Malawi out-patient waiting room
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This year we celebrate 87 years since The Union was founded. Over the past decades, we have changed and evolved as an institution to keep up with the rapidly changing trends in tuberculosis and lung disease. Today, The Union remains the global focal point for education, technical assistance and research in tuberculosis and lung health.

The Union’s unwavering focus on tuberculosis control and lung health in low- and middle-income countries has been redefined over the past few years. As a previous manager of the national TB programme of Sudan, my years as President of The Union were a golden opportunity to look at The Union from a different perspective: that of a health worker in a developing country struggling to fight TB.

The Union has undergone an extensive evaluation process to redefine what it represents and which audiences we want to target. This has helped us to identify new directions The Union should take to help with TB control and promotion of lung health.

In addition, a detailed strategic plan for The Union with all its scientific sections was developed, and The Union’s expenditure was redistributed to allocate more of its resources to TB and lung health.

Consequently, this has helped guide us to take the TB model, together with our experience in tackling TB, and create a more comprehensive approach towards lung and public health. The Comprehensive Approach to Respiratory Illness Prevention and Lung Health has been one of our most important achievements in the last few years.

The Union has also recently concentrated on strengthening its interregional council as a move towards better co-ordinating activities among The Union regions, improving human resources
and decentralising services and technical assistance for low- and middle-income countries. However, more needs to be done in this area. If we are to send a strong global message about the importance of partnerships and bottom-up planning, we need to encourage The Union’s efforts to promote continued capacity building and strengthening of the interregional council. This will help members to participate in The Union’s scientific sections and become more able and equipped to lead the World Conference in issues stemming from the grassroots of low- and middle-income countries.

The Union’s recent shift to a broader focus on lung health has led to the establishment of several key partnerships and coalitions, including the Bloomberg Initiative to Reduce Tobacco Use, funded by US philanthropist Michael Bloomberg, which is now overseeing projects in more than 30 countries worldwide.

In addition, the establishment of the Asthma Drug Facility (ADF) has been one of our great achievements to ensure equity in access to treatment of asthma, and has been endorsed by all the main global stakeholders in asthma.

We are increasingly adopting a horizontal approach, thus promoting integrated health services at the point of delivery of care, such as our continued efforts to integrate TB and HIV strategies and our comprehensive approach to child lung health.

The Union’s quest for new ways to tackle TB and lung diseases has repeatedly highlighted poverty as a serious and commonly occurring obstacle to TB control and lung health promotion. Reducing poverty itself is one of the Millennium Development Goals, as it has been proven to improve health and sustainable development. We need to look further to break this vicious cycle of poverty, disease and death; we need to invest more in empowerment of the poor and advocate for debt relief of poorer nations. The world today has new emerging and rapidly growing economies, whose sheer existence is proof of development but is also a sign of future changes to trends and patterns of global disease burden. The 2008 World Conference theme is “Global threats to lung health: the importance of health system responses”. It reflects our need to be able to predict rapid global changes affecting health and to assess and strengthen our preparedness to respond to these threats.

I would like to take this opportunity to thank all our many loyal partners, benefactors and donors, but most importantly, the members of The Union for their continued dedication and enthusiasm. The Union is an ambitious and committed organisation, and I take great pride in being part of its Board over the past few years.

Asma El Sony, MD PhD
President, International Union Against Tuberculosis and Lung Disease 2003-2007
The year 2007 marks again a period of extraordinary growth for The Union, in terms of projects, budget and personnel. The rapid expansion of our organisation has been a challenge for all of us, but thanks to the devotion of all of The Union staff and consultants and their determination to get things done, we have been able to face these challenges and contribute with our work to improve lung health in low- and middle-income countries.

There were several highlights in 2007 which deserve special mention, but it is impossible to describe them all in this summary. The World Conference in Cape Town, which attracted more than 3,000 participants, was certainly an event that we will never forget. It was the first World Conference to be held in the Africa Region of The Union, and through the many presentations and discussions it became very clear that the dimension of the dual epidemics of tuberculosis and HIV is not only of concern for scientists and health care personnel. The community has a crucial role to play, as was witnessed by more than 5,000 activists demanding new tools for the diagnosis, treatment and prevention of tuberculosis.

The second highlight was the launch of several projects in the framework of the Bloomberg Initiative to Reduce Tobacco Use. Within a very short period of time it was possible to offer grants to several organisations and government agencies of those countries hardest hit by the tobacco epidemic. Our previous experiences with the grants system developed for FIDELIS were extremely helpful and showed that we can learn from our experiences in tuberculosis and apply them in tobacco control and possibly in the future for other important global public health threats.
Growth of any organisation, especially if it happens in a short period of time, causes a multitude of challenges. During 2007, The Union continued with a process of decentralisation and created several new regional (Mexico, Egypt) and country offices (Myanmar, Uganda, Russia) to be closer linked to local realities and improve the impact of collaborative projects in regions and countries. Finding new human resources, i.e., new competent and motivated colleagues, has been a big challenge in 2007. We have strengthened The Union’s recruiting capacity by hiring a Human Resource Director whose main task is to assist in identifying talents throughout the world who can join our organisation in order to reinforce the many areas in which we are working. Retaining good staff and consultants in a rapidly changing and competitive working environment is a particular difficult task that we are facing.

The budget of The Union has been increasing every year, and thanks to a well organised Department of Finance and Development it has been possible to end the year with a balanced budget. Challenges such as the depreciation of the US dollar against the Euro and other currencies have demanded careful management of our financial resources, which are obtained mainly through grants, gifts and managed funds. Our income is expected to increase in the coming years for TB research, tobacco control and other public health interventions, and we can proudly say that we are ready to absorb additional funds by the continued application of prudent fiscal management practices.

The support received from our members (Constituent, organisational and individual) allows The Union to develop new projects that are currently not yet funded by development agencies and other donors.

These projects are often innovative in nature and are always aimed at improving health services in low-income countries. A key example of projects that have benefited from seed funding from our members is the very successful child lung health project in Malawi, which is now being funded by other donors and is being scaled up in other countries. Currently, membership funding is partly supporting the development of the Asthma Drug Facility which aims to provide affordable good quality inhalers to low-income countries.

As we grow, The Union’s values are the cornerstone of all our projects and activities. We need to continue to provide services of excellent quality, we need to conform to the highest levels of ethical standards, and we need to continue working in partnership with all our colleagues around the world. Very importantly, we need to undertake all our activities using solidarity and transparency. I would like to thank all those who have supported us in 2007 in achieving our mission to improve lung health in low- and middle-income countries.

Nils E. Billo, MD, MPH

Executive Director,
International Union Against Tuberculosis and Lung Disease
Living and dying with TB in Kolkata, India. A young 15-year-old girl seriously ill with brain tuberculosis.
For more than eight decades, the mission of The Union has been the prevention and control of tuberculosis. Over recent decades, The Union has extended its line of work to include HIV, lung health and tobacco control, as well as other related health problems, on a worldwide basis, with a particular emphasis on low- and middle-income countries.

On 17 October 1920, at the Sorbonne in Paris, delegates from 31 countries gathered to pledge their commitment in the campaign against tuberculosis and decided to create an organisation that would centralise all experience of the disease. Three days later, the International Union Against Tuberculosis in its present form was founded.

In 1993, The Union’s TB model was adopted by the World Health Organization (WHO) as part of the internationally recommended DOTS Strategy which was expanded in 2006 to the broader Stop TB Strategy that addresses TB from medical, political, social and organisational perspectives. The Union has since developed programmes for the management and treatment of TB-HIV co-infection, asthma, pneumonia in children under 5 years of age, and tobacco control. By providing leadership and expertise in global lung health, The Union is committed to helping countries achieve the United Nations’ Millennium Development Goals for 2015, which range from halving extreme poverty to stopping the spread of HIV/AIDS and providing universal primary education.

Since then The Union has come a long way. It is active today in more than 75 countries each year, providing technical assistance, education, training and research to promote lung health in low- and middle-income countries. Still based in Paris, with regional offices in the Middle East, Africa, Asia and Latin America, The Union counted almost 10,000 members and subscribers from 145 countries in 2007, with activities focused on tuberculosis control and prevention, HIV care, child lung health services, asthma management and tobacco control activities.

### AMONG ITS FLAGSHIP PROJECTS IN 2007, THE UNION COUNTS:

- **The FIDELIS Initiative** (Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB) funded by the Canadian International Development Agency (CIDA), which has funded 53 TB case-finding projects in 18 countries since 2003.

- **The Laboratory Strengthening Activities** funded by the United States Agency for International Development (USAID), concentrating on operations research and the creation of regional reference laboratories. It also provides training and technical assistance to improve key TB diagnostic services, with a main focus on acid-fast bacilli (AFB) microscopy.

- **The Integrated HIV Care for Tuberculosis Patients Living with HIV/AIDS (IHC)** project funded by multiple donors, which is a programme operating in Benin, DR Congo, Myanmar, Uganda and Zimbabwe. The goal is a reduction in the burden of tuberculosis and HIV among individuals and communities in resource-limited settings.

- **The Child Lung Health Programme** in Malawi, which has reduced the pneumonia case fatality rate in children under 5 by more than 50% since 2000.

- **The Bloomberg Initiative to Reduce Tobacco Use** supports a competitively awarded grants programme to develop and deliver high-impact tobacco control interventions in low- and middle-income countries to reverse the global tobacco epidemic through specific key interventions, with more than 40 high-impact tobacco control projects supported in over 20 countries. It is funded by the World Lung Foundation as part of the Bloomberg Initiative to Reduce Tobacco Use.

- **Five regional conferences** that were held in North America, Latin America, Europe, Asia Pacific and Africa in 2007.

- **Numerous research projects** conducted in 47 countries, including clinical trials of TB treatment in 12 countries.
The Union provides innovative technical assistance, training and advice to national health programmes and organisations, stressing:

- **Quality**: to provide outstanding levels of support
- **Integrity**: conforming to the highest levels of ethical standards
- **Leadership**: encouraging growth and advancement
- **Teamwork**: to capitalise on the strengths of each staff member, donor, member, partner, grantee and the general public
- **Solidarity**: giving priority to those in most need who have the least resources

### The Union’s key activities: Education, Technical Assistance, Research and Advocacy

**Education** is directed at health-care providers, decision makers and the public at large. It is carried out through dissemination of information, training and public education.

- We disseminate information through:
  - Conferences, courses and publications (technical guides, the International Journal of Tuberculosis and Lung Disease)
  - Scientific statements
  - Joint meetings, reports and recommendations with the Stop TB Partnership, the World Health Organization and other international health organisations and institutions.

**Technical Assistance** aids in the exchange of technology, skills and knowledge between technically advanced and developing countries as well as between developing countries. This assistance promotes, within the priorities of each country, national self-sufficiency in developing, implementing and evaluating programmes for tuberculosis control and the promotion of lung health.

**Research** is carried out in the fields of specialisation of The Union within the organisation, in collaboration with its Collaborating Centres and in cooperation with external research institutions and organisations.

- Research is carried out in partnership with technical consultants, research institutions and individual researchers.
- Members and scientific groups within the organisation may initiate research with a view to promoting collaborative links among the members and with external groups.
- A Documentation Centre is available to provide essential information for those carrying out research in the fields of tuberculosis and lung health.

**Advocacy** efforts such as World Tuberculosis Day, World Asthma Day, World AIDS Day, World No Tobacco Day and through our World and Regional Conferences represent an opportunity to highlight the importance of very important issues for government officials and the community as a whole. These World days and all related events, as well as our Conferences, are a powerful tool to advocate for better health at both local and global level. The Union also advocates through the Stop TB Partnership, which includes The Union, WHO and other international partners. The main aim of the Stop TB Partnership is to tackle one of the major public health problems of this century by joining forces and adopting a common strategy to reduce the burden of tuberculosis.

### Our specific aims are:

- To gather and to disseminate knowledge on all aspects of tuberculosis, lung disease, as well as HIV and related community health problems
- To alert doctors, decision makers, opinion leaders and the general public to the dangers presented by tuberculosis and lung disease
- To co-ordinate, assist and promote the work of its Constituent Members worldwide
- To establish and maintain close links with the World Health Organization, other United Nations organisations, and government and non-government institutions in health and development sectors
Through its various departments, The Union provides a neutral platform to fight TB, HIV, asthma, tobacco and lung disease, conducting clinical trials, organising international conferences and training courses.
The Union has been at the centre of efforts to prevent, treat and control tuberculosis since 1920. The Union’s work in TB today aims to ensure high-quality, countrywide DOTS coverage and meet global targets for tuberculosis control in low- and middle-income regions.

