'altimètre continue de grimper. J'arrive à 8200 m à l'endroit où j'ai dû faire demi-tour lors de ma première tentative. Cette fois, il n'y a pas de vent, je poursuis l'ascension.

Le jour se lève, le paysage est certainement magnifique mais je n'ai plus la force de l'apprécier. Je dois franchir plusieurs blocs rocheux. Ce n'est pas une escalade technique mais épuisante. Après le passage de chaque bloc, je m'allonge sur la glace plusieurs minutes pour reprendre mon souffle.

Je regarde mon altimètre de plus en plus souvent: 8300 m, 8400 m, 8500 m...

Tout à coup, j'aperçois quelque chose devant moi. Ma cornée est gelée, je vois trouble mais il me semble voir une personne allongée! Je monte de 10 mètres et j'arrive en effet à proximité d'un alpiniste sur le dos. Naïvement je pense qu'il se repose en descendant du sommet. Lorsque je pose ma main sur son bras, je comprends que le pauvre ne repartira jamais. J'apprendrai plus tard qu'il s'agit d'un alpiniste tchèque décédé l'an dernier.

Dix mètres plus haut, j'arrive sur une plateforme minuscule. Plusieurs drapeaux sont plantés. Il me faut plusieurs secondes pour réaliser que je suis au sommet! Il est 8h45.

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J'avais imaginé ce moment des centaines de fois: A qui allais-je penser au sommet? Est-ce que je serai ému? La vue sera-t-elle magnifique?

La réalité est différente: je ne ressens aucune émotion, je ne pense à personne et je ne profite même pas de la vue. Une seule pensée en tête: vite redescendre pour retrouver un taux d'oxygène viable si je ne veux pas terminer comme le tchèque ou le taïwanais.

Je reste au sommet moins de cinq minutes mais je prends quand même quelques photos avant de descendre.

Un alpiniste et son sherpa arrivent juste à ce moment. Ils ont l'air surpris de me voir ici sans oxygène. L'alpiniste hurle au travers son masque à oxygène: «Congratulations!» Je n'ai même pas la force de répondre, je lui tape juste sur l'épaule en remerciement.

Dès le début de la descente, je chute dans les rochers. Je déchire mon pantalon en duvet, toutes les plumes s'envolent! Cette chute a l'avantage de me réveiller. La plupart des accidents surviennent lors de la descente, il faut donc rester concentré!

L'alpiniste et son sherpa me doublent rapidement, quelques minutes plus tard ils seront hors de vue. Je suis de nouveau seul sur le Lhotse.

Pourtant j'entends discuter. Je mets quelques minutes à réaliser que ce sont mes chaussures qui discutent entre elles... En effet, je commence à délirer! Est-ce la fatigue ou le manque d'oxygène (sûrement les deux) mais j'entends clairement une discussion politico-culturelle entre mes chaussures! C'est vraiment un phénomène étrange à vivre. D'un côté, je suis lucide et suis concentré sur la descente, je ne commets aucune faute même lors des passages délicats. D'un autre côté mon cerveau invente une conversation intellectuelle entre mes chaussures que j'ai du mal à comprendre!

La descente est interminable. Je suis épuisé et je m'arrête toutes les deux minutes pour m'allonger sur le sol. Je n'ai plus rien à boire depuis plusieurs heures, je mange de la neige pour me désaltérer.

Puis j'aperçois enfin ma tente au camp III. Il me reste encore plusieurs heures de marche mais c'est bon pour le moral!

Le 23 mai à 19h, je rejoins enfin le camp III, vingt-quatre heures après l'avoir quitté! J'aurai mis quatorze heures pour monter et dix heures pour descendre. Arrivé devant ma tente, je me souviens avoir levé un poing vers le ciel en signe de victoire. Puis je suis rentré m'allonger, sans prendre le temps d'enlever mon casque, mon sac à dos et mes crampons!

Je rejoins le camp II le lendemain. Je suis toujours épuisé mais j'ai retrouvé mes esprits et cessé de délirer. J'arrive au camp de base le surlendemain.

