The connection between breath and life is fundamental, yet the evidence shows that lung health is not high on the public health agenda:

- Lung diseases afflict people in every country and every socioeconomic group, but take the heaviest toll on the poor, the old, the young
- Chronic respiratory diseases cause approximately 7% of all deaths worldwide and represent 4% of the global burden of disease; deadly synergies exist between diseases such as tuberculosis and HIV/AIDS, influenza and asthma, COPD and lung cancer;
- Diseases once primarily found in industrialized countries, such as asthma, COPD and lung cancer, are now major problems in low- and middle-income countries
- We, the Forum of International Respiratory Societies (FIRS), convening at the 40th Union World Conference on Lung Health in Cancún, Mexico on 6 December 2009, recognize that hundreds of millions of people around the world suffer each year from treatable and curable lung diseases.

The Year of the Lung was organised by the Forum of International Respiratory Societies (FIRS). FIRS includes the Asociacion Latinoamericana del Thorax (ALAT), the American College of Chest Physicians (ACCP), the American Thoracic Society (ATS), the Asia Pacific Society of Respirology (APSR), the European Respiratory Society (ERS), the International Union Against Tuberculosis and Lung Disease (The Union), and the Pan African Thoracic Society (PATS).
IN MY 2009 MESSAGE, I FOCUSED ON THE WORD “POOR” and the problem of poverty in relation to health. Now, in 2010, it is time to focus on the word “solutions”. In addition to being central to our vision “Health solutions for the poor”, this word is a good touchstone for the year. First, it was key to our 2010 World Conference theme: “From Research and Innovation to Solutions”. Efforts to overcome health challenges begin with research and innovation, but they count for nothing unless they lead to workable solutions.

Second, The Union has a strong track record in developing solutions—as the milestones of our 90-year history in this report show. We continue to work towards solutions, whether through networking across the Federation; the technology and knowledge transfer provided by our courses, conferences and consultations; or activities ranging from the Centre for Operational Research, the TREAT TB initiative and TB/HIV programmes to the Bloomberg Initiative tobacco control grants and the Asthma Drug Facility.

Solutions were also the focus of The Union’s participation in the 2010 Year of the Lung campaign, which concluded at the conference in Berlin. This campaign successfully stimulated activities that gave much-needed visibility to lung diseases and the millions of deaths they cause each year.

Economic solutions were also paramount in 2010. The Union Board worked hard to support Executive Director Nils Billo and his team to address The Union’s economic challenges, and I would like to congratulate everyone on their extraordinary achievement in going from a -1.8 million euros operating result in 2009 to +3.6 million euros in 2010. This demonstrates the resilience and capacity of a highly motivated and dedicated team.

Nonetheless, moving forward will require the commitment of the whole Union—both the Institute and the Federation. While most of our support comes today from big donors who fund specific projects, we face a major challenge in sustaining our independent activities and the innovation that has produced such success in the past. For these and the core activities mandated by our founding members—courses, the World Conference, and the journal—we rely heavily on the unrestricted support of our constituent, organisational and individual members. These funds make it possible to respond flexibly to the changing and evolving health needs of poorer populations and support innovative solutions that have not yet received international attention, such as the Asthma Drug Facility.

Of course, Union membership means much more than the payment of fees, essential though that is. Real membership in The Union includes engagement in its activities, from participating in conferences and working groups to serving as an officer or board member. We are always seeking ways to expand these opportunities and broaden their scope.

I promised, in 2009, that the Board would continue to ask itself “What more can The Union do for its members?” Through the collaboration of the Membership Unit and the Board’s Communications, Membership and Fundraising Committee, we have reviewed the fee structure and benefits, and we have made as many innovations as possible within the present economic constraints. In particular we have taken steps to better integrate the activities of the Institute and the Federation through the Inter-Regional Council, region web pages, more cross-reporting and collaborations between region offices and members.

But, as always, the key benefit of Union membership remains the inspiration and motivation that comes from being part of an organisation with a clear focus on solutions to health challenges in poor populations. We will continue this work in the year to come, and I urge those who are already members to remain with us and engage, and I encourage those who have not yet joined us to do so now!
2010 WAS IN MANY WAYS A VERY SPECIAL but also a very difficult year. We celebrated our 90th anniversary as a Federation in Berlin at the highly successful 41st Union World Conference on Lung Health. We also participated in the 2010 Year of the Lung advocacy campaign, with many events and activities, as you will be able to see in this Activity Report.

DESPITE DIFFICULT REDUCTIONS, A YEAR WITH SIGNIFICANT ACHIEVEMENTS

On the other hand, The Union had also to face – like many other organisations around the world – the hard consequences of the global economic crisis, which necessitated a very painful restructuring process and a reduction in the number of our staff and consultants. This put a lot of pressure on all of us, and hard decisions had to be made that affected not only Union departments, but also, above all, individual lives and careers. This was a difficult process for the whole organisation.

Nevertheless, we continued to strive to improve lung health and find health solutions for the poor, with all our departments, offices and projects carrying forward the excellent and innovative work for which The Union is rightly known. We were also able to end the year with a positive financial result after several years with large losses. I would like to thank all my collaborators, who worked hard to keep morale high in these difficult times and produced the outstanding achievements you can read about in this report.

COLLABORATION IS KEY TO THE UNION’S APPROACH

The Union is known as a scientific Institute that works in many countries in close collaboration with other non-governmental organisations, as well as with government institutions and ministries of health to improve preventive and treatment programmes, to advocate for better health systems and to suggest ways to improve legislation and enhance the health of affected populations. Central to this process is taking into account local factors and using local expertise.

As a Federation, The Union also collaborates with our constituent, organisational and individual members, and it is crucial that we can rely on this network and learn from each other’s experience. This valuable exchange across disciplines, countries and regions is a strong motivating force for working together to organise events, such as the World and Region Conferences and courses, joint publishing projects and research. These efforts advance our knowledge in many areas – from a deep understanding of clinical and programmatic issues to the workings of health systems and the need for stronger advocacy to make the case for lung health, and public health in general.

FOSTERING INCLUSIVITY AND HIGH ETHICAL STANDARDS

The Union’s vision “Health solutions for the poor” was adopted in 2009, and one of our main goals is to foster such solutions through operational research, whether it is conducted through our own programmes, such as the Centre for...
Operational Research, or by members and other partners.

All Union research and activities are overseen by our Ethics Advisory Group (EAG), which ensures that all projects meet the highest ethical standards. While it plays a very essential role in all that we have achieved, the EAG works very much in the background, and I would like to take this opportunity to thank the chair, Prof Mary Edginton, and all those who serve with her, for their important contribution.

Another group whose work exemplifies The Union’s approach is the Coordinating Committee of Scientific Activities (CCSA). This group, comprised of members who volunteer to serve, oversees the scientific quality of our World Conference. To foster the greatest inclusivity and creativity, the World Conference has adopted a “bottom up” approach that means anyone, anywhere, may propose an idea for a session. It is then the job of the Scientific Sections, and ultimately the CCSA to sift through these hundreds of proposals and develop a varied and scientifically important conference. CCSA chair, Prof Michael Kimerling, and its members have approached this task with great enthusiasm and energy – and their success was especially notable this year. The World Conference in Berlin was one of the best of its kind, and I thank them for their efforts.

Of course, the success of an organisation such as The Union is contingent upon the efforts of many – board members, staff, consultants, committees, members, advisors and donors who all play an important role and ultimately help to improve the health of millions of people around the world. I thank you all and hope that we will be able to count on your collaboration and support to carry out our mission in the future.

ABOUT THE ETHICS ADVISORY GROUP (EAG)

The Union’s Ethics Advisory Group (EAG) was established in 2004 to provide ethical guidance on The Union’s work at national and international levels. Its role is to safeguard the dignity and rights of study participants and to promote ethical standards in lung health services. There are six members, selected to ensure professional and geographic representation.

The EAG reviews every protocol in which a Union staff member or consultant is the principal researcher, likely to be a co-author, or if The Union funds or sponsors the study. Through a formal application process, the EAG evaluates especially the societal value of the study; study methods; participant selection, including their informed consent forms for studies involving more than record reviews; any risks to participants; confidentiality of participant information; local community and health service involvement; and local ethics committee approval. Studies involving existing data and record reviews must also be reviewed by the EAG.

The EAG also attempts to meet the objective of promoting ethical standards in The Union by writing and stimulating debate on issues and by organising sessions at conferences.
The origins of The Union date back to 1867 when international experts first convened in Paris to discuss the pervasive problem of tuberculosis, then known as “The White Plague”. This led to a series of international conferences that tracked breakthroughs, such as Prof Robert Koch’s discovery of *M tuberculosis* in Berlin in 1882. The need for ongoing collaboration culminated in the formation of the Central Bureau for the Prevention of Tuberculosis in Berlin in 1902.

**1920s**
World War I forced the Central Bureau to close and also caused a tremendous upsurge in TB throughout Europe. At the first post-war international conference, held in Paris in 1920, 31 national lung associations pledged to work together to stop TB. They formed the International Union Against Tuberculosis (IUAT) on 17 October 1920.

**1930s**
As a central resource supporting the efforts of its constituent members, the IUAT organised 10 conferences between 1920 and 1939 and began publishing the IUAT Bulletin in 1923.

**1940s**
A decade of tumultuous change brought not only World War II, but also the discovery of streptomycin, which proved effective against tuberculosis, and the formation of the World Health Organization (WHO). The IUAT was the first non-governmental organisation officially recognised, and it successfully lobbied for a strong Division of TB within the WHO.

**1950s**
Sir John Crofton’s “Edinburgh method” of treating TB using a combination of drugs made TB curable for the first time. The IUAT’s international conferences and symposia offered opportunities to keep abreast of these changes, and scientific committees were formed to foster dialogue about TB control strategies. Members also began to collaborate by region.

In 2009, the Board of Directors approved a new mission, vision and values to guide The Union’s work in its 10th decade and beyond:

**MISSION**
The Union brings innovation, expertise, solutions and support to address health challenges in low- and middle-income populations.

**VISION**
Health solutions for the poor

**VALUES**

**QUALITY:** We deliver our services and products to the highest possible standards.

**ACCOUNTABILITY:** We are responsible stewards of resources and deliver on our commitments.

**INDEPENDENCE:** We maintain the freedom to pursue innovation and are guided by the best evidence to improve the health of the poor.

**SOLIDARITY:** We stand together as one Union to overcome the greatest challenges to improve health among the communities we serve.
90 years of collaboration and innovation

In the 1960s, the IUAT played a very active role in international research through its scientific committees. Activities ranged from participating in the international clinical trial that validated the “Edinburgh method” as the gold standard for TB treatment to the establishment of the Tuberculosis Surveillance Research Unit (TSRU).

In the 1970s, as the burden of TB shifted from the West to low- and middle-income countries, the IUAT launched the Mutual Assistance Programme to transfer technology and expertise to the newly formed national TB programmes (NTPs) in these countries. The NTP’s unsuccessful efforts to manage TB led the IUAT to develop and test a multifaceted TB control model that included government commitment, diagnosis by microscopy, standardised treatment, an uninterrupted supply of medicines and recording and reporting to assess outcomes.

In the 1980s, the first edition of Management of Tuberculosis (The Orange Guide) came out in 1986, based on experience in implementing the IUAT TB model in nine low-income countries. The decline of TB led the IUAT to expand its focus, becoming the International Union Against Tuberculosis and Lung Disease (IUATLD) in 1986. However, by the late 80s, the impact of HIV/AIDS on TB control was beginning to be seen.

By 1993, WHO had declared TB a global emergency, and, in 1995, the IUATLD’s directly observed treatment, short course model – DOTS – became the WHO strategy for addressing this crisis. The IUATLD offered its international TB course to train new leaders; provided technical assistance to more than 40 countries each year; created a clinical trials division; and launched the peer-reviewed International Journal of Tuberculosis and Lung Disease. In addition, it established programmes focused on asthma, child lung health and tobacco control.

In the new century, the IUATLD became “The Union” – a name in the three official languages of French, Spanish and English reflects the united mission of more than 3,400 members in 150 countries, the headquarters in Paris, and the network of offices established in the seven regions between 2003 and 2009. While The Union continued to be a major force in TB control, it also established important new and expanded programmes focused on the TB/HIV epidemic, tobacco control, operational research, laboratory strengthening, child pneumonia and non-communicable diseases.
Health Solutions for the Poor

The Union Institute conducted technical assistance, education and research activities aimed at fulfilling its vision of “health solutions for the poor” in 80 countries in 2010. With headquarters in Paris, The Union also has offices close to the people we serve in Africa, the Asia Pacific, Europe, Latin America, North America, the Middle East and South-East Asia. In addition, more than 3,400 Union constituent, organisational and individual members were working towards our common mission.

- **14 Headquarters and offices**
- **96 Union constituent and organisational members**
- **Technical assistance projects** in 63 countries
- **Education activities** in 45 countries
- **Research projects** in 11 countries
- **IHC TB/HIV programmes** in 5 countries
- **BI tobacco control grants** in 30 countries
- **TREAT TB partners** in 8 countries
- **ADF clients** in 6 countries
This was a year of transition for The Union’s three offices in Africa. With the Tuberculosis Control Assistance Program (TB CAP) winding down by the end of 2010, the Uganda, Zimbabwe and DR Congo offices prepared to finish those projects, while continuing TB/HIV projects and turning to new activities. The Zimbabwe office received funding to participate in TB CARE, which, like TB CAP, is funded by the United States Agency for International Development (USAID). The Union also continued its work with numerous other countries to address the challenges created by TB, MDR-TB, child pneumonia, asthma and tobacco use.

➔ Nine of the 22 high-burden TB countries are in Africa

➔ A daily ARV dose costs only 40 cents, but more than 70% of sub-Saharan Africans live on less than US$ 2 per day

➔ Non-communicable diseases will cause 46% of deaths by 2030, up from 25% in 2004

Sources: see page 59
TUBERCULOSIS AND HIV

TB/HIV COURSE LEADS TO COUNTRY-LEVEL ACTION PLANS

In 2010, The Union offered its new course “Working Together – Strengthening the Implementation of Collaborative TB/HIV Activities” in both Malawi and South Africa. Each participating country sent representatives from both the TB and AIDS programmes, and by the end of the course, these teams developed country-level action plans to break barriers and make national collaborative TB/HIV guidelines more operational. The inaugural course, held in Malawi, was funded by the Norwegian Agency for Development Cooperation (NORAD). The South Africa session was sponsored by the University Research Corporation LLC, funded by USAID.

IHC PROGRAMME

The Integrated HIV Care for Tuberculosis Patients Living with HIV/AIDS (IHC) Programme is funded by a grant from the European Commission.

IHC IN ZIMBABWE AT MID-POINT IN PROJECT

Since The Union’s IHC Programme in Zimbabwe began in Bulawayo and Harare in 2007, a midterm evaluation of this five-year programme took place in January 2010. The objective was to advise on the future implementation of the IHC package in the cities and elsewhere in the country. From January to December 2010, a total of 884 TB patients were registered at three pilot sites and 847 (96%) consented to be HIV tested. Of the tested patients, 677 (80%) were found to be HIV-positive; 667 (99%) were commenced on cotrimoxazole preventive therapy; and 479 (71%) started on antiretroviral treatment.

IHC IN THE DEMOCRATIC REPUBLIC OF CONGO CONTINUES CARE AND RESEARCH

Recruitment and care of co-infected patients continued in the 13 pilot centres in the North Kivu Province, while the survival of the patients enrolled in the cohort further increased. Research on the viral load and virological profile of the HIV patients was validated by the Kinshasa School of Public Health ethics committee.

The decision by the Ministry of Health to take over the antiretroviral (ARV) drug supply is a major step towards sustainability; it will also permit the screening of other HIV patients for tuberculosis. Studies were implemented to identify the actual cost of providing free HIV and TB services and by whom the costs are borne, resulting in funding recommendations to the local health fund for TB and AIDS. IHC also permitted the Minister of health to establish a sector-wide TB/HIV coordination mechanism, whose secretariat was entrusted to The Union.