Despite recent progress, TB remains an important global public health problem. One third of the world’s population is currently infected with the tubercle bacillus, nearly 9 million new cases occur each year and more than one and a half million deaths are due to TB. Multidrug-resistant TB (MDR-TB) is a particularly dangerous form of drug-resistant TB, which is defined as disease caused by bacilli resistant to at least isoniazid and rifampicin, the two most powerful anti-tuberculosis drugs. Rates of MDR-TB are high in some countries and threaten TB control efforts globally.

In the field, Union consultants advise national tuberculosis programmes on guidelines and policies, while providing technical training for health care providers and programme personnel, carrying out research projects and clinical trials, as well as conducting educational programmes on topics ranging from MDR-TB to financial management.

**Activities in 2007 by The Union’s TB Department:**

- Regular technical assistance in 22 countries (12 in Africa, 6 in Latin America, 4 in Asia) through 39 missions conducted by 12 consultants. Technical assistance includes ongoing support to the full range of DOTS activities, one-time reviews of specific components, e.g., laboratory activities, provision of MDR training and follow-up.
- Additional technical support provided through one-time visits, special requests and programme reviews
- Other technical work in 34 countries (13 in Africa, 10 in Latin America, 9 in Asia, 2 in Europe); 73 missions conducted by 14 consultants
- Union consultants from the TB and Lung Health Departments were involved in 33 advisory committees and 76 courses and workshops

**Laboratory Strengthening Division: Improving Case Detection**

In most low- and middle-income countries, microscopic examination of sputum is still the only widely available diagnostic tool for identifying tuberculosis. With the growing threat of drug-resistant tuberculosis, it is critical that laboratories be properly equipped, staffed and

“Despite impressive progress in global tuberculosis control efforts, the remaining hurdles towards eliminating tuberculosis as a public health problem remain significant. The work of the Department of Tuberculosis Control and Prevention in 2007 - ranging from intensive technical assistance to education and training - aimed to ensure that the remaining challenges are adequately addressed at the country level.”

_I.D. Rusen, MD, MSc_
provided with clear standards for measuring the quality of their work. The Union’s laboratory strengthening activities helps laboratories in Asia and Africa to improve case detection and drug-susceptibility testing, implement external quality assurance (EQA) standards and conduct research.

Clinical Trials Division: TB Drug Treatment

The Clinical Trials Division at The Union was involved in two clinical trials in 2007:

Study C: evaluating fixed-dose vs. individual medications

The use of fixed-dose combination (FDC) drugs in the treatment of tuberculosis by control programmes has been strongly recommended by The Union and WHO to prevent the emergence of drug resistance due to monotherapy, reduce the risk of incorrect dosage, simplify procurement and prescribing practices, aid adherence and facilitate directly observed treatment. However, large-scale trials examining their use have not been conducted. To this end, The Union launched a multicentre clinical trial, Study C, to evaluate the effectiveness, acceptability and toxicity of a FDC when given in the initial intensive phase of treatment of patients with newly diagnosed smear-positive pulmonary tuberculosis. The primary outcomes to be assessed are: failure rate at the end of treatment, relapse rate at the end of the follow-up period, and the occurrence of severe adverse events during treatment.

Between August 2004 and September 2006, a total of 1587 patients were randomised from 11 centres in 10 countries. By 31 March 2007, all patients had completed the treatment phase of the study and they are now in the post-treatment follow-up phase. This trial, funded by USAID, is expected to end in March 2009.

Pharmacokinetics of rifabutin combined with antiretroviral therapy in the treatment of tuberculosis patients with HIV infection in South Africa

Tuberculosis is the main cause of death in HIV-infected persons. Combining TB drugs and antiretroviral therapy (ART) is, however, fraught with many difficulties due to drug-drug interactions, cumulative toxicities and paradoxical reactions. There is a lack of randomised trials to determine the optimum combination of anti-tuberculosis and antiretroviral drugs. To develop combinations of rifabutin-based TB therapy (RBT) with ARVs for the joint treatment of TB and HIV, a pharmacokinetic (PK) study is being launched by The Union in patients with advanced immunodeficiency in South Africa and Vietnam. The purpose of this PK study is to compare the bioavailability of different doses of RBT in combination with efavirenz, nevirapin, lopinavir/r based ART. The results of the PK study will be used for a multicentre phase III evaluation. The study is being funded by the French National Research Agency on HIV/AIDS ANRS (Agence Nationale de Recherches sur le SIDA et les hépatites virales).
Tuberculosis and HIV are inextricably intertwined. The Union’s HIV Department is developing models and best practices in collaboration with national tuberculosis and AIDS control programmes to help reduce the morbidity and mortality caused by these two diseases.

Despite the fact that today HIV infection can be managed with antiretroviral medication, and tuberculosis is curable, it is estimated that more than two million people die each year from HIV and one-and-a-half million from tuberculosis. HIV and TB form a lethal combination, each speeding the other’s progress. Almost one third of HIV-infected individuals are also infected with *Mycobacterium tuberculosis*. The greatest burden of this dual epidemic of TB and HIV is in the developing world, particularly in sub-Saharan Africa.

One of the biggest obstacles in treating TB and HIV co-infection is lack of coordination between HIV and TB programmes at international, national and community levels. The Union joined international efforts to address the dual epidemic by launching its *HIV Care (IHC) Programme for tuberculosis patients living with HIV/AIDS* in 2005. The concept of integrated care entails offering individuals with tuberculosis who are registered for anti-tuberculosis treatment with the *National Tuberculosis Programme* (NTP), as well as their relatives, HIV testing and counselling. If they are found to be positive, TB patients and relatives are offered integrated HIV care that includes antiretroviral therapy (ART).

The IHC programme, which works with national TB and AIDS programmes to strengthen their collaboration and build the capacity of the countries’ general health systems to deliver high-quality HIV and TB care, now serves patients in Benin, Democratic Republic of Congo, Myanmar, Uganda and Zimbabwe. The goals of the programme are to:

- secure political commitment from the country for collaborative TB-HIV activities
- offer routine HIV counselling and testing for TB patients
- provide standardised HIV treatment regimens and regular patient follow-up
- improve recording and reporting for TB-HIV indicators
- strengthen logistics for TB and HIV
- implement patient and health systems-oriented operational research

In 2007, the IHC programme was being implemented in:

- Uganda (funded by USAID through TB CAP and a separate cooperative agreement through the United States Agency for International Development [USAID])
- Myanmar (funded by the Yadana Consortium, which includes Total)
- Benin (funded by the European Commission and the Swiss Development Agency)
- Democratic Republic of Congo (DRC) (funded by the European Commission and USAID)
- Zimbabwe (funded by the European Commission)

“HIV continues to be one of the main reasons for failure to meet TB control targets. Thus, intensified collaboration between HIV/AIDS and TB programmes is not only key to the achievement of comprehensive HIV care and support, but it also helps to effectively reduce the burden of TB”

*Paula I. Fujiwara, MD, MPH*
Uganda

In Uganda, the interaction of TB and HIV is increasing the burden of both of these prevalent diseases. HIV is clearly impacting on TB control; with approximately half of TB patients also co-infected with HIV, implementation of collaborative TB and HIV programme activities is critical.

The Union opened its first country-based office in sub-Saharan Africa in October 2007, based in Kampala, Uganda. At the same time, registration as an international non-governmental organisation was completed and a Memorandum of Understanding with the Ministry of Health was signed. Technical assistance activities focus on improving the ability of the general health system to deliver quality, integrated care for TB and HIV. Key activities include strengthening TB and HIV control activities, providing diagnostic HIV counselling and testing to TB patients and increasing active TB case finding among people living with HIV/AIDS. Programme activities were planned for 12 districts in the first year of the agreement.

National level activities aim to improve the coordination and collaboration between the TB and HIV programmes within the country and are centred around a number of key activities that strengthen capacity in coordination, supervision and management. These include:
- Coordination of meetings leading to policy development for TB and HIV
- Training in management and leadership of both TB and HIV programme managers
- Joint planning of activities between TB and HIV national programmes
- Monitoring and supervision of TB and HIV national programme activities
- Revision of monitoring and evaluation tools for collaborative TB and HIV activities
- Revision of Uganda’s community-based TB care (CBDOTS) strategy
- Participation in the update and revision of TB infection control guidelines to adapt World Health Organization guidelines to the Ugandan context.

In 2007, The Union, through the United States Agency for International Development’s (USAID) Tuberculosis Control Assistance Program (TB CAP), was named the coordinating partner for TB-HIV activities in Uganda. TB CAP in Uganda aims to foster collaboration between the national tuberculosis and HIV control programmes, develop coordinated plans for the two diseases and implement the country’s guidelines.

District level activities include:
- Dissemination of TB-HIV policy guidelines to ensure availability at health facility level
- TB-HIV coordination between the District Health Teams and other partners to improve communication and coordination
- Joint planning between managers so that activities are aligned with district needs
- Monitoring and supervision to ensure that activities are carried out in accordance with country policy

Achievements in 2007
- The Union and its local partners launched a three-year technical assistance and service delivery programme to improve the ability of the general health system to deliver quality, integrated care for TB and HIV and support and improve Uganda’s community-based care model of tuberculosis control.
- In collaboration with the National Tuberculosis and Leprosy Programme and the AIDS Control Programme, both qualitative and quantitative methods are being used to discover the systems, health provider and client barriers to TB-HIV collaboration and to provide recommendations to improve service delivery. Results from phase 1 of this activity became available in early 2007; phase 2 results are expected in early 2008. Preliminary results were presented at the 38th Union World Conference on Lung Health in Cape Town, South Africa in November 2007.
- Provider training of staff in Health Sub-Districts on TB and HIV
- Provision of HIV counselling and testing, cotrimoxazole preventive therapy and antiretroviral treatment to TB patients
- Advocacy, communication and social mobilisation to strengthen CBDOTS and TB-HIV collaborative activities, with the aim of improving awareness and treatment outcomes for patients.
The Union

Tobacco Control

- Promoting effective tobacco control policy through technical resources
- Training a new generation of managers and practitioners
- Supporting effective programmes through grants
- Building knowledge for action through research

- 50% of all deaths from lung disease are linked to tobacco use
- 80% of smokers live in low- and middle-income countries
- 520 million people will die from tobacco use in the next 50 years
- 1 in 5 deaths from TB could be prevented if people did not smoke

The Union achievements as a partner in the Bloomberg Initiative in 2007:

**Grants programme**

The Union manages, in collaboration with US partner Campaign for Tobacco-Free Kids, the grants programme for the Bloomberg Initiative to Reduce Tobacco Use. The grants programme focuses on 15 countries in which approximately 80% of the world's smokers live. The grants are short-term (1-2 years), and range from US$10,000 per year for a short-term advocacy campaign to US$500,000 per year for a comprehensive tobacco control initiative, supporting national governments. In 2007, some 80 projects in more than 30 countries were selected for funding from almost 1200 project proposals received. Priority for funding was...
“Tobacco use kills more than tuberculosis, HIV/AIDS and malaria combined. In the 21st century, tobacco use will cause 1 billion deaths, mostly in low- and middle-income countries. Effective policies, meaningfully enforced, are the key to curbing tobacco use and saving lives.”

Sinead Jones, MD, MPH

given to projects that lead to a sustainable improvement in tobacco policies, such as tax/price measures, smokefree environments, and advertising bans.

The grants programme and grantees in the recipient countries were supported by a team of international experts in tobacco control with diverse experiences of working with and for governmental and non-governmental agencies.

Resource centres
Five tobacco control resource centres/offices were established by the end of 2007. Resource centres support the Bloomberg Initiative and The Union tobacco control efforts regionally and in countries in different ways. Their function and expertise include:
- Legal expertise, management and leadership
- Support to partners
- Capacity building
- Learning and knowledge sharing
- Advising on issue/region-specific knowledge
- Familiarity with the political landscape and policy issues
- Local access and networks
- Relationships with local communities and connections with institutions
- Technical expertise

In 2007, two existing Union Resource Centres in India and China went through a transition from an exclusively TB focus to include tobacco control, adding tobacco control expert staff to strengthen their ability to provide technical advice and support to partners. New centres were established in Cairo and Mexico, and an office was opened in Russia.

Building organisational and technical capacity for tobacco control through training
In 2007, a three-course management series was offered in Bangladesh, China, India and Indonesia. In each country a cohort of invited participants from the public and private sector attended the course. The manager series includes: leadership and general management; budget management and financial reporting; human resources development; and management of managers. 70 people in Indonesia, 69 in India, 58 in China, and 51 in Bangladesh benefited from the courses.

Building knowledge through research
Research at The Union focuses on describing the burden of tobacco-related lung disease, understanding the underlying drivers of tobacco use and helping people to stop smoking.

Tobacco smoking and tuberculosis care outcomes
- A joint Union-WHO/Stop TB report and systematic qualitative review of the evidence linking tobacco smoke exposure to tuberculosis was written in 2007.
- A shorter version of the above report was published in the October 2007 issue of the International Journal on Tuberculosis and Lung Disease (IJTLD). It featured a meta-analysis of pooled results prepared by The Union. It examined the strength of the evidence and the odds ratios for the association between: 1) passive smoking and tuberculosis disease, 2) active smoking and tuberculous infection, tuberculosis disease, retreatment of tuberculosis disease and tuberculosis mortality.

