NEWSLETTER

OF THE ASSOCIATION OF FORMER STAFF MEMBERS

VOLUME XVII, NO. 2 **OCTOBER, 2006**

The lives of these children in a small village in India have been changed by PAHO retiree Sam Koilpillai ("thatha" or "Grandpa" to them!) (see story on page 2)

CONTENTS

HOW TO ACCESS THE PAHO INTRANET

If you are connected to the Web and have an electronic mail address you can now, as retired staff, access the PAHO Intranet. To do that you must first obtain a password from PAHO's system administrator.

To obtain a password do the following:

1. In your Web browser (Internet Explorer, Netscape, etc) type the address:

http: //intranet.paho.org/login/LogIDAdd.asp

AN INTRANET PASSWORD SCREEN WILL THEN APPEAR.

2. In the proper boxes you must type your email address and name. In the last text box, type "I am a retired PAHO employee" and ONLY THEN CLICK ON "SUBMIT."

3. You will receive a message from PAHO's system administrator in the next 24 hours at your email address with a password that will permit you to log into the PAHO Intranet.

4. Once you receive your password you can begin accessing the PAHO Intranet. To log in you type the following address:

http://intranet.paho.org

5. Type your email address and password in the appropriate boxes and click "LOG IN."

6. Once you bring up the Web page, select STAFF SERVICES to reach the AFSM page.

Note: Should you have any difficulty following these instructions, please contact Ms. Cristina Mitchell (mitchelc@paho.org) or Ms. Marina Molina (molinama@paho.org) or by telephone at 202/974-3312.

GREETINGS FROM INDIA!

by Samuel Koilpillai

I retired in 1988 after working at our head-quarters in Washington and in the Caribbean field for 26 years. After retiring, I went back to my motherland India with dreams of starting a social service project. After selecting a rural area in a backward district in South India, and after getting the necessary buildings and infra-structure built, the project was started in 1991 near Hosur Town, about 50 kilometers from Bangalore.

It began in a small way with an orphanage of three babies and a primary health clinic with a doctor couple, one nurse and two helpers to serve the poor and the underserved people of the villages in that area. But today, we're running a full-fledged Children's Home of 65 kids, ranging in age from 1 day to 14 years, with an active adoption program. And the clinic has grown to a 22-bed rural hospital with an outreach program that extends quality medical care, preventive and curative, to villages within a radius of 25 kilometers. The program serves a minimum of 10,000 people annually.

To give you an inkling of how busy I've been during my retirement years, here's a short write-up:

At the Children's Home, there is a continuous inflow of abandoned and unwanted infants – around 10 a month. At the same time, each month 5 to 8 children are given out to adoptive parents within India. You may be interested to know that from 1991 until now we have given shelter and loving care to around 320 children; and we have found permanent homes (some of them affluent) for nearly 200 of them.

Most of the admissions are newborn baby girls, given away by their parents because they are too poor to provide for them, including a dowry when they grow up. Several of them were rescued from the very jaws of female infanticide which was widely practiced here. Many of the babies suffer from malnutrition, serious illnesses or birth defects.

For these and other sick children, we provide necessary medical care in our own hospital. Sometimes more expensive specialist care or surgery is needed, which is given in tertiary care hospitals in Bangalore. Most of the children, however, are growing and developing normally.

The cost of running the Children's Home has increased considerably in recent years because more than 50% of the children are babies requiring expensive food and medical/surgical services and around-the-clock monitoring in the hospital. It costs around US$ 4,500 a month to run the Children's Home – which works out to an average of $69 per child per month.

To meet this cost, we depend mostly on contributions from friends in America. These gifts are channeled through a non-profit charitable organization, Community Uplift Projects (CUP) International, registered in Maryland, USA. Donations to CUP are tax-deductible and may be sent to: CUP International, 17517 Queen Elizabeth Dr., Olney, MD 20832, USA.

Health Services Project

As I mentioned, the health services project has also grown enormously since its inception in 1991. It consists of a community health program in the surrounding villages, including mobile clinics to provide curative care, "health camps" to do screening for various diseases and conditions such as diabetes, hypertension, and cataract, and health education to vulnerable population groups on topics such as prenatal care, communicable diseases, safe drinking water, environmental health, and personal hygiene.

Also, a full service rural hospital has been established, with modern diagnostic and obstetric services and 24/7 emergency care. Thus, the people of the rural communities in that area now have access to quality medical care which they did not have before.