TB CAP

The Tuberculosis Assistance Control Program (TB CAP) was funded by the United States Agency for International Development (USAID).

TB CAP IN ZIMBABWE BUILDS CAPACITY THROUGH PLANNING AND TRAINING

The Union worked closely with the Zimbabwe National Tuberculosis Programme as the coordinating organisation for TB CAP activities in country. The key accomplishments in 2010 included completion of the national TB control strategic plan; revision of TB control guidelines and development of new training materials, as well as a child TB situation analysis; expanded TB training and support supervision; a second national TB control performance review meeting; and a new sputum sample transportation system for the country’s three largest cities. Selected health officials attended a Union management course and 14 health workers attended courses on MDR-TB control and management.

TB CAP IN UGANDA PASSES ON LESSONS LEARNT

Uganda’s TB CAP programme held a close-out meeting with all partners in September. Achievements of the programme, which operated in 12 districts from 2007 to 2010, included improvements in TB treatment success, HIV counselling and testing of TB patients, renovation of TB/HIV facilities, use of cotrimoxazole preventive therapy and systematic collection of data on TB services among people living with HIV/AIDS (PHAs).

The collaboration between The Union Uganda Office and the National Tuberculosis and Leprosy Programme (NTLP) was seen as a strength of the programme. They worked together on projects ranging from revising the national TB guidelines to supporting the National TB/HIV Coordination Committee. A further goal of the meeting was to share lessons learnt with those who might benefit from them.

DR CONGO TB CAP PROGRAMME ENDS WITH SIGNIFICANT ACHIEVEMENTS

In DR Congo, TB CAP was active between 2005 and 2010 in the provinces of Maniema and South Kivu, and, from 2008 through 2010, in East Equateur and East and West Kasai Occidental. Activities were coordinated by The Union DR Congo Office and implemented with several partners. Each partner faced significant challenges in this resource-poor country.

Programme highlights were increased training of staff in areas from TB control to financial management; renovation of lab facilities and hospital rooms for MDR-TB patients; media and advocacy campaigns to increase support for TB control; and nearly 400 ex-TB patients trained to provide patient education and support.

In addition, TB/HIV activities included training and providing guidelines and support for 14 district TB health care centres that offered HIV testing, counselling and integrated care. These centres counselled and tested 11,166 TB patients in 2010 – 36% of all those tested in the DR Congo.
TUBERCULOSIS

MDR-TB MANAGEMENT

Helping countries to manage drug-resistant tuberculosis is a key part of The Union’s support to national tuberculosis programmes. In some cases, this support focuses on improving the laboratory network. In other settings, the aim is to improve infection control, advise on drug supply management, address patient care issues or ensure accurate case monitoring.

In Africa, in 2010, The Union offered a training workshop on infection control in Benin that was attended by participants from five francophone countries – Benin, Burkina Faso, Cameroon, Côte d’Ivoire and Togo. In addition, an International MDR-TB course for anglophone African countries was offered in Namibia and a national course was held for participants from across South Africa.

RESEARCH PROBES THE ROOTS OF TB DRUG RESISTANCE IN SOUTH AFRICA

As part of the TREAT TB initiative, The Desmond Tutu TB Centre launched a probe into the roots of drug resistance in high-burden communities in the Western Cape Province of South Africa. Using its extensive network of community-based researchers, its unique database on molecular genetics and its solid base in child care, it is exploring the role of previous treatment in promoting drug resistance, the characteristics of particularly virulent strains of bacteria in the community and the impact and amelioration of drug resistance in children sharing the household with patients with MDR-TB.

TREAT TB (Technology, Research, Education and Technical Assistance for TB) is a five-year initiative funded by the US Agency for International Development (USAID).

BUILDING CAPACITY OF TB LABORATORY NETWORKS

At the request of national tuberculosis programmes, The Union assessed several laboratory networks and provided support for improving their performance, with emphasis on the management of MDR-TB and capacity to use new tools and diagnostics. Reviewers also considered candidates for a proposed Supranational Reference Laboratory (SRL) in the region.

**Benin:** Reviewed procedures at the National Reference Laboratory (NRL) in preparation for a World Health Organization assessment visit. Addressed management issues as well.

**Cameroon:** Assessed the NRL at the Pasteur Institute Yaounde for possible upgrade to SRL status and reviewed intermediate-level and smear-microscopy laboratories.

**DR Congo:** Reviewed progress of the NRL in Kinshasa, MDR-TB management, drug and supply management, and transition to LED microscopes in some locations.

**Republic of Niger:** Visited the new TB NRL and made a rapid assessment of the TB laboratory network. Advised on effective MDR-TB management.

**Republic of Senegal:** Assisted with strategic decisions regarding the TB laboratory network, in view of the expected EXPAND-TB (Expanding Access to New Diagnostics for TB) project. Reviewed daily work at the NRL and provided help with management issues.

**Tanzania:** Worked with the NRL in Dar es Salaam to evaluate its performance and management of the laboratory network. Tanzania was also a candidate for SRL status.

SUPPORTING NTPs IN FRANCOPHONE COUNTRIES

The Union provided technical assistance to national tuberculosis programmes (NTPs) in francophone Africa with support from the Agence Française de Développement (AFD) in 2010. AFD also funds The Union’s French language courses, training materials, technical guides; journal articles and website.

The most pressing problem is maintaining a consistent drug supply.
ADF CLIENTS USE DIFFERENT STRATEGIES TO FINANCE QUALITY-ASSURED ASTHMA MEDICINES

Benin was the first country in Africa to receive quality-assured essential asthma medicines through The Union’s Asthma Drug Facility (ADF). The first shipment came in February, and the cost of treating a patient with severe asthma for one year dropped from 79 to 48 euros.

To build a sustainable system that can eventually provide all asthma patients with ongoing access to affordable treatment, the National Tuberculosis Programme established a revolving fund and cost recovery system for asthma medicines based on the first set of medicines purchased through the ADF by The Union.

Burundi funded their asthma medicines with a global Fund TB grant that included a Practical Approach to Lung Health (PAL) component; and, in Kenya, the Kenya Association for the Prevention of Tuberculosis and Lung Disease purchased inhalers through ADF with funds from the World Lung Foundation.

All of these ADF clients are working towards the long-term management of asthma through the general health services. In addition to medicines, they received a technical package, including training materials, an information system and a technical guide to help them improve their services.

PAL WORKSHOP IN ALGERIA DESIGNED TO IMPROVE PRIMARY RESPIRATORY CARE

The Practical Approach to Lung Health (PAL) strategy was developed by the Stop TB Partnership to improve the quality of care for patients coming to primary health care facilities with respiratory symptoms, such as cough or difficult breathing, while at the same time improving the detection of TB cases. In June 2010, The Union co-organised a workshop in Annaba, Algeria on the PAL strategy. Representatives from 12 francophone African countries participated.

Benin saw the cost of treating a patient with severe asthma for one year drop from 79 to 48 euros.
**CHILD LUNG HEALTH**

**CHILD TB DESK GUIDE DEVELOPED FOR HEALTH WORKERS**

Although TB in children is increasingly included in national and international policy and guideline development, the wide policy–practice gap remains a major challenge. Training and training tools are required to facilitate improved management of child TB cases, increase screening of child contacts and provide a better understanding of the issues particular to children and the rationale behind the guidelines.

Since most children with TB are managed by health workers who are not paediatricians, in 2010 The Union produced a desk guide on child TB management for health workers aimed at the district or more peripheral level of care, in partnership with experts from sub-Saharan African countries and with support from the Tuberculosis Control Assistance Program (TB CAP). The desk guide was introduced at a meeting in Kigali, Rwanda to national tuberculosis programme staff from seven regional anglophone countries.

**RESEARCH**

**TB/HIV DRUG COMBINATION STUDY COMPLETED IN SOUTH AFRICA**

One of the challenges of treating TB/HIV co-infected patients is determining the optimal combination of anti-TB and antiretroviral (ARV) drugs. In 2010, The Union completed a pharmacokinetic (PK) study of patients in South Africa with advanced immunodeficiency and tuberculosis. The goal was to develop effective combinations of rifabutin-based TB therapy (RBT) and ARV drugs for the joint treatment of the two diseases. A sister study in Viet Nam also moved forward. This project has been funded by the French National Agency for Research on AIDS and Viral Hepatitis (ANRS).

**VILLAGE DEATH REGISTERS YIELD DATA ON ART IMPACT IN MALAWI**

Village registers of births and deaths provided vital health data for a study conducted by Médecins sans Frontières—Brussels, The Union and district authorities in Malawi. Data from registers recording deaths in 210 villages from 2000 to 2007 were triangulated with data of coffin sales and church funerals, and showed a highly significant linear downward trend in death rates as the percentage of people living with HIV/AIDS enrolled into HIV care and ART increased. The results of this study were published in May 2010 in PLOS One.

**OR ASSISTANCE PROGRAMME PAIRS SERVICE PERSONNEL AND ACADEMICS IN SOUTH AFRICA**

The Desmond Tutu TB Centre (DTTC), a regional partner of TREAT TB, launched an innovative programme to embed operational research (OR) into the routine activities of the National Tuberculosis Control Programme in South Africa. Funded by USAID, this innovative initiative sponsored collaboration amongst programme managers to develop a list of priorities for operational research from the grass roots. It then modelled an approach to bring together local health services personnel with local academic
partners, with facilitation from mentors in the DTTC and launched 18 OR projects in the nine provinces of the country as well as the Cape Town metropolitan area.

TREAT TB (Technology, Research, Education and Technical Assistance for TB) is a five-year initiative funded by the US Agency for International Development (USAID).

TOUCH-SCREEN SYSTEM USED FOR ART AND DIABETES

Use of touch-screen monitoring in Malawi more than doubled in its second year. The system developed by the Baobab Health Trust began to receive support from The Union in 2009. By 2010, 11 government sites had electronically registered 93,000 patients on antiretroviral treatment, up from 43,000 at 5 sites the year before. An article on the use of the Baobab system for managing antiretroviral therapy appeared in *PloS Medicine* in August 2010.

In Blantyre, a pilot project using the DOTS monitoring system to co-manage diabetes was also expanded to close to 2,000 patients by the end of 2010. This project is the first of its kind and a model for concurrent monitoring of infectious and non-communicable diseases, such as TB and diabetes. An article on the use of the Baobab system and DOTS for monitoring diabetes mellitus has been published in *Tropical Medicine and International Health*.

This programme is the first of its kind and a model for concurrent monitoring of infectious and non-communicable diseases, such as TB and diabetes.

TOBACCO CONTROL

AFRICAN COUNTRIES JOIN CAMPAIGN AGAINST TOBACCO

Tobacco control is advancing rapidly in Africa as more countries ratify the WHO Framework Convention on Tobacco Control (FCTC) and begin to draft and implement tobacco control measures. In 2010 The Union worked closely with Bloomberg Initiative grantees and nurtured relationships with governments, particularly in francophone countries, to support their projects. Successes included:

**Chad** and **Niger** adopted legislation committing to 50% graphic health warnings in 2011.

**Burkina Faso** strengthened legislation weakened by tobacco industry interference.

**Côte d’Ivoire** ratified the FCTC in August, with support from non-governmental organisations (NGOs).

**Mauritius** revised existing smokefree legislation to integrate health and occupational health into one law.

**Benin** developed draft legislation through collaboration of the government, NGOs and The Union.

**Madagascar** decreed that cigarette packets must have at least 50% graphic health warnings on the front and back.

**South Africa** received technical assistance to develop tax and regulatory reforms.

In addition, the third International Francophone Conference on Tobacco Control (CIFCOT III) took place in Niger in September, with support from The Union. CIFCOT III brought together government representatives and NGOs from 15 francophone counties. National working groups were formed as a result. Throughout the year, The Union also continued to provide technical support to organisations such as the African Tobacco Control Alliance (ATCA) and African Tobacco Control Regional Initiative (ACTRI) to build their capacity.

THE UNION AFRICA REGION

803 members in 2010

The Africa Region annual meeting in November in Berlin was attended by 96 members from 26 countries. Major topics were a proposed region charter and the Africa Region Conference in Abuja, Nigeria in March 2011, which will focus on “TB, TB/HIV and other lung diseases: challenges to the attainment of the MDGs in Africa”. The region also held elections for new officers electronically for the first time in 2010. The response was encouraging, and three new officers were elected.

Constituent members

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

Officers

President: Jaafar Kabir (Nigeria)
Vice President: Martin Gninafon (Benin)
Secretary General & Board Representative: Osséni Tidjani (Togo)
Treasurer: Genevieve Dorbayi (Ghana)
The Union Asia Pacific Office (UAP) opened in Singapore in January 2010. It has now been established as an independent organisation with its own Board of Directors and, as such, it is known as The International Union Against Tuberculosis and Lung Disease Asia Pacific Limited. It serves as a base for activities in the region sponsored by The Union and its partners. As a sign of its support, the Economic Development Board (EDB) awarded the UAP a grant of S$860,000 (US$ 623,000) over three years.

One of the major activities of new office is supporting Union courses in the region. In 2010, this included seven International Management Development Programme (IMDP) courses for tuberculosis and other public health managers held in Singapore and Thailand; four IMDP courses for tobacco control managers in China; an international TB course in Viet Nam; and MDR-TB courses in China and Thailand.

The Asia Pacific is also served by The Union China Office in Beijing, which focuses primarily on coordinating tobacco control projects.
GUANGZHOU IMPLEMENTS A STRINGENT SMOKEFREE LAW

Guangzhou implemented one of the most stringent tobacco control laws in mainland China in September 2010, thanks to the efforts of the Guangzhou Association of Tobacco Control (GATC). A Union grantee, GATC worked with the government of Guangzhou and the media to raise awareness about the importance of passing such laws. The law is being enforced in workplaces from offices and educational facilities to governmental agencies and hospitals. A survey found that public support for the law was as high as 89%.

GATC also collaborated with the Asian games Committee to draft and approve the General Policies on Smoking Control at Venues. As a result, the 16th Asian Games in November were declared smokefree for the first time.

HOSPITALS BEGIN TO GO SMOKEFREE

Twenty traditional Chinese medicine (TCM) hospitals went smokefree in 2010, with support from The Union’s grantee, the Chinese Association of Chinese Medicine. In preparation, they trained medical staff and placed posters and billboards advocating the new policy. Inspectors ensured that no violations occurred and rewards were given for proper implementation. Eleven hospitals also started referring patients to smoking cessation services.

In addition, 41 general hospitals passed smokefree policies, under the coordination of another Union grantee, the WHO Collaborating Centre for Tobacco or Health, bringing the total of smokefree hospitals to 61 by the end of the year. They were primarily larger hospitals that can set “best practices” for the other health care facilities in China.

PUBLIC HEALTH STUDENTS LEARN ABOUT TOBACCO CONTROL AT CHINESE UNIVERSITIES

In 2010, 496 public health undergraduate students at seven Chinese universities took part in a newly developed tobacco control curriculum. In five universities, the course is compulsory for public health students. With a grant from The Union, Zhejiang University led the project, which will eventually involve an additional 17 universities.

One goal is to train health professionals who understand tobacco control policies, so they can promote them and contribute to future public health policy-making initiatives.

SEVEN CITIES ADVANCE TOWARDS TOBACCO CONTROL

Seven Chinese cities with an average population of at least 10 million are participating in a Chinese Centre for Disease Control and Prevention (CDC) project funded by The Union. Because of their size and diversity, the cities are expected to influence the promotion of local and national tobacco control laws, as well as pass their own. Advances in 2010 included:

> Shenyang established a high-level group to aid smokefree enforcement.

> The China Tobacco Control Legal Working Group was established to assist in revising draft legislation.

> Nanchang sent its draft forward to the People’s Congress, and Harbin approved its draft legislation in 2010.

> All developed action plans to help them push for smokefree laws.

INDONESIA’S BOGOR CITY GOES SMOKEFREE

Bogor City became the second city in Indonesia to go smokefree, effective 31 May 2010, as part of a major sub-national drive on tobacco control. The new legislation ensures 100% smokefree public places, workplaces and public transport; a ban on tobacco advertising, promotion, sponsorship and sales in health, educational, religious, child care, government and sports facilities; and a ban on cigarettes being displayed at points of sale.

