NEWSLETTER

THE ASSOCIATION OF FORMER PAHO/WHO STAFF MEMBERS

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AFSMs with Dr Tedros at the World Health Assembly

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Editorial

A Man of His Word

By Hernan Rosenberg

We already reported on the excellent meetings that took place between WHO's Director General and the Global Council of AFSMs, where Dr. Thedros demonstrated his support for former staff by proposing a series of measures to facilitate our work, exceeding our own expectations. To our surprise, two weeks after the meeting each AFSM received an invitation from WHO to participate in the celebrations of the 75th anniversary of that Organization. Just as he promised. Our President and I attended the meeting on behalf of AFSM PAHO. In another article in this newsletter we present some a description of the activities and colleagues from other regions that we were able to meet in a few very busy days. Here I just mention that we visited the school where our President spent a year - several years ago, that resulted in an exhilarating walk of 25,000 steps (my record).

One of the most interesting proposals made by Dr. Tedros is to institutionalize the relationship between AFSM and WHO. Since it is a subject that we have raised several times, I would like to reflect upon it.

AFSM is a private association of former employees, with no formal relationship with WHO (or PAHO). This contrasts, for example, with the situation of the Staff Association, which has a formal and even constitutional relationship with the institution. That is why the Staff Association has an office, computer services and other benefits, in addition to various associated functions, such as appointing a representative to selection committees.

AFSM does not have any comparable formal link. Of course we have excellent relations with the PAHO Administration and with the PWRs in many countries, with activities ranging from social ones to those of monitoring procedures associated with retirement by the PWR. But these relationships are based on

the kindness and good will of the Regional Director or the PWR. In other words, there is no formal link, apart from the recognition that former staff are part of the family, and that "once PAHO, always PAHO." Even in the few situations where former staff have a formal role (such as on some health insurance committees), these positions are filled by direct vote at the global level, not through AFSMs.

Some International Financial Institutions such as the IMF already incorporate their AFSMs into their formal work, but this is not the case UN system in general. Seen in this light, the DG's offer is revolutionary, and it would put WHO at the forefront of many UN agencies.

The benefits of such an offer will be felt mainly in the countries. In effect, the care of AFSM former staff members will become a defined activity within the functions of the PWR office instead of depending on the good will and availability of a staff person. For their part, PAHO staff will be able to use the services provided to former employees as part of their performance report, rather than as a distraction from their regular activities. In other words, it is a win-win situation.

But with benefits always come obligations. The most important for AFSM members is to respond promptly and well to collaboration needs, facilitating contacts in the countries through our Focal Points, responding to technical queries on healthy ageing, participating in pre-retirement activities for active staff members, on committees and many other things that will arise in the future. All of these require the active participation of our members. This will be an opportunity that may not occur again, due to our having a DG so active and favorable to improving the conditions of former employees. Greater incorporation of members in the work of AFSM is the only way to keep pace with creating a better future, where the “WHO family” becomes a reality.

The DG. has kept his Word; let's not let him down.

AFSMs attendance at the 76th World Health Assembly
20-24 May 2023[1]

By M.R. Kanaga Rajan, President, AFSM/SEARO, New Delhi

1) Background: AFSMs established the Global Council to discuss matters of mutual interests, share information and coordinate joint actions. The presence of the Director-General, WHO, Dr Tedros Adhanom Ghebreyesus in our 28 March 2023 Global Council Meeting and his full participation in the deliberations were supportive and encouraging. The DG has set exemplary standards in translating his thoughts and assurances into actions and I am happy to share with you that our efforts to enhance the profile of AFSMs have started bearing fruits. This includes his invitation to AFSM Presidents plus one more to attend the 76th World Health Assembly in Geneva.

2) Walk-the-Talk on 21 May 2023: A special Walk-the-Talk event was organized by WHO on the occasion of 75th Anniversary. The event began at 7.30 AM. with attendance of about 3-4000 people braving the inclement weather and rain. There was a gala carnival atmosphere with live band and folk music. Stalls were put up by WHO, other UN and international organizations, and partners promoting health, and distributing health-promoting messages, souvenirs, and WHO slogans. The Walk covered a distance of 4.2 km. The event showcased WHO's pre-eminent position as the global health leader. AFSM leaders had a brief opportunity to greet the DG, walk with him, and exchange a few words of gratitude and appreciation.

3) High-level inauguration and Opening of the 76th World Health Assembly, 22 May 2023: The WHA was held at the new Main Plenary Hall at the Palais de Nations. In attendance were Ministers of Health and Ambassadors from across the globe, UN Heads of Agencies, accredited International Organizations and Partners in Health. AFSM was seated inside the main plenary hall as special guests of the DG. After the speeches by the outgoing and incoming Presidents of the World Health Assembly, the inaugural address was delivered by the President of the Swiss Confederation.

The WHO Director-General, Dr Tedros, addressed the Assembly tracing the 75-year history of WHO, acknowledging the contributions of Member States and the contributions of each previous DG starting with Dr Chisolm to Dr Margaret Chan. During his speech, the DG presented awards for lifetime achievement and global leaders including Prof J-J Muyembe of DRC and Professor Peter Piot of Belgium.

In the evening, AFSMs were invited to attend the reception hosted by the President of the Swiss Confederation during which we had opportunity to interact with Dr. Tedros and a former DG, Dr Gro Harlem Brundtland.

[1] This is a reduced version of the complete longer report.

4) Sideline meetings: In addition to attending the WHA plenary sessions, we had sideline meetings with UNJSPF, UNFCU, AFICS (Association of Former International Civil Servants), WHO personnel programming activities for the Decade of Healthy Ageing, and the Director of HR/HQ, designated by the DG as the liaison for AFSM.

5) Meeting with the Director-General, WHO: Dr Tedros invited and received AFSMs with warmth in his office at the Palais de Nations. Dr Tedros sat amongst us and reiterated his commitment to institutionalize AFSMs as entities in WHO. He was spontaneous and gracious and mentioned he is honored to have us in attendance and pleased to acknowledge and thank us for our work and experience as former staff. He repeated his slogan **Once-WHO-Always-WHO**. He took us to the room where he receives ministers of health and dignitaries and took official photographs with us. He graciously gave us gifts and memorabilia. Throughout the meeting, we were hosted with sumptuous snacks, fruits, juices, tea, and coffee.

6) AFSM Global Council Meeting: Topics discussed and deliberated included recognition and institutionalization of AFSMs, agenda for the next Global Council meeting, status and exchange of views on newsletters and communications, bon-homie and the need for continuous engagement with each other and with WHO/HQ.

As former WHO staff members, we are second to none to fly the WHO flag high and contribute to WHO and its causes.

Welcome to New Members of AFSM

From Bolivia, Joaquin Cuellar Salcedo
From Colombia, Henry Hernandez Venecia
From Costa Rica, Carlos Eugenio Rosales
From Costa Rica, Enrique Perez Gutierrez
From Ecuador, Miguel Malo Serrano
From Trinidad & Tobago, Karen Sealey
From Washington DC, Godfrey Carmel Xuereb

Health Insurance and Pension Update

By Carol Collado and Rolando Chacon

Health Insurance

Since our last newsletter column, WHO has effectively lifted the global emergency status of Covid 19. This, of course, is of great relief to everyone since the three-year-long battle with this disease has left the world spinning with its effects on all aspects of life. Those effects - health, social, and economic - and the resulting population- and individual-based changes have their own consequences, and many things will never return to pre-pandemic norms. Even though the most severe consequences are mitigated through our increased knowledge and the development of vaccines and treatments, there are still reasons to maintain caution. One remaining concern is that of Long Covid, irrespective of the strength of the initial infection. Several European studies have correlated neuroinflammatory incidences with Long Covid. It is good to be aware of this should you or someone close to you who has had Covid begins to show signs of "brain fog" memory problems. In this case, he/she should seek medical attention as there are treatments that can lessen these effects. In most countries, precautionary measures such as social distancing and mask wearing have become rare. The issue of whether to use these types of preventive measures is individual and should be based upon risk-based assessments of the prevalence in your community, your personal risks such as chronic health problems or immunity problems, and the types of activity involved. It is still recommended that masks be used in places such as health care facilities like doctors' offices or hospitals. A final word on prevention regarding Covid for now: The Vaccines and Related Biological Products Advisory Committee that advises the United States Food and Drug Administration (the regulatory body for vaccines in the US) recommends that all susceptible populations, including the ageing populations, receive the 100% Omicron booster, not the previous vaccines with single or bivalent bases.