My wife and I are happy that the social service project in India, Anantha Ashram (which means "a haven for eternal values" such as love and charity), is not only benefiting thousands of the poor and the needy, but has also been a source of tremendous satisfaction and blessings to us during our retirement years.

Let me close this write-up with an invitation: If you come to India and visit the Bangalore area for any reason, please plan to look us up in Hosur and even stay with us if possible. Our telephone number: 011-91-4344-262-190; e-mail address: samargaret@sify.com; e-mail address in the USA: cupinter@netzero.net. We would love to hear from you.

NEW VACCINE AGAINST SHINGLES*

A recent medical breakthrough is a vaccine against shingles.

More than one million Americans – most of them over the age of 60 – will develop shingles in 2006. Shingles is a viral infection that is often mild and short-lived but can result in debilitating chronic pain for months or years.

The virus responsible for chickenpox can also lead to shingles in adults. After a chickenpox infection, the virus remains in the body and settles in nerve tissue near the spinal cord, where it lies dormant – forever, if you're lucky. However, it can become reactivated – for any number of reasons – and then travel along the nerve fibers back to the skin to cause shingles.

The first symptom of shingles is a burning or tingling pain or an itch on one side of the face or body, followed within three to five days by a painful, blistery rash that lasts several weeks. Some patients are left with persistent pain – a condition known as post-herpetic neuralgia (PHN), which can continue for months and even years after the rash clears up.

There is no specific treatment for shingles. Topical creams and lotions can ease the pain, but more powerful opioids (narcotics) are often needed. The best way to reduce the chances of developing the dreaded PHN is to start taking an antiviral medication, such acyclovir, as soon as shingles is suspected – preferably within 72 hours after the onset of symptoms.

A new vaccine (marketed as *Zostavax*) has been approved in the US for persons 60 or older who have had chickenpox and whose immune system has not been compromised by cancer, HIV, active tuberculosis, steroids or other immunosuppressive drugs. It requires just one shot and will cost about US$150. **The PAHO/WHO health insurance will cover the shot.** This vaccine reduces the chances of developing shingles by 51%. (And, for those who do come down with shingles, the attack should be much less severe.)

The side effects of the vaccine are minimal: pain, tenderness and swelling at the site of injection, and perhaps a mild headache.

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*As published in the *Parade* supplement in the *Washington Post*, 27 August 2006

WHAT ARE WE DOING NOW?
by Gloria Khokhar

Who said there was no life after PAHO? PAHO was just one stage of our lives, when our working hours were managed according to higher management's priorities, deadlines, rush jobs and temperamental outbursts of **...** whoever we had to endure! Well, that was then, but now we are really enjoying our life and our priorities. Any deadlines which we impose onto ourselves are our own and most importantly we enjoy our bursts of energy and creativity.

We are busy, very busy, with ongoing projects or planning future ones. That is the idea behind this new section in the *Newsletter.* We will briefly let you know what we are doing, and where and how to contact us in case you are interested in learning more about it or joining in the fun.

We would like YOU to be featured here, so kindly send a note by regular mail or email, or call:

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The *Newsletter* has already featured the following members of AFSM. For easy reference, and in case you want to read the complete article, you will find the citation in parentheses.

Álvaro Uribe Acevedo – He is living in Santafé de Bogotá, Colombia. An enthusiastic admirer of music, he has an extensive collection of music in different formats, from old-fashioned records to DVDs. He has expanded his knowledge and pursued his interests in symphonic music and opera, often traveling to different countries to attend great concerts. He participates in a discussion group of music lovers called "Euterpe" and he is writing his memoirs. Email: auribe@isoft.net (*Newsletter,* Vol. XV, No. 3, December 2004).

Helena Restrepo – She is living in Cali, Colombia. A true admirer of music and painting, she is fully enjoying her "golden age of retirement". She takes courses on music appreciation, evolution of classical music, styles of music, opera and psychoanalysis, historical development of modern music and literature. In summary, she has found "liberation as a result of a deep and intimate contact with the good music." Email: restrepoh@telecast.com.co (*Newsletter,* Vol. XV, No. 3, December 2004).