An increasing number of cities in Indonesia are developing, passing and implementing smokefree legislation. The Union is working with the government, civil society, academic institutions and advocates in 18 cities that are in different stages of the process. Support for tobacco control has grown since Muhammadiyah, the second largest Islamic organisation in Indonesia with more than 30 million members, issued a fatwa on smoking.

LAO PR MOVES FROM PASSING A LAW TO IMPLEMENTATION

In 2010, the Lao People’s Republic passed a law calling for more smokefree places, an end to tobacco advertising and stronger pack warnings. It also calls for using the revenues received from a tax rise to set up a health promotion fund.

With the law in place, the Adventist Development and Relief Agency (ADRA), a Union grantee, shifted its focus from passage to implementation and helped the government establish procedures for monitoring and enforcement. They also built community awareness of what the law required by designing and broadcasting TV and radio spots in collaboration with the media and seeking coverage in the print media.
TUBERCULOSIS

MDR-TB TRAINING IN CHINA AND THAILAND

At the request of the People’s Republic of China National TB Programme, The Union offered its five-day course on the clinical management of drug-resistant tuberculosis in three cities: the southeastern city of Hangzhou; the capital of the Inner Mongolia Autonomous Region, Hohhot; and the northeastern city of Harbin. Attended by 117 health professionals, the courses covered mechanisms in the development of resistance to anti-TB medicines, global epidemiology, case finding, drug susceptibility testing, principles of infection control and treatment and other related topics.

An international course, the 3rd Comprehensive Course on Clinical Management of Drug-Resistant Tuberculosis, was offered in Bangkok, Thailand. It was attended by 19 specialist physicians working with TB and MDR-TB from nine countries.

TB LABORATORY SERVICES ACROSS THAILAND REVIEWED

The Bangkok Supra-Reference Laboratory requested a review of TB laboratory services and quality assurance provided by the National TB Reference Laboratory, 12 Regional Reference Laboratories and 1,000 smear microscopy labs serving Thailand. One of the main challenges is the workload of more than 110,000 smears per year. Overall, however, the review found the laboratory services of good quality.

RESEARCH

OR Course Produces Plans for Three Studies

In a five-day course on research protocol development in Beijing, 41 participants developed proposals based on national priorities. They focused on TB infection among contacts of patients with MDR- and drug-susceptible TB; two-year follow-up of cured re-treatment TB patients and the impact of payment on adherence to TB treatment.
LUNG HEALTH & NON-COMMUNICABLE DISEASES

ASTHMA PILOT PROJECT IN ANHUI CONTINUED IN 2010

The Union launched an asthma management pilot project in 2008 at the Huaiyuan County Hospital and five township health centres in China’s Anhui Province. Inhaled corticosteroids had never before been available at these facilities, and patients were usually diagnosed with chronic bronchitis and treated with antibiotics and oral steroids.

After The Union’s training, health care workers identified a substantial number of asthma patients. However, the cost of a 200-puff inhaled beclometasone (250 µg/puff) inhaler was about 100 Chinese Yuan (US$ 15) – too high for many patients. Of those with persistent asthma, 24% refused to pay, and many who started using the medicine were lost to follow-up.

To resolve the cost issue, the project was extended through 2010, and asthma was included in the Huaiyuan County Government Chronic Disease Programme. Each asthma patient now receives 400 Chinese Yuan (US$ 60) per year for inhaled beclometasone.

DIABETES THREATENS TO ESCALATE TB RATES IN CHINA

Global data shows that diabetes increases the risk of TB by a factor of 2-3. In China, which has 90 million persons with diabetes and 150 million with pre-diabetes, as well as a high rate of TB, this interaction poses a serious public health risk. In August, The Union co-hosted a seminar for TB and diabetes experts in Beijing to review the current global and national status and implications for future control of both diseases. Participants worked together to define the research agenda to reduce the joint burden of disease. In outlining ways forward, they agreed that a priority would be to institute bi-directional screening for the two diseases.

WORKSHOP ON NCDS AND TOBACCO IN MELBOURNE

The role of tobacco as a major risk factor for non-communicable diseases, including heart disease, cancers and chronic respiratory diseases, was the subject of a workshop co-sponsored by The Union at the UN Department of Public Information / Non-Governmental Organisation (DPI/NGO) Conference in Melbourne, Australia. Representatives of more than 300 NGOs from 70 countries attended the conference on reaching the Millennium Development Goals (MDGs). Workshop cosponsors were the World Lung Foundation, American Cancer Society, World Heart Federation and the Framework Convention Alliance.

NEW ASTHMA PROJECT IN VIET NAM SUPPORTED BY UNION STAFF CAMPAIGN

In the summer 2010, Union staff launched “Solidarity Viet Nam”, a Year of the Lung fundraising campaign to purchase quality-assured essential asthma medicines through the Asthma Drug Facility for patients in poor communities in Viet Nam. Paris staff coordinated the project, with contributions coming from Union offices, the Board of Directors and online donations. More than 20,000 euros were raised for the project proposed by our partners in Viet Nam, the Community Health Research and Development Institute (CHDI). The project is part of their ongoing efforts to find the best way to provide care and inhalers for patients with low access to the health services.

THE UNION ASIA PACIFIC REGION
575 members in 2010

In 2010, The Union Asia Pacific Region committed to raising awareness and collaborating on solutions to such regional challenges as: the increasing incidence of MDR-TB, the continuing high prevalence of smoking and the increase in young women smokers. Data in the region indicate the fact that chronic obstructive pulmonary disease (COPD) is increasing, yet only 10-20% of the estimated cases are captured in the health care system. Partnership and collaboration among stakeholders are needed to effectively address these problems. The Union APR, through its scientific committee, will study workforce needs and expertise already available through various partners. Focus will be along the lines of TB, HIV, lung health and tobacco control. Planning also continued for the 3rd Conference of The Union Asia Pacific Region on 8–11 July 2011 in Hong Kong. The theme will be “Current challenges in tuberculosis and lung health”.

Constituent members

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

Organisational member

Tropical Disease Foundation (The Philippines)

Officers

President & Board Representative: Camilo Roa Jr (The Philippines)
Conference President: S H Lee (Hong Kong)
Vice President: Wang Xie Xiu (China)
Secretary General: Elizabeth Cadena (The Philippines)
Treasurer: Babe Chan Ying-Yee (Hong Kong)
The Union South-East Asia (USEA) office in Delhi is The Union’s largest region office. This team works with governments, civil societies, corporations and international agencies and brings expertise to Union services in the region.

TB control is a major focus for USEA. In 2010, work began on Project Axshya, a five-year civil society project to strengthen TB care and control in India supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund). Several other TB control initiatives also feed into Project Axshya, including a project funded by Eli Lilly, and two important secretariats housed at USEA: The Partnership for TB Care and Control in India, a civil society coalition, and the TB and Poverty Subgroup of the Stop TB Partnership’s DOTS Expansion Working Group, which moved from the UK to India in 2010.

The USEA also consolidated and strengthened its work on tobacco control during 2010 and provided grant negotiation and financial monitoring for countries within and outside of South-East Asia.

Educational programmes coordinated by USEA included operational research capacity building, management skills development, MDR-TB training and media awareness courses.

This region is also served by The Union Office in Myanmar, which coordinates HIV and TB/HIV activities in that country.
TUBERCULOSIS

LANDMARK PROJECT INVOLVING CIVIL SOCIETY IN TB CONTROL LAUNCHED

A five-year project to strengthen civil society involvement in TB control was launched in April 2010 with funding from a Round 9 Global Fund grant. The Government of India, The Union and World Vision India (WVI) are the principal recipients of the US$199.54 million grant, of which The Union component is US$ 57.8 million. While the government focus is on scaling up access to MDR-TB diagnosis and treatment, The Union and WVI are leading the civil society component to increase the reach, access and effectiveness of India’s Revised National TB Control Programme (RNTCP) by engaging all sectors to strengthen TB care and control.

The civil society component, titled Project Axshya (meaning ‘free of TB’), will cover 374 districts across 23 states of India, reaching some 744 million people by 2015, especially focusing on those who have the greatest difficulty in accessing TB services – women, children, tribal populations, communities living in geographically difficult areas and people co-infected with TB and HIV. Of the 23 states covered by the project, The Union will manage 16; WVI two, and both will jointly manage five states.

Start-up activities in 2010 included establishing a project management unit in USEA and orienting nine sub-recipient partners to lead the project in their respective states and districts. These partners are public health organisations that have significant experience in TB care and control, their own grassroots networks, and the trust of communities with which they work. Project launches began in August with orientations for government and civil society personnel to build awareness about the activities to come.

TREAT TB SPONSORS TWO TB RE-TREATMENT STUDIES

Two research projects on tuberculosis cases requiring re-treatment were carried out in India in 2010. The first resulted from the 2009 TREAT TB Global Consultation on Re-treatment Regimens. In “Tuberculosis Re-treatment Others: Profile and Treatment Outcomes in the State of Andhra Pradesh” researchers from TREAT TB’s partner in India, the RNTCP, and The Union found that 30% of patients classified as ‘re-treatment other’ were predominantly patients with sputum smear-negative TB and had significantly better outcomes than smear-positive re-treatment patients. This study was accepted by the International Journal of Tuberculosis and Lung Disease for its January 2011 issue.

The proposal for the second study, “Source of Previous Treatment for Re-treatment TB Cases Registered under the National TB Control Programme, India” was developed during a TREAT TB-sponsored research protocol development workshop in India in September 2009. This study was implemented by the RNTCP.

TREAT TB (Technology, Research, Education and Technical Assistance for TB) is a five-year initiative managed by The Union and funded by the United States Agency for International Development (USAID).

MDR-TB COURSE IN INDIA TRAINS THE TRAINERS

USEA organised a five-day course in Delhi on the clinical management of multidrug-resistant tuberculosis (MDR-TB) in October, marking a beginning for Union technical courses in the country. The curriculum was designed not only to train the 42 participants but also included a “TOT” (training-of-trainers) component, so that they could in turn build capacity in others. Course participants were a mix of specialists, faculty from medical colleges, district programme managers and post-graduate students. The curriculum was developed by The Union’s MDR-TB Unit in collaboration with RNTCP and the Lala Ram Sarup Institute for TB and Respiratory Diseases.
CAPACITY BUILDING PROJECT FUNDED BY ELI LILLY

A one-year grant from Eli Lilly will build capacity in four specific constituencies to enhance their role in India’s TB control efforts. They are rural health care providers, including traditional and informal providers who are often the first point of contact for TB patients; the media, with emphasis on vernacular media; programme managers; and physicians and health professionals working with MDR-TB.

TECHNICAL ASSISTANCE FOR LABORATORY NETWORK IN BANGLADESH

The Union was requested to review the status of Bangladesh’s TB laboratory networks in 2010. The focus was on detection and management of MDR-TB patients, smear microscopy and planning for the National Drug Resistance Survey in 2011. The reviewers found well-motivated personnel and fairly well-equipped facilities. Recommendations included addressing the huge workload for smear microscopy and providing greater support and training for the National TB Reference Laboratory.

TB CONTROL IN BANGLADESH HAS ACHIEVED COMMENDABLE SUCCESS

Six teams of international and national reviewers, including The Union, took part in the 5th Joint Monitoring Mission of the Bangladesh NTP in October to evaluate programme performance since 2007.

According to the review teams, the programme has achieved commendable success. TB diagnostic and treatment services are provided countrywide, including in the most remote upazilas. However, the NTP has faced problems with programme management, human resources, financing and drug supplies.

The reviewers recommended strong policy advocacy, coordinated action with partners and allocation of necessary domestic resources. Recent advances and WHO policy recommendations need to be utilised to implement the Stop TB strategy and achieve the Millennium Development Goals (MDGs).

ENGAGING INDIAN MEDIA IN TUBERCULOSIS CONTROL

On 22 March 2010, prior to World TB Day, the Partnership for TB Care and Control and The Union organised a consultation with health journalists on strengthening media involvement in TB control. Journalists brainstormed with civil society members on strategies and story ideas to expand and sustain reporting on TB and other lung diseases. Ideas included the need to use multiple communication channels, institute a ‘science-media interface’, encourage reporting of successes and create a ‘ripple effect’ between mainstream, regional and vernacular media. Participants concluded that such initiatives could significantly help support a constant stream of stories that would enhance national TB control efforts. Following this consultation, extensive coverage of TB control efforts appeared in the Indian media.

JOINT REVIEW COMMENDS PAKISTAN’S NTP

Federal, provincial and district health officials joined the World Health Organization (WHO) and other partners and donors, including The Union, for a joint review of TB care in Pakistan in December 2010. Overall the mission visited more than 30 centres (out of 1160) selected as a representative sample of facilities and services.

Reviewers were impressed with the quality of the programme and the commitment of staff, despite limited resources. Case notification for all forms of TB increased steadily from 2001 to 2009, and treatment success for new smear-positive cases in 2008 was 90%.

The reviewers commended the National Reference Laboratory for achieving a 100% proficiency rate for first-line drug susceptibility testing. Recommendations noted the need to scale up the countrywide network, expand external quality assessment (EQA) and address human resource issues.
ADVANCING TOWARDS A SMOKEFREE INDIA

Throughout 2010, India advanced towards fulfilling the promise of the ‘smokefree public places’ legislation passed in October 2008. Some highlights included:

> The jurisdictions of Sikkim, Villupuram, Shimla and Coimbatore became smokefree by World No Tobacco Day in May and Bhubaneshwar City by October. The Union provided technical support to these initiatives, which have made it possible for a combined 6.7 million people to breathe cleaner air. Popular acceptance of the new laws has been widespread.

> Mizoram has the highest rates of tobacco use in India with 80% of men, 60% of women and over 50% of high school students using tobacco regularly. In 2010, the Chief Minister supported the establishment of a model Smoke Free Group under the Department of Health and Family Welfare that is working with The Union and other partners to make all public places, including schools and government buildings, smokefree by mid-2011.

> In October, Delhi hosted the Commonwealth Games, which offered smokefree venues, facilities and transport, thanks to guidelines developed by the Government of Delhi, a Bloomberg Initiative grantee, in collaboration with the Commonwealth Games organising committee and The Union.

HEALTH WORKER GUIDE TEACHES THE DANGERS OF TOBACCO

With nearly a million deaths from tobacco annually, India’s National Tobacco Control Programme needs a variety of strategies to address tobacco use. In 2010, the Ministry of Health and Family Welfare collaborated with The Union on a guide that community health workers can use to teach people about the dangers of tobacco and help them quit. The Health Worker Guide was launched on World Health Day (7 April 2010) and since has been translated into Hindi, Tamil, Malayalam, Gujarati and Assamese.

DEFINING “SMOKEFREE”

A place is considered smokefree when there is no smoking or evidence of smoking present:

- NO cigarette butts are found on the premises
- NO smoking accessories (matchboxes, lighters and ashtrays) are available
- YES: anti-smoking signage is posted visibly

BANGLADESH GAINS GROUND IN FIGHT AGAINST TOBACCO

Since 2007, The Union has awarded more than US$ 1.5 million in Bloomberg Initiative grants to help the Government of Bangladesh, a coalition of more than 300 non-governmental organisations and other groups to implement the 2005 national tobacco control law. In December 2010, the Global Adult Tobacco Survey of Bangladesh showed that progress is being made, but there is still much to do: 43% of adults (41.3 million) currently use tobacco (either by smoking or in smokeless forms), but 7 in 10 current smokers plan to quit, or are thinking about quitting, and 4 in 10 are now aware of anti-smoking information on the television and radio.

TOBACCO PACKAGES IN PAKISTAN NOW BEAR PICTURE WARNINGS

A gruesome photo of a person with mouth cancer began appearing on tobacco packages in Pakistan in August 2010. This was a significant success for The Union’s grantees, the Ministry of Health and a Pakistan-based consortium of tobacco control organisations. They worked tirelessly to make the warnings a reality, including campaigning against the tobacco industry, which attempted to prevent an earlier ruling on packaging and labelling from going through.
HIV

MORE THAN 11,000 TB PATIENTS TESTED FOR HIV

Since The Union launched its Integrated HIV Care (IHC) programme in 2005, more than 11,000 TB patients in Myanmar have been tested for HIV. The testing is carried out by the National TB Programme in Mandalay, where TB nurses have been trained for counselling and testing by the National HIV/AIDS Programme. They now offer provider-initiated counselling and testing for HIV among adult TB patients. In 2010, 87% of registered adult TB cases were tested for HIV in Mandalay.