Cessation programmes for smokers and other tobacco users in tuberculosis treatment
- In February 2007, the IJTLD published the results of a joint Union-EpiLab study in Sudan. This showed the feasibility, and potentially important treatment outcome benefits, of adding tobacco cessation interventions to tuberculosis case management.
- The above studies were instrumental in the development of a Union Guide on tobacco cessation treatment for tuberculosis patients. It is based on a series of six educational articles published from March to August 2007 in the IJTLD. The Guide covers the steps necessary for successfully integrating cessation treatments into tuberculosis case management.
The total number of people with asthma is higher in the developing world than in industrialised countries. There are approximately 3 million asthmatics in Japan and in France, compared with estimations of over 15 million in India and over 30 million in Africa. Despite the existence of effective medications and international guidelines, as well as progress made in the implementation of such guidelines over the last decade, asthma treatment for patients in the majority of developing countries still faces a major obstacle in the continued high cost of essential asthma medications.

Asthma Division: Promoting standard case management with affordable medicines

The total number of people with asthma is higher in the developing world than in industrialised countries. There are approximately 3 million asthmatics in Japan and in France, compared with estimations of over 15 million in India and over 30 million in Africa. Despite the existence of effective medications and international guidelines, as well as progress made in the implementation of such guidelines over the last decade, asthma treatment for patients in the majority of developing countries still faces a major obstacle in the continued high cost of essential asthma medications.

In 2007, The Union Asthma Division

- Developed a technical package for training in standard asthma management, including a participant manual, instructor manual and slides
- Collaborated with partners: World Health Organization (WHO) and its Practical Approach to Lung Health (PAL), International Study of Asthma and Allergies in Childhood (ISAAC), Global Alliance against Chronic Respiratory Diseases (GARD)
- Made presentations in international conferences and published results of research projects.
THE ASTHMA DRUG FACILITY (ADF)

The Union is establishing the Asthma Drug Facility (ADF) to make good-quality essential asthma medicines available and affordable in low- and middle-income countries, and to facilitate implementation of standard case management of asthma with evaluation of the quality of care.

In 2007 the ADF worked with three pharmacist consultants to enhance its operations and quality assurance system. The ADF also addressed technical issues related to the transition from inhalers that contain chlorofluorocarbons (CFCs) to CFC-free inhalers. This transition is a consequence of the Montreal Protocol on Substances that Deplete the Ozone Layer, an international agreement signed by more than 160 countries in 1987 that called for a general ban on CFC production on the basis that CFCs are a major cause of global warming.

The availability of affordable CFC-free asthma medicines through the ADF, leading to annual treatment costs of less than $US30 for one patient with persistent asthma, and the introduction of standard case management, should help patients to access affordable medicines and quality care. It will also allow governments to save millions in the costs of medicines and unnecessary emergency room visits and hospitalisations.
The Union

Lung Health

Child Lung Health Division: Reducing deaths from pneumonia

In low- and middle-income countries, lower respiratory infections are the second-leading cause of death in children aged 0-14 years. 10 million pneumonia deaths occur annually in children under 5 years of age, over 90% of which are in the developing world. Pneumonia is the leading cause of death in children under 5 years of age.

Many low-income countries have not been able to deliver the vaccines that prevent pneumonia in children or the antibiotics necessary to treat it. Inadequate drug distribution and frequent rupture in stocks further hampers the effort to effectively treat pneumonia in children. In addition, standard case management of childhood pneumonia is not being implemented. This means that a child presenting to the health centre or hospital with cough or difficult breathing may not be treated using evidence-based treatment regimens.

Comprehensive Approach to Lung Health

This project in Sudan, China and Benin is a comprehensive – rather than disease-specific – approach to improving the quality of lung health services at the first referral care level.

In 2007 the project focused on:

- Standard case management of asthma in adults
- Standard case management of pneumonia in children under 5
- Tobacco cessation in tuberculosis patients
- A study to determine the risk associated with indoor air pollution (smoke from solid fuels used in dwellings) and tuberculosis

Improving X-ray for diagnosis

- Participation in the Chest Radiograph Reading and Recording System (CRRS) 2007 in Cape Town, South Africa. The CRRS was devised to address differences and inconsistencies in reporting of chest radiographs for lung disease that are not fully met by current reporting systems.
- Participation in preparing a “Handbook for District Hospitals in Resource Constrained Settings on Quality Assurance of Chest Radiography”, developed under the funding of USAID and coordinated by the Japan Anti-Tuberculosis Association (JATA). The handbook aims at improving the quality of chest radiography for the diagnosis of TB and lung diseases in developing countries.

Achievements in 2007

- Expansion of the Child Lung Health (CLH) Malawi Project into CHAM (Christian Health Association of Malawi) hospitals funded by the Scottish Executive. This innovative project for integrated child lung health in Malawi is having a considerable effect on reducing case fatality rates in children aged under 5 admitted with severe/very severe pneumonia. Initially funded by a grant from the Bill and Melinda Gates Foundation, the main goal of the CLH Project is to improve the survival and well being of children in Malawi. The project is seen as a model for other countries in sub-Saharan Africa.

- Development of a technical package for training in standard case management of pneumonia, tuberculosis, asthma and HIV-related lung disease in hospitalised children <5 years, including participant manual, instructor manual and slides.

- Collaboration with partners:
  - Stop TB Partnership – DOTS Expansion Working Group (DEWG) on TB in children <5 years
  - WHO/UNICEF Global Action Plan for Pneumonia (GAPP)
  - WHO working group on clinical use of oxygen in low-income countries
  - WHO working group on improving in-patient paediatric care in low-income countries

- Development of workshops, presentations and publications
Under-5 clinic out-patient department waiting room in Malawi.
Since 2002, The Union has grown and changed considerably. With an initial 30 Union staff and consultants, by 2007 it counted 110 staff and consultants working from 4 sites in Paris, one regional centre in India, a start-up centre in China and by the end of the year several individual offices throughout the world.

- **Technical assistance**
  in 41 countries

- **Education Activities**
  in 45 countries (courses conducted in 8)

- **Research Projects**
  in 21 countries

- **FIDELIS**
  28 projects in 18 countries

- **IHC**
  in 5 countries

- **Clinical trials**
  Centres in 10 countries
Promoting Lung Health Worldwide
India

The India Resource Centre (IRC) is a regional resource centre of The Union for the South Asian region and includes expertise in TB control, tobacco control, programme and financial management.

The India Resource Centre is located in New Delhi, India, and serves the region of the world with the highest burden of TB and tobacco related morbidity and mortality. India alone accounts for 30% of the global burden of TB, causing about 400,000 deaths each year. Tobacco also takes a major toll on the health of Indians: smoking in persons between the ages of 30 and 69 years is responsible for about 1 in 20 deaths among women and 1 in 5 deaths among men. Because of population growth, the absolute number of deaths in this age group will rise by about 3% per year. The resource centre coordinates technical and financial support for 3 of 5 priority countries (India, Indonesia and Bangladesh) identified by the Bloomberg Initiative to Reduce Tobacco Use.

Management Education Programmes for TB and Tobacco Control

The success of organised public health programmes such as tuberculosis and tobacco control depends upon effective management. However, National Tuberculosis Programmes (NTPs) and National Tobacco Control Programmes (NTCPs) universally face a critical lack of competent management at different levels. Recognising this need for management capacity in public health programmes, The Union, with support from various donors, has implemented a package of management training programmes with the aim of strengthening TB and tobacco control programmes across the world. The objective of The Union’s International Management Development Programme (IMDP) is to address management challenges that hamper the successful implementation and expansion of tuberculosis and tobacco control programmes. Over the last year, The Union has successfully conducted several international and national educational courses that have focused on improving the management, finance and logistics skills of managers working in public health control programmes. Management principles remain the same, whether they are applied in TB control, tobacco control, HIV or malaria control programmes. These courses strengthen the individual management competencies of programme managers as well as management systems within public health control programmes.

In 2007, the IRC coordinated 18 management training programmes that were attended by over 250 intermediate and senior level programme managers and health care workers from national and sub-national levels and NGOs in more than 15 countries. These courses were planned and implemented in collaboration with various partners, including the Work for Better Bangladesh Trust (WBBT), Research Training and Management International (RTMI) Bangladesh, the World Health Organization (WHO) country offices in Afghanistan and Bangladesh, Centre for Disease Control (CDC) China, National TB and Leprosy Programme (NTLP) Uganda, Institute of Health Management and Research (IHMR) India, and Ministries of Health (MOH) in Afghanistan, Indonesia, Bangladesh, India, Thailand and Timor Leste.

Technical assistance for TB control

Technical assistance to public health programmes is one of the pillars of the Union. In India, the Union, through the IRC, has been identified by the Government of India’s Revised National TB Control Programme (RNTCP) as a sub-recipient in the Round 4 grant from the Global Fund to fight AIDS, Tuberculosis and Malaria. Through this project, the RNTCP has requested the resource centre to provide technical assistance to the TB programme in the state of Orissa (population 38 mil-
lution). The project seeks to enhance capacity in advocacy, communication and social mobilisation (ACSM) in TB control and thus contribute to improved programme performance. The project started in October 2007, and the project period is 30 months.

**Coordinating and motivating synergy for tobacco control**

The IRC has worked closely with the national governments of Indonesia, India and Bangladesh and with sub-national governments of Chennai, Delhi, Sikkim and Ahmedabad in India, Bogor and South Sulawesi in Indonesia and Chittagong in Bangladesh, to promote synergy and coordinated action for tobacco control through the Bloomberg Initiative (BI) grant programme managed by The Union. The IRC also works in close coordination with civil society organisations to increase access to funding and high quality technical and programme management expertise. This has contributed to increasing interest in governments to address policy issues related to tobacco control as well as implementing smoke-free jurisdictions within their countries. The IRC also provides coordination in technical and logistic areas to partners within the Bloomberg Initiative within the high priority countries in the region.

**Procurement**

The Procurement Unit of the Union is located at the IRC, and supported procurement of drugs to the value of around USD 700,000. It provided procurement assistance to Chile, Panama and Nicaragua for anti-tuberculosis drugs, and supported procurement, including laboratory equipment, vehicles, ARVs and CD4 test kits, for the Integrated HIV Care Programme in Myanmar, Benin, DR Congo and Zimbabwe.

Technical support was provided to the Global Drug Facility (GDF) in monitoring and evaluation of the procurement and supply chain management systems in the NTPs of Mongolia and Myanmar.

**Outreach to affected communities**

Despite a lot of interest, cost and distance make it difficult for persons from affected communities to participate in the Union’s annual World Conference. As efforts to increase community participation in TB control and care gain momentum, innovative methods are needed to connect people to access and share the latest news from the Union’s World Conference.

To bridge this distance, the IRC, in coordination with the World Care Council and partners, brought together some of the key actors in the fight against TB and HIV, using the Union Conference 2007 in Cape Town as a focal point to advance social mobilisation in India and Indonesia.

By video recording key elements of the sessions at the South African event, and organising interviews and teleconferences with speakers and experts on issues relevant to the two countries, the essential points of the Union Conference were delivered to India. Members of civil society and health professionals from India got together to learn, exchange and discuss how to turn the information from the Conference into practical steps in local communities.
China Resource Centre
The China/Union FIDELIS Centre was established in 2003. It was renamed the China Resource Centre in 2007. The Centre is bringing the lung health expertise of The Union to China, and in 2007 focused on:

- FIDELIS, which supports innovative TB control activities for increasing case detection of new smear-positive cases, while maintaining high cure rates within the DOTS strategy. By the end of 2007, 15 FIDELIS projects had been implemented in 13 provinces of China since its inception in 2003, covering 37% of the Chinese population. Most are in poor, remote areas. By the end of 2007, more than 280,000 new smear-positive cases were detected, a significant increase over the baseline one year before.

- The Bloomberg Initiative (BI), which supports a competitively awarded grants programme to develop and deliver high-impact tobacco control interventions in low- and middle-income countries. For China, the country with the largest population of smokers in the world, this is an ambitious step forward. The Union is working with key organisations to support their goal of promoting smoke-free public places. In 2007, there were five Union-supported BI projects, with a grant total of $1.86 million. Major approaches include enhanced legislation and government regulation of smoke-free public places, and a media campaign against smoking. The BI project also supported smoke-free TB centres and smoke-free families. One BI project in China supports capacity building for tobacco control advocacy among public health professionals.