Au camp de base, beaucoup de personnes viennent me saluer et me féliciter. Je commence alors à comprendre que j'ai réalisé une belle ascension.

Le retour à Genève est très rapide. Je dois effectuer la marche de retour en deux jours pour ne pas rater mon avion à Kathmandu. Une semaine après avoir foulé le sommet du Lhotse, je reprends le travail à Genève.

L'expédition au Lhotse était vraiment une belle aventure, maintenant place aux prochains objectifs: ascension du Manaslu (8163 m) au Népal en septembre 2013. Puis en 2014, traversée entre deux sommets de 8000 m au Pakistan. Toutes ces ascensions sont ma préparation pour un gros objectif en 2015, toujours sans oxygène. Mes chaussures auront certainement des choses à raconter... ■

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LA NOUVELLE LOI SUR LA NATIONALITÉ SUISSE ET LE STATUT DES FONCTIONNAIRES INTERNATIONAUX



TEXTE ET PHOTO, ELIZABETH JAMES

M. Cruz Melchor Eya Nchama, candidat au Grand Conseil de la République et Canton de Genève, livre des propos par rapport au statut des fonctionnaires internationaux. Pour ce Conseiller municipal de la commune du Grand-Saconnex, également membre de la commission communale de

la naturalisation, de nouvelles dispositions légales envisagées par le Conseil Fédéral vont favoriser et faciliter la possibilité aux étrangers de se naturaliser, dans l'optique où ceux-ci démontrent une capacité à s'intégrer du mieux possible.

Tout d'abord, lorsque l'on évoque le statut des fonctionnaires internationaux à Genève, il est nécessaire de tenir compte des divers accords et lois qui régissent le statut de tout étranger en Suisse. Avant la création des Nations Unies, il n'existait qu'une seule loi sur les étrangers: la «Loi fédérale du 26 mars 1931 sur le séjour et l'établissement des étrangers» qui depuis a été remplacée par une nouvelle loi en 2005. Après la création de l'ONU, un accord de siège a été conclu entre le Conseil fédéral Suisse, par le biais du Conseiller fédéral Max Petitpierre et le premier Secrétaire Général des Nations Unies, M. Trygve Lie. Cet accord: «Accord sur les privilèges et immunités» est entré en vigueur le 1er Juillet 1946. D'autre part il faut également souligner que les personnes de l'Union Européenne, domiciliées en

Suisse bénéficient depuis 2002 de l'accord de libre circulation entre la Suisse et les pays membres. Celui-ci est pleinement appliqué depuis 2007.

Il existe donc trois types de statuts en Suisse concernant les étrangers: les fonctionnaires internationaux – les Européens – ainsi que tout autre ressortissant étranger qui séjourne de manière légale. Par ailleurs, il existe la Loi fédérale sur l'asile du 26 Juin 1998 et, concernant les procédures de naturalisation, depuis 1952 la Loi fédérale sur l'acquisition et la perte de la nationalité Suisse. Les discussions actuelles à Berne touchent justement à la modification de cette dernière loi citée.

Pour ce qui est de la question du permis de séjour Ci, on doit bien distinguer celui-ci du permis C, car ce dernier concerne tout étranger non-diplomatique qui s'installe de manière régulière en Suisse – en tant que détenteur d'un permis B par exemple, alors que le permis Ci concerne uniquement les

Suite de l'article en p.47

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TEXTE & PHOTOS CLAUDE MAILLARD

Ce sport, c'est le trail, course pédestre nature effectuée sur des sentiers et chemins, courue en autonomie et autosuffisance sur des distances généralement longues. Son origine viendrait de la course «The Western States Trail Ride» qui traverse les Etats de l'Ouest américain, longue de 100 miles et qui doit se réaliser en moins de vingt-quatre heures, normalement à cheval! En 1974, Gordy Ainsleigh, un cavalier dont le cheval est blessé, relève le défi de parcourir le tracé à pied en moins d'une journée. Il mettra vingt-trois heures et quarant-sept minutes. La «Western States Endurance Run», course à pied de 161 km avec un dénivelé de 6000 mètres, venait de naître et une nouvelle discipline voyait le jour: le trail.