WHO has also ended the global emergency on Monkey Pox (described in a previous AFSM newsletter). One threat to our health that is on the watch list is a revival of the spread of Asian/"Bird" Flu. Initially seen in North America, it has now been identified in both Central and South America. In 2022 it caused the destruction or death of more than 131 million domestic poultry, with the accompanying economic implications of cost increases in all poultry-related products, and the impact on available food products that in turn affected nutritional status. One additional concern is that it has been found in domestic animals such as cats and dogs, with the potential to then pass it on to their humans. It is being monitored and WHO expects to have an updated risk analysis in September.

Another incipient threat is that of the changes in climate and its resulting environmental changes. One of the first to appear was that of increasing temperatures, making the

environments more propitious for vector-borne diseases such as Malaria, Zika, and Dengue. Malaria and Dengue have been identified further south in the Americas and in peri-urban areas. Increasing temperatures are also threatening many older populations that do not have access to cooling environments. Recent heat waves in the Northern Hemisphere have resulted in record-breaking losses of life in the ageing population. If you are in these areas, please be careful, stay hydrated, and avoid being outside for long periods when the sun is high.

The role of diet and exercise in both health and ageing is well recognized. Continuing research confirms that consumption of a healthy diet, including fish, greens, berries, nuts, and controlled quantities of fats and carbohydrates, contributes to good health and longevity. WHO has updated the guidelines for total fat, saturated and trans-fats, and quality carbohydrates[1]; and for the first time it has defined recommendations for different ages of children and adolescence in order to reduce the risk of unhealthy weight gain and diet-related noncommunicable diseases such as type 2 diabetes, cardiovascular disease, and certain types of cancer.

In terms of exercise, it is now known that ANY exercise is better than none. This can be as simple as stretching exercises for those not able to walk or perform other more energetic activities. Remember: you are responsible for doing what you can to be healthy!!

Some interesting news and resources:

WHO has initiated a WhatsApp channel in Colombia, with more expected soon. Under Status or Updates, it provides access to valuable current information.

A multi-UN agency effort to prevent and respond to violence against women and girls has created a new website RESPECT https://respect-prevent-vaw.org/.

Our own AFSM website https://afsmpaho.com has added several health-related documents. On the home page you can find a banner that will lead you to a three-page document on "important actions in case of death". It synthesizes and gives directions on what to do for health, pension, life insurance, and credit union matters. We recommend that you print it and keep it with your important papers so that it is handy in case of death. Under Resources, you will also find new documents that identify the work AFSM is doing with the PWR Offices to stimulate the inclusion of retirees as part of the WHO/PAHO family and the PWR responsibilities. There is also a document on "Recommendations of AFSM" that specifies the things that should be kept updated so as not to miss out on any of the benefits to which we are entitled.

In keeping with the WHO definition of health becoming a reality, a North American insurance company, Elevance Health, published in the New England Journal of Medicine a "Whole Health Index" that incorporates both patient-level and population-level data

1https://www.who.int/news/item/17-07-2023-who-updates-guidelines-on-fats-and-carbohydrates

representative of social, physical, and behavioral health factors. It is seen as useful in guiding actions at both individual- and population-level health.
https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0015.

Stay safe, be healthy, and enjoy being retired!

Pension

The UNJSPF has announced that it would begin to send the Certificates of Entitlement (CE) by mail starting 30 June 2023. Forms are to be sent to all those who have not already used the digital option (DCE) for this year. If you have already registered with the DCE but have not yet utilized it in 2023, you have a choice to either use the paper form sent to you or the DCE, but if you have already used the DCE this year, you do not need to send in anything further. Before making the decision, please go to your Member Self Service (MSS) to check that your DCE has been registered for 2023.

There are several ways to demonstrate that you are still alive, by:

- signing and returning by mail the paper CE or scanning and uploading it through the MSS
- downloading a copy of the CE from your MSS, printing it, signing it, and uploading it within the MSS
- registering for the DCE and completing the instructions on your smart phone

Anyone needing assistance with this process can contact us through our email: afsmpaho@gmail.com

The UNJSPF has signed a contract to move the majority of its Information and Communication Technology (ICT) to the cloud. This process was started in March 2023 and will be implemented in phases through 2024. Cost savings and flexibility are several of the expected advantages. Further information can be found at https://www.unjspf.org/newsroom/migrating-the-unjspf-it-systems-to-the-cloud-what-you-need-to-know/.

Save the dates!
Luncheon in person on 5 October
Virtual General Meeting on 6 December

It has been too many years since we enjoyed our last wonderful, delicious luncheon together, with guest speakers, and time to enjoy and cherish our friendships across the years and continents.

With thanks to Hortensia Saginor, our AFSM Membership Officer, we are planning a luncheon on Thursday, 5 October at 12 noon. We are sending this announcement to all our members inviting those of you who may be planning to visit the greater Washington, DC area to consider the possibility of joining us on 5 October. The site will be announced in due time.

Our guest speakers will be:

- **Martha Pelaez, former PAHO's Regional Advisor on Ageing and current Chair of the PAHO AFSM Committee on Healthy Ageing. She is also a Member of the Board of Directors of the US National Council on Aging. We are pleased that she has agreed to make a presentation on The UN Decade of Healthy Ageing. This world-wide collaboration among many societies is intent on improving the lives of older people, their families, and their communities. We, the former Staff Members of the Pan American Health Organization, can be both beneficiaries of and advocates for this exciting endeavor.**

- **Hernan Rosenberg, formerly PAHO's External Relations and Resource Mobilization Officer, who subsequently became Head of PAHO's Planning and Program Support Unit. Hernan is playing a key role as a member of the Global Council of AFSMs, representing AFSM PAHO, in our conversations with WHO's Director General, Dr. Tedros Adhanom Ghebreyesus. Hernan is Vice President of PAHO AFSM and a founding member of the US-based Development Outcomes Organization. His presentation will focus on both the challenges and key strategies under consideration by AFSM and Dr. Tedros for the formalization of the participation of AFSM in WHO's activities.**

Please also note that AFSM's Annual General Meeting will continue to be virtual and will be held on Wednesday, 6 December, at 10:30 AM, Washington, DC time. Please save the date and join us.

Keeping our Muscle Mass as we Age

By María Teresa Cerqueira

Losing muscle mass is a natural process of ageing. It starts early, when we are in our 30s. If we do nothing, it is likely that we will have signs of sarcopenia (an age-related, involuntary loss of skeletal muscle mass and strength) by our 80th birthday. Sarcopenia affects how we function, and it is a major risk factor for falls. Less muscle mass means greater weakness and less mobility, both of which may increase our risk of falls and fractures. People with sarcopenia are at more than double the risk of having a fracture from a fall, such as a broken hip, collarbone, leg, arm, wrist, or knee. But because we lose muscle mass does not mean it is gone forever. The good news is that we can do something to postpone the damage of sarcopenia and even reverse it; it does not cost money and we don't need a prescription.

