The Union
HEALTH SOLUTIONS FOR THE POOR

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Each year, in my tenure as The Union President, I have focused my message on a different aspect of our strategic vision. In 2008, it was the overall structure of the organisation. In 2009, it was “Poverty”, a concept central to The Union’s vision and mission; and in 2010, it was “Solutions”, a word that guides The Union’s “can do” attitude to the huge health challenges that it tackles. In this, my final message for The Union Activity Report, I will focus on the word “Partnership” and reflect a little on the development of The Union in recent years. This will, I hope, give some perspective to the current state of The Union as it looks ahead to future work guided by a new strategic plan for 2012–2020.

Partnership

Partnership was a core element of the theme of the 42nd Union World Conference on Lung Health in Lille: “Partnerships for scaling up and care”. In my opening address at the conference, I looked at the definition of partnership as “an arrangement where parties agree to co-operate to advance their mutual interests”. The Union is very definitely a partnership and, in the Board and Institute’s preparatory work for developing the new strategic plan, there has been a strong focus on defining the mutual interests of the partnership.

Mutual interests

Everything flows from a common agreement about overarching goals and mutual interests. In recent years we have worked hard across The Union to deepen our common agreement that we are collectively interested in scaling up innovation, expertise, solutions and support to address health challenges in low- and middle-income populations. The focus of The Union’s work for poorer populations is now explicit and well established. It lays a strong foundation for the work now needed to define the priority health challenges that the Union is particularly well placed to tackle.

Partners

Partners come in all shapes and sizes. This diversity is enshrined within The Union’s constitution, which embraces constituent members, organisational members and individual members. In the past, these members of the partnership have been almost exclusively health professionals.

In recent years we have seen and encouraged a wider engagement of affected communities and the private sector. Both are now formally represented on The Union Board and are well placed to add strength to the depth and effectiveness of The Union’s work. This is a timely and welcome development, but it is still in its infancy and we will need to invest more work and energy to engage an increasingly diverse membership.

Economic downturn

The global economic crisis has been very much to the fore in my years as The Union President. It has had a negative impact on The Union in at least two ways. First, the poor have been disproportionately disadvantaged by the recession in many countries, so their health needs are now more challenging than they were. Second, The Union’s finances were severely affected, and we were forced to downsize our central operations, lay off several valued staff members and seek many efficiencies. There has been much pain in this time, not just for The Union, but also, and more importantly, for the poorer populations that The Union seeks to serve. We must acknowledge and applaud the steadfast dedication of The Union’s core staff, which has enabled the organisation not only to survive, but also to gain strength as a force for good. Turning adversity into opportunity, we have decentralised many activities to country and regional offices. This has heightened the visibility and effectiveness of The Union around the world.

Finally

Let me round off with some aspirations. As I highlighted in Lille, I want to encourage the entire organisation to engage in a deep and constructive debate on the issue of partnership. For a partnership to work, it requires many things, including agreement on

- levels of give-and-take,
- areas of responsibility,
- lines of authority and succession,
- and how success is evaluated and distributed.

A strong partnership also requires leadership and vision. We are extremely fortunate to have excellent leadership in place for the coming years: strong executive leadership from Nils Billo and his senior management team; visionary strategic leadership from an increasingly vital Board; and dedicated, motivated, intelligent and personable leadership from our newly elected President, Jane Carter. I know that Jane holds The Union values very dear: Quality, Accountability, Independence and Solidarity. These will provide powerful guidance in the years to come. I wish her and the whole Union all the very best, thank you all for your support in my years as President, and look forward to continuing my own personal support of The Union for years to come.
This Activity Report 2011 shows in an impressive way how The Union is working in all regions through its regional offices – close to the health problems affecting millions of people around the world. As the decentralisation process of The Union continues, activities are planned more and more locally, in collaboration with local governments and NGOs, and therefore guarantee a much better buy-in from all stakeholders.

SUPPORTING THE GLOBAL CAMPAIGN FOR NCDS

The Millennium Development Goals (MDGs) were established in order to improve the lives of people, and in particular of poor populations. Three of the MDGs specifically address health: MDG 4 (reducing child mortality), MDG 5 (improve maternal health), and MDG 6 (combat HIV/AIDS, malaria, and other diseases). None of the MDGs include Non-Communicable Diseases (NCDs), i.e., diseases and conditions, such as chronic respiratory diseases, which cause a large burden in terms of mortality and morbidity worldwide. Health and development are inextricably linked, and in The Union we are taking this into account when we plan our activities, not only in our traditional projects related to tuberculosis, such as Project Axshya in India, but also when it comes to dealing with NCDs.

The Union is contributing substantially to reducing the burden of NCDs, first through its tobacco control and capacity-building programmes; second, by making sure that asthma is recognised as a major public health problem and barrier to development for many communities around the globe; and finally through its efforts to begin addressing the co-epidemics of TB and diabetes and our participation in the international NCD Alliance.

THE BLOOMBERG INITIATIVE: 5 YEARS ON

Tobacco contributes to the deaths of nearly six million tobacco users each year and a further 600,000 deaths are attributed to second-hand smoke. Tobacco use is also a major risk factor for NCDs, including cardiovascular disease, chronic lung disease, cancers and diabetes.

2011 marked the end of the first five years of the Bloomberg Initiative to Reduce Tobacco Use (BI). Through BI, The Union and the other partners have helped make it possible for 21 countries to pass 100% smokefree laws, and, this period also saw a 400% increase in people protected from second-hand smoke. The Union supported 34 low- and middle- income countries under the BI programme between 2007 and 2011. Many governments and NGOs receiving this support have been able to achieve 100% smokefree environments, have improved their tobacco control legislation and are investing in training public health professionals. The Union’s support also included giving technical and legal advice on a variety of tobacco control issues.

BUILDING AWARENESS OF ASTHMA: THE LEADING CHRONIC CONDITION AMONG CHILDREN

In 2011, The Union entered into a strategic collaboration with the International Study of Asthma and Allergies in Childhood (ISAAC) and created the Global Asthma Network (www.globalasthmanetwork.org). The two organisations published the Global Asthma Report 2011 which was launched to coincide with the United Nations High-Level Meeting on Non-Communicable Diseases (NCDs) in New York on 19–20 September 2011.

The aim of the Global Asthma Network (www.globalasthmanetwork.org) is to progress from this report and engage government ministers, policymakers, health workers, asthma sufferers, donors and media in efforts to improve asthma care globally. Core activities are global surveillance, promotion of standard case management of asthma, operational research, capacity building and access to quality-assured medicines.
FINISHING HEALTH SOLUTIONS FOR THE POOR THROUGH OPERATIONAL RESEARCH

Health systems will need to become more efficient if NCDs are to be tackled in efficient and cost-effective ways. New approaches need to be devised and tested, and our Centre for Operational Research (COR) under the leadership of Prof Anthony Harries is contributing by training colleagues from low- and middle-income countries in these skills. In 2011, the COR staff, fellows and trainees produced 68 publications, a very impressive achievement.

To further disseminate the findings of operational research and promote discussion of health policy, in 2011 The Union launched a new open-access online journal, *Public Health Action*. This new journal is getting quite a lot of attention, and submissions are increasing steadily. It complements our long-standing journal *International Journal of Tuberculosis and Lung Disease*, which saw its Impact Factor rise again in 2011.

PARTNERSHIPS FOR SCALING UP AND CARE

The Union’s educational programmes continued to make an important impact in 2011. Our World Conference in Lille, France, which explored the theme of “Partnerships for scaling up and care” attracted a very good attendance, despite the global economic downturn, and Union courses and other educational activities took place in 57 countries.

LOOKING BACK: IN MEMORIAM

Sadly, for us at The Union and all who have benefited from our International Management Development Programme (IMDP), the year 2011 was overshadowed by the tragic death of one of our enthusiastic and very competent collaborators, Jamshed Chhor, while on duty travel in Bangkok at an IMDP course in April 2011. Jamshed was instrumental in developing the network of IMDP courses around the world, and it will be indeed very difficult to replace him. We miss Jamshed and will keep him in very good memory.

LOOKING AHEAD TO 2020

Finally, I would like to highlight an important process that started at the end of 2011 at the World Conference in Lille. The Board of Directors initiated a strategic planning process for The Union to address our challenges and opportunities for the period 2013–2020. There is no doubt that The Union has a lot to offer, however, we will need to be very smart and ambitious to develop and put in place a strategy that will benefit the vulnerable populations in greatest need.

I am sure that by applying our core values of quality, accountability, independence and solidarity we will be able to continue to contribute to many health solutions for the poor, with the help of our excellent staff, consultants and members.
The Union Institute’s 300 staff and consultants offered technical assistance, provided education and training and conducted research in 89 countries in 2011. With headquarters in Paris, The Union also has offices close to the people we serve in Africa, Asia, Europe, Latin America, the Middle East and North America.

In addition, The Union’s 2,838 individual and organisational members were active in 150 countries around the world, working towards our common vision: health solutions for the poor.

- 14 Headquarters and offices
- 100 Union constituent and organisational members
- Technical assistance projects in 48 countries
- Education activities in 57 countries
- Research projects in 15 countries
- Tobacco control grants in 34 countries
- TB-HIV programmes in 6 countries
- TREAT TB partners in 12 countries
- NCD advocacy and activities in 6 countries
- ADF clients in 4 countries
The Union has three offices serving Africa – in the DR Congo, Uganda and Zimbabwe – as well as partnerships with both francophone and anglophone countries throughout the continent. In addition to its technical assistance, education and research programmes in tuberculosis, multidrug-resistant TB and TB-HIV, The Union assists countries in Africa to improve their management of asthma, child pneumonia and other lung diseases. Tobacco control has become another growing area of Union activity there.

Health challenges in Africa

- Some 800,000 people in sub-Saharan Africa require simultaneous treatment for TB and HIV.
- 350,000 children under 5 die each year from acute lower respiratory infections due to indoor air pollution.
- The number of diabetics is projected to rise from 7 million in 2000 to 18.2 million in 2030.

Sources: see page 69
**SHORT-COURSE REGIMEN FOR MDR-TB SHOWS EXCELLENT RESULTS IN AFRICA**

Four francophone African countries shared their successful experience with a shortened regimen for multidrug-resistant TB (MDR-TB) at a Union workshop in Douala, Cameroon. This was the third MDR-TB workshop for francophone countries providing training and an opportunity to exchange experiences in managing MDR-TB.

After the 2008 workshop, Benin, Cameroon, Niger and Togo decided to treat their MDR-TB patients with a short-course regimen similar to one used successfully in Bangladesh. The only differences were that they used a 12-month regimen, rather than nine, and that it included prothionamide throughout the continuation phase.

The treatment results reported by the countries generated great interest: 90% cured among the 120 patients (20% HIV positive) on the short-course regimen versus a 59% success rate among the 339 patients who received the long-course regimen. No failures and no relapses were reported – and medications cost 180€, as opposed to more than 2,000€ for the standard regimen. Workshop funding was provided by the Agence Française de Développement (AFD).

**MDR-TB APPROACH COMBINES COURSES AND TECHNICAL ASSISTANCE**

More than 100 physicians and other health care professionals attended three offerings of The Union course on the clinical management of multidrug- and extensively drug-resistant TB (MDR- and XDR-TB). The 5-day course covers the clinical, diagnostic and therapeutic aspects of MDR-TB, XDR-TB and HIV. Following the course, The Union provided online clinical assistance with the most complicated MDR- and XDR-TB cases throughout the year.

In addition, the consultants worked with the national tuberculosis programmes in each country to assess their progress in dealing with drug-resistant TB and provide support for planning and implementation of effective prevention, infection control, case finding, diagnosis and treatment. TB CARE, US Agency for International Development (USAID), KNCV-Namibia and I_TECH Botswana funded the courses.

**Botswana:** 32 health care professionals from Botswana and neighboring countries attended this course, which included a visit to the national tuberculosis reference laboratory. The fifth day was devoted to a field visit to the largest MDR facility in the country, where the participants discussed the more complicated cases and how to manage them.

**Namibia:** This 2nd international MDR-TB course in Namibia attracted 31 participants working in TB, HIV and MDR-TB from six countries. In addition to those attending the 5-day course, more than 20 physicians from the private sector attended two evening lectures.
> **South Africa**: The 31 participants in this course were all from South Africa. It was the first time the course had been offered since the establishment of an MDR-TB directorate and published guidelines for the country.

**UGANDA DEVELOPS ROADMAP FOR MDR-TB**

In Uganda, The Union found that the National Tuberculosis and Leprosy Programme (NTLP) had made notable progress on 21 of the 24 recommendations from the previous review in December 2010. Continuing concerns are the lack of a specific budget line for second-line TB medications and the need to increase public awareness that TB and TB-HIV are “everyone’s problem”. New recommendations focused on improving MDR-TB case detection and treatment. Deliverables included a roadmap to prevent and combat drug-resistant TB; a draft national plan for programmatic management of MDR-TB (PMDT) 2011–2016; a national PMDT training plan and a draft DR-TB implementation/operational plan for 2011–2016.

**WORKING WITH FRANCOPHONE NTPS TO MEET CHALLENGES OF TB CONTROL**

The Union provided technical assistance at the request of the national tuberculosis programmes (NTPs) in several francophone countries in 2011 with funds from the ADF. Highlights follow:

> **Benin**: Benin’s programme continues to be outstanding: its success rate is more than 90%; 99% of TB patients are HIV tested; and 15% HIV-positive. Retreatment cases are tested for resistance and 94% of those treated for MDR are cured with a short-course regimen. The Union also consulted with the NTP on drug supply management, childhood TB management and the need to strengthen its operational research component.

> **Burkina Faso**: The review found that treatment success in Burkina Faso had increased and the medication supply was adequate. However, lack of a manager for the National Reference Laboratory had created many problems, including poor utilisation of existing equipment.

> **Côte d’Ivoire**: The civil war in Côte d’Ivoire during the first half of 2011 led to major disruptions, but only two clinics in Abidjian were completely looted. In fact, the lateness of the Global Fund delivery caused the greater problem regarding medication supplies. MDR-TB bacteriological diagnosis is still not available in the country, and The Union consultation focused on managing MDR-TB, maintaining the drug supply and the 2012–16 Five-Year Plan.

> **Madagascar**: Following a review in April, The Union recommended that its pharmacist analyse Madagascar’s medication supply problems and make recommendations. The principal conclusion of this visit was that the NTP had done its best to avoid ruptures in stocks, but that the government needed to ensure the budget for TB medications to reduce dependence on outside agencies.

> **Togo**: The first visit focused on the strategic plan for 2012–16, as well as a review of the 2010 results, while the second visit focused on the next Global Fund application. Togo’s success rate improved from 79% in 2008 to 81% in 2009, but the death rate remained level at about 10%. Directly observed treatment remains weak, and monitoring needs strengthening. The HIV testing rate for TB patients increased to 80%, but TB-HIV management needs improvement.

**SPARK-TB TB-REACH IN KAMPALA SLUMS**

The Union Uganda Office’s SPARK-TB project (Slum Partnership to Actively Respond to Tuberculosis in Kampala) received funding from TB-REACH in May and launched its activities on 1 October 2011. The project is designed to improve access to quality TB diagnosis and treatment within private health facilities in the slums of Kampala. The goal is to improve both TB case detection and treatment success by working with Uganda’s National TB and Leprosy Programme (NTLP) to create a public-private partnership with 100 private clinics across Kampala district’s five administrative divisions.
HIV and Tuberculosis

**ADULT MORTALITY IN BULAWAYO AND HARARE, ZIMBABWE: 1979–2008**

The effects of the HIV/AIDS epidemic and the impact of HIV care and antiretroviral therapy (ART) on death rates in two large cities in Zimbabwe were described in a collaborative study conducted by the Health Services Departments of the Cities of Bulawayo and Harare and The Union. The data covered the 30-year period since the beginning of the epidemic.

The results showed that, after a substantial rise in crude mortality rates, there was a decline associated with the introduction of ART. While this outcome was not surprising, the study demonstrated that well-kept records are needed to measure what is happening at the population level and assess the impact of better access to care through the expansion and decentralisation of HIV treatment services. This study was published in the 2011 Supplement of the *Journal of the International AIDS Society*.

**SERVICES EXPANDED BY ZIMBABWE TB-HIV PROGRAMME**

Since 2007, The Union, in collaboration with the Cities of Bulawayo and Harare, has been conducting operational research on TB-HIV at three pilot sites. The programme has served TB patients, who were offered HIV testing and care, if found positive. Family members of patients were also offered HIV and TB screening. In 2011, the pilot sites reached out to 234 partners of TB patients. Of these, 175 (75%) were found to be HIV-positive, and, of the 88 ART-eligible partners, 81 (92%) were commenced on ART. The pilot sites also initiated ART for 521 HIV-positive TB patients from near-by clinics that had not been accredited as ART initiating sites.

All three sites also extended HIV care to other ART-eligible patients living in the clinic catchment areas, using medicines supplied by the Ministry of Health and Child Welfare. In Bulawayo, this expanded service began on 1 January 2010 and in Harare on 1 October 2011. The first-year ART retention was over 80% at all pilot sites.

**TB CARE LAUNCHED IN ZIMBABWE**

The Union Zimbabwe Office is coordinating TB CARE, a programme funded by USAID, which focuses on basic TB control activities. Eighty percent of the activities budget is allocated to strengthening case finding and case holding, decreasing the burden of TB and HIV, monitoring and evaluation. The programme also seeks to support the National Tuberculosis Programme in addressing the growing concern about drug-resistant TB and to contribute towards health systems strengthening.

**THE UNION DR CONGO OFFICE APPOINTED SECRETARIAT FOR NATIONAL TB-HIV GROUP**

In late 2010, the DR Congo Ministry of Health created a TB-HIV working group and asked The Union DR Congo Office to serve as secretariat member. One of the working group’s first outcomes was a TB-HIV roadmap for the country. Three studies were included in the roadmap and have been integrated into The Union’s Integrated HIV Care for TB Patients Living with HIV/AIDS (IHC) programme activities. The research team began the first study in March 2011, providing training for lab technicians and nurses who will work on a virological profile. A study of resistance to antiretrovirals also took place in Butembo, North Kivu district. In addition, the team updated the cohort analysis of the last five years, while simultaneously organising logistics and systems for this new phase of the IHC programme.

**TB-HIV COURSE HELPS ZIMBABWE AND NAMIBIA FOSTER COLLABORATION**

Teams from the TB and HIV/AIDS programmes in Zimbabwe and Namibia, as well as patient representatives and HIV activists, participated in The Union’s 4-1/2 day course “Working Together: Strengthening the Implementation of Collaborative TB-HIV Activities” in July 2011. The curriculum follows the World Health Organization (WHO) framework for TB-HIV collaboration, highlighting the key components, such as the “3 I’s”: Intensified TB case finding, Infection control and Isoniazid preventive therapy.

During the course, teams from each programme prepared barrier-breaking plans for TB-HIV collaboration under the direction of faculty from The Union. Local experts and past course participants also assisted. After the course, follow-up was provided to support the team’s progress. TB CARE I in Zimbabwe and Namibia funded this course.
**Building Capacity of Laboratory Networks**

A major focus of The Union is to improve TB care and control and prevent the increase in drug-resistant TB by supporting the development of effective tuberculosis laboratory services at every level of the network. At the request of health officials, The Union provides laboratory reviews including site visits; evaluation of results, policies and systems; assistance with strategic planning; and training.

> **DR Congo:** The 2011 visit focused on the TB National Reference Laboratory (NRL), Bas Congo provincial coordination and the National Institute for Biomedical Research (INRB), as well as the Kinshasa University Hospital renovated TB laboratory. It also covered the progress of the NRL, MDR-TB management and the microscopy network.

> **Tanzania:** This consultation covered the EXPAND-TB project and drug-surveillance activities, and considerable time was spent improving data management at the TB National Reference Laboratory (CTRL) in Dar Es Salaam. The Union also provided feedback on the proposed guidelines for MDR-TB. Supervision, coordination of staffing, supply management and training continue to be challenges for the laboratory network.

> **Uganda:** This visit marked the end of the TB CAP project “Strengthening TB laboratory networks in preparation of the creation of a new TB Supra-National Reference Laboratory in East Africa”. The goal was to assess the progress made over the entire life of the project and in preparation for a final evaluation by WHO to decide on the suitability of the candidate SRL.

**TB CARE FUNDS NEW TOOLS FOR LABORATORY STRENGTHENING**

The Union collaborated with the WHO, the KNCV Tuberculosis Foundation (KNCV) and Management Services for Health (MSH) on several TB CARE projects designed to improve laboratory services with funding from USAID, including:

> **GLI assessment tool:** The partners tested the quality of the WHO Global Laboratory Initiative (GLI) assessment tool through field evaluations in Uganda and Kenya. The tool was revised following these assessments, but still requires a process of peer review.

> **Practical handbook:** In collaboration with country and external experts, the partners developed a practical handbook for developing a national laboratory strategy.