Suivant la longueur de l'épreuve, on distingue plusieurs catégories de trail. D'une distance inférieure à 21 km, il prend le nom de «Course nature». De 21 à 42 km, c'est le «Trail découverte» aussi appelé «Marathon

trail». Viennent ensuite le «Trail» (parcours supérieur à 42 km, allant jusqu'à 80 km et avec un dénivelé minimum de 2000 m) et enfin l'«Ultra-trail», le top des tops, avec des distances au-delà de 80 km et des dénivelés pouvant atteindre les 10 000 m.

Les cinq vies de Dachhiri Dawa Sherpa

Dawa, comme tout le monde l'appelle, est Népalais. L'homme, à l'éternel sourire, est très attachant. Il est gentil, calme, serein et il en émane un certain bonheur que l'on a instantanément envie de partager. Il est discret mais fort, courageux et infatigable. Derrière le courant d'énergie qu'il incarne se cache un champion, un très grand champion mondial de trail.

Né il y a 44 ans dans les montagnes de l'Everest, dans un petit village perché à 2700 mètres d'altitude, Dawa entre dans un monastère à l'âge de 6 ans. Il y apprend le bouddhisme, les arts martiaux et la méditation.



Dawa Sherpa lors de la reconnaissance de sa nouvelle course qu'il va organiser en 2014 au Ladakh et Zaskar.

Mais, quelques années plus tard, il doit regagner Chulemo Taksindu Solukhumbu pour s'occuper de ses huit frères et sœurs suite au décès de son père. Son rêve de devenir médecin s'envole. Pour gagner sa vie, il trouve du travail comme cuisinier dans une agence qui organise des trekkings dans la région. Bosseur, et, avec l'aide de quelques touristes, il apprend vite l'anglais et obtient ensuite son diplôme de guide. En 1994, il prend le départ du Super Marathon de l'Himalaya, sa première course dont il ne verra jamais l'arrivée, victime du mal des montagnes. Déçu mais pas découragé pour autant, il s'engage à nouveau dans l'épreuve l'année suivante où il tombe amoureux d'Annie, une touriste venue découvrir son pays. Consciente des capacités de Dawa, elle se débrouille pour le faire venir en Suisse afin qu'il puisse participer à des courses et s'entraîner avec d'autres coureurs, ce qui n'était pas possible au Népal. En 1998, Annie deviendra sa femme. Dawa trouve du travail à Genève chez Induni, l'une des plus importantes entreprises suisses de construction. Robert Galay et Christian Danz, les deux directeurs d'Induni, séduits par les prouesses de leur collaborateur, décident de l'aider. Et depuis tout ce temps, Dawa (Team Quechua) troque tous les week-ends son bleu de travail contre sa tenue de



Dawa Sherpa à l'entraînement dans les Alpes.



Joëlle Ettinger, présidente de TrailLéman.

trail. Il participe à de nombreuses courses et devient rapidement l'un des meilleurs coureurs du monde en remportant les épreuves les plus difficiles. Son palmarès est édifiant avec plus de cent victoires. Il monte sur la première marche du podium à l'Annapurna Mandala Trail, remporte le Grand Trail du Mercantour, décroche la victoire à la 6000 D, s'adjuge l'Ultra Trail du Mont-Blanc, finit en vainqueur la Trace des Ducs de Savoie. L'Himal Race, le Marathon des Glaciers, la Vulcano Sicile, les Templiers, le Ladakh Trail, le Grand Raid Nouvelle-Calédonie, le Grand Raid des Pyrénées, l'Ultra Trail Atlas Toubkal l'ont également vu gagner. Dawa s'est illustré dans le monde entier.

En dehors d'être un des meilleurs traileurs du monde, Dawa est aussi un grand fondeur. En 2002, le Comité olympique népalais lui propose de s'initier au ski de fond parce qu'il vit en Suisse, les pistes de ski n'existant pas dans son pays natal. Formation terminée, il participe aux Jeux Olympiques de Turin, à ceux de Vancouver, prend part à deux reprises aux Jeux Asiatiques et au Championnat du Monde de ski nordique.