Maintaining our muscle mass as we age is essential for prolonging an active and healthy life. It is important for mobility and strength in our daily activities. Loss of muscle mass is rarely discussed, and many people accept its signs (such as loss of energy and strength) as a natural and even normal part of ageing. But losing muscle mass as we age is not a given. Our muscle mass decreases as we age at about 3-8% per decade by age 30, and the rate of loss can be even higher after the age of 60. This involuntary loss of muscle mass, strength, and function is a fundamental cause that contributes to much of the disability in older people. As the saying goes "use it or lose it".

Lack of physical activity and movement causes atrophy (the progressive degeneration or shrinkage of muscle or nerve tissue). People often feel tired due to a sedentary lifestyle. Many of us are "couch potatoes"! Watching TV contributes to sitting down and not moving. In addition, the many food advertisements induce us to eat many empty calory snacks. Overweight and obesity also contribute to less physical activity.

While there is no stopping time, there are many ways to help it slow down. It is possible for many older adults to increase muscle strength with exercise. It may indeed take work, dedication, and tenacity to work on an exercise plan, but it is never too late to maintain and even rebuild our muscle mass.

"Disuse atrophy" can be prevented and treated with regular exercise and better nutrition. If necessary, healthcare providers can recommend physical therapy or an exercise plan. Even if we can't actively move certain joints in our body, we can still do exercises wearing a splint or brace.

Maintaining leg strength and balance are the two keys to preventing falls. Specifically, activities like walking up steps and doing squats help leg strength, and balancing can be improved in different ways, including simply standing on one leg! Do activities to maintain leg strength, such as squats or walking up stairs. Try standing on one let for about 10 seconds, make sure to do this safely, next to a table for balance.

To gain more muscle mass, we need a structured and detailed exercise plan. It should be tailored to the individual with the goal of progression and improvement. It should focus on individual elements like specific exercises, load repetitions, and rest periods, and it should challenge but not be overwhelming.

Check with the health care provider before embarking on any kind of strength-training routine. Then enlist a well-qualified personal trainer to help set up a detailed sequence and supervise your initial workouts to ensure they are performed safely and in the best manner. As we progress, you can often perform them on our own. A typical exercise plan might include:

- 8 – 10 exercises that target all the major muscle groups
- 12-15 repetitions
- 2-3 times a week

Examples of strength training:

- Chest: bench press, chest press, push-ups.
- Shoulders: overhead press, lateral raise, front raise.
- Biceps: biceps curls, hammer curls, concentration curls.
- Triceps: triceps extensions, dips, kickbacks.
- Back: one-arm row, back extensions, pulldowns.
- Legs: squats (squatting is one of the best resistance workouts you can do), lunges (a great way to enhance strength and stability in the legs by balancing all the body weight on one leg for a short period of time), leg extensions, and resistance bands

After we have established a routine, there are several ways to progress. The easiest is to add a second and then a third set of the exercises. Another way is to decrease the number of reps per set and increase the weight or resistance to the point where we are able to complete at least eight reps, but no more than 12. As we improve, we can increase weight by trial and error, so we stay within the range of eight to 12 repetitions. It is very important to stay hydrated.

In summary, walking alone will not strengthen, maintain, or reverse upper body muscle mass so important for maintaining function. As we age, we need endurance, balance, and strengthening exercises to ensure that our heart and muscles function. And both cardio and strengthening exercises have been proven to be a great way to avoid memory loss!

Our diet is critical, and the protein in the foods we eat play a major role in building muscle mass. The body breaks down protein in our diets into amino acids, which are the building blocks that build and make up our muscle mass. Experts in the field of protein and aging recommend a protein intake between 1.2 and 2.0 g/kg/day or higher for elderly adults doing resistance training. For example, a 140 - pound woman would need about 90 g a day, a 175-pound man would need about 79 g to 103 g a day. If possible, divide the protein equally among daily meals to maximize muscle protein synthesis. This is a high amount compared with the average diet, but there are many ways to get the extra protein needed. Both animal and vegetable sources are good. Fish, lean meats, eggs, milk are good, as well as beans, nuts and soybean products such as edamame. All of them have excellent sources of the proper ratios of all the essential amino acids. However, it is important to stay away from red and processed meat due to their high levels of saturated fat and additives. Instead, opt for healthier choices, such as:

- 3.5 ounces of lean chicken or salmon (31g and 24 g)
- 6 ounces of plain Greek yogurt (17g)
- 1 cup skim milk (9 g)
- 1 cup cooked beans (18 g)

Protein powders can be added to all recipes or dishes, such as soups, shakes, cereals, yogurt, oatmeal, and many other dishes. Although food sources are much better, when consuming enough protein or calories is a struggle, dietary supplements can be helpful.

In summary, for older people exercise and good nutrition are key to healthy ageing! Recommendations include:

1. Eat adequate amounts of protein. The body breaks down protein-rich foods into amino acids, which it uses to build muscle.
2. Do resistance training daily. A consistent strength training routine builds muscle mass.
3. Increase the intake of Omega-3s rich foods or supplements.
4. Make sure the healthcare provider checks your vitamin D levels.
5. Move, walk, dance, swim, or play some sport. Be more active in the day than inactive.

In conclusion: Keep moving. To maintain muscle and strength engage in regular exercise, including resistance training. Join a group that regularly walks or does yoga. Remember protein: eat good sources of protein from fish, nuts, low fat milk, yogurt, cheese, lean meats, eggs, and beans. Aim for 20-25 grams of protein at every meal.

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Protein Intake and Muscle Function in Older Adults
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Balance and leg strength rational
https://bigthink.com/health/balance-predicts-death-older-adults/

Muscle Changes in Aging
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3874224/

Protein Consumption and the Elderly: What is the Optimal Level of Intake?
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4924200/

In Memoriam

DEATHS INFORMED IN 2023
AND NOT PREVIOUSLY REPORTED

In 2022	In 2023
Ma. Therese McDermit – May 19	Rene Gonzalez – May 5, 2023
Rafael Cedillo – May	Nancy Louise Hurst – (? June 2023)
Teresa Sherman – August 20	Julieta Rodriguez – July 5, 2023
Robert Tonn – September 19	Miguel Segovia, – July 23, 2023
Virgilio Escutia – September 21	
Hernando Cardenas – November 22	
Jairo Niño – (? December 2022)	

Progress in the Growth of AFSM in Bolivia

By Hugo Prado Monje

On 4 November 2022, a meeting was held with Dr. Alfonso Tenorio, interim PAHO/WHO Representative in Bolivia, in the absence of the Representative, Dr. Alma Morales. Mr. Gilberto Barros, the Representation Administrator, also participated. Former staff members Horacio Toro Ocampo and Hugo Prado Monje proposed said meeting with the purpose of seeking ways to improve and systematize relations and collaboration between the Country Office, former PAHO staff in Bolivia, and the Association of Former PAHO/WHO Staff Members (AFSM).

After a productive exchange of ideas, it was concluded that the Representation was in the best position to collaborate with the former staff on their most important issues, such as health insurance, the United Nations Pension Fund, agreements with health institutions for their care, the promotion of social interactions among former staff, and their inclusion in the activities promoted by the Representation in social activities and matters of technical and scientific development.

Subsequently, Horacio Toro Ocampo was appointed Focal Point of the AFSM for Bolivia, and since then, with the collaboration of other members of the Association, including José Luis Zeballos who lives in La Paz, he has maintained contact with the Representation. Thus, thanks to the willingness of the Representative and other office staff, a permanent and fluid exchange of information and collaboration with the Focal Point and the AFSM in Washington has been maintained.

The agreements that have been reached so far are the following:

1. Appoint a Focal Point of the Representation for contact with former staff. In this case, Lic. Gilberto Barros was designated as Focal Point.

2. Ensure contact with all former staff living in Bolivia to update the database with their names, addresses, and contact information. This database will include the spouses and support persons designated by the former staff. The Representation has entrusted Ms. Carmela González with this issue.