- Comprehensive Approach to Respiratory Illness Prevention and Lung Health Promotion Project, including
  - Standard case management of pneumonia among children under 5
  - Standard case management of asthma in adults
  - Tobacco cessation among tuberculosis patients
  - A case-control study on the association between indoor air pollution and TB

- Training courses: The Union is continuing to work on improving the capacity of project managers and people working with government and NGOs. The Union Training Course on Management and Leadership (CML) as well as the Course on Human Resources Management (HRM), were conducted in China; 40 participants received the training.

Bloomberg Initiative - 2007 accomplishments included:

- Beijing’s 66,000 taxi cabs smoke-free in September
- Two public service announcements aired on Beijing TV and Beijing Bus TV
- TB centres smoke-free in seven cities in Hunan; 200 staff and 2780 village doctors were trained in the seven cities
- Zhejiang and six other key universities have developed a tobacco control curriculum and begun implementing it
- Literature review on best practices for advocacy completed by Zhejiang University
- Planned legislation on smoke-free public places in major Olympic cities was on the agenda of government legal offices
Myanmar

The Integrated HIV Care for Tuberculosis Patients Living with HIV/AIDS (IHC) programme is active in seven townships in Mandalay District, and has registered more than 5,000 adult TB patients. IHC provides a comprehensive care and treatment package for co-infected TB-HIV patients, screened through voluntary confidential counselling and testing services at the TB clinics of Mandalay General Hospital and 5 townships in Mandalay City. Of 4,498 TB patients tested for HIV, one third, or 1,511, were found to be co-infected with HIV. Of 281 family members tested for HIV, 60% were found to have HIV.

TB patients diagnosed with HIV are placed on cotrimoxazole treatment and, when eligible, are started on antiretroviral therapy shortly after diagnosis. HIV counselling and testing services are also offered to the sexual partners and children of co-infected patients to help health providers to identify new cases and increase enrolment in the IHC. In September 2007, a Memorandum of Understanding was signed with the Ministry of Health to support expansion of the IHC programme to all seven Mandalay townships and the city of Pakokku.

South East Asia Region Conference

The first South East Asia Region (SEAR) conference will be held in New Delhi, India, in September 2008. The theme of the conference will be “TB, HIV and Lung Health in Resource Limited Countries”.

The Union’s South East Asia Region includes Bangladesh, India, Myanmar, Nepal, Pakistan and Sri Lanka. India is the current chair of the SEAR, and Sri Lanka is the Vice Chair. Dr M.M Singh, who currently represents the TB Association of India and Chair of the SEAR, is also the SEAR representative on the Union Board of Directors.

Achievements

- Expansion to Pakokku (treatment for all HIV+, not just TB-HIV co-infected)
- Opening of Union office in December 2007
- New HIV out-patient department opening in additional Mandalay hospital
- IHC provides 28% of National AIDS Programme (NAP) patients with antiretroviral therapy
- ~10,000 patients on antiretroviral therapy through NGOs
- ~5-10,000 patients treated through the private sector
- Participation in Cape Town, South Africa in November 2007.
Benin

Twenty TB diagnostic and treatment centres in all regions of Benin now participate in the IHC programme. These centres have been equipped with a three-year supply of rapid HIV tests, equipment and consumables for performing manual CD4 cell counts, cotrimoxazole and antiretroviral medications.

TB patients diagnosed with HIV are placed on cotrimoxazole preventive treatment (CPT) and, when eligible, are started on antiretroviral therapy shortly after diagnosis of TB. To date approximately 100 health care workers (doctors, nurses, laboratory technicians) have received training on HIV.

As of the end of December 2007, 4,900, or 93%, of TB patients have been tested for HIV, of whom 15% were found to be co-infected with HIV. Of these, 79% were receiving CPT during TB treatment, and 24.5% of co-infected patients were receiving antiretroviral therapy.

Achievements:

- IHC integrated into Ministry of Health structure, which now means joint supervision for TB and HIV activities
- Implementation of manual CD4 cell count method (Dynabeads®), which is expected to help reduce the delay in enrolling eligible co-infected patients in antiretroviral therapy and increase the overall uptake of the treatment. Dynabeads® can be used in sites that have only a light microscope, thus enabling health care providers to offer CD4 testing to co-infected TB patients at the same site where they receive their treatment. This provides quicker, affordable results and prevents patients from getting lost in the referral system.
- Ongoing research and training to implement viral load measurement at central laboratory
- Supplementation of failing National Programme to Combat AIDS procurement system (rapid tests)

Africa Region Conference

The 16th Africa Region Conference took place on 7 November 2007, one day before the 38th Union World Conference on Lung Health, in Cape Town, South Africa. Organised by the Africa Region, with support from The Union Headquarters in Paris, the 300 delegates considered TB-HIV: a challenge for NTPs and NAPs in Africa; MDR-/XDR-TB: how can we prevent it; Community and TB care; and Asthma: a neglected public health problem in Africa.

The pursuant elections resulted in a new office as of November 2007:

President: Dr Sary Mathurin Dembele (Burkina Faso)
Secretary: Pr Oumou Bah-Sow (Guinea)
Treasurer: Dr Benattia Zitouni (Algeria)
Representative on the Board: Prof Osséni Tidjani (Togo)

Members representing the sub-regions of Africa:

- Mrs E N Makoena: South Africa
- Prof Francis Adatu: East Africa
- Dr Félix Salaniponi: Central Africa
- Prof Martin Gninafon: West Africa
- Dr Norreddine Zidouni: North Africa

Countries of the Africa Region are: Algeria, Angola, Benin, Democratic Republic of Congo, Egypt, Eritrea, Ghana, Kenya, Madagascar, Malawi, Mali, Morocco, Mozambique, Rwanda, Senegal, South Africa, Togo, Tunisia, Uganda and the United Republic of Tanzania.
Democratic Republic of Congo

HIV diagnostic and care activities are now conducted in 23 TB diagnostic and treatment centres in two provinces – 13 in North Kivu and 10 in Bas Congo. Of 4419 registered TB patients, 95% were tested for HIV, and 14% of these were found to be co-infected with HIV. Of the co-infected patients, 97% received CPT, and 52% received antiretroviral therapy. One hundred and thirty-eight health workers were trained, with refresher training planned.

Achievements:
- Introduction of manual CD4 cell count method (Dynabeads®)
- Socio-economic operational research study in progress
- Increased collaboration with National AIDS Control Programme (NACP)

Zimbabwe

In Zimbabwe, up to 80% of TB patients are co-infected with HIV. While the health services have made progress towards providing HIV care to patients with TB, challenges from staff shortages to an irregular antiretroviral drug supply remain. In September 2007, The Union received funding from the European Commission to support Zimbabwe’s efforts by introducing its Integrated HIV Care for TB Patients Living with HIV/AIDS (IHC) programme there. The three pilot implementation sites at municipal primary health care centres (2 in Bulawayo, 1 in Harare) registered about 900 TB patients. These centres will be equipped with a supply of rapid HIV tests, equipment and consumables for providing cotrimoxazole and antiretroviral medications. The main objective is to develop innovative strategies for feasible and sustainable TB-HIV services that can be replicated by other local authority health departments and district health services in the country and outside Zimbabwe.

Achievements:
- TB patients offered HIV diagnosis and recruitment to HIV care, pending the arrival of IHC 2 drugs
- Drug and rapid HIV test delivery expected May
- Vehicle tender completed and delivery expected
- Pilot site teams inducted and community awareness creation ongoing
- Coordination meetings held between partners and Union consultant
The 11th North America Region Conference was held 22-24 February 2007 in Vancouver, Canada, on the theme “Powering-up political will for TB control”. Organised by the British Columbia Lung Association (BCLA), the conference attracted 450 delegates. Sessions covered TB prevention and control, including the global impact of international standards; the implications and challenges of human resources; the effects of drug-resistant TB; new tools and technologies; and jurisdictional aspects of TB prevention and control.

Presided by Dr Kevin Elwood (Canada), the North America Region represents the USA and Canada.

The 12th Latin America Region Conference was held 27-31 March 2007 in the Dominican Republic in conjunction with five other Latin American respiratory events: XXI Congreso Federacion Centroamericana y del Caribe de Neumologia y Cirugia del Torax; X Congreso Nacional de Neumologia y Cirugia del Torax; III Congreso Nacional de Neumopediatria; X Encuentro Iberolatinoamericano de Neumologia y Cirugia del Torax and the ACCP VII Course: Pulmonary and Critical Care Medicine.

Dr Jose A Caminero from The Union led a plenary session on XDR-TB and co-moderated panels on MDR-TB and the tobacco epidemic in Latin America; TB nursing expert Edith Alarcon and member of The Union Board also participated.

In 2007, TB-HIV activities in Latin America included:
- MDR-TB intensive training courses in Paraguay, Dominican Republic and Colombia
- International course on Epidemiology and Control of TB in El Salvador
- International course on Clinical and Operational Management of patients with MDR-TB in Mexico
- Intensive Training Courses for Specialist Physicians in Ecuador
- Monitoring visits for technical assistance to MDR-TB Projects in Paraguay, El Salvador and Dominican Republic.

Presided by Dr Elizabeth Ferreira from Mexico, the Latin America Region represents Bolivia, Brazil, Chile, Cuba, Guatemala, Guyana, Haiti, Honduras, Peru and Mexico.

Other members of the Latin America Region office:
- Vice President: Dr Cesar Bonilla Asalde (Peru)
- Secretary General: Sra Edith Alarcón Arrascue (Peru)
- Secretary: Dr Joseney Santos (Brazil)
Europe

The 4th Europe Region Conference was held 27-30 June 2007 in Riga, Latvia. Organised by the Europe Region and the State Centre of Tuberculosis and Lung Diseases of Latvia, with additional support from The Union Headquarters in Paris and other organisations, the conference attracted 800 delegates who were greeted by Latvia’s President Vaira Vike-Freiberga on the opening night.

The scientific programme, conducted in English and Russian, included seven postgraduate courses on the challenges posed by TB, TB-HIV and MDR-TB in Europe, paediatric respiratory medicine, lung cancer, COPD and pneumonia. The four-day event also offered nine main symposia, five corporate-sponsored symposia, two clinical seminars and nearly 200 posters. Special features included a full-day programme on Hot Topics in Respiratory Medicine targeted at general practitioners, internists, paediatricians and other specialists from the Baltic countries; a workshop for journalists to help improve the accuracy and scope of media coverage of TB and lung health in Europe; a 2-day meeting of the Stop TB Partnership for Europe co-sponsored by The Union; and sessions on the contribution of nurses in TB management, care and control organised by The Union’s Nursing and Allied Professionals (NAP) Europe Region Network.

Other achievements:

- The Europe Region is on the Executive Committee of the Europe Stop TB Partnership, launched in October 2006.
- The Europe Region participated in other high-profile educational and advocacy events in 2007: World TB Day was commemorated in Brussels, Berlin, Stockholm, London and other capitals to raise awareness at the European Union level. Following World TB Day, the EU Commissioner for Health asked the European Centre of Disease Control (ECDC) to develop a TB Action Plan.
- In close collaboration with the German Ministry of Health, a WHO European Ministerial Forum was held on 22 October in Berlin: 49 of the 53 countries of the Europe Region participated and launched a Berlin Declaration on Tuberculosis, which recognised that a Europe-wide approach will be key to the control and eventual elimination of TB.
- The Europe Region held two meetings in 2007, participated in the Plan to Stop TB in 18 high-priority countries in the WHO European Region, 2007-2015, raised awareness on TB at the G8 Summit held in Germany in June, and developed their own Strategic Plan for TB and lung disease.

Middle East

The 26th Middle East Region Conference was held 20-22 March 2007 in conjunction with the 5th Annual Scientific Conference of the Saudi Thoracic Society in Riyadh, Saudi Arabia, on the theme "Recent Advances in Respiratory Care".

Presided by Dr Abdul Rahman Al-Rajhi, the Middle East Region represents Iraq, the Islamic Republic of Iran, Jordan, Saudi Arabia, Sudan, Syrian Arab Republic, Turkey and Yemen.

Members of the Middle East Region office:
President: Dr Abdul Rahman Al-Rajhi (Saudi Arabia)
Secretary General and Representative on the Board: Prof Mohammad Reza Masjedi (Iran)
The Union is committed to furthering educational development among low- and middle-income countries through training officials working in public health programmes. To accomplish this, The Union has created the **International Management Development Programme (IMDP)**, a series of courses that address the challenges faced by national programme managers and health care administrators in resource-limited settings.

The courses focus on developing essential skills crucial for managing public health programmes such as project management, budget development and administration, auditing, developing successful leadership techniques, and managing human resources. Each of the courses is part of an entire management-educational process that follows a natural progression in management training.

After completion of the programme, participants are better prepared to anticipate and effectively cope with the challenges of operating programmes in the dynamic and constantly changing world of public health. By focusing on cultivating local human resources, the International Management Development Programme is training leaders in public health who can confidently make decisions that have a direct and positive impact on human lives. In addition, the programme aims to create long-term, sustainable development in health care throughout the developing world.

