Activity Report of the International Union Against Tuberculosis and Lung Disease

1 July 2002–31 December 2003
The International Union Against Tuberculosis and Lung Disease promotes lung health in middle- and low-income countries through technical assistance, education and research.
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Table of contents

2 Executive Director’s Summary
4 Message from the President
5 Partners in the Fight Against Lung Disease

8 SCIENTIFIC ACTIVITIES
9 Introduction
10 TECHNICAL ASSISTANCE
11 Malawi
13 FIDELIS
15 Myanmar
17 Democratic Republic of Congo
18 Highlights of Technical Assistance 2002–2003

22 EDUCATION
23 International Courses and Training
24 Highlights of Educational Programmes
26 Courses Offered 2002–2003
27 World Conferences
28 Regional Conferences
29 Publications and Resources

30 RESEARCH
31 Tuberculosis / Clinical Trials
32 Tobacco Prevention
33 Asthma
34 Child Lung Health
36 Health Policy
37 Scientific Publications

38 ADVOCACY AND COMMUNICATION
40 Tuberculosis
42 Tobacco Control
43 Communication

46 MEMBER ACTIVITIES
48 SCIENTIFIC SECTIONS
48 Officers
48 Bacteriology and Immunology
49 Nurses and Allied Professionals
50 Respiratory Disease and Child Lung Health
51 Tobacco Prevention
51 Tuberculosis
53 TB in Animals

54 AWARDS
56 BOARD MEETINGS AND GENERAL ASSEMBLIES

58 IN MEMORIAM

60 FINANCE AND ADMINISTRATION
In the 18 months covered by this Activity Report – 1 July 2002 through 31 December 2003 – the International Union Against Tuberculosis and Lung Disease has experienced unprecedented growth that has created many new opportunities and challenges.

Since 2002, we have seen the Union’s budget increase from US $10.6 million to US $18.325 million. This increase can be attributed to the ongoing support of longstanding donors such as the Norwegian Ministry of Foreign Affairs, the Swiss Development Agency and the French Ministry of Foreign Affairs – all of whom were instrumental in helping the Union develop the DOTS strategy in the 1980s and continue to play a critical role in the fight against TB today. Our growth is also a reflection of the expansion of the DOTS strategy, which, since its launch as a worldwide programme by the World Health Organization (WHO) in 1995, is now being implemented in most countries. Global recognition of the Union’s work has brought significant support from new sources, such as the Canadian International Development Agency (CIDA) and the Bill and Melinda Gates Foundation, in addition to increased funding from partners such as the United States Agency for International Development (USAID).

New initiatives

■ FIDELIS – the Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB – is a new programme administered by the Union and funded by a grant from CIDA. It is designed to make the DOTS treatment strategy accessible in every area where TB is found, no matter how poor or remote. During its successful first year, FIDELIS funded DOTS expansion projects totalling US $1.9 million in China, Kenya, Pakistan and Sudan.

■ The HIV/AIDS epidemic has received wide attention in the global media and in the affected countries. The increase in tuberculosis due to the HIV epidemic is less well known. It is now essential to find new approaches to tackle both of these diseases in a coordinated way. The Union – with a grant from USAID received in October 2003 – is piloting TB/HIV control projects designed to address this problem in several countries. The USAID grant also includes substantial funding to strengthen both laboratory networks in low-income countries and the Union’s tuberculosis clinical trials programme.

■ Asthma now affects 10–15% of the world’s population and, sadly, most of the asthmatics in low-income countries do not have access to essential asthma drugs. As a result, the Union has launched an initiative to improve access to good quality and affordable asthma drugs by creating an Asthma Drug Facility (ADF). Modelled after the successful TB Global Drug Facility, this initiative is being supported by other respiratory societies, the WHO and Médecins Sans Frontières (MSF).

Technical assistance and education

■ In addition to these new initiatives, in 2003 the Union offered technical assistance to TB programmes ranging from brief consultancies to multi-year project management assistance in 53 countries, benefiting hundreds of thousands of TB patients, their families and communities.
Our education programme continues to be very active. During this reporting period we offered more than 30 courses and workshops designed for people working at all levels of health care in 19 countries.

For many members, the courses and workshops offered at Union conferences are critical to their professional fulfilment and to the development and success of their TB control and other programmes. The World Conferences on Lung Health in Montreal (2002) and Paris (2003) were very well attended. The Union regional conferences, such as the Latin American Region Conference in 2002 and the Eastern Region Conference in 2003, also play an important role in the sharing of ideas and information.

To expand our worldwide dissemination of knowledge about the epidemiology of tuberculosis and lung diseases, programmatic issues and research, the *International Journal of Tuberculosis and Lung Disease* is now available online, and key articles and special editions have been produced in French, Russian and Chinese.

Collaborations

An important role of the Union is to actively participate in global networks that share our goals and to foster new initiatives. The Union supported the creation of TB Alert, an organisational member that is now a strong tuberculosis advocate in the UK. The Union also works closely with the International Non-Governmental Coalition Against Tobacco (INGCAT), which played a crucial role in seeing the Framework Convention on Tobacco Control adopted by the World Health Assembly in 2003.

The Union is a founding member of the Stop TB Partnership. Since its launch at our World Conference on Lung Health in Bangkok in 1998, we have participated on the Board and in most of the Working Groups. From March to mid-October 2003, I served as Acting Executive Secretary while the Board sought a replacement for the former Executive Secretary, Dr Jacob Kumaresan, The creation of the TB Global Drug Facility (GDF) has been one of the Partnership’s major achievements. Dr Paula Fujiwara from the Union serves on the GDF’s Technical Review Committee, and Union consultants have participated in several GDF country missions.

In order to improve collaboration with member associations and governments in South East Asia, the Union has opened a Resource Centre in New Delhi, India. This Centre will play an important role in producing and disseminating educational material for the region and beyond.

What’s ahead

In the coming year, the Union will continue to strengthen tuberculosis programmes through technical assistance and educational activities, including the publication of our journal and technical guides. In addition, 2004 will see the roll-out of the laboratory strengthening programme and the establishment of collaborative TB/HIV projects in several countries. Innovative new approaches to reaching the poorest communities affected by tuberculosis, supported by FIDELIS, will play a crucial role in many countries’ efforts to achieve the 2005 WHO Global TB targets. We will also advocate for expansion of the Child Lung Health project, which has shown such outstanding results in reducing case fatalities from pneumonia among children under five in Malawi. Tobacco use, a major public health problem worldwide, continues to concern us and we will pursue the development of tobacco prevention messages and cessation activities amongst health care services in low-income countries.

Thank you for supporting our efforts to combat TB and lung diseases around the world. I hope to see you at one of our regional conferences or at the World Conference, where we can exchange experiences and continue to develop new approaches to promoting global lung health for all. Your ongoing support and collaboration are vital to our success.

Niels E Billo, MD, MPH
In October 2002, the Board of Directors and General Assembly of the International Union Against Tuberculosis and Lung Disease decided to return to a calendar-year fiscal reporting system. Consequently this activity report covers an 18-month period from 1 July 2002 to 31 December 2003.

As you will appreciate from this report, the past 18 months have been an extremely busy and productive time for the Union, with greatly increased activity in many areas of lung health. I would like to take this opportunity to thank our Union members and the many donor agencies, foundations and benefactors for their contributions supporting our efforts and for their commitment to improving lung health around the world. Without the loyal support and participation of our members, in particular, the Union’s work would not be possible.

Each year our World Conference offers an opportunity for all of us associated with the Union to come together and assess how we are doing in the fight against tuberculosis and lung disease. What have we achieved? Where are we in relation to the World Health Organization’s targets of detecting 70% of smear-positive tuberculosis cases and curing 85% of them by 2005? During this reporting period, we held two very successful World Conferences on Lung Health: one in October 2002 in Montreal, which was highlighted by the participation of Canada’s Minister for International Cooperation, Right Honorable Susan Whelan, and one in October 2003 in Paris, which brought together more than 1,500 participants from some 120 countries. Both events were informative and thought-provoking and sent us all back to work reinvigorated and ready to redouble our efforts to succeed.

The Union has played a key role in the Stop TB Partnership since its inception. It is fundamental to the whole concept of the Union that we can only achieve our goal of better lung health for all if we work together, strengthen our collaborations and share our resources.

In another collaborative effort, the Union has also actively supported the International Non-Governmental Coalition Against Tobacco (INGCAT). This group and its former director, Yussuf Saloojee, contributed to the adoption of the Framework Convention on Tobacco Control (FCTC) by the World Health Assembly in May 2003. The consequences of tobacco use represent one of the most serious public health problems facing the world today, and the Union is dedicated to reducing the burden of death and disease it causes.

Finally, I would like to thank the Union Secretariat for its hard work during my term as President. It has been a great pleasure to serve you. I would also like to wish my successor, Dr Asma El Sony, all the best as President of this very committed organisation, the Union.

Prof Anne Fanning
President, 2000–2003
Partners in the Fight Against Lung Disease

The International Union Against Tuberculosis and Lung Disease collaborates with a wide variety of partners, including donor agencies, universities, government departments, and non-governmental organisations (NGOs) around the world. Reports on some of our significant collaborations in 2002–2003 follow.

The Stop TB Partnership

Stop TB is a global partnership to accelerate social and political action to stop the spread of tuberculosis. The Union was a founding member in 1998, and since then more than 300 organisations have joined.

The Stop TB Partnership has set goals that go beyond the World Health Organization (WHO) 2005 targets that aim to detect 70% of all smear-positive tuberculosis cases and cure at least 85% of them. Stop TB’s goal for 2010 is to reduce the prevalence of TB – and deaths from it – by 50% compared with the 2000 levels. By 2015 we would like to see a decrease in the incidence of TB throughout the world.

To achieve these targets, the Partnership has set the following mission:

■ ensure that every patient has access to free TB treatment and cure
■ stop the transmission of TB
■ protect vulnerable populations from TB
■ reduce the social and economic toll that TB exerts on families, communities and nations

The Union is actively contributing to the Partnership through its technical assistance, education, research and advocacy programmes. Members of the Union staff have also participated in numerous activities of the Partnership, notably the Executive Director who served the Stop TB Partnership Secretariat as Acting Executive Secretary from 1 March to 15 October 2003.

The Union contributes to the DOTS Expansion Working Group, the DOTS Plus Working Group and the Green Light Committee. We also advocated strongly for a sub-group on Paediatric Tuberculosis and a Working Group on Advocacy and Communication, both of which have been now been endorsed by the Stop TB Coordinating Board.

The Union has also played an important role in the development of an important new partner, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which has a memorandum of understanding with the Stop TB Partners. Union staff helped develop the structure and function of the GFATM, and Dr Paula Fujiwara, Deputy Executive Director of the Union, is one of four TB experts on the Technical Review Panel. This new funding mechanism offers much promise and the Stop TB Partners are eager to see it succeed.

The Stop TB Partnership is constantly striving to improve its performance and define new goals for the years to come. The Second Ad Hoc Committee on the TB Epidemic has identified several points that need to be addressed urgently if we are to succeed in reducing the global burden of TB. These include improving health infrastructures, strengthening the role of primary care providers, enhancing the collaboration between TB and HIV/AIDS services, seeking contributions from the corporate sector, alleviating poverty and adopting equity initiatives. The WHO has been asked to increase its core budget funding for the Stop TB Department significantly to reflect its stated commitment to tuberculosis. ■
The Norwegian Heart and Lung Patients Association (LHL)

The Union has collaborated for several years with the Norwegian Heart and Lung Patients Association (LHL) in Nepal, Sudan and Senegal. As a patient organisation, LHL offers the substantial experience it has gained in tuberculosis treatment in Norway to other countries. Nepal and Sudan now figure among the world’s model National Tuberculosis Programmes (NTP), and Senegal has also made significant improvements in its case finding and success rates in recent years.

Collaborations of organisations such as the Union and LHL and an NTP are always beneficial. The dialogue with a country about technical and policy issues leads to improvements, adaptations of the DOTS strategy to the specific country’s situation and synergies among all the partners involved. With support from the Norwegian Agency for Development Cooperation, LHL has been able to raise funds to support these countries for many years. To achieve and maintain positive results in tuberculosis control, this kind of constant support is critical, and LHL’s recognition of that fact has been instrumental to the success of these country partners and of the Union.

DOTS: The Union Provides Key to Global TB Control

The strategy for tuberculosis control that has become known all over the world as DOTS was originally conceived by Dr Karel Styblo, late Director of Scientific Activities for the Union, in the course of his pioneering work for the Tanzania National Tuberculosis Programme in the 1980s. The plan for tuberculosis control that Styblo outlined was adopted by the World Health Organization in 1995 and branded DOTS: Directly Observed Treatment, Short Course.

Sometimes referred to as the IUATLD Model, or the Tuberculosis Model, the DOTS strategy has five essential components:

- government commitment to sustaining TB control activities
- case detection by sputum smear microscopy
- standardised regimens of 6 – 8 months’ treatment with proper case management and directly observed treatment (DOT) for at least the initial two months
- regular uninterrupted supplies of essential TB drugs
- standardised recording and reporting.

Over the past decade the DOTS strategy has been implemented in more than 102 countries, and by World TB Day March 2003, it had been administered to 10 million patients.
The Tuberculosis Coalition for Technical Assistance (TBCTA)

The Tuberculosis Coalition for Technical Assistance (TBCTA) was established in 2000 as a USAID-supported project executed through a unique partnership of six organisations that are actively involved in global TB control. They are the Union, the KNCV Tuberculosis Foundation, the WHO, the American Lung Association, the American Thoracic Society and the Division of Tuberculosis Elimination of the Centers for Disease Control and Prevention (CDC). The purpose of TBCTA assistance is twofold. First it is meant to improve and expand the capacity of USAID to respond to the global TB epidemic by providing state-of-the-art, contact-appropriate, technically sound and cost-effective consultation and technical assistance to high-incidence countries and USAID missions. In addition, it complements and expands existing global TB control efforts, such as the Stop TB Partnership, the programmes of WHO and the activities of individual TBCTA partners. The ultimate goal is to work in collaboration with other global TB partners to accelerate the pace of DOTS expansion in order to meet the global targets.

Funds are given for core activities, such as programme management, initial visits to countries where assistance might be needed and training and courses. Field support is provided to carry out specific scopes of work in each country. The funds for field support from TBCTA have risen from US $1 million in FY 2001 to US $8.4 million in FY 2003, of which $3.5 million were managed by the Union. During the reporting period, the TBCTA has supported 18 courses, four regional workshops on DOTS Expansion, World Conferences, the two held in Montreal and Paris, and the two regional conferences that were held in Uruguay and Nepal. Funding from TBCTA has also supported nursing activities in Brazil, the technical assistance programmes in Senegal and the Democratic Republic of Congo, and clinical trials.

Forum of International Respiratory Societies (FIRS)

The Union is a founding member of the Forum of International Respiratory Societies (FIRS), which was established in 2002 on an initiative by Adam Wanner, then president of the American Thoracic Society. The goal of the Forum is to unite advocacy efforts for lung health. Other founding members include the American College of Chest Physicians, the Asian Pacific Society of Respirology and the Latin American Thoracic Society. The first meeting, held in Lausanne in January 2003, identified the following areas of activity: to encourage respiratory societies from low-income countries to join FIRS; to support the Framework Convention for Tobacco Control, the Stop TB Partnership and the Practical Approach to Lung Health (PAL); and to study the biomass-fuel impact and its relationship to lung health.

Activities to date include establishing a budget shared by all founding organisations and sending a letter to the World Asthma Meeting suggesting more clinical content. FIRS plans to meet twice a year to discuss issues of mutual interest for the participating organisations. The leader in 2003 was Anne Fanning, President of the Union.
Regular collection of data and accurate record keeping are critical to the success of the DOTS strategy for TB control.
The International Union Against Tuberculosis and Lung Disease provides technical assistance, offers education programmes, and conducts research studies in the areas of tuberculosis control, child lung health, control and prevention of tobacco use and the management of asthma in low-income countries. A new division to support the work of nurses and allied professionals was formed in January 2003.

During the reporting period 1 July 2002 to 31 December 2003, the Union provided these services in a total of 53 countries: 24 in Africa, 3 in Europe, 15 in Latin America, 10 in the Eastern Region and 1 in the Middle East.