3. Hold sessions via Zoom with former staff, to support them administratively and in real time in filling out health insurance forms, Certificates of Entitlement (CE), and others as necessary.

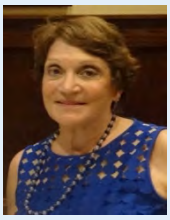
4. Make a special call to all former staff to collaborate with this initiative, providing correct details of themselves, their spouses, designated persons, with addresses, telephone numbers, emails, and others information considered to be important.

5. Currently, AFSM through its Focal Point, is in permanent contact with Dr. Alma Morales PWR/BOL and the Representation's staff, whom we thank for their generous willingness to collaborate with our former staff and their families.

My Journey on the Silk Road – Part 1

The Silk Road Story

By Marilyn Rice



I have always been fascinated by other cultures, traditions, and beliefs, and to experience the Silk Road in person was on my bucket list. I had planned a trip to five of the Stans of Central Asia (Tajikistan, Uzbekistan, Turkmenistan, Kazakhstan, and Kyrgyzstan) in 2020 and due to Covid it was postponed three times. Finally, in April 2023, I was able to take the trip to four of them, but Turkmenistan was still closed due to a ten-day Covid quarantine requirement. So, I would have to miss experiencing the most closed country in the world after North Korea.

I had toyed with writing this article as a chronological description of the countries and sites that I visited, but to better describe overall what has happened in those countries over time, and to avoid duplications, I decided to break my article into installments. The first one for this newsletter will cover the history and story of the Silk Road. Part two, for the September newsletter, will cover more current and retrospective topics like religion, and customs (beliefs and practices – marriage and bride stealing, superstitions, and dress). The third part will show different aspects of architecture, mostly religious buildings. Part four will address Craftsmanship and Artistry. In Part Five I will share with you some of the wonderful music and dance I witnessed. And Part Six will show you the variety of Foods and Markets I experienced.

The Story of the Silk Road

The Silk Road is neither an actual road nor a single route. The term instead refers to a network of routes used by traders for more than 1,500 years, from when the Han dynasty of China opened trade in 130 B.C.E. until 1453 B.C., when the Ottoman Empire closed off trade with the West. In the first century B.C.E, the Silk Road was a major commercial route travelled by merchants, starting in Xian, China and ending in Rome, Italy, running 8,000 km and taking more than a year to complete the journey. One end connected the Eastern Mediterranean to Central Asia and the other went from Central Asia to China. To protect themselves, traders joined together in caravans with camels or other pack animals. Over time, large inns cropped up to house travelling merchants. Few people traveled the entire route, giving rise to a host of middlemen and trading posts along the way. Even though there were many goods transported from east to west along this route, such as porcelain, horses, and paper, silk was the most important and precious item. Silk was in great demand among the Roman aristocracy, and its origins and production techniques in China were kept a secret, spun from the cocoons of mulberry-tree-eating worms. Although relatively few people could afford silk, a lot of people devoted their lives to making it. Around the 10th century,

present day Turkmenistan became the biggest exporter of silk to the European market and the primary language of literature, government, and commerce switched from Persian to Arabic.

Arguably, the most important thing traded along the silk road was ideas. It was the primary route for the spread of Buddhism, making it one of the greatest religions of the world. Many monasteries became waystations for caravans of people to stay along the Silk Road. The same was true later for the establishment of Islam, with its madrassas (religious schools) also serving as waystations for caravans.

The movements of Genghis Khan (1155-1227) and his Mongol followers were instrumental in increasing trade among diverse populations as they pillaged most of the cities, with just a few architectural gems being spared. They executed widespread genocide of the indigenous Indo-Persian people, with their culture and heritage quickly replaced with Mongolian-Turkic ones. They also destroyed the region's cities and irrigation systems. By the 13th century, silk was produced in Europe; but the finest silk is still considered to be produced in Central Asia. Central Asia has been shaped by being at the heart of the east-west trading route and the constant flow of ideas.

Marco Polo (1254 –1324) followed with establishing many learning centers, and when Amir Temur took over, he tried to restore or build new structures as quickly as possible, with the motto "if you want to know how strong I am, look to what I have built and left". He successfully united all of western Central Asia, Iran and Asia Minor. He also planted many gardens and fruit orchards, and these major cities were centers for learning and knowledge, where historical manuscripts were produced, some of which can still be seen. In Tashkent we saw one of the oldest Korans still in existence and in Bukhara we saw one of the oldest existing Jewish torahs.

In 1370 Amir Temur established an empire with Samarkand as its capital and he ruled until 1405 when he died of pneumonia. He spent his life on war campaigns. He controlled 70% of the Silk Road and ensured its safety, thereby supporting and promoting trade over 13,000 km. He left behind newly built enormous structures. One of his grandsons, Ulugbek, built the first astronomy

observatory in Asia, and by taking calculations every day for a year he was able to calculate the length of a solar year; he was off by only 50 seconds. Today astronomy is still very developed in Uzbekistan; there are six craters on the moon named after Ulugbek. After Amir Temur's death, his rulers fought among themselves for power and control leading to the empire's collapse and the rise of sea transport to replace the Silk Road.

The transoceanic main cities of Dushanbe in Tajikistan, and Tashkent, Samarkand, and Bukhara in Uzbekistan, were some of the most prosperous in the world due to the travelers on the Silk Road, and since they were at the heart of the east-west trading route they were the center of a constant flow of ideas, resulting in these cities becoming major centers for learning. The horses introduced to China contributed to the might of the Mongol Empire, while gunpowder from China changed the very nature of war in Europe and beyond. Diseases also traveled along the Silk Road. Some research suggests that the Black Death, which devastated Europe in the late 1340s likely spread from Asia along the Silk Road. Paper was invented in China during the 3rd century B.C., and its

use spread via the Silk Road, arriving first in Samarkand in around 700, before moving to Europe through the then-Islamic ports of Sicily and Spain, fostering significant industrial change, with the written word becoming a key form of mass communication for the first time. The eventual development of Gutenberg's printing press allowed for the mass production of books and, later, newspapers, thus enabling a wider exchange of news and information.

By the 19th century Russians began settling in Central Asia, eventually becoming militarily involved, with all the major Central Asian cities becoming Russian protectorates. By the 1920's the Soviet Union was established, and all these territories succumbed to communism. The Communist Party was the only legal party, and religion of any kind was considered subversive so that mosques and madrassas were closed as places of worship.

The Amu Daria River used to be a major water source running into the Aral Sea. In the desert water is more valuable than gold and historically nomads moved to follow it as its course changed over time, until people learned to harness the water to supply hundreds of thousands of people with water for their daily use. The shores of the Aral Sea began to recede when the USSR first began to divert large amounts of water away from the Amu Daryla and Syr Darya rivers for cotton crop irrigation. Now it is almost dried up, due to the Soviet movement to raise a major crop of water-consuming cotton, and Uzbekistan had no direct access to the open sea. The Soviets tried to do away with the life of the nomads of Central Asia, who had survived just fine by living in their yurts and moving around according to the seasons with their animals. Under Stalin the nomads were forced to move into houses on collective farms, and into towns, and cities and to stay there throughout the year – a psychological shock for them. Even though the Soviets gave them schools and health care, kitchen equipment and tractors, they had to come to terms with space and time in a new way and to farm the land for cotton. Since the former nomads have lived this new way now for a few generations, even with the breakup of the Soviet Union and the independence of the countries, people have stayed in the cities where the newer generations have become accustomed.

The Soviets merged countries and peoples without consideration of their culture and languages. Many Turks and Tajiks live in Afghanistan, in Uzbekistan many speak Tajik as their native language, and Uzbeks comprise a good percentage of the populations of Kyrgyzstan and Tajikistan.