**Lung Health & Non-Communicable Diseases**

**REVOLVING FUND SUSTAINS BENIN ASTHMA PROJECT**

A revolving fund established by the Benin National Tuberculosis Programme (NTP) in 2008 has proved a successful mechanism for supplying five pilot sites with a sustainable supply of essential asthma medicines. More than 400 new patients with persistent asthma have been identified and treated during the past two years at these sites.

Using The Union’s standard case management approach, all asthma patients at the sites have been evaluated and patients with persistent asthma prescribed inhaled beclomethasone since 2008. Preliminary results on treatment outcomes show a dramatic decrease in asthma severity and emergency room and hospital visits.

Since 2010, inhaled beclomethasone has been purchased at affordable prices through The Union’s Asthma Drug Facility (ADF). At the time of the initial purchase, the NTP established a plan to charge patients a small fee to build up a revolving fund that would be used to replenish the supply. This system has worked well for the pilot sites. Unfortunately donor funds did not come through for a planned nationwide expansion of the project.

**BURUNDI IDENTIFIES 1,000 ASTHMA PATIENTS IN TWO DISTRICTS**

The Burundi National Tuberculosis Programme implemented a Practical Approach to Lung Health (PAL) project with funding from the Global Fund that provided standardised management of asthma in all facilities in two districts. The approach to care was based on The Union guide, Management of Asthma: a guide to the essentials of good practice and medicines were purchased through the ADF.

In one year, the project identified more than 1,000 new cases of persistent asthma out of a population of 400,000. Although data on treatment outcomes were not yet available, a dramatic decrease in emergency visits.
The first draft was completed in September and tested in Africa during the latter part of the year.

> **Microscopy network accreditation tool:** A start-up workshop served to define the contents of the tool. The partners completed a first draft. Pilot testing and adaptation are scheduled for 2012.

> **Developing Benin for SRL:** The partners worked with the Benin National Reference Laboratory (NRL) on preparations for it to join the Supra Reference Laboratory Network (SRLN) based on the quality of its staffing and performance. An agreement between the Benin NRL and Antwerp SRL was formalised. Renovations of the NRL will take a year or two.

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**Child Lung Health**

**IMPROVING THE SURVIVAL OF CHILDREN WITH HIV AND LUNG DISEASE**

Lung diseases, and especially pneumonia, are major causes of morbidity and mortality among children infected with HIV in low-income countries. To address this issue, The Union’s Child Lung Health Division organised the 1st International Course on the Management of Childhood Lung Disease in the HIV-Infected Child. The eight-day course was held in Malawi in August 2011. National TB and AIDS programmes from nine sub-Saharan countries nominated 18 participants to attend and subsequently serve as focal person for childhood TB-HIV for their programme.

The course covered both the clinical aspects of childhood lung disease in the HIV-infected child and the programmes and activities needed to strengthen health service delivery. By the end of the course, participants had developed and presented a draft operational research proposal to address a problem specific to their country. Follow-up support and advice were provided to assist the teams in carrying their research forward. The Norwegian Agency for Development Cooperation (Norad) funded this course.

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**Managing Diabetes in Malawi**

The Centre for Operational Research has adapted the TB DOTS framework to track different diseases, and this model has been applied to diabetes in three central hospitals in Malawi. By September 2011, 2,210 patients with diabetes had been registered at Queen Elizabeth Central Hospital in Blantyre. Quarterly cohort reporting has been set up, and third quarter results showed that 2,193 of the registered patients were alive and in care. Additional hospitals in Lilongwe and Zomba have also launched similar programmes, each registering some 40 patients by the end of the year. Funding for this activity came from the World Diabetes Foundation.
The South African health system is rolling-out both line probe assays (LPA) as well as Xpert MTB/RIF for the diagnosis of tuberculosis and drug-resistant tuberculosis. To follow this process and assess the impact of these new tools on both the health system and patients, TREAT TB launched the Policy Relevant Outcomes from Validating Evidence on Impact (PROVE IT) study in January 2011. The Desmond Tutu TB Centre, a TREAT TB partner, is implementing the study.

The goals of the PROVE IT study are to identify the number of additional cases of drug-resistant TB discovered through the use of new tools; to assess how diagnosis through the use of new tools impacts on the time for patients to be placed on appropriate treatment; to determine how new tools affect the transmission of drug-resistant TB; to determine what types of patients benefit most from the introduction of new tools; to assess what laboratory measures are needed to optimise the use of new tools in various settings; and to analyse the uptake of the intervention and any changes and/or transfer of policy.

In 2011, the team analysed the records and outcomes of hundreds of patients, conducted 41 cost-assessment interviews with patients and conducted 42 interviews with clinicians and healthcare providers.

Related PROVE-IT studies are being conducted in Brazil and Russia. TREAT TB is funded by the United States Agency for International Development (USAID).

ORAP: HOW CAN RURAL AREAS FIND PRACTICAL SOLUTIONS TO TB CONTROL?

TREAT TB and the Desmond Tutu TB Centre at Stellenbosch University in South Africa are working to build a sustainable focus on and more unified approaches to operational research as an integral component of the National TB Control Programme, through the Operational Research Assistance Project (ORAP). This initiative aims to strengthen the capacity of South African professionals at national, provincial and local levels to conduct operational research independently. In 2011, six new operational research studies were launched by ORAP trainees. These studies are set for completion in 2012. Support for ORAP is provided by the Desmond Tutu TB Centre and the Free State Province Health Department.

MORE THAN 145,000 ART PATIENTS REGISTERED FOR ELECTRONIC MONITORING

The three-year agreement between The Union’s Centre for Operational Research (COR) and the Baobab Health Trust in Malawi has been renewed, continuing their joint efforts to expand an electronic monitoring system for anti-retroviral therapy (ART) and non-communicable diseases. By September, 145,352 ART patients had been registered at 17 government clinics and 79,799 were alive and retained on therapy.

MONITORING ART IN MALAWI

The Union continued its collaboration with the HIV Unit of Malawi’s Ministry of Health, providing nationwide supervision and monitoring of HIV-infected patients on ART. A review took place between October and December to report on national data in the public and private sectors. By the end of September, 408,236 patients had been initiated on ART and had known treatment outcomes. Of these 292,372 were alive and on ART at their original registration clinic. The data also showed which ART treatment regimen each patient received.

OR FELLOWS PROGRAMME CONTINUED

Talented young researchers continued to make valuable contributions through The Union’s Operational Research Fellows programme. In Africa there were two senior fellows and one junior fellow in 2011. They come from Malawi, South Africa and Zimbabwe and are researching issues such as treatment outcomes in HIV-infected adolescents and treatment outcomes of adult patients with recurrent TB. In addition, two fellows funded by the Desmond Tutu TB Centre completed their second year and two additional fellows funded by AMPATH concluded their first year. All of the fellows reached the milestones of conducting their own research and of submitting at least two papers each in 2011.

UNION OR FELLOW NAMED JUNIOR OUTSTANDING AFRICAN SCIENTIST

Mr Hannock Tweya, one of The Union’s Operational Research Fellows, received the Junior Outstanding African Scientist award from the European and Developing Countries Clinical Trials Partnership (EDCTP) in October 2011. The 10,000-euro award recognises an African scientist working on HIV/AIDS, TB and malaria research.

Mr Tweya, who is from Malawi, became a Junior OR fellow in 2009 and was promoted to Senior OR fellow in April 2011. He was honoured for his participation in a national ART survey of health care workers, as well as other studies, and his involvement in training others to conduct operational research. His papers have been published in Tropical Medicine and International Health and other journals.
Tobacco Control

CHAD AND OTHER COUNTRIES
LEAD TOBACCO CONTROL EFFORTS IN AFRICA

Tobacco control has become an increasingly important part of public health efforts in Africa with the increase in smoking rates – thanks to intensive tobacco industry marketing campaigns – and the rise of non-communicable diseases, including lung cancer and chronic respiratory diseases.

The Union worked with Bloomberg Initiative grantees in seven African countries in 2011 and supported their progress on a number of important initiatives:

> **Chad** implemented bans on smoking in public places. Work also began to include tobacco control as part of the national poverty reduction strategy, which will be a first for the region.

> **Chad** and **Niger** implemented bans on all forms of direct advertising and prepared to introduce graphic health warnings.

> **In Mauritius**, monitors found smokefree implementation to be effective.

> **Gabon**’s National Draft Law was adopted and passed the first reading in Parliament. The Union supported the review process.

> **Burkina Faso**’s law was expanded to cover bans on smoking in public places and other provisions, and mandated the establishment of a tobacco control cell.

> **Benin**’s revised National Draft Law was adopted in October despite expected efforts from the tobacco industry to try to weaken the proposed law. However, not everyone favours tobacco control. In **Senegal**, the prime minister threatened to lower the cost of Marlboro cigarettes. The Union provided support to advocates working to counter the tobacco industry’s influence and activities.

JOURNALIST TRAINING BUILDS AWARENESS OF TOBACCO PANDEMIC

The Union conducted a workshop for journalists from nine francophone countries (Benin, Burkina Faso, Chad, Gabon, Guinea, Mali, Niger, Senegal and Togo) in 2011. The training included presentations and discussions on the Framework Convention on Tobacco Control and tobacco industry tactics to delay or prevent tobacco control policy implementation. The goal was to establish a journalists’ network that can support tobacco control measures.

The Union Africa Region

799 members in 2011

The Union Africa Region held its 18th conference in Abuja, Nigeria on 3-5 March 2011. More than 600 delegates from 32 countries participated in the event, which focused on the theme “TB, TB/HIV and other lung diseases: challenges to the attainment of the MDGs in Africa”. One outcome of the conference was that 60 new members joined The Union while at the event.

A General Assembly was held in Abuja to discuss the Region Charter and a strategic plan, and these discussions continued at the annual region meeting in Lille, France at the World Conference in October. Both meetings were attended by more than 100 members and officers. Key decisions were to submit the Africa Region Charter to the Paris headquarters by the end of November 2011 and to appoint the Nigeria members to coordinate the strategic planning process. Members also voted to hold the next region conference in Kigali, Nigeria in 2013.

Constituent members

Comité Algérien de Lutte Contre la Tuberculose (CALTMR) (Algeria)
Programa Nacional de Controlo de Endemias (Angola)
Ministère de la Santé (Benin)
Ministère de la Santé (Burkina Faso)
Ministère de la Santé Publique (Cameroon)
Programme National de Lutte Contre la Tuberculose (DR Congo)
Ministerio de Sanidad y Bienestar Social (Equatorial Guinea)
Ministry of Health (Eritrea)
Ghana Society for Prevention of TB and Lung Disease (Ghana)
Ministère de la Santé et de l’Hygiène Publique (Guinea)
Kenyan Association for the Prevention of TB and Lung Disease (KAPTLD) (Kenya)
Institut d’Hygiène Sociale (Madagascar)
Ministry of Health and Population (Malawi)
Comité Anti Tuberculeux de Lutte contre les Maladies Respiratoires du Mali (CAMM) (Mali)
Ministerio de Saude (Mozambique)
National TB & Leprosy Control Programme (Nigeria)
Ministère de la Santé (Senegal)
South African National TB Association (SANTA) (South Africa)
Ministry of Health (United Republic of Tanzania)
Comité National Anti-Tuberculeux (CNART) (Togo)
Ligue Nationale Contre la Tuberculose et les Maladies Respiratoires (Tunisia)
National TB / Leprosy Program (Uganda)

Organisational member

Desmond Tutu HIV Foundation (South Africa)

Officers

President: Jaafar Mansur Kabir (Nigeria)
Vice President: Martin Gninafon (Benin)
Secretary General & Board Representative: Osséni Tidjani (Togo)
Treasurer: Genevieve Dorbayi (Ghana)
The Union Asia Pacific Office (UAP) in Singapore facilitates technical assistance and training programmes throughout the region. It also serves as the office of the International Union Against Tuberculosis and Lung Disease – Asia Pacific Ltd, an independent charity in Singapore and an organisational member of The Union.

Major activities of the UAP in 2011 included coordinating eight International Management Development Programme (IMDP) courses held in Bangkok, Singapore and Kuala Lumpur and providing support to seven TB, MDR-TB, tobacco control and operational research courses in Singapore, Indonesia and Fiji.

**The Union China Office** in Beijing coordinates The Union’s tobacco control activities in China, as well as offering expertise in tuberculosis and lung health.

**Health challenges in the Asia Pacific**

- High rates of obesity and diabetes are found in the 22 Pacific Islands countries.
- About 100,000 MDR-TB cases emerging in China each year.
- Close to 370 million tobacco users live in China, Indonesia and the Philippines alone.

Sources: see page 69
SMOKEFREE PUBLIC PLACES: NEW COMMITMENT FROM CHINESE GOVERNMENT

In March, the Chinese government announced a new regulation stipulating that 28 types of public places in China would become smokefree. This was a huge step forward for a country where smoking is a cultural norm, despite the fact that one million Chinese die of tobacco-related diseases each year. The Implementation of Regulations on Public Places Sanitation Administration (2011) issued by the Ministry of Health stipulated that hotels, restaurants, theatres, shopping centres, bars and a number of other types of venues would become smokefree. The Union and its partner, the Chinese Center for Disease Control (CDC), assisted with the development of the regulations and supported the National Tobacco Control Office to promote a smokefree China.

“SEVEN CITIES” PROGRESS: HARBIN PASSED FIRST 100% SMOKEFREE LAW

The “Seven Cities” project began two years ago with support from the Bloomberg Initiative to Reduce Tobacco Use (BI). The Union has worked throughout that time with the project grantee, the Chinese CDC and local partners, such as the China Tobacco Control Legal Working Group, to promote smokefree legislation in the seven participating cities.

> Harbin raised the bar in May 2011 by becoming the first city to pass comprehensive smokefree legislation. All indoor public places and workplaces became smokefree. The most stringent local smokefree legislation in China to date went into effect on 31 May 2012.

> Tianjin passed “The Tobacco Control Regulation of Tianjin” banning smoking in nearly all public and workplaces, with the exception of restaurants, bathing houses and discothèques, where smoking rooms with separate ventilation are allowed. A Health Promotion Committee is aiding plans to enforce the law, which went into effect 31 May 2012.

> Lanzhou’s municipal government approved the “The Tobacco Control Regulation of Lanzhou”, which proposes to ban smoking in all public and workplaces. The first review of the law by the Lanzhou People’s Congress was planned to take place by the end of June 2012.

> The Guangzhou Regulation on Smoking Control in Public Places took effect in September 2010. According to a 2011 study, smoking in public places has declined by 5.4%, and the number of smokers has decreased from 18.6% in 2009 to 17.4% in 2011. Most importantly, the Government of Guangzhou allocated government funds in both 2010 and 2011 to ensure local sustainability of tobacco control.

POLITICAL AND PUBLIC SUPPORT FOR SMOKEFREE INDONESIA IS HIGH

A ministerial decree to guide sub-national governments on the establishment and implementation of smokefree policy was released jointly by the Ministry of Health (MOH) and Ministry of Interior in February 2011. The Union supports the MOH to build the capacity of public health systems under a BI grant.

The decree provides a legal framework for sub-national governments to adopt smokefree policies based on the 2009 Health Law. By the end of 2011, more than 22 million people in Indonesia were covered by sub-national smokefree policies.

Public support for new sub-national laws was also very high according to a poll carried out in 2011 by Swisscontact Indonesia Foundation. The foundation is strengthening implementation of smokefree policies in Jakarta, under a BI grant managed by The Union.
SMOKEFREE EFFORTS IN INDONESIA PUSHED BY MAYORS’ ALLIANCE

An alliance of 12 Indonesian mayors was launched in January to help enact tobacco control legislation at a sub-national level. With support from the MOH and The Union, the mayors joined forces to develop and implement local regulations for 100% smokefree public places and workplaces and to ban outdoor tobacco advertisements over the course of the year.

The alliance will reciprocate the support of the MOH by backing its initiatives to consolidate tobacco control implementation, as well as plans to integrate non-communicable disease control programmes into its agenda at the national and sub-national levels.

Alliance members also hoped to inspire the 96 members of the Mayors Association of Indonesia and encourage them to join in their efforts. More than 20 of these mayors had already joined the Alliance by the end of 2011.

Five additional cities developed 100% smokefree policies after the alliance was launched: Payakumbuh, Bukittingi, Sragen, Makassar and Padang. Bali – a province – also declared itself smokefree.

Four cities – Bogor, Payakumbuh, Bukittingi and Sragen – have also successfully banned outdoor tobacco billboards and advertising in smokefree places.

‘MY CITY MY LOVE’ - SMOKEFREE MANILA CAMPAIGN STANDS UP TO TOBACCO INDUSTRY

The new smokefree policies of the Metro Manila Development Authority (MMDA), a Union grantee under the Bloomberg Initiative to Reduce Tobacco Use, have been fiercely contested by the tobacco industry. The MMDA’s push to enforce Manila’s smokefree policy under the “Metro Ko Love Ko” – “My City My Love” – campaign included the launch of campaign billboards throughout Greater Manila and an increase in enforcement activities.

Both Philip Morris and Fortune Tobacco threatened to take legal action against the MMDA’S initiative. Nevertheless, local partners and the public supported the campaign. Surveys by local media network ABS-CBN showed more than 90% public acceptance of the smoking ban. The Philippines Medical Association also announced its full support.

Tuberculosis

INTENSIVE TRAINING IN MDR-TB OFFERED IN CHINA AND THAILAND

The Union continued to work closely with China to address its growing burden of multidrug-resistant tuberculosis and help scale up its Programmatic Management of Drug-Resistant TB (PMDT). Three MDR-TB courses were offered over the course of the year:

The 7th–9th Comprehensive Courses on the Clinical Management of Drug-Resistant TB took place in Nanjing (April), Jinan (June) and Chengdu (August). In all 120 clinicians from across China completed these 5-day intensive courses. All sessions covered the MDR-TB situation locally and globally, the principles of TB control, why resistance to anti-TB medications develops, case finding and clinical manifestations, drug susceptibility testing, adverse reactions, infection control and contact management.

In addition, with adverse effect management a critical factor in successful treatment, The Union was invited to co-offer a two-day workshop in Beijing on managing side effects and the use of cycloserine for MDR- and XDR-TB treatment. Proposed by the World Health Organization (WHO) China Office and the China National Center for TB Control, the workshop examined case studies from five different provinces. The 35 participants included several senior TB experts.

Due to flooding in Thailand, the IV International MDR-TB Course had to be postponed until the last week of December, and only half of the 23 registered participants were able to attend. They were from Cambodia, Fiji, Indonesia, Sudan and Vietnam, as well as Thailand.

MDR-TB PROGRAMME IN INDONESIA MONITORED

As a TB CARE project partner, The Union monitored Indonesia's Programmatic Management of Drug-Resistant Tuberculosis (PMDT) in September. Indonesia has had a Green Light Committee approved PMDT
programme since 2007, and is now in the expansion phase. By the end of August 2011, there were five PMDT sites, with 310 patients on treatment, eight cured and one who completed treatment.

The review covered various issues, including recordkeeping, handling of complicated DR-TB cases and available clinical guidelines. The Union also explored how remote support (e.g., Internet) could help fill gaps in clinical management and identified physicians to use this approach for the most complicated DR-TB cases. With only five laboratories performing cultures, the review found that capacity for diagnosis and follow-up was limited; but, overall the scale up at the programmatic level was appropriate, and there was no evidence of drug stockouts or other major problems.

A 5-day national MDR-TB course was offered as part of this mission. It included an overview of the clinical issues and MDR-TB and MDR-TB/HIV case reviews.

PAPUA NEW GUINEA’S REMOTE AREAS FACE MDR-TB CRISIS

The remote South Fly District of Papua New Guinea took steps to gain control over an increasing caseload of MDR-TB beginning with an evaluation by an expert team led by the WHO. Union experts were invited to participate in the six-day mission to the capital, Daru, and Western Province health facilities. They found that a coherent and comprehensive TB control effort is needed to curb the spread of drug-resistance in the community and prevent unnecessary deaths. Recommendations included immediate strengthening of all elements of DOTS, as well as measures such as the use of fixed-dose combinations rather than single drugs. Finally long-term technical assistance was recommended to strengthen TB services in general and to establish a Programmatic Management of Drug-Resistant TB (PMDT) programme through training and other support.

TB CONTROL IN THE AUSTRALASIAN REGION

TB control issues in the Australasian region were the focus of a day-long meeting in Melbourne, Australia in August 2011. The guest speaker was Prof Donald A Enarson, Senior Advisor to The Union, who spoke on the history and current role of The Union in global TB control. Other presenters covered regional issues from MDR-TB in Papua New Guinea to TB control in the Australian indigenous population. Members of the National TB Advisory Committee (NTAC) to the Australian Ministry of Health and Ageing attended, as well Australia-based TB researchers. The meeting was organised by Dr Stephen Graham of The Union, who is a member of NTAC, and partially funded by the Centre for International Child Health, University of Melbourne.