- 38 countries received technical assistance
- 13 countries received intensive technical assistance
- 28 countries participated in research studies
- 4 countries received FIDELIS support
- Education programmes were held in 19 countries
The Union offers technical assistance in lung health to governments, associations and professional groups. Services are provided at the request of a partnering organisation or agency on a cost-recovery basis. Priority is given to managing lung conditions that exact the heaviest toll in low-income countries: tuberculosis, pneumonia in children under five, asthma and the consequences of tobacco use.

While in the past most of the Union’s activity focused on TB, technical assistance in the areas of child lung health, asthma management and tobacco prevention is also showing strong results. The new division for nursing will further broaden the impact of our technical assistance programme.

The Union offers three levels of technical assistance:
- Intensive — in which the contracting agency requests long-term support;
- Contractual — which is limited to specific, usually short-term, tasks; and
- Other related activities.

FEATURED PROJECTS
This report includes stories on four different successful technical assistance projects:
- The Malawi Child Lung Health Project, which has applied standard case management to childhood pneumonia;
- The first year of FIDELIS, an innovative DOTS Expansion initiative;
- Progress in Myanmar, a country that is about to reach the WHO 2005 TB targets; and
- Progress in the Democratic Republic of Congo, which, despite seemingly insurmountable obstacles, is becoming one of the world’s TB success stories.

OTHER HIGHLIGHTED PROJECTS FROM 2002–2003
- Nigeria
- Senegal
- South Africa
- Sudan
- Uganda
Saving Children’s Lives in Malawi

There aren’t as many birthdays as there should be in the small African country of Malawi. About 20% of all children born here die before they reach the age of five, and half of those deaths occur in the first year of life.

Pneumonia is a leading cause of death among children in Malawi, second only to malaria. On any given day, according to a recent demographic health survey, 27% of all children under five are ill with cough or experience short, rapid breathing.

Pneumonia accounted for 18% of Malawi’s hospital admissions in 2000 and, in many district hospitals, more than 26% of hospitalised children died from it. The highest prevalence of pneumonia — and death from it — occurs among children less than one year old.

“There are a lot of children dying in Malawi,” said Mrs Rachel Maganga, Programme Manager of Malawi’s Acute Respiratory Infection Programme. “We have one of the highest childhood mortality rates in Africa. Everyone in the country wants to do something about it.”

THE UNION ASKED TO HELP SOLVE THE PROBLEM OF PNEUMONIA

To combat this problem, in 1994 the Government of Malawi asked the Union for technical support to help improve child lung health. The Union already had a solid history of experience in the country through its successful tuberculosis programme, which was introduced there in 1985.

“The Union had a lot of credibility,” said Prof Robert Gie, Professor of Paediatrics at Stellenbosch University in South Africa. “They had been involved in Malawi for a long time and they knew all the players. Their credentials had already been established.”

MODEL OF CARE USED FOR TB PROVES SUCCESSFUL WITH PNEUMONIA

The Union’s model of technical assistance is based on its very effective tuberculosis control programme, which involves training health care staff in standard case management, ensuring adequate stocks and uninterrupted supply lines of drugs and laboratory materials, programme supervision and monitoring through consistent data collection and analysis, accountability and transparency, and regular external evaluation. The Union has successfully introduced this model into many existing government health delivery systems in developing countries, and it is the basis of the World Health Organization’s DOTS strategy.

“We knew that we could apply this model of health service delivery to child lung health in Malawi by implementing it on paediatric wards at the district hospital level and focusing on those children most at risk of dying,” said Penny Enarson, the Union’s consultant to the Child Lung Health Project. “We were sure that standard case management of children with pneumonia by trained staff with a regular supply of effective antibiotics would result in a significant decline in deaths.”

But implementation of a countrywide programme such as this costs a great deal of money, and the Union — which relies on grants and funds from more affluent organisations and governments— struggled for five years to secure funding for the project.

“From 1994 to 1999 we tried to get funding to start the model, without any success,” said Penny Enarson. “Then we sent a proposal to the Bill and Melinda Gates Foundation. Malawi was in a priority region for the Gates Foundation, and they quickly made a grant of $1.93 million to launch the Child Lung Health Project, beginning in 2000. They have been a wonderful supporter.”

With Gates Foundation funding in hand, staff of the Ministry of Health could begin with the project. Working in collaboration with Drs Peter Kazembe and Charles Mwansambo, paediatricians in the government health services, they began to implement the programme within the framework of existing policies and procedures, and selected five district hospitals as pilot sites. In September 2000, the project recruited faculty and began training clinical practitioners and senior nurses in standardised management of severe and very severe pneumonia, asthma, HIV-related lung disease and tuberculosis. A data monitoring and information system was introduced to promote a culture of data generation and use.

“One of the benefits of standard case management is a rational use of drugs,” said Penny Enarson. “Many people think, because we advocate the use of antibiotics, that their use will increase. But it actually declines in a programme like this because standard case management eliminates the use of antibiotics for children presenting with just a cough or a cold. By using a simple guideline based on clinical signs, health workers can be more discriminating in deciding which child with cough should be given an antibiotic.”

CASE FATALITY REDUCED BY AN AVERAGE OF 40% IN FIRST YEAR

Data collected in the first year in the five pilot districts found that, even in a short time, these district hospitals had reduced their case fatality rate for pneumonia by an average of 40% over the estimated baseline rate.

“This was a remarkable achievement in the face of widespread HIV infection, cutbacks in health service funding and an extreme shortage of staff,” said Penny Enarson. “It showed that the programme could be successful.”

Training was expanded to five additional districts in 2001 and six more in 2002. The programme became so highly regarded by Malawi’s Ministry of Health and Population that the
Deaths from pneumonia have decreased dramatically in Malawi

Minister of Health presented it as one of that year’s success stories when he addressed parliament in June 2002.

By the end of 2003, the Child Lung Health Project had been expanded throughout Malawi, and the countrywide results—in terms of both children treated and lives saved—were dramatic.

“At the beginning of the programme, the number of children actually completing treatment was very low, around 50%,” said Penny Enarson. “Over the past three years we have seen a gradual increase, and we are now seeing completion rates as high as 80% in some hospitals.”

“The case fatality rate for children hospitalised with severe and very severe pneumonia averaged 26% when we started. We thought it would be really something if we got that rate below 10%, and we’ve achieved that. In some places, it’s down below 5%. We now think that we will probably get it below 5% countrywide by the time we have completed the project. That is quite an accomplishment.”

**SUSTAINABILITY WILL BE THE CHALLENGE**

The biggest challenge facing any grant-funded project is sustainability. One of the primary goals of the Child Lung Health Project’s coordinators is to ensure the life of the project by strengthening the management and technical capacity at central and district levels of the Ministry of Health.

“One of the most important marks of the success of this programme is that it has now been completely taken over by the Malawians,” said paediatrican Robert Gie. “They completed a two-week review by a team of international professionals, and next year Penny Enarson will only go back to Malawi to advise. After that, the Malawians are on their own.”

But will one of the poorest and least developed countries in the world have the resources, capability—and the will—to carry on the Child Lung Health Project once outside support comes to an end in December 2004? Can Malawi’s African neighbours—equally resource-poor—implement similar programmes in child lung health?

“In a just and right world, all African countries—indeed, all developing countries—should be able to sustain a programme like this,” said Penny Enarson. “But in the real world, the one we live in today, they won’t be able to do it without outside assistance.”

While sustaining a self-sufficient national health programme for respiratory diseases in children may be difficult, the Child Lung Health Project has demonstrated that this approach to the management of children with pneumonia can work in a small, developing country with limited resources. This important lesson can serve as a model for other countries in Africa, and for other regions of the developing world. “Malawi is not the only country that is having a problem with pneumonia in children,” said Rachel Maganga. “It is a global problem. We have shown that introducing standard case management to district hospitals is feasible and successful. We hope that our experience can help other countries save lives.”

**Union Consultant:** Penny Enarson

**Funding Agency:** Bill and Melinda Gates Foundation with the International Tuberculosis Foundation (ITF)

**Local Partners:** Acute Respiratory Infection Control Programme, Ministry of Health and Population, Malawi
FIDELIS Funds Innovative Projects in Its First Year

Millions of people throughout the world still have very limited access to health care, blocked by the barriers of poverty or geography from receiving the treatment they need and deserve. Three people die from tuberculosis somewhere in the world every minute, and countless others who could otherwise be treated and cured are contracting and spreading the disease each day.

But a new initiative — conceived by the Stop TB Partnership, hosted by the Union, and funded by the Canadian International Development Agency (CIDA) — is reaching out to remote areas of the world to expand the DOTS strategy and facilitate tuberculosis treatment and cure for those who otherwise have no access to health care.

PLATFORM FOR INTERNATIONAL PARTNERSHIP

A unique platform for international partnership, the Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB (FIDELIS) marshals community action, technical support and funding for innovative programmes to control TB. Its goal is to prevent more than 1,000,000 new TB infections and avert more than 10,000 deaths each year. More than 150 million people are expected to benefit in the first years of the project.

“The objective of FIDELIS is to support TB control activities that use the DOTS strategy in innovative ways,” said Prof Donald Enarson, the Union’s Scientific Director and coordinator of the project. “Ultimately we hope to see the projects increase detection of new smear-positive cases and, at the same time, maintain high cure rates among people who would not otherwise receive modern TB treatment.”

SOLUTIONS TO TB CONTROL LIE WITHIN THE COMMUNITIES

The philosophy of FIDELIS is that the solutions for addressing the constraints to DOTS expansion lie within the affected communities. During its first year, FIDELIS funded DOTS expansion projects totalling US $1.9 million in China, Kenya, Pakistan and Sudan. The National Centre for TB Control and Prevention (NCTB) and the Chinese Centre for Disease Control and Prevention in Beijing received funding for three projects that began on 1 October 2003:

- In Gansu, a remote area of western China that has the lowest GDP per capita in the country, TB case detection is being improved by providing for sputum collection at the village level. This is a step towards decentralised free diagnostic services. By 31 December 2003, 16,000 village doctors in 1,063 townships and another 350 medical/paramedical staff had been made aware of DOTS principles and the project. In the
first two months of the project, 1,299 smear-positive cases were detected, which was 85% of the targeted number.

- **In Hubei**, the project is designed to provide a new approach to hospital/TB dispensary collaboration. Hubei is a mountainous province in southern China where one-third of the 60 million people live below the poverty line. Although DOTS has been in place for 10 years in Hubei, many patients defaulted during the time between diagnosis and treatment. Of the 57% of TB cases diagnosed in county general hospitals, only 22% made it to the referred county TB dispensary. Goals of this project are to increase new smear-positive case detection from 22 to 38 per 100,000 population by improving access to sputum microscopy services; to ensure that 90% of patients are referred from the hospital to the dispensary for treatment; to establish sputum microscopy units in 40 county general hospitals; and to increase the cure rate to 85% or more. In the first three months of the project, new sputum microscopy examination facilities were put in place that will operate under a new systematic laboratory quality-assurance system. In addition, some 170 medical and paramedical staff and 80 laboratory technicians were trained. Case detection in the first two months exceeded the target of 1,409 by 3%.

- **In southern China’s Hunan Province**, more than 80% of its 65.32 million people live in agricultural areas. A weak referral system, difficult terrain and a poor economy contribute to the lack of access to health care services. Only 43% of the population is aware of TB control measures and less than 5% seek initial care at the local TB dispensary which is mandated to provide free diagnostic and treatment services. The goals of this one-year project are to detect an additional 3,200 smear-positive cases through a strengthened referral system; to ensure that 90% of TB suspects are successfully referred from hospitals to the TB dispensaries; and to develop national guidelines for referrals. In the first quarter of the project year, more than 400 medical and paramedical professionals were trained; government orders enforcing the perceived referral system were issued; and 1,328 chest symptomatics were screened.

Other projects that have been approved for funding by FIDELIS will begin on 1 January 2004. They include an additional project in China, two in Pakistan and one each in Sudan and Kenya. Target results for the eight projects include the cure of approximately 51,000 smear-positive TB patients and prevention of some 500,000 new infections and more than 7,700 deaths.

**EXCELLENT RESULTS FOR FIRST YEAR**

“One of the strengths of FIDELIS is the efficiency with which the programme works,” said Don Enarson. “We are very pleased to have so many projects up and running in the first year.”

Proposals are screened and evaluated by an independent Proposal Review Committee (PRC) within one month of submission, and approved proposals receive funds about two months after the PRC has made its recommendation.

Another important feature of FIDELIS is that it is results-driven. Financial support is accompanied by comprehensive services to applicants and recipients, including assistance in formulating and refining proposals; timely disbursal of funds to approved projects; and technical support, such as technical advice, training, implementation counselling and assistance in monitoring projects in the field. The Global Contracts Director visits project sites at the start of each project to finalise the work plan and sign the contract, and staff of FIDELIS follow up with regular visits to guide and monitor implementation of the work plan. For more information about FIDELIS and the submission of proposals, visit [www.fidelistb.org](http://www.fidelistb.org) or e-mail [fidelis@iuatld.org](mailto:fidelis@iuatld.org)

Union Consultant: Prof Donald Enarson, FIDELIS Coordinator
Funding Agency: Canadian International Development Agency (CIDA)
Myanmar Closing in on 2005 Targets

Despite being one of the poorest and most isolated countries in the world, Myanmar is on schedule to reach the Global Plan to Stop TB’s goal of detecting 70% of smear-positive TB cases and curing 85% of them by 2005.

How does one of the poorest of the world’s 22 high-burden countries manage to have such a successful TB programme? Government commitment and a strong health infrastructure are the answer, according to a recent review of Myanmar’s National Tuberculosis Programme (NTP).

Myanmar’s Ministry of Health has identified tuberculosis as being second only to malaria as a health priority, and the minister himself chairs the central TB supervisory committee. There is direct ministerial involvement in TB programme reviews and strong participation in World TB Day. Tuberculosis
control is managed at the township level — average population of 130,000 — and TB treatment is supervised by trained volunteers at rural health centres and in patients’ homes.

DOTS COVERAGE EXPANDS BY 24% IN THREE YEARS

In March 2003, a joint review team from the World Health Organization (WHO) and the Union visited Myanmar’s NTP and found its work to be outstanding. The DOTS strategy covered 88% of the population in 2002, up from 64% in 1999. At the time of the review, DOTS services had been implemented in 259 out of 324 townships. Case finding had consequently improved greatly over the past four years, with the estimated smear-positive case detection rate rising to 73% in 2002, in excess of the 70% target. Treatment success in the 2001 cohort was 81%, about the same as it has been since 1996. The principal obstacle to reaching the 85% target is the 10% default rate.

According to the review team’s report, the central NTP staff is meticulous in its adherence to the principles of the DOTS strategy. Its drug and diagnostic supply management, case finding, treatment, recording and reporting and evaluation of programme performance were also of the highest quality.

In addition, the review team found that Myanmar’s health care system has a strong administrative structure, and the government’s commitment to the TB programme is high, with infrastructure and staff costs borne entirely by the national budget.

UNION ASSISTANCE IMPROVES LABORATORY NETWORK

“Viet Nam will probably be the next of the 22 high-burden countries to reach the 2005 Global Plan targets,” said Union Executive Director Dr Nils E Billo, who participated in the review with Dr Hans L Rieder from the Union and Dr G R Khatri and Dr Holger Sawert from the WHO.

The Union/WHO review focused on two issues: developing procedures to support the national tuberculosis laboratory network and reaching a consensus on anti-tuberculosis medications and treatment regimens. The team also looked at the functioning of the NTP in selected health care facilities in Yangon.

One significant problem facing Myanmar has been the age of its laboratory equipment. Although it has been carefully used and maintained, its outdated equipment, such as monocular microscopes, should be replaced, according to the review team. As a result, the Union arranged for the purchase of new binocular microscopes and other equipment and supplies to upgrade the National Tuberculosis Reference Laboratory and to increase the capabilities of the microscopy network across the country.

The Union also arranged the purchase of much-needed vehicles to address another serious problem, transportation, so that staff responsible for supervising the quality control of case-finding and treatment activities can reach rural clinics.

GLOBAL DRUG FACILITY HELPS SOLVE CHALLENGE OF DRUG SUPPLY

Until recently, maintaining an uninterrupted supply of TB drugs had been a challenge for Myanmar. In 2001, the Global Drug Facility (GDF) committed to providing 80% of the total anti-TB drug requirements for DOTS in the country. This support is available for two years and may be extended thereafter.