In 2007, the International Management Development Programme trained hundreds of participants working in the fields of tuberculosis, HIV/AIDS, and tobacco control, and continues to expand globally. For further information about the IMDP, please visit [www.union-imdp.org](http://www.union-imdp.org).

**International Management Development Programme courses for TB and Tobacco control**
- Management, Finance, and Logistics
- Budget Planning & Project Management
- Human Resources Development and Management
- Leading Management Teams

**In 2007 IMDP courses were held in:**
- Afghanistan
- Bangladesh
- Benin
- China
- Egypt
- India
- Indonesia
- Thailand
- The Philippines
- Uganda
INTERNATIONAL MANAGEMENT DEVELOPMENT PROGRAMME COURSES 1 JANUARY–31 DECEMBER 2007

INTERNATIONAL MANAGEMENT DEVELOPMENT PROGRAMME FOR TB CONTROL

Course on Management Finance and Logistics (National Tuberculosis Programme)
India: Jaipur
5-16 February 2007
Participants: 18
Coordinator: Jamshed Chhor
Donors: DHHS-CDD, Norad, WLF

Course on Management of Managers
Thailand: Bangkok
18-30 July 2007
Participants: 8
Coordinator: Jamshed Chhor
Donors: Norad, WLF

Course on Human Resources Development and Management
Thailand: Bangkok
19-30 November 2007
Participants: 23
Coordinator: Jamshed Chhor
Donors: Norad, WLF

Course on Management and Leadership
India: Bangalore
13-21 June 2007
Participants: 24
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

IN–COUNTRY CUSTOM–DESIGNED COURSES

Course on Management Finance and Logistics (National Tuberculosis Programme)
Afghanistan: Kabul
27 November – 7 December 2007
Participants: 26
Coordinator: Dr Nevin Wilson/Dr G.R. Khatri
Donor: World Food Programme for NTP Afghanistan

Course on Management and Leadership
Indonesia: Bogor
8-16 May 2007
Participants: 24
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Management and Leadership
Bangladesh: Dhaka
11-20 March 2007
Participants: 26
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Human Resources Management
China: Beidaihe
17-25 September 2007
Participants: 22
Coordinator: Lin Yan
Donor: Bloomberg Philanthropies

Course on Human Resources Management
India: Puri
23-27 October 2007
Participants: 23
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Human Resources Management
Indonesia: Makassar
30 October – 3 November 2007
Participants: 22
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Human Resources Management
China: Haiku
23-27 October 2007
Participants: 23
Coordinator: Lin Yan
Donor: Bloomberg Philanthropies

Course on Budget and Financial Management
India: Goa
20-24 August 2007
Participants: 22
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Budget and Financial Management
Indonesia: Bogor
6 – 10 August 2007
Participants: 24
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Budget and Financial Management
Bangladesh: Dhaka
30 September – 4 October 2007
Participants: 25
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Budget and Financial Management
China: Haiku
4 – 8 December 2007
Participants: 18
Coordinator: Lin Yan
Donor: Bloomberg Philanthropies

Racing Ahead Creating Change Agents for Organisational Effectiveness (Tropical Disease Foundation)
Philippines: Manila
8 October to 13 October 2007
Participants: 150
Coordinator: Jamshed Chhor
Partner: Tropical Disease Foundation

Course on Management Finance and Logistics (National Tuberculosis Programme)
Uganda: Kampala
24 September – 4 October 2007
Participants: 25
Coordinator: Megan Elliott / Anna Nakanwagi
Donor: TBCAP

Course on Management and Leadership
China: Beidaihe
17-25 September 2007
Participants: 22
Coordinator: Lin Yan
Donor: Bloomberg Philanthropies

Course on Management and Leadership
Indonesia: Bogor
6 – 10 August 2007
Participants: 24
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Management and Leadership
Bangladesh: Dhaka
30 September – 4 October 2007
Participants: 25
Coordinator: Partha Pratim Mandal
Donor: Bloomberg Philanthropies

Course on Management and Leadership
China: Haiku
4 – 8 December 2007
Participants: 18
Coordinator: Lin Yan
Donor: Bloomberg Philanthropies
Union technical courses provide the theoretical and practical knowledge required for both the clinical and management aspects of tuberculosis control. Designed to be offered in various formats and for audiences ranging from laboratory technicians and nurses to specialist physicians and administrators, the curricula are developed by Union experts and consulting faculty. Each presentation is customised to meet the needs of the host country or region, in collaboration with the National Tuberculosis Programme (NTP) or other local partners.

More than 1,000 national tuberculosis programme (NTP) managers from countries around the world have completed The Union’s international tuberculosis courses. These intensive courses cover modules on the bacteriologic basis of TB control, clinical presentation and diagnosis of TB, epidemiologic basis of TB control, interventions for TB control and elimination, the principles of TB control in a national programme and the elements of DOTS expansion. Teaching methods include lectures, discussion, group work, laboratory bench work and field visits to local NTP facilities. The international tuberculosis courses are offered in three languages. The English and French courses are three weeks long; the Spanish course is presented in an intensive 9-day format.

The objectives of Union courses are to:
- Advance the clinical knowledge and expertise of health care workers and managers
- Increase the management capacity and human resource development of NTPs
- Create local capacity to conduct health systems and services research that is designed to meet local needs
- Strengthen relationships and understanding between NTPs and other sectors of the health care system, including specialist physicians and physicians in private practice
- Identify individuals who may pursue careers in public health

Funding for Union courses and sponsorship of individual participants is provided by a variety of international agencies, sponsors, and local partners.
**Union Technical Courses 1 January–31 December 2007**

**Courses in Spanish**

**Curso Nacional de Actualización de Manejo Clínico de la Tuberculosis con Resistencia a Fármacos**
Paraguay: Asunción
1-2 February 2007
Participants: 29
Coordinator: José A Caminero
Donor: Pan American Health Organization (PAHO) and Green Light Committee

**XVI Curso Internacional de Epidemiología y Control de la Tuberculosis**
El Salvador: San Salvador
19-27 March 2007
Participants: 25
Coordinator: José A Caminero
Donor: The Union

**Curso Internacional de Manejo Clínico y Operativo de la Tuberculosis con Resistencia a Fármacos**
Mexico: Mexico City
2-7 July 2007
Participants: 33
Coordinator: José A Caminero
Donor: TBCAP

**Courses in English**

**International Tuberculosis Course**
Vietnam: Hanoi
27 August-14 September 2007
Participants: 25
Coordinator: Hans L Rieder
Donor: NORAD

**International Tuberculosis Course**
Tanzania: Arusha
19 November-7 December 2007
Participants: 25
Coordinator: Hans L Rieder
Donor: NORAD

**National Intensive Course on Clinical Management of MDR and XDR-TB Patients**
Namibia: Windhoek
5-7 November 2007
Participants: 37
Coordinator: José A Caminero
Donor: TBCAP

**Courses in French**

**Cours de Mycobactériologie appliquée aux besoins des PNT**
Benin: Cotonou
11-22 June 2007
Participants: 11
Coordinator: Armand Van Deun
Donor: The Union

**Cours International sur la Lutte contre la Tuberculose**
Benin: Cotonou
20 August-7 September 2007
Participants: 26
Coordinator: Arnaud Trébucq
Donor: French Ministry of Foreign Affairs

**Atelier francophone sur la prise en charge des tuberculeux multirésistants dans le cadre des programmes nationaux de lutte contre la tuberculose**
Côte d’Ivoire: Abidjan
22-26 October 2007
Participants: 21
Coordinator: Arnaud Trébucq
Donors: TBCAP and French Ministry of Foreign Affairs.
In the summer of 2007, The Union and the Stop TB Partnership (STBP) agreed to unite their resources in order to further increase visibility and awareness on tuberculosis as a public health burden, aggravated by the HIV co-infection and the increase in multidrug-resistant forms of TB (MDR-TB). The 38th Union World Conference on Lung Health was held 8-12 November 2007 in Cape Town, South Africa – the epicentre of the TB-HIV crisis. The theme was “Confronting the challenges of HIV and MDR in TB prevention and care”. Delegates from more than 120 countries gathered to discuss the deadly spread of MDR-TB and the high rate of TB and HIV co-infection, both of which have dramatically increased the global threat of TB. Its 3,000 conference registrations, 700 of which were from South Africa, was a record for The Union.

Conference highlights

- More than 5,000 TB-HIV patients and advocates marched and demonstrated for new drugs, diagnostic tools and a tuberculosis vaccine. The march ended at the Convention Centre where the marchers met leaders of The Union, the organisers of the conference.
- 100 reporters from print, radio and television media in North America, Europe, Africa, and Asia covered the conference.
- Press conferences covered topics including new tools, the South African National TB Programme, XDR-TB, HIV-TB, tobacco control and new TB diagnostics.
- South Africa’s Minister of Health, Dr Manto Tshabalala-Msimang, was the special guest at the formal conference opening.

South African Advocate Patricia Lambert, who headed the WHO-AFRO Region delegation to the Framework Convention on Tobacco Control (FCTC), gave the special guest lecture at the opening ceremony. In her talk “South Africa and international tobacco control: fighting for the FCTC”, Adv Lambert described the challenges that face delegations struggling to forge a strong tobacco control treaty despite competing interests within countries and the powerful tobacco industry lobby. The Africa Region played a pivotal role in the negotiations by its decision for all 46-member countries to speak as a single voice. Adv Lambert is now Director of the International Legal Consortium (ILC) of the Campaign for Tobacco-Free Kids.
Awards

Three members were awarded Honorary Membership by the Union Board of Directors:

- **Dr Daniel Nyangulu**, National Tuberculosis Control Programme Advisor, Community Health Sciences Unit, Lilongwe, Malawi
- **Prof Martin Gninafon**, Coordinator of the National TB Control Programme, Ministry of Health, Cotonou, Benin
- **Prof Abulhassan Zia Zarifi**, Scientific Consultant and Head of the Mycobacteriology Unit, National Research Institute of Tuberculosis and Lung Disease, Tehran, Iran

Union Awards

An awards ceremony recognising outstanding contributions to TB control from individuals, governments and non-governmental organisations is held each year by The Union during the World Conference. During this ceremony, The Union acknowledges remarkable achievements through four international awards:

**Union Scientific Prize:**

The Scientific Prize of US$ 2,000 is awarded to a researcher under 45 years of age for his/her work on tuberculosis or non-tuberculous lung disease during the previous two years.

Recipient: **Madhukar Pai**, MD, PhD (Canada/India) is an assistant professor of epidemiology at McGill University. His doctoral research focused on the evaluation of new tests for TB diagnosis. He assisted in the development of the International Standards for Tuberculosis Care.

**Karel Styblo Public Health Prize:**

The Karel Styblo Public Health Prize of US$ 2,000 is awarded to a health worker (layperson or physician) for his/her contribution to tuberculosis control or non-tuberculous lung disease.

Recipient: **Lucy Chesire** (Kenya) has broken new ground in TB advocacy through her inspirational leadership. A clinical nutritionist from Kenya, her experiences with HIV and TB have led her to become an international TB-HIV spokesperson and activist.
Other Awards

Japan Anti-Tuberculosis Association’s Princess Chichibu Global Memorial TB Award
This US $10,000 award commemorates Princess Chichibu of Japan, who was active for many years in the Japan Anti-Tuberculosis Association (JATA) and served as its president. The award recognises outstanding achievement in anti-tuberculosis activities.
Recipient: Dr Jaap F Broekmans (Netherlands) has played a central role in the development of many of the most important organisations involved in tuberculosis control over the course of a distinguished 30-year career. He served as Executive Director of the Royal Netherlands Tuberculosis Foundation (KNCV) from 1987 to 2005.

Stop TB Partnership-Kochon Prize 2007
The Stop TB Partnership-Kochon Prize is fully funded by the Kochon Foundation, a non-profit foundation registered in the Republic of Korea. The Prize was established in 2006 in honour of the late Chairman Chong-Kun Lee, founder of both the Foundation and Chong Kun Dang Pharmaceutical Corp. in Korea. "Kochon" is the pen name that he used.
Recipient: Mr Faruque Ahmed on behalf of BRAC (Bangladesh Rural Advancement Committee), which began a community-based TB control project in 1984 in one sub-district and has now expanded to 283 sub-districts in 42 districts.
Recipient: Ministry of Health, People’s Republic of China, with special mention of Prof Zhao Fengzeng and Dr Wang Longde, who accepted the award. The MOH has made remarkable strides in implementing and expanding TB control.