People were more identified with their clans, cultures, and language than to what country they belonged. In 1991, with the breakup of the Soviet Union, the five post-Soviet Central Asian republics were created following lines drawn up in the 1920's under Stalin, with the idea of creating stronger ties to Russia than to each other, thereby giving Moscow more economic and political control. To this day, this relationship is stronger than cooperation among the five countries, and with economic hard times, many men leave their families to go work in Russia and send money back home. About 40% of Tajikistan's revenues come

from remittances from workers abroad, most of them in Russia. Under the USSR, there were no real borders to cross, but today they create physical barriers and hatred among people. There are still many commonalities among the territories in language (most people speak Russian) and religion (Islam). But all the countries are adamant about wanting to keep the Islamic fundamentalists out. I found Uzbekistan with its many important cities (Bishkek, Samarkand, Tashkent) the most developed country and Kyrgyzstan the most rural and least modern with still many nomadic people despite its large geographic territory.

Geographically, Uzbekistan is mainly a desert climate, but for the Fergana Valley surrounded by the mountainous border with Tajikistan and Kyrgyzstan. Tajikistan is mostly mountainous with the highest peaks in the Pamir Mountains (eventually joining the Himalayas in the southeast). Although Kazakhstan is the ninth-largest country in the world, much of it is covered by desert. Kyrgyzstan is very mountainous, dominated by snowcapped peaks, glaciers, and high-altitude lakes.

The people we met shared very mixed feelings about the benefits and difficulties of living under the Soviet regime and those experienced in their lives afterwards. On the negative side, under Stalin, people couldn't travel abroad, cars were only for the privileged, all religions were

suppressed, and any creativity or opposition to the government way of doing things was immediately squelched. On the positive side, life was predictable, access to education and health services was free, job security and maternity leave were guaranteed, and women were treated equally to men in salaries and employment opportunities; no one died of hunger, and everyone had shelter and some pension upon retirement. After the collapse of the Soviet system, things changed drastically and suddenly – there was no transition. People were free to travel abroad, if only they had the resources, but travel to each of the newly independent states became very difficult. Today there is great inequality, poverty, unemployment, homelessness, starvation, crime, substance abuse, and limited access to education and health care services. There is much more corruption in the governments, and value is placed on luxury and material things.

In today's world, each of the four countries is struggling for its own identity, independence, and survival. Wedged between Russia and China, these two world powers are vying for influence and dominance. We saw the result of this in the roads and train lines built by each one across the vast terrain of Uzbekistan. Tajikistan, (where part of the opposition has been brought into government and the role of non-governmental groups has expanded in recent years) seems to be the most politically open country, though it still struggles to give true voice to the population. Initially Kazakhstan and Kyrgyzstan seemed to be making steady progress toward the development of democratic or quasi-democratic politics, but in the past two years the regimes in each country have become more autocratic. Uzbekistan has had strongman rulers since the outset, and when we were there in April the current president succeeded in getting a referendum passed replacing the two five-year limits on presidential terms with two seven-year terms, making him eligible for another 14 years of rule when his current second five-year term ends in two more years. Invariably, those in power in each country view their continuation in office as inseparable from maintaining their country's stability. This is partly because they view themselves as the most fit to rule, and partly because they do not want to lose their power and the opportunities that have allowed each of these men to enrich themselves, their families, and their cronies.

Appropriate Management of Cholesterol in People with Hypercholesterolemia: what does the evidence say?

Interview with Dr. José Francisco Parodi[1]

Martha Peláez[2]**, PhD (MP)**: Dr. Parodi, many older people are prescribed statins, the cholesterol pill, but there seems to be a dilemma in the medical community about the value of statins for older people. What information can you give us to make informed decisions and, above all, how can I evaluate if the prescription that the doctor gives me is what is best for me? In other words, how sure and confident can I be that taking a statin at my age is a good decision?

Dr. J. F. Parodi MD (JFP): This is a difficult question to answer, both for oneself and many times for doctors as well. In the past, before PAHO/WHO defined healthy ageing in direct relation to function and the ability to "be and do what one considers valuable," medicine was disease-focused. Now the 21st century gives way to medicine centered on the person, that is, on the person's functioning. This is especially appropriate in the management of the person with hypercholesterolemia[3].
(https://heart.bmj.com/content/106/4/261)

(MP): It is interesting that even with this paradigm shift, most clinical studies are done with mortality as the main indicator instead of looking at how well individuals are functioning in their daily lives. That is, how can we extrapolate the results of a clinical study with a drug to daily clinical practice with older persons?

(JFP): In general we must consider whether the population (age and health characteristics) of the group in the clinical study resemble my age and health characteristics; We must also consider other indicators such as: i) the time that must elapse for one to benefit from the treatment, ii) the number of people that should be treated to demonstrate important odds that one person will receive the benefit, iii) interaction with other drugs used, iv) side effects, v) the ease of use and, above all, vi) the health priorities of the person who is going to take it.

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[1] Doctor José F. Parodi MD, PhD, MPH. Geriatric Physician. President of ALMA the Latin American Academy of Geriatric Medicine (Academia Latinoamericana de Medicina del Adulto Mayor). Director of the Center for Aging Research in the School of Human Medicine, University San Martín de Porres.
[2] Martha B. Peláez, PhD, member AFSM and Chair of AFSM Committee on Healthy Aging.
[3] Hypercholesterolemia is the medical term for high cholesterol.

In summary: in older persons the benefits of a treatment should result in optimizing function and be in line with what matters to the persons and their life expectancy.

(MP): Many older people are concerned that studies sometimes contradict each other in a very short time. What appears to be true today is contradicted tomorrow. The result is a lack of confidence in the information we receive. We also know that the results of studies conducted at population level are not 100% applicable at the individual level.

(JFP): It is true, but the information from the studies should not be considered in isolation. For example: Risk scores in one study may overestimate vascular risk in ethnically diverse populations, in those of higher socioeconomic backgrounds, or in those who are receiving preventive care. They may also underestimate vascular risk in those of lower socioeconomic status or those with chronic inflammatory conditions. That's why you shouldn't make snap decisions without consulting with your doctor.

(MP): So, the key question of this conversation: How much cholesterol is necessary for my body to function? High or low cholesterol: which is better for older persons?

(JFP): Cholesterol is very important for the structure and functioning of the human being. It is part of the membranes of our cells and necessary for the formation of hormones, the metabolism of vitamin D, and necessary for the absorption of calcium and bile acids. Most of the cholesterol that is in our body is produced by us, only 20% comes from food.

In early and mid-life, high cholesterol is considered a risk factor for health and disability due to its association with cardiovascular diseases, such as coronary heart disease and stroke.

Within the heterogeneity of older persons low cholesterol has been associated with higher mortality. (https://dx.doi.org/10.1093/gerona/59.3.M293). This has also been described with other traditional risk factors (low body mass index, low blood pressure, low glucose). Finally, common sense says that the same intervention will not generate the same impact on different people.

(MP): Very interesting, but older people who have high cholesterol continue to ask: What does the scientific evidence say about the use of statins in older people?

(JFP): Let's look at some studies.

The meta-analysis by Gencer et al. of 2020, of studies conducted with 244,090 patients from 29 trials (https://pubmed.ncbi.nlm.nih.gov/33186535/) includes a combination of primary and secondary prevention with statins for adults older than 75 years (mean age 79 years). It was observed that among older patients, risk reduction was not statistically different for statin and non-statin treatments.

Ravnskov et al. in 2016 concluded that high LDL-C was inversely associated with mortality in most people over 60 years of age. This finding is inconsistent with the traditional cholesterol hypothesis (ie, that cholesterol, particularly LDL-C, is a factor that tends to promote fatty plaque in the arteries). Therefore, since older people with high LDL-C live as long as or longer than those with low LDL-C, it questions the validity of the cholesterol hypothesis.