Luis Odría - He is living in Orlando, Florida, USA. Since 1995 he has been working for private companies and has won awards as Best Employee. He is a well-recognized authority on the art of bullfighting. He has written two books on the subject (illustrated by him) which have been published in Spain: "El arte del toreo y los secretos de la lidia" and "Cronología histórica del toreo 1526-2003". Tel.: 407/886-5016 (*Newsletter, Vol*. XV, No. 2, August 2004).

Solum Donas – He is living in San Jose, Costa Rica. He has many artistic interests. Among his present activities, he is converting his traditional photographic collection into a digital one. He is very active painting and sculpting in wood and iron; he enjoys exhibiting his works as well as writing poetry, stories and essays. Email: solumct@gmail.com (*Newsletter,* Vol. XVI, No. 2, August 2005).

Sumedha Khanna – She is living in Gualala, California, USA. She is the director of a center called "Healing Well" where she focuses on communicating with women in her community to enhance their health through the integration of body, mind and spirit practices. She is collaborating with the Institute of Noetic Sciences on the concept of Integral Medicine. Email: khannas@mcn.org (*Newsletter,* Vol. XVI, No. 2, August 2005).

Features

In every issue we will feature one member of the AFSM in the USA and one member from another country. In this issue:

Carmen Anderson - She spent 29 years working in PAHO and one of her most relevant assignments was Administrative Assistant to Elsa Moreno in the Maternal and Child Health Program. She is living in Arlington, Virginia, USA. Carmen is more active than ever. Her interests range from physical exercise, lifting weights, Yoga and Pilates, to enjoying and learning more about art. She is a disciplined French and piano student and she is a bilingual Docent at the National Museum of Women in the Arts. If you want to ask Carmen for details of her

activities or how to join her, call 703/532-7622 or email: andersoc@juno.com.

Elsa M. Moreno – She has worked in the fields of public health and maternal and child health for 47 years. During her years in PAHO she held the highest posts in these areas in several countries as well as in Headquarters. During the PAHO Centennial (2002) she was distinguished as a Hero of Public Health in the Americas. She lives in her original Tucumán, Argentina, and she is very active as an advisor, consultant and teacher preparing future leaders in public health. Elsa has many interests and she belongs to "Grupo Alberdi" a multicultural group where she enjoys the company and conversation of well-known intellectuals and prominent people. She is proud of the many friends she made in PAHO. You may contact her at Tel. 54-381-422-6904 or email: emoreno@tucbbs.com.ar

Sources and contacts:

Art - National Museum of Women in the Arts. Carmen Anderson: Tel. 703/532-7622 and email: andersoc@juno.com

Bullfighting – Luis Odria: Tel. 407/886-5016

Health and Healing – Sumedha Khanna: Tel. 707/785-2566; and email: khannas@mcn.org

Maternal and Child Health – Elsa M. Moreno: Tel. 54-381-422-6904 or email: emoreno@tucbbs.com.ar

Music – Appreciation, classical, discussion, opera, recordings:

- Helena Restrepo: Tel. 572-893-1495 and email: restrepoh@telecast.com.co

- Álvaro Uribe Acevedo: Tel. 571-211-5418 and email: auribe@isoft.net

Wood and Iron Sculpting – Solum Donas: Email: solumct@gmail.com

As published in USA TODAY: "*Dictionary definition of retirement: To disappear, to go away."*

Our definition of retirement: To connect, to reinvent, freedom!

BEING JUST A LITTLE OVERWEIGHT CAN PUT YOU AT RISK OF DYING PREMATURELY!

A large US government study has found that those who are just moderately overweight in their fifties were 20 to 40% more likely to die in the next decade. Another study involving more than one million Korean adults produced similar results.

The findings were welcomed by public health and obesity experts as powerful new evidence that people should do whatever they can to maintain a healthy weight.

About two thirds of Americans are now overweight, including about a third who are obese. Anyone with a body mass index (BMI) between 25 and 29.9 is considered overweight, and a BMI of 30 or above is considered obese.

To calculate your body mass index:**

Take your weight in pounds, divide it by your height in inches, divide it a second time by your height in inches, and multiply the result by 703.

Studies clearly show that obesity increases the risk for a host of ailments, including heart disease, diabetes, cancer and arthritis, and that obese people are more likely to die prematurely.