Courir avec Dawa...

Depuis 2008 Dawa se propose de faire découvrir sa passion au travers de courses qu'il organise au Népal et sur l'île de Java en Indonésie. A ses côtés, que vous soyez coureurs ou marcheurs, préparez-vous à vivre des moments inoubliables! Le deu-

xième Trail des 3 Vallées reliant Katmandu à Khudi, élaboré par son association «Courir au Népal», est long de 353 km avec des dénivelés positif et négatif de près de 19 000 m. L'autre course organisée au Népal, le Solukhumbu Trail (1^{er} au 25 novembre prochain) vous emmènera sur les terres natales de Dawa, empruntant la route historique du camp de base de l'Everest. Un peu plus courte, elle s'élance de Jiri et prend fin à Lukla, après avoir traversé le parc de Sagarmatha. C'est à l'est de Java que Dawa organise «Les Volcans de l'Extrême» dont c'était la troisième édition cette année. Disputée en dix étapes, longue de 230 km, l'épreuve a pour cadre les fameux volcans Bromo, Semeru et Kawah Ijen, avant de se terminer en beauté sur les plages de Bali. Enfin, une nouvelle épreuve va voir le jour au Ladakh l'an prochain.

Mais «Courir au Népal» n'a pas pour seul but d'organiser des courses à pied. L'ensemble des bénéfices dégagés est intégralement investi dans la réalisation de projets humanitaires. C'est ainsi qu'a été construite l'école monastique de Mera et que le dispensaire de Taksindu a pu rouvrir. Pour cela, Dawa est aidé par l'Iffremmont, Institut de formation et de recherche en médecine de montagne, dont le siège est à Chamonix. L'accès à l'eau potable et la scolarisation des enfants font également partie des priorités de l'association (dachhiridawasherpa@gmail.com – Tél: +41 79 59 63 180).

Les moins sportifs peuvent également participer aux projets en se procurant le livre et le film «Les cinq vies de Dachhiri Dawa Sherpa» et le DVD du Trail des 3 vallées.