Ramos et al. studied, in 2018, a cohort that included 46,864 participants (mean age 77 years; 63% women). In participants older than 74 years without type 2 diabetes, statin therapy was not associated with a reduction in atherosclerotic cardiovascular disease (CVD) or all-cause mortality, even when the incidence of atherosclerotic CVD was statistically significantly higher than the proposed risk thresholds for statin use. In the presence of diabetes, the use of statins was statistically significantly associated with reductions in the incidence of atherosclerotic CVD and all-cause mortality. This effect diminished after the age of 85 and disappeared in the 90'
(https://www.bmj.com/content/362/bmj.k3359)

Nanna et al. in 2019 examined data from the National Institutes of Health[4] that prospectively measured cardiovascular risk factors and disease incidence. Adults aged 75 years or older without cardiovascular risk factors were included, evaluating the associations between LDL-C and the incidence of cardio-cerebrovascular disease (cerebrovascular accident, myocardial infarction, and cardiovascular death). The 5-year event rates were also evaluated in patients with and without hyperlipidemia[5] , stratified by the number of other risk factors (smoking, diabetes, and hypertension). A total of 2,667 adults, 75 years of age or older, without cardiovascular risk factors were evaluated; the median age was 78 years. They found no association between LDL-C and cardiovascular risk factors. They concluded that LDL-C was not associated with cardiovascular disease risk in adults 75 years and older, even in the presence of other risk factors. (https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16123)

Strandberg et al., in 2019, posed challenges for future studies as the existing data could not address the uncertainties about the benefits and harms of statins for the primary prevention of vascular disease in people aged 75 years or older, especially those with comorbidities, frailty, and cognitive impairment.
(https://pubmed.ncbi.nlm.nih.gov/37167234/)

Marcellaud et al. in 2023, conducted 3 systematic reviews with the objective of evaluating (1) the impact of hypercholesterolemia on mortality and the main adverse cardiovascular events in subjects > 80 years of age, (2) the efficacy of statins in preventing cardiovascular events at that age, and (3) the safety and tolerance of statins in this population. Regarding the first objective (16 studies, 121,250 participants), 7 studies

[4] Framingham Study, Framingham Offspring Study, Multi-Ethnic Study of Atherosclerosis, and Cardiovascular Health Study
[5] LDL-C ≥130 mg/dL or on lipid-lowering drugs

(10,241 participants) did not find that total cholesterol and low-density lipoprotein levels were associated with a high rate of major cardiovascular events in octogenarians. A total of 6 studies (14,493 participants) found elevated levels associated with CVD, while 3 studies (96,516 participants) found the opposite, with an increased risk of major adverse cardiovascular events with lower cholesterol levels. In 8 studies (436,005 participants) that addressed the efficacy of statins, the majority did not indicate a significant decrease in the rate of major cardiovascular events in these subjects. Finally, in terms of tolerability (9 studies, 217,088 participants), the most important side effects in this population were muscle, liver, and gastrointestinal disorders. These events were more frequent than in the younger population. It concludes that, in the absence of convincing evidence, the benefit of statins in primary prevention for much older patients is uncertain. Its prescription in this context should only be assessed on a case-by-case basis, taking into account the physiological state, comorbidities, level of risk, and expected life expectancy. (https://doi.org/10.1016/j.amjcard.2022.10.015)

Mielke et al. reported in 2005 that high cholesterol in old age was associated with a lower risk of dementia. Increased cholesterol levels at age 70, 75 years, and 79 years were associated with a reduced risk of dementia between ages 79 and 88. Examination of quartile cholesterol levels showed that risk reduction was apparent only among the highest quartile. Triglyceride levels were not associated with dementia. (https://www.neurology.org/lookup/doi/10.1212/01.WNL.0000161870.78572.A5)

Murphy et al. found similar results recently, mentioning that the continuous use of statins does not delay cognitive deterioration or clinical progression in Alzheimer's disease. (https://pubmed.ncbi.nlm.nih.gov/37167234/)

Late-onset depression, defined as that which appears in older people, is multicausal. A study by de Giorgi et al. reported that cardiovascular risk factors are responsible for a subgroup of them called vascular depression. Studies of the use of statins to improve mood in later life are conflicting. In most of them, the effect of using statins does not psychologically improve people. (https://pubmed.ncbi.nlm.nih.gov/34385939/)

In 2018, an expert panel concluded that there is insufficient evidence regarding the benefits and harms of statins in older people, especially those with concomitant frailty, polypharmacy, comorbidities, and cognitive impairment. It also noted that there is a lack of tools to assess ASCVD risk in people 80 years and older; and a paucity of evidence for the effect of statins on outcomes of importance to older adults, such as statin-associated muscle symptoms, cognitive function, and incident diabetes mellitus. It will be important for future trials to consider greater representation of very old adults, women, underrepresented minorities, and individuals with different health, cognitive, socioeconomic, and educational backgrounds.

(MP): The subject is complicated. You already commented that in the case of pharmaceutical treatments for the elderly, the issue of age, functioning, life expectancy, and quality of life are important factors. Since there are very few Geriatric doctors like you, most doctors follow established protocols for adults. Are there recommendations for physicians on appropriate prescriptions for people over 70 years of age?

(JFP): There are several tools for the appropriate prescription of medications in the elderly. One of the best known is the STOPP/START criteria (http://www.evidencia.org.ar/)

It is recommended to suspend or not prescribe (STOPP: Screening Tool of Older Persons' Prescriptions) certain medications depending on the person's conditions

- for example, Statins for primary cardiovascular prevention in people ≥ 85 years and established frailty with an expected life expectancy probably less than 3 years (lack of evidence of efficacy).

It is recommended to start or prescribe (START: Screening Tool of Older Persons' Prescriptions) certain medications according to the person's conditions,

- Statin therapy with a documented history of coronary, cerebral, or peripheral vascular disease, unless the patient's condition is end-of-life or established moderate or severe frailty.

There are also online tools with which people can check the interactions of medicines that have been prescribed or that they take on their own so that they can consult with their doctor and decide based on the risk/benefit value.
https://www.drugs.com/interaction/list/?drug_list=276-0

(MP): Thank you Dr. Parodi, you have given us a lot to think about. In conclusion, lowering cholesterol is not always good, but statins may be necessary in some cases; And it is always important to remember that in many cases taking statins is not the only way to have a good lipid profile that is appropriate for the person. Therefore, it is important to:

- Keep myself informed about my health conditions
- Have a good relationship with my healthcare provider and
- Always be a co-participant in all decisions that affect my quality of life

How About a Health Passport?

By Sumedha Mona Khanna

I have realized that as I age, I need to visit a health care facility more often than before. Besides the annual physical exam, I need to see a cardiologist, an endocrinologist, a dentist, a physiotherapist, among others. And as new conditions show up, more specialist services are added. Each time I visit one of these services, I am asked for all the same information, including personal, health insurance, medications, etc. I often go to my medical folder (hoping that I updated everything and filed all relevant information) and dig out the information requested by that specialist/service. This often takes time and leaves me hoping that all relevant and updated information is available in my folders. I am sure many of us are familiar with this situation.

So, I came up with the idea of creating a "*Health Passport"*.

When we travel, especially outside the country in which we live, we always need a Passport with the required visas. We are also advised to carry relevant medical information, vaccination status (if required), and names and information about contacts in the event of an emergency. So, the idea of a "*Health Passport"* is worth considering.

What might be the useful information to include in a *Health Passport?*

Here is a Sample:

HEALTH PASSPORT
NAME:
ADDRESS:
Your Photo Page 1

GENERAL INFORMATION
NAME: D/O/B: Gender: Marital Status: Ethnicity:
Email: Telephone:
Identity Document: Education Level: Family Members (to be notified if necessary) Page 2

HEALTH AND MEDICAL INFORMATION
Primary Doctor: Health Insurance: Health Care Providers: Medical Conditions: Other important and relevant information:
Medications (currently taken): Alternative/Herbal (currently taken) Page 3

Note: Add additional pages as necessary.