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* Taken from a report in the *Washington Post*, 23 August 2006

**A "Body Mass Index Table" was included in a previous *Newsletter* (Volume XV, No. 2, August 2004).

NUTRITION, PHYSICAL ACTIVITY AND HEALTHY AGING

by Carlos Hernán Daza*

When talking about healthy aging, we should bear in mind the epidemiological factors that result in health or disease at this stage of life and be particularly aware of two of the main risk factors that determine the prevalence of chronic noncommunicable diseases: diet and physical activity at all ages.

Other related risk factors, such as hypertension, high cholesterol, limited intake of fruits and vegetables, overweight or obesity, lack of physical activity, and smoking, should also be considered. Five of these factors are closely associated with a poor diet and physical inactivity.

The determinants of noncommunicable diseases are largely the same across the population: excessive consumption of high-calorie food with limited nutritional value and high fat, sugar, and salt content; little physical activity in the home, school, and work environment; lack of recreation and increasing use of mechanized transportation. In older adults, a sedentary lifestyle and restricted physical activity are major contributors to this problem.

While the effects of diet and physical activity on health tend to interact, especially where obesity is concerned, physical activity in itself offers additional benefits independent of nutrition and diet. Therefore, physical activity is essential for conserving and improving physical and mental health.

A rational approach to the nutritional problems that affect old age is to consider them in terms of the epidemiological triad: host, agent, and environment. From this perspective, the most important elements of the *host* are the biological changes that accompany aging and the effects of acute and chronic diseases.

The factors related to the *agent* are energy and specific nutrient deficiencies in the diet, interactions among nutrients, the effects of non-nutritional factors in the diet, and in some cases, dietary excesses. Of equal or even greater importance are the inherent factors in the physical, biological, and social *environment* that affect nutrition in old age.

Although the elderly are at greater risk of suffering from nutritional deficiencies, these problems vary among geographical and socio-economic groups and among individuals and population groups. There are other factors that impact the health and well-being of this age group; they include disease or physical and mental deterioration, loneliness, social isolation, the loss of loved ones, poor eating habits, and poverty.

While the *host* changes over time and aging is unavoidable, there are wide variations among individuals due to genetic and environmental influences, including nutritional adaptation. Thus, chronological age is a relatively poor predictor of the physiological status of individuals in this age group (Scrimshaw, N.).

We know that energy intake in affluent populations declines with age, perhaps in response to a reduction in physical activity. In the seventh and eighth decades of life, food intake decreases; this phenomenon is even more pronounced in hospitals and geriatric institutions and can lead to intake levels incompatible with adequate physical activity or even for meeting basic metabolic needs and maintaining body mass.

The energy needs of older adults are currently defined largely by the amount and intensity of their physical activity and less by energy consumption. It is important to maintain muscle tone, muscle mass and an adequate level of physical activity through adequate daily exercise.

Loss of lean tissue, muscle tone, and muscle mass, accompanied by lesser appetite, will result in a growing risk of vitamin, mineral, and protein deficiencies. Physical inactivity and the absence of a sense of well-being can lead to progressive isolation and psychosocial deterioration.

In old age, one of the most important preventive and health promotion measures is to increase moderate physical activity to three hours a day; this includes walking and moving around inside and outside the home, with 20 minutes of aerobic exercise using arms and legs to maintain cardiovascular efficiency and a sense of well-being.

The type and intensity of the exercise should be suited to an individual's existing limitations, but even someone with arthritis or difficulty walking needs to exercise more and increase energy expenditure. Changing the attitudes of older adults so that they stay physically active throughout life may be one of the most important prevention measures for a healthy old age (James, W.P.T.)

During the aging process, there is a progressive reduction in body protein due to the reduction in skeletal muscle mass. These changes are accompanied by a change in the general pattern of corporal protein synthesis and breakdown, which is estimated at 30% in young adults and 20% or less in older adults.

The consequences of inadequate protein intake are expressed in varying degrees of biochemical and functional change in human beings of any age. Old age, however, poses the additional risk of developing diet-induced changes in protein and amino acid metabolism, which compromises the ability of cells and organs to respond effectively to debilitating stimuli (Young, V.R. et al.).

Essential amino acids should furnish at least 3% of total food energy. The optimal level is from 6 to 10%. Dietary fat should account for 25 to 30% of total energy intake. These proportions can be a little higher in societies whose traditional diets are high in fat and somewhat lower in those where fat intake is lower. There are no valid reasons for recommending higher cholesterol consumption for the elderly, but there are for promoting the consumption of a variety of carbohydrate-rich foods that provide at least 55% of their energy needs (Forum, K.R. et al.).