2007 UNION CHRISTMAS SEALS CONTEST
The Union holds a Christmas Seals Contest each year at its World Conference on Lung Health, honouring the commemorative stamps that have helped raise money for tuberculosis and lung disease for more than 100 years. Conference delegates voted for their favourite seals, and the winners are announced at the General Assembly.
The winners of the 2007 contest were:
- 1st prize: Tuberculosis Association of India (above)
- 2nd prize: National Tuberculosis Association, Taipei-China (opposite)
- 3rd prize: Japan Anti-Tuberculosis Association (below)
The Union’s Scientific Sections offer members an opportunity to affiliate with other members who share the same interests and collaborate on research, publications and other projects. Their principal responsibilities are to plan the scientific programme for Union conferences and to participate in the governance of The Union through the General Assembly.

Working Groups (WG) are subcommittees of the Scientific Sections that take on specific projects. Both Scientific Sections and Working Groups hold annual meetings at the World Conference. The following are summaries of the 2007 Scientific Section and Working Group reports.

**Lung Health Scientific Section**  
(Formerly the Respiratory Disease Scientific Section)

**Chair:** Stephen Graham

**Working Group**

**COPD**

The Burden of Lung Disease has applied for funding with Wellcome Trust to extend its work to low- and middle-income countries. If this is successful, the programme will recruit additional centres in low- and middle-income countries, in part through The Union.

**Working Group**

**COPD in Maghreb**

The working group is implementing Burden of Obstructive Lung Disease (BOLD) activities in Algeria, Morocco and Tunisia, where COPD is a major problem. Funding has been provided for three centres in the Maghreb to join the BOLD programme, and the BOLD protocols have been translated for local use. An initial meeting was held in Fez in September 2007.

**Working Group**

**Childhood TB**

The focus of this group is on knowledge dissemination and training to improve the application of child TB guidelines and to improve child TB management. The group held a TB workshop at the 2007 World Conference on Lung Health. The group is trying to raise funds to publish an official Union booklet on Child TB, and to develop teaching modules for international use.

**Working Group**

**BCG**

The initial main objective of this group was to improve the surveillance of BCG adverse events and develop guidelines for the management of children with BCG disease. An update was presented of 2007 WHO recommendations about BCG safety in HIV-infected children.

**Tuberculosis Scientific Section**

**Chair:** Muhammad Amir Khan

The Tuberculosis Section meeting focused on the proposed restructuring of The Union sections. The meeting was comprised of members of the previous sections of Tuberculosis, Zoonotics, Nursing and Allied Professionals and Bacteriology.

**Working Group**

**Health Systems Strengthening**

A group of Union members, representing various organisations and regions, discussed the need for more concerted efforts on health systems strengthening for better disease control in developing countries. It was agreed that the TB Scientific Section of The Union (the biggest section, with a membership of more than 1,000) needs to organise a working group on this issue.

**Working Group**

**TB in Big Cities**

The second meeting of this WG was organised on Saturday 10 November 2007; 45 persons attended the meeting. Topics discussed included Missed Opportunities, a survey of tubercu-
-loss case detection in health facilities in low-income countries. Three sites are participating in the pilot project: Burkino Faso (Mathurin Dembele, Ouagadougou), DRC (Valentin Bola, Kinshasa) and Guinea (Alioune Camara, Conakry). The survey rollout took place in August – November 2007, with 6,403 patients seen. The group also discussed Development of referral system for TB patients diagnosed in tertiary hospitals in big cities (Darakshan Badar, Punjab TB Control Programme), a protocol that has been designed to evaluate the current status of the tuberculosis programme in tertiary care hospitals and to develop a valuable and practical referral system.

Nursing and Allied Professionals Section
Chair: Mariam Walusimbi, Uganda
This was the last meeting of this group as a section. The Coordinating Committee on Scientific Activities proposed for vote at the General Assembly that the NAP Section become a subsection under the Tuberculosis Section.

Working Group
Regional Mobilisation
European region
The European Network participated in the 4th Union Europe Region conference in Riga, Latvia, 27-30 June 2007. Highlights included two symposia, a post-graduate course, a poster session and a business meeting.

Latin American Region
A book about DOTS implementation in Brazilian regions has been published in English with PAHO/WHO funding and was distributed during the World Conference. A WG member is coordinating a TB project on primary health care evaluation in primary health care services in TB care. It has been developed to evaluate TB control strategies in Brazil from socio-epidemiological and economics health services indicators.

Working Group
Education and Training
The NAP Education and Training Working Group sponsored two post-graduate courses, one workshop, five symposia and an education and materials display and discussion session. In addition, we convened an education and training working group meeting. The approximately 20 people in attendance discussed topics including the planned Union reorganisation, activities for the next year and The Union's new electronic submission process for abstracts.

Working Group
Case Management
Previously the Working Group developed “Best Practice for the Care of Patients with Tuberculosis: a Guide for Low-Income Countries”, which was published by The Union in March 2007. Nearly all the 4000 copies were distributed and it will be reprinted. The Group organised a post-graduate course “How to Implement The Union’s Best Practice Guide”.

Union Scientific Section meeting during the 38th World Conference in Cape Town.
The International Journal of Tuberculosis and Lung Disease

A journal’s Impact Factor is a measure of the frequency with which the average article in a journal has been cited in a particular year. The IJTLD’s Impact Factor, announced in June 2007, rose from 1.456 to 2.035. This is due mainly to the opening up of electronic access to the back issues of the Journal on Ingenta: the IJTLD is consistently listed among the top three of 10,000 titles in terms of numbers of articles downloaded, with an average 8,500 downloads monthly in 2007 in comparison to 6,300 per month in 2006. Online subscriptions to the IJTLD have been increasing steadily over the last 2–3 years, with a parallel drop in print subscriptions. This increase is partly due to general international trends, but another reason seems to be the recently implemented €20 on-line membership category for colleagues in low-income countries and €65 for colleagues in middle- and high-income countries (with respectively 665 and 383 members in these categories for 2007).

Article submissions remained high in 2007, at more than 50 per month, and as a result of the fast response times, a high rejection rate (65%) and the shorter article lengths, the average time from submission to publication was shortened to 8 months, and from acceptance to publication to 4 months. The next step to further shorten the turnaround time might be the introduction of e-publication before print—the pros and cons of e-publication will be assessed and debated in the near future.

Two main policy issues were addressed in 2007—plagiarism and author accountability. A case of plagiarism that came to light in the Journal was dealt with swiftly and firmly by the Editorial Board, and an official policy was established. As a result of this experience, the problem of author accountability was discussed, the copyright form was modified and authors are now requested to declare their interests on submission.

The key educational topics for the Journal in 2007 were occupational lung disease (OLD) and the association of tuberculosis and tobacco. A series of six State of the Art reviews was published on OLD, and a six-part serialisation of the new Union Guide on Tobacco cessation interventions for tuberculosis patients.

As can be seen from the increase in the Impact Factor, the number of electronic downloads and the faster turnaround times, the IJTLD is continuing to improve. We are aware, however, that to best serve our aim of greater dissemination, the optimal solution for both readers and authors is open access to the full journal. We hope that this will soon become a possibility.

NULDA BEYERS
Editor, Tuberculosis - South Africa

MOIRA CHAN-YEUNG
Editor, Lung Disease - Hong Kong

CLARE PIERARD
Managing Editor

Publications and Other Resources

The Union’s publication programme supports the dissemination of the latest research and information about the prevention, treatment, and control of tuberculosis and lung disease, with emphasis on low- and middle-income countries. A series of technical guides is available in several languages, CD-ROMs, PowerPoint presentations, posters and electronic publications.

To reach the widest possible audience, most of these materials are available free of charge from The Union website at www.iuatld.org

Technical Guides
New guides and translations in 2007

English

Priorities for tuberculosis bacteriology services in low-income countries, 2007, 2nd ed (English).
Authors: H L Rieder, A Van Deun, K M Kam, S J Kim, T M Chonde, A Trébucq, R Urbanczik
Quantity printed: 3000

This second edition of the “Red Book” provides useful guidance to national officers responsible for the reference laboratory on its role, main responsibilities and technical and organisational aspects of smear examination and surveillance of anti-tuberculosis drug resistance. There are many superb books on mycobacteriology. The purpose of this monograph is...
Authors: P Enarson, D Enarson, R Gie.
ISBN (French): 2-914365-30-6
Quantity printed: 2000

This guide was translated into French with the support of the French Ministry of Foreign Affairs. The second edition of this Union technical guide focuses on severe/very severe pneumonia, asthma and tuberculosis in children. It includes a health service delivery system based on The Union’s experience with tuberculosis in low-income countries and incorporates the technical approach to the management of pneumonia in children developed by the World Health Organization.

Interventions for Tuberculosis Control and Elimination, 2002
Language: Spanish translation, 2007
Authors: H Rieder
In electronic format only

This is the fourth in a series of guides based on the material taught in the international TB courses. It deals with interventions directed against the Mycobacterium tuberculosis complex - treatment, prophylaxis, BCG vaccination and preventive chemotherapy - and weighs the role of each in current practice.

Reprints of existing guides

Management of the child with cough or difficult breathing, a guide for low-income countries, 2005, 2nd edition (English) 2000
Diagnostic Atlas of Intrathoracic Tuberculosis in Children, 2005 (French) – 2000 reprints
Guia de enfermeria para la implementación y expansión de la estrategia DOTS, 2004 (Spanish) – 2000 reprints
Registre Tuberculose, for the NTP in Togo 300 reprints
Registre Laboratoire, for the NTP in Togo 300 reprints

Other materials

CD-ROM:
Quantities printed: 1000

The 2007 version of The Union’s International Tuberculosis Courses on CD-ROM replicates the Union’s Tuberculosis Division website http://www.tbrieder.org and contains Union tuberculosis and research publications, slide shows (clinical, epidemiology, interventions) and course material (mycobacteriology, operations research).

Best practice of the care for patients with tuberculosis: a guide for low-income countries, 2007 (English)
Authors: G Williams, E Alarcón, S Jittimanee, M Walusimbi, M Sebek, E Berga, T Scatena Villa.
ISBN: 2-914365-28-4
Quantity printed: 3000

This guide was developed by the Nursing and Allied Professional Section’s Case Management Working Group together with the Nursing Division. It gives detailed guidance on practical aspects of patient care, from the onset of symptoms to the completion of treatment. It aims to give health care workers the tools to ensure the highest possible quality of care whatever their role or circumstances. It is based largely on evidence gathered from experts in the field, and has been developed in partnership with the type of health-care providers who will be using the guide in practice.

Most of the Union technical guides are available at http://www.iuatld.org
Manuscripts in peer-reviewed journals

**Aït-Khaled N, Enarson DA, Bissell K, Billo NE.** Access to inhaled corticosteroids is key to improving quality of care for asthma in developing countries. Allergy 2007; 62: 230-236.


Books/chapters


In opening essential opportunities to make a significant difference in the fight against tuberculosis and lung disease, membership activities represent a major part of The Union’s life-force. Union members help support these life-saving opportunities. Thanks to committed individuals, countries and world renowned experts in lung health who share a common mission, The Union has become a major development platform for the dissemination of scientific knowledge to fight lung disease through field work and research.

Individual members, benefactors and 15-year members, as well as organisational and constituent members, make a vital contribution to The Union’s endeavours. Their support makes possible projects involving innovative research, education and technical assistance programmes, leading to numerous successful initiatives, such as the “Malawi Child Lung Health Project” which has reduced by 50% the case fatality rate in children under five. This project received its start-up funding from the support provided by these invaluable contributions.

**Individual members**
are physicians, microbiologists, researchers, epidemiologists, veterinarians, nurses, laboratory staff, students, teachers, trainers, activists, etc., who become affiliated to one of the four Scientific sections (Tuberculosis, HIV, Lung Health and Tobacco control) and sub-sections related to their field of expertise.

**Benefactor and Fifteen-year members**
are individual members who choose to support The Union financially on a long-term basis in its projects and activities. Thanks to their generosity, The Union can use this funding to support and initiate innovative projects.

**Organisational members**
are non-governmental organisations (NGOs), professional societies, nurse or patient associations, foundations, Ministries of Health, etc. Several organisations from the same country can join The Union as organisational members if they share our vision of prevention and control of respiratory diseases and related health problems.

**Constituent members**
are members who represent their countries in The Union. As there can only be one constituent member per country, these members usually play a prominent role in the international scientific community. It is usually the principal lung association of a country or the National Tuberculosis Control Programme that serves as Constituent Member. As part of an international network, Constituent Members influence health care and public health policies in their country and abroad. Constituent Members pay a yearly membership fee based

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### 2007 Membership Figures

- Constituent members: 80
- Organisational members: 12
- Individual members with print & online journal: 530
- Individual members with online journal, low-income countries: 665
- Individual members with online journal, other countries: 383
- Individual Fifteen-year members: 9
- Individual Benefactor members: 21
- Individual Honorary members: 32
- Total 1,732 members
on World Health Organization (WHO) indicators related to their country’s level of development. Constituent Members are grouped into seven Union Regions: North America, Latin America, Europe, Africa, Middle East, South East Asia and Asia Pacific. The regions organise a regional conference every 2-3 years and offer educational courses.