HIV and Tuberculosis

TB-HIV ACTION PLANS DEVELOPED IN BEIJING COURSE

The Union China Office, in collaboration with the Chinese Center for Disease Control (CDC) organised the first Asia offering of “Working Together: Strengthening the Implementation of Collaborative TB-HIV Activities” in May 2011. The 4-1/2 day course held in Beijing was attended by 30 participants from 13 provinces and the national centres for TB and HIV/AIDS prevention and control. The curriculum covered diagnosing HIV in TB patients, intensive TB case finding among people living with HIV, isoniazid preventive therapy for people living with HIV/AIDS, infection control, drug supply management and antiretroviral therapy (ART) as a tool for TB prevention. A team approach was used to encourage collaboration between TB and AIDS representatives. Teams from each province drafted joint action plans to address barriers to TB-HIV collaborative services. The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) funded this course.
BIDIRECTIONAL TB-DIABETES SCREENING FUNDED FOR CHINA AND INDIA

In August 2011, the World Health Organization and The Union published a global framework for managing TB and diabetes mellitus. Bi-directional screening for active TB in patients with diabetes and for diabetes in patients with TB is an essential component of this plan, which aims to foster the earlier diagnoses needed for better treatment outcomes and control of both diseases.

The World Diabetes Foundation gave The Union an 18-month grant to work with policy-makers and front-line staff in China and India to develop and implement these new procedures. In China, a national stakeholders’ meeting was held in May that enabled The Union and those working at pilot hospitals and clinics to develop further plans for both screening and quarterly recording and reporting in line with The Union’s model for TB. In July The Union held training for staff from the 11 health facilities, and the implementation of screening started in September. In India, the national stakeholders’ meeting was held in October followed by training of site staff in December. Implementation is planned for the first quarter of 2012.

ABC SMOKING CESSION PROGRAMME OFFERED IN INDONESIA

In Bogor City, Indonesia, 10 primary health care centres (PHCC) offered the “ABC” smoking cessation intervention, which is described in The Union’s guide Smoking cessation and smokefree environments for tuberculosis patients. ABC stands for A=ask, B=brief advice, and C=cessation support; and the intervention is designed to be carried out in conjunction with the DOTS programme. The intervention also promotes establishing 100% tobacco-free health care settings and offers suggestions for creating smoke-free homes to help TB patients and their families quit smoking and to protect them from exposure to secondhand smoke.

Between March and August 2011, 211 new TB patients were diagnosed in Bogor, of whom 165 (72%) were current smokers. All participated in the ABC programme. Of them, 60.6% had quit for three months by the time they completed their six-month TB treatment, and 65% had made their homes smokefree. In addition, by October, of 348 health facilities including private clinics, 91% were found fully compliant with Bogor City tobacco-free policies. Tobacco-free health service is defined zero evidence of smoking and tobacco promotion, sponsorship and advertisements within the premises of the health facility.
Child Lung Health

IMPROVING NTP MANAGEMENT OF CHILD TB

A workshop entitled “Child TB in NTP: from policy to practice” was hosted by The Union Asia Pacific Office in Singapore on 10–11 September 2011. The goal was to support the efforts of national tuberculosis programmes to improve the representation of children in their plans, activities and reports. The workshop focused on identifying priority child TB activities, training needs and how to evaluate the results. Representatives from Bangladesh, Cambodia and Indonesia attended, and each country identified its own priorities and plans. Other participants included Médecins Sans Frontières and Institut Pasteur, Cambodia. The workshop was developed by The Union’s Child Lung Health Division and the University of Otago, New Zealand with funding from AusAID.

Research

OR SYMPOSIUM AND COURSE OFFERED IN THE FIJI ISLANDS

The Fiji Islands hosted a two-day symposium on operational research (OR) in September. The symposium included presentations by The Union’s Centre for Operational Research; the Fiji College of Medicine, Nursing and Health Sciences (CMNHS); the Ministry of Health; the WHO; the Fiji National Tuberculosis Programme (NTP); The Global Fund and the Secretariat of the Pacific Community. The event was open to all and gained wide coverage in the local media.

The public event was followed by the launch of The Union’s three-module OR course, which was jointly organised by the same partners and attended by 12 participants. In module 1, they learned to develop their own research protocols. They will return for modules 2 and 3 in 2012, with the ultimate goal of completing their research, analysing the data and writing up the results for publication in a peer-reviewed journal. The Fiji course was funded by the Global Fund.

REVISED PROTOCOL FOR PHARMACOKINETIC STUDY IN VIET NAM APPROVED

The Union has been conducting a phase II pharmacokinetic (PK) study of different doses of rifabutin combined with antiretroviral therapy (ART) in the treatment of tuberculosis patients with HIV infection (ANRS 12150b Trial). A trial in South Africa was completed in 2010, and a sister trial planned for Ho Chi Minh City, Viet Nam was approved in 2011 by The Union and national ethics committees. Due to changes recommended in the 2010 WHO Guidelines for Antiretroviral Therapy, The Union redesigned the protocol for this second trial to be in line with current recommended practice. Screening of patients started in the last quarter of 2011, and by the end of the year 12 patients had been recruited to the study.

The Union Asia Pacific Region

428 members in 2011

The 3rd Conference of The Union Asia Pacific Region held in Hong Kong on 8–11 July brought together 1,000 delegates from 32 countries. The conference organised by the Hong Kong Tuberculosis, Chest and Heart Diseases Association focused on “Current Challenges in TB and Lung Health” and included sessions on TB, TB-HIV, tobacco control, smoking cessation, asthma, COPD and pneumonia.

The bi-annual APR Council meeting was held at the conference. They discussed issues ranging from membership concerns to collaborations with other organisations such as the Western Pacific Regional Office of the WHO and the Asia Pacific Society of Respirology.

Ms. Babe Chan of Hong Kong, longtime treasurer, stepped down in July. The region passed a resolution thanking her for her excellent work and dedication. Mr Simon Yat-Wa Chan of Hong Kong was elected to replace her.

The next APR conference will be held in Hanoi, Viet Nam in April 2013, hosted by the Viet Nam Association Against Tuberculosis and Lung Disease (VATLD).

Constituent members

Australian Respiratory Council (ARC) (Australia)
Chinese Anti-tuberculosis Association (CATA)
(People’s Republic of China)
National Tuberculosis Association (Taipei, China)
Hong Kong TB Chest and Heart Diseases Association (Hong Kong)
The Indonesian Association Against Tuberculosis (Indonesia)
Japan Anti-Tuberculosis Association (JATA) (Japan)
Korean Institute of Tuberculosis (KIT) (Republic of Korea)
Malaysian Association for the Prevention of Tuberculosis (Malaysia)
Mongolian Anti-Tuberculosis Association (Mongolia)
Philippine Tuberculosis Society, Inc. (The Philippines)
SATA CommHealth (Singapore)
The Anti-Tuberculosis Association of Thailand (Thailand)
National Hospital of TB and Respiratory Disease (Viet Nam)

Organisational members

Tropical Disease Foundation (The Philippines)
The International Union Against Tuberculosis and Lung Disease, Asia Pacific Ltd (Singapore)

Officers

President & Board Representative:
Camilo Roa Jr (The Philippines)
Conference President: Dinh Ngoc Sy (Viet Nam)
Vice President: Wang Xie Xiu (China)
Secretary General: Elizabeth Cadena (The Philippines)
Treasurer: Simon Yat-Wa Chan (Hong Kong)
The Union South-East Asia Office (USEA) in Delhi is The Union’s largest regional office. It provides public health expertise to the region, working with governments, civil society, corporations and international agencies. Throughout 2011, partnerships were key to defining and sustaining The Union’s work in the region and underpinned several initiatives.

TB and tobacco control continued to be the major focuses for USEA in 2011. While Project Axshya remained USEA’s centerpiece on TB control, tobacco control advanced through several smokefree policy, enforcement and technical assistance initiatives. USEA also conducted operational research, coordinated various capacity-building programmes, and provided grant monitoring services.

Two secretariats housed at USEA supported various initiatives – The Partnership for TB Care and Control in India, a civil society coalition of 95 partner organisations by December 2011, and the TB & Poverty Sub-Working Group of the Stop TB Partnership.

This region is also served by The Union Office in Myanmar, located in Mandalay. This office focuses on HIV and TB-HIV activities in that country, working in close partnership with the health system at every level.

**Health challenges in South-East Asia**

- South-East Asia bears about a third of the world’s TB burden, and India has the highest TB burden globally.
- Tobacco is a leading killer, with over a million tobacco-related deaths each year in India alone.
- The region has the second highest HIV burden globally, with TB-HIV co-infection on the rise.

*Sources: see page 69*
Tuberculosis

PROJECT AXSHYA REACHED 240 DISTRICTS ACROSS 21 STATES OF INDIA IN 2011

Project Axshya made impressive gains in 2011. Led by a Project Management Unit at USEA, its nine sub-recipient partners progressed on implementing the project in their respective states and districts. The Union’s mandate for this five-year civil society initiative is to develop and implement Advocacy, Communication and Social Mobilisation (ACSM) activities leading to strengthened TB control and universal access to TB care nationally, and to reach over 570 million people in 300 districts across 21 states by 2015.

In Year 1 (April 2010–March 2011), the team put systems and structures for this complex project into place and launched it successfully. Using a phased approach, the project covered 90 districts in 15 states in year 1 and expanded to 240 districts across 21 states by the end of 2011. The aim is to engage stakeholders at every level of civil society and the health care system, and to reach vulnerable groups such as women and children, marginalised and poor sections, and TB-HIV co-infected populations.

A major mass media campaign ‘Bulgam Bhai’ was developed during the year for TV, radio and street theatre, in collaboration with the Population Services International, India and BBC World Service Trust. This 360-degree communication campaign aims to increase awareness of TB, encouraging those with two or more weeks of cough to get tested. In addition, activities of the India Partnership for TB Care and Control fed into the project. While the number of activities is easy to quantify, the project’s ultimate objective is to produce meaningful changes in behaviour and attitude leading to more accessible and effective TB care. That will be the true benchmark of its success.

Project Axshya is funded by a Round 9 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund). Other principal recipients in the US$ 199 million grant are the Government of India, which is focusing on scaling-up access to MDR-TB diagnosis and treatment, and World Vision India, which is also working on ACSM in another 74 districts in the country.

AXREAL PROVIDES REAL-TIME MONITORING FOR PROJECT AXSHYA

The Union’s web-based activity monitoring system, AxReal, keeps track of Project Axshya activities in real-time at district, state and national levels. Developed by USEA’s IT team, AxReal was used by 120 district coordinators and project managers to record and monitor activity data from 240 districts in 21 states in 2011. The programme shows action plans, quarterly reports, budget information and feedback. A “dashboard” depicts, at a glance, real-time progress in graphic and tabular forms.

10,000 RURAL HEALTH CARE PROVIDERS SENSITISED TO TB IN INDIA

In the first year of Project Axshya, more than 2,500 rural health care providers and traditional healers from 90 districts were trained to identify TB symptoms and refer them to the nearest designated microscopy centre for sputum examination and to serve as DOT (directly observed treatment) providers for TB patients. The training is part of the project’s focus on rural practitioners since they are the first point of contact for a majority of rural populations in India, and many people in remote tribal areas rely on traditional healers. Through this training Project Axshya hopes to contribute to much-needed early diagnosis and correct treatment of TB in populations served by these healers. The activity continued in the project’s second year, reaching nearly 10,000 rural practitioners in 240 districts by the end of 2011.

BUILDING TB AWARENESS THROUGH THE MEDIA IN INDIA

The Union continued to work both with India’s journalists and civil society organisations to improve TB news coverage. In March, USEA participated in an award ceremony organised by its Chennai-based partner, the Resource Group for Education and Advocacy for Community Health (REACH), to honour print journalists for TB stories in English and local languages. The winning stories covered issues ranging from the impact of TB on mining communities to the availability of free treatment.

Over the year, USEA, REACH and the Indian Media Centre for Journalists (IMCFJ) also coordinated zonal workshops for members of the Partnership for TB Care and Control, India, to help them work effectively with the media. Each partner organisation was required to develop a media plan within a month of the training, and the organisation generating the most coverage about TB would receive an award on World TB Day 2012. Eli Lilly & Company (India) funded both the activities.

TECHNICAL CAPACITY BUILDING ON MDR-TB AND OTHER AREAS

Sixty specialists attended The Union’s comprehensive courses on the clinical management of multidrug-resistant TB (MDR-TB), organised by USEA and the Lala Ram Swarup Institute on Lung and Respiratory Diseases (LRS Institute). Participants came primarily from India to learn about clinical, diagnostic and therapeutic issues related to MDR- and extensively drug resistant (XDR) TB, and the most important measures to prevent them. The courses “trained the trainers” too so that participants could disseminate the knowledge in their home states and countries. The Union also conducted courses on TB epidemiology and leadership and management for TB for state and district programme managers.
The Union’s Integrated HIV Care (IHC) programme in Myanmar received funds to expand activities designed to decrease HIV-related morbidity and mortality in HIV-infected adults and children. Some 12,000 patients will receive antiretroviral treatment (ART) by the end of 2015 through the grant, which comes from The Global Fund via the UN Office for Project Services (UNOPS), Myanmar.

The IHC programme also aims to strengthen support for TB-HIV collaborative activities and to prevent HIV mother-to-child transmission by providing triple-drug therapy to HIV-positive pregnant women.

Enrolment in the drug-resistance survey was completed as planned, and testing at the National Tuberculosis Reference Laboratory continued. Records and databases were reviewed, and reasons for any errors seen by re-testing quality assurance identified. This review was conducted by The Union under an agreement with World Health Organization (WHO), TB Lab Services and the Antwerp Supranational Reference Laboratory.

The IHC programme also aims to strengthen support for TB-HIV collaborative activities and to prevent HIV mother-to-child transmission by providing triple-drug therapy to HIV-positive pregnant women.

As part of the five-year agreement, The Union is working with the Myanmar Department of Health. All activities supported by The Union are implemented in, by and with the public sector. Partners include the National Tuberculosis Programme and the National AIDS Programme, who in turn operate out-patient departments in seven township health centres, township hospitals, district and tertiary hospitals.

The IHC programme is offered at 14 sites in the city of Mandalay and its seven townsships, as well as townsships in Pakokku, Lashio, Taunggyi, Monywa, Myeikhtila and Myinchan and the Thar Ke Ta Hospital in Yangon. As of the end of December 2011, the programme had enrolled 14,419 patients; 10,693 of whom are on active follow-up, and 8,337 of whom were on ART. The IHC programme is also supported by the Three Diseases Fund and the Yadana Consortium operated by Total/MGTC.

While most of the 14 Integrated HIV Care (IHC) programme sites in Myanmar are in or near the city of Mandalay, a new site opened in 2011 at the Monywa General Hospital in Monywa, a small town three hours away. Within a few months, more than 400 adults and children had been enrolled at the site, with about half taking antiretrovirals. All drugs and laboratory testing for HIV/TB and opportunistic infections are supplied free of charge, but patients have to pay for other non-HIV/
TB medicines, which they buy at the private pharmacy attached to the hospital.

The IHC team supported this new site by visiting facilities and meeting with staff to conduct monitoring and evaluation. Due to the lack of air-conditioning, a new facility was constructed for this programme. The team also met with the People Living with HIV/AIDS Network, 15 volunteers who provide three adherence sessions for each newly enrolled patient. By the end of 2011, 732 patients had been enrolled at the Monywa site, of whom 425 were on ART.

The Myanmar office and COR collaborated on data collection

The Union Office in Myanmar worked with the Centre for Operational Research (COR) to provide regular, timely and accurate recording and reporting of data on HIV-infected patients in treatment through the IHC programme. The study found that 14,419 patients had ever enrolled for treatment and 10,693 were on active follow-up. Of these, 10,083 had started on ART and 8,337 were alive and retained on treatment.

Research

Operational Research Courses Offered in Three Indian Cities

Operational research courses were held in Hyderabad, Delhi and Bangalore in 2011. The 27 participants each developed a research protocol, conducted a study, analysed the results and wrote up a paper for publication during the three-modules of the course. By the end of the year, 12 papers had been submitted and four were in press or had been published.

Interns Learn Operational Research at USEA

Three operational research (OR) interns spent periods of time at USEA during the year, conducting studies with the support of Union experts and resources. A medical student from the USA developed a protocol for gauging patient knowledge of TB through various stages of treatment to study the correlation between poor knowledge and the number of missed doses during treatment. A physician from the state of Himachal Pradesh in India assessed compliance with the state’s tobacco control laws, gaining hands-on experience with EpiData software.

The third intern, a graduate of Edinburgh University, UK, carried out two studies. One, covering 60 districts, measured the impact of a Union sensitisation course for village health and sanitation committees on knowledge and action concerning the social determinants of TB. The second studied the impact of sputum collection and transportation programmes on TB control in India, particularly for vulnerable and marginalised groups.

Smoking Cessation Made as Simple as ABC in Bangladesh

In Bangladesh, BRAC piloted The Union’s ABC (A=ask, B=brief advice, C=cessation support) approach to smoking cessation for tuberculosis patients in 17 peri-urban DOTS centres beginning on 8 May 2011. Cohort results for the 239 new sputum-smear positive TB patients registered for smoking cessation between May and August showed that 80% of them successfully had quit smoking by the end of their six-month TB treatment. These results demonstrate that brief advice and support for smoking cessation given by DOT providers at each visit to a smokefree health care facility can produce a remarkable quit rate among TB patients.

In addition to encouraging patients to quit smoking and/or to continue not smoking, The Union approach promotes establishing 100% tobacco-free health care settings and offers suggestions for creating smoke-free homes to help TB patients and their families to quit and to protect them from exposure to second-hand smoke.

Tamil Nadu Conference on NCDS and Infectious Diseases

The Union participated in a conference in March that focused on the link between non-communicable diseases (NCDs) and primary health care. Dr. Nevin Wilson, Regional Director of The Union South-East Asia Office, spoke about Union-led studies on combining TB treatment and tobacco control activities to demonstrate the feasibility of introducing them at the primary health care level. Conference participants learned that integrating efforts to manage infectious diseases and NCDs is not only good public health practice, but also cost effective.
**Indian States Advance Towards Smokefree Goal**

Several cities, districts and states made good progress towards a smokefree India in 2011 with grants through the Bloomberg Initiative and technical support from The Union. Highlights included:

> **Kerala:** Ernakulam district – a popular tourist destination – became smokefree and will be a model for Kerala’s 13 other districts. In addition, the state banned tobacco sales within 100 yards of educational institutions – the result of a three-year campaign. The Kerala Voluntary Health Services (KVHS), The Union’s partner in the state, helped achieve these successes.

> **Himachal Pradesh:** Smokefree enforcement was strengthened across all districts in the state, benefitting people in rural areas in addition to its urban population.

> **Mizoram:** The Chief Minister of Mizoram declared the state smokefree on 30 June after two years of strictly enforcing state legislation.

> **Madhya Pradesh:** Smokefree policies were implemented in eight districts of the Indore division that have prioritised tobacco control through excellent government support and public-private collaboration.

> **Punjab:** Smokefree Mohali district was launched in 2011, making it the first smokefree district in Punjab. The state government and the Generation Saviour Association (GSA) organised a workshop of 100 stakeholders from government and civil society to plan for the transfer to smokefree. Enforcement was scaled up with the increased display of ‘No Smoking’ signs and penalties for violators.

> **Gujarat:** The state constituted tobacco control cells in all districts.

> **Orissa:** The state capital Bhubaneswar was declared smokefree. The state minister of health released the Law Enforcers Resource Manual, developed by the non-governmental organisation HRIDAY, which will be used to train the state’s law enforcement officers about tobacco control.

> **Tamil Nadu:** Smokefree policies implemented in the Chennai Metropolitan Area had a spill-over effect throughout the state, with many districts putting effective enforcement mechanisms in place.
The Union South-East Asia Region

307 members in 2011

The Union South-East Asia Region (SEAR) held its annual meeting in Lille, France at the World Conference in October, with representatives from six countries participating. Each organisation presented its current activities and future plans. Other issues discussed included SEAR’s finances, the need for training and a desire to use The Union as a platform for giving wider visibility to members’ activities, perhaps through a publication. A committee comprising a representative from each member country will work together to increase membership, identify training needs and seek opportunities for members.

Constituent members
National Tuberculosis Control Program (Afghanistan)
National Anti-TB Association of Bangladesh (NATAB) (Bangladesh)
The Tuberculosis Association of India (India)
Myanmar Medical Association (Myanmar)
Nepal Anti-Tuberculosis Association (Nepal)
Pakistan Anti-Tuberculosis Association (Pakistan)
Ceylon National Association for the Prevention of Tuberculosis (CNAPT) (Sri Lanka)

Organisational members
Sandoz Private Limited (India)
SAARC Tuberculosis and HIV/AIDS Center (Nepal)

Officers
President: Mzaffar Hossain Paltu (Bangladesh)
Vice President: Devendra Bahadur Pradhan (Nepal)
Board Representative: Khairuddin Ahmed Mukul (Bangladesh)
Scientific Committee Chair: R. C. Jain (India)

India’s Plastic Packaging Ban Affects Chewing Tobacco Cost

An environmental law that bans plastic packaging for chewing tobacco went into effect in March, despite opposition from manufacturers and others. The ban increased the cost of chewing tobacco products, thereby making them less affordable to the estimated 206 million adult users in India, the majority from low-income households. The Union organised a meeting of stakeholders, including senior Ministry of Environment and Forests officials, for possible collaboration on implementation, enforcement and compliance. It also developed a report for the intervener documentation submitted to the Supreme Court by the Delhi-based Health For Millions Trust in support of the legislation.