Myanmar had been using an intermittent treatment regimen throughout the country, and the NTP was initially uneasy about implementing the GDF’s preferred six-month, rifampicin-throughout treatment regimen, given in the form of daily fixed-dose combinations. They were concerned about the impact of daily treatment on the workload of health care workers, as well as on patient compliance. After discussions with the review team, the National Technical Advisory Group reached a consensus on using the GDF approach. It will also test the feasibility of a directly observed daily regimen versus a directly observed daily intensive phase followed by an intermittent continuation phase, before reaching a final decision on the implementation of the revised treatment regimens.

Another significant challenge that Myanmar faces is staff recruitment and retention. Its vacancy rate is high and includes a number of crucial laboratory positions. To help strengthen the NTP staff’s skills and capacity, the Union conducted a course in operations research for 10 selected staff members in Yangon from 1 to 12 December 2003.

According to Nils Billo, the Union plans to continue its support of the TB programme in Myanmar, with particular emphasis on TB/HIV issues. “Myanmar demonstrates that commitment and thoroughness can contribute to the success of DOTS, even under the most difficult circumstances.”

Union Consultants: Dr Hans L Rieder, Dr Nils E Billo
Local Partner: National TB Control Programme, Myanmar
Against the Odds, Democratic Republic of Congo Is Succeeding

The Democratic Republic of Congo (DRC) is a vast country — almost the size of a continent — with problems just as large.

Its 50 million inhabitants have one of the lowest per capita incomes in Africa, and the government’s annual expenditure for health is less than US $5 per inhabitant. Nearly one in four children dies before reaching the age of five, and the average life expectancy for those who do survive is only 45 years.

The problems confronting the Congo’s health care system are daunting. The country’s communication systems are extremely dilapidated and its roads turn into marshy quagmires during the rainy season. Small villages are difficult to reach at any time of year. To make matters worse, the Congo has been wracked by civil war for most of the past 40 years.

UNION ASSISTANCE RANGES FROM TRAINING TO TRUCKS

Despite these seemingly insurmountable obstacles, the Democratic Republic of Congo is becoming one of the world’s TB success stories. Since 2001, the DRC Ministry of Health has entrusted monitoring of its tuberculosis programme to the Union, acting on behalf of the Stop TB Partnership. In addition, the Union is providing technical assistance in the form of laboratory and office equipment, training of personnel, purchase of vehicles, with financial assistance from the Tuberculosis Coalition for Technical Assistance (TBCTA).

“The Congo is an amazing place,” said Prof Donald Enarson, the Union’s Scientific Director. “It is a country that has been caught up in civil war for almost 40 years. At times, the government barely functions. Yet TB services are expanding even in the war-torn provinces — although some people have to go to the clinic during the night, when the shooting stops, in order to take their medicine.”

The Democratic Republic of Congo currently ranks twelfth on the list of the world’s 22 high-burden countries. The National Tuberculosis Programme (NTP) was established in 1980, and today a variety of NGOs and funding agencies are active in the country. As a result, major strides have been made:

■ 70% of the population had access to DOTS by the end of 2002, despite ongoing civil strife in many provinces.
■ Case notifications have been steadily rising due to improved case finding.
■ The case detection rate in 2002 was 55%, surprisingly high for a country with an underdeveloped primary care system and difficult access to health services.
■ Treatment success was 78% in the 2001 cohort, with a default rate of 10%.
■ Monitoring and supervision have shown marginal improvements, aided by better Internet and telephone connections as the overall telecommunications system is strengthened.

■ Recording and reporting have improved through two Internet connections in provincial coordination units.
■ A proposal has been made to install an electronic register for TB data. Provincial interagency coordinating committees (locally called TB Task Forces) were created in some provinces, and quarterly meetings are being held in provincial coordination units.
■ TB Task Forces are being established in the remaining 18 provincial coordination units.
■ World TB Day 2003 was commemorated in 20 provinces.

“It is hard to believe that they have been able to do something to develop health services in a country whose TB control programme did not have a telephone, or a fax or even a proper roof over the office not long ago. Yet the Congo’s tuberculosis programme is remarkable.”

Prof Nadia Aït-Khaled, Union consultant

Secondary school students support World TB Day in Kinshasa
South Africa Shows Progress

Tuberculosis continues to be a major public health problem in South Africa, with an estimated burden of 226 new smear-positive cases and 556 total cases per 100,000 population. With its high rate of HIV infection, South Africa is particularly vulnerable to a growing TB/HIV epidemic.

In October 2003, at the invitation of the South African Tuberculosis Control Programme, a joint WHO/Union/KNCV Review Team visited South Africa to evaluate the programme in the context of the five elements of the DOTS strategy.

The team found that the DOTS strategy is now being implemented in 182 of 183 districts in South Africa, and standardised short-course treatment regimens with fixed-dose combination tablets are being applied everywhere.

Despite widespread DOTS implementation, direct observation is not guaranteed and self-administration occurs in many places. The treatment success rate is still low, with high treatment interruption and transfer-out rates. There is no tracing of primary defaulters and hardly any tracing of treatment interrupters.

The national government and eight of the country’s nine provinces have now developed medium-term development and action plans for tuberculosis control, but there is no specific budget line for tuberculosis at either the national or provincial levels. South Africa still does not have a tuberculosis programme manual that clearly outlines policies and technical aspects.

Staffing at national level has been increased, but in the provinces there is often insufficient staff to guarantee quality TB control. At many facilities, the staff is overburdened and there is a high turnover rate. Access to smear microscopy in some remote areas is not guaranteed, and there is no monitoring according to international standards.

A recent drug resistance survey found that the number of MDR-TB patients is increasing, primarily as a result of the unsatisfactory treatment of new cases and an unacceptably high treatment interruption rate among confirmed MDR-TB patients.

Overall the team found that, while clear progress has been made since the last review in 2002, the programme still has many significant problems to overcome and critical issues that need urgent attention.

Union Consultants: Dr Chen-Yuan Chiang, Prof Don Enarson
Funding Agency: USAID and the Union
Local Partner: South Africa National TB Programme

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HIGHLIGHTS OF TECHNICAL ASSISTANCE 2002–2003

A young MDR-TB patient, Cape Town.
New National Tuberculosis Programme in Lagos State, Nigeria, Makes Promising Start

A modern National TB Programme was launched in Lagos, Nigeria in January 2003 and has witnessed rapid growth in its first year, thanks to the unfailing support of Dr Leke Pitan, Commissioner for Health of Lagos State; Dr Jide Idris, Permanent Secretary of Health; and Dr Margaret Williams, Lagos TB Control Programme Officer.

The new programme was designed using the classical components of the DOTS strategy: case detection by sputum smear microscopy, regular and uninterrupted drug supplies, directly observed treatment during the first two-month intensive phase of treatment, and case recording and reporting.

Lagos is home to 10 million people and the former capital of Nigeria. For strategic reasons, and to achieve the maximum effect within a minimum of time, the new programme was launched in the five principal hospitals, where the majority of tuberculosis patients already go for treatment. The participation of at least one primary health care centre per hospital was requested, and the programme was initiated with a total of 11 health facilities participating.

In less than one year, more than 4,000 tuberculosis cases were detected, of which 73% were smear-positive.

By using the addresses of TB patients registered at the facilities involved in the programme, the NTP identified new health facilities for extending the programme. Plans are to bring in an additional five hospitals and six primary health care centres in the first quarter of 2004.

Union Consultant: Dr Arnaud Trébucq
Funding Agencies: The Union, CIDA, TB Global Drug Facility (GDF), Ministry of Foreign Affairs, France
Local Partner: Lagos TB Control Programme
Senegal Is Making Progress

In 2003, at the request of the National Tuberculosis Programme (NTP), the Union returned to Senegal to monitor its progress in TB treatment and control. The Union has been involved with Senegal’s anti-tuberculosis efforts since 1984. The NTP in Senegal has also been receiving intensive and financial support from the Norwegian Heart and Lung Patients Association (LHL) since 1986.

Important improvements have been made over the past 12 months in NTP organisation and Central Unit monitoring. A particular commitment was made by the Ministry of Health since the last review in 2001 to provide extra support to the NTP Central Unit. Staffing has also increased, with two new doctors and two technicians joining the central unit. In another positive development, Senegal has signed a contract with USAID for technical assistance, and initial funds have arrived.

Senegal’s NTP is organised at the health centre level in all regions of the country, and more than 5,600 cases of smear-positive pulmonary tuberculosis were detected in 2003. Senegal nevertheless still has a long way to go to reach the 2005 WHO Global Targets. Diagnosis and treatment have not improved over the past year: the cure rate is still less than 60% and the rate of people defaulting has reached 26%. These results can be attributed to the fact that directly observed treatment is not yet well organised at the health centres, decentralisation has not been managed successfully in some districts and supervision at all levels needs to improve. In addition, regional and district head doctors need to be more involved in meeting the NTP’s goals.

However, if energetic measures can be taken to address these challenges and difficulties, the Union consultant felt that quick progress should be possible, thanks to the new positive developments in Senegal’s NTP.

Union Consultant: Prof Nadia Aït-Khaled
Local Partner: National Tuberculosis Programme, Senegal
Funding Agencies: USAID-Dakar office via TBCTA, LHL and the Union

Sudan Focuses on Building Quality

Sudan is the largest country in Africa, with terrain ranging from vast expanses of desert in the north to tropical jungles in the south. For nearly 40 years, the country has been torn by civil war.

Although Sudan is not one of the 22 high-burden countries, TB and TB control have been significant challenges. Thanks to the leadership of Dr Asma El Sony of Sudan’s National Tuberculosis Programme, DOTS services were started initially in refugee camps, and the NTP began to forge a network of TB services across the country. Since 1995, the Norwegian Heart and Lung Patients Association (LHL), with technical assistance from the Union, has supported these efforts, and the country celebrated its DOTS ALL OVER status in January 2003.

The activities of the Union are focused on helping Sudan improve the quality of its DOTS programme. In February 2003, Dr Armand Van Deun from the Union offered a training session on rechecking sputum smears that was attended by participants from five states. He returned for a weeklong series of meetings with NTP managers six months later, and a second training programme on rechecking sputum smears was held for State Laboratory Coordinators and State Coordinators. Dr Van Deun also visited TB laboratories, hospitals and other health care services in Sinnar and Khartoum States and gave lectures at Sudan and Rabat Universities.

As a result, the Union made recommendations to Sudan’s NTP regarding the continuing training of laboratory personnel, the system for reporting results and the supervision of quality assurance in AFB microscopy. In looking ahead, the review noted that, like many low-income countries, Sudan is faced with both micro-challenges, such as maintaining supplies of small essentials such as microscope bulbs, and macro-challenges, such as preparing to deal with multi drug-resistant TB.

Union Consultants: Prof Donald Enarson, Dr Armand Van Deun
Funding Agency: The Norwegian Heart and Lung Patients Association (LHL)
Local Partner: Dr Asma El Sony, National Tuberculosis Programme, Sudan
Uganda Pioneers Community-Based Care Network

The Union has been collaborating with the Uganda National Tuberculosis and Leprosy Programme (NTLP) since September 2001. Consultants from the Union, the Global Office of the United States Agency for International Development (USAID), and the TB Global Drug Facility (GDF) visited Uganda, with Ministry of Health officials, to review progress in April and September 2003.

The main focus of the NTLP during the year continued to be the expansion of its model of community-based tuberculosis care. During the initial two-week hospitalisation of a person with tuberculosis, a local health worker visits the patient’s community to educate and sensitise members about the disease and to help the community choose a treatment supporter for the patient — an individual who will be responsible for directly observed treatment and working with a health worker who reports outcomes to the district health services.

By September 2003, 34 of the 56 health districts had fully or partially initiated community-based tuberculosis care. Treatment success rates for the 2001 cohorts in Kiboga, Rakai and Apac — the districts that pioneered and implemented the model between 1998 and 1999 — reached 83%, while the outcome for the rest of the country, including the capital city Kampala, hovered around 60%.

The NTLP continues to face challenges, the most serious of which is a lack of financial support and staff at all levels of the health system. This hampers efforts to adequately perform the essential tasks of tuberculosis control, including diagnosis of cases by smear microscopy, training, supervision and recording and reporting of treatment outcomes. Political instability in northern and eastern Uganda has also interfered with the effectiveness of the programme.

By the end of 2003, NTLP staff were busy developing work plans and budgets in order to receive funds from the approved grant of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Union Consultant: Dr Paula Fujiwara
Funding Agency: Canadian International Development Agency and the French Ministry of Foreign Affairs
Local Partner: Uganda National Tuberculosis and Leprosy Programme (NTLP)
One of the principal functions of the International Union Against Tuberculosis and Lung Disease is to offer education and training to all those active in promoting lung health. Educational services are provided in formats ranging from three-week residential courses to posters and downloadable technical guides that meet the needs of the health care community at every level and in every part of the world. Union training courses are renowned for their high-quality instructors, who are experts with extensive experience not only in theory, but also in practice.

In this reporting period, extra funding from several donors, including the Canadian International Development Agency (CIDA) and the United States Agency for International Development (USAID), enabled the Union to expand its network of courses and educational workshops. International and national TB courses are now being held on a regular basis in Tanzania, Benin, Vietnam, Nicaragua and other countries, and more than 820 people have had the opportunity to improve their skills in managing the disease in their home countries through these courses. New this year were workshops for nurses and district health personnel that have helped them better understand the ways in which the DOTS strategy has – or has not – been adopted by different countries and how they can contribute to its success.

For many members, conferences are their primary opportunity to network with colleagues and share experiences, refresh skills and gain new insights.

The Union convenes conferences in each of its six regions – Africa, Eastern, Middle-East, Latin America, North America and Europe – every other year, as well as holding the annual World Conference on Lung Health.

In addition, the Union provides educational opportunities through publications, such as its technical guides. These publications are written for middle- and low-income countries, but the principles very often also apply to high-income countries. Most Union guides and manuals can be downloaded at no charge from the Union’s website or purchased by contacting the Secretariat.

Our medical journal, the *International Journal of Tuberculosis and Lung Disease*, is distributed monthly to more than 2,000 individuals and libraries and is the best publication for keeping up to date with tuberculosis.

Other educational materials include presentations, slide shows, CDs and videos. The Union’s website is also an invaluable source of information on all areas of activity and links to other informative sites.

Following are the 2002–2003 highlights of our courses, conferences, publications and other educational activities.
Courses in International Tuberculosis Control

The Union’s International Tuberculosis Control course is a three-week programme for 25 participants. The curriculum is built around the study of five modules:

- bacteriologic basis of tuberculosis control
- clinical presentation and diagnosis
- epidemiologic basis of tuberculosis control
- interventions for tuberculosis control and elimination of TB
- principles of tuberculosis control in a national programme

Approximately half of the course consists of formal lectures and discussion, interspersed with and supplemented by laboratory bench work. One quarter of the course time is allocated to practical exercises in reviewing data from a real country, which is fictitiously named Asiam. Participants work in groups to review Asiam’s TB programme and derive conclusions for practical recommendations. The final quarter of the course time is allocated to group field visits and discussion of their findings.

Courses in Operations Research to Promote Lung Health

The Union has conducted courses in research methods for the promotion of lung health and tuberculosis control for more than a decade. These successful courses are designed to enable countries to develop and implement their own national health research programmes.

The premise underlying this training is that all national tuberculosis programmes have access to sufficient data to show them how they need to improve their management, but they lack the skills to collect and analyse the information. This two-week course provides those skills. Participants go through all the stages of a research project, from formulating a research hypothesis and designing a questionnaire, to data collection, analysis and preparation of the final report. Since data processing is an essential component of operations research, basic computer knowledge is essential, and participants are trained to use EpiData and EpiInfo software as part of the course. The course material, *Research Methods for Promotion of Lung Health: Guide to Protocol Development for Low-Income Countries*, was prepared by the Union research faculty and published by the Union in 2001.
Multi drug-resistant tuberculosis (MDR-TB) is a growing problem in many Latin American countries. As part of its ongoing work in Latin America, the Union conducted two intensive training courses — one in Mexico and one in Bolivia — to help improve the management of cases with suspected or proved MDR-TB.

Representatives of nine countries attended the course in Mexico, and seven different countries were represented in Bolivia. Each country sent the directors of its National TB Programme and TB Laboratory Network and the National Clinical Officer in charge of the NTP. At the conclusion of each course, the representatives signed basic agreements for the best management of MDR-TB, committing themselves to implementing these practices in their own countries.