When joining the Union, individuals and organisational and constituent members receive a membership package that includes a print and/or online subscription to the International Journal of Tuberculosis and Lung Disease (IJTLD) and the opportunity to participate in the activities of a Scientific section. They also receive free publications and educational resources, as well as a discount for the annual World Conference.

The members create dynamic networks and gain visibility for their work in our e-newsletters, web sites, local and world conferences, in the IJTLD and in the technical guides.

By the end of 2007, membership of the Scientific sections was as follows:
- Bacteriology and Immunology: 67 members
- Nursing and Allied Professionals: 40
- Respiratory Disease/Child Lung Health: 58
- Tobacco Prevention: 26
- Tuberculosis: 1,322
- Zoonotic Tuberculosis: 10

**ACHIEVEMENTS**

During the 2007 General Assembly, the six former Scientific sections were reorganised to allow better synergy between the members and the four Union technical departments: Tuberculosis, Lung Health, HIV and Tobacco Control. Through participation in their selected Union Scientific section, sub-section and working groups, our members make a direct contribution to the progress of lung health worldwide. The Scientific sections, sub-sections and working groups actively participate in elaborating the content of The Union’s World Conferences on Lung Health.

**THE UNION SCIENTIFIC SECTIONS**

- The **Tuberculosis section** now has 3 sub-sections:
  - Bacteriology and Immunology
  - Zoonotic TB
  - Nurses and Allied Professionals

- The **Lung Health section**, intended for the members of the former Respiratory Disease/Child Lung Health section, includes a sub-section for Nurses and Allied Professionals

- The **HIV section** includes a sub-section for Nurses and Allied Professionals

- The **Tobacco Control section**, for the members of the former Tobacco Prevention section, also includes a sub-section for Nurses and Allied Professionals
Souleymane Sangaré, 1938-2007

It was when he came to Rome from Mali in 1968 to participate in the International Course on Public Health organised by the WHO and the Carlo Forlanini Institute that I first met Souleymane Sangaré. I regularly taught one of the 2-week modules of the course. That year I noticed him immediately as one of the most active and attentive participants, asking the most pertinent, and often embarrassing, questions. He was extremely persistent, wanting to be entirely sure that he understood the answers I gave, and I had the impression that this exercise taught me as much as it did him. His gravity and honesty also impressed Dr Johannes Holm, the then Executive Director of the UICT, and Dr Herman Van Geuns of the Netherlands. At their request, and with the aid of one of his loyal assistants, Toumani Sangaré, he accepted the responsibility for the Union’s first pilot field project in Africa, which involved the systematic collection and examination of sputum samples from subjects presenting with tuberculosis symptoms over a huge area, the Kayes administrative circle.

He participated in the first regional African conference on tuberculosis in Ghana in 1968, and then in all Union conferences, in Africa and elsewhere.

After his medical studies in Dakar, Sénégal and Toulouse, France, he specialised in therapeutic and medical hydrology and occupational medicine, then in pneumophthisiology, and became a professor of pneumophthisiology in September 1974 in Paris. For several years he was a member of the International Advisory Group for the WHO’s Extended Programme on Immunization. He was named Chevalier de la Légion d’Honneur by the French government, and received decorations from Senegal, Egypt, Burundi, Mali and the Federal Republic of Germany.

In 1973, Dr Sangaré became the Union’s Africa Region representative, a sometimes very difficult task, as given his youthful appearance there were often heated discussions with senior local authorities, and from 1977 to 1993 he was the Secretary General of the Africa Region. It was also Sangaré who promoted the idea of one of his colleagues, Dr Benattia Zitouni, and contributed to creating World TB Day, an idea endorsed by the WHO and first celebrated on 24 March 1982, the anniversary of Robert Koch’s presentation of his discovery of the tubercle bacillus in 1882 in Berlin.

He was calm, reasonable, attentive and always amiable, and it was always a pleasure to have his advice and opinions. An anecdote comes to mind that bears no relation to tuberculosis. One day, when I happened to be at the Paris office, he phoned from Bamako in a panic: one of his sons had been bitten by a rabid dog, and they’d run out of the vaccine in Bamako. I rushed to the Institut Pasteur in Paris, then dashed to Roissy airport to try to find a kindly, reliable pilot who would agree to deliver the phials on his arrival in Mali. That would certainly no longer be possible today...

Souleymane Sangaré was a great physician, a good man, a pioneer for Africa and an example for us all. May we all have the courage to follow his path.

It is with sadness and profound admiration that we say goodbye to our friend and colleague, and extend our condolences to Madame Sangaré, their seven children and large family.

ANNIK ROUILLON
Former Executive Director
International Union Against Tuberculosis and Lung Disease
Paris France
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Acknowledgements
Our thanks to Professeur Ossénie Tidjani, Dr Bénattia Zitouni and Professeur Oumou Sow for providing precious background information on Professeur Sangaré’s many achievements.
George Wills Comstock, MD, MPH, DrPH
1915-2007

George Wills Comstock, Professor Emeritus of Epidemiology at the Johns Hopkins Bloomberg School of Public Health and a physician-epidemiologist of unparalleled eminence in the field of tuberculosis control, died of prostate cancer at his home in Smithsburg, Maryland, USA, on 15 July 2007. He was 92. In a career that spanned close to seven decades, Comstock made important contributions to all areas of the study of tuberculosis, conducting landmark studies of tuberculosis epidemiology, natural history, preventive therapy and BCG vaccination. From his earliest years with the United States Public Health Service through his recent period of so-called retirement, Comstock’s analysis, wisdom and keen insight into the public health implications of clinical and epidemiological data helped shape public policies for tuberculosis control in the United States and the world. The hallmark of all of Comstock’s research is his focus on the community-level burden of disease and outcomes of public health interventions.

Born in Niagara Falls, New York, Comstock graduated from Antioch College and Harvard Medical School. He later received an MPH from the University of Michigan and a DrPH from Johns Hopkins. After serving as a ship’s doctor in World War II, Comstock joined the US Public Health Service Tuberculosis Program and was sent to Muscogee County, Georgia, to organize field research in preparation for a trial of BCG vaccine. The results of the trial, and of another study in Puerto Rico that he also helped lead, showed low overall efficacy of BCG. As a consequence, BCG was never formally adopted as a control strategy in the USA.

Comstock went to Alaska in the mid-1950s, where a tuberculosis epidemic was ravaging the native population. He organized one of the first cluster-randomized trials in medical history, enrolling the entire population of the Bethel region in a trial of isoniazid, with each household randomly allocated to receive the drug or a placebo. After one year, tuberculosis incidence was reduced by 69% in the isoniazid households, and this benefit was sustained through 5 years of follow-up. In a remarkable post-script to the trial, prior to the existence of institutional review boards and before the birth of bioethics, Comstock returned to Bethel to ensure that all residents of the region received isoniazid therapy, arguing that it was essential that the population that bore the burden of the research fully benefited from its fruits.

Comstock retired from the Public Health Service in 1962 and joined the faculty of the Johns Hopkins University School of Hygiene and Public Health, as it was then known, establishing a public health research training center in Hagerstown, Maryland, where he taught students and conducted population-based research. In addition to continuing his work in tuberculosis, he also conducted seminal work in cardiovascular and cancer epidemiology, ocular disease and nutrition. The center was named in his honor in 2005. In his 45 years as a faculty member, he taught and mentored thousands of students who have gone on to leadership roles in public health and medicine, and served as a dissertation advisor to hundreds. He served as Editor of the American Journal of Epidemiology for 9 years and was later named Editor Emeritus. Although he officially retired in 2003 at the age of 88, he continued to teach his beloved ‘Epidemiologic Basis for Tuberculosis Control’ class, review journal articles, and publish papers. He maintained an active medical license, most recently renewed in 2006.

Comstock was revered by his peers and esteemed by his students. He received numerous awards, including the Trudeau Medal, the John Snow Award, the Maxwell Finland Award, and others. He was also an accomplished musician and played in several orchestras, most recently the Frederick (MD) Symphony.

Comstock is survived by his second wife, Emma Lou Davis Comstock, three children and five grandchildren. His first wife, Margaret Karr Comstock, died in 1999. In a 2000 documentary video entitled ‘Lucky All My Life’, Comstock attributed his success to being a survivor who had the good fortune to work with wonderful and talented colleagues and to find himself in the right place at the right time. But those who knew, studied under, collaborated with, or simply learned from this great and kind man know that we were the lucky ones.

RICHARD E. CHAISSON, MD
Johns Hopkins University Center for TB Research Baltimore, MD, USA
e-mail: rchaiss@jhmi.edu
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 31st December 2007. In the 87 years since its establishment, The Union has created a history of accomplishment and vision for the future.

87 years of making a difference in the world

For 87 years, The Union has harnessed the expertise of public health experts, scientists, and voluntary organisations to strengthen health systems, develop a standardised approach for the control of tuberculosis, and provide technical support to countries that need it. Giants of business and industry such as Michael Bloomberg have provided financial assistance to The Union’s programmes at unprecedented levels.

The Union has established itself over the past 87 years as an important conduit of hundreds of millions of new and additional funds for tuberculosis, TB-HIV and tobacco control activities worldwide. We have worked to develop efficient, flexible and effective processes for managing large grant programmes in some of the most challenging countries in the world. We have become recognised as a creative source of ideas for mobilising resources with our partner, the World Lung Foundation.

As an organisation, The Union has honed its expertise in financial stewardship so that donors can have confidence in our fiduciary services and financial controls. Our effective systems of financial accountability and oversight, and regular reporting mechanisms have been one of key factors convincing donors to select The Union as recipient of major grant initiatives.

Our continued financial performance demonstrates the historical role of The Union as an organisation that has been a leader in international health since its establishment in 1920. The three key elements of The Union’s financial management approach have been growth, efficiency, and stability. In other words, our financial management strategy is founded on continued forward-looking opportunities for growth, efficiency of management and services, and maintenance of a stable financial position.

Growth does not come without new challenges. We enter Fiscal 2008 with improved financial condition but at the same time additional challenges created by new offices and staff, changing priorities of funding agencies, declining revenue from constituent members, the effects of currency exchange rates, costs of office space, retention of talented staff and rising costs of personnel and travel.

The Union strives to be the most effective manager of the resources entrusted by our members and donors. To be the best, we must achieve superior operating performance and deliver high quality services and science. We must constantly strive to be an effective advocate, a good neighbour and a strong partner in the communities in which we all work. We must provide a diverse and highly competent group of employees and consultants with respect, opportunity and a place to build satisfying careers. And we must remain committed to integrity, accountability and continuous improvement.

Financial Overview

During the 87th year of The Union’s existence the level of programme funding has risen to new heights. The organisation operated within the framework of a balanced budget, donors continued their generous commitment to our programmes, and our balance sheet experienced favourable financial results. Through careful fiscal management, our operating budget finished the year with 4,233 € (US $6,217) surplus.

We continue to finance the most significant portion of our major activities and budget requirements through grants, gifts and managed funds. Grant revenue is expected to increase significantly over the next few years as a result of increased funding for tobacco control, tuberculosis research and HIV.
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 2007 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. 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 of The Union’s financial position. Their opinion follows this report. Their examination was made in accordance with generally accepted accounting standards and included a review of the system of internal accounting controls to the extent they considered necessary to determine what audit procedures would be required to support their opinion.

A complete Audit Report, including detailed comments and notes to supplement the Balance Sheet and the Income and Expenditure Accounts, is available upon request.

The Union is approaching the centennial of its establishment with a hopeful sense of opportunity for global progress and clear understanding of our organisation strengths and organisational values. We approach our centennial as a more effective and purposeful organisation. We are proud of what we have achieved and confident that the best is yet to come. With your help and engagement, we continue to work with a renewed sense of purpose and unwavering commitment to improve lung health and create a better world.

We are delighted with what we have accomplished during Fiscal 2007 as an organisation and look forward to building on these achievements as we strive to provide even more valuable services in the future. In sum, our Fiscal 2007 accomplishments demonstrate that we have the management depth and talent to improve our operating performance and keep The Union as a key player in international health.

I would like to thank our members and our donors for the continued trust and support of The Union. I would also like to thank the management team and all our staff and consultants for their exemplary work and sacrifice.

Respectfully submitted,

Louis-James de Viel Castel
Treasurer
International Union Against Tuberculosis and Lung Disease

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Statutory Auditors’ Report on the financial statements

For the year ended 31st December 2007
(free translation of a French language original)

In compliance with the assignment entrusted to us by the Executive Committee, we hereby report to you, for the period ended 31st December 2007 on:

- 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 required by law.