When the 11,111th patient was tested at the Mandalay General Hospital's TB Out-Patient Department (TB OPD), a celebration was held that included a gift to the patient and a certificate of appreciation to the TB OPD team. A campaign T-shirt was created with the slogan: “By taking an HIV test, I can protect myself, my family and my community”.

HIT PROGRAMME PROVIDES ART IN MYANMAR

The HIV Treatment (HIT) programme in Myanmar is an outgrowth of the IHC programme that offers comprehensive HIV care, including antiretroviral therapy (ART), to all HIV-infected patients and their HIV-positive relatives. The programme covers approximately 2.1 million people in Mandalay district and in Pakokku, Lashio and Taunggyi municipalities.

Funding in 2010 came from Three Diseases Fund (3DF), which awarded the programme US $1,045,000 to put an additional 2,790 patients on ART by the end of June 2011; and the Yadana Consortium, which has funded the project since it began as the IHC programme in 2005.

RESEARCH

COR BUILDS OPERATIONAL RESEARCH CAPACITY IN INDIA

The Union’s Centre for Operational Research (COR) began collaborating with the Public Health Foundation of India in 2010, and the first three-module operational research course was offered jointly in June with assistance from USEA. Ten participants developed protocols that were approved by The Union and local ethics committees; and eight carried on to the second module, with the final module scheduled for 2011.

In September, another OR workshop was held in collaboration with the US Centers for Disease Control and Prevention and the Revised National Tuberculosis Control Programme that resulted in the development of 17 research protocols addressing local priorities.

THE UNION SOUTH-EAST ASIA REGION

335 members in 2010

The Union South-East Asia Region held its annual meeting at the World Conference in Berlin in November. They discussed how members could contribute to the technical capacity of the region, build a stronger relationship with The Union South-East Asia Office (USEA) in Delhi and collaborate. Increased membership is essential and, in the future, USEA will support these efforts, drawing on its relationships with some 400 non-governmental organisations in the region. The Executive Committee held a subsequent meeting in Colombo in December to map out a two-year plan.

Constituent members

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

Organisational members

Sandoz Private Limited (India)
SAARC Tuberculosis and HIV/AIDS Centre (STAC) (Nepal)

Officers

President: WD Ailapperuma (Sri Lanka)
Vice President: VK Arora (India)
Secretary General & Board Representative: Chaudhary Muhammad Nawaz (Pakistan)
Treasurer: Princely Daya Fonseka (Sri Lanka)
The Union Middle East Office in Cairo, Egypt works with partners in the region to build national capacity, leverage partnerships and networking, manage Bloomberg Initiative (BI) grant projects and provide technical assistance for strategic planning and effective implementation of tobacco control policies. In 2010, the office worked with over 70 organisations and key focal points at the national and sub-national levels in the Middle East region. The office coordinated 13 courses and training workshops that included training of journalists and media personnel in Egypt to encourage the formation of a media consortium that supports tobacco control.

The Union also works closely on a variety of lung health projects with EpiLab, its Collaborating Centre in Sudan, and other partners, including national tuberculosis programmes throughout the region. The Union provided extensive technical assistance to these programmes in 2010, with a focus on building the capacity for MDR-TB management.

The Middle East

➔ 81.5% of Egyptians are exposed to smoke in their homes
➔ 37.7% of adult men, but only 0.5% of women smoke in Egypt
➔ In the Middle East and North Africa, the average case detection rate for TB (all forms) was 67.26% in 2008

Sources: see page 59
TOBACCO CONTROL

EGYPT RAISES TOBACCO TAX TO REDUCE CONSUMPTION

Currently, nearly 20% of adults in Egypt use some form of tobacco product. Shisha (waterpipe), in particular, has become popular among young people and women. Consequently the cost of treating tobacco-related diseases is some US$ 616 million per year.

Over a two-year period, the Egyptian government and the World Health Organization (WHO) used a grant from The Union to build support for increasing taxes as a deterrent to tobacco use. The project also included an economic study on the viability of a tax increase. In July 2010, the government succeeded in passing a tax that raises the retail price of cigarettes by 40% and shisha and smokeless tobacco products by 100%.

NGOS IN LEBANON FORM TOBACCO CONTROL COALITION

In January, The Union Middle East Office and the Framework Conventional Alliance offered tobacco control training in Lebanon to representatives from 20 non-governmental organisations (NGOs). As an outcome of the training, the NGOs decided to form a coalition and nominated a coordinating organisation to lead it. Since then, the members have drafted their internal regulatory system and national strategy.

MANAGEMENT TRAINING FOR TOBACCO CONTROL GRANTEES

Bloomberg Initiative grantees in Pakistan, Egypt and Lebanon sent representatives to two management courses developed by The Union’s International Management Development Programme in 2010. The five-day courses were held in Cairo and coordinated by The Union Middle East Office. They covered management and leadership, management of managers, training of trainers and project management. Although instruction was in English, an Arabic interpreter was available. The courses were designed not only to advance the participants’ managerial skills, but also to provide a networking opportunity for the tobacco control NGO coalitions from the three countries.

A new tax on shisha (waterpipe) raised the retail price by 100%. Shisha has become popular among young people and women who falsely believe that it is safer than cigarettes.
MDR-TB PROGRAMMES MONITORED IN SIX COUNTRIES

The Union participated in Green Light Committee (GLC) monitoring visits to evaluate the ongoing management of multidrug-resistant tuberculosis in Djibouti, Egypt, Jordan, Lebanon, Morocco and Syria. These visits included reviews of the national tuberculosis programme (NTP) performance and practices, laboratory reviews, visits to hospitals and other facilities, training updates on MDR-TB management and a clinical review of complicated cases.

**Djibouti** has one of the highest incidence rates of TB in the world, and a smear-positive detection rate of 42%. The MDR-TB rate is thought to be high, but remains unknown due to reduced laboratory capacity. Applications to the GLC were turned down in 2008 and 2009 because of this shortcoming, and The Union provided support to make needed improvements in 2010.

**Egypt** In 2009, Egypt’s NTP was approved to expand its MDR-TB programme to 225 patients. Since then two more hospitals provide treatment; and progress has been made in reducing the length of hospitalisations, management of defaulters and culture and drug-susceptibility test reporting. Recommendations in 2010 included completing an MDR-TB plan and guidelines, involving primary health care in the programme and continuing the national survey of drug resistance.

**Jordan** had a TB case detection rate of 73% and a treatment success rate of 83% in 2009. Despite staffing challenges and concerns about laboratory management, GLC recommendations were followed, and the NTP’s performance was consistent and effective since the review in 2009. MDR-TB treatment is free and centralised. One challenge was MDR-TB cases coming from other countries, such as Iraq.

**Lebanon** had a TB case detection rate of 90% and a 90% treatment success rate in 2009 for cases handled by the NTP. There was a low incidence of MDR-TB, with the 11 cases at the time of the

LUNG HEALTH & NON-COMMUNICABLE DISEASES

**ASTHMA TRAINING IN SUDAN**

Health care staff involved in an asthma pilot project in Gezira, Sudan received training in standard case management of asthma and use of EpiData to monitor and record data from the project in September 2010. Quality-assured inhalers procured through the Asthma Drug Facility (ADF) were delivered in Khartoum, and the Minister of Health, Gezira State expressed interest in expanding standard case management of asthma to the whole Gezira State.

**MONITORING COPD IN MOROCCO**

Monitoring for the Burden of Obstructive Lung Disease (BOLD) Initiative took place in Fez, Morocco in May, as part of the BOLD Maghreb project. The visit was organised by the Imperial College, London and the BOLD Fez Centre with the participation of the principal investigators of the BOLD Study in Maghreb and the BOLD Executive Committee, on which The Union serves. Four centres were included in the BOLD study in Maghreb: two centres in Algeria, and one each in Tunisia and Morocco. The Magreb project was initiated as part of the broader BOLD Initiative by the COPD in Magreb Working Group of The Union’s Lung Health Scientific Section with support from the Department of Lung Health and NCDs.
visit in December 2010. All were receiving free treatment through the NTP, and the programme was considered to be good and appropriate.

**Morocco**: MDR-TB incidence in Morocco is estimated at 300 new cases per year. Morocco was approved for GLC support in 2009, and the drugs will arrive in early 2011. The pilot project will be in Casablanca and Rabat. Both a hospital ward in Casablanca and an ambulatory treatment plan have been prepared.

The review recommended improving MDR-TB diagnosis, establishing a task force to oversee policies and implementation and development of guidelines.

**Syrian Arab Republic**: Syria’s case detection rate was 88% for all forms of TB in 2009, and its treatment success for smear-positive cases was 86% (2008). Since the 2009 review, the NTP developed a comprehensive plan and guidelines for MDR-TB. The National Reference Laboratory has been refurbished, and hospital conditions have improved. New recommendations focused on strengthening MDR-TB diagnosis, reducing hospital stays and improving re-treatment case monitoring.

**SUDAN’S NTP IS WELL ESTABLISHED**

The Technical Advisory Committee (TAC) to the Sudan National Tuberculosis Programme (NTP), which includes The Union, met in Sudan to review progress since its 2009 visit. The TAC consulted with government and WHO representatives and visited the NTP’s central unit, national reference laboratory, health facilities in Khartoum State and Gezira State, the Epi Lab and the Norwegian Embassy.

The TAC found that the NTP is in line with international recommendations and well established. The NTP manual and manuals on subjects such as drug-resistant tuberculosis and childhood tuberculosis are up to date. A proposal to the Green Light Committee for MDR-TB was approved. Areas that need further work include laboratory data collection, directly observed therapy, defaulter tracing and patient education.

**LABORATORY TRAINING OFFERED IN KHARTOUM**

The Union provided an expert review and training for the National Tuberculosis Reference Laboratory in Khartoum in March 2010. The goals included observing and improving all aspects of smear microscopy and introducing light-emitting diode (LED) fluorescence microscopy techniques. The review also included observing and improving culture and drug-sensitivity testing.

**THE UNION MIDDLE EAST REGION**

**158 members in 2010**

The Union Middle East Region faces socio-economic challenges and political instability both of which make it difficult to provide health services. Tuberculosis and MDR-TB are particular problems because the capacity and resources of the national tuberculosis programmes are limited. Lung cancer is a leading cause of death and smoking rates are high, so tobacco control is also a high priority concern.

In 2010, members of The Union Middle East Region continued to work towards strengthening their effectiveness in addressing these regional challenges. Elections for new officers were held and planning started for a region conference in 2012.

**Constituent members**

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

**Organisational members**

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

**Officers**

President: Hani Algouhmani (Syria)  
Vice President: Georges Saade (Lebanon)  
Secretary General & Board Representative: Mohammed Awad Tag Eldin (Egypt)  
Treasurer: Nehad Saleh (Egypt)
Latin America is served by Union offices in Mexico and Peru. The Union Mexico Office in Mexico City focuses on providing technical assistance, legal expertise, training and other services in support of tobacco control for the region. Over the past three years, The Union has forged close relationships with governments, non-governmental organisations and other stakeholders seeking full implementation of the WHO Framework Convention on Tobacco Control (FCTC).

The Union Peru Office in Lima is now in its second year and is becoming a hub for TB and lung health technical assistance and training, as well as providing other services to The Union’s Spanish-speaking constituents.

➔ 72.1% of Mexico’s smokers have considered quitting, but only 10.9% of those who have smoked for 1 year or more succeed

➔ A survey of 10 countries found that on average 73.2% of annual asthma-related costs were for unscheduled health care

➔ Brazil is one of the 22 countries that account for 80% of the global TB burden

Sources: see page 59
BUILDING CAPACITY TO MANAGE MDR-TB IN LATIN AMERICA

The Union worked with the national tuberculosis programmes (NTPs) in Mexico, Honduras, El Salvador, and Nicaragua to advance their management of multidrug-resistant tuberculosis (MDR-TB) in 2010.

In addition to the technical assistance described below, courses in MDR-TB management were offered in Spanish in the Dominican Republic, Ecuador, Mexico and Nicaragua.

Ecuador: A stronger awareness of the health problems of the poor has contributed to renewed efforts to build up the NTP. The MDR-TB component has improved, and The Union was requested to hold an MDR-TB course in Guayaquil that was attended by 35 clinicians from the public and private sector. The Union and the NTP have established ongoing communication via email regarding complicated clinical cases and policy controversies.

El Salvador: Political commitment to TB has always been very strong and, consequently, El Salvador has one of the most successful NTPs in the region. The Union has participated in monitoring MDR-TB there since 2004. The NTP has followed the Green Light Committee (GLC) recommendations and the MDR-TB Project is excellent. Recommendations included improving drug supply management and strengthening human resources at the National Reference Laboratory.

Dominican Republic: Dominican Republic hosted The Union’s 3rd International Pan-American Health Organization (PAHO) Region MDR-TB course with 35 participants from more than 15 countries and a national MDR-TB course focused on private physicians. The MDR-TB programme was also reviewed by The Union for the GLC and found to have high levels of proficiency in both programme and clinical management despite the limited resources.

Honduras: This NTP had several leadership changes in recent years, and the MDR-TB programme suffered. Now motivated staff and new leaders have transformed the situation. MDR-TB wards have been renovated and clinicians and managers are committed to the programme. The GLC review included a field evaluation and clinical update. Reviewers made suggestions for improvements and helped develop new MDR-TB guidelines.

Mexico: The GLC review of the NTP’s MDR-TB component evaluated achievements and considered the need for and feasibility of expansion. Reviewers assessed the management of second-line drugs and other issues, including coordination among TB, MDR-TB, HIV and TB/diabetes programmes. The assessment showed enormous effort and ability to implement the MDR-TB programme, but noted the need for a national plan for universal access.

Nicaragua: At the NTP’s request, The Union offered a national MDR-TB course that was attended by 39 participants from across the country. The content was customised with the participants’ input and covered both theory and practice. The group also reviewed complicated clinical cases and how best to handle them. In addition, The Union assisted in developing a new MDR-TB guide and MDR-TB and TB/HIV teaching materials.

TB NURSING WORKSHOP OFFERED IN PERU

The Union Peru Office in Lima hosted a workshop on 29 September–1 October introducing the Guide to competencies in TB for nursing to participants from private and public universities. The guide was designed as a tool for training nurses at the university level, as well as those who are already in service. The first of its kind to be held in Peru, this workshop was offered with support from the Peruvian Association of Nursing Schools and the Pan-American Health Organization.

TREAT TB PARTNERS MEET IN RIO TO REVIEW FIRST YEAR

International and regional partners in the TREAT TB (Technology, Research, Education and Technical Assistance for Tuberculosis) initiative met in Rio de Janeiro, Brazil on 24–25 May 2010 to review the first-year achievements and challenges. The extensive consultations and preparations carried out since late 2008 laid the groundwork for the implementation phase. The initiative is committed to undertake research activities under a Diagnostic Tools Initiative (systematic reviews, field evaluation research and global consultations) and under Patient Management Research (the MDR-TB STREAM study and global consultations). Regarding country-initiated activities, Malawi and South Africa successfully launched initial projects in 2010, with Brazil soon to follow. TREAT TB is a five-year initiative funded by the United States Agency for International Development (USAID).
Lung health, tuberculosis and tobacco control were some of the key issues discussed at the 13th Conference of The Union Latin America Region held in San Salvador, El Salvador, on 17 March 2010. The main objectives of the conference and of the other adjunct events were the unification and standardisation of criteria for dealing with pneumology in Central and South America. Region members also held their annual meeting in Berlin in November 2010.