Technical Trainings for Tobacco Control in India

The Union organised training programmes on implementation and enforcement of the national tobacco control law (COPTA) for all staff under India’s National Tobacco Control Programme (NTCP) being implemented in 21 states. The 84 programme managers trained between November 2010 and January 2011 included state and district nodal officers, WHO state consultants and NTCP staff from state tobacco control cells. The Union also coordinated a National MPOWER Workshop in September and the Third National Smokefree Workshop in India in October.

Bangladesh’s 2005 Smokefree Transport Law Implemented

Implementation of Bangladesh’s 2005 law mandating smokefree public transportation finally began in February. According to the law, all public places and public transport, including water vehicles, buses, trucks and small vans must be smokefree. If vehicle owners do not comply, their vehicles will fail licensing tests.

Union-managed BI grantees – WBB Trust (Work for a Better Bangladesh), The Alliance for Co-operation and Legal Aid Bangladesh (ACLAB), Action In Development (AID) and the NATAB Tobacco Control Project – contributed to this success. As part of their efforts, WBB Trust organised public campaigns and demonstrations to demand the tobacco control law amendment and increases in tobacco taxation. ACLAB, AID and NATAB are working for smokefree implementation in districts and sub-districts of three divisions.

Comprehensive Tobacco Control Law Passed in Nepal

Nepal’s Legislature-Parliament passed a comprehensive tobacco control law in April, which took effect in July 2011. The Tobacco Product Control and Regulatory Bill 2010 has provisions for 100% smokefree environments; bans tobacco use in public places, workplaces and public transports; prohibits sale of cigarettes, bidi and chewing tobacco to children under 18; calls for graphic health warnings to cover 75% of tobacco packaging; and bans tobacco advertising, promotion and sponsorship. A health tax on tobacco products is also included.

The Union provided technical assistance to its BI grantee, the National Health Education, Information and Communication Centre (NHEICC), which works under the umbrella of the Ministry of Health and Population (MOHP), as well as other stakeholders. The Health and Environmental Forum of Nepal (HEFON) and other civil society organisations also made a major contribution to building support in parliament for this new law.
The Union offices in Mexico and Peru are becoming increasingly well known as resources for the Latin America region. **The Union Mexico Office** in Mexico City focuses on providing technical assistance, legal expertise, training and other services in support of tobacco control for the region. In 2011, The Union’s contributions were recognised by the President of Mexico and other partners who have made substantial progress with support from this team. **The Union Peru Office** in Lima provides a base for TB and lung health technical assistance and training, as well as other services to The Union’s Spanish-speaking constituents.

**Health challenges in Latin America**
- More than 4% of new TB cases are drug-resistant in Latin America
- 34% of adults in Chile smoke, despite a ban on smoking in most public places.
- 40 million people in Central and Latin America have asthma.

Sources: see page 69
**WITH NEW LAW, BRAZIL WENT 100% SMOKEFREE IN DECEMBER**

On 15 December, President Dilma Rousseff signed a bill making Brazil 100% smokefree. The new law bans smoking in all enclosed public spaces, extending an existing smoking ban to all states and eliminating designated smoking areas, popularly known as *fumodromos.*

It also calls for tobacco tax increases, bans points-of-sale ads and restricts use of flavourings in tobacco products. Larger graphic health warnings will also be required, but this provision will not be implemented for five years. Supporters predict it will reduce tobacco use from 15% to 9% by 2022. Brazil will host the 2014 Football World Cup and 2016 Olympics so the reach of this law – in terms of protecting Brazilians and visitors, and setting an international example – is considerable.

The National Institute of Cancer (INCA)–Ministry of Health and Alliance Against Tobacco Use (ACT), both Union-managed Bloomberg Initiative (BI) grantees, helped the government reach this milestone by fostering collaboration between national and local organisations, raising awareness of tobacco control among decision-makers and providing legal and technical assistance.

**ECUADOR’S DRAFT TOBACCO LAW SUPPORTED BY THE UNION**

The Union has played an instrumental role in Ecuador’s efforts to pass tobacco control legislation by supporting both civil society and the government. In February, The Union, the Ministry of Health and the Pan-American Health Organisation (PAHO) met with Ecuadorian Assembly members to draft legislation that was then presented to the plenary. The Union also provided legal and technical advice to the Health Commission of the National Assembly.

The draft proposal bans smoking in closed public spaces and workplaces, and advertising, promotion and sponsorship of tobacco products. It also calls for graphic health warnings. The Congress received the proposal positively, paving the way for a comprehensive national tobacco control law to be passed in 2012.

**NEW GRAPHIC HEALTH WARNINGS IMPLEMENTED IN MEXICO**

The Union grantees, the National Office for Tobacco Control and the National Institute of Public Health, worked to develop new graphic health warnings to be included on tobacco packaging in 2011. The grantees evaluated the effectiveness of the first round of graphic warnings implemented in 2010, and carried out additional research to recommend improvement for the second round of warnings in 2011.

In October 2011, amendments to the existing tobacco control law were introduced in the House of Representatives that would enlarge the size of these images and increase the number of pictures used. Other amendments to the same law call for a ban on tobacco advertising, promotion and sponsorship (TAPS) and for all enclosed public spaces to be 100% smokefree. The amendments had not yet passed as of the end of 2011. The Union provided extensive technical and legal assistance throughout this process.
THE UNION FEATURED AT MEXICAN PRESIDENT’S WORLD NO TOBACCO DAY EVENT

President Felipe Calderón highlighted Mexico’s tobacco control achievements at a World No Tobacco Day celebration, held for the first time at his official residence, Los Pinos, on 31 May 2011. Mirta Molinari, Director of The Union Mexico Office (UMO), was among the invited speakers, along with the President and Minister of Health. That The Union was the only non-profit organisation asked to speak was clear recognition of its position as a leading public health organisation in the country.

Ms Molinari applauded the political will of the government and congratulated the President on its progress. During the past three years, Mexico has passed a General Tobacco Control Law; taxes on tobacco have increased; and graphic health warnings have been implemented. The Union supported these efforts through a BI grant that helped to establish the National Office for Tobacco Control under the purview of the Ministry of Health.

NEW LAW IN ARGENTINA PASSED AFTER LONG CAMPAIGN

On 1 June 2011, Argentina’s National Congress approved a comprehensive tobacco control law. This long-awaited legislation will protect the 40 million people in Argentina against the dangers of tobacco use and help reduce numbers of smokers.

The new law includes 100% smoke-free environments in enclosed public and work places, strengthened graphic health warnings, sponsorship and promotion bans and stricter controls on the manufacture of tobacco products. The law is a major achievement for the coalition of Argentinean advocates, journalists, medical associations and health professionals, who pushed for the legislation. The Union has supported their efforts by providing technical assistance and training.

BUENOS AIRES FOCUSED ON SMOKING DANGER TO PREGNANT WOMEN AND MOTHERS

The Buenos Aires Ministry of Health (MOH), a Union BI grantee, emphasised the danger of pregnant women smoking during the 2011 World No Tobacco Day celebrations in May. According to Argentina’s Risk Fact National Survey 2009, 15–20% of pregnant women smoke, endangering themselves, their unborn children and other family members.

UNION MISSION SUPPORTS CHILE’S SMOKEFREE CAMPAIGN

The Ministry of Health (MOH) of Chile began work to amend the current tobacco control legislation in order to make all public and workplaces 100% smokefree in 2011. Smoking rooms permitted in restaurants and bars will be eliminated. The bill was discussed in Congress and is likely to be approved during 2012.

In addition, a 2011 presidential decree mandated stronger graphic health warnings covering 50% of both sides of the packaging on national and imported tobacco products. These warnings will be used for 12 months and can be renewed every year. Throughout the process of developing and putting forward these bills, The Union worked closely with the MOH, which became a BI grantee in mid-2011.

PERU NTP AND THE UNION COLLABORATE ON ACTION PLAN

The Union developed a cooperative action plan with the National Tuberculosis Control Programme (NTP), which included among the deliverables a model for serving people with TB and MDR-TB. Emphasis was on Madre de Dios, the department with the highest rates of TB and DR-TB incidence in the entire country. This project was financed by USAID through the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) programme.

In addition, The Union Peru Office participated in the Annual Infection Risk and Prevalence Study in the Lima Metropolitan Area and Callao, in coordination with the National Institute of Statistics and Data Processing and the NTP. The study results showed a 5% prevalence and an annual tuberculosis infection risk of 0.78%.

NICARAGUA TRAINING AND ACTIVITIES LEAD TO PRACTICAL MDR-TB GUIDE

In Nicaragua, The Union and the National Tuberculosis Programme developed a multi-objective plan for the 2011 mission. First, the team assessed the epidemiological situation of MDR-TB and its management and suggested amendments to past recommendations. Then, The Union provided a two-day refresher course in Managua for 29 clinicians, who were updated regarding changes in the diagnosis and management of both MDR-TB and TB-HIV. Finally, the NTP requested The Union’s collaboration on a practical guide for managing MDR-TB, for which the mission provided opportunities for all involved to actively debate and discuss the content.

TRAINING BUILDS TB AND MDR-TB CAPACITY IN THE REGION

The Union works closely with Latin American countries to build, refresh and retain highly trained clinicians to treat and control tuberculosis. Courses focus
on drug-susceptible and drug-resistant TB with both international and national courses offered in 3- to 9-day formats. The courses provide clinicians with the knowledge and skills to effectively manage drug-resistant tuberculosis, especially MDR-TB and XDR-TB. The curriculum reviews the epidemiological and biological aspects, diagnostic tests, principles of treatment and clinical challenges.

> **El Salvador:** The Union’s flagship International Course on the Epidemiology and Control of Tuberculosis was offered for the 20th time in San Salvador this year. The 32 participants came from nine countries: Argentina, Dominican Republic, Ecuador, El Salvador, Haiti, Honduras, Nicaragua, Paraguay and the USA.

> **Mexico:** In April, the 3-day national course on the clinical management of multi-drug resistant TB was held for the first time in the City of Puebla, Mexico. The Mexican government and USAID sponsored this course attended by 41 participants representing 19 states and eight institutions and organisations. The Union and the National TB Programme led the faculty of 15 experts.

> **The Dominican Republic:** The 5-day international course on clinical management of MDR-TB held in Domingo in May was organised with the National Programme for the Control of Tuberculosis and the Pan-American Health Organization (PAHO). The 19 participants were clinicians from nine countries: Colombia, Dominican Republic, El Salvador, Nicaragua, Panama, Paraguay, Santa Lucia, Uruguay and Venezuela.

**MONITORING PROGRESS IN THE FIGHT AGAINST MDR-TB**

The Union reviewed several MDR-TB projects on behalf of the Stop TB Partnership’s Green Light Committee, which provides second-line TB drugs to qualifying projects.

> **Bolivia:** The GLC project in Bolivia has expanded from 11 patients in 2004 to 161 patients by October 2011. The review team assessed implementation, needs, coordination and response to previous recommendations. New challenges include TB-HIV collaboration: for example, not all TB patients have access to HIV testing and counseling. Other issues included the need to strengthen MDR-TB case finding and develop clear agreements about hospitalisation. A key recommendation was to complete the national plan offering universal access to care for all DR-TB cases.

> **Dominican Republic:** The Union has monitored the MDR-TB project in the Dominican Republic since 2005, and it has showed steady improvement. In 2010 it expanded nationwide. The 2011 review found that the laboratory system had improved and clinical and programmatic measures are optimal, despite budget difficulties. With the advent of GeneXpert use, more patients are likely to be diagnosed. Plans need to be made to prevent defaulters with the NTP expansion of MDR-TB care in primary health care facilities. Greater collaboration between TB and HIV/AIDS programmes will also be critical. This programme is a model for other middle- and low-income countries.

> **El Salvador:** The Union has been monitoring the progress of El Salvador’s DOTS-Plus project since 2005, and it has developed a national plan for scaling up MDR-TB care, improving identification and diagnosis and providing more social and economic support for patients.
into a well-functioning project. With both excellent case finding and clinical management, the NTP has achieved a near-perfect approach. While many objectives have been achieved, the 2011 review recommended that the NTP complete its drug-resistance surveillance study, ensure that the drug requests do not exceed requirements, and use the Supranational Reference Laboratory for drug susceptibility testing.

> Guatemala: Guatemala’s MDR-TB project was approved for expansion to 75 patients in September 2010. However, the number of patients in the cohort rose to 81 by the time of the review in November 2011, with the additional patients funded from other sources. Some issues observed by the reviewers included that MDR-TB case detection was very low, health services were closed on weekends, and 30% of patients abandoned treatment (2009). Recommendations included creating a budget line so the government bears the cost of second-line drugs and developing a national plan to expand TB care.

> Peru: Peru is in the expansion/consolidation phase of its MDR-TB project, which was approved by the GLC in 2000. It now serves 2,000 patients with funds from the Global Fund to Fight AIDS, TB and Malaria (The Global Fund). The 2011 review was conducted in conjunction with an evaluation of the national TB control strategy vis à vis the Stop TB strategy. Reviewers found that MDR-TB cases were handled appropriately and that the time between diagnosis and treatment was acceptable. The programme was commended for its recordkeeping, drug management and staff training. The team recommended including expansion as part of the national TB plan and strategies for improved coordination and integration.

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**TREAT TB Partner in Brazil assesses new diagnostic tools**

Rede-TB, a Brazilian TB research network and partner in TREAT TB, began its assessment of new tools for the diagnosis of MDR-TB, including line probe assay (LPA) and Xpert MTB/RIF, in May 2011. The pragmatic clinical trial is being conducted in five different sites in Brazil and will determine which tools are most appropriate for roll-out in the Brazilian public health system.

The study is part of TREAT TB’s PROVE IT (Policy Relevant Outcomes from Validating Evidence on Impact) study, which sets out to evaluate new DR-TB diagnostic tools in terms of the costs for both patients and health systems, their health system and policy requirements, and their impact on the time between diagnosis and treatment, as well as on patient outcomes. The study also analyses the uptake of the intervention and any changes and/or transfer of policy. In 2011, baseline evaluations were completed, local research teams trained, community advisory boards engaged and the implementation phase started in four sites.

PROVE IT is also being implemented by teams in South Africa and Russia. TREAT TB is funded by the United States Agency for International Development (USAID).
Lung Health & Non-communicable Diseases

**EL SALVADOR ADF PROJECT**

The main objectives of El Salvador’s Asthma Drug Facility (ADF) Project are:

> to implement standard case management of asthma in three pilot sites,
> to increase accessibility of proper asthma care and affordability of essential asthma medicines through ADF, and
> to evaluate the potential of expanding the pilot project to the whole country.

The most important activities carried out were: prepare and sign an agreement between The Union and the government of El Salvador, select the three pilot sites, offer training, implement the project, and evaluate it.

From the inclusion of the first patient (March 2010) through the first year of the project (March 2011) 240 cases of persistent asthma were registered, of whom 37 (15.4%) were mild, 141 (58.8%) moderate and 62 (25.8%) severe. The results of the annual evaluation of the patients under treatment showed that 51% of them improved, 47% remained stable and 2% worsened.

The Union proposed that this project could be expanded applying lessons learned from the pilot and suggested using the ADF to purchase essential asthma medicines.

**REGIONAL PAL WORKSHOP HELPS COUNTRIES BUILD ACTION PLANS**

The Union helped facilitate the 2nd regional PAL workshop and participated in the 5th meeting of low-TB prevalence countries of the Americas organised by the Pan American Health Organization (PAHO) in February-March 2011 in San Juan, Puerto Rico. The workshop covered the Practical Approach to Lung Health (PAL) concept and requirements, ways to adapt the PAL approach, progress and constraints in countries implementing PAL and action plans for moving forward.

Each of the nine countries participating in the workshop was represented by the national tuberculosis programme manager and another professional involved in PAL development. PAL is part of the Stop TB Strategy because it helps strengthen health systems and improves TB case finding at the primary health care level.

**The Union Latin America Region**

**306 members in 2011**

The Union Latin America Region’s annual meeting was held in Lille, France in October at the World Conference. The officers’ reports showed progress had been made on increasing communication between members and the two Union offices in the region – in Mexico and Peru. Members also discussed plans for the next region conference to be held in conjunction with the Caribbean and Central American Congress of Pneumology in Panama, March 2012.

**Constituent members**

- Ministerio de Salud y Deportes (Bolivia)
- Fundação Atualpho de Paiva (Brazil)
- Ministerio de Salud (Chile)
- Programa Nacional de Control de Tuberculosis (Cuba)
- Fundación Ecuatoriana de Salud Respiratoria (FESAR) (Ecuador)
- Ministerio de Salud Publica y Asistencia Social (El Salvador)
- Liga Nacional Contra la Tuberculosis (Guatemala)
- Comité Nacional de Lucha Contra la Tuberculosis y Enfermedades del Aparato Respiratorio (Mexico)

**Officers**

President: vacant
Vice President: Regiane Cardoso De Paula (Brazil)
Secretary General & Board Representative: Jesús Felipe González Roldán (Mexico)
Treasurer: Miguel Angel Lindero Olalde (Mexico)
The Union Middle East Office based in Cairo, Egypt manages Bloomberg Initiative (BI) grants, provides technical assistance and works with its partners to build national and regional capacity for planning and implementing effective tobacco control policies. In 2011, the office worked with over 70 organisations and key focal points at the national and sub-national levels in the Middle East region. The office also coordinated 13 tobacco control technical and management courses and workshops. In addition, The Union works closely with EpiLab, its Collaborating Centre in Sudan, and other partners, including national tuberculosis programmes throughout the region. The Union provided extensive technical assistance to these programmes in 2011, with a focus on building the capacity for MDR-TB management.

**Health challenges in the Middle East**

- Shisha (waterpipe) use is linked to chronic bronchitis and implicated in transmission of 17% of TB cases.
- One hour of smoking shisha involves inhaling 100-200 times the smoke from one cigarette.
- More than 700,000 people died from TB, respiratory infections, lung and related cancers, COPD and asthma in 2008.

Sources: see page 69
**TAX RAISED TO REDUCE TOBACCO CONSUMPTION IN EGYPT**

The Egyptian government raised the national tax on the retail price of all cigarette brands by an additional 10% in July 2011. This followed an earlier rise of 40% in July 2010, which also imposed a 100% rise on shisha (water pipe) and smokeless tobacco products. The new tax is the result of two years of work on the part of the Ministry of Health, the Ministry of Finance and the World Health Organisation (WHO), who collaborated with support from a Bloomberg Initiative (BI) grant managed by The Union. Throughout this period, The Union helped build political and public support for the tax rise.

An economic report, published by The Union and released in March 2011, emphasised that the tax rise would not only boost government revenue, but also reduce the cost of treating tobacco-related diseases, which amounts to approximately US $650 million annually. Nearly 20% of the adult population in Egypt use some form of tobacco product.

**NEW TOBACCO CONTROL LAW IN LEBANON ACHIEVES A MILESTONE**

The Union was recognised by Lebanon’s Ministry of Public Health for its role in the adoption of a comprehensive tobacco control law in August 2011. The new law will make Lebanon 100% smokefree, ban all forms of tobacco advertising, promotion and sponsorship (TAPS) and impose health warnings over 40% on the front and back of cigarette packs.

Enforcement of the law will require facing Lebanon’s shisha (water pipe) culture and high-end cigar lounges, which are very popular. Formerly Lebanon permitted all forms of TAPS and health warnings were in small print. To ensure the sustainability of the new law, The Union has continued to support the National Tobacco Control Programme at the Ministry of Public Health and its partners as they plan for effective enforcement and rigorous monitoring.

**THE UNION AND ITS PARTNERS MARK WORLD NO TOBACCO DAY IN EGYPT**

World No Tobacco Day (31 May) was celebrated in Egypt by all key national players on 29 May at an event that The Union Middle East Office (UME) planned and coordinated with the Coalition for Tobacco Control. Tobacco control proponents, including all BI partner organisations, the Ministry of Health, leaders from the civil society and the media participated. The representative of the Ministry of Health discussed Egypt’s achievement, such as the tax increase, and goals, such as smokefree health care facilities. Dr Gihan El Nahas, UME Director, spoke about the importance of implementing the Framework Convention on Tobacco Control (FCTC), especially in light of tobacco’s impact on the increase in non-communicable diseases (NCDs).

**ISLAMABAD LAUNCHES SMOKEFREE INITIATIVE**

On World No Tobacco Day (31 May), Islamabad became the first city in Pakistan to initiate steps towards becoming a model smokefree city. National legislation already bans smoking in public places and on public transport and prohibits the sale of tobacco products to children under the age of 18. The Tobacco Control Cell (TCC), supported by The Union, has been instrumental in this smokefree city initiative.