As a follow-up to the courses, Union representatives visited Mexico, Guatemala, Honduras, El Salvador, Costa Rica, Nicaragua, Dominican Republic, Venezuela, Colombia, Ecuador and Bolivia. At each visit, the review team evaluated the country’s follow-up to the agreements signed during the course. The Central Unit of the NTP, the Central Laboratory and the Units in charge of the management of MDR-TB cases were evaluated, and meetings were held with officers of the NTP at the national level, officers of the TB laboratory network and clinical officers in charge of the management of MDR-TB.

Overall, Union representatives found that the courses and the subsequent agreements had had a positive impact in all of the countries. In seven—Mexico, El Salvador, Honduras, Nicaragua, Costa Rica, the Dominican Republic and Bolivia—management of MDR-TB cases was found to be very effective. There was a DOTS programme in place for patients who first present with TB, and good management of cases who relapse or for whom the treatment fails. Each of these countries has the capacity to detect MDR-TB cases, including a laboratory qualified to carry out first-line drug susceptibility testing. They have also designed plans for re-treatment with second-line drugs adapted to the drug history of the country and its conditions.

Mexico, Bolivia, Costa Rica, Honduras, El Salvador and Nicaragua have submitted their DOTS-Plus projects to the Green Light Committee so that they can obtain second-line drugs at a reduced price. Mexico, Costa Rica and Bolivia have been approved, and the Committee is expected to approve the other three in the near future. The Dominican Republic expects to submit its application in March 2004.

In Guatemala, Venezuela and Ecuador, DOTS treatment of new TB patients is improving, and there is the capacity to develop a DOTS-Plus project. However, although significant progress has been made, these countries still fall short of the conditions needed for obtaining the approval of a DOTS-Plus project.

In Colombia, the highest priority is still adequate management of newly detected TB patients through DOTS expansion.

“While we have made significant progress, there is still much to do,” says Dr Jose A Caminero, the Union representative who organised the courses. “The important thing is that most Latin American countries now recognise that multi drug-resistant tuberculosis is a problem that must be addressed. This is the vital first step that we can build on.”
Web-Based Course for Prospective International TB Consultants a Success

Up to four times the number of TB consultants now available are needed to meet the demand for technical assistance in low-income countries. With such a huge resource gap, many countries are going without help, and objectives such as the Millennium Development Goals must remain distant ideals.

To bring new people into the field as expeditiously as possible, the Union designed a course for North American TB controllers interested in serving as consultants in the developing world. This innovative programme was offered from September 2002 to June 2003 in a Web-based format to make it accessible to participants from all over the North American region.

“We decided to use the Web because the participants were geographically dispersed and the size of the curriculum required too much time for a short residential course,” says Prof Anne Fanning, one of the course planners and President of the Union.

A team of TB experts developed and taught the curriculum, which covered the epidemiology of TB, the TB control programme rationale, the application of theory and practical real-world examples. Each module began with a synchronous session — where all participants were online together with the instructor — followed by both individual and small-group online activities. The Web-based learning programmes used were CentraOne and WebCT.

“As far as we know, this was the first time such a course has been offered online,” says Prof Fanning, “and we hope it will become a model for future distance-learning programmes on disease control.”

Evaluations of the course content and online learning experience were positive overall. “The response to the curriculum was very good,” says Anne Fanning, “but some people were affected by technical problems. We now know that high-speed Internet is really essential for this type of programme.”

The final component of the course offered participants the chance to apply what they had learned through field experience. “Participants thought this would be even more valuable than a week of face-to-face classes,” says Prof Fanning.

Apparently they were right. Of the three who had gone into the field by the time of this report, one was immediately offered a consultancy.

New Division Provides Education and Other Services for Nurses

The Union Nursing Division was established in January 2003 to provide education and training, research and technical assistance to support the work of nurses and allied health professionals in tuberculosis control around the world.

Impetus for creating the new Division came from a highly motivated and successful Nurses and Allied Professional Scientific Section (NAPS), which has provided an excellent model for collaboration between members and the Union Secretariat.

In its first year, the Nursing Division staff taught courses and workshops and gave presentations in London, The Hague, Paris, Geneva, Uruguay, the Dominican Republic, Uganda and Nepal. Plans are underway to develop a best practices manual for TB nursing. This much-needed publication will be produced by the Nursing TB Taskforce, a group that includes members of NAPS, the Stop TB Partnership, the Nursing and Midwifery Services of WHO and the International Council of Nurses. This task force will also participate in high-profile conferences and events to improve awareness and understanding of nurses and their role.

Throughout the year, the Division provided support to colleagues from the European, African, Eastern and Latin American Regions via telephone and e-mail regarding networking, funding and conference activities.
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<tr>
<th>COURSES OFFERED BETWEEN 1 JULY 2002 AND 31 DECEMBER 2003</th>
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<tr>
<td><strong>INTERNATIONAL COURSE ON THE ANTITUBERCULAR FIGHT</strong></td>
</tr>
<tr>
<td>Language: French</td>
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<tr>
<td>Coordinator: Dr Arnaud Trébucq</td>
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<tr>
<td>Donor: The French Ministry of Foreign Affairs</td>
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<td>Benin: Cotonou</td>
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<td>9–27 September 2002</td>
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<td>Participants: 21</td>
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<td><strong>APPLIED EPIDEMIOLOGY FOR OPERATIONS RESEARCH IN TUBERCULOSIS CONTROL</strong></td>
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<td>Language: English</td>
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<td>Coordinator: Dr Hans L Rieder</td>
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<td>France: Paris</td>
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<td>13–24 January 2003</td>
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<td><strong>OPERATIONS RESEARCH FOR THE MIDDLE EASTERN REGION</strong></td>
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<td>Coordinator: Prof Donald Enarson</td>
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<td>Egypt: Cairo</td>
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<td>13–22 October 2002</td>
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<td><strong>INTERNATIONAL COURSE ON TUBERCULOSIS FOR PROFESSORS OF UNIVERSITIES AND MEDICAL SCHOOLS</strong></td>
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<td>Language: Spanish</td>
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<tr>
<td>Coordinator: Dr Jose A Caminero</td>
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<td>Donor: DFID, NTP Guatemala</td>
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<td>Guatemala: Guatemala City</td>
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<td>29–30 August 2002</td>
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<tr>
<td>Coordinator: Dr Hans L Rieder</td>
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<tr>
<td>Donor: TBCTA, The Netherlands Medical Committee, The Union</td>
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<td>Vietnam: Hanoi</td>
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<td>26 August–13 September 2002</td>
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<td>25 August–12 September 2003</td>
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<td><strong>AFB MICROSCOPY ADVANCED COURSE</strong></td>
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<td>Coordinator: Dr Armand Van Deun</td>
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<td>Thailand: Bangkok</td>
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<td>3–14 March 2003</td>
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<td><strong>E-LEARNING FOR TB CONSULTANTS</strong></td>
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<td>Donor: TBCTA</td>
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The annual World Conferences on Lung Health organised by the Union offer a unique opportunity for Union members to come together and report on their activities, hear the latest in research developments, and take advantage of a rich menu of courses, lectures, poster discussions and meet-the-expert sessions. Many of the delegates who attend these conferences from low-income countries have few other opportunities to network, so the conference is an excellent venue for building the global TB community. Popular highlights of the event are the presentation of the annual Union awards and voting on the best Christmas seals of the year.

33rd IUATLD World Conference on Lung Health in Montreal

On 6–10 October 2002, TB experts, advocates and health care workers from 100 countries gathered for the 33rd IUATLD World Conference on Lung Health, which was hosted by the Quebec Lung Association and held in Montreal, Canada.

The conference took its theme, Stop TB, Stop Poverty, from the 2002 World TB Day, and many of the presentations related to this concept. Highlights were the announcement by the Right Honorable Susan Whelan, Canadian Minister of International Cooperation, that Canada will contribute an extra C$80 million over the next four years to help stop TB around the globe; and a speech by Dr Richard Feachem, Executive Director of the newly formed Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), in which he praised the 1,300 delegates’ efforts and achievements.

34th Union World Conference on Lung Health in Paris

More than 1,500 delegates from 120 countries convened in Paris for the 34th World Conference on Lung Health, 30 October–2 November 2003. It offered a scientific programme that included 7 post-graduate courses, 4 workshops, 31 symposia, 37 poster sessions and 4 plenary sessions.

In keeping with the theme of globalisation and opportunity for health, international experts spoke on issues such as the SARS epidemic, the increasing burden of HIV in TB control, the role of nutrition in lung health and the impact of new funding mechanisms, such as the Global Drug Facility (GDF) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The growing role of HIV in Union activities was also reflected. In a press conference on 31 October, the Union announced the United States Agency for International Development (USAID) grant for applying the TB model for managing co-infected TB/HIV patients.
Each of the The Union’s six regions — Africa, Eastern, Europe, Latin America, Middle-East and North America — usually organises a conference every two years. Since the African, European, Middle-Eastern and North American regions all held conferences in the first half of 2002, only the Eastern and Latin American regions convened during this reporting period.

10th IUATLD Latin American Region Conference, Uruguay: 11–15 December 2002

The 10th Conference of the Latin America Region of the IUATLD was held together with the 24th Panamerican Congress of ULASTER and the 3rd Congress of ALAT in Punta del Este, Uruguay. The Conference gathered more than 400 participants from Latin America and other continents.

The Union sponsored several workshops and symposia, including one on Tuberculosis in Prisons. An event involving NGOs from all the countries with a major TB burden was proposed for 2004 to improve TB control and place it higher on the public health agenda.

22nd IUATLD Eastern Region Conference Nepal: 22–25 September 2003

The Eastern Region Conference, attended by more than 250 delegates, concluded with the Kathmandu Declaration which called for active and ongoing support for TB control in the region through linkages between TB and HIV/AIDS, strengthening MDR-TB surveillance and supporting anti-tobacco activities.
The International Journal of Tuberculosis and Lung Disease

During the reporting period 1 July 2002–31 December 2003, the International Journal of Tuberculosis and Lung Disease (IJTLD) underwent some major changes.

When the eight-year editorship of Professor Michael Iseman ended in December 2002, the Publications Policy Committee of the Union, with the approval of the Board of Directors, decided to formally separate the role of Editor-in-Chief into two positions: an editor for tuberculosis and other mycobacterial disease and an editor for non-tuberculous lung diseases. The reasons for this change were to strengthen the published papers in each of these categories and to divide what was becoming a steadily increasing workload. Dr Nulda Beyers, Associate Professor of Paediatrics at the University of Stellenbosch, South Africa, and Professor Moira Chan-Yeung, Professor of Medicine at the University of Hong Kong, SAR China, began their five-year mandate as Editors-in-Chief for tuberculosis and lung disease respectively in January 2003.

Increases in submissions to the Journal continued, with a consequent increase in the backlog of accepted articles. The Editorial Board decided at its November 2003 meeting to shorten the length of articles, to increase the number of pages from 100 to 120 as of January 2004, and above all to increase the rejection rate, which in 2003 was a low 40%. The Science Citation Index published for the year 2002 gave an impact factor of 1.888.

The first issue of the Russian version of the Journal was published in July 2003 and distributed to 1,500 readers. It is also accessible on the Union website. In addition the Journal continues to publish a Chinese version, which is distributed to more than 4,000 physicians in China three to four times per year. Articles in French are also published on the Union website.

Use of the online version of the Journal on ingenta increased from an average of 176 articles accessed per month during the previous reporting period to an average of 550 per month during the current period.

Clare Pierard
Manager Editor

New in 2002-2003

Diagnostic Atlas of Intrathoracic Tuberculosis in Children
Robert Gie, MD
November 2003
English only

- Diagnosis of TB in children is difficult. Either children with chronic chest diseases are unnecessarily treated for tuberculosis, or the diagnosis is made so late that the children die or suffer severe lung damage. The goal of this illustrated atlas is to assist health care workers practising in low-income countries in interpreting chest radiographs of children suspected of having TB.

A Tuberculosis Guide for Specialist Physicians
Jose A Caminero, MD
Spanish edition: May 2003
English edition: 2004

- This innovative guide discusses the clinical and epidemiological aspects of tuberculosis in the context of the National Tuberculosis Programme (NTP) in 18 illustrated chapters. This book is a stand-alone reference for anyone involved in the treatment, control and prevention of tuberculosis and is especially valuable for specialist physicians working in developing countries.

Tuberculosis in the World

- This short educational video on the DOTS strategy, featuring Prof Donald Enarson, includes a historical account of tuberculosis in Europe, the present risks of MDR-TB and the compounding effects of HIV/AIDS, as well as a visual presentation of the five components of the DOTS strategy.

Tuberculosis Documentation for Health Care Professionals 2003

- Published in autumn 2003, this CD-ROM is a replica of the website www.tbrieder.org. It contains the PDF versions of the Union technical guides as well as other international publications, Power Point presentations, photographs, educational material for courses and other invaluable data and references for understanding global TB control.
Research

Research has played an important role in the work of the International Union Against Tuberculosis and Lung Disease since the 1950s, when it organised the first international collaborative clinical trial to study tuberculosis. Later research conducted by Dr Karel Styblo and the Tuberculosis Surveillance Research Unit (TSRU) in the 1960s formed the basis of what is now known as the DOTS strategy. This strategy has since saved millions of lives around the world, and Union researchers continue to make critically important contributions to our understanding of the causes, treatment and management of lung disease.

Today the Union’s Scientific Divisions conduct research in tuberculosis, tobacco prevention, asthma and child lung health. In addition, the new Nursing Division, created in January 2003, studies the role of nursing in TB control, and a Health Policy Research Unit examines this crucial area.

The work of the Scientific Divisions is overseen by Prof Donald Enarson, Director of Scientific Activities.
In 2003, the TB Division began recruitment for a second major clinical trial — Study C. This trial of alternative TB treatment regimens will evaluate the outcomes of patients treated with an initial two-month intensive phase of drug treatment — in which they receive a fixed-dose combination tablet daily — followed by a four-month period in which they receive a fixed-dose combination tablet three times a week. The study will involve up to 2,000 subjects in 11 countries. If this regimen proves successful, it could have a major impact on both patients and health care systems as it will reduce the number of interactions required between patients and health care workers in order to complete treatment successfully.

The Clinical Trials Division also carried out a contract funded by the European Commission to evaluate clinical-trials capacity in sub-Saharan Africa, outlining an approach for identifying potential sites for international multi-centre collaborative trials, a method for evaluating the capacity of these centres to carry out clinical trials and the need for capacity strengthening to promote clinical trials in the region.

In collaboration with the Institut Pasteur, Paris, a workshop was held in Paris in October 2003 to evaluate the network of clinical trials for vaccine development and to discuss the ethical issues related to such trials. This workshop developed materials on ethics review procedures and resources for use by centres.

Generous support from the Global Alliance for TB Drug Development has made it possible for the Division to also offer a series of workshop and capacity-strengthening activities to improve laboratory services within the clinical trials network, evaluate and strengthen ethics review procedures and improve the knowledge of the collaborators in the clinical trials network on the scientific and technical aspects of clinical trials.

Prof Donald Enarson
Division Head

STUDY A: CLINICAL TRIAL AND PRELIMINARY RESULTS

Study A, which ran between 1998 and 2001, involved 1,355 patients with newly diagnosed smear-positive pulmonary tuberculosis, from eight centres in Africa and Asia. The patients were randomised to receive one of three regimens:

1) Ethambutol, isoniazid, rifampicin and pyrazinamide daily for two months, followed by ethambutol and isoniazid daily for a further six months;
2) The same drugs in the initial intensive phase but given three times a week followed by the same continuation phase of daily ethambutol and isoniazid; or
3) A regimen with the same initial intensive phase as in the first regimen, followed by four months of daily rifampicin and isoniazid.

Follow-up continued for 30 months after the start of chemotherapy. Sputum examinations for microscopy and culture were carried out at regular intervals. An unfavourable outcome was defined as failure during, or relapse following, treatment. All follow-up is to be completed at the end of June 2004.