Anyone can create a Health Passport along these lines and can even have it printed as a little booklet (like the travel passport we have). I did that and am finding it so much easier when I visit a health care provider. I can update it as needed after each visit, so it is useful to have additional pages.

I would appreciate comments and ideas regarding this proposal. KHANNAS@mcn.org

Obituario de Francisco J. López Antuñano, 1931 - 2023

Por Violeta Mata García

El Gremio de la Salud Pública lamenta el sensible fallecimiento de Francisco J. López Antuñano, destacado médico salubrista y pionero fundador del Consejo Nacional de Salud Pública, de México. Francisco se destacó en diversas materias dentro de la salud pública entre las que se encuentra la lucha contra el tabaquismo y la malaria. En ésta última desarrolló programas de prevención y control con la Organización Panamericana de la Salud en Colombia, Brasil, Puerto Rico y Panamá. En Washington se desempeñó como oficial médico de desarrollo de programas de salud.

Nació el 28 de abril de 1931 en la Ciudad de México. Estudió medicina en la Universidad Autónoma de México y realizó los estudios de la Maestría en Salud Pública de la Universidad Johns Hopkins, en Baltimore, en 1975. Le sobreviven su esposa María de los Angeles, tres hijos y siete nietos.

Por sus múltiples aportes a la Salud Pública y la pasión con la que ejerció la medicina, hacemos un reconocimiento póstumo a su brillante carrera.

Descanse en Paz.

Musings of an Ageing Woman, Part 9
Scooter Adventures

By Yvette Holder

Whoever would have thought that getting old would be an adventure? Perhaps not the kind of adventure that we would have imagined in our youth, but an adventure, nevertheless. I moved from two legs to three legs and walking with the cane sufficed for quite a while. But then gradually, the dependence on the cane grew to the point where my daughter claimed I had the cane in a death grip. So, I advanced to a Rollator (walker). Whereas there was some elegance in walking with the cane – I could dangle it and swing it jauntily, I could twirl it like the cheerleader I never was – but there was still a shred of dignity. Not so with the Rollator. No dignity whatever, but at least there was the comfort of the seat that travelled with me. Then, not long afterward, I realized that I needed a mobility aid that would have me completely off my left hip. The SCOOTER! And here the adventure really begins.

I determined one Friday afternoon that I could not endure another week of the torture that walking had become, especially if I wanted to walk the 1000-odd meters to church on a Sunday morning (I had given up weekdays anyway). I went online, researched what was available and pricing, and then sought a store with such devices near to home. I called, and they had it for sale or for rent. My hip replacement surgery was going to be in 2 month's time so I thought that rental would be a better option as I was optimistic that I would walk again. The salesman quoted me $65/month (which I thought extremely reasonable) and yes, they were open on Saturdays. I called my friend, Mary, and we set out on Saturday to rent the scooter. It was near lunchtime and there was a restaurant chain that I like in the strip mall, so we had an early lunch. And then, emboldened and fortified (for I had not discussed this with my kids), I went to procure my scooter. We sailed into a store that seemed to have every assistive device one could imagine. I asked about the scooter rental and the salesman said that they had none. "But I called yesterday afternoon, and you said that you had one". I almost wailed in disappointment. He calmed me and reassuringly told me that the call may have gone to their other branch where they should have rentals. He checked and they did. So off went Mary and I post-haste as we had not ascertained what

time the other store closed. I did call and we had half an hour to spare. We arrived in time, and the salesman there showed me the rental. I sat in it, but it was most uncomfortable with my legs either practically up under my chin if I planted them on the platform or stuck out off the platform in front of the scooter. Nevertheless, I decided to take it - at $65/month I could tolerate it for two months. It could be no worse than anything I had endured thus far. I handed the salesclerk my credit card and he rang it up, saying, “That will be $250 and tax for this month”. “Wait a minute”, I stopped him, “I was told that it was $65 per month”. “You didn’t speak with me, but that would have to be our knee scooter”, he replied.

It had been too good to be true. And now I regretted not checking the For Sale card that I saw on the bulletin board at my complex. There was an offer of a scooter for $700 but the card was faded, and I did not know if the scooter was still available. Besides, I was on my way to rent – cheaper cost and disposable! What to do? In desperation, I asked what he had for sale, as I dreaded returning home with the prospect of trying to hobble until my surgery date. He showed me some new ones and then added that he had a used one for sale. “How much?”, I asked. “$750 plus tax”, he replied. Sounds good, I thought, as it is no more than the rental if I were to keep the latter for three months. He brought it out. I sat in it – it was far more comfortable than the rental. “Does it fold?”, I asked. He replied that it didn’t but that it did break out into three rather heavy parts for easier transportation. He proceeded to demonstrate a few times how easy it was, showed me how to charge it, start it, control the speed (from tortoise to hare), reverse and stop, and rang up the sale as it was now near closing time. He carried the parts out to the car and Mary and I drove home with my new acquisition. We parked the car and decided that it would make more sense to re-assemble the scooter in the car park and I could then scoot into the elevator and ride to my condo.

First challenge and first lesson learned – do it yourself first before leaving the store. Mary and I spent more than half an hour (in public embarrassment, I thought, though no one passed by), trying to reassemble the scooter – a task that took the salesclerk less than 5 minutes. It all seemed so easy in the store but when we tried to do it, the parts would not click into place. We eventually got it together and I have since tried to take it apart again but have only succeeded in getting the seat off. Flushed with assembly success, I hopped onto the scooter and headed to the elevator.

Second challenge and two lessons learned – just as with a car, learn to operate and test drive before purchasing. Operating the scooter requires skills that only Lakshmi has – many hands. Controlling movement - stop/start and backward/forward) steering for direction, and controlling speed are three separate operations, each requiring a hand. It is not possible to

do all three at once, as I learned to my detriment (but that's another tale). Meanwhile, I still had to get out of the car park, into the elevator, out of the elevator, down my corridor, through my door, and into my unit. Getting out of the car park was the practice run to operate the scooter. I went backward when I thought I was going forward. Releasing the movement lever to operate the speed control resulted in frequent and sudden stops. I learned that I would have to keep one hand on the lever and use the other hand to adjust the speed, but I couldn't steer as I had no more hands. I would have to keep going straight. To steer, I would have to set the speed, and then I could use the movement lever with one hand and steer the handle with the other. But I would have to be careful, for if I were to get too close to the hare I could shoot off before I could control the steering. I am now quite proficient as I can move forward and steer with one hand and adjust speed with the other. Reversing is another story.

But back to my attempt to get home on my scooter. The car park is large and forgiving so I eventually found myself heading to the elevator, after stopping and starting, going in the wrong direction, and scaring some birds out of their nests as I attacked shrubs that had moved into my path. I angled the device and when the elevator door opened, I drove in toward the furthest corner so that I could maneuver to exit when I got to my floor. While the elevator was ascending, I tried turning the scooter around to face the door so I could drive out. Big mistake! I boxed myself into an increasingly tighter corner and several ascents/descents later, I realized that I could only reverse out of the elevator. I would have to drive in, stay put, and reverse the same way I went in. Fortunately, no one else needed the elevator. The ride down the walkway was uneventful, as was the entry into my unit, save for a few minor collisions with kitchen cupboards. Saturday's happenings were enough to convince me that I was not yet ready to scoot to Sunday Mass the next day. More adventures await!

Let's Move Forward in the Decade of Seniors Following a Healthy Path to Ageing

***By María Edith Baca Cabrejos*[1]**

We start ageing from the moment we are born, but dreams and desires do not age, nor do our rights. ¿So why limit ourselves in life? Why turn ourselves off when we can still give light? There are many questions that still have no answer. Providing them is not the intention of these notes either. The purpose is to encourage an internal dialogue, one's own, to the extent that those who will read these reflections will be older people with doctorates in life, older people who still feel that we can continue enriching health with wellbeing and rights.