**LEGAL ACTION TAKEN AGAINST TOBACCO INDUSTRY IN PAKISTAN**

The Tobacco Control Cell (TCC) in Pakistan took legal action against Philip Morris International – Pakistan (PMI-Pakistan) for violating the tobacco control advertising law in 2011. The violation occurred when PMI-Pakistan printed an A4-sized advertisement in one of Pakistan’s Sunday magazines. The company claimed it had misinterpreted the law and promised to adhere to it in future. However, since the ad appeared nationally, the TCCs in all provinces subsequently also filed complaints against PMI-Pakistan.

The TCC is part of the National Tobacco Control Programme and a recipient of a BI grant administered by The Union. Its goal is to build public awareness and strengthen tobacco control infrastructure at the provincial and district levels. Capacity to enforce bans on tobacco advertising is high within the TCC thanks to a Union training on tobacco advertising promotion and sponsorship that took place in 2010.
Lung Health & NCDs

FEDERATION AGAINST LUNG DISEASE FORMED IN EGYPT

The Union Middle East Office (UME) helped a group of non-governmental organisations to establish and register the first federation working against lung disease in Egypt. Through the technical and administrative assistance of The Union, Egyptian Federation Against Lung Disease members have developed considerable experience in tobacco control. They have also participated in the technical and management courses offered by The Union and coordinated by UME over the past three years. The federation is expected to add to the global momentum building towards addressing the devastating impact of non-communicable diseases (NCDs).

SUDAN’S ASThma PROJECT LAUNCHED AFTER DELAYS

A six-month delay in obtaining customs clearance and official certification for medicines purchased through the Asthma Drug Facility (ADF) slowed the implementation of the ADF project in Sudan until mid-2011. This necessitated a well-planned roll-out of the project in Khartoum and Gezira States in order to ensure that the medicines will reach patients before their expiration date in mid-2012. The focal people assigned to the project in each state managed this process.

The delays also affected the planned expansion to the whole Gezira state, but this was resolved through meetings between The Union, EpiLab and Gezira’s Minister of Health. Most participating sites began to recruit patients in May 2011.

Tuberculosis

SUPPORTING MDR-TB MANAGEMENT IN THE MIDDLE EAST

The Union monitored the MDR-TB management activities of the national tuberculosis programmes (NTPs) in Egypt, Jordan, Lebanon and Morocco for the Stop TB Partnership’s Green Light Committee (GLC) during 2011.

> Morocco: In Morocco, the TB treatment success rate is 88%, meeting global targets. There are approximately 300 new MDR-TB cases each year, but the documented numbers are much lower – 75 in 2011 – so notification and case finding policies need improvement. The first GLC drugs arrived in February 2011, and enrolment started soon after, but it was very slow, due to human resource constraints and reluctance from both patients and clinicians to accept hospital treatment. On the other hand, the NTP has a new manager and the MDR-TB team followed most of the previous recommendations.

> Jordan: According to the current trends in TB prevalence (less than 8 cases per 10^5), Jordan is approaching TB elimination. The MDR-TB incidence from within the country is 4–5 new cases each year, but cases coming from other countries and increasing case detection brought the figure to 10 cases in 2010. All MDR-TB cases diagnosed and treated for free by the NTP under the GLC programme, which started in 2005. The review found most of the previous recommendations had been followed. External Quality Assurance (EQA) is still needed in the laboratory services and the quality of drug susceptibility testing remains a major concern.

> Lebanon: The Lebanon NTP detects an average 500 TB cases per year (detection rate: 74%) and is able to cure up to 90% of the national cases. Some 46% of cases come from outside the country — a burden that is increasing — and more than 70% of these patients are cured. Lebanon has a low prevalence and incidence of MDR-TB cases (5–7 cases per year). They are diagnosed and treated for free through the NTP and GLC, and most technical recommendations are followed. The NTP performance remains overall good and appropriate. Lebanon’s exceptional private-public mix, where 85% of medical care is private – including diagnosis of TB patients – works adequately.

> Egypt: Since the first GLC approval in 2005, this programme has grown, and, as of December 2011, the cumulative number of patients was 344. This review evaluated the coordination between the NTP, the community, the laboratory network and the drug-procurement agency, as well as case finding, infection control, treatment and other issues. It found that the project’s expansion continues, that drug susceptibility testing is available and management of the second-line drugs is adequate. Challenges include the unstable situation in the country, the uncertainty of funding for MDR care and the need to reduce hospital stays, now at 7–9 months.

SUDAN NTP REVIEW AND REVISED TB CONTACT MANAGEMENT PLAN

The Technical Advisory Committee (TAC) to the National Tuberculosis Programme (NTP) in Sudan reviewed progress since 2010 on 24 September–6 October 2011. Significant progress included that the new central leadership is keen and focal points are now in place. Both supervision and the timeliness of reporting have improved, and TB control activities have resumed in the Darfur region. Reviewers observed that data analysis, contact and defaulter tracing, DOT provision, infection control and MDR-TB management still need further attention.

Another visit in March focused on TB contact management policy and practice. As a result, guidelines were revised and a plan developed for implementing contact screening and management at peripheral level health facilities.
The Union Middle East Region

112 members in 2011

Members of The Union Middle East Region are active in 14 countries and regularly participate in World Days for TB, tobacco control and asthma. Planning for the 27th Conference of The Union Middle East Region on 27–30 March 2012 in Cairo, Egypt was a major focus for 2011. The event was held in conjunction with the 53rd International Congress of the Egyptian Society of Chest Diseases & Tuberculosis. The region’s annual meeting was held at the World Conference in Lille, France in October. Members discussed the need to participate in such advocacy events as World TB Day to raise visibility and to support efforts to enforce tobacco control policies. They also discussed ways to build a stronger relationship between members and The Union Middle East Office in Cairo.

Constituent members

- Egyptian General Association Against Smoking, TB and Lung Disease (Egypt)
- Iranian Charity Foundation for Tuberculosis and Lung Disease (Islamic Republic of Iran)
- Jordanian Society Against Tuberculosis and Lung Disease (Jordan)
- Ministry of Public Health (Lebanon)
- Ministry of Health (Saudi Arabia)
- Federal Ministry of Health (Sudan)
- Comité Syrien de Défense Contre la Tuberculose (Syrian Arab Republic)
- Turkish Anti-TB Association (Turkey)
- Ministry of Health (Yemen)

Organisational member

- Tobacco Prevention and Control Research Centre (TPCRC) (Islamic Republic of Iran)

Officers

- President: Hani Algouhmani (Syria)
- Vice President: Georges Saade (Lebanon)
- Secretary General & Board Representative: Mohammed Awad Tag Eldin (Egypt)
- Treasurer: Nehad Saleh (Egypt)
Europe is the home of The Union’s headquarters in Paris and two other offices. The International Union Against Tuberculosis and Lung Disease – United Kingdom is located in Edinburgh, Scotland and is an independent charity working towards lung health in the UK and internationally. Also known as The Union Europe Office, this office houses the Department of Tobacco Control, the hub of our international efforts to halt the tobacco pandemic. The Union Russia Office in Moscow is a country office dedicated to tobacco control and lung health in that country and Eastern Europe.

Health challenges in the Europe Region

- 28% of all new TB cases in one region of northwestern Russia were MDR-TB in 2010, a new record level.
- Russia has almost 44 million tobacco users.
- Patients in Eastern Europe co-infected with HIV were at greater risk of MDR-TB.

Sources: see page 69
**Lung Health & Non-Communicable Diseases**

**THE UNION PARTICIPATED IN NCD GLOBAL MINISTERIAL MEETING IN MOSCOW**

Ninety health ministers and over 200 other senior health officials participated in the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease (NCD) Control in Moscow on 28–29 April. The conference was a milestone in the campaign that culminated in the UN High-Level Summit on NCDs on 19–20 September 2011 in New York.

Dr Nils E Billo, Executive Director of The Union, spoke at a roundtable session on access to essential medicines and technologies, one of the top five priority interventions recommended by the NCD Alliance of which The Union is a principal partner. As part of his presentation, Dr Billo described the Asthma Drug Facility (ADF), which enables low- and middle-income countries to purchase quality-assured essential asthma medicines at affordable prices.

**THE WHO/UNION COLLABORATIVE FRAMEWORK FOR TB AND DIABETES LAUNCHED**

The WHO/Union Collaborative Framework for the Care and Control of TB and Diabetes was published in August, culminating two years of work on the part of the World Health Organization (WHO) Stop TB Department and Department of Chronic Diseases and Health Promotion, the World Diabetes Foundation and The Union.

The framework emphasises three main activities: a) establishment of mechanisms of collaboration; b) detection and management of TB in diabetes patients; c) detection and management of diabetes in TB patients. The next steps are to encourage operational and other research so that, by 2015, new evidence can be reviewed to determine whether the Framework can be updated, strengthened and made definitive.

**CALL TO ACTION ON CHILDHOOD TB**

At least one million cases of TB occur in children under 15 each year, yet the true global burden is unknown because of the lack of child-friendly diagnostic tools and inadequate surveillance and reporting of these cases. The DOTS Expansion Working Group’s Subgroup on Childhood TB, chaired by Dr Stephen Graham of The Union’s Child Lung Health Division, launched a “Call to Action for Childhood TB now!” at a meeting in Sweden in April. The campaign, which aims to bring more attention and resources to this issue, had more than 800 supporters by the end of the year.

**CALL TO ACTION for CHILDHOOD TB**

We, participants gathered at the ‘International Childhood Tuberculosis Meeting’ held March 17-18, 2011 in Stockholm, Sweden recognize that:

- Worldwide, at least 1 million TB cases occur each year in children under 15 years of age.
- The true global burden of TB in children is unknown because of the lack of child-friendly diagnostic tools and inadequate surveillance and reporting of childhood TB cases.
- Children with TB infection today represent the reservoir of TB disease tomorrow.
- Children are more likely to develop more serious forms of TB such as miliary TB and TB meningitis resulting in high morbidity and mortality.
- Despite policy guidelines, the implementation of contact tracing and delivery of isoniazid preventive therapy (IPT) to young and HIV-infected children is often neglected by public health programmes.
- Most public health programmes have limited capacity to meet the demand for care and high-quality services for childhood TB.
- TB care for children is not consistently integrated into HIV care and maternal and child health programs. BCG, the only licenced TB vaccine, has limited efficacy against the most common forms of childhood TB and its effect is of limited duration.
- Due to inadequate case detection it is estimated that a large number of children suffering from TB are not appropriately treated. This is further compounded by drug stock outs and the lack of child-friendly formulations of drugs for TB treatment and prevention.
- Children are rarely included in clinical trials to evaluate new TB drugs, diagnostics or preventive strategies.

To address this current situation, we, the undersigned, call for:

- National TB programmes to include and prioritize childhood TB in their national strategic plans in order to address millennium development goals for children and pregnant women.
- All health care providers to integrate childhood TB into their services.
- The scientific community to include children—of all ages—in clinical and operational implementation of research and development initiatives.
- Donors to encourage collaboration with investigators, local researchers, local communities and policy makers to address the growing need to develop TB drug and diagnostic product developers to specifically focus on childhood TB.

Latin America | The Middle East | Europe | North America
CAMPAIGN SUPPORTS COMPLIANCE WITH SMOKING BAN IN POLAND

The MANKO Association, a Bloomberg Initiative (BI) grantee, worked for years to introduce a smoking ban in Poland, which came into effect in November 2010, and to enforce it. To gain support from restaurants and bars for compliance, they published an online map of “no smoking” restaurants and bars, and, to encourage businesses to join the initiative, offered them free advertising on the site. The map was also printed and distributed at tourist information desks. MANKO also supported enforcement by providing the public with a telephone number to anonymously report breaches of the smokefree law. This information was then passed to law enforcement officials.

Through its intensive awareness-building media campaigns and positive publicity, MANKO has now become a household name — and Poland has become a leader among countries in the region addressing tobacco control issues.

RUSSIA DRAFTS A TOBACCO CONTROL LAW THAT MEETS ALL FCTC REQUIREMENTS

In August, the Russian Ministry of Health and Social Development (MoHSD) released draft legislation that addresses all of the WHO Framework Convention on Tobacco Control (FCTC) requirements, including provisions on tax increases, advertising bans, smokefree places, warning labels, cessation services and public education activities.

Supporters expect the reading of the bill in the Duma to be completed in 2012.

Although Russia adopted the FCTC in 2008, it still has nearly 43 million tobacco consumers and about 400,000 Russians die annually due to tobacco-related diseases. The Union has been supporting work on tobacco control policies there since 2008.

TURKEY UPHOLDS SMOKEFREE LEGISLATION

Turkish coffee and tea shop owners lost a court appeal that they hoped would exempt them from the ban on indoor smoking in January 2011. There has been widespread resistance to Turkey’s tobacco control legislation from the tobacco industry and its front groups and allies among the media and the hospitali-ty sector, including restaurants and cafes. Nonetheless, a smoking ban has been in force since July 2009, through the efforts of BI partners, including The Union and the Tobacco Control Coalition, managed by the Turkish Thoracic Society and the Ministry of Health who continue to champion the law in face of legal challenges.

NEW RUSSIAN VERSION OF THE IJTLD FOCUSED ON TB DRUG RESISTANCE

The third Russian edition of the International Journal of Tuberculosis and Lung Disease was published online in May. An editorial committee selected articles that were published in the IJTLD during the past two years, based on their interest and relevance for Russian-speaking specialists. The main theme was anti-tuberculosis drug resistance with translations of State of the Art and original articles on this subject, in addition to locally conducted research.
TREAT TB TEAM COLLABORATING ON VIRTUAL IMPLEMENTATION PROJECT

For stakeholders from policy-makers to materials supply managers, it is essential to be able to envision the impact of new tools and systems. Using data modeling software, TREAT TB partners from the UK and Taiwan are building a virtual implementation approach that combines both traditional transmission modeling with operational modeling concepts. The aim of this project is to provide valuable guidance on the effectiveness of and challenges associated with the adoption of new diagnostic tools in high-burden, low-resource countries.

At the March TREAT TB review meeting in Liverpool, England, Drs Ivor Langley of the Liverpool School of Tropical Medicine, Dr Hsien-Ho Lin of the National Taiwan University, and colleagues from the Brigham Women's Hospital / Harvard School of Public Health presented initial models. The modeling team then worked with partners in Tanzania to collect data that the models could use to project the performance of new diagnostic tools within the Tanzanian health system. Drs Langley and Lin described their work to the wider TREAT TB team in October in Lille, France.

LINE PROBE ASSAY STUDY UNDERWAY IN ARKhangelsk

A study of the use of line probe assays (LPA) for diagnosing multidrug-resistant tuberculosis (MDR-TB) began enrolling patients in Arkhangelsk, Russia in April 2011. The study, implemented by TREAT TB partner Northern State Medical University in Arkhangelsk, is part of the multi-country PROVE-IT (Policy Relevant Outcomes from Validating Evidence on Impact) study. It will evaluate LPA in terms of costs for patients and health systems, health system and policy requirements, impact on the time between diagnosis and treatment and patient outcomes, as well as uptake of the intervention and any changes and/or transfer of policy.

In 2011, 161 of the projected 250 patients were enrolled, and 70 patients took a patient costs questionnaire. Researchers also interviewed 14 stakeholders about the LPA roll-out.

Related PROVE-IT studies are being conducted in Brazil and South Africa. TREAT TB is funded by the United States Agency for International Development (USAID).

95% OF PARTICIPANTS COMPLETED OR COURSE AND PUBLISH PAPERS

The second cohort completed the intensive operational research (OR) course developed by The Union and Médecins Sans Frontières in June 2011. The 12 participants came to the Paris headquarters for all three 5-day modules spaced out over nine months. The aim is to help participants develop the skills to conduct and publish operational research. By the end of the year, all had completed their projects, written them up and submitted the papers for publication in an international peer-reviewed journal, and nine had their papers in press or published.

To expand the reach of this innovative approach, this course was also offered in Fiji and India in 2011.

The Union Europe Region

548 members in 2011

A major focus in 2011 was planning for the 6th Conference of The Union Europe Region in London, England on 4-6 July 2012. The theme selected by the members was “TB and lung disease: threats and promises”. A working group created in Berlin in November 2010 also drafted the Region Charter during the year with the goal of submitting the final version in 2012.

A report presented at the annual meeting in Lille, France in October showed the membership of the region was predominantly affiliated with the TB section (461 members), but there were 25 affiliated with the HIV section, 18 with lung health and 44 with tobacco control.

Constituent members

Verein Heilanstalt Alland (Austria)
Pulmonary Outpatient Centre (Croatia)
Danmarks Lungeforening (Denmark)
Tartu University Clinics, Lung Clinic (Estonia)
Finnish Lung Health Association – Filha Ry (Finland)
National Centre of Tuberculosis & Lung Disease (Georgia)
Deutsches Zentralkomitee zur Bekämpfung der Tuberkulose (Germany)
Reykjavik Health Care Services (Iceland)
Tobacco Free Research Institute (Ireland)
Israel Lung and Tuberculosis Association (Israel)
Ligue de Prévention et d’Action Médico-Sociale (Luxembourg)
KNCV Tuberculosis Foundation (The Netherlands)
Nasjonalfor'enningen for Folkehelsen (Norway)
Associação Nacional de Tuberculose e Doenças Respiratórias (Portugal)
Ministerio de Sanidad y Política Social (Spain)
Swedish Heart-Lung Foundation (Sweden)
Ligue Pulmonaire Suisse (Switzerland)

Organisational members

Alter Santé Internationale et Développement (France)
Comité National contre les Maladies Respiratoires (France)
CheckTB (The Netherlands)
Norwegian Association of Heart and Lung Patients (Norway)
King Oscar II Jubilee Foundation (Sweden)
TB Alert (United Kingdom)
The International Union Against Tuberculosis and Lung Disease, Inc (United Kingdom)

Officers

President: Jean-Pierre Zellweger (Switzerland)
Vice President: Peter Davies (UK)
Secretary General & Board Representative: Maryse Wanlin (Belgium)
Treasurer: vacant
The Union North America Office in New York is the home of The Union North America (UNA), a U.S. non-profit, tax-exempt organisation, and organisational member of the federation in its own right. UNA works closely with members throughout the region and supports fundraising efforts for The Union internationally. The New York office also provides a base for staff and consultants working on the TREAT TB initiative, marketing and communications for the International Management Development Programme (IMDP) and The Union Ethics Advisory Group.

**Health challenges in the North America region**

- Life expectancy in Haiti is 60 years for men, 63 years for women.
- The TB rate among Inuits is 186 times that of Canadian-born non-aboriginals.
- The US has the 5th highest number of smokers in the world.

Sources: see page 69
Lung Health & Non-Communicable Diseases

UN HIGH-LEVEL MEETING PUTS NCDS ON THE MAP

In September, The Union and other principal partners from the Non-Communicable Diseases (NCD) Alliance participated in the United Nations High-Level Meeting on Non-Communicable Diseases (NCDs) in New York. Past President Prof Asma El Sony of Sudan represented The Union, speaking at a roundtable session on the challenges that low-income countries face from the increase in chronic respiratory diseases and the need for tobacco control to eliminate a major risk factor. This UN meeting marked a step change in the way governments view the rising threat of NCDs, but the meeting did not result in the hoped-for global targets.

In a related event held at the New York Academy of Medicine, The Union and the International Study of Asthma and Allergies in Childhood (ISAAC) launched their Global Asthma Report 2011 both in print and web editions (www.globalasthmareport.org).

Child Lung Health

WORKSHOP ON PEDIATRIC TB DIAGNOSTIC RESEARCH HELD IN WASHINGTON

The Union served on the faculty of a three-day course on addressing the challenges for child TB diagnostic research, sponsored by the US National Institutes of Health and held in July in Silver Springs, Maryland. The main output from this meeting was the development of case definitions for intrathoracic TB in children for purposes of standardising reporting of diagnostic research studies in children. Dr Stephen Graham of The Union’s Child Lung Health Division chaired the diagnostic panel working group.
In late 2010, the World Health Organization (WHO) recommended Xpert MTB/RIF, a highly sensitive, easy-to-use nucleic acid amplification test that rapidly identifies drug-sensitive and rifampicin-resistant TB. In its recommendation, WHO stated that further research would be required to fully assess Xpert MTB/RIF.

To meet this need, TREAT TB created a web tool that provides a comprehensive overview of ongoing research activities assessing Xpert MTB/RIF worldwide. Information was collected, and the results were made accessible on the TREAT TB website in the form of an interactive mapping tool. By the end of 2011, the tool offered detailed information on 22 research projects in 15 countries. This initiative was designed to complement WHO’s own efforts to monitor Xpert MTB/RIF.

The TREAT TB initiative is funded by the US Agency for International Development (USAID)

**XPERT MTB/RIF RESEARCH MAPPING TOOL DESIGNED BY TREAT TB**

In late 2010, the World Health Organization (WHO) recommended Xpert MTB/RIF, a highly sensitive, easy-to-use nucleic acid amplification test that rapidly identifies drug-sensitive and rifampicin-resistant TB. In its recommendation, WHO stated that further research would be required to fully assess Xpert MTB/RIF.