**Constituent members**

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

**Officers**

- President: Andres Leibovich (Argentina)
- Vice President: Regiane Cardoso De Paula (Brazil)
- Secretary General & Board Representative: Jesús Felipe González Roldán (Mexico)
- Treasurer: Miguel Angel Lindero Olalde (Mexico)

**TOBACCO CONTROL**

**HIGH COSTS FOR HEALTH CARE BRING SUPPORT FOR SMOKEFREE BUENOS AIRES**

Public demand for smokefree environments and the high cost of treating tobacco-related diseases were among the many reasons behind declaring Buenos Aires a smokefree city in December. The city’s Ministry of Health, the congress, civil society and other stakeholders debated the issue for months before the 100% smokefree declaration went ahead. The ban, in this city of 3 million, is supported by 76% of people polled and extends to restaurants, bars, shopping malls and all enclosed public spaces, including workplaces. Approximately US$ 124 million or 12% of the city’s health spending goes to treat tobacco-related illnesses. The Ministry of Health, The Union’s grantee under the Bloomberg Initiative, was instrumental in pushing forward this legislation.

**STRENGTHENING TOBACCO CONTROL IN CENTRAL AMERICA**

In February, Costa Rica, Guatemala, El Salvador, Nicaragua and Honduras sent government and civil society representatives to a workshop co-hosted by The Union in San Salvador, El Salvador. The goal was to support the efforts of these countries to draft and promote tobacco control legislation, while a parallel workshop supported El Salvador’s ratification of the WHO Framework Convention for Tobacco Control (FCTC). Cosponsors for these events were the Framework Convention Alliance, Campaign for Tobacco-Free Kids, Pan-American Health Organization, the Inter-American Heart Foundation and Corporate Accountability International.

In Colombia, The Union participated in a workshop to strengthen a civil society coalition in Bogotá and provided technical support to Sergio Arboleda University, which received funding to promote a tobacco tax increase and improve enforcement of smokefree laws there. The Union also sponsored and promoted a legal workshop for Colombia and nine countries from the South American region.

**MEXICO APPROVES LONG-AWAITED TOBACCO TAX INCREASE**

The Mexican Congress approved a long-awaited tax increase in October, which raised the price of tobacco products by 37%. This was an important step for Mexico, since treating tobacco-related illnesses cost approximately US $5.7 billion in 2008, and price increases have proven to reduce tobacco consumption. The Union’s legal support, as well as its technical assistance in targeting decision-makers, facilitated this change. This increase also demonstrated the effective engagement of The Union and its partners from the civil society with the government.

**SMOKEFREE BRAZIL: 73.5% LESS CARBON MONOXIDE AFTER ONE YEAR**

In August, Brazil marked one year since the passage of smokefree laws affecting some 75 million people in seven states – and the National Institute of Cancer (INCA) and the Alliance Against Tobacco (ACT), Union grantees that were instrumental in the passage of the smokefree laws, joined the one year celebration in Sao Paolo State. An assessment conducted by the government found a 99.7% compliance rate among the public, with only 822 out of 360,741 public places inspected found to be in violation. The Heart Institute in Brazil also reported a 73.5% reduction in carbon monoxide in the environment.

**LUNG HEALTH & NON-COMMUNICABLE DISEASES**

**THROUGH THE ADF, COST OF ASTHMA INHALERS FALLS DRAMATICALLY IN EL SALVADOR**

The cost of treating a patient with severe asthma for one year dropped from 83 to 35 euros in El Salvador with the switch to using quality-assured essential asthma medicines purchased through The Union’s Asthma Drug Facility. El Salvador began to use the new HFA inhalers in some pilot sites of its asthma management programme in early 2010. In addition to supplying the medicines, The Union provided training and an information system for monitoring patient care. The goal is to achieve effective long-term management of asthma in the general health services.
Europe

Europe has the highest % of countries reporting MDR-TB (44 out of 53 countries or 83%)

The rate of newly reported cases of HIV infection nearly doubled between 2000 and 2007.

Only 9 out of 53 countries in the region have comprehensive smokefree laws

More than 40 million Russians smoke (39.1% of adults)

Three Union offices serve the region and the world

The Union has three offices in Europe, each with a different role in its operations. The headquarters in Paris provides leadership and coordination for the scientific departments, offices and special projects. Central services for education, membership, scientific publications, administration, finance and development, human resources, communications, logistics and travel and information technology are also based in Paris.

The Union Europe Office in Edinburgh is now an independent non-profit organisation, The International Union Against Tuberculosis and Lung Disease-United Kingdom, with its own Board of Directors. This makes it possible for this office to work more closely with region members and participate in fundraising. Edinburgh is also the home of the Department of Tobacco Control, which provides leadership and coordination for tobacco control activities throughout the world.

The Union Russia Office in Moscow supports tobacco control grants through technical assistance and capacity building of stakeholders in Russia, a priority country where 39.1% of adults smoke.
TOBACCO CONTROL

300 GRANTS IN FOUR YEARS DEMONSTRATE SUSTAINABLE PROGRESS

When the Bloomberg Initiative to Reduce Tobacco Use (BI) was launched in 2006, it placed strong emphasis on supporting tobacco control activities that brought evidence-based results. Collectively, The Union and its partners in BI have now signed over 300 grant agreements. Since the beginning of the initiative, The Union has distributed US $70 million and worked with over 80 organisations in more than 30 countries.

Projects have ranged from establishing government tobacco control cells and the creation of 100% smokefree environments to raising taxes on tobacco through policy development and implementation. The Union’s services have included technical assistance; project monitoring; technical and management training; and resources, such as smokefree guides, case studies and economic impact reports.

A 2010 Union report showed the countries working with The Union had made significant progress in the following areas:

> Tobacco control is becoming a priority policy issue
> Government programmes have penetrated from national to sub-national level
> Inter-sectorial tobacco control coalitions have been established
> Tobacco control cells have been established as required under FCTC obligations
> Tobacco tax increases on tobacco are a priority

PREPARING FOR SMOKEFREE OLYMPICS IN SOCHI

The Union and its tobacco control partners in Russia have teamed up to ensure that the 2014 Winter Olympics in Sochi are smokefree. In June 2010, they toured the region to identify a local partner for this campaign. The visit also included a symposium on the benefits of going smokefree. A smokefree Olympics is expected to build both awareness and support for local and national smokefree policies.

SIBERIA’S KRASNOYARSKY REGION LEADS THE WAY WITH SMOKEFREE MEDICAL FACILITIES

Siberia’s Krasnoyarsky Regional Centre of Medical Prevention, a Union grantee, organised a smokefree medical facilities conference in May. The event marked World No Tobacco Day and helped promote the Ministry of Health’s ban on smoking, advertising or selling tobacco products in health care facilities. The decree passed in May also requested health care managers to offer smoking cessation counselling for staff and patients and to review the smoking regulations and enforcement mechanisms at their facilities.

RESEARCH

OPERATIONAL RESEARCH COURSE PRODUCES ACCOMPLISHED RESEARCHERS AND TRAINERS

The first cohort of 12 participants completed The Union/Médecins sans Frontières operational research (OR) course in March 2010, with all completing original papers. The course held in Paris covers all the steps from developing an OR protocol to submitting a paper. By December 2010, 10 of the papers had been published or were in press at journals such as *PloS One*, *Tropical Medicine and International Health* and the *International Journal of Tuberculosis and Lung Disease*.

The course was offered again, beginning with the first module in August, and this time the faculty included not only experts from The Union and MSF, but also three participants from the first cohort, who were invited to assist as facilitators. This practice of bringing former students back to teach is characteristic of the course’s “see one, do one, teach one” philosophy. The OR course is offered with funding provided by an anonymous donor.

THE UNION CO-ORGANISES LUNG DISEASE CONGRESS IN MOSCOW

The Union co-organised the 20th National Congress on Lung Disease in Moscow in November, including plenary sessions on the Global Adult Tobacco Survey (GATS) in Russia and smokefree health care. More than 4,000 delegates attended. A major topic of discussion was the new Concept on National Policy to Combat Tobacco Use, approved in October, which calls for stronger tobacco control policies to be implemented over five years beginning in 2011.
TUBERCULOSIS

EVALUATING THE FUTURE OF DIGITAL RADIOGRAPHY AS DIAGNOSTIC TOOL FOR TB

In March, TREAT TB sponsored a two-day meeting in Paris that brought together more than 20 experts to discuss the potential of digital radiography as a diagnostic tool for TB control in low-resource, high-burden settings. Digital radiography raises the possibility of radically improving TB detection, diagnosis and treatment, but the technology comes with its own requirements. The experts concluded that operational research is needed to answer key implementation questions.

PLANS FOR MDR-TB TREATMENT CLINICAL TRIAL MOVE FORWARD

Planning sessions were held in Paris for the launch of TREAT TB’s clinical trial of a shortened, standardised treatment regimen of anti-tuberculosis drugs for patients with multiple drug-resistant tuberculosis, known as STREAM. The trial will test the effectiveness of a nine-month regimen that was used successfully in a pilot study by scaling it up to four countries with up to 400 patients. Enrolment for the trial will begin in 2011.

THE UNION EUROPE REGION

641 members in 2010

The Europe Region is working on an action plan for exchanging knowledge and experience between Eastern and Western Europe, focused on issues such as increased TB rates in some settings, TB and migration, the rise of chronic obstructive pulmonary disease (COPD) and the need for tobacco regulation. Plans are also underway for the 6th Conference of The Union Europe Region in London, England on 4-6 July 2012.

Constituent members

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

Organisational members

Alter Santé Internationale et Développement (France)
Comité National contre les Maladies Respiratoires (France)
AIMAR (Italy)
CheckTB (The Netherlands)
Norwegian Association of Heart and Lung Patients (Norway)
King Oscar II Jubilee Foundation (Sweden)
TB Alert (United Kingdom)

Officers

President: Jean-Pierre Zellweger (Switzerland)
Vice President: Peter Davies (UK)
Secretary-General & Board Representative: Maryse Wanlin (Belgium)
Treasurer: vacant

TREAT TB (Technology, Research, Education and Technical Assistance for TB) is a five-year initiative funded by the United States Agency for International Development (USAID) and managed by The Union.

UNION TB EXPERTS TEACH AT UNIVERSITIES FROM NORWAY TO SPAIN

The Union’s tuberculosis experts gave courses, lectures and workshops on a variety of TB-related subjects at universities in Belgium, France, Germany, Norway, Spain, Switzerland and the United Kingdom in 2010. Courses on international health, MDR-TB, TB epidemiology, microscopy and other topics were targeted to medical students, student nurses and post-graduate MDs.

In addition, The Union participated in WHO and Stop TB working groups and task forces, such as the WHO Global Task Force on TB Impact Measurement, the Child TB Subgroup of the DOTS Expansion Working Group, WHO Strategic and Technical Advisory Group (STAG), and the Green Light Committee.
NAR serves as model for new dynamic between Federation and Institute

The International Union Against Tuberculosis and Lung Disease, Inc. became an independent, U.S. nonprofit organisation with its own Board of Directors in 2010. This New York office of The Union works closely with Union members in the region, meeting monthly with the Executive Committee and working together to build visibility, establish new partnerships and raise funds for The Union’s activities worldwide.

Expanding the donor and membership base are key mutual concerns. The tax-exempt status of the New York office makes it eligible to solicit and receive tax-deductible grants and gifts. It also acts as the U.S. fiscal agent for The Union North America Region.

This model that blends and links the structure of the Institute and the Federation of Union members is a first for The Union and will be replicated in other regions during the coming years.
THE UNION NORTH AMERICA OFFICE IS THE HUB FOR KEY UNION PROJECTS

The Union North America Office plays a key role in managing and coordinating several of The Union’s most important projects.

> TREAT TB (Technology, Research, Education and Technical Assistance for TB) is a five-year initiative funded by a cooperative agreement with the United States Agency for International Development (USAID). Partners in six regions collaborate on such TREAT TB projects as PROVE IT, which is assessing Line Probe Assays, both in terms of the cost of rolling out this new diagnostic tool and its impact on patient outcomes, and STREAM, a clinical trial to evaluate a shortened standardised regimen for MDR-TB. Coordination and financial management for TREAT TB are handled by the New York office.

> International Management Development Programme (IMDP) marketing and communications are managed by the New York office. IMDP has become a respected resource for management education, and, in 2010, it was awarded Authorized Provider status by International Association for Continuing Education & Training (IACET). Logistical support for IMDP courses is provided by the offices in Singapore, New Delhi, Mexico City, Cairo and Beijing.

The Ethics Advisory Group provides ethical guidance on The Union’s work. Its six members, who represent different regions and professions, review every protocol in which a Union staff member or consultant is the principal researcher, likely to be a co-author, or if The Union funds or sponsors the study. The New York office provides administrative support for the EAG, which reviewed 64 research proposals in 2010.

COR STUDIES LEAD TO CHANGES IN POLICY AND PRACTICE

The Centre for Operational Research was established in 2009 to stimulate and expand operational research in low- and middle-income countries and to build capacity for operational research through innovative courses and an operational research fellowship programme.

In 2010, COR activities generated 38 scientific publications (36 scientific papers in peer-reviewed journals and two other documents). Many of the research and opinion papers have led to changes in policy and practice. In addition, there were six operational research fellows in Malawi, South Africa, Zimbabwe, India, Viet Nam and Brazil, who were supported directly by The Union, and four more in South Africa and Kenya, supported through memoranda of understanding with institutions. Since the start of the fellowship programme, the fellows have conducted 38 research projects, of which 19 were completed and submitted for publication by the end of 2010. The Centre for Operational Research is funded through the generous support of an anonymous North American donor.

THE UNION NORTH AMERICA REGION

397 members in 2010

NAR countries defined
In November 2010, the issue of which countries should affiliate as members with North America and which with Latin America was resolved. The Union Board of Directors approved the definition of the NAR to include English-, French- and Dutch-speaking countries, as well as the United States and Canada.

NAR also ratified its regional charter in 2010, which calls for creation of an NAR Council that will advise the Executive Committee. Other activities included the annual conference and special assistance to support TB control in Haiti, following the devastating earthquake there. Fundraising for the construction of a MDR-TB teaching hospital in Haiti was promoted through NAR’s network.

Constituent members

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

Organisational members

British Columbia Lung Association (Canada)
Canadian Lung Association (Canada)
American College of Chest Physicians (USA)
American Lung Association (USA)
American Thoracic Society (USA)
LW Scientific, Inc (USA)
World Lung Foundation (USA)

Officers

President/Board Representative: Masae Kawamura (USA)
Vice President/Programme Chair: Ann Rafferty (USA)
Secretary/Treasurer: Kevin Schwartzman (Canada)

“Under One Sun”: 14th Union NAR Conference

“Under One Sun” was the theme of the 14th Conference of the North America Region, held in Orlando, Florida on March 10–12, 2010. The location was chosen to encourage participation from Caribbean and Latin American countries. In support of this goal, travel grants were awarded to 15 participants from eight countries from the NAR and Latin America Regions – Brazil, Guyana, Antigua, Suriname, Haiti, El Salvador, Trinidad and Tobago and Mexico. Delegates from beyond these regions came from Korea, Dubai and Algeria.

The Lifetime Achievement Award was presented to Dr Jean William Pape, Director of Les Centres GHESKIO in Port-au-Prince, Haiti. Ms. Joy Marshall, York Region, Ontario received the Service Award. Other highlights included keynote speeches by former US President Bill Clinton (via videotape), Dr Pape and Dr Paul Farmer, Director of Partners in Health.
Union Courses

The Union’s courses provide the knowledge and skills required by health care professionals and managers to develop public health programmes that are clinically sound and administratively effective. Curricula cover theory and international best practices with emphasis on the challenges presented by limited-resource settings. Union courses serve participants from various disciplines, working at different levels and in diverse environments. Content is customised for international, national or specific-interest groups. Instructors include international and local experts with extensive teaching and field experience. To help ensure that participants are able to apply their new skills when they return to work, instructors use a variety of teaching methods from lecture/discussion to fieldwork.
IMDP: IACET-CERTIFIED TRAINING OFFERED IN NINE COUNTRIES

The Union’s International Management Development Programme (IMDP) continued to expand its educational offerings to health professionals in 2010 by developing two new courses designed to help organisations improve their programme strategy and create valuable partnerships that aid in the implementation of health projects.