These financial statements have been prepared by the Treasurer. 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 the professional standards applicable in France. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statements presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements give a true and fair view of the Company’s financial position and its assets and liabilities as of 31st December 2007, and of the results of its operations for the year then ended in accordance with the accounting rules and principles applicable in France.
2 Justification of our assessments

In accordance with the requirements of article L.823-9 of the Commercial Code relating to the justification of our assessments, we bring to your attention the following matter:

Rules and accounting principles:

Note III of the Annexes to Financial Report explains the rules and accounting procedures in force in the Union.

As part of our opinion concerning the rules and accounting principles applied in your association, we have checked the suitable feature of the accounting principles above mentioned, and of the informations supplied in the Annexes, and we made sure of their correct practice.

The assessments were made in the context of our audit of the financial statements, taken as a whole, and therefore contributed to the formation of the opinion expressed in the first part of this report.

3 Specific verifications and information

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

We have no matters to report regarding the fair presentation and the conformity with the financial statements of the information given in the financial report, and in the documents addressed to the members with respect to the financial position and the financial statements.

Levallois-Perret, August 7th 2008

KPMG Entreprises
Department of KPMG S.A.

[Signature]

Jérôme Bastache
Partner
### Balance Sheet


#### ASSETS

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<tr>
<td>Software</td>
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<td>4 434 094</td>
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<td>Fixtures and equipments</td>
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<td>487 259</td>
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<tr>
<td>Other tangible fixed assets</td>
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<td>736 652</td>
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<tr>
<td>Financial fixed assets</td>
<td>48 606</td>
<td>71 553</td>
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<tr>
<td><strong>Total 1</strong></td>
<td><strong>4 638 543</strong></td>
<td><strong>6 828 398</strong></td>
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</tbody>
</table>

#### Current assets

| Constituent members   | 231 501     | 340 793     | 272 578     | 358 985     |
| Suppliers advance     | 22 787      | 33 545      | 91 743      | 120 825     |
| Managed funds receivable | 4 271 608 | 6 288 234 | 7 099 521 | 9 350 069 |
| Other receivables     | 85 699      | 126 157     | 217 881     | 286 949     |
| Sundry debtors        | 2 069 163   | 3 046 015   | 510 450     | 672 262     |
| **Total 2**           | **6 680 758** | **9 834 744** | **8 192 172** | **10 789 090** |

| Financial investment for managed funds | 0         | 0          | 0          | 0          |
| Cash and bank for managed funds         | 2 433 162 | 3 581 858 | 1 868 497 | 2 460 810 |
| Cash and bank of the Union              | 821 609   | 1 209 491  | 1 031 546  | 1 358 546  |
| **Total 3**                            | **3 254 772** | **4 791 349** | **2 900 043** | **3 819 356** |

#### Prepaid expenses

| **Total 4** | 117 480 | 172 942 | 149 349 | 196 693 |

#### Realisable exchange losses

| **Total 5** | 49 843 | 73 374 | 222 742 | 293 350 |

#### Grand Total

| **Grand Total** | **14 741 396** | **21 700 807** | **15 867 626** | **20 897 662** |

2007: 1 € = 1,4721 US$
2006: 1 € = 1,3721 US$

| 54 |
## LIABILITIES

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<thead>
<tr>
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<tr>
<td></td>
<td>€</td>
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<td>€</td>
<td>US $</td>
</tr>
<tr>
<td>Equity</td>
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<tr>
<td>Reserves</td>
<td>429 820</td>
<td>632 738</td>
<td>429 820</td>
<td>566 073</td>
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<td>Result from the financial year</td>
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<td>6 217</td>
<td>1 284</td>
<td>1 691</td>
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<td>Restatement reserve on premises</td>
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<td>2 778 435</td>
<td>1 887 396</td>
<td>2 485 700</td>
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<td>2 101 337</td>
<td>1 423 219</td>
<td>1 874 379</td>
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<td>116 857</td>
<td>222 741</td>
<td>293 350</td>
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<td>7 101 010</td>
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<td>Current bank advances (Short-term)</td>
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<td>2 788 474</td>
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<td>Suppliers and similar accounts</td>
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<td>Tax and social security</td>
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<td>Charges to be paid (Accrued Expenses)</td>
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<td>65 488</td>
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<td>Other Creditors</td>
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<td>384 324</td>
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<td>8 118 366</td>
<td>4 937 631</td>
<td>6 502 860</td>
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<td>Deferred income</td>
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<td><strong>Total 4</strong></td>
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<td>145 424</td>
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<td>Realisable exchange profit</td>
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<td><strong>Total 5</strong></td>
<td>519 955</td>
<td>765 424</td>
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<td>248 267</td>
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<td><strong>Grand Total</strong></td>
<td><strong>14 741 396</strong></td>
<td><strong>21 700 807</strong></td>
<td><strong>15 867 626</strong></td>
<td><strong>20 897 662</strong></td>
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2007: 1 € = 1,4721 US$
2006: 1 € = 1,3721 US$
## INCOME STATEMENT (in €)

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<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Operating Income</strong></td>
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<tr>
<td>Contributions</td>
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<td>Operating grant</td>
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<td>1 183 158</td>
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<td>20 941 804</td>
<td>11 695 478</td>
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<td>Write back of provisions and transferred charges</td>
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<td>228 334</td>
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<td><strong>25 382 880</strong></td>
<td><strong>16 528 033</strong></td>
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<td><strong>Operating Expenses</strong></td>
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</tr>
<tr>
<td>External charges</td>
<td>3 530 827</td>
<td>9 538 803</td>
<td>13 069 630</td>
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<td>16 621</td>
<td>278 954</td>
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<td>103 247</td>
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<td>495 618</td>
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<td>9 758 926</td>
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<td><strong>37 013</strong></td>
<td><strong>-92 392</strong></td>
<td><strong>953 273</strong></td>
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<td><strong>Net result for financial year</strong></td>
<td><strong>4 223</strong></td>
<td><strong>0</strong></td>
<td><strong>4 223</strong></td>
<td><strong>1 284</strong></td>
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</table>

**2007:** 1 € = 1,4721 US$  
**2006:** 1 € = 1,3721 US$
<table>
<thead>
<tr>
<th>INCOME STATEMENT ( in US $)</th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Operating Income</strong></td>
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<td></td>
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<tr>
<td>Contributions</td>
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<td>1 046 242</td>
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<td>1 741 727</td>
<td>2 749 344</td>
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<td>336 130</td>
<td>312 217</td>
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<td><strong>24 364 188</strong></td>
<td><strong>37 366 138</strong></td>
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<tr>
<td>External charges</td>
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<td>367 383</td>
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<td>3 791 725</td>
<td>2 715 828</td>
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<td>Social contributions</td>
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<td>2 110 672</td>
<td>1 202 282</td>
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<td>Depreciation charges and addition to provisions</td>
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<td>1 602 468</td>
<td>652 729</td>
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<td>28 329 967</td>
<td>28 329 967</td>
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<td><strong>3 911 337</strong></td>
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<td>Foreign exchange profit or loss</td>
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<td><strong>6 217</strong></td>
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<td><strong>6 217</strong></td>
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</tr>
</tbody>
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2007: 1 € = 1,4721 US$  
2006: 1 € = 1,3721 US$
Platinum Benefactor
Mr Louis James DE VIEL CASTEL, France

Gold Benefactors
Dr Koichi HONMA, DOKKYO UNIV. SCHOOL OF MEDICINE, Japan
Prof. Philip HOPEWELL, University of California, San Francisco, United States of America
Prof. Charles M NOLAN, Public Health - Seattle & King County, United States of America
Prof. John F. MURRAY, United States of America

Silver Benefactors
Dr Armand VAN DEUN, Institut de Medecine Tropicale, Belgium
Prof. Margaret BECKLAKE, Montreal Chest Institute, Canada
Prof. Riitta MUOTKA, Pulmonary Association Helsinki, Finland
Prof. Robert LODDENKEMPER, Deutsches Zentralkomitee zur Bekämpfung der TB (DZK), Germany
Prof. Panagiotsis SPYRIDIS, University of Athens, Greece
Dr Nobukatsu ISHIKAWA, Research Institute of Tuberculosis, Japan
Dr Seiya KATO, Research Institute of Tuberculosis, Japan
Dr Toru MORI, Research Institute of Tuberculosis, JATA, Japan
Dr Ikushi ONOZAKI, Research Institute of Tuberculosis, Japan
Dr Sang-Jae KIM, The Union, Republic of Korea
Dr Richard O’BRIEN, Switzerland
Dr Hans RIEDE, Switzerland
Mr Donald CALLARMD, United States of America
Dr Bonita T. MANGURA, New Jersey Medical School, United States of America
Dr Edward NARDELL, Harvard Medical School / Public Health, United States of America
Prof. Lee REICHMAN, New Jersey Medical School, United States of America
Dr Dean SCHRAUNFAGEL, Univ of Illinois at Chicago, United States of America
Prof. Jeffrey R. STARKE, Baylor College of Medicine, United States of America

Constituent Members
National Tuberculosis Control Programme, Afghanistan
Comité Algérien de Lutte contre la Tuberculose, Algeria
Programa Nacional Controlo Endemias, Angola
Australian Respiratory Council, Australia
Verein Heilanstalt Alland, Austria
National Anti TB Association, Bangladesh
Belgian Lung and TB Association, Belgium
Ministère de la Santé, Benin
Programa Nacional de Controle de Tuberculose, Bolivia
Fundaçao Ataulpho De Paiva, Brazil
Ministère de la Santé, Burkina Faso
Cambodia Antituberculosis Association (CATA), Cambodia
Canadian Lung Association, Canada
Ministerio de Salud Publica, Chile
Chinese Anti-Tuberculosis Association, China
Programme National de Lutte Contre la Tuberculose, Congo (Democratic Rep.)
Comite Antituberculeux de la Cote D’Ivoire, Côte D’Ivoire
Pulmonary Outpatient Center, Croatia
Ministerio de Salud Publica, Cuba
Danish Lung Association, Denmark
Central Association Against Tuberculosis, Egypt
Ministry of Health, Eritrea
Tartu University Clinics, Lung Clinic, Estonia
Finnish Lung Health Association - Filha Ry, Finland
National Centre of TB and Lung Diseases, Georgia
Deutsches Zentralkomitee Zur Bekämpfung der TB (DZK), Germany
Ghana Society for Prevention of TB & Lung Disease, Ghana
Liga Nacional Contra La TB, Guatemala
The Guyana Chest Society, Guyana
Ministère de la Santé Publique, Haiti
Programa Nacional de Tuberculosis, Honduras
The Hong Kong TB Chest and Heart Diseases Association, Hong Kong
Semmelweis University/ Hungarian Respiratory Society, Hungary
Reykjavik Health Care Services, Iceland
The Tuberculosis Association of India, India
The Indonesian Association Against Tuberculosis, Indonesia
Iranian Charity Foundation for TB and Lung Disease, Islamic Republic of Iran
Iraqi Anti-Tuberculosis and Chest Disease Society, Iraq
Research Institute for a Tobacco Free Society, Ireland
Israel Lung and TB Association, Israel
Japan Anti-Tuberculosis Association, Japan
Jordanian Society Against TB and Lung Disease, Jordan
Kenyan Association for the Prevention of TB and Lung Diseases, Kenya
Korean Institute of Tuberculosis (KIT), Korea, Republic of
Ligue de Prévention et d’Action Médico-Sociale, Luxembourg
Institut d’Hygiène Sociale, Madagascar
Ministry of Health and Population, Malawi
Malaysian Association for the Prevention of TB, Malaysia
Direction Nationale de la Santé, Mali
Comite Nacional de Lucha Contra la Tuberculosis, Mexico
Mongolian Anti-Tuberculosis Association, Mongolia
Ligue Marocaine Contre la Tuberculose, Morocco
Ministerio de Salude, Mozambique
Myanmar Medical Association, Myanmar
Nepal Anti-Tuberculosis Association, Nepal
Royal Netherlands Tuberculosis Foundation, Netherlands
Nasjonalforeningen For Folkehelsen, Norway
Pakistan Anti Tuberculosis Association, Pakistan
Philippine TB Society Inc, Philippines
Associacao Nacional de Tuberculose, Portugal
PNILT, Rwanda
Ministry of Health, Saudi Arabia
Ministère de la Santé, Senegal
Singapore AntiTB Association, Singapore
South African National TB Association, South Africa
Ministerio de Sanidad y Consumo, Spain
Ceylon National Association, Sri Lanka

Finance
Federal Ministry of Health, Sudan
Swedish Heart Lung Foundation, Sweden
Ligue Pulmonaire Suisse, Switzerland
Comité Syrien de Défense Contre la Tuberculose, Syrian Arab Republic
National Tuberculosis Association Taipei China, Taipei, China
Ministry of Health, Tanzania, United Rep.
AntiTuberculosis Association of Thailand, Thailand
C N A R T, Togo
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