There is no conclusive evidence to sustain the hypothesis that older adults benefit less than young people from greater consumption of dietary fiber. On the contrary, studies in this age group demonstrate the usefulness of dietary fiber in treating constipation. Diets high in non-absorbable fiber, such as cracked wheat (bran) supplements or products made with hygroscopic plant fiber (e.g., Metamucil) are currently accepted for long-term management of these conditions.

In addition to their use in treating constipation and diverticulitis, high-fiber diets can be specifically indicated for diabetes. It would be useful, whenever possible, to advise older adults to increase their intake of a variety of fiber-rich foods such as vegetables, fruits, legumes, and grains, instead of exclusively consuming supplements made of grain. Mineral intake should be monitored and supplementation with calcium and iron salts can be recommended.

New foods should gradually be added to the diet, and in selecting and preparing them, nutritional deficiencies, dental problems, and palatability should be considered. A well-designed diet should include, for example, whole-grain bread, pureed beans or peas, and cooked fruits (Jenkins, D.J.A. et al.).

Theoretically, there is reason to believe that with advancing age, changes can occur in the chemical potential of interstitial and intracellular fluid that would facilitate water loss in this age group. There is no doubt that dehydration is more dangerous in older adults than in young people and thus, diuretic therapy for elderly patients should be prescribed with caution (Steen, B).

Several countries have issued recommendations on vitamin intake for older adults (up to the age of 50) but none has adequately addressed the problem of the changing nutritional requirements of advancing age. Moreover, only one country, the United States, has prepared estimates or issued recommendations for the daily intake of 13 essential vitamins.

Given the growing popularity of megavitamins among the elderly, especially ascorbic acid (vitamin C) and tocopherol (vitamin E), which are said to retard the aging process, it will be necessary to define maximum intake levels for these vitamins (Wahlqvist, M.L. et al.).

Mineral requirements and intake recommendations for older adults have usually been estimated by extrapolating from studies on young people. Several nutrients--calcium, fluorine, selenium, zinc, copper, and chromium, for example--can in theory be related to the aging process and have been shown to be beneficial in controlled studies on supplementation with some of these nutrients.

However, the health risks associated with age do not seem to be attributable to erroneous requirement estimates or recommendations on dietary intake, but to the inability of the customary diets of the elderly to meet their nutritional needs.

The health problems resulting from several mineral deficiencies begin at an early age with

the gradual depletion of bodily reserves. Interventions to prevent that depletion are as important as efforts to reestablish bodily reserves (Mertz, W.).

Nutritional anemia usually means iron deficiency, protein deficiency or, less commonly, folate deficiency, and the prevalence of these deficiencies in older adult reflects the situation in the general population, with some exceptions.

Older adults are less susceptible to iron deficiency due to their reduced need for this nutrient, and more likely, when anemia is present, it is due to chronic inflammatory processes. Notwithstanding, given the higher prevalence of iron deficiency in the general population, the problem continues to receive great attention, even in older adults (Finch, C. A.).

Older people get sick more often than young adults, and the characteristics of their diseases reveal a common morbidity pattern of infections, cancer, immunological and autoimmune disorders, and degenerative diseases--all of which suggests reduced immunocompetence associated with the aging process.

Since nutrition is a critical determinant of immunity, it is important to consider whether nutritional problems contribute to lower immunity and higher morbidity in the elderly.

Recent studies suggest that correcting nutritional deficiencies improves the immune response, including antibody levels after immunization for common infectious diseases. It is to be expected that better nutrition contributes especially to reduction of the disease burden in the general population and older adults (Chandra, R.K.).

Complementing the statements contained in the preceding paragraphs, the following is a transcription of the main agreements adopted by the 57th World Health Assembly (May 2004) under the title *Global Strategy on Diet, Physical Activity, and Health*--agreements that are of fundamental importance in preventing the chronic noncommunicable diseases that strike the general population and the elderly in particular.

The overall goal of the Global Strategy is to promote and protect health by guiding the development of an enabling environment for sustainable actions at individual, community, national and global levels that, when taken together, will lead to reduced disease and death rates related to unhealthy diet and physical inactivity.