In April, “Influencing, Networking and Partnership” was created with the goal of training participants to develop and foster valuable networks that can help facilitate health programme initiatives. One of the first participants, Dr. Feiying Liu, chief of the TB Division in Guangxi Center for Disease Control in China, said, “During the course, I learned how to influence government officers to allocate more money for TB control, as well as how to set up networking groups on the provincial and county level, and also how to collaborate better with different kinds of organisations and levels of staff in my division.”

“Strategic Planning and Innovation” was offered for the first time in August. The course trained participants to develop strategies that prepare health organisations for unexpected challenges. “The course enhanced my knowledge and skills for strategic planning. Upon returning from the course, I revised the organisational TB and HIV/AIDS strategy, incorporating changes in the training curriculum for the field staff, and organised trainings for field health coordinators”, said course participant Dr. Amgalan Badamjav, Communicable Disease Specialist for World Vision Mongolia.

Also in 2010, the IMDP furthered its commitment to educational excellence by becoming an Authorised Provider with the International Association for Continuing Education and Training (IACET). In obtaining this approval, the IMDP demonstrated that it complies with exceptional standards of practice internationally, and is able to offer continuing education units (CEU) for its programmes.

In addition, the IMDP instituted post-course monitoring programmes for participants’ action plans. At the conclusion of each course, participants create action plans that directly transfer their IMDP training to their organisation. Post-course monitoring helps extend the IMDP’s impact after a course has finished and continue the learning process within health organisations.

ROSTER OF TECHNICAL COURSES REFLECTS THE UNION’S STRENGTHS

The Union has been a highly regarded provider of international and national TB courses for nearly 20 years. These courses are now offered in four languages in locations from China to South Africa to Nicaragua. Additional courses build capacity in special skills from managing multidrug-resistant TB and applied bacteriology to programme monitoring and evaluation.

The Centre for Operational Research has become a leading provider of courses over the past three years. These programmes range from one-day workshops at conferences to the three-module, nine-month Operational Research course co-developed with Médecins sans Frontières and the OR fellows programme. The TREAT TB initiative also sponsors protocol development and other research skill-building workshops. All of these programmes are designed to develop local capacity to address local problems and then pass on the knowledge, experience and solutions found through publication.

In 2010, a new course was offered to improve national implementation of collaborative TB/HIV activities as measured by achievement against selected key indicators from the Global Plan to Stop TB. The curriculum trains leaders from both TB and AIDS programmes to work together more effectively, with the goal of bringing about changes in policy at the national level, and ultimately improving outcomes for patients.

Technical training is also key to the success of The Union’s tobacco control activities. Courses are offered to assist countries in meeting requirements under the WHO’s Framework Convention on Tobacco Control (FCTC) and are based on FCTC’s available guidelines, the MPOWER tobacco control strategy and global best practices.

Other courses offered by The Union address topics such as child lung health management, childhood tuberculosis, using EpiData and chest X-ray reading and reporting. Custom-designed courses are also available on request.

IMDP IN 2010

IMDP for TB control: 7 courses
IMDP for Tobacco control: 18 courses
Custom-designed courses: 3 courses
Country locations: 9
Number of participants: 552

TECHNICAL COURSES IN 2010

International courses: 15
National courses: 21
Custom-designed courses: 1
Country locations: 20
Number of participants: 884
The 41st Union World Conference on Lung Health in Berlin, Germany was an opportunity both to look back at the history of tuberculosis and The Union and forward to what the future might hold.

The theme was “TB, HIV and lung health: from research and innovation to solutions”, and the packed five-day scientific programme offered many opportunities for the 2,500 delegates from 120 countries to share their latest information, experiences and ideas. Highlights included the release of the World Health Organization’s Global TB Report 2010 and the Stop TB Partnership’s day-long symposium on “Universal access to TB prevention, diagnosis, treatment and care”.

Set in Berlin, where Prof Robert Koch discovered the *Mycobacterium tuberculosis*, the conference honoured the 100th anniversary of his death with a plenary lecture by Dr Giorgio Rosigno of the Fund for Innovative New Diagnostics (FIND), who spoke on “Diagnosis of TB from Robert Koch to 2010.”

2010 also marked the 90th anniversary of the founding of The Union, and Dr Thomas R Frieden, Director of the US Centers of Disease Control and Prevention (CDC) evoked the dramatic changes that took place in TB treatment and control in the 20th century in his Sir John Crofton Lecture on “TB and tobacco control: their role on the global health agenda”. Dr Frieden used his lecture to pay homage to the remarkable career of Sir John Crofton, who, in the 1950s, developed the ‘Edinburgh method’ of combining drugs to make curing TB not only possible, but achievable. The Union coordinated the international clinical trial of this method which became the “gold standard” of TB treatment. A long-time Union member, Sir John was also a passionate advocate of tobacco control, today a major focus of The Union.

Other plenary sessions focused on today’s opportunities and challenges with Prof Anthony D Harries of The Union speaking on “Scaling up operational research and using it to strengthen TB and HIV care in resource-poor countries” and Dr François Boillot of ALTER-Santé leading a panel discussion on “Financing health systems to improve TB and HIV outcomes and to strengthen chronic care”.

The conference also culminated the 2010 Year of the Lung, launched at the 2009 World Conference. The campaign sought to raise awareness of the suffering and death caused by lung disease and build commitment to change.
The annual Christmas Seals contest celebrates the tradition of producing colourful seals or stamps to raise funds for tuberculosis and lung disease. Union members select the winners, which are announced at the General Assembly.

**2010 WINNERS WERE:***

1st prize: Tuberculosis Association of India (A) and Japan Anti-Tuberculosis Association (B)

2nd prize: Philippine Tuberculosis Society, Inc. (C) and Comité Nacional de Lucha contra la Tuberculosis y Enfermedades del Aparato Respiratorio, Mexico (D)

3rd prize: National Tuberculosis Association, Taipei, China (E) and Malaysian Association for the Prevention of Tuberculosis (F)

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**UNION AWARDS**

The 2010 awards ceremony was held at the Inaugural Session of the World Conference on Friday, 12 November 2010. The Union presents awards in two categories:

The Karel Styblo Public Health Prize is given to a health worker (physician or lay person) or an organisation for contributions to tuberculosis or non-tuberculous disease over a period of at least 10 years.

The Union Scientific Prize recognises a researcher under 45 years of age who has published significant work on tuberculosis or lung disease in the previous two years.

**KAREL STYBLO PUBLIC HEALTH PRIZE**

The Association for Social Development of Pakistan (ASD) was honoured for pioneering a model collaboration with Pakistan’s National TB Programme that has had a significant impact on the country’s efforts to combat TB (photo 1).

**THE UNION SCIENTIFIC PRIZE**

Dr Keertan Dedha (South Africa) was honoured for his outstanding contributions and ongoing research programme in the priority area of TB and extensively drug-resistant TB (photo 2).

**OTHER AWARDS**

*Princess Chichibu Global Memorial TB Award*
Dr GR Khatri (India) (photo 3)

*Stop TB Kochon Prize*
Dr Armand Van Deun (Belgium) (photo 4)
Publications

THE INTERNATIONAL JOURNAL OF TUBERCULOSIS AND LUNG DISEASE (IJTLD)

To increase the visibility of the IJTLD in 2010, a separate monthly e-TOC (electronic table of contents) was launched for all recipients of The Union E-News. Submissions continued their upward trend, reaching 63 articles per month, while full-text downloads from the Ingenta site increased to more than 14,500 per month, and the Impact Factor increased from 2.304 in 2009 to 2.548 in 2010.

Special articles included the State of the Art series on anti-tuberculosis drug resistance and an Educational series on Mycobacterium bovis. The two supplements in 2010 were the Proceedings of the June 2009 IGRA Symposium, published with the June issue; and the Abstract Book for the 41st Union World Conference on Lung Health in Berlin, Germany, distributed on CD, with an Abstract e-Print Zone made available at the conference. The Year in Review series for 2009 covered lung disease, clinical tuberculosis and treatment, sputum-based laboratory tests, and latent TB infection (LTBI), tuberculosis skin testing (TST) and interferon-gamma release assays (IGRAs).

As a consequence of the high submission rate, the time from acceptance to publication was increasing to an unacceptable level (from 4.2 to 5.2 months), and two measures were taken: the rejection rate was tightened, and we introduced e-publication before print for Review Articles, which take up significant journal space.

The main change to the Journal in 2010 was the ending of the respective mandates of Editors in Chief Nulda Beyers and Moira Chan-Yeung, who left the Journal in December 2010 after eight fruitful years. The results of their efforts are visible in the continued growth and popularity of the “Grey Journal”. We thank them for all that they gave to the IJTLD and wish them well in their future endeavours. The new EICs, approved by the Board of The Union in November 2010, assume their duties in January 2011. They are Drs Wing-Wai Yew (Hong Kong) and Martien Borgdorff (The Netherlands) for TB articles, and Prof Donald Enarson (Canada) for Lung Disease articles.

Clare Pierard
Managing Editor

NEW UNION PUBLICATIONS IN 2010

The Union is committed to disseminating its latest research, policy and practices to the widest possible audience. Most publications are available as PDFs at no charge from www.theunion.org. To order print copies, please go to the website or contact documents@theunion.org.

TEXTBOOKS

Tuberculosis
V Farga, J.A. Caminero
3rd ed, Spanish; print only

TECHNICAL GUIDES

Management of Tuberculosis: A Guide to the Essentials of Good Clinical Practice
Technical consultants of The Union 6th ed, English, Spanish, French; print or PDF
Publication of this guide was made possible through the support of MISERIOR (UK and SP) and l’Agence Française de Développement (FR).

Smoking Cessation and Smokefree Environments for Tuberculosis Patients
K Bissell, T Fraser, C-Y Chiang, D Enarson 2nd ed, English; print or PDF

Desk Guide for Diagnosis and Management of Tuberculosis in Children
SM Graham, et al.
English; print or PDF

Guidance for National Tuberculosis and HIV Programmes on the Management of Tuberculosis in HIV-infected Children: Recommendations for the Public Health Approach
Multiple authors; co-published with the World Health Organization (WHO) English; print or PDF
The Union coordinated and led the development of these guidelines in collaboration with the WHO and with support from the Tuberculosis Coalition for Technical Assistance (TBCTA) funded by the US Agency for International Development (USAID).
As a scientific organisation, The Union places high importance on conducting and publishing research. In 2010, 64 research proposals from technical staff and consultants were approved by The Union Ethics Advisory Group, and more than 70 research, review and opinion pieces were published in peer-reviewed journals.

This research delved into such important public health issues as TB epidemiology and drug resistance, new TB diagnostics, patterns of TB infection, contact investigation and patient monitoring, relapse and re-treatment, mother-to-child HIV transmission, ART treatment outcomes, the TB/HIV epidemic, diagnosing ART failure, HIV mortality reduction, quality care in resource-limited settings, using electronic medical record systems to monitor ART, defining asthma severity, using vital registration systems to monitor population mortality, poverty and lung health, prevention and control of chronic respiratory diseases, childhood TB, oxygen therapy, child pneumonia, diabetes-associated TB, building capacity for tobacco control and health system strengthening.

The journals in which Union research was published included:

- AIDS Care
- American Journal of Respiratory and Critical Care Medicine
- Annals of Tropical Paediatrics
- BioMed Central (BMC)
- BMC Health Services Research
- BMC Infectious Diseases
- BMC Public Health
- BMC Research Notes
- Clinical Infectious Diseases
- Clinics in Chest Medicine
- Current Opinion in HIV and AIDS
- Enfermedades Infecciosas y Microbiología Clínica
- European Respiratory Journal
- Expert Review of Respiratory Medicine
- Indian Journal of Medical Research
- International Journal of Tuberculosis and Lung Disease
- Journal of Acquired Immune Deficiency Syndrome
- Journal of Allergy and Clinical Immunology
- Journal of Clinical Microbiology
- Lancet
- Lancet Infectious Diseases
- Medicina Clínica
- Microbial Drug Resistance
- PLoS Medicine
- PLoS One
- Presse Médicale
- Respirology
- Salud pública de México
- Scandinavian Journal of Infectious Diseases
- Therapeutic Advances in Respiratory Disease
- Tobacco Control
- Transactions of the Royal Society of Tropical Medicine and Hygiene
- Tropical Medicine and International Health

In addition, 21 TB staff and consultants participated in developing the 6th edition of Management of Tuberculosis: Essentials of Good Clinical Practice, popularly known as The Orange Guide. The Union also collaborated with the World Health Organization on projects such as the new WHO guide to managing TB in HIV-infected children and a quality audit tool for TB monitoring.

Further details about The Union’s published research may be found on The Union website at www.theunion.org. Go to ‘What We Do’, select your topic (e.g., Tuberculosis) then click on ‘Publications and Research’.
CHILD TB EXPERT PETER DONALD IS AWARDED THE UNION MEDAL

Prof Peter Roderick Donald – South Africa (on the left)

Prof Peter Roderick Donald of South Africa was awarded The Union’s highest honour, The Union Medal, for his lifetime contribution to tuberculosis and non-tuberculous lung disease on Sunday, 14 November 2010 in Berlin, Germany. His citation highlighted his outstanding contributions to child lung health, especially childhood tuberculosis.

Prof Donald is emeritus professor in the Department of Paediatrics and Child Health of the Faculty of Health Sciences, Stellenbosch University, South Africa. His interests in the field of tuberculosis include childhood TB, tuberculous meningitis and TB epidemiology.

For more than 20 years, he has been involved in the assessment of anti-tuberculosis agents in children and adults. He was principal investigator in 12 studies of the early bactericidal activity (EBA) of anti-tuberculosis agents, and his work helped establish EBA as a reliable, objective technique for these assessments. Although now enjoying his retirement, he remains active in various TB research activities.

THREE NEW HONORARY MEMBERS NAMED AT THE GENERAL ASSEMBLY

The Board of Directors confers lifetime Honorary Membership on individuals who have made outstanding contributions to tuberculosis and lung disease. These honours are announced at the General Assembly, which was held in 2010 on Sunday, 14 November in Berlin, Germany.

Prof Anne Fanning (Canada)
Anne Fanning is professor emeritus, Faculty of Medicine and Dentistry, University of Alberta, Canada. She served as Alberta Health’s Director of Tuberculosis Services (1987–1996) and WHO Medical Officer for Global TB Education (1998–9). She is Past President of The Union (2000–03) and continues to work with Union and WHO working groups, as well as part time for the Global Health Initiative at her university. She was made a member of the Order of Canada in 2007.

Prof Francoise Portaels (Belgium)
As a young research assistant for Belgium’s Institute of Tropical Medicine (ITM), Francoise Portaels became passionately interested in Africa and the infections causing leprosy and Buruli ulcer. She completed her PhD focusing on leprosy, TB and other mycobacterial diseases and moved up through the academic ranks to head ITM’s newly created Mycobacteriology Unit in 1983. Author of close to 400 publications, she has received 11 scientific awards and is widely known as a lecturer and an inspiration to her students.

Dr Abbas Hassan El Masry (Sudan)
Abbas Hassan El Masry was born in Abri, Sudan in 1927 and graduated from the medical school of Alexandria University, Egypt in 1954. He specialised in respiratory medicine in Wales (UK) in 1962 and served as a chest physician for the Sudan Ministry of Health’s Tuberculosis Training Centre (1963–1971). He was senior chest physician for El Shab Hospital in Khartoum and principal investigator for clinical trials and surveys focused on case finding and treatment of TB and bronchial asthma.

NEW INSTITUTE AND FEDERATION COLLABORATIONS

Several initiatives to integrate the work of The Union Institute and Federation of members advanced this year. The annual Inter-Regional Council meeting, held in Berlin, saw each region office director make a presentation to the members and vice versa, with the goal of increasing collaboration in terms of programmes and services, membership development and funding. These efforts were also supported by the increased visibility of the regions and scientific sections in The Union Village at the World Conference; the region web pages that offer news about both Institute and member activities; new reports sent to members that summarise the Institute’s activities by region; and annual reports prepared by the members of each region that were disseminated to the whole Federation.