Study A’s preliminary results showed:
- At two months, a significantly higher proportion of those receiving the daily intensive phase were culture-negative when compared to those receiving the three-times-weekly intensive phase (84.5% compared to 76.9%)
- Twelve months after stopping chemotherapy the proportions with an unfavourable outcome were 10.4% of patients with regimen 1, 13.7% of those with regimen 2 and 4.9% of those with regimen 3
- Both eight-month regimens were significantly inferior to the six-month control regimen
- Adverse effects leading to interruption of treatment of seven days or more occurred in 28 patients with the first regimen, five with the second and 11 with the third
- The eight-month ethambutol-based regimens were not equivalent to the six-month rifampicin-based regimen
- The three-times-weekly intensive phase was inferior to the daily treatment in its two-month culture conversion rate.
The Tobacco Prevention Division seeks to improve the involvement of health care workers in tobacco control and to increase the effectiveness of cessation interventions for patients in general care and with lung diseases, including TB.

ETTAM (Etude Tuberculose-Tabac au Maroc)
Union collaboration with the Department of Epidemiology and Public Health, Faculty of Medicine and Pharmacy, University Sidi Mohammed Ben Abdullah, Fez, Morocco

In light of the results of our earlier Sudan feasibility trial of tobacco intervention for patients receiving treatment for tuberculosis, this randomised, controlled trial has been set up in Morocco to further investigate the acceptability and efficacy of a standardised minimal tobacco intervention for tuberculosis patients over the course of their treatment. Tuberculosis patients are first divided into smoking and non-smoking groups. Smokers are then randomised into intervention and control groups. This trial began in November 2003 and will recruit approximately 2,000 tuberculosis patients. Post-treatment follow-up will provide data on both tobacco cessation rates and tuberculosis treatment outcomes.

MARTA (Maroc Tabac)
National survey of knowledge, attitudes and practices concerning tobacco, April 2000–present
Union collaboration with the Department of Epidemiology and Public Health, Faculty of Medicine and Pharmacy, University Sidi Mohammed Ben Abdullah, Fez, Morocco.

Very little is known about the prevalence of tobacco use and current attitudes about tobacco control in Morocco. With the recent purchase of the national tobacco monopoly by Altadis, Morocco could be on the verge of a massive campaign to increase smoking prevalence and consumption, which could also be extended throughout Northern Africa. The MARTA survey is designed to determine the prevalence and evolutionary stage of tobacco use among the population of Morocco; to determine individuals’ knowledge and attitudes about use, exposure and control approaches; and to determine the indicators for effective tobacco control strategies for different population groups.

This survey will provide information about the social and cultural factors affecting tobacco use and the level of support for broad tobacco control measures. This is highly desirable in the current climate where administrative support is being given to Altadis’ new investments in Morocco.
Feasibility of introducing tobacco interventions into tuberculosis treatment
Union collaboration with EPILAB, the Sudan National Tuberculosis Programme and the University of Khartoum

The relationship between tobacco use and the outcome of tuberculosis treatment is a growing subject of study. There have been no previous studies about the feasibility of a systematic and standardised tobacco cessation intervention as a part of tuberculosis treatment. This study looks at the major issues that determine the feasibility of a new procedure: acceptability to staff, patients and the health care centre; effectiveness; and impact on tuberculosis treatment processes and outcomes. A report on the analysis of data from 48 medical assistants, other staff from 24 treatment centres and 513 male tuberculosis patients is in preparation.

The outcome data indicate that health professionals can find personal and professional satisfaction from engaging in systematic standardised tobacco cessation interventions with tuberculosis patients undergoing treatment. Patients enrolled in the trial had lower default rates and better treatment outcomes than those not enrolled. Many patients reported that they stopped tobacco use and sustained abstinence over six months.

Karen Slama, PhD
Division Head

A simple plastic bottle helps the patient get the most out of medication

GASP (Global Asthma Survey of Practice)
The Union Audit of Asthma in Emergency Rooms

The Asthma Division commissioned a Working Group of the Respiratory Disease Scientific Section to devise and assess an audit tool for use in emergency rooms that will inform local health services about the need to improve asthma management and identify the targets for improvement. The Working Group is coordinated by Prof Peter Burney. In 2002–2003, Prof Burney and Prof Aït-Khaled carried out an initial survey in 15 centres. The first results will be presented in Paris during the 35th World Conference on Lung Health in October 2004.

The Asthma Division also worked with several other groups around the world.

ISAAC (International Study on Asthma and Allergies in Childhood)

ISAAC is coordinated by Dr Innes Asher in New Zealand. The Union’s Prof Nadia Aït-Khaled is on the steering committee and serves as the Regional Coordinator for Francophone Africa. ISAAC’s Phase III objectives were to estimate the trend of asthma and allergic diseases over five years (between Phase I and Phase III) and to finish the world map showing the prevalence of asthma and allergic diseases by recruiting new centres. During the period of this report, 16 centres completed ISAAC Phase III in Francophone Africa. The Asthma Steering Committee meeting was held in Stockholm in September 2002.

ARIA (Allergic Rhinitis and its Impact on Asthma)

The ARIA initiative is coordinated by Prof Jean Bousquet. A clinical survey coordinated by Isabelle Annesi (INSERM) and Prof Aït-Khaled was launched in several African countries and five countries have already submitted their data. Prof Aït-Khaled is also on the Executive Committee, which met in June 2003.

Prof Nadia Aït-Khaled
Division Head
Child Lung Health Project
Funded by the Bill and Melinda Gates Foundation with the International Tuberculosis Foundation as fiscal agent

The Child Lung Health Project in Malawi has shown that a well-planned, well-implemented and well-assessed public health project focusing on a few diseases can make a difference. The project was designed to establish a sustainable, reproducible system for the surveillance, diagnosis and management of the respiratory diseases that afflict children in many African countries, including acute respiratory infection and pneumonia, tuberculosis, HIV-related lung disease and asthma. The project applied the Union model for successful health and public health services for tuberculosis to the problem of respiratory diseases, and implemented it using a step-wise approach that emphasised monitoring and evaluation, sustainability, reproducibility and efficacy. Special emphasis was given to the need for sustainability beyond the life of the project funding. By July 2003, all 22 district hospitals and two of the three central hospitals in Malawi had implemented the CLH Project.

Outcomes included the following:

- Children presenting for treatment increased from less than 150 children per month in the last quarter of 2000 to more than 600 children by early 2003.
- 24,743 children were treated between 1 October 2000 and 31 December 2003.
- At the outset, just over 50% were treated successfully. This had gradually increased to more than 80% by March 2003.
- With standard case management by trained staff, fatality declined from almost 30% to an average of 12.9% in 2001, 10.6% in 2002 and 9.6% in 2003.

To demonstrate how this cost-effective model can be applied to neighbouring countries, the division co-sponsored an international training course in September 2003 in Lilongwe.
International Course on Improving Child Survival in Eastern/Southern Africa

This course was held as part of the international meeting for the Southern African Development Community (SADC) countries in Lilongwe, Malawi on 22–26 September 2003. The course consisted of presentations, discussion and group work that covered the burden of childhood lung disease and the advances that can be made by introducing simple case management guidelines within the Integrated Management of Childhood Illness strategy (IMCI) at the district hospital level.

The course was intended for officials from the Ministries of Health, Controllers of Preventive Health, Paediatricians, ARI/IMCI Programme Managers and Public Health Specialists. The 15 participants represented nine countries: Kenya, Lesotho, Botswana, Namibia, Zimbabwe, Zambia, Tanzania, Mozambique and South Africa.

At the end of the course each country had developed and presented a written plan outlining a CLH programme for in-patient management of the sick child according to the priorities of their country, indicating the domain, the setting, the policies, the case management strategy and the management process to be employed.

Developing Childhood TB Guidelines

Funded by the Centers for Disease Control and Prevention (CDC)

On 28–29 October 2003, the Division cosponsored a workshop on developing childhood TB guidelines with the Centers for Disease Control and Prevention (CDC), the International Paediatric Association, the National Institutes of Health and the World Health Organization (WHO). This event was organised to bring together 23 experts on childhood TB from industrialised, low- and middle-income countries to review available data and to lay the groundwork for developing guidelines for the management of TB in children. The specific problems of children with drug-resistant TB (MDR-TB) and with HIV co-infection were also discussed. These guidelines will be used by clinicians and national TB programmes in low-resource settings.

At the end of the workshop, a writing committee was formed to begin the process of writing the guidelines. Sub-groups will write sections on diagnosis, treatment, vaccine and reporting and recording.

Diagnostic Atlas of Intrathoracic Tuberculosis in Children

The Union, through the TB in Children Working Group, supported Prof Robert Gie in developing and publishing the Diagnostic Atlas of Intrathoracic Tuberculosis in Children in 2003, funded by CDC and TBCTA. More details about this atlas are on page 29.

Childhood Tuberculosis Subgroup of the Stop TB Partnership DOTS Expansion Working Group

Several key partners have sought the development of a Childhood TB subgroup of the DOTS Expansion Working Group (DEWG) with the goal of reducing the global burden of mortality and morbidity caused by TB in children. They include the Union, the International Paediatric Association (IPA), the Centers for Disease Control and Prevention (CDC), the National Institutes for Health (NIH) and WHO (Child and Adolescent Health Department and Stop TB Department), as well as paediatricians in countries with a high incidence of TB and representatives of academic and research institutions. The DEWG of the Stop TB Partnership approved the establishment of the Childhood TB subgroup in October 2003. As the subgroup develops, new members are expected to become involved, including representatives of a broad range of agencies and organisations that share our goals and objectives.

Penny Enarson
Division Head
The goal of the Health Policy Unit is to research factors that influence the formulation and implementation of policies relating to lung health.

DOTS Expansion: District-Level Policy Processes
Funded by TBCTA

Beginning in June 2002, the Health Policy Unit held a series of regional workshops to examine district-level policy processes involved in DOTS expansion. Workshops have been held so far in Durban, South Africa (June 2002), Punta del Este, Uruguay (December 2002) and Paris, France (October 2003). The workshops bring together the national tuberculosis programme manager and a district-level tuberculosis programme team of three people (e.g., a medical doctor, nurse and laboratory technician) from four to six countries each time. The questionnaires and discussions do not deal with the technical content of the DOTS strategy or tuberculosis policy. Instead, they explore factors, such as political, social, financial and organisational factors, that might affect the success of implementing and adapting the DOTS strategy at the district level. The research aims to generate a series of regional pictures of policy processes, based on the perceptions of personnel at different levels in the programmes (national and district) and from different disciplinary perspectives (doctor, nurse, laboratory technician).

Policy Transfer of the DOTS Strategy:
A global national and sub-national analysis of Brazil and Mexico, Malawi and Zambia.
Funded by the UK Department for International Development (DFID).
Co-funded by the Union

A four-country study including two pairs of countries – Malawi and Zambia, Brazil and Mexico – was started in 2003 to compare policy processes involved in DOTS implementation and expansion and to identify what facilitates and hinders these processes. This qualitative research will explore how the DOTS strategy moves between global, national and sub-national levels. It has a particular interest in the activities of communication, learning and adaptation and in political, social, organisational and resources issues that might influence policy processes. The goal of the study is to generate insights that could be useful for DOTS expansion in other countries as well.

Prior to the launch of the four-country study in September 2003, the Health Policy Unit carried out pilot research in Mexico, including a pilot study of the sub-national level in the state of Veracruz, Mexico, in July 2003. The Health Policy Unit is coordinating this collaborative research which involves the London School of Hygiene and Tropical Medicine and researchers from institutions in the four participating countries: Brazil – University of Rio de Janeiro State; Federal University of Rio de Janeiro; Mexico – Mexican Health Foundation (FUNSALUD); Malawi – Equi-TB; Chancellor College, University of Malawi; and Zambia – INESOR; Demography Department, University of Zambia.

Karen Bissell, MA
Coordinator
The results of research studies conducted by the Union’s Scientific Divisions are disseminated worldwide through publication in peer-reviewed scientific journals and books. During this reporting period, 13 articles appeared in peer-reviewed journals, including the International Journal of Tuberculosis and Lung Disease, Archivos de Bronconeumologia, JANO: Medicina y Humanidades, Infection Control and Hospital Epidemiology, Pediatric Pulmonology, the European Respiratory Journal, The Lancet, The American Journal of Critical Care and The Journal of Infectious Diseases. In addition, Union researchers contributed chapters to books on AIDS and tuberculosis and to a variety of scientific reports.
Advocacy and Communication
Advocacy: Awareness Is the First Step Towards Action

One of the overarching goals of the Union is to increase awareness of the public health, social, economic and political impact of tuberculosis and other lung diseases on countries around the world. This awareness is essential at every level – from individual patients, family members and health care workers to health ministers and government, business and opinion leaders. Awareness is the first step towards action, and TB and other lung diseases need to remain high priorities in order to reduce the tremendous damage they wreak, especially in low-income countries. In particular, politicians and those controlling budget decisions at the district, state, national and international level need to understand that only sufficient funding will lead to sustainable improvement in TB and other health services.
FIDELIS

FIDELIS, a project sponsored by the Canadian International Development Agency (CIDA) and managed by the Union, supports local initiatives to expand DOTS to the poor and other groups who have little access to health care. In 2003, its first year, FIDELIS provided US $1.9 million to projects in China, Kenya, Sudan and Pakistan. More than 150 million people stand to benefit from these efforts.

TB and Poverty Workshops

The Union sponsored workshops on TB and poverty at both the Montreal (2002) and Paris (2003) World Conferences on Lung Health. The goal of these workshops was to re-emphasise that TB is a disease of the poor and that access to diagnosis and treatment needs to be improved in all countries, but especially in high-burden countries. Seventeen of the 22 high-burden countries that have 80% of the world’s TB cases are classified as low income by the World Bank, i.e., their annual GNP per capita is less than US $745.

World TB Day

World TB Day 2003, held on 24 March, marked the 10th anniversary of the World Health Organization declaration that tuberculosis is a global emergency. The theme “DOTS cured me – it will cure you too!” was a plea to expand the DOTS strategy and increase case detection. For the first time, former TB patients were enlisted as spokespersons to help carry the message.

The Union contributed to World TB Day by distributing press releases in three languages, carrying information on its website and in its print and electronic newsletters, participating in radio programmes in Paris, sending the Stop TB information packs to its organisational and constituent members, and covering World TB Day events in South Africa in collaboration with the Stop TB Partnership.

TB Video and CD-ROM

In 2003 the Union also produced an educational video entitled “Tuberculosis in the World”, which can be used for education and advocacy.
TB Patients as Advocates

The Nurses and Allied Professionals Scientific Section has been advocating for patient participation at Union events for a number of years. During the 34th World Conference on Lung Health in Paris in 2003, Winstone Zulu, a recovered TB patient and advocate from Zambia, gave a passionate presentation on the rights of TB patients as part of the opening ceremony. He emphasised that scientists should think of tuberculosis not only in terms of numbers and percentages, but also in terms of the human face of the disease.

Training Workshop for Indian Journalists

The Union sponsored a two-day media training workshop in Puri, Orissa, in May 2003. The goal of the workshop was to raise the awareness of both the print and electronic media to the incidence of TB in India and to the successes and challenges of the Revised National Tuberculosis Control Programme (RNTCP). More than 20 print, TV and radio journalists participated in the workshop, which was the first of its kind to be held in India. The Union’s Regional Coordinator in India, Ms Sunita Kripalani, conducted working sessions to outline ways in which the media could contribute to awareness of and advocacy for tuberculosis.

Distribution of AFB Smear Staining Poster

To help promote the proper use of acid-fast bacilli (AFB) smear staining to diagnose tuberculosis, the Union printed and distributed 20,000 copies of a colour poster describing the procedure. This project was coordinated by the Union’s representative in India, which enabled the Union to reduce printing costs. Funding for this project came from the Centers for Disease Control and Prevention (CDC), the Japan Research Institute of Tuberculosis (RIT) and the Japan Anti-TB Association (JATA). Printing and distribution was funded by TBCTA.

Stop TB Advocacy Efforts

The Union has participated actively in several Stop TB Partnership meetings devoted to increasing the capacity of all stakeholders in advocacy and communication. At a workshop in Cancun in June 2003, communication specialists gave presentations on how to improve the visibility of tuberculosis at the national and sub-national level. The Stop TB Partnership Task Force on Advocacy and Communication discussed the recommendations of these experts at their follow-up meeting in September 2003 in Johannesburg, South Africa. This led to a recommendation to the Stop TB Coordinating Board to create a Task Force on Advocacy and Communication. This group will help to ensure that appropriate tools are used to increase the visibility of tuberculosis worldwide.
Progress Towards a Treaty

Progress towards the public health treaty Framework Convention on Tobacco Control (FCTC) continued in late 2002 with marathon meetings and high tensions among participants. The principal opponents to a strong convention, notably the United States, Germany and Japan, put forward wording to weaken each amendment and contributed to disagreements about substantive issues, such as the measures needed to combat exposure to tobacco smoke or the strength of advertising bans.