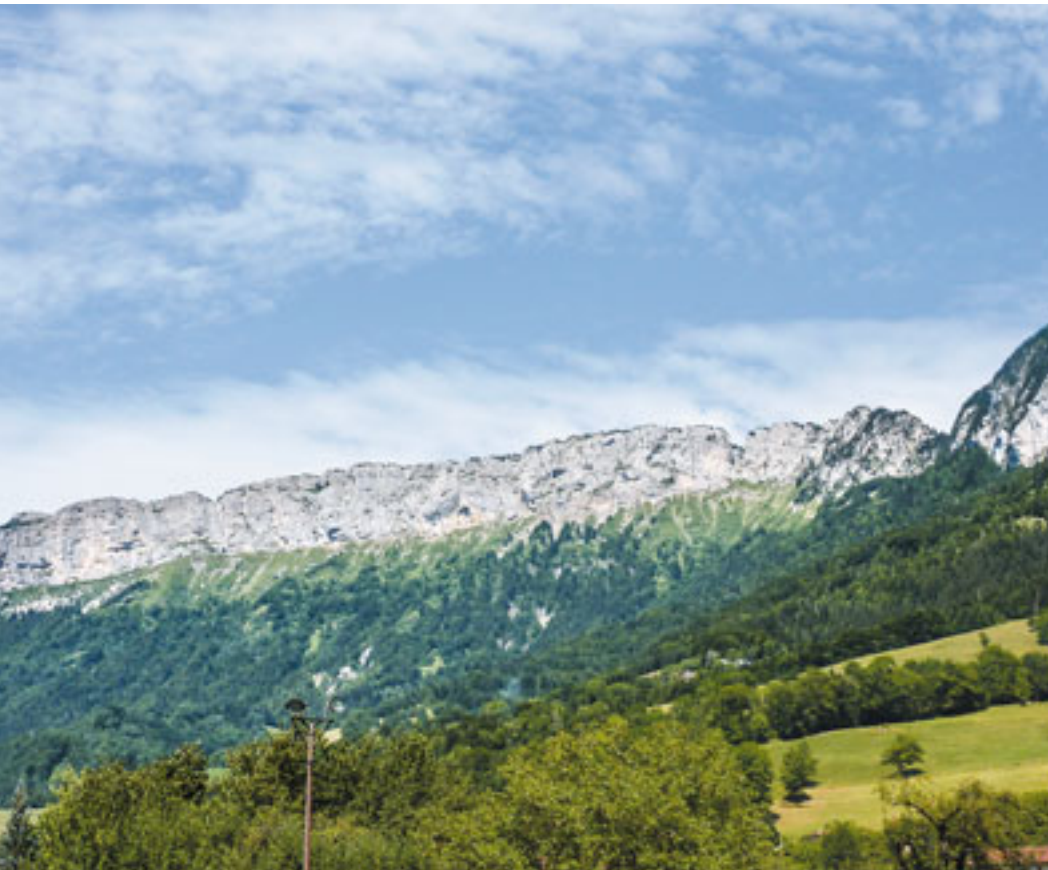
TrailLéman

Troisième à l'Ironman du Brésil 2005 (enchaînement de 3,8 km de natation, 180 km de vélo et 42,2 km de course à pied), Joëlle Ettinger est la présidente de TrailLéman, club qui a comme objectif premier de réunir les traileurs de la région genevoise et lémanique. Joëlle, qui a décroché plusieurs succès (victoires du Semi de Jussy, au Run-Evasion-Rhône et au km vertical du Môle, deuxième au trail du Salève et au Crozet raid, troisième au Transju'trail) est également vice-championne suisse longue distance et championne suisse par équipe en triathlon. Après dix-sept années de courses sur bitume, elle a senti le besoin de changer de terrain de jeu. L'envie d'affronter de nouveaux défis l'a tout naturellement poussée vers les courses de montagne et le trail est alors devenu une réelle passion pour elle. Ne trouvant pas de club de trail dans la région genevoise, elle décida alors de créer TrailLéman (trail.leman@gmail.com – www.trailleman.com) en 2011 en compagnie de deux autres passionnés, Corinne Gaillard et Christian Piffard.

Quant au parrain du club, il était tout désigné: ce sera Dawa Sherpa! ■

POURQUOI NE PAS LE FAIRE ?

LE PARMELAN PAR LE COL DU PERTUIS



Je vous propose des petites balades à des degrés de difficulté différents, pour vous changer les idées, vous oxygéner et vous déstresser. N'oubliez pas: ne rien faire nuit à votre santé.

Je vous souhaite des journées de marche et de détente agréables et ensoleillées.

TEXTE ET PHOTOS ANDRÉ ROTACH

Prendre l'autoroute A41 direction Annecy et la sortie 17, Annecy-le-Vieux. Suivre Thônes par la D916, la D16 et la D216 puis Dingy-Saint-Clair et la Blonnière. Monter jusqu'au bout de la route et stationner au parking du Saugy (1040 mètres) point de départ. Prendre la direction Col du Pertuis par un sentier assez étroit au départ, large ensuite et assez raide. Après vingt minutes, prendre le petit sentier sur la gauche. Arrivée au col du Pertuis (1565 mètres) en une heure quinze. Continuer en direction du Parmelan. Arrivée au sommet (1825 mètres) en trois

heures de montée presque ininterrompue. Depuis le refuge, vision lunaire d'une roche très particulière et vue à 360° du Mont Blanc au Jura.

Pour le retour, prendre la direction du petit Montoir (un peu plus long mais préférable pour les genoux) puis de la Blonnière en passant par le col de Barman (1127 mètres). Retour au parking du Saugy en 2 heures soit au total le tour en cinq heures pour, au GPS, un dénivelé total de 904 mètres et 12,7 km de distance.

Pour plus de détails: voir le Guide Franck n° 4 Aravis/Bornes

Indispensables: deux cartes IGN pour la France 3430 OT Mont Salève et 3431 OT Annecy.

Ne pas oublier de vous équiper de bonnes chaussures de marche et de vêtements adaptés à l'altitude et à la saison.