THE UNION IS VIRTUALLY EVERYWHERE

Today members can vote in Union elections, register for courses and conferences, submit session proposals and abstracts, read the latest news from The Union headquarters and regions, receive the IJTLD’s eTOC, download technical guides, watch conference web casts, update their membership information and renew – all online. Learn more at The Union website www.theunion.org.

MEMBER NEWS

JOIN US ONLINE AT WWW.THEUNION.ORG
The Union General Assembly was held on Sunday, 14 November 2010 from 18:00 to 19:30 at the ICC Berlin in Berlin, Germany. Dr S Bertel Squire, The Union President, welcomed constituent, organisational, honorary and individual members and scientific section chairs.

ELECTIONS

Based on the Nominating Committee’s recommendations, the General Assembly elected two new individual member representatives: Ms Carol Nyirenda (Zambia) (photo opposite) and Ms Siphiwe Mavis Ngwenya (Swaziland) (photo below). The General Assembly also voted to renew the mandates of Dr Dean Schraufnagel (USA), who wished to stand for a third term.

The General Assembly also delegated the authority to the Board of Directors to authorise the sale or re-mortgaging of Union property, approving the following clause as required by French law: If the apartment situated at 72 Blvd St Michel, Paris is sold at auction, it must be sold for at least the price of 1,075,000 euros confirmed by the fiscal department (i.e., Service France Domained) or the price reached at public auction.

Dr Nils Billo informed the members that the 2011 World Conference would be in Lille, France and the 2012 conference at a location to be determined in Asia. The General Assembly voted and approved this plan and delegated the responsibility for making the final decision on the venue to Dr Billo.

RESOLUTIONS

The General Assembly unanimously approved the Activity Report, treasurer’s report and the audited accounts for the period of 1 January to 31 December 2009 and the budget for fiscal 2011.

The deficit from 2009 was addressed through drastic cost-cutting measures in 2010, including reduction of personnel. These steps reduced costs by 2 million euros. A negative result of 140,000 euros was estimated for 2010, but the situation is much less severe than in 2009 and a positive result is projected for 2011.

The General Assembly also voted to renew the mandates of board members representing the following regions: Dr Camilo Roa Jr (The Philippines) for the Asia Pacific Region and Dr Maryse Wanlin (Belgium) for the Europe Region.

DISCHARGE AND POWER

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

AWARDS/REMEMBRANCE

The Union’s highest honour and the only award conferred by the membership is The Union medal. In 2010, The Union Medal was presented to Prof Peter Donald (South Africa) for his outstanding and special contributions to TB and lung disease. In addition, Prof Anne Fanning (Canada), Prof Francoise Portaels (Belgium) and Dr Abbas Hassan El Masry (Sudan) were made Honorary Members of The Union. Finally several members who passed away in 2010 were remembered and the results of the annual Christmas Seals contest were announced.

The Union honours the passing in 2010 of the following members who made significant contributions to TB and lung health:

Dr Mazakasu Aoki (Japan)
Prof Wallace Fox CMG (UK)
Prof Jorge Alberto Pilheu (Argentina)
Dr NC Sen Gupta (Singapore)
Dr MM Singh (India)
Dr Abolhassan Zia-Zarifi (Iran)

Please visit “In Memoriam” at www.theunion.org for more details.
Scientific Activities

Union members with common professional interests affiliate through scientific sections, sub-sections and working groups. They collaborate on research, publications and other projects; help plan the scientific programme for Union conferences; and participate in the governance of The Union through the General Assembly. Annual meetings are held each year at The Union World Conference on Lung Health.

**TUBERCULOSIS SCIENTIFIC SECTION**

2,445 MEMBERS IN 2010

The TB Scientific Section was very active at the World Conference in Berlin. TB Executive Committee members met to discuss sessions proposed for the 2011 World Conference; the sub-sections and working groups met to discuss achievements and future plans; and some members staffed the scientific section stand in The Union Village to encourage new participation. Leadership was handed over to new officers whose remit began after the conference. At the annual meeting, the TB section heard reports from the working groups and a Global Indigenous Stop TB Initiative Working Group was proposed. This section and its sub-sections help to organise numerous conference sessions for every World Conference; in 2010, these included five post-graduate courses, six workshops and 30 symposia. They also collaborated with the other sections on several sessions.

*Chair:* Digambar Behera (India)
*Vice Chair:* Richard Zaleskis (Denmark)
*Programme Secretary:* Edward Nardell (USA)
*Secretary:* CN Paramasivan (India)

**Working Groups**

- TB Control in Prisons (Leader: Massoud Dara – 95 members)
- TB and Migration (Leader: Deliana Garcia – 102 members)
- TB Infection Control (Leaders: Grigory Volchenkov and Grace Egos – 326 members)
- TB Social Determinants and Ethics (Leader: Carlton Evans – 153 members)
- TB/HIV Data Management and Development (Leader: Rory Dunbar – 114 members)

**TB BACTERIOLOGY AND IMMUNOLOGY SUB-SECTION**

368 MEMBERS IN 2010

*Chair:* Christopher Gilpin (Australia)
*Programme Secretary:* Rumina Hasan (Pakistan)

This sub-section created a new working group on TB Laboratory Accreditation in February 2010, and the first meeting, held during the World Conference in Berlin, was attended by 60 specialists. This sub-section also organised one workshop and six symposia dedicated to issues related to bacteriology and immunology, which were well attended.

**Working Groups**

- TB Laboratory Accreditation (Leaders: Christopher Gilpin, Tom Shinnick, Armand Van Deun – 42 members)

**TB NURSES AND ALLIED PROFESSIONALS (NAPs) SUB-SECTION**

87 MEMBERS IN 2010

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

The formation of the new TB Executive Committee has increased the voice of the NAPs and other sub-sections in section affairs. Sub-section members heard about this and other news, as well as reports from the working groups at their annual meeting. This active sub-section organised several sessions at the 2010 World Conference, including two post-graduate courses, one workshop and three symposia.
Working Groups

- Regional Mobilisation of NAPS  
  (Leader: Maruschka Sebek – 30 members)
- Best Practice for Patient Care  
  (Leaders: Gini Williams and Inge Schreurs – 162 members)
- TB Education and Training  
  (Leaders: Nisha Ahamed and Amera Khan – 292 members)

* The other sections also have small NAPs sub-sections

ZOONOTIC TB SUB-SECTION
19 MEMBERS IN 2010

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

This sub-section organised a symposium for the 2010 World Conference on the public health and socioeconomic challenges of zoonotic TB. At the annual meeting, members heard that the working group completed a targeted survey of human and animal health laboratories to assay available techniques for differentiating M. bovis from M. TB and if they report these results regularly. Its next step is to establish guidelines to differentiate the two forms.

Working Group

- M. bovis  
  (Leaders: Claude Turcotte and John Kaneene – 28 members)

The Oxygen Systems Working Group report was published in the International Journal of Tuberculosis and Lung Disease in 2010.

HIV SCIENTIFIC SECTION
107 MEMBERS IN 2010

Chair: Reuben Granich (Switzerland)
Vice Chair: Soumya Swaminathan (India)
Programme Secretary: Nickolas DeLuca (USA)
Secretary: Alasdair Reid (UK)

The HIV Section met their goal of increasing membership by 30% in 2010 and agreed at their annual meeting in Berlin to continue working towards a stronger presence both internally and externally. For the 2010 World Conference, this section organised two post-graduate courses and three workshops on TB/HIV, as well as three symposia on TB/HIV and seven on HIV. Perhaps most importantly, the HIV Section has focused on science-driven programming with an emphasis on abstract-based symposia.

TOBACCO CONTROL SCIENTIFIC SECTION
638 MEMBERS IN 2010

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

At its annual meeting in Berlin, the Tobacco Control Scientific Section discussed several ideas for working groups to provide ongoing activities and opportunities for collaboration among the members. Increasing the involvement of members is still a priority for this section. They organised four symposia on tobacco control at the 2010 World Conference and collaborated with the Lung Health and TB sections on a post-graduate course, workshop and symposium.

LUNG HEALTH SCIENTIFIC SECTION
91 MEMBERS IN 2010

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

Lung Health Section members heard final reports from the working groups on BCG surveillance, oxygen systems and childhood TB training at the annual meeting. Some of these working groups are planning to extend their remit with new tasks. A highlight of the year was the publication of the oxygen systems working group’s report in the International Journal of Tuberculosis and Lung Disease. This section organised three workshops and four symposia for the 2010 World Conference on topics from child pneumonia to COPD in low-income countries. Attendance ranged from 40 to 100 people.

Working Groups

- BCG Surveillance (Leader: Anneke Hesseling – 34 members)
- Childhood TB Training (Leader: Ben J Marais – 114 members)
- COPD in Low-Income Countries  
  (Leader: Peter Burney – 37 members)
- Oxygen Systems (Leader: Steve Graham – 9 members)
- Tobacco Cessation Interventions for TB Patients (Tara Singh Bam – 9 members)
I am pleased to submit the annual Report of the Treasurer of the International Union Against Tuberculosis and Lung Disease (The Union) for the fiscal year ended 31 December 2010. The Union, in its 90th year, continues to make significant progress in its operations, charting new areas of growth and building for the future.

While the acute phase of the global economic crisis has passed, challenges still remain, and this continues to have an impact on the resources of many of our members, donors and The Union itself. Several of our large constituent members no longer pay the same level of membership fees they paid in the past years. Donors are less willing to finance indirect cost of organisations; therefore, it has become imperative for The Union to widen its sources of revenue.

The values of The Union have ensured that it continues to be a respected organisation, and the quality of its work has enabled it to secure projects that have not only lent credibility to the organisation but, more importantly, have given hope to the numerous beneficiaries who have benefitted from its health solutions for the poor. The Union has seen tremendous growth over the past few years, and today it is well-positioned to meet the challenges faced by organisations working in international health. It has 13 offices across the globe, and therefore has the capacity to raise and disburse funds locally, allowing it to think internationally and act locally, where required. This is very important as today most donor funds are allocated geographically, and therefore it is essential to be seen on the ground to access these funds.

The growth has come with challenges. The volatility of the US dollar continues to plague organisations across all sectors, and The Union too needs to have adequate safeguards in place for this, especially since over 80% of The Union’s revenue is in US dollars. The cost of operations is still important, and while in 2010 most of the cost reductions have been implemented, it would still be necessary to reduce costs further as well as raise revenues. The deficits of 2009 and earlier years need to be reversed, and this is possible only by achieving a surplus of revenues over expenditure. In 2010, we have witnessed this shift towards higher revenues over expenditure, and this momentum must and will be continued in the future.

The Union values its independent views and has always pursued those activities that it believes will make a difference, which at times may be contrary to the popular viewpoint, and therefore may result in not receiving the desired level of funding from donors. Contributions from members have enabled The Union to pursue this line of independence, and it will be important to work closer with them. As we move into 2011 and beyond, The Union will ensure that overall spending is made within the available resources as we continue to invest in programmes that define our mission and values.

In 2010, The Union had anticipated a deficit in operations, however, due to strict fiscal management, including the difficult task of downsizing the operations of The Union and strong budget controls, The Union has posted a surplus of revenues over expenditure. The current position of The Union when viewed against the challenges of previous years as well as the changing global environment shows that it has the resilience, creativity and commitment to overcome the challenges and excel as it has done so in its 90 years of existence.

**FISCAL 2010 HIGHLIGHTS**

- Total net financial result for the year was a surplus of 0.384 million euros compared to a deficit of 3.381 million euros in 2009. Total revenue was 43.9 million euros compared to 34.9 million in 2009.
- Revenue from grants, gifts and operating grants amounted to 39.9 million euros compared to 31.9 million euros in 2009.
- Total expenditure was 40.2 million euros compared to 36.8 million euros in 2009.
• The current bank advances (overdraft) stood at 0.7 million euros compared to 0.9 million euros in 2009.
• The operating result was 3.6 million euros compared to -1.8 million euros in 2009.

We enter Fiscal 2011 on a positive note, although concerns for both revenues and expenditures remain, and we need to continuously strive to increase revenues and reduce expenditure. This is particularly important as funding organisations are more interested in funding only those costs that are directly related to projects and staying cost-efficient would increase our chances of obtaining funding in the competitive environment in which we need to perform.

The Union, as it continues to strengthen its core activities – scientific, educational and research programmes – needs to be cognizant of the changing economic environment and position itself, so that, it takes advantage of the opportunities, as well as ensures the diversification in operations through the numerous offices located across the world, which would enable it to reach our desired beneficiaries in the most optimal manner.

With the breadth of resources entrusted to The Union by donors, government agencies, members and other supporters, the need for prudent fiscal oversight is great. Working closely with our Board of Directors and our auditors, we continue to review and improve our financial policies, procedures and practices. Such oversight will ensure the continued financial strength needed to pursue The Union’s agenda in Fiscal 2011 and beyond.

FINANCIAL STATEMENTS

This report describes the financial position of The Union. The documents on the following pages consist of the audited financial statements for Fiscal Year 2010 audited by KPMG.

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

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

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

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

At the end of 2010, The Union’s achievements are a matter of pride, and this is all the more special given the tough economic environment in which we have delivered these outcomes. We need to ensure that this momentum is continued into 2011 and beyond.

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

Thank you.

Louis-James de Viel Castel
Treasurer
L’Union Internationale Contre la Tuberculose et les Maladies Respiratoires
Association reconnue d’utilité publique
Siège social : 68, boulevard Saint-Michel-75006 Paris

Rapport du commissaire aux comptes sur les comptes annuels
Exercice clos le 31 décembre 2010

Messieurs, Messieurs,
En exécution de la mission qui nous a été confiée par votre assemblée générale, nous vous présentons notre rapport relatif à l’exercice clos le 31 décembre 2010, sur :
• le contrôle des comptes annuels de l’Association Union Internationale Contre la Tuberculose et les Maladies Respiratoires, tels qu’ils sont joints au présent rapport ;
• la justification de nos appréciations ;
• les vérifications et informations spécifiques prévues par la loi.
Les comptes annuels ont été approuvés par le conseil d’administration. Il nous appartient, sur la base de notre audit, d’exprimer une opinion sur ces comptes.

Opinion sur les comptes annuels
Nous avons effectué notre audit selon les normes d’exercice professionnel applicables en France ; ces normes requièrent la mise en œuvre de diligences permettant d’obtenir l’assurance raisonnable que les comptes annuels ne comportent pas d’anomalies significatives. Un audit consiste à vérifier, par sondages ou au moyen d’autres méthodes de sélection, les éléments justifiant des montants et informations figurant dans les comptes annuels. Il consiste également à apprécier les principes comptables suivis, les estimations significatives retenues et la présentation d’ensemble des comptes. Nous estimons que les éléments que nous avons collectés sont suffisants et appropriés pour fonder notre opinion.
Nous certifions que les comptes annuels sont, au regard des règles et principes comptables français, réguliers et sincères et donnent une image fidèle du résultat des opérations de l’exercice écoulé ainsi que de la situation financière et de patrimoine de l’association à la fin de cet exercice.

2
Justification des appréciations
En application des dispositions de l’article L.823-9 du Code de commerce relatives à la justification de nos appréciations, nous portons à votre connaissance les éléments suivants :

Règles et principes comptables
La note n°2 page 7 « Principes, et méthodes comptables » de l’annexe expose les règles et méthodes comptables en vigueur dans l’association.
Dans le cadre de notre appréciation des règles et principes comptables suivis par votre association, nous avons vérifié le cadre comptable et les méthodes comptables visées ci-dessus et des informations fournies dans l’annexe des comptes et nous nous sommes assurés de leur correcte application.

Estimations comptables

Prévisions pour risques
Votre association constitue des provisions pour couvrir les risques liés aux pertes liées aux opérations ou devises et pour litiges préjudiciables, telle que mentionnée dans l’annexe des comptes sociaux.