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**STREAM MDR-TB PROTOCOL APPROVED FOR IMPLEMENTATION IN 2012**

The Union’s evaluation of a standardised treatment regimen of anti-tuberculosis drugs for patients with multidrug-resistant tuberculosis or STREAM will seek to determine whether a 9-month regimen developed and implemented by the Damien Foundation and the Institute of Tropical Medicine, and used with notable success in Bangladesh, can be used in different settings with comparable results. In 2011, The Union prepared for the implementation of this clinical trial by obtaining ethics approval from the Ethics Advisory Group, as well as local ethics committees in Ethiopia, South Africa and Vietnam. STREAM will begin in 2012.

In addition to ethics approval, The Union prepared for STREAM’s implementation throughout 2011 by finalising the protocol, visiting and evaluating potential sites and meeting with ministry of health officials in all STREAM target countries.

**LAM PERFORMANCE FOUND HIGHLY VARIABLE IN TREAT TB SYSTEMATIC REVIEW**

The Union’s TREAT TB initiative commissioned researchers from Canada’s McGill University to conduct a systematic review of nine eligible publications evaluating the performance of the LAM urine assay as a diagnostic test for tuberculosis in 2010. The results were published in the *European Respiratory Journal* in June 2011. Although many TB experts have high hopes for this test, the data found its performance highly variable and its sensitivity suboptimal for routine clinical use.

In July 2011, the *International Journal of Tuberculosis and Lung Disease* published the results of a systematic review of Interferon-Gamma Release Assays for the Detection of TB in Children. This year the McGill team conducted an evaluation of economic analyses in TB research and assessed the feasibility of implementing a new diagnostic test in resource-limited settings.

**WITH 68 PUBLICATIONS IN 2011, COR IS FUNDED FOR TWO MORE YEARS**

The Centre for Strategic Health Information and Operational Research was refunded for two more years through 2012. The goals of COR are to foster and enhance the use of operational research (OR) through training and an OR fellows programme; enhance and strengthen vital registration programmes; track the role of OR in changing policy and practice; adapt the use of the DOTS framework to track different diseases, such as HIV/AIDS, diabetes mellitus and hypertension; develop and expand electronic data systems for tracking diseases; and collaborate with the WHO and other partners.

Six OR fellows are now affiliated with the programme, working in Brazil, India, Malawi, South Africa, Vietnam and Zimbabwe. In addition, four OR fellows were appointed through memoranda of understanding with the Desmond Tutu TB Centre in South Africa and AMPATH in Kenya.

Four COR training programmes served 51 participants in France and India. Additional courses with 37 participants in Luxembourg, France and Fiji began in 2011 and will be completed in 2012.

During 2011, COR staff, fellows and trainees produced 68 publications: 43 research papers, 23 opinion/review papers and two contributions to international documents. COR is funded by an anonymous North American donor.
The Union North America Region

338 members in 2011

The Union North America Region (NAR) created an NAR Council as part of its charter, approved in 2010. The Council’s primary role is to provide guidance to the region. It met for the first time in 2011 in Vancouver, British Columbia in conjunction with the 15th Conference of The Union North America Region on 24-26 February 2011. Key identified priorities named by the Council were expansion of membership throughout the region; development of educational opportunities specifically for those working in the field; and advocacy, especially highlighting the rising TB rates in indigenous populations in North America.

The conference focused on the theme “Engaging Vulnerable Populations: Tools and Strategies to Halt TB”. The scientific programme had a strong focus on TB in indigenous populations and the impact of immigration and migration on TB control in North America. Region funds were used to provide travel grants to the conference for deserving individuals from Latin America, Haiti, the Caribbean, and Mexico who would otherwise have not been able to attend.

The NAR Lifetime Achievement Award was given to Dr Philip Hopewell (USA) and Service Awards were given to Dr Dick Menzies (Canada) and Dr Kevin Elwood (Canada). The region also sponsored webinars to provide continuing education for at-risk populations, such as those in the Latin America Region, Haiti and the Caribbean.

The NAR is working closely with the Latin American Liaison Committee and The Union North America Office, which is represented on the Executive Council. An annual meeting was also held at the World Conference in Lille, France in October. The next NAR conference is scheduled for San Antonio, Texas (USA) on 23-25 February 2012.

Constituent members
The Guyana Chest Society (Guyana)
Programme National de Lutte contre la Tuberculose (Haiti)

Organisational members
British Columbia Lung Association (Canada)
Canadian Lung Association (Canada)
American College of Chest Physicians (USA)
American Lung Association (USA)
American Thoracic Society (USA)
LW Scientific, Inc (USA)
Population Services International (USA)
The International Union Against Tuberculosis and Lung Disease, Inc (USA)
World Lung Foundation (USA)

Officers
President/Board Representative: Jane Carter (USA)
Vice President / Programme Chair: Ann Raftery (USA)
Secretary/Treasurer: Kevin Schwartzman (Canada)

STUDY C CLINICAL TRIAL RESULTS PUBLISHED BY JAMA
The results of The Union’s Study C clinical trial were published by the Journal of the American Medical Association (JAMA) on 13 April. Study C tested a fixed-dose combination drug against the standard TB regimen of four separate drugs and found their effectiveness comparable. JAMA hosted a press conference in Washington D.C. to announce this and other important news published that month.

COR AND MSF SPONSOR SUPPLEMENT ON HIV/AIDS EPIDEMIC IN AFRICA
The Union’s Centre for Operational Research (COR) and Médecins Sans Frontières guest-edited a supplement to the Journal of the International AIDS Society on programmatic and operational challenges in the HIV/AIDS epidemic in sub-Saharan Africa. The open access supplement was timed for the IAS Conference in Rome, Italy on 17–20 July 2011. COR is funded by an anonymous donor from North America.

OPERATIONAL RESEARCH GUIDES PUBLISHED BY TREAT TB
The TREAT TB Initiative published two new guides for public health professionals and other researchers in 2011. Operational Research: A Guide to Country Level Implementation and Programme Support describes The Union’s experience in supporting country-level operational research (OR) activities, highlighting examples from the many Union-supported initiatives. Operational Research to Improve Health Services: A Guide for Proposal Development was published in collaboration with the Desmond Tutu TB Centre in South Africa and is designed for use by the Operational Research Assistance Programme (ORAP) in that country.
For more than 30 years, The Union has been building technical and management capacity in low- and middle-income countries through its education and training programmes. Developed and taught by experts with both teaching and field expertise, each course is presented with material customised to meet the real-life situations in which the participating clinicians, programme managers and other health care professionals work every day. The curricula offer not only the latest theory and international best practice but also take into account the challenges faced in limited-resource settings. The goal is to help individuals and health systems deliver the quality public health programmes and care that patients need and deserve.
In 2011, The Union’s International Management Development Programme (IMDP) trained close to 600 participants from over 40 countries. Professionals specialising in a variety of health fields attended 29 courses held throughout the year to develop their existing skills and gain new ones to help improve the quality of health services provided by the organisations for which they work.

During 2011, participants were trained in the following areas:
- Budgeting and Finance
- Project Management
- Leadership
- Communications and Mass Media
- Strategic Planning
- Drug-Supply Management
- Human Resources
- Partnership Building

Courses took place in 10 countries including Malaysia, Mexico, Egypt, China, Indonesia, Singapore, Bangladesh, India, Zimbabwe, and Thailand. Participants were offered the unique experience of networking, sharing experiences and learning from health professionals in similar fields from around the world.

Dr Natalia Celauro from Paraguay, who works in tobacco control, had this to say about her IMDP experience: “This transfer of knowledge gave us the opportunity to implement other successful projects and adapt them to our context. Also, it is important to know the larger process of working in tobacco control, not only in my country, but also on a regional level.”

The IMDP continued to expand its online educational opportunities in 2011 with the launch of The Health Manager, an online publication that focuses on management education for health professionals. Each issue addresses one aspect of managing a health organisation, such as putting together a budget for a grant or project, managing a national drug programme or developing a strategic plan. Insights from executives with long experience in managing public health organisations are also featured. The Health Manager is available at no charge and may be found on both The Union and IMDP websites.

Technical courses

The Union’s technical courses focus on current health challenges in low- and middle-income countries. In 2011, the number of courses offered in clinical management of drug-resistant tuberculosis, development and implementation of TB-HIV collaborative programmes, building support for tobacco control and conducting operational research all increased, reflecting the importance of these broad areas.

The Union’s national and international TB courses continued to provide the foundation knowledge for preventing, controlling and treating TB.

Courses in mycobacteriology, as well as laboratory skill training, support more effective TB control by improving diagnosis, infection control, case monitoring and other critical areas.

With the increasing incidence of MDR-TB, courses were offered in a variety of formats, often combined with clinical programme reviews and the development of programmatic management of drug-resistant TB (PMDT) activities.

A TB-HIV course, first introduced in 2010, is focused on to improving national implementation of collaborative TB-HIV activities as measured by achievement against selected key indicators from the Global Plan to Stop TB.

How to address the specific needs of children with TB, pneumonia, as well as HIV-related lung disease, was the goal of a new international course in 2011.

Operational research courses are designed to develop local capacity to identify and address local problems, test solutions and then pass on the knowledge, experience and solutions found through publication.

In tobacco control, this year’s focus was on refining training courses towards a needs-based approach. For example, the course introducing the MPOWER tobacco control measures was modified to introduce the concept in medical and nursing school curricula.

Other courses offered by The Union addressed topics such as using EpiData and chest X-ray reading and reporting. Custom-designed courses were also available on request.
Despite the difficult global economic environment, the 42nd Union World Conference on Lung Health in Lille, France on 26–30 October 2011 attracted 2,400 lung health professionals, health policy-makers, activists and community representatives from 129 countries worldwide – a sign that the importance of lung health is gaining greater recognition.

The 2011 scientific programme was also one of the most extensive ever offered with more than 160 post-graduate courses, workshops, symposia, plenaries, meet-the-expert sessions and poster-related sessions exploring the theme “Partnerships for scaling-up and care”.

Mr Mikkel Vestergaard Frandsen, CEO of Vestergaard Frandsen, gave the special guest lecture at the opening ceremony on “How the private sector can contribute to the scale-up of health services”. Plenary speakers were Dr Lucica Ditiu, Executive Secretary of the Stop TB Partnership on “Hard talk: why we need to change the way we think and speak about TB”; Dr Samira Asma, Chief of Global Tobacco Control for the US Centers for Disease Control and Prevention, on “How in the world we measure and scale up tobacco and NCD prevention” and Prof Andrew Nunn of the UK Medical Research Council, who gave the Sir John Crofton Lecture on “The use of clinical trials to find new and shorter treatment regimens”.

Plenary sessions were streamed live over the Internet; and all presentations approved for web distribution by the presenters are available on the World Conference website as webcasts at no charge.
UNION AWARDS

Outstanding contributions to the fight against TB and lung disease were honoured at an opening ceremony of the 42nd World Lung Conference on Lung Health in Lille, France.

THE UNION YOUNG INVESTIGATOR PRIZE

This prize was established in 2011 to recognise scientific achievement in the fields of TB or lung health in the past five years while the researcher was aged 35 years or younger.

Dr Keren Middelkoop, clinician and senior investigator at the Desmond Tutu HIV Research Centre, the University of Cape Town, South Africa, received this award for her work in the epidemiology of TB and HIV and the impact of HIV and antiretroviral therapy on patients with TB.

THE UNION SCIENTIFIC PRIZE

This prize acknowledges researchers at any stage of their career in TB or lung health.

Dr Haileyesus Getahun of the World Health Organization's Stop TB Department received the award for his contributions to the development of evidence-based TB and HIV policy and practice. As coordinator of the Global TB/HIV Working Group of the Stop TB Partnership, he has helped to set the global advocacy agenda for worldwide response among stakeholders.

OTHER AWARDS

> The Stop TB Partnership-Kochon Prize

The International Nepal Fellowship and Professor Alimuddin Zumla, Director of the Centre for Infectious Diseases and International Health, University College London Medical School were co-winners of this award.

> The Princess Chichibu Memorial TB Global Award

Richard J. O'Brien, Senior Consultant for TB Product Development, Foundation for Innovative New Diagnostics (FIND), Switzerland, received this honour.

Christmas Seals Contest

The annual Christmas Seals contest and exhibition at the World Conference celebrate the tradition of producing colourful seals or stamps to raise funds for tuberculosis and lung disease. Union members select the winners, which are announced at the General Assembly.

The 2011 winners were:

1st prize: Japan Anti-tuberculosis Association (JATA)

2nd prize: Korean National Tuberculosis Association

3rd prize: Comité Nacional de Lucha Contra la Tuberculosis y Enfermedades del Aparato Respiratorio (Mexico)
2011 marked the beginning of a new era for the IJTLD, now in its 15th volume, with the arrival of three new Editors in Chief, Dr Wing-Wai Yew (TB), Dr Martien Borgdorff (TB) and Prof Donald Enarson (Lung Disease) to take on the posts of the two outgoing EICs, Profs Nulda Beyers and Moira Chan-Yeung. The addition of a second EIC for TB reflects the continued high rate of submissions to the IJTLD, which increased once again to an average of 68 per month in 2011, and the consequent greater workload for the editorial board and staff.

In September the day-to-day handling of Manuscript Central was outsourced to a US company, Aegis, freeing up editorial office staff for other journal duties. In the ongoing effort to reduce turnaround times and article backlogs, it was decided to implement e-publication of original articles in addition to review articles, which were published online systematically as of 2010. At the same time, the excess page charge was increased to 200€ rather than 100€ per printed page over the journal limit to encourage authors to put more material online; and the requirement for pre-submission queries was introduced for review and perspective articles.

The special State of the Art series in 2011 consisted of 11 articles on operational research, with Don Enarson as series editor. In addition to the Abstract Book for the 42nd Union World Conference on Lung Health in Lille, France, distributed on CD, two other supplements were published: Guidelines for conducting tuberculin skin test surveys in high-prevalence countries in January, sponsored by the KNCC, and Ethics and social determinants: key elements of tuberculosis prevention, care and control sponsored by the WHO/TDR in June. The Year in Review series changed this year to two general articles on the previous year’s content that were kindly provided by Laloo et al. and Chee et al.

As the IJTLD now goes more online than print readers, in 2011 advertising began to be sold for the monthly e-TOC (electronic table of contents) in addition to print and online advertising (on the Ingenta site). Full-text downloads from the Ingenta site increased by another thousand to more than 15,500 per month, and the Impact Factor increased slightly from 2.548 in 2010 to 2.557 in 2011.

At the end of 2011, Don Enarson announced his departure from the IJTLD to concentrate on The Union’s new online journal, Public Health Action, handing over the post of EIC for Lung Disease articles to Prof Guy Marks.

Clare Pierard
Managing Editor
Introducing Public Health Action (PHA)

2011 also saw the birth of The Union’s new quarterly online journal, Public Health Action (PHA). The Union’s second peer-reviewed scholarly journal, PHA was launched on 1 May 2011, with the first issue appearing in September.

PHA is an online only, open-access journal whose aim is to encourage, communicate and report new knowledge, dialogue and controversy in health systems and services for poor and vulnerable people, promoting The Union’s vision “health solutions for the poor”. Launched with a small editorial board of experts in public health and operational research, with Prof Donald Enarson at the helm as Editor in Chief, PHA welcomes articles on public health services issues, including policy, practice, systems, quality assurance/quality improvement, economics, equity, ethics and access in vulnerable and resource-limited communities.

To enable PHA to remain open access, authors are required to pay a single publication charge of 500€ on acceptance. The e-alert of each new issue is distributed to The Union’s mailing list within five days of publication online. To ensure that articles appear online rapidly, we endeavour to keep the total turnarond time, i.e., from submission to publication, to three months. Papers that are accepted between the publication dates (21 March, 21 June, 21 September and 21 December) are published online within four weeks of acceptance as “advance release” articles, and are referenced with the following issue.

The first two issues, published online on Ingenta on 21 September and 21 December 2011, consisted of non-solicited articles that addressed operational research issues in TB, malaria and HIV, discussing how to improve the quality of health services and systems for the poor.

Clare Pierard
Managing Editor

New Union publications in 2011

The Union is committed to disseminating its latest research, policy and practice to the widest possible audience. Most publications are available as PDFs from www.theunion.org at no charge. Print copies may be ordered by writing documents@theunion.org

TECHNICAL GUIDES

Operational Research: A Guide to Country Level Implementation and Programme Support
TREAT TB/The Union with funds from USAID.
English; PDF only

Operational Research to Improve Health Services: A Guide for Proposal Development
TREAT TB/The Union; co-published with the Operational Research Assistance Programme (ORAP) of the Desmond Tutu TB Centre (DTTC) with funds from USAID.
English; PDF only

The WHO/Union Collaborative Framework for Care and Control of Tuberculosis and Diabetes
Coordinated by A.D. Harries (The Union), K. Lönnroth (WHO)
English; print or PDF
ADVOCACY RESOURCES

Global Asthma Report 2011
The Union; co-published with the International Study of Asthma and Allergies in Childhood (ISAAC)
English; print, PDF or website (www.globalasthmareport.org)

DR-TB Drugs Under the Microscope: Sources and prices for drug-resistant tuberculosis medicines
The Union; co-published with Médecins Sans Frontières
English and Polish; PDF, summary, annex, correction

Christina Czart Ciecierski, et al.
The Economics of Tobacco and Tobacco Taxation in Poland
English and Polish; PDF, summary, annex, correction

Non-Communicable Diseases (NCD) Alliance Briefings
The Union was a contributing author to several NCD Alliance documents produced to build support for NCDs:
- Access to Essential Medicines and Technologies for NCDs
  English; print or PDF
- Noncommunicable Diseases: A Priority for Women’s Health and Development
  English; print or PDF
- Focus on Children and Noncommunicable Diseases
  English; print or PDF

Tobacco-free Sports:
A tobacco-free futures action guide
Anne Jones, with funds from the Bloomberg Philanthropies and support from World Lung Foundation
English (2009); Russian (2011); print or PDF

TRAINING RESOURCES

Building Capacity for Tobacco Control: training package
The Union/WHO
with funds from the Bloomberg Initiative to Reduce Tobacco Use
English (2011); PDF

MPOWER brochures
Set of six brochures describing Monitor, Protect, Offer, Warn, Enforce and Raise
The Union in collaboration with Bloomberg Initiative partners; funded by the Bloomberg Initiative.
English, French, Spanish, Arabic, Russian, Chinese; print or PDF

The Health Manager
A monthly online magazine that addresses a different health management topic each month.

ECONOMIC REPORTS

The Economics of Tobacco and Tobacco Taxation in Poland
Christina Czart Ciecierski, et al.
English and Polish; PDF, summary, annex, correction
Research published in 2011

Research – and publication – are critical to carrying out The Union’s vision of health solutions for the poor since a solution that is not tested and shared makes little impact. In 2011, The Union’s technical staff and consultants published 108 research, review and opinion pieces in peer-reviewed journals. Studies examined topics such as the quality assessment of smear microscopy and drug susceptibility testing, the relationship between exposure to the combustion of solid fuel and TB, managing TB in prisons, childhood TB, the burden of NCDs and risk factors for these diseases, and the link between the diabetes epidemic and TB. Editorials discussed issues ranging from the obligation to treat a disease if you test for it and the use of isoniazid preventive therapy (IPT).

> Highlights of the year included:

• The results of The Union clinical trial of a fixed-dose combination drug versus separate drugs (Study C) were published in the *Journal of the American Medical Association* (JAMA).

• The Union and Medecins Sans Frontieres guest-edited a supplement to the *Journal of the International AIDS Society* on the HIV/AIDS epidemic in sub-Saharan Africa.

• A book chapter on cardiac arrest was published in a family medicine text. (“Las 50 principales consultas en Medicina de Familia”. Capítulo: Parada Cardiorrespiratoria en el adulto. semFyC. 2011)


> The peer-reviewed journals in which Union research was published in 2011 included:

AIDS
American Journal of Respiratory and Critical Care Medicine
Annals of Tropical Paediatrics
BMC Health Services Research
BMC Medicine
BMC Pregnancy and Childbirth
BMC Public Health
BMC Research Notes
Essential Medicines Monitor
European Respiratory Journal
European Respiratory Journal Express
Expert Review of Respiratory Medicine
Health Care Management Science
International Journal of Tuberculosis and Lung Disease

Journal of Acquired Immune Deficiency Syndrome
Journal of the American Medical Association
Journal of the International AIDS Society
Lancet
New Iraqi Journal of Medicine
PLoS ONE
Public Health Action
Solthis Newsletter
Therapeutische Umschau
Tuberculosis
Transactions of the Royal Society of Tropical Medicine and Hygiene
Tropical Medicine and International Health

The Ethics Advisory Group (EAG)

The EAG ensures that Union activities meet highest ethical standards

The Ethics Advisory Group (EAG) was established to provide ethical guidance on The Union’s work at national and international levels. Its roles are to safeguard the dignity and rights of study participants and to promote ethical standards in lung health services.