The Global Strategy has four main objectives**:**

(1) to reduce the risk factors for noncommunicable diseases that stem from unhealthy diets and physical inactivity by means of essential public health action and health-promoting and disease preventing measures;

(2) to increase the overall awareness and understanding of the influences of diet and physical activity on health and of the positive impact of preventive interventions;

(3) to encourage strategies and action plans to improve diets and increase physical activity in the general population and actively engage all sectors, including civil society, the private sector and the media;

(4) to monitor scientific data and key influences on diet and physical activity; to support research in a broad spectrum of relevant areas, including evaluation of interventions; and to strengthen the human resources needed in this domain to enhance and sustain health.

There is evidence that, with the control of other dangers and health risks, people can remain healthy after 70, 80, and 90 years of age if they adopt health-promoting behaviors, a healthy diet, and adequate regular physical activity, and avoid tobacco use.

Concerning diet, the following recommendations are formulated:

- Achieve an energy balance and a normal weight;
- Limit energy intake from fats, replace saturated fats with unsaturated fats, and try to eliminate transfatty acids;
- Increase the intake of fruits and vegetables, as well as legumes, whole grains, and dried fruits;
- Limit the intake of free sugars;
- Limit the intake of salt (sodium) of every origin and use iodized salt.

The term “diet” covers all aspects of nutrition, overnutrition and malnutrition, micronutrient deficiencies, and excessive consumption of certain nutrients; food security (accessibility, availability, and affordability of food); and the safety and quality of the food products consumed.

Physical activity is a determinant of energy expenditure and, thus, of energy balance and weight control. It lowers the risk of cardiovascular disease and diabetes, and it offers considerable advantages in terms of many diseases, in addition to those associated with obesity.

Its beneficial effects on the metabolic syndrome are mediated by mechanisms that go beyond the control of excess bodyweight. For example, it lowers blood pressure, improves cholesterol and high-density lipoprotein levels, improves control of high blood sugar in overweight people, without them having to lose too much weight, and lowers the risk of colon cancer and breast cancer in women.

Regarding physical activity, the Global Strategy recommends that people stay sufficiently active throughout life. The type and intensity of the physical activity will result in different health outcomes: at least 30 minutes of regular, moderate physical activity almost daily reduces the risk of cardiovascular disease and diabetes, as well as colon and breast cancer.

Muscle strengthening and balance training enable the elderly to reduce falls and improve functionality. For weight control, a higher level of physical activity than the one recommended may be necessary.

In short, the aim is to promote a healthy diet and regular physical activity at all stages of life, so that aging occurs within a process in which healthy practices and habits are an integral part of a good quality of life.

It would be desirable for the Association of Former Staff Members of PAHO to develop a project to promote healthy lifestyles in which physical activity and proper nutrition become part of the daily activities of all members.

A program of this type would also serve as a catalyst, encouraging the Secretariat of PAHO to give greater priority to programs for the promotion of healthy aging that include activities in the areas of nutrition and physical activity.

References:

World Health Organization. Global Strategy on Diet, Physical Activity, and Nutrition. Resolution WHA57.17.

Nutrition in the Elderly. Edited by A. Horwitz et al. Published for WHO by Oxford University Press, New York, 1989.

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*Article prepared for the Panel on Healthy Aging, Second International Meeting of AFSM, Buenos Aires, 25-28 April 2006.

IN MEMORIAM

Joseph J. Mascolo	22 May 2002
Mary T. Meagher	30 June 2003
Mario Galdos	22 August 2004
Frank A. Butrico	25 September 2005
Luis Melendez	20 December 2005
Dorothy Blake	15 January 2006
Mauricio Martins da Silva	23 February 2006
Naim H. Kent	1 March 2006
Guillermo Boquin	1 March 2006
Jose S. Barzelatto	7 April 2006
Guillermo Varas	8 May 2006
Conrado Oreste Ristori	9 May 2006
Juan Jose Sagardia	22 June 2006
Rodrigo F. Donoso Pueima	28 June 2006
Carlos Ferrufino	12 August 2006
Eduardo H. Sarue	14 August 2006

THE BACK PAGE

The AFSM Board and committee coordinators would like to know about the needs of its members. We might not be able to solve all your problems, but we have resources that could be utilized. We might either help in some way or refer you to the right source.

We would also like to have your input to the *Newsletter,* either in the form of articles for publication, or in comments on the content. What kinds of articles do you like? Are there some that should be eliminated? Are we missing something that should be included?

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Note: The term of each member of the Board expires in December of the year in parenthesis.

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