We know from WHO (2021) that older people represent about 13.5% of the world's population and that in 2030, one in six people will be 60 years of age or older.[2]

Ageing is multidimensional

Let's start with the premise that not all of us age in the same way. Not just because of our own genetic predisposition, but fundamentally because of our different life, family, population, socioeconomic, sociocultural, and socioenvironmental circumstances. Some older people spend their lives on large ships, others on yachts, boats, or barges. According to WHO (2021), "at least 142 million older people in the world cannot meet their basic needs", that is, they go through life on barges and do not have the right to dignified and healthy ageing, and they are being left behind.

This diversity in the way one lives life overwhelms each of us in a different way and the body also reacts to it in different ways. And if, in addition, one's life has been without love since birth, then lifelong mental suffering can be predicted. The lack of attachment and affective ties from early childhood, and the helplessness and lack of social protection throughout life enable one to predict the type of ageing that these older people will experience. We cannot ask them to age in a healthy manner. This population group, which is growing more and more in the world, has the right to universal health care, to social protection provided by the government, to the approval and fulfillment of global mandates, and to the solidarity of communities, free of discrimination and violence.

Advances in science and evidence now make it possible to better respond to the needs and health problems of people as they age, and resilience as a gift of life teaches us to overcome adversities, to lift our spirits, to enhance intelligence and push forward until the end. Despite these two powerful tools, it is not possible to age in a dignified and healthy way without an

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[1] Health psychologist with more than 23 years of experience as a national consultant for PAHO in Peru and 10 months as IPC for Headquarters. I hold a "doctorate in life" as a caregiver for my family members that have already departed: my father (97 years old), my mother (95) and my older brother (67) who suffered from dementia. In addition to being a caregiver, together with my young sister and a team of caregivers, I was able to be a provider thanks to the opportunity that PAHO gave me to enrich public health in my country and at the same time be able to give my family a dignified, autonomous, and healthy life. I dedicate these notes to them in a month when they left us.

[2] World Health Organization. Decade of healthy ageing: baseline report. Summary, 2021. https://www.paho.org/en/documents/decade-healthy-ageing-baseline-report-summary

environment that gives us ground, that covers us, gives us security, solidarity and dignified treatment; and that also promotes mutual family and community support networks.

I have condensed in my reflections the four priority areas of the Decade for Healthy Ageing 2020-2030: dignified treatment free of ageism, friendly and safe environments, comprehensive care focused on the needs of the elderly, and the continuity of sustainable long-term care. The route to follow is traced and it is promising.

Where to start? How to do it?

The first thing is to start with our own house. We can't change anything on the outside if we don’t change what’s on the inside.

We can start by applying what WHO/PAHO has written in various publications where people-centered care is highlighted. Give the elderly in or near our homes a voice with active and empathetic listening, respecting their right to their own decision-making.

At the same time, identify what their needs, problems, and expectations are in order to support them based on this clarity, taking care not to impose our own needs and problems on them. Giving them security and accompaniment is essential and revitalizing, as long as it does not become an exercise in sanctioning our control and a brake on potentialities, decisions, and desires.

To older people who had to navigate in badges facing stormy seas or others who did not have the right to decent work and were abandoned, will need us to give them peace of mind, health, and wellbeing. They don't have the strength to keep fighting, they have that right and they have to advocate for it.

Some older people who had the gift of birth surrounded with love and accompanied on their journey through life; they had the additional privilege of having a decent job that facilitated dreams, allowing them to go through the vicissitudes of life in better conditions. We not only have the right, we have the ethical obligation and the desire to promote health and wellbeing for those who grow old without exercising these rights.

On all fronts and with various strategies

The task is daunting; the several hundred years without having properly prepared ourselves as individuals, families, communities, and countries for an ageing population with universal health care, wellbeing, and rights cannot be resolved in a decade. This decade is very useful to shore up everyone's mind at once with key ideas to break down barriers and promote the call to action; to turn the stomach of those who continue to approach the elderly as if they were hindrances in life and development; to squeeze the hearts of those who act as if they will never get old; and to see investment in this as a strategic national and global priority.

This means acting simultaneously on all fronts to address the very causes that subject us to adverse ageing; we can turn healthy aging into a "continuous process of optimizing

opportunities to maintain and improve physical and mental health, independence, and quality of life throughout life".[3]

At the family level, we need give love to our elders while respecting their right to dignity. We need to listen to them, making them feel that we care while not denying or exaggerating their problems, but rather enhancing their intrinsic abilities. We need to accompany their journey in the way they choose to follow it, creating and recreating a care system that makes them feel that they are not alone and that they are not prisoners. This offers a formula that could help a large group of families who provide caregiving in response to the conditions of their elderly. However, due to the heterogeneity of older adulthood, it won't be appropriate for everyone.

Don't leave caregivers behind

Do not forget that older people are increasingly caring for other older people, and we must prepare for this, including them in the care system as well as with measures to promote self-care.

In addition, it must be borne in mind that it is usually women who are in charge of socially caring for the elderly. Who cares for the caregivers? The answer deserves a separate and necessary specialized article, but it is important to recognize that men should and can also be good caregivers.

Promotion of leadership as a strategic challenge

The way forward for the implementation of global mandates, and the legal, political, and regulatory frameworks of the Member States of the United Nations will require advocacy, based on information and evidence. It will mean including the elderly in a leading role in investing, managing, operationalizing, supervising, monitoring, evaluating, and rendering accounts. It sounds simple, but the existing multidimensional barriers in the way make this pathway a hill with an unpaved slope.

This scenario is what compels us to be part of the solution. Having the privilege of still being able carve out the path of our own ageing can only be appreciated.

The added value of AFSM in the Decade of Healthy Ageing

The value added by AFSM to the Decade and the call to action means that PAHO can now count on a group of ageing dreamers committed to these transformations and to dignified and healthy ageing for everyone everywhere.

[3] Pan American Health Organization.
https://www.paho.org/en/healthy-aging

CREDIT UNION NEWS
PAHO/WHO FCU

SCAMS TARGETING OLDER ADULTS

The rate of fraud and scams among adults 60 years and older is staggering. Every year, people lose millions of un-recovered monies due to fraud, scams, and con artists. Here are the most common scams.

Types of Scams Targeting Older Adults

- **Sweepstakes and Lottery Scams** –Always ignore calls or notices that "you have won a lottery or prize." In order to claim such prize, the winner has to wire or send money, cashier's check, gift card upfront to cover government taxes and processing fees. In every single case, NO PRIZE or LOTTERY EXIST.
- **IRS or other Government Impersonation Scams** – The IRS, Social Security Administration or Medicare will never call to discuss your personal information over the phone. You should hang up and never return calls from any of these government agencies.
- **Romance Scams** - Beware of sweetheart scammers, who have no intention of meeting you. They are often in other countries and may ask for money to travel or to obtain a visa to the U.S.
- **Grandparent Scams** – Are scammers claiming to be the grandchild of an elderly person and will often use high pressure tactics to play on the emotions of the older adult to get money for some urgent financial problem.
- **Internet and Email Scams** – Scammers often claim to be representatives from a well-known credit union or bank, credit card company or an online store. Do not share personal information such as your social security number, account number, date of birth and other pertinent information that will give them access to your accounts.
- **Letter of Late Payments and Invoices** – Are official looking notices from reputable companies demanding payment for past due bills. When in doubt, contact the company or bank directly using legitimate contact information.

If you are the victim of any of the above scams or any other scams, tell a close and trusted family member or a friend about the suspicious communication and NEVER provide any personal information to someone you do not know. Register unknown call on the National Do Not Call Registry. Call your local police and report such scams to the FTC, Federal Trade Commission (Reportfraud.FTC.gov). The site provides additional information about how to protect yourself scammers.

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