The Union put its resources into supporting the activities of the Framework Convention Alliance, an umbrella organisation whose purpose was to enhance the visibility of civil society (particularly NGOs) and incorporate best practices in tobacco control as the standard for the treaty. As a result, Union support helped NGO representatives from around the world attend the meetings in Geneva as observers. The Union was also involved in between-session lobbying; preparing briefings, fact sheets and a daily newspaper of events; and developing a full-page advertisement asking delegates to protect health by approving a strong treaty. The Union also kept its members informed about issues and progress in the ratification process of the treaty.

The final treaty was approved in May 2003 after 13 straight days of negotiations. The United States and Germany gave warning that they might not accept the final wording, but in the end they accepted the treaty as did the other delegations. At the 2003 World Health Assembly, the text of the treaty was accepted unanimously and the treaty was opened for signature. As of the end of 2003, more than 85 countries had signed the FCTC, including Germany and Japan, and five countries had ratified it: Fiji, Malta, Norway, Seychelles and Sri Lanka. Forty countries must ratify for the treaty to become international law.

World No Tobacco Day

Tobacco free film, Tobacco free fashion was the youth-oriented theme for World No Tobacco Day, held on 31 May 2003. The Union contributed to international advocacy efforts by distributing the WHO information packs and by carrying the information on its website and in its electronic and print newsletters.

Burning Issues

A newsletter called “Burning Issues” was developed by the Tobacco Prevention Division and distributed to delegates at the Union’s 34th World Conference on Lung Health in 2003. It contained a variety of facts about the consequences of tobacco use and the need for tobacco control.

INGCAT

The Union and the World Heart Association are the founding members of the International Non-Governmental Coalition Against Tobacco (INGCAT). INGCAT is also a member of the Framework Convention Alliance and helped to coordinate successful lobbying efforts for the treaty. In 2003, INGCAT hosted a successful meeting with the Framework Convention Alliance and other international tobacco control organisations to explore future working principles and opportunities for collaboration. With new director Doreen McIntyre, appointed in September 2003, INGCAT has focused its attention on working with member organisations to establish priorities, review needs and investigate resources for tobacco control. INGCAT now has a website at www.ingcat.org
For an international federation like the Union, good communication is critical for keeping everyone informed and connected. The Union’s communication programme uses both print and electronic media to reach members and others active in promoting lung health around the world. Electronic tools play an increasingly important role in strengthening the Union’s membership community. A wide range of services and resources are now available to members via the website, which was redesigned and expanded during 2003. In addition members now receive both a biannual print newsletter and a monthly e-newsletter.

### The Website

The English version of the revamped website was launched in January 2003, followed by the Spanish and French versions in March. Funding for the development of the website and its translation into French was provided by a grant from the French Ministry of Foreign Affairs.

The new website gives members online access to:
- information on the Union, the *International Journal of Tuberculosis and Lung Disease*, and Union conferences, courses, Scientific Divisions and Scientific Sections
- pdf versions of technical guides, fact sheets, press packs and other membership information
- e-payment services for individual memberships and library subscriptions
- an online donation option
- 200 links to other websites, including the sites of our members, partners, the Stop TB Image Library and other educational resources
- versions in French of more than 150 selected articles published in the IJTLD

The new website is available in both high- and low-band resolution so that members around the world can access and use the site easily. The Union web addresses are [www.iuatld.org](http://www.iuatld.org) (English), [www.uictmr.org](http://www.uictmr.org) (French), [www.uicter.org](http://www.uicter.org) (Spanish).

### The e-newsletter

A monthly e-mail newsletter was launched in February 2003. Distributed to nearly 8,000 people around the world, the e-newsletter is in text-only format to make it as widely accessible as possible. Each news item includes a brief summary and links to further information. The e-newsletter provides updates on Union conferences, courses and other events and meetings; new publications; news from the Divisions; and an e-alert for each new issue of the *International Journal of Tuberculosis and Lung Disease*.

### The Union Newsletter

The Union Newsletter was also revamped during this period, building on the editorial scope and structure of the previous version. The first issue appeared in April 2003. This 24-page full-colour publication is printed in English (5,000 copies), French (1,500 copies) and Spanish (1,000 copies), and is mailed to all Union members, partners and contacts. The goal of this publication is to keep members informed about events, advocacy, news from the field and the Secretariat, new publications and upcoming courses and conferences. It also serves as a vehicle for introducing potential new members to the organisation and for reminding current members of our aims and mission.
Press Coverage of the Union

The Union regularly sends news about its activities to general and medical press contacts around the world, issuing its releases in English, Spanish and French. During this reporting period, the World Conferences in Montreal and Paris generated considerable media interest.

A press conference held at the opening of the 33rd World Conference addressed the theme of tuberculosis and poverty – the theme of World TB Day 2002. The conference was chaired by Prof Anne Fanning, and included Prof Donald Enarson, Dr Francis Adatu (Uganda), Dr JS Chauhan (India) and Dr Mario Raviglione (WHO), who spoke on issues ranging from TB control in their own high-burden countries to global measures to reduce poverty and increase case detection.

A speech on poverty and health given at the closing plenary session by Stephen Lewis, United Nations Special Envoy for HIV/AIDS in Africa, also received local and international coverage.

Press coverage of the 33rd World Conference on Lung Health included two TV news flashes, three radio programmes, and more than 60 articles in English and French in the national and international press.

The 34th World Conference on Lung Health, held in Paris in 2003, included two international press conferences. The first, “SARS: will it make a comeback?” was chaired by Prof Donald Enarson with Dr Julie Gerberding of the Centers for Disease Control and Prevention (USA) and Dr Christophe Paquet of the Institut de Veille Sanitaire (France) speaking. The second press conference on “3x5 for HIV: the inextricable link with TB,” was chaired by Dr Paula Fujiwara. Prof Michel Kazatchkine of the Global Fund to Fight AIDS, Tuberculosis and Malaria (France), Dr Alex Coutinho (Uganda) and Winstone Zulu, an ex-TB patient who is HIV-positive (Zambia), discussed the issues of tuberculosis and HIV from a global, national and patient perspective.

All Union press packs and press releases are regularly published on the Union website.

STOP TB IMAGE LIBRARY

Photographs that vividly and effectively depict TB are vital to telling the story of this devastating disease and the worldwide efforts to control and eradicate it. Both the media and those who produce advocacy, scientific and other communications need such photographs, but the cost of taking or acquiring them is often prohibitively expensive.

To fill this need for good, accessible photographs, the Stop TB Partners, in collaboration with the Union, launched the online Stop TB Image Library in January 2003. Located at http://stop.tb.lpipserver.com, or accessible via the Union website at www.iuatld.org, the Image Library contains more than 1,000 digital images depicting TB patients, health care workers, diagnosis, treatment, research and other related subjects in countries around the world. Low-resolution images from the collection may be used by anyone without charge. Use of the high-resolution images is free to fully paid constituent and organisational members of the Union and Stop TB Partners, who are given password access to the collection.

Other interested parties can contact the Image Library manager for information about access and use.

In its first year, the library was used to illustrate publications produced by the Centers for Disease Control and Prevention (CDC), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Ministry of Health of South Africa, the Ministry of Health of Peru, the World Health Organization (WHO), the TB Global Alliance, Stop TB Partners in India, USAID, Heinemann Education publishers (UK), and others. Nearly 27,800 people visited the library, and 550 bookmarked it.

To build awareness of the new library, the Union sent computer mouse mats with images from the collection to all Union constituent and organisational members, individual Union benefactors, and Stop TB Partners. An Image Library bulletin, depicting scenes from World TB Day 2003 in South Africa, was distributed during the 34th Union World Conference on Lung Health and a computer-based exhibit of the collection was developed for use at conferences. Gary Hampton, a professional photographer who is the Image Library Manager, also held a meet-the-expert session on ways to use the library at the 34th World Conference.

Additions to the collection came during this period from India, Indonesia, the Congo, Ethiopia and Prisons in Honduras. The library is actively seeking more photographs from other sources. Hampton also travelled to South Africa and Uganda to take photographs of the TB programmes there. One of the main goals of the library is to take and/or acquire photographs depicting tuberculosis in all of the 22 high-burden countries (HBCs). To date the HBCs covered by the library collection are India, Bangladesh, South Africa, Ethiopia, Democratic Republic of Congo, Kenya, Myanmar, Uganda and Indonesia.
Member Activities
The Scientific Sections were created to give members of the International Union Against Tuberculosis and Lung Disease an opportunity to work together, share their expertise and experience and convey that to their colleagues around the world. Depending on their interest and experience, members can choose to work with a Scientific Section in Bacteriology and Immunology, Respiratory Disease and Child Lung Health, Nurses and Allied Professionals, Tobacco Prevention, Tuberculosis or Tuberculosis in Animals. The activities of these Sections range from planning symposia and workshops to be presented at the annual World Conferences to developing protocols for research and preparing manuals and other training materials.

Specific tasks are taken on by the Working Groups (WG) of each Section. Typically these groups hold annual meetings at the Union World Conference on Lung Health to summarise the activities of the previous year, hear reports from their members and plan activities for the coming year. Some tasks require Working Groups from different Sections to collaborate, further increasing the opportunity for members to gain new experience and contacts. The Scientific Sections also sometimes collaborate with the Scientific Divisions on projects. Officers of the Scientific Sections report to the Chair of the Scientific Coordinating Committee, who is an elected member of the Board of Directors.

Reports on the activities of the Scientific Sections and their Working Groups given at the 34th Union World Conference on Lung Health in 2003 follow. These reports will also be published, in English only, on the Union website and will remain available until spring 2005.

The reports and contact details of the Scientific Sections for the period October 2001–November 2002 were published in the April 2003 Union Newsletter in English, French and Spanish and were available on the Union website, under Scientific Sections, until June 2004.

Full reports and contact details are available from the Union Secretariat.
Scientific Sections

At their annual meeting in 2003, the Bacteriology and Immunology Section proposed the following events for the 35th World Conference on Lung Health:

- Workshop: Practical laboratory issues in low-resource settings
- Symposia:
  - Drug resistance: is it worth measuring?
  - Microscopy and culture
  - Bacterial virulence of tubercle bacilli and genetic susceptibility in humans
At their annual meeting in 2003, the NAPS Section proposed the following events for the 35th World Conference on Lung Health:

- TB education and training materials display
- TB education and training materials discussion session
- Plenary Session: Nursing and Millennium Development Goals
- Postgraduate Courses:
  - Adapting education and training materials for local context
  - Transforming practice into a presentation
- Symposia:
  - Tuberculosis in prisons or closed institutions (with the TB Section)
  - Impact of new mechanisms to increase access to high-quality anti-tuberculosis drugs (with the TB Section)
  - Ensuring quality of care in DOTS implementation/Integrating laboratory, NTPs and organisation
  - Human resource development for TB control

**Working Group:**

**Education and Training**

Leader: Maria Fraire

The principal objective of the Education and Training Working Group is to develop, improve and maintain access to training and education resources for nurses and allied professionals.

For the 34th World Conference on Lung Health, the WG co-sponsored a postgraduate course on advocacy and health communication, in collaboration with the TB Section’s Training and Education Working Group.

In 2003 the group also collected TB training and education materials from high- and low-burden countries to include in the National Prevention Information Network (NPIN) TB Resource Guide and online searchable database. It held an exhibition of these materials and led a discussion on them at the World Conference.

Other activities included assisting in the development of the NAPS promotional brochure to be finalised in 2004; advocating Union membership in the TB-Educate listserv – an existing TB education and training listserv – and the TB Education and Training Network; and promoting membership of NAPS and the Education and Training Working Group to Union members.

**Working Group**

**Case Management**

Leader: Liz Rose

The objectives of the Case Management Working Group are to raise the profile of patient care and the importance of patient-centred approaches to TB control; to organise related symposia and postgraduate courses; and to develop a manual of standard approaches to patient care.

At the 33rd World Conference on Lung Health in Montreal in 2002, the WG put on a postgraduate course on developing strategies for effective case management for patients’ complex situations. Feedback from this course and discussions at the WG meeting in Montreal have been used to contribute to the manual on best practices for patient care begun in 2003.

At the 34th World Conference on Lung Health, the WG conducted a symposium on patient-centred approaches to the care of TB patients. The Tuberculosis Coalition for Technical Assistance (TBCTA) sponsored four group members to attend the annual WG meeting so that they could participate in discussions of the manual in preparation. The manual, which will be printed and distributed with funds from TBCTA, should be ready for the 35th World Conference in 2004.

**Working Group**

**Increasing NAPS Activities at a Regional Level**

Leader: Gini Williams

This WG was set up in October 2001 with the aim of increasing support for and the participation of NAPS at a regional level to raise their profile locally and creating a realistic mechanism for them to become involved at an international level.

Since then, a total of four regional workshops funded by the TBCTA have taken place in Bucharest, Romania (European Region); Durban, South Africa (African Region); Punta del Este, Uruguay (Latin American Region); and Kathmandu, Nepal (Eastern Region) at the same time as the regional conferences. A total of 15 nurses and allied professionals were sponsored to attend the workshops and to participate in the regional conference. Each workshop followed the same format with focused discussions about the participants’ experience of implementing the DOTS strategy and their opportunities for training and research. Two representatives (four in the Latin American Region) were elected from each region to attend the World Conference and the NAPS business section meeting in October 2003.

Future activities for 2004 include a workshop and symposium at the African Regional Conference in Algeria in February; a postgraduate course, poster session and symposium at the European Regional Conference in Moscow in June; and celebrations of the NAPS’ 10th anniversary during the 35th World Conference on Lung Health in Paris.
Member Activities / Scientific Sections

Respiratory Disease and Child Lung Health Section

These two sections were merged during the 34th World Conference on Lung Health in Paris in 2003.

Working Group:
Global Asthma Survey of Practice (GASP)
Leader: Peter Burney

Created in 2003, this Working Group has been commissioned by the Union Asthma Division to do an audit on the asthma treatment in emergency room/casualty departments in low-income countries. What follows is a short report.

INTRODUCTION
Asthma is an increasing problem in many parts of the world, including many areas where medical resources are scarce. Medical intervention to control asthma has been shown to be cost effective even in areas of relative deprivation. However, the control of asthma, as for most chronic diseases, requires continuity of care, which many places are ill-equipped to provide. This may result in inefficient use of resources with an increased burden being placed on secondary care. In order to assess the extent of the problem it would normally be necessary to undertake prevalence surveys that are beyond the resources of most countries and would not be appropriate for long-term monitoring, at least in local areas.

OBJECTIVES
To devise and assess an audit tool for use in emergency rooms that will inform the local health services of the need for improving asthma management and identify the targets for improvement.

OVERALL STRATEGY
This project is based on the principles guiding development of complex interventions. The first part relates to the development of tools and their demonstration. The second part, to be designed in light of results from the first part of the study, will be a more formal trial. To date we have completed an initial survey of patients in emergency rooms.

PROTOCOL FOR THE INITIAL SURVEY
An initial survey of 1,005 patients was carried out in 2002–2003 in 15 centres. The contributors at the World Conference in 2003 discussed this experience. The project was feasible, but there were difficulties in collecting the data in very busy units without any extra resources. It also became clear that the interpretation of some of the survey questions had varied between sites. To improve on this, we decided that the design of some parts of the survey needed to be reviewed and funding sought for a more definitive survey. All those at the meeting agreed that they would make time to complete a further survey.

A very small sub-group of the WG will meet at the American Thoracic Society in 2005 to review what needs to be done and to seek funds for the work to be completed.

Working Group:
Air Pollution in Low-Income Countries
Leader: N Zidouni
Report submitted by Jean-François Tessier

This Working Group has decided to prepare a cooperative project to measure the health impact of air pollution in low- or middle-income countries. To this end, one member, Laurent Filleul, is preparing a short questionnaire on available data per country. If a sufficient number of responses are received, a new poster discussion for the 35th Union World Conference will be prepared.

The group has also decided to write guidelines with the help of experts. A short draft will be prepared for the next WG business meeting in October 2004.

Symposium proposed for the 35th World Conference:
- Improvement of indoor and ambient air quality in developing countries

The full report of this Working Group and the list of members are available in French on the Union website: www.iuatld.org
Members of the Tuberculosis Section held the annual meeting of the Tuberculosis Section at the 34th World Conference in Paris. It was attended by 63 members who heard reports from the Secretariat and voted on a variety of issues. Leaders of the Working Groups also made presentations.