The research role involves a review of every protocol in which a Union staff member is the principal researcher, likely to be a co-author, or if The Union funds or sponsors the study. Through a formal application process, the EAG evaluates especially the societal value of the study, the methods (poor science is unethical), informed consent forms for studies involving more than record reviews, local community involvement and confidentiality of participant information. Studies involving existing data and record reviews are also included.

The number of applications to the EAG has risen significantly over the past three years, largely as a result of courses run by the Centre for Operational Research and research sponsored by the TREAT TB initiative. In 2011, 65 applications detailed studies to be carried out in the following countries: Fiji (14), South Africa (9), Malawi (7), India (6) and others (Brazil, Cambodia, Kenya, Liberia, Madagascar, Myanmar, Peru, Sierra Leone, Viet Nam, and Zimbabwe). Of these applications, 18 were reviewed by the full committee, and 47 were reviewed by the EAG Chairperson.

In addition to research proposal reviews, the EAG organises sessions at the annual Union conference. In 2011, these included a workshop with series of case stories in TB and HIV that illustrated ethical questions and a symposium on the roles of external agencies and funders in international TB control and development. Invited editorials and papers on ethical issues are also written for The Union’s journals.

The six members of the EAG have been selected to ensure professional and geographic representation. In 2011 members were citizens of South Africa, India, South Korea, Philippines, Sudan and the USA. Their professional experience ranges from social science and research to clinical medicine and public health.
The Federation

News from the Federation

The Union is a federation of individuals and organisations from 150 countries who are committed to the common cause of health solutions for the poor.

HONOURS

> The Union Medal awarded to Prof John F Murray

Prof John F Murray (USA) received The Union’s highest honour at the 2011 General Assembly in Lille, France in recognition of his distinguished contributions to the understanding of lung disease and to The Union. Prof Murray trained at Stanford University and is a Diplomate of the American Board of Internal Medicine with Subspecialty Board Certification in Pulmonary Disease. His academic career has spanned some 50 years, and, since 1994, he has been Professor Emeritus at the University of California, San Francisco. A long-time Union member, board member and advisor, he has served as an editor for The Union’s various journals for more than 30 years. He also served as editor for such important resources as Murray and Nadel’s *Textbook of Respiratory Medicine*, now in its fifth edition, and he has published hundreds of papers, chapters and books.

Prof Murray has received many awards, including honorary doctor of sciences degrees from the Universities of Paris and Athens and the first John F. Murray Award, created in his honour, from San Francisco General Hospital in California. A well-known figure around The Union headquarters, “John”, as he is familiarly known, is an essential part of The Union’s history and present – shaping its values, goals and achievements.

> New Honorary Members named

Three individuals with highly diverse backgrounds and interests were named Honorary Members of The Union at the 2011 General Assembly in Lille, France. Honorary Membership is a lifetime status given in recognition of distinguished contributions to the fight against tuberculosis and lung disease. As Honorary Members, they are looked to as resources for both guidance and inspiration.

Prof Robert Loddenkemper (Germany) studied medicine in Germany, held a research fellowship in the US and then became a professor of Internal Medicine at the Free University of Berlin. Since 1983, he has also been Chief of Internal Medicine/Pulmonology at Berlin’s Lungenklinik Heckeshorn. Prof Loddenkemper is author or co-author of more than 500 papers on TB and other fields and has served on the editorial board of several journals. As a Union member, he has served on the Coordinating Committee of Scientific Activities, as President of The Union Europe Region and as a Board Member. He is also an Associate Editor of the IJTLD.

Prof Margaret Becklake (Canada) trained in medicine at the University of the Witwatersrand, South Africa and returned there after postgraduate training in the UK. She held positions in the Department of Medicine and was Physiologist to the Miners’ Pneumoconiosis Bureau. In 1957 Prof Becklake moved with her family to Montreal where she was fortunate in receiving positions at the Royal Victoria Hospital and McGill University. She held appointments in the Departments of Medicine and of Epidemiology, Biostatistics and Occupational Health and she is now Emeritus Professor there. In her 50-year career, Prof Becklake has been a highly regarded researcher, teacher and mentor who has always retained her focus on the development of knowledge that will lead to a reduction of disease.

Prof Elif Dağlı (Turkey) studied medicine in Turkey and the UK, and then became a Paediatric Consultant at Atatürk Chest Hospital in Ankara and joined the faculty of Marmara University in Istanbul,
where she eventually served as chair of the Department of Paediatrics for 10 years. Prof Dagli helped found the Turkish National Committee on Tobacco or Health, which she has headed since 2008. She also helped draft Turkey’s tobacco control legislation in 1996 and 2008) and participated in the negotiations for the WHO Framework Convention on Tobacco Control. A Union member active in tobacco prevention for many years, she chaired the Coordinating Committee of Scientific Activities from 1999-2001.

**SCIENTIFIC HIGHLIGHTS**

> **TB social determinants and ethics supplement published**

The TB Social Determinants and Ethics Working Group developed a supplement to the IJTLD on social determinants and ethics in TB prevention, care and control that was published in June 2011. It included three editorials and nine articles. Funding for the supplement, which is available at no charge on the IJTLD online site, was provided by TDR and the World Health Organization.

> **Smoking cessation approach piloted in 9 countries**

The Lung Health Scientific Section established a working group to research a simple, cost-effective approach to smoking cessation for TB patients in December 2009. This group’s efforts led to the development of the ABC approach outlined in The Union guide *Smoking Cessation and Smokefree Environments for Tuberculosis Patients* published in 2010. The ABC (A=ask, B=brief advice, C=cessation support) approach has now been piloted in Bangladesh, Benin, Brazil, China, India, Indonesia, Mongolia, Nepal and South Africa. Initial results were presented at the World Conference in Lille, France in October 2011.

**OTHER HIGHLIGHTS**

> **Member survey**

More than 1,000 people responded to a survey asking what was most important to them about The Union, about their member benefits and the services they use most frequently. Top benefit: subscription to the IJTLD. Most frequent reason for joining: The Union’s mission and good work.

> **New categories of membership**

Student memberships (for first-time members under 35 and in training) and associate organisational memberships (for first-time member organisations from low- and middle-income countries) became available in 2011. For details, please visit Union Services or the main website at www.theunion.org.
TUBERCULOSIS SCIENTIFIC SECTION
2,216 active members in 2011

The TB section works through an Executive Committee that helps to coordinate and carry forward the activities of the sub-sections and working groups, representing them on the Coordinating Committee of Scientific Activities. More than 90 proposals were submitted for sessions at the 2011 World Conference, so they have a challenging job. At the annual meeting, members discussed progress, such as improved ongoing communication between working groups, and challenges, such as the inadequate space for discussions in the poster area provided at the Lille Grand Palais. The working groups also presented summaries of their activities during the year.

> Chair: Digambar Behera (India)
Vice Chair: Richard Zaleskis (Denmark)
Programme Secretary: CN Paramasivan (India)
Secretary: Bonita Mangura (USA)

> Working Groups
• TB Control in Prisons (Leaders: Massoud Dara and Sarabjit Chadha) – 149 members
• TB and Migration (Leaders: Deliana Garcia and Michael Voniatis) – 192 members
• TB Infection Control (Leaders: Grigory Volchenkov) – 603 members
• TB Social Determinants and Ethics (Leaders: Carlton Evans and Delia Boccia) – 229 members
• TB-HIV Data Management and Development (Leader: Rory Dunbar) – 335 members
• Global Indigenous Stop TB Initiative (Leader: Anne Fanning) – 6 members

TB NURSES AND ALLIED PROFESSIONALS (NAPS) SUB-SECTION*
111 active members in 2011

> Interim Chair: Stacie Stender (South Africa)
Programme Secretary: Kerrie Anne Shaw (Australia)

At the 2011 World Conference, this active sub-section sponsored two courses, two workshops, three symposia, three oral abstract presentations, nine posters and a meet-the-expert session. Since 2010, membership has increased by 28%. At the annual meeting, each working group reported on its activities, and plans for the coming year were discussed.

> Working Groups
• Regional Mobilisation of Nurses and Allied Professionals (Leader: Maruschka Sebek) – 45 members
• Best Practice for Patient Care (Leaders: Gini Williams and Inge Schreurs) – 320 members
• TB Education and Training (Leader: Amera Khan) – 487 members

TB BACTERIOLOGY AND IMMUNOLOGY SUB-SECTION
394 members in 2011

> Chair: Rumina Hasan (Pakistan)
Programme Secretary: Marina Shulgina (Russian Federation)

The annual meeting of this sub-section focused on the symposia presented in 2011 and ideas for new symposia and working groups proposed for 2012. The TB Laboratory Accreditation Working Group launched the Global Laboratory Initiative tool – a stepwise process towards laboratory accreditation. Available at www.gliquality.org, this tool has been developed to help national TB reference laboratories implement Quality Management systems. Future priorities for this working group include developing guidance for the accreditation of TB laboratory networks, checklists for the three levels of the laboratory network and Quality Management training modules.

> Working Groups
• TB Laboratory Accreditation (Leaders: Christopher Gilpin, Tom Shinnick, Armand Van Deun) – 153 members

*The HIV, Tobacco Control and Lung Health Sections also have small NAPS sub-sections.
Zoonotic TB Sub-section
16 active members in 2011

> Chair: John Kaneene (USA)
> Programme Secretary: Alejandro Perera (Mexico)

This sub-section sponsored a symposium at the 2011 World Conference that was attended by 35 people, and put forward a proposal for a new symposium in 2012. At the annual meeting, the *Mycobacterium bovis* Working Group presented their final report, which highlighted the need for animal and human laboratories to share TB surveillance data, based on a survey conducted in nine regions.

> Working Groups
- *Mycobacterium bovis* (Leader: John Kaneene) – 39 members

HIV Scientific Section
138 active members in 2011

> Chair: Reuben Granich (USA)
> Vice Chair: Soumya Swaminathan (India)
> Programme Secretary: Alasdair Reid (UK)
> Secretary: Sandya Wellwood (Namibia)

The HIV Section meeting was attended by approximately 30 members. Outgoing Chair Reuben Granich welcomed them and presented achievements against the work plan for 2011. The section now has 138 members (5% of The Union membership) with a 74% renewal rate. Major goals focus on improving the World Conference, and the section succeeded in advocating for the 2011 conference programme to be organised by day, rather than by type of session, which many delegates found more user-friendly. In Lille, more symposia were replaced by abstract-driven sessions focused around specific themes, and this trend looks set to continue. Members expressed pleasure at making an impact that has benefited all sections. Future goals include having the schedule arranged in tracks. A Union TB-HIV course was offered in Lille, building on the success of the Berlin course.

Tobacco Control Scientific Section
387 active members in 2011

> Chair: Hamdy El Sayed (Egypt)
> Vice Chair: Wang Jie (China)
> Programme Secretary: Amanda Amos (UK)
> Secretary: E Vidhubala (India)

Vice Chair Wang Jie led the annual section meeting in October 2011, which was attended by 45 members. All three working groups gave presentations on their activities during the year, and a number of issues were discussed. Major concerns were how to build the presence of tobacco control at the conference and within The Union and how to identify funding to bring activists and other civil society representatives, as well as those presenting posters, to the conference. Members also expressed a desire to see tobacco control applicants/nominees for The Union Awards. Ideas for 2012 sessions were encouraged, but it was also noted that the 2012 World Conference dates overlap with the Conference of the Parties, and this will affect the participation of key people in tobacco control.

> Working Groups
- Countering Tobacco Industry Interference in Public Health Policies (Leader: Anne Jones) – 21 members
- Strengthening NCD Prevention Through Tobacco Control (Leader: Trish Fraser) – 27 members
- Getting Research into Tobacco Control Policy at Regional/Country Level (Leader: Akramul Islam) – 28 members

Lung Health Scientific Section
97 active members in 2011

> Chair: Guy Marks (Australia)
> Vice Chair: Gregory Erhabor (Nigeria)
> Programme Secretary: Simon Schaaf (South Africa)
> Secretary: Anneke Hesseling (South Africa)

The 20 members who attended the annual meeting were welcomed by Chair Guy Marks. They discussed changes in the leadership and heard reports from this section’s diverse and active working groups. Two new working group ideas were presented: indoor air pollution and pulmonary rehabilitation post-TB and other conditions. This section organised a workshop and nine symposia for the Lille conference, as well as oral abstract and poster sessions. Highlights included an asthma symposium offered in three languages and a symposium on MDR-TB in children attended by more than 200 people. The members also discussed possible changes to the section’s name that would make child lung health (which includes child TB) more visible – and therefore attract those interested in that issue.

> Working Groups
- Childhood TB Training Tools (Leaders: Anne Detjen, James Seddon) – 178 members
- COPD in Low- and Middle-Income Countries (Leader: Peter Burney) – 99 members
- Tobacco Cessation Interventions for TB Patients (Tara Singh Bam) – 73 members

Complete reports from both sections and working groups are available online from Union Services, the members-only website at http://registration.theunion.org.
ELECTIONS

Based on the Nominating Committee’s recommendations, the General Assembly elected Dr Reuben Granich (Switzerland) and renewed the mandate of Dr Muhammad Amir Khan (Pakistan); both are individual members.

The General Assembly also validated the mandates of board members representing the following regions: Dr E. Jane Carter (United States) for the North America Region and Mr Khairuddin Ahmed Mukul (Bangladesh) for the South-East Asia Region.

RESOLUTIONS

The General Assembly unanimously approved the Activity Report, treasurer’s report and the audited accounts for the period of 1 January to 31 December 2010 and the budget for fiscal 2012.

Given the current economic climate, the General Assembly unanimously approved freezing constituent member fees for the next two years at the rate of the World Health Assembly (WHA) scale of assessments that was approved in 2009 for 2010-11, instead of applying fee increases based on the revised WHA scale of assessments for 2012-2013.

The General Assembly also unanimously approved a fee increase for online-only individuals from upper-middle and high-income countries from 65€ to 80€ per year.

The General Assembly approved the renewal of the mandate of KPMG, auditors, for a period of six years, ending when the General Assembly will be called to rule on the audited accounts ending year 2016, in conformity with the legal dispositions.

Finally, the General Assembly approved the modification of the Constitution and Bye-laws as per the proposition made by the Board of Directors.

DISCHARGE AND POWER

The General Assembly, having read the reports presented, gave full discharge to the President and the Board of Directors for the management of that period. The Assembly also gave power to the Board of Directors, or its President by delegation, to fulfil all the formalities of distribution/diffusion relative to the aforementioned adopted Resolutions.

WORLD CONFERENCES

Dr Nils Billo informed the members that the upcoming World Conferences would be held in Kuala Lumpur, Malaysia in 2012 and in Paris in 2013. Several locations have expressed interest in hosting the conference in 2014. The General Assembly agreed that this decision would be discussed by the Board in 2012.

AWARDS/REMEMBRANCE

The Union’s highest honour and the only award conferred by the membership is The Union Medal. In 2011, The Union Medal was presented to Prof John F Murray for his highly distinguished career contributing to the fight against TB and lung disease. In addition, Prof Margaret Becklake (Canada), Prof Elif Dagli (Turkey) and Prof Robert Loddenkemper (Germany) were made Honorary Members of The Union. Several members who passed away in 2011 were remembered and the results of the annual Christmas Seals contest were announced.

THANK YOU!

The meeting closed with Prof Squire passing the baton to Dr E Jane Carter, the newly elected President. He will now serve as Past President. The outgoing Past President, Prof Asma El Sony, who served on the board for 12 years, received a standing ovation and hearty thanks for her strong leadership and dedicated service to The Union.
I am pleased to submit the annual Report of the Treasurer of the International Union Against Tuberculosis and Lung Disease (The Union) for the fiscal year ended 31 December 2011. The year 2011 has been a year during which The Union has continued on its path of recovery and consolidation. The Union has experienced two consecutive years with positive results. This has happened in an environment affected by the global economic crisis that started in 2008 and still continues to affect organisations across the world. The challenges from previous years still remain, including reductions in the level of membership fees from constituent members and donors less willing to finance indirect costs, as well as the fact that there are now many organisations applying for the same funding. This has a direct impact on the resources of The Union and, therefore we will need to be flexible and innovative in order to operate within a balanced budget in future years.

In the last five years The Union has funded both programmatic and support activities of approximately 180 million euros. Through its programmatic funding (87% of total funding) The Union has delivered quality health solutions for numerous beneficiaries around the world. Despite a tough economic environment, The Union has not only achieved its goals and objectives but also taken the organisation to new levels. The year 2011 was no different, and the work done by The Union has ensured that it remains a valued organisation, as shown by the faith donors have in us, demonstrated by their re-investments into the activities and programmes of The Union.

The decentralisation plan initiated in early 2007 to build capacity of The Union through its offices is showing results as more funding is being raised at the country office levels. In 2011 the share of expenditure by offices rose to 58% up from 3% in 2007. The offices permit The Union to be close to the ground, and this global structure allows it to tap into international expertise and resources and adapt them for implementation at local levels. The Union has also been able to build capacities at the offices that enable it to be more flexible as well as cost-effective when technical expertise is needed at regional or country levels.

The Union offices in 2011 have also increased their staff strength and are contributing to the growth of The Union. It will be important as the offices become more accustomed to the values of The Union that they will be able to become more self-reliant and eventually begin providing technical expertise, as well as financial resources, for The Union as a whole. This will enable The Union to further its values of independence, solidarity, and accountability, as well as quality. Further, with the establishment of offices in different parts of the world, The Union is now closer to its members, and this will ensure that members benefit from stronger ties between them and the offices.

In the years ahead, it is important that we look to further reduce costs, as well as make concerted efforts to raise revenues. The Union has made changes within the organisation to increase and coordinate efforts to raise funds through the establishment of a new fundraising unit.

Innovation has played a key role in defining The Union. When we see the achievements of The Union against the backdrop of the challenges it has had to face as well as the difficult global environment in which it operates, it is clear that The Union is an organisation that is committed to its vision and mission and has the strength, creativity and indefatigable character that will enable it not only to overcome but also to excel in all that it endeavors to do.
FISCAL 2011 HIGHLIGHTS

- Total net financial result for the year was a surplus of 0.346 million euros compared to a surplus of 0.384 million euros in 2010. Total revenue was 30.1 million euros compared to 43.9 million euros in 2010.
- Revenue from grants, gifts and operating grants amounted to 27.1 million euros compared to 39.9 million euros in 2010.
- Total expenditure was 31.7 million euros compared to 40.2 million euros in 2010.
- The current bank advances (overdraft) stood at 0.271 million euros compared to 0.712 million euros in 2010.
- The operating result was a deficit of 0.277 million euros (surplus 1.035 million euros in 2010) along with an exceptional result of 0.682 million euros (deficit 0.184 million euros in 2010).

In 2012 we will need to ensure that we continue the trend of positive financial results. To ensure that the expenditures do not exceed our revenues, we will need to find cost efficiencies in all the different areas of our work and ensure that adequate funding is available before we embark on new activities. To do this we will need to make optimal use of our offices and empower them to ensure that they take on activities that were managed centrally, as well as maintain strong budgetary controls.

The Union has great strength in the way it conducts its technical assistance, educational and operational research activities and how each of these are interlinked and contribute to its core competency. It is imperative that The Union focuses on those areas in which it has expertise so that it continues to provide its beneficiaries with high-quality services.

With the breadth of resources entrusted to The Union by donors, government agencies, members and other supporters, the need for prudent fiscal oversight is great. Working closely with our Board of Directors and our auditors, we continue to review and improve our financial policies, procedures and practices. Such oversight will ensure the continued financial strength needed to pursue The Union’s agenda in Fiscal 2012 and beyond.

FINANCIAL STATEMENTS

This report describes the financial position of The Union. The document on the following pages consists of the audited financial statements for Fiscal Year 2011 audited by KPMG.

The audited financial statements present a snapshot of The Union’s entire resources and obligations at the close of the fiscal year. A complete Audit Report, including detailed comments and notes to supplement the Balance Sheet and the Income and Expenditure Accounts, is available upon request.

We have presented the accounts in euros and US dollars in order to facilitate comparison of accounts.

The financial statements and the accompanying notes of The Union include all funds and accounts for which the Board of Directors has responsibility. These statements illustrate The Union’s formal financial position presented in accordance with generally accepted accounting principles.

The auditor, KPMG, provides an independent opinion regarding the fair presentation in the financial statements of The Union’s financial position. Their opinion is included in this report. Their examination was made in accordance with generally accepted auditing standards and included a review of the system of internal accounting controls to the extent they considered necessary to determine the audit procedures required to support their opinion.

I would like to thank you, the members of The Union, and our donor agencies for your confidence and continued support of The Union.

Thank you.

Louis-James de Viel Castel
Treasurer
Auditor’s Opinion

Règles et méthodes comptables
La note n°2 pages 9 « Principe et Méthodes comptables » de l’annexe expose les règles et méthodes comptables en vigueur dans l’association.

Dans le cadre de notre appréciation des règles et principes comptables suivis par votre association, nous avons vérifié que les comptes étaient en conformité avec les règles et principes comptables français.