Prévision pour dépréciations
Votre association constitue des provisions pour couvrir les dépréciations constatées ou envisagées sur les actifs de l’entreprise, telle que mentionnée dans l’annexe des comptes sociaux.
Nous tenons à constater que la situation financière et les hypothèses sur lesquelles se fondent ces estimations, à savoir par sondages les salaires effectués par l’association, à composer les estimations comptables par période précédente avec les réalisations correspondantes.
Les appréciations ainsi portées s’inscrivent dans le cadre de notre démarche d’audit des comptes annuels, pris dans leur ensemble, et est donc contribué à la formation de notre opinion exprimée dans la première partie de ce rapport.

3
Vérifications et informations spécifiques
Nous avons également procédé, conformément aux normes d’exercice professionnel applicables en France, aux vérifications spécifiques prévues par la loi.
Nous n’avons pas d’observation à formuler sur la sincérité et la conformité avec les comptes annuels des informations données dans le rapport financier du Trésorier et dans les documents adressés aux membres sur la situation financière et les comptes annuels.

La Défense, le 1er juillet 2011

KPMG Entreprises
Département de KPMG S.A.

Née Cottier
International Union Against Tuberculosis and Lung Disease
Charitable Organization

Registered office: 68, boulevard Saint-Nicholas - 75006 Paris

Statutory auditor’s report on the financial statements

Year ended 31 December 2010

To the Members

In compliance with the assignment entrusted to us by your General Assembly, we hereby report to you, for the year ended 31 December 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 approved by the Board of Directors. Our role is to express an opinion on these financial statements based on our audit.

1 Opinion on the financial statements

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

2 Justification of our assessments

In accordance with the requirements of article L.823-9 of the French Commercial Code ("Code de commerce") relating to the justification of our assessments, we bring to your attention the following matters.

Rules and accounting principles
The note no. 7 to the financial statements explains the rules and accounting principles applied by the Organization.

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

Accounting estimations

Contingencies and loss provisions
Your Organization sets up provisions against exchange losses and provision for disputes, such as mentioned in note no. 3-2-2 of the appendix of the social accounts.

Wear and tear allowances
Your Organization sets up provisions to cover the depreciations noticed or envisaged on assets, such as mentioned in note no. 3-1-4-5 of the appendix of the social accounts.

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

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

- Year ended 31 December 2011

3 Specific verifications and information

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

We have no matters to report on to the fair presentation and the consistency with the financial statements of the information given in the Treasurer’s financial report, and in the documents addressed to Members with respect to the financial position and the financial statements.

La Défense, 18 July 2011
Balance Sheet 1 January 2010 – 31 December 2010

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<td>€3 022 105</td>
<td>US$ 4 038 137</td>
</tr>
<tr>
<td>Inter-offices accounts</td>
<td>€512 525</td>
<td>US$ 684 835</td>
</tr>
<tr>
<td>Other receivables</td>
<td>€699 633</td>
<td>US$ 934 850</td>
</tr>
<tr>
<td>Sundry debtors</td>
<td>€63 982</td>
<td>US$ 85 493</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>€11 554 244</td>
<td>US$ 15 438 781</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Bank &amp; Cash</strong></td>
<td>€5 827 842</td>
<td>US$ 7 787 162</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Prepaid Expenses</strong></td>
<td>€82 751</td>
<td>US$ 110 572</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Exchange Losses</strong></td>
<td>€692 080</td>
<td>US$ 924 758</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grand Total</strong></td>
<td>€26 414 497</td>
<td>US$ 35 295 052</td>
</tr>
</tbody>
</table>

2010: 1 € = 1,3362 US$
2009: 1 € = 1,4406 US$
### LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserves</td>
<td>2 287 820</td>
<td>3 056 985</td>
</tr>
<tr>
<td>Result carried forward</td>
<td>-5 097 607</td>
<td>-6 811 422</td>
</tr>
<tr>
<td>Result from the financial year</td>
<td>384 908</td>
<td>514 314</td>
</tr>
<tr>
<td>Restatement reserve on premises</td>
<td>1 887 396</td>
<td>2 521 939</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td>-537 483</td>
<td>-718 184</td>
</tr>
<tr>
<td><strong>Contingency Reserves</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Contingency Reserves</strong></td>
<td>176 197</td>
<td>235 434</td>
</tr>
<tr>
<td><strong>Dedicated Funds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Dedicated Funds</strong></td>
<td>5 880 817</td>
<td>7 857 948</td>
</tr>
<tr>
<td><strong>Debts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants to be paid</td>
<td>10 319 405</td>
<td>13 788 789</td>
</tr>
<tr>
<td>Committed grants related to future budget years</td>
<td>3 022 105</td>
<td>4 038 137</td>
</tr>
<tr>
<td>Inter-offices accounts</td>
<td>945 533</td>
<td>1 263 421</td>
</tr>
<tr>
<td>Borrowing from credit institutions</td>
<td>2 450 561</td>
<td>3 274 440</td>
</tr>
<tr>
<td>Current bank advances</td>
<td>712 403</td>
<td>951 913</td>
</tr>
<tr>
<td>Suppliers and similar accounts</td>
<td>696 308</td>
<td>930 407</td>
</tr>
<tr>
<td>Tax and social security</td>
<td>604 929</td>
<td>808 306</td>
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<tr>
<td>Charges to be paid (accrued expenses)</td>
<td>268 008</td>
<td>358 112</td>
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<tr>
<td>Other creditors</td>
<td>300 681</td>
<td>401 770</td>
</tr>
<tr>
<td><strong>Total Debts</strong></td>
<td>19 319 933</td>
<td>25 815 295</td>
</tr>
<tr>
<td><strong>Deferred Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Deferred Income</strong></td>
<td>897 438</td>
<td>1 199 157</td>
</tr>
<tr>
<td><strong>Foreign Exchange Unrealised Gains</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Exchange Gains</strong></td>
<td>677 595</td>
<td>905 406</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>26 414 497</td>
<td>35 295 052</td>
</tr>
</tbody>
</table>

2010: 1 € = 1,3362 US$
2009: 1 € = 1,4406 US$
# Income/Expenses

In euros - 1 January 2010 – 31 December 2010

## INCOME STATEMENT (in €)

<table>
<thead>
<tr>
<th>Operating Income</th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>588 027</td>
<td>0</td>
<td>588 027</td>
<td>571 426</td>
</tr>
<tr>
<td>Operating grants</td>
<td>3 710 625</td>
<td>0</td>
<td>3 710 625</td>
<td>3 027 834</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>189 507</td>
<td>36 069 521</td>
<td>36 259 028</td>
<td>28 947 311</td>
</tr>
<tr>
<td>Write back of provisions and transferred charges</td>
<td>363 360</td>
<td>305 223</td>
<td>668 583</td>
<td>890 980</td>
</tr>
<tr>
<td>Other income</td>
<td>1 057 670</td>
<td>1 575 656</td>
<td>2 633 325</td>
<td>1 542 230</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>5 909 189</strong></td>
<td><strong>37 950 400</strong></td>
<td><strong>43 859 588</strong></td>
<td><strong>34 979 781</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>External charges</td>
<td>-2 041 609</td>
<td>-16 137 253</td>
<td>-18 178 861</td>
<td>-17 175 811</td>
</tr>
<tr>
<td>Taxes</td>
<td>-27 210</td>
<td>-1 059</td>
<td>-28 269</td>
<td>-24 230</td>
</tr>
<tr>
<td>Wages and salaries</td>
<td>-963 118</td>
<td>-2 691 247</td>
<td>-3 654 365</td>
<td>-4 850 081</td>
</tr>
<tr>
<td>Social contributions</td>
<td>-590 139</td>
<td>-1 015 992</td>
<td>-1 606 131</td>
<td>-2 093 311</td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>-702 209</td>
<td>-17 451</td>
<td>-719 660</td>
<td>-527 150</td>
</tr>
<tr>
<td>Other expenses</td>
<td>-555 960</td>
<td>-15 420 366</td>
<td>-15 976 326</td>
<td>-12 136 143</td>
</tr>
<tr>
<td><strong>Total Operating Expense</strong></td>
<td><strong>-4 880 245</strong></td>
<td><strong>-35 283 368</strong></td>
<td><strong>-40 163 612</strong></td>
<td><strong>-36 806 726</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Result</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive foreign exchange difference</td>
<td>925 709</td>
<td>2 473</td>
<td>928 181</td>
<td>672 561</td>
</tr>
<tr>
<td>Interest and financial income</td>
<td>155</td>
<td>35 866</td>
<td>36 021</td>
<td>695</td>
</tr>
<tr>
<td>Write back of financial provisions</td>
<td>104 478</td>
<td>0</td>
<td>104 478</td>
<td>261 519</td>
</tr>
<tr>
<td>Negative foreign exchange difference</td>
<td>-1 389 669</td>
<td>-2 064</td>
<td>-1 391 733</td>
<td>-1 043 652</td>
</tr>
<tr>
<td>Interest and financial charges</td>
<td>-136 267</td>
<td>0</td>
<td>-136 267</td>
<td>-154 687</td>
</tr>
<tr>
<td>Provision of risk for foreign exchange losses</td>
<td>-7 259</td>
<td>0</td>
<td>-7 259</td>
<td>-103 130</td>
</tr>
<tr>
<td><strong>Total Financial Result</strong></td>
<td><strong>-502 853</strong></td>
<td><strong>36 275</strong></td>
<td><strong>-466 579</strong></td>
<td><strong>-366 694</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exceptional Result</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Write back of dedicated funds</td>
<td>0</td>
<td>903 706</td>
<td>903 706</td>
<td>1 668 868</td>
</tr>
<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>-3 564 021</td>
<td>-3 564 022</td>
<td>-2 371 096</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations on Dedicated Funds</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Result for Financial Year</strong></td>
<td><strong>384 908</strong></td>
<td><strong>0</strong></td>
<td><strong>384 908</strong></td>
<td><strong>-3 381 100</strong></td>
</tr>
</tbody>
</table>

---

2010: 1 € = 1,3362 US$

2009: 1 € = 1,4406 US$
## INCOME STATEMENT (in US$)

### General Funds

<table>
<thead>
<tr>
<th>Operating Income</th>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>785,722</td>
<td>0</td>
<td>785,722</td>
<td>823,196</td>
</tr>
<tr>
<td>Operating grants</td>
<td>4,958,137</td>
<td>0</td>
<td>4,958,137</td>
<td>4,361,898</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>253,219</td>
<td>48,196,094</td>
<td>48,449,313</td>
<td>41,701,496</td>
</tr>
<tr>
<td>Write back of provisions and</td>
<td>485,522</td>
<td>407,839</td>
<td>893,361</td>
<td>1,283,546</td>
</tr>
<tr>
<td>transferred charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other income</td>
<td>1,413,259</td>
<td>2,105,392</td>
<td>3,518,649</td>
<td>2,221,737</td>
</tr>
</tbody>
</table>

**Total Income**

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,895,859</td>
<td>50,709,325</td>
<td>58,605,182</td>
<td>50,391,873</td>
</tr>
</tbody>
</table>

### Operating Expenses

| External charges                       | -2,727,998 | -21,562,597 | -24,290,594 | -24,743,473 |
| Taxes                                  | -36,358    | -1,415      | -37,773     | -34,906     |
| Wages and salaries                     | -1,286,918 | -3,596,044  | -4,882,963  | -6,987,027  |
| Social contributions                   | -788,544   | -1,357,569  | -2,146,112  | -3,015,624  |
| Depreciation charges and addition to   | -938,292   | -23,318     | -961,610    | -759,412    |
| provisions                             |            |              |            |             |
| Other expenses                         | -742,874   | -20,604,693 | -21,347,567 | -17,483,328 |

**Total Operating Expense**

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>-6,520,984</td>
<td>-47,145,636</td>
<td>-53,666,619</td>
<td>-53,023,770</td>
</tr>
</tbody>
</table>

### Operating Result

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,374,875</td>
<td>3,563,689</td>
<td>4,938,563</td>
<td>-2,631,897</td>
</tr>
</tbody>
</table>

### Financial Result

| Foreign exchange profit                | 1,236,932   | 3,304   | 1,240,235 | 968,891     |
| Interest and financial income         | 207         | 47,924  | 48,131    | 1,001       |
| Write back of financial provisions    | 139,604     | 0       | 139,604   | 376,744     |
| Foreign exchange loss                 | -1,856,876  | -2,758  | -1,859,634 | -1,503,485  |
| Interest and financial charges        | -182,080    | 0       | -182,080  | -222,842    |
| Provision of risk for foreign          | -9,701      | 0       | -9,701    | -148,571    |
| exchange losses                       |            |         |          |             |

**Total Financial Result**

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>-671,914</td>
<td>48,470</td>
<td>-623,445</td>
<td>-528,262</td>
</tr>
</tbody>
</table>

### Exceptional Result

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>-188,649</td>
<td>-57,445</td>
<td>-246,092</td>
<td>-699,027</td>
</tr>
</tbody>
</table>

| Write back of dedicated funds         | 0           | 1,207,530 | 1,207,532 | 2,404,172 |
| Obligations for projects              | 0           | -4,762,244 | -4,762,246 | -3,415,803 |

### Operations on Dedicated Funds

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-3,554,714</td>
<td>-3,554,714</td>
<td>-1,011,631</td>
</tr>
</tbody>
</table>

### Net Result for Financial Year

<table>
<thead>
<tr>
<th>31.12.2010</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>514,312</td>
<td>0</td>
<td>514,312</td>
<td>-4,870,817</td>
</tr>
</tbody>
</table>

---

2010: 1 € = 1,3362 US$  
2009: 1 € = 1,4406 US$
Acknowledgements

DONORS
We gratefully acknowledge the following foundations, organisations, governments and agencies for their support of The Union’s work in 2010.

Action Damien
Agence Française de Développement
Agence nationale de recherche sur le sida et les hépatites virales (ANRS)
Anonymous
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Eli Lilly and Company India Pvt. Ltd.
European Commission, Democratic Republic of Congo
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The International Union Against Tuberculosis and Lung Disease, Inc.
Johns Hopkins University Bloomberg School of Public Health
Ligue Pulmonaire Suisse (LPS)
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Norwegian Agency for Development Cooperation (Norad)
Norwegian Association of Heart and Lung Patients (LHL)
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Singapore Economic Development Board
Singapore Tourism Board
Stop TB Partnership
Swiss Agency for Development and Cooperation
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USAID
USAID through a grant managed by World Vision
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University Research Co., LLC
World Diabetes Foundation
World Health Organization (WHO) through a grant managed by EnCompass LLC
World Lung Foundation with financial support from Bloomberg Philanthropies
The Yadana Consortium operated by Total/MGTC

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

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Gold
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Silver
Ayobami Abdulqazim, Nigeria
Margaret R Becklake, Canada
Nobukatsu Ishikawa, Japan
Seiya Kato, Japan
Robert Loddenkemper, Germany
Edward Nardell, USA
Charles M Nolan, USA
Richard O’Brien, USA
Hans L Rieder, Switzerland
Dean Schraufnagel, USA
S Bertel Squire, United Kingdom
Jeffrey R Starke, USA
Armand Van Deun, Belgium

Individual donors
In addition we would like to acknowledge the following individuals and groups who made personal gifts of 100 euros or more.

Nils E Billo, France
Florent Corcelle, France
José Luis Castro, France
Paula I Fujiwara, USA
Nathalie Guillerm, France
Cécile Macé, France
John F Murray, USA
Sylviane Ratte, France
The Union China Office, China
The Union South-East Asia Office, India
Louis James de Viel Castel, Switzerland
Jean Luc Vol, France

15-year members
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E Jane Carter, USA
Chen-Yuan Chiang, Taipei, China
Asma El Sony, Sudan
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Anne Fanning, Canada
Paula I Fujiwara, USA
Ludwing Gresely Sud, Ecuador
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*Elected in Cancún, Mexico, 6 December 2009*
The International Union Against Tuberculosis and Lung Disease comprises:

- An Institute with five scientific departments, a network of region/country offices and headquarters in Paris.
- A Federation of members that governs the organisation through a General Assembly, which elects the Board of Directors. Organisations and individuals may join The Union and participate in the activities of its scientific sections and regions. Collaborating Centres are member organisations that collaborate with the Institute on specific projects.

* non-communicable diseases  **
EAG reports to the Board