Proposals for the 35th Union World Conference on Lung Health

- **Postgraduate Courses:**
  - Planning and implementing public–private partnerships (EducationWG)

- **Symposia:**
  - 2 sessions from the TB/HIV WG
  - 1 session on TB in Prisons

### Working Group

#### TB/HIV

**Leaders:** Renee Ridzon and Bess Miller

During the 34th World Conference on Lung Health, the TB/HIV Working Group sponsored and convened a symposium on TB/HIV co-infection successes and challenges for integration of treatment and prevention services and a TB/HIV poster discussion session.

Their annual WG meeting, a lively forum for exchanging information and experience, focused on different issues: the role of activists, the need to conduct operational research the need to address capacity building and the use of incentives and food in the treatment of TB.

Given the increasing magnitude of TB/HIV co-infection, and the continued need for group members to share experience and data, the TB/HIV WG expressed its wish to renew its five-year mandate to convey TB/HIV co-infection issues at professional meetings and to hold meetings during Union regional conferences.

As an advocacy group, the WG has been successful in “getting the message” to the HIV community and the TB community. In addition to convening sessions during the Union World Conferences on Lung Health, the TB/HIV WG has scheduled sessions at the last two International AIDS meetings in Durban and Barcelona, sponsored a plenary session at the Paris AIDS meeting in July 2003 and chaired a session on TB/HIV at the December 2003 meeting of the World STI/AIDS Congress in Uruguay. For the International AIDS meeting in Bangkok in 2004, the group plans to work closely with the World Health Organization (WHO).

The WG reviewed and found the Union’s statement on the treatment of HIV-related TB to be outdated. However, a new statement will not be necessary if the Union adopts the revised WHO statement.

### Working Group

#### Education

**Leader:** Amir Khan

The Education Working Group (WG) organised one postgraduate course for the 34th World Conference on Lung Health on planning and implementing public–private partnerships which was attended by 25 people. The WG also reviewed TB training experiences in the private sector, with financial support from the TB Coalition for Technical Assistance (TBCTA), and in collaboration with the WHO and the Nuffield Institute for Health (UK). Findings were presented in a poster session.

J. Prignot also reported on the Helsinki meeting on Tobacco or Health in August 2003.

A high point of the year was the publication of *Tobacco: A Global Threat* by J. Crofton and D. Simpson. English and French editions are available and can be ordered from the Union Secretariat.

Proposed activities for November 2003–October 2004 include working with the chairs of the Union regions to identify one contact member per region.

### Tobacco Prevention Section

Members of the Tobacco Prevention Section organised two symposia for the 34th World Conference on Lung Health:

- Understanding tobacco products, which included a presentation by J. Prignot on smoking measurements and intake markers in ventilated vs. standard cigarettes;

- Problems in lung health, featuring presentations, also by J. Prignot, on smoking cessation in COPD patients and Belgian experience in medical education on smoking cessation.

J. Prignot also reported on the Helsinki meeting on Tobacco or Health in August 2003.

A high point of the year was the publication of *Tobacco: A Global Threat* by J. Crofton and D. Simpson. English and French editions are available and can be ordered from the Union Secretariat.

Proposed activities for November 2003–October 2004 include working with the chairs of the Union regions to identify one contact member per region.
Working Group:

TB in Prisons
Leader: Michael Kimerling

This Working Group was formed in 1998, at a time when TB in prisons was not considered a high-priority issue. One of the goals of this working group has been to “mainstream” TB control in prisons — that is, to see it accepted and integrated into the overall efforts to fight TB. Substantial progress has been made as evidenced by the increase in regional initiatives, symposia at Union regional conferences, poster displays and/or poster discussion sessions at the Union World Conferences in Montreal (2002) and Paris (2003), and training sessions, some of which were reported on during the WG meeting:

TB AMONG PRISONERS: BALTIC SEA REGION AND RUSSIA
Meetings for improving prison TB programmes in the Baltic Sea Region and Russia were held in Sigtuna, Sweden, in 2000 and St Petersburg, Russia, in 2002. Sponsors were the Norwegian and Swedish governments.

EUROPEAN REGION QUESTIONNAIRE/SURVEY/INVENTORY
This survey of TB prison programmes, conducted by KNCV, is near completion.

PAHO-GORGAS TB INITIATIVE
The Pan American Health Organization (PAHO) sponsored a regional workshop on TB control in prisons for Latin America in Honduras in August 2003. It brought together NTP man-
agers and prison medical directors from Honduras and all of the high-burden Latin American countries. Participants developed a country-specific joint work plan for prison TB control linking the prison and civilian programmes and agreed on the next steps needed, including new research.

ASIA
The Thai prison TB programme is being expanded nationally.

WHO EUROPEAN NETWORK ON PRISON AND HEALTH (HEALTH IN PRISONS PROJECT)
This group held their annual conference, which was jointly organised by the WHO European Office and the Ministry of Justice and Ministry of Health of the Russian Federation, in Moscow in October 2003. Conference goals included reviewing and highlighting the importance of prison health in the overall public health agenda and refreshing and promoting the collaborative framework and activities of the enlarged network of national counterparts for the WHO Health in Prisons Project.

CONCLUSION
The annual meeting of the WG at the 2003 World Conference was attended by more than 50 people, representing Africa, Asia, Europe, South America and North America. This was an increase over attendance in previous years. The WG unanimously voted to continue meeting annually and to sustain their advocacy efforts in order to maintain momentum.

Goals for 2004 include updating the e-mail list and conducting an inventory of TB in Prisons projects.

Working Group: Trans-Border Migration and TB
Leader: Fraser Wares

This Working Group was formed to review existing practices, policies and guidelines, and recent initiatives on trans-border TB control, particularly the movement of persons from areas of high to low TB prevalence. Guidelines that were gathered this year from Australia, Canada, New Zealand, Red Crescent, United Kingdom and the United States were distributed to WG members on CD-ROM. The group intends to make this information available via an e-mail network.

The WG conducted a symposium and poster session on migration after crisis at the 34th Union World Conference on Lung Health in 2003.

Working Group: Mycobacterium bovis
This group has reached the end of its five-year mandate and has been disbanded.

Tuberculosis in Animals Section

The Tuberculosis in Animals Scientific Section organised a symposium on tuberculosis in wildlife that was held at the 34th World Conference on Lung Health. After the symposium, Dr De Kantor provided information about the epidemiological situation of bovine tuberculosis in South America, and Dr Camacho gave a special report on bovine tuberculosis control in Bolivia, a new programme that will start in 2004.

Among the topics discussed at their annual meeting were contributions to the International Journal of Tuberculosis and Lung Disease and membership in the Section. Members expressed particular concern about the small number of veterinarians, microbiologists and researchers from the veterinary field who participate in the Union.

The Section would like to increase the presence of veterinarians from a variety of countries and backgrounds at the 35th Union World Conference on Lung Health. They would also like to create more interest in the veterinary aspects of TB control among physicians and encourage cooperation between the two professions.

Actions proposed to increase the participation and visibility of the Section include:

- Sponsoring veterinarians from low-income countries, e.g., by waiving the conference fee for speakers
- Reducing the membership or conference fee for veterinarians
- Choosing a theme of broad interest to both veterinarians and physicians for the 2004 symposium
- Increasing the number of Union publications on veterinary topics, including specific guidelines for tuberculosis control in animals
- Organising a training session for veterinarians during the World Conference

Proposed actions for 2004 include compiling a mailing list to inform as many people in the veterinary profession as possible about the Section; preparing a review on tuberculosis transmissibility through milk; and presenting data from regional medical–veterinary surveillance systems on tuberculosis due to M. bovis. Due to the importance of TB in animals and the difficulties in collecting data, the Section recommends that this activity be continued for the next three years.

Proposal for the 35th Union World Conference on Lung Health:

- Symposium: Food safety:
  Can you get tuberculosis from your food?
Awards

The Union presents awards at its annual World Conference on Lung Health to individuals and organisations that have made an outstanding contribution to lung health. The Nominating Committee, which is composed of Union members, studies the proposals and nominates the successful candidates.

**Scientific Prize**

The Scientific Prize of US $2,000 is awarded to a researcher aged under 45 for work on tuberculosis or non-tuberculous lung disease published in the past two years.

**2002:** Awarded to Dr Jose Antonio Castro-Rodriguez, a pulmonary physician from Chile, for his paper “A clinical index to define risk of asthma in young children with recurrent wheezing”.

**2003:** Awarded to Dr Elizabeth Corbett from the United Kingdom, who lives in Zimbabwe, for her impressive body of research on tuberculosis associated with HIV and silicosis in the South African gold mines. Dr Corbett has published more than 16 articles, many of which have been published in the *International Journal of Tuberculosis and Lung Disease* (IJTLD).

**Karel Styblo Public Health Prize**

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

**2002:** Awarded to Dr Anne Horgheim for her work over the past decade in strengthening NTPs in Nepal, Sudan and, most recently, in Arkhangelsk, Russia, and for her long-term commitment to training and supervising field staff and working with national teams to develop their TB control manuals.

**2003:** Awarded to Prof Oumou Bah-Sow from Conakry, Guinea, for her lifelong commitment to tuberculosis care which included the establishment of the National Tuberculosis Programme in Guinea.

**Union Medal**

The Union Medal is awarded to those members who have made an outstanding contribution to the control of tuberculosis or non-tuberculous lung disease through their scientific work and/or actions in the field.

**2002:** Awarded to Dr Arata Kochi, director of the World Health Organization Global TB Programme from 1989–2001 and to the Right Honourable Susan Whelan, Minister for International Cooperation, in recognition of Canada’s commitment to tuberculosis.

**2003:** No Union Medal was awarded.
This annual award memorialises Princess Chichibu of Japan (1909–1995) who was active for many years in the Japan Anti-Tuberculosis Association (JATA) and served as its president. The US $10,000 award is given in recognition of outstanding achievement in anti-tuberculosis activities. Candidates are recommended by the Union Awards Committee irrespective of their nationality, and the winner is selected by JATA. The president of JATA presents the award at the World Conference on Lung Health.

2002: Presented by Dr Toru Mori of JATA to Dr Peter Small of Stanford University for his work in molecular research.

2003: Presented by Dr Nobukatsu Ishikawa of JATA to Prof Donald Enarson of the Union for his outstanding contribution to tuberculosis treatment and control.

**FRANZ REDEKER PRIZE**

The Franz Redeker Prize of 5,000 euros is awarded by the German Central Committee Against Tuberculosis every four years to honour the most distinguished scientific work related to the fight against tuberculosis from a socio-medical point of view. It will next be awarded in 2006. No award was presented in 2002.

**HONORARY MEMBERSHIP**

The title of Honorary Member of the Union is granted to a person who has made a distinguished contribution through active participation in the Union’s activities and the fulfilment of its goals. Union Constituent Members may nominate candidates three months before the World Conference.

2002: Awarded to Dr Pierre Chaulet for his contribution to tuberculosis and lung health; Dr Michael Iseman for his outstanding contribution as Editor-in-Chief of the *International Journal of Tuberculosis and Lung Disease*; and Dr Earl Hershfield of Canada for his contribution to strengthening lung associations in Asia with support from the Canadian International Development Agency (CIDA).

2003: No Honorary Memberships were awarded.

More information about the Union awards is available at www.iuatld.org

**CHRISTMAS SEALS**

Individuals have been contributing to the struggle against tuberculosis by purchasing Christmas seals for nearly 100 years. Conceived by Einar Holboell, a Danish postal worker who wanted to raise money to treat poor children with TB, Christmas seals first appeared in Denmark in 1904. The Danish campaign sold 4 million stamps that year, and the idea quickly spread to other countries across Europe and North America.

Today millions and millions of Christmas seals are sold each year, and, in many countries, they are still the main source of funding for TB control. In India, for example, profits from the sale of Christmas seals support 500 TB centres.

In honour of the Christmas seal’s colourful and remarkable role in the history of TB control, the Union holds a contest each year to select the best seal designs. The seals are displayed at the World Conference, and all delegates are invited to vote for their favourites.

**Winners in 2002:**

1st prize: Japanese Anti-Tuberculosis Association (A)
2nd prize: Canadian Lung Association (B)
3rd prize: Royal Netherlands Tuberculosis Association (C)

**Winners in 2003:**

1st prize: Canadian Lung Association (D)
2nd prize: Korean National Tuberculosis Association (E) and Philippines Tuberculosis Society (F)
3rd prize: Comite Nacional de Lucha Contra la Tuberculosis, Mexico (G)
Board Meetings and General Assemblies

Between 1 July 2002 and 31 December 2003, the Union Board of Directors held five meetings: two at each World Conference and a three-day retreat in Paris in May 2003. The annual General Assemblies were held each year at the World Conference.

Following are summaries of all of these proceedings. Full details can be obtained from the Union Secretariat.

REPORTS FROM THE BOARD MEETINGS

Board Meetings during the 33rd World Conference
7 – 10 October 2002

Agenda items included the proposed change of the fiscal year to a calendar year; a decrease in unrestricted funds and membership contributions; holding World Conferences in Paris due to practical and logistical considerations; a change in editorship of the International Journal of Tuberculosis and Lung Disease (IJTLD); the cost of World Conferences and need for sponsors; a recommendation to seek local government and World Health Organization (WHO) support for symposia at regional meetings; presentation of plans for a media centre in India; a recommendation that the Eastern Region divide into two smaller regions; and Secretariat human resource issues.

The Board Retreat
2 – 4 May 2003

NEWS FROM THE SECRETARIAT

Reports were given on the progress of the Child Lung Health Project; the creation of the new Nursing Division; the activities of the Asthma Division; the Tobacco Prevention Division’s advocacy work and the Framework Convention on Tobacco Prevention; technical presentations on the FIDELIS project; the new HIV Department; and TB Clinical Trials.
NEWS FROM THE REGIONS

- The North American Region seeks stronger communication between the Secretariat and the regions, better membership lists, and more flexibility in their use. Their focus is TB, but they are open to other subjects, such as tobacco and asthma, and would like to link with other regions to sponsor symposia.
- The Middle-East Region reported similar communication concerns. They would like the Europe and North American Regions to participate in their meetings.
- The next meeting of the Europe Region in Moscow in June 2004 is expected to attract 4,000 participants.
- The Eastern Region is still considering its division into two parts.
- The Africa Region enumerated the scientific content of its forthcoming conference.
- The deliberations of the Inter-Regional Council (IRC) on relations between the Scientific Sections and the regions were also reported.

BUDGET

The Board received a mid-year budget update for the current 18-month reporting period.

REPORTS FROM THE GENERAL ASSEMBLIES

2002: 10 October, Montreal

The General Assembly heard and approved the President’s report, the Treasurer’s report and a budget for 2002–2003, which took into account the considerable growth in the Union’s activities. The Assembly discussed membership decreases and measures to strengthen the regions. They also heard a report on the Chinese version of the International Journal of Tuberculosis and Lung Disease (IJTLD). Constituent members in arrears were reminded that they must pay their dues by the end of 2002 or risk losing their status. Approved resolutions included the decision to hold future World Conferences on Lung Health in Paris, to strengthen regional conferences as a corollary to this decision, and to change the fiscal year ending from 30 June to 31 December.

2003: 2 November, Paris

The President’s report, the Treasurer’s report and the budget for 2004 were all approved at this meeting. The Assembly also approved the purchase of additional premises for the Secretariat in Paris. The decision to continue to hold World Conferences on Lung Health in Paris until 2006 was reiterated, and the dates of the 2004 regional conferences were announced. A concern was raised about the Board of Directors’ nomination procedures and the Nominating Committee agreed to review the procedures.

A minute of silence was observed in memory of Professor Jacques Chrétien, Mr Jean-Pierre Mallet, Dr Annalena Tonelli and Dr Ihsan El Rifai.

"This is a time of great opportunity – the strategy for curing TB is being applied with increasing vigour through partnerships in Stop TB, with targets to expand DOTS, partnering with HIV, and seeking new drugs, diagnosis and vaccines. The role of industrialised nations is clearly to support this movement as part of a larger commitment to addressing the obscene disparity between rich and poor."

Prof Anne Fanning, President of the Union.

October 2002, Montreal
TONE RINGDAL, 1942–2002

Tone Ringdal was a dedicated public health practitioner who collaborated with the Union for more than 20 years. She died in a traffic accident on 31 July 2002 at the age of 60.