Estimations comptables
Votre association comptabilise ses dépenses et charges sur l’ensemble de ses activités, telle que mentionnée en note n°3.2-2 de l’annexe des comptes sociaux.

Provisions pour risques
Votre association comptabilise ses provisions pour risques liés aux pertes prévues sur ses activités et les provisions pour douteux, telles que mentionnés en note n°3.2-2 de l’annexe des comptes sociaux.

Provisions pour dépréciations
Votre association comptabilise ses provisions pour les dépréciations constatées ou estimées sur ses actifs de l’entreprise, telles que mentionnées en note n°3.1-4.2 de l’annexe des comptes sociaux.

Nous avons vérifié que les données et les hypothèses sur lesquelles se fondent les estimations, à revêtir par sondages calculs effectués par l’association, sont cohérentes et appropriées en lien avec les réalisations correspondantes.

Les estimations ainsi portées s’inscrivent dans le cadre de notre démarche d’audit des comptes annuels, près dans leur ensemble, et ont donc contribué à la formulation de notre opinion exprimée dans la présente partie de ce rapport.

Vérifications et informations spécifiques
Nous avons également procédé, conformément aux normes d’exercice professionnel applicables en France, aux vérifications spécifiques prévues par la loi.

Nous n’avons pas observé d’ irrégularité et la concordance avec les comptes annuels des informations données dans le rapport financier du Trésorier et dans les documents adressés aux membres sur la situation financière et les comptes annuels.

Paris La Défense, le 17 septembre 2012
KPMG Audit NM

Bernard Bigot
Signé

Auditor's Opinion

This is a free translation into English of the statutory auditor's report on the financial statements issued in France and is provided solely for the convenience of English-speaking users. The statutory auditor's report includes information specifically required by French law such as reports, whether modified or not. This information is presented below the main section on the financial statements and includes an explanatory paragraph describing the auditor's assessment of certain significant accounting and auditing matters. These assessments were considered for the purpose of issuing the audit opinion on the financial statements issued as a whole and not to provide separate assurance on individual account balances, transactions, or disclosures.

This report also includes information relating to the specific verification of information given in the management report and in the documents addressed to the members.

This report should be read in conjunction with, and considered in accordance with, French law and professional auditing standards applicable in France.

International Union Against Tuberculosis and Lung Disease
Charitable organization
Registered office: 68, boulevard Saint-Michel - 75006 Paris

Statutory auditor's report on the financial statements

Year ended December 31st, 2011

Ladies and Gentlemen

In compliance with the assignment entrusted to us by your General Assembly, we hereby report to you, for the year ended December 31st, as:

- the audit of the accompanying financial statements of International Union Against Tuberculosis and Lung Disease;
- the justification of our assessments;
- the specific verifications and information reported by law.

These financial statements have been approved by the Board of Directors. Our role is to express an opinion on these financial statements based on our audit.

1. Opinion on the financial statements

We conducted our audit in accordance with professional standards applicable in France; these standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit involves performing procedures, selecting and applying sampling techniques or other methods of selection, to obtain audit evidence about the amounts and disclosures in the financial statements. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made, as well as the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the financial statements give a true and fair view of the assets and liabilities and of the financial position of the organization as at December 31st, 2011 and of the results of its operations for the year then ended in accordance with French accounting principles.

2. Justification of our assessments

In accordance with the requirements of article L133-9 of the French Commercial Code ("Code de commerce") relating to the justification of our assessments, we bring to your attention the following matters.

Major events of the year

The note n°1-3 page 6 describes the extension of a loan agreement for the financing of the association.

On the basis of our assessment of major events of the year, we analyzed the agreement and we are confident in its validity.

Rules and accounting principles

The note n°2 page 7 to the financial statements explains the rules and accounting principles applied by the organization.

On the basis of our assessment of the rules and accounting principles applied by your organization, we have checked the appropriateness of the accounting principles shown on the basis, and of the information provided in the notes to the financial statements, and we verified their correct application.

Accounting estimations

Deducted funds

Your organization sets up dedicated funds, such as presented in note n°3.2.3 of the appendix of the social accounts, internal funding received allocated to a specific project meets the criteria laid down by the French accounting rules and principles.

Contingencies and loss provisions

Your organization sets up provisions against exchange losses and provision for disputes, such as mentioned in note n°3.2.3 of the appendix of the social accounts.

Wear and tear allowances

Your organization sets up provisions to cover the depreciation in the book or the inventory, as mentioned in note n°3.1.4.2 of the appendix of the social accounts.

Our audit includes evaluating the appropriateness of the data and the hypotheses on which these estimations are based, to review by sampling tests the calculations made by the organization, to compare the accounting estimations of the previous periods with the corresponding realizations.

These assessments were made as part of our audit of the financial statements, taken as a whole, and therefore contributed to the opinion we formed which is expressed in the first part of this report.

3. Specific verifications and information

We have also performed, in accordance with professional standards applicable in France, the specific verifications required by French law.

We have no matters to report as to the fair presentation and the consistency with the financial statements of the information given in the Treasurer's financial report, and in the documents addressed to members with respect to the financial position and the financial statement.

Paris La Défense, September 1st, 2012

KPMG Audit NM

Benoit Bazzillon
Partner

KPMG Audit NM - Year ended December 31st, 2011

Acknowledgements
## Balance Sheet

1st January 2011 – 31 December 2011

### ASSETS

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<td>135,546</td>
<td>181,117</td>
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<tr>
<td><strong>Total Fixed Assets</strong></td>
<td><strong>7,284,228</strong></td>
<td><strong>9,425,062</strong></td>
<td><strong>8,257,580</strong></td>
<td><strong>11,033,779</strong></td>
</tr>
</tbody>
</table>

| Current Assets       |            |            |            |            |
| Constituent members  | 443,358    | 573,661    | 503,724    | 673,076    |
| Suppliers advance    | 0          | 0          | 6,000      | 8,017      |
| Managed funds receivable | 2,828,814 | 3,660,202  | 6,746,275  | 9,014,373  |
| Receivable on committed grants | 422,699    | 546,930    | 3,022,105  | 4,038,137  |
| Inter-offices accounts | 1,633,158 | 2,113,143  | 512,525    | 684,835    |
| Other receivables    | 267,893    | 346,627    | 699,633    | 934,850    |
| Sundry debtors       | 150,143    | 194,270    | 63,982     | 85,493     |
| **Total Current Assets** | **5,746,065** | **7,434,833** | **11,554,244** | **15,438,781** |

| Bank & Cash          |            |            |            |            |
| Financial investment for managed funds | 0          | 0          | 0          | 0          |
| Cash and bank for managed funds | 2,848,153 | 3,685,225  | 4,836,163  | 6,462,081  |
| Cash and bank of the Union | 747,679   | 967,422    | 991,679    | 1,325,081  |
| **Total Bank & Cash** | **3,595,832** | **4,652,647** | **5,827,842** | **7,787,162** |

| Prepaid Expenses     |            |            |            |            |
| **Total Prepaid Expenses** | **41,764** | **54,038** | **82,751** | **110,572** |

<table>
<thead>
<tr>
<th>Foreign Exchange Unrealised Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Exchange Losses</strong></td>
</tr>
</tbody>
</table>

|                      |            |            |            |            |
| Grand Total          | **17,671,539** | **22,865,203** | **26,414,497** | **35,295,051** |
### LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserves</td>
<td>2 287 820</td>
<td>2 960 210</td>
<td>2 287 820</td>
<td>3 056 985</td>
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<tr>
<td>Result carried forward</td>
<td>-4 712 701</td>
<td>-6 097 764</td>
<td>-5 097 607</td>
<td>-6 811 422</td>
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<tr>
<td>Result from the financial year</td>
<td>346 428</td>
<td>448 243</td>
<td>384 908</td>
<td>514 314</td>
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<tr>
<td>Restatement reserve on premises</td>
<td>1 887 396</td>
<td>2 442 102</td>
<td>1 887 396</td>
<td>2 521 939</td>
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<tr>
<td><strong>Total Equity</strong></td>
<td>-191 057</td>
<td>-247 209</td>
<td>-537 483</td>
<td>-718 184</td>
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<tr>
<td><strong>Contingency Reserves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contingency liability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Contingency Reserves</strong></td>
<td>491 481</td>
<td>635 927</td>
<td>176 197</td>
<td>235 434</td>
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<tr>
<td><strong>Dedicated Funds</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Total Dedicated Funds</strong></td>
<td>4 594 007</td>
<td>5 944 186</td>
<td>5 880 817</td>
<td>7 857 948</td>
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<tr>
<td><strong>Debts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Grants to be paid</td>
<td>5 345 536</td>
<td>6 916 589</td>
<td>10 319 405</td>
<td>13 788 789</td>
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<tr>
<td>Committed grants related to future budget years</td>
<td>422 699</td>
<td>546 930</td>
<td>3 022 105</td>
<td>4 038 137</td>
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<td>Inter-offices accounts</td>
<td>1 417 183</td>
<td>1 833 693</td>
<td>945 533</td>
<td>1 263 421</td>
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<tr>
<td>Borrowing from credit institutions</td>
<td>1 980 111</td>
<td>2 562 066</td>
<td>2 450 561</td>
<td>3 274 440</td>
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<td>Current bank advances</td>
<td>260 284</td>
<td>336 781</td>
<td>712 403</td>
<td>951 913</td>
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<tr>
<td>Suppliers and similar accounts</td>
<td>831 607</td>
<td>1 076 016</td>
<td>696 308</td>
<td>930 407</td>
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<tr>
<td>Tax and social security</td>
<td>685 757</td>
<td>887 301</td>
<td>604 929</td>
<td>808 306</td>
</tr>
<tr>
<td>Charges to be paid (accrued expenses)</td>
<td>240 014</td>
<td>310 554</td>
<td>268 008</td>
<td>358 112</td>
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<tr>
<td>Other creditors</td>
<td>339 449</td>
<td>439 213</td>
<td>300 681</td>
<td>401 770</td>
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<tr>
<td><strong>Total Debts</strong></td>
<td>11 522 640</td>
<td>14 909 143</td>
<td>19 319 933</td>
<td>25 815 295</td>
</tr>
<tr>
<td><strong>Deferred Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Deferred Income</strong></td>
<td>572 808</td>
<td>741 156</td>
<td>897 438</td>
<td>1 199 157</td>
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<tr>
<td><strong>Foreign Exchange Unrealised Gains</strong></td>
<td>681 660</td>
<td>882 000</td>
<td>677 595</td>
<td>905 401</td>
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<tr>
<td><strong>Total Exchange Gains</strong></td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>17 671 539</td>
<td>22 865 203</td>
<td>26 414 497</td>
<td>35 295 051</td>
</tr>
</tbody>
</table>
### INCOME STATEMENT (in €)

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contributions</strong></td>
<td>603 347</td>
<td>0</td>
<td>603 347</td>
<td>588 027</td>
</tr>
<tr>
<td><strong>Operating grants</strong></td>
<td>2 840 090</td>
<td>0</td>
<td>2 840 090</td>
<td>3 710 625</td>
</tr>
<tr>
<td><strong>Grants and gifts</strong></td>
<td>3 071</td>
<td>24 263 841</td>
<td>24 266 912</td>
<td>36 259 028</td>
</tr>
<tr>
<td><strong>Write back of provisions and transferred charges</strong></td>
<td>215 634</td>
<td>266 884</td>
<td>482 517</td>
<td>668 583</td>
</tr>
<tr>
<td><strong>Other income</strong></td>
<td>530 234</td>
<td>1 388 730</td>
<td>1 918 964</td>
<td>2 633 325</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>4 192 376</td>
<td>25 919 455</td>
<td>30 111 830</td>
<td>43 859 588</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Operating Expenses</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>External charges</strong></td>
<td>-1 968 160</td>
<td>-13 409 642</td>
<td>-15 377 801</td>
<td>-18 178 861</td>
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<tr>
<td><strong>Taxes</strong></td>
<td>-25 974</td>
<td>-815</td>
<td>-26 789</td>
<td>-28 269</td>
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<tr>
<td><strong>Wages and salaries</strong></td>
<td>-727 181</td>
<td>-2 589 646</td>
<td>-3 316 828</td>
<td>-3 654 365</td>
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<tr>
<td><strong>Social contributions</strong></td>
<td>-387 584</td>
<td>-1 038 504</td>
<td>-1 426 088</td>
<td>-1 606 131</td>
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<tr>
<td><strong>Depreciation charges and addition to provisions</strong></td>
<td>-644 707</td>
<td>-19 733</td>
<td>-664 440</td>
<td>-719 660</td>
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<tr>
<td><strong>Other expenses</strong></td>
<td>-650 679</td>
<td>-10 232 783</td>
<td>-10 883 462</td>
<td>-15 976 326</td>
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<tr>
<td><strong>Total Operating Expense</strong></td>
<td>-4 404 285</td>
<td>-27 291 123</td>
<td>-31 695 408</td>
<td>-40 163 612</td>
</tr>
</tbody>
</table>

| **Write back of dedicated funds** | 0 | 3 183 013 | 3 183 013 | 903 706 |
| **Obligations for projects**    | 0 | -1 877 145 | -1 877 145 | -3 564 022 |
| **Total Operations on Dedicated Funds** | 0 | 1 305 868 | 1 305 868 | -2 660 316 |

| **Operating Result**        | -211 909      | -65 800       | -277 709 | 1 035 660 |

<table>
<thead>
<tr>
<th><strong>Financial Result</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Foreign exchange difference</strong></td>
<td>291 475</td>
<td>-45 247</td>
<td>246 228</td>
<td>-463 552</td>
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<tr>
<td><strong>Interest and financial income</strong></td>
<td>-62 708</td>
<td>102 897</td>
<td>40 189</td>
<td>-100 246</td>
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<tr>
<td><strong>Financial provisions</strong></td>
<td>-329 301</td>
<td>0</td>
<td>-329 301</td>
<td>97 219</td>
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<tr>
<td><strong>Total Financial Result</strong></td>
<td>-100 534</td>
<td>57 650</td>
<td>-42 884</td>
<td>-466 579</td>
</tr>
</tbody>
</table>

| **Exceptional Result**      | 674 583       | 8 151         | 682 733 | -184 173 |

| **Income Tax**              | -15 712       | 0             | -15 712 | 0 |

| **Net Result for Financial Year** | 346 428 | 0 | 346 428 | 384 908 |

---

2011: 1 € = 1.2939 US$
2010: 1 € = 1.3362 US$
### INCOME STATEMENT (in US$)

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>780 671</td>
<td>0</td>
<td>780 671</td>
<td>785 722</td>
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<tr>
<td>Operating grants</td>
<td>3 674 792</td>
<td>0</td>
<td>3 674 792</td>
<td>4 958 137</td>
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<tr>
<td>Grants and gifts</td>
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<td>31 394 984</td>
<td>31 398 957</td>
<td>48 449 313</td>
</tr>
<tr>
<td>Write back of provisions and transferred charges</td>
<td>279 009</td>
<td>345 321</td>
<td>624 329</td>
<td>893 361</td>
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<tr>
<td>Other income</td>
<td>686 070</td>
<td>1 796 878</td>
<td>2 482 948</td>
<td>3 518 649</td>
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<tr>
<td><strong>Total Income</strong></td>
<td>5 424 515</td>
<td>33 537 183</td>
<td>38 961 697</td>
<td>58 605 181</td>
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<tr>
<td><strong>Operating Expenses</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External charges</td>
<td>-2 546 602</td>
<td>-17 350 736</td>
<td>-19 897 337</td>
<td>-24 290 594</td>
</tr>
<tr>
<td>Taxes</td>
<td>-33 608</td>
<td>-1 055</td>
<td>-37 662</td>
<td>-37 773</td>
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<tr>
<td>Wages and salaries</td>
<td>-940 900</td>
<td>-3 350 743</td>
<td>-4 291 644</td>
<td>-4 882 963</td>
</tr>
<tr>
<td>Social contributions</td>
<td>-501 495</td>
<td>-1 343 720</td>
<td>-1 845 215</td>
<td>-2 146 112</td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>-834 186</td>
<td>-25 533</td>
<td>-859 719</td>
<td>-961 610</td>
</tr>
<tr>
<td>Other expenses</td>
<td>-841 914</td>
<td>-13 240 198</td>
<td>-14 082 111</td>
<td>-21 347 567</td>
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<tr>
<td><strong>Total Operating Expense</strong></td>
<td>-5 698 704</td>
<td>-35 311 984</td>
<td>-41 010 688</td>
<td>-53 666 618</td>
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<td>Write back of dedicated funds</td>
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<td>4 118 501</td>
<td>4 118 501</td>
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<td>-2 428 838</td>
<td>-4 762 246</td>
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<td>1 689 663</td>
<td>-3 554 714</td>
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<tr>
<td><strong>Operating Result</strong></td>
<td>-274 189</td>
<td>-85 139</td>
<td>-359 328</td>
<td>1 383 849</td>
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<tr>
<td><strong>Financial Result</strong></td>
<td></td>
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</tr>
<tr>
<td>Foreign exchange difference</td>
<td>377 140</td>
<td>-58 545</td>
<td>318 594</td>
<td>-619 398</td>
</tr>
<tr>
<td>Interest and financial income</td>
<td>-81 138</td>
<td>133 138</td>
<td>+52 001</td>
<td>-133 949</td>
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<td>883 388</td>
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<td><strong>Income Tax</strong></td>
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<td>-20 330</td>
<td>0</td>
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<tr>
<td><strong>Net Result for Financial Year</strong></td>
<td>448 243</td>
<td>0</td>
<td>448 243</td>
<td>514 314</td>
</tr>
</tbody>
</table>

2011: 1 € = 1,2939 US$
2010: 1 € = 1,3362 US$
Acknowledgements

Donors

We gratefully acknowledge the following foundations, organisations, governments and agencies for their support of The Union’s work in 2011.

Action Damien
Agence Française de Développement
Agence Nationale de Recherche sur le Sida et les hépatites virales (ANRS)
Délégation générale à la langue française et aux langues de France, DGLFLF
Department for International Development (DFID) of the British government
Economic Development Board of Singapore
Eli Lilly and Company India Pvt Ltd
European Commission, Democratic Republic of Congo
European Commission, Europe Aid Cooperation Office
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The Global Fund through a grant managed by the United Nations Office Project Services (UNOPS) in Myanmar
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International Union Against Tuberculosis and Lung Disease Inc. with funds from an anonymous donor
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Ligue Pulmonaire Suisse (LPS)
Mairie de Lille, France
Management Sciences for Health, USA
MISEREOR
National Lung Hospital, NTP Viet Nam
National Press Foundation
Norwegian Agency for Development Cooperation (Norad)
Norwegian Association for Heart and Lung Patients (LHL)
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Programme National de Lutte contre la Tuberculose, Madagascar
PNT du Cameroun
Research Institute for a Tobacco-Free Society LBG with funds from the Commission of the European Communities
Stop TB Partnership
TBCARE I implemented by the Tuberculosis Coalition for Technical Assistance (TBCTA) with funds from the United States Agency for International Development (USAID)
Three Diseases Fund through a grant managed by the UNOPS in Myanmar
Tuberculosis Control Assistance Program (TB CAP) implemented by the TBCTA with funds from the USAID
USAID
USAID through a grant managed by World Vision
US Department of Health and Human Services Centers for Disease Control and Prevention (CDC)
University Research Co, LLC
World Diabetes Foundation
World Health Organization (WHO) through a grant managed by EnCompass LLC
World Health Organization
World Lung Foundation with financial support from Bloomberg Philanthropies
The Yadana Consortium operated by Total/MGTC

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Benefactor and 15-year members are individuals who generously support The Union’s work.

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Gold
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Richard O’Brien, USA

Silver
Margaret R Becklake, Canada
Philip Hopewell, USA
Nobukatsu Ishikawa, Japan
Seiya Kato, Japan
Robert Loddenkemper, Germany
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Edward Nardell, USA
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S Bertel Squire, United Kingdom
Jeffrey R Starke, USA
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E Jane Carter, USA
Chen-Yuan Chiang, Taipei, China
Asma El Sony, Sudan
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Anne Fanning, Canada
Paula I Fujiwara, USA
Ludwing Gresely Sud, Ecuador
Anthony David Harries, United Kingdom
Joseph Ntaganira, Rwanda

Individual donors

In addition we would like to acknowledge the following individuals and groups who made personal gifts of 50 euros or more.

Anne Fanning, Canada
Elizabeth Joekes, United Kingdom
Nils E Billo, France
Commune de Premierfait
International Council of Nurses
Jay Evans, USA
Marushka Sebek, The Netherlands
The International Union Against Tuberculosis and Lung Disease comprises:

• An Institute with four scientific departments, a network of region/country offices and headquarters in Paris.

• A Federation of members that governs the organisation through a General Assembly, which elects the Board of Directors. Organisations and individuals may join The Union and participate in the activities of its scientific sections and regions. Collaborating Centres are member organisations that collaborate with the Institute on specific projects.

* non-communicable diseases
** EAG reports to the Board
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* Elected in Berlin, Germany, 14 November 2010