BON CRAPAHUTAGE
ET (S)PORTEZ-VOUS BIEN. ■

WHY NOT DO IT?

LE PARMELAN PAR LE COL DU PERTUIS



I offer small hikes of varying degrees of difficulty, to clear your mind, get some fresh air and relax a bit. Remember: doing nothing is detrimental to your health. I hope you have fun hiking in pleasant and sunny weather.

TEXT AND PHOTOS BY ANDRÉ ROTACH
Translation by Ryan Kennedy

Take the motorway A41 toward Annecy and take exit 17 to Annecy-le-Vieux. Follow Thônes by the D916, D16 and D216 then Dingy-Saint-Clair and Blonnière. Go up to the end of the road and park in the parking "Saugy" (1,040 meters) and you are at the starting point. Take the direction of Col du Pertuis, a wide, fairly steep and narrow trail

initially. After twenty minutes, take the foot-path on the left. Arrive at Col du Pertuis (1,565 meters) in one hour fifteen minutes. Continue towards the Parmelan, arriving at the summit (1,825 meters) in three hours of almost uninterrupted climb. From the refuge, lunar vision of a very particular rock with excellent 360 degree views of Mont Blanc and the Jura.

To return, take the direction of the Petit Montoir (a little longer but better for the

knees) and the Blonnière going through Barman pass (1,127 meters). Return back to the parking lot in Saugy in two hours totaling around five hours and, by GPS, a vertical total of 904 meters and a distance of 12.7 km.

For more details see: Guide Franck No. 4 Aravis/Bornes

Indispensable: both IGN maps for France 3430 Mont Sâlevé OT and OT 3431 Annecy.

Do not forget to wear good walking shoes and clothing suitable for the altitude and season.

HAPPY EXPLORING!
AND KEEP WELL. ■

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SERGIO DA SILVA

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Nous aimerions vous inviter à soumettre vos photos sur l'eau pour notre concours 2013. ■

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LA NOUVELLE LOI SUR LA NATIONALITÉ SUISSE ET LE STATUT DES FONCTIONNAIRES INTERNATIONAUX

Suite de l'article en p.41



membres de la famille des fonctionnaires internationaux et diplomates. Le permis Ci est délivré notamment pour permettre aux détenteurs de pouvoir travailler

sur le marché suisse du travail. Une des raisons primordiales de l'existence du permis Ci remonte à l'époque où l'Organisation mondiale du Commerce était sur le point d'être fondée. L'Allemagne désireuse de voir le siège de cette organisation implanté à Bonn a fait figure de concurrence à la Suisse. L'Allemagne a notamment offert des propositions alléchantes aux diplomates telles que la possibilité automatique de leurs familles d'obtenir un droit de travail,

ce qui en temps normal est difficile d'accès aux étrangers dans ce pays. La Suisse donc a répondu avec une offre similaire qui s'est traduite par l'octroi du permis Ci de manière automatique. Les discussions actuelles sur la loi suisse de naturalisation ne vont en aucune manière remettre en question ce permis. On doit également souligner le fait qu'il est tout à fait dans l'intérêt suisse de défendre la «Genève internationale».

Pour ce qui est des modifications concernant la loi sur la nationalité, le principal enjeu touche à l'ajustement du calcul du nombre d'années nécessaires à la naturalisation. La nouvelle proposition exigerait huit ans pour les adultes au lieu de douze actuellement. De même, en ce qui concerne les enfants entre 10 et 20 ans, chaque année comptant double; un enfant peut être natu-



ralisé en quatre ans. D'autre part, lorsque des adultes déposent une demande de naturalisation, ils peuvent également inclure la demande en faveur de leur enfant. On doit toutefois insister sur le fait qu'il est très important que les demandeurs puissent être en mesure de démontrer une intégration réussie, ainsi que la maîtrise de la langue locale d'où ils effectuent la demande. ■

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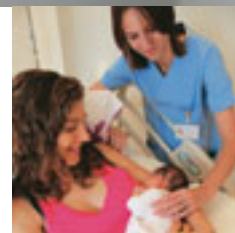
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