Dr Ringdal was born in Voss and graduated from medical school in Oslo in 1969. She obtained a degree in tropical medicine and public health in Uppsala in 1976 and a master’s in public health from the University of Tromsø in 1999. She was licensed as a general practitioner in Norway in 1979 and specialised in public health in 1985.

Dr Ringdal worked in Liberia in 1976–77 and in Angola in 1980–82. From 1985 to 1999 she worked for “Nasjonalforeningen for Folkehelsan” in Norway as a consultant to their tuberculosis projects in low-income countries and as secretary to its Tuberculosis Council. She collaborated closely with the Union from 1988 onward.

Until early 2002, Dr Ringdal was the driving force behind the NO-TB-Baltic project and consulted for agencies such as NORAD and the WHO. At the time of her death she had recently joined a Task Force on Communicable Disease Control in the Baltic Sea Region.

I first met Tone Ringdal in 1990 when she interviewed me for a post with Nicaragua’s National Tuberculosis Programme. I still remember my first impression — how she skillfully explained to a newcomer the logic applied in the Union collaborative programmes. Cool and clear. No nonsense. Many remember and respected her for this. We are thankful to her for her many contributions and bid farewell to an excellent person.

Thuridur Arnadottir
Iceland

JEAN-PIERRE MALLETT, 1915–2003

Jean-Pierre Mallet was Treasurer of the International Union Against Tuberculosis and Lung Disease for 39 years, from 20 October 1954 to 7 October 1993. He fulfilled this mission with dedication and devotion and left the organisation with a solid legacy of good financial practice.

Born and educated in Paris, Mr Mallet began his career in 1938 at Mallet Frères, his father’s bank. He was a highly decorated pilot during World War II and returned to banking to become managing partner of Mallet Frères in 1944. He initiated the merger that created Banque de Neuflize Schlumberger Mallet (NSM) in 1966 and was still active at the time of his death, serving as Honorary President of the Banque de Neuflize Schlumberger Mallet Demachy (NSMD). He was married and the father of three children.

Mr Mallet’s deep respect for others led him to become involved with voluntary organisations, among them the national French association, le Comité National de Défense Contre les Maladies Respiratoires et la Tuberculose, and the Union. He was invited to become Treasurer of the Board of Directors in 1954 and held that position until his retirement in 1993.

As Treasurer, Mr Mallet attended every World Conference and wrote his own speeches, first in French and then in English. He worked with six Executive Directors during his tenure, and he was responsible for decisions ranging from salary increases and development of the staff insurance scheme to selection of the audit company.

In his final speech to the Board of Directors in October 1993, Mr Mallet paid tribute to all the people he had met and worked with and to their remarkable achievements. A friend of the Union until the end of his life, Mr Mallet died in his sleep at the age of 87 on 19 May 2003.

Wendy Atkinson
Communication Coordinator of the Union
Jacques Chrétien, 1922–2003

Professor Jacques Chrétien was a member of the Union throughout his long medical career and served as President of the Committee on Respiratory Diseases, President of the Executive Committee and Council, and Editor-in-Chief of the scientific journal.

Professor Chrétien’s enlightened direction led to the development of the tuberculosis control methods proposed and perfected by the Union during the 1980s and 1990s, which have since been adopted and applied by the World Health Organization and many governments and organizations. It is because of the success of these operational protocols that the Union is called upon to develop and support national TB control programmes and to provide courses on TB and pulmonary diseases around the world.

As editor of the IUATLD Bulletin, Professor Chrétien aimed to both improve the scientific quality of the articles and reduce the workload it created. To accomplish this, he first engineered a merger with the prestigious Edinburgh-based journal, Tubercle, to form Tubercle and Lung Disease. This led to the establishment of the International Journal of Tuberculosis and Lung Disease, which became the reference journal in these areas of clinical science and public health.

Professor Chrétien recommended that the organisation move its headquarters to boulevard St Michel in 1986. And it was he who selected Dr Nils Billo and Professor Donald Enarson, two particularly competent and equally motivated successors, when Dr Karel Styblo, Director of Scientific Activities, and I retired.

To the end of his life, Professor Chrétien continued to earn our respect and admiration. His wisdom, determination and constant search for excellence illuminated a crucial period in the evolution of the Union – and the development of the valuable tools and strategies for which it is now recognised worldwide.

Annik Rouillon
Former Executive Director of the Union
Paris
Finance and Administration

Mother and child who both have MDR-TB, Cape Town, South Africa
This Activity Report covers an accounting period of 18 months – July 2002–December 2003. The increase in revenue and projects experienced during this reporting period made it necessary for the Union to revamp its financial information systems and hire additional staff in order to meet the complex reporting requirements of our donors and the volume of transactions.

During the reporting period, accounting staff prepared 148 financial reports for donors, prepared accounts for 15 external audits, and organised the disbursement of per diem to approximately 500 individuals. Staff also procured drugs, supplies and equipment for the National TB Programmes of several countries for a value of almost two million euros.

The Department of Finance and Development is responsible for the proper maintenance of the Union’s financial records which includes ensuring the integrity of data submitted, recorded and reported to both internal and external users of our accounting information. The Department delivers a wide range of financial management services to the Union, incorporating innovative business practices and compliance with financial regulations, national and international.

The Department staff support the training, research and technical assistance activities of the Union by providing efficient and effective financial and administrative services, by enabling access to information and resources, and by promoting the financial health and security of each unit and of the Union as a whole.
I am pleased to submit the annual report of the Treasurer of the International Union Against Tuberculosis and Lung Disease for the fiscal year ended 31 December 2003.

Equipped for tomorrow

Fiscal 2003 changed the Union faster and more lastingly than any other period in the organisation’s history. For the Union, 2003 was a time of transition and transformation in which we laid the foundation for greater international activities and continuing growth. Our goal was to create an infrastructure to support the changing activities of the Union and to offer convincing perspectives for the future. Yet we are proceeding prudently to accomplish our work as efficiently and cost-consciously as possible and in awareness of our responsibility towards our employees and consultants who are driving and invigorating this major change process with great dedication.

During 2003 the Union invested its resources in opening two additional offices in Paris to house the Department of Scientific Activities and the Clinical Trials Programme respectively. Significant investments were made to modernise the Union’s computer equipment and information systems. A department of HIV was established and a Resource Centre was opened in New Delhi to support the Union’s training and development activities worldwide.

Financial overview

The confidence of international donors in the work of the Union was demonstrated by two important developments in 2003:

- the Canadian Agency for International Development’s decision to award CAD $19 million for the management of the FIDELIS project for 3 years;
- the signing of a five-year cooperative agreement for the amount of US $14.2 million with the United States Agency for International Development (USAID).

The financial environment was difficult in 2003. Although the Union’s revenue increased to 44 million euros (US $55.6 million), chiefly through managed funds, our financial performance was marked by an unsatisfactory level of unrestricted revenue. After three consecutive years with positive results, the total reported operating result for 2003 was negative for 1.069 million euros (US $1.348 million). However, this includes a provision for risk-of-exchange loss of 637,807 euros (US $803,445), as required by French laws. This provision is a precaution and not an actual loss. Therefore, the actual net loss is 432,000 euros (US $544,190), which is mainly attributed to insufficient revenue for the following:

- the International Journal of Tuberculosis and Lung Disease;
- bank interest and financial charges;
- external audits;
- World Lung Health Conferences (two were held during this reporting period).

The Union’s budget has two major funds: the “General Fund” and the “Restricted Fund”. The General Fund, which accounts for approximately 14% of total revenue, comprises the funds over which the Union’s Board of Directors retains full control to use in achieving its mission and objectives. The General Fund includes revenues derived from membership, conferences, operating grants and gifts.

Growth in General Fund revenue fell short of the forecast in Fiscal 2003 by 29%.

The Restricted Fund revenue, which accounts for 86% of total revenue, includes all funds that are generally subject to special grant reporting proce-
dures and limitations. Restricted funds are subject to legally binding limits established by the organisation providing the funds for specific purposes, programmes, departments or countries. The Restricted Fund reflects a substantial increase from the amount budgeted in FY 2002.

Cash flow
It is important to note that restricted funds do not come to the Union as simple cash transfers. The donor agencies mandate many requirements as conditions for the grants and often the Union has to advance its own unrestricted funds or borrow funds in anticipation of revenue in order to start programme implementation. In Fiscal 2003, substantial delays in the arrival of funds from several major donors made it necessary for the Union to advance nearly three million euros on a short-term basis. This situation puts tremendous pressure on the Union’s finances.

Future perspectives
The continuing weak dollar trend will have unsatisfactory effects on the Union’s finances in future years as well. More than 95% of the Union’s revenue is in foreign currencies (US or Canadian dollars and Swiss francs). As an organisation headquartered in France, the Union incurs its operating expenses in euros and is required to present its annual accounts in euros. In addition, funding will be difficult to obtain in coming years as an increasing number of donor agencies are providing funds directly to the countries or to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Funding for international tobacco prevention projects and asthma is very limited and difficult to obtain.

We will quickly, competently and systematically address these challenges and actively work to diversify and increase our sources of revenue – aiming to create an organisation that convinces through performance. Wherever we are unable to increase sources of revenue, we will aim at establishing strategic alliances or collaborating with other organisations. We will consistently streamline General Fund expenditures focusing our budget on priority areas. Cost-cutting programmes and restructuring measures will also be necessary in some areas to optimise growth and quality.

Financial statements
This report describes the financial position of the Union. The document on the following pages consists of the financial statements for Fiscal Year 2003 audited by KPMG. The audited financial statements present a snapshot of the Union’s entire resources and obligations at the close of the fiscal year. We do not provide a comparative analysis of Fiscal 2002 and Fiscal 2003 as the periods are different for each fiscal year (12 months vs 18 months). 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.

I would like to thank our members and donors for the support to the Union and for the trust you continue to place in our organisation during these challenging times. Rest assured that the management team will do everything in its power to ensure the Union’s success in its activities. I would also like to thank our employees and consultants, who have shown exemplary dedication to the Union in the past year.

Louis-James de Viel Castel
Treasurer
To the Honorary Treasurer of International Union Against Tuberculosis and Lung Disease

Dear Sir,

In compliance with the assignment entrusted to us by the Executive committee, we are pleased to submit our report concerning the audit of the accounts of the association International Union Against Tuberculosis and Lung Disease, for the period beginning July 1st, 2002 and ended December 31st, 2003 as attached to the present report.

These financial statements have been prepared by the Union. Our responsibility is to express an opinion on these financial statements based on our audit.

Opinion on the annual accounts

We conducted our audit in accordance with the professional standards applicable in France. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made in the preparation of the accounts, as well as evaluating the overall financial statements presentation. We believe that our audit provides a reasonable basis for our opinion.

For your information, the Union has proceeded to a restatement of the premises based on an evaluation performed by an independent expert. The net difference (US$ 2,377,552.33) between market value and historical cost is credited to equity as restatement reserve.

In our opinion, the financial statements give a true and fair view of the financial position and its assets and liabilities as of December 31st, 2003 and of the results of its operations for the year then ended in accordance with the accounting rules and principles applicable in France.

Levallee-Perret, August 24th, 2004

KPMG Entreprises

Francois Kinnel
Partner

**Union Budget**
- **Revenues**
- **Expenditures**

**Financial Year 2003**
- **Expenditure**
  - Courses: 5%
  - Managed Funds: 22%
  - Personnel: 16%
  - Services and Publications: 4%
  - Conferences: 48%
  - Travel: 14%
  - Other: 4%

**Financial Year 2003**
- **Sources of Revenue**
  - Courses: 19%
  - Managed Projects: 6%
  - Membership: 4%
  - Other Income: 48%
  - Conferences: 9%
  - Grants and Gifts: 14%

Fiscal Year: 1 July 2002 to 31 December 2003
**Balance Sheet**

1 July 2002 - 31 December 2003

<table>
<thead>
<tr>
<th>Assets</th>
<th>Net Amount</th>
<th>31.12.2003 (18 months)</th>
<th>30.06.2002 (12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed assets</strong></td>
<td></td>
<td>€</td>
<td>US$</td>
</tr>
<tr>
<td>Software</td>
<td>62 224</td>
<td>78 384</td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>500 000</td>
<td>629 850</td>
<td></td>
</tr>
<tr>
<td>Building</td>
<td>2 070 000</td>
<td>2 607 578</td>
<td></td>
</tr>
<tr>
<td>Fixtures and equipments</td>
<td>73 417</td>
<td>92 484</td>
<td></td>
</tr>
<tr>
<td>Other tangible fixed assets</td>
<td>225 547</td>
<td>284 122</td>
<td></td>
</tr>
<tr>
<td>Financial fixed assets</td>
<td>34 119</td>
<td>42 980</td>
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<tr>
<td><strong>Total 1</strong></td>
<td>2 965 308</td>
<td>3 735 398</td>
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</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constituent members</td>
<td>292 099</td>
<td>367 957</td>
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<tr>
<td>Suppliers advance</td>
<td>222 568</td>
<td>280 369</td>
<td></td>
</tr>
<tr>
<td>Managed funds receivable</td>
<td>12 212 562</td>
<td>15 384 164</td>
<td></td>
</tr>
<tr>
<td>Other receivables</td>
<td>519 501</td>
<td>654 415</td>
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<tr>
<td>Sundry debtors</td>
<td>604 895</td>
<td>761 986</td>
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<tr>
<td><strong>Total 2</strong></td>
<td>13 851 625</td>
<td>17 448 891</td>
<td></td>
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<tr>
<td>Financial investment for managed funds</td>
<td>6 616 361</td>
<td>8 334 630</td>
<td></td>
</tr>
<tr>
<td>Cash and bank for managed funds</td>
<td>5 794 744</td>
<td>7 299 639</td>
<td></td>
</tr>
<tr>
<td>Cash and bank of the Union</td>
<td>1 947 436</td>
<td>2 453 185</td>
<td></td>
</tr>
<tr>
<td><strong>Total 3</strong></td>
<td>14 358 541</td>
<td>18 087 454</td>
<td></td>
</tr>
<tr>
<td><strong>Prepaid expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total 4</strong></td>
<td>133 933</td>
<td>132 004</td>
<td></td>
</tr>
<tr>
<td><strong>Realisable exchange losses</strong></td>
<td>641 601</td>
<td>808 225</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>31 911 305</td>
<td>40 198 670</td>
<td></td>
</tr>
</tbody>
</table>

NB: 2002 1 € = 0.9856$

2003 1 € = 1,2597$
### Liabilities

<table>
<thead>
<tr>
<th></th>
<th>31.12.2003 (18 months)</th>
<th>30.06.2002 (12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserves</td>
<td>€ 429 820</td>
<td>US$ 541 445</td>
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<tr>
<td>Result carried forward</td>
<td>€ 123 269</td>
<td>US$ 155 282</td>
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<tr>
<td>Result from the financial year</td>
<td>-1 069 793</td>
<td>US$ -1 347 618</td>
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<tr>
<td>Restatement reserve on premises</td>
<td>€ 1 887 396</td>
<td>US$ 2 377 552</td>
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<tr>
<td><strong>Total 1</strong></td>
<td>€ 1 370 692</td>
<td>US$ 1 726 660</td>
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<tr>
<td><strong>Contingent liability</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Total 2</strong></td>
<td>€ 637 387</td>
<td>US$ 802 917</td>
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<tr>
<td><strong>Investment grant</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Total 3</strong></td>
<td>€ 558</td>
<td>US$ 550</td>
</tr>
<tr>
<td><strong>Dedicated funds</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Total 4</strong></td>
<td>€ 24 623 667</td>
<td>US$ 31 018 433</td>
</tr>
<tr>
<td><strong>Debts</strong></td>
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<td></td>
</tr>
<tr>
<td>Borrowing from credit institutions</td>
<td>€ 162 349</td>
<td>US$ 204 512</td>
</tr>
<tr>
<td>Short term borrowing from credit institutions</td>
<td>€ 3 782 801</td>
<td>US$ 4 765 195</td>
</tr>
<tr>
<td>Suppliers and similar accounts</td>
<td>€ 304 841</td>
<td>US$ 384 008</td>
</tr>
<tr>
<td>Tax and social security</td>
<td>€ 285 960</td>
<td>US$ 360 223</td>
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<tr>
<td>Charges to be paid</td>
<td>€ 105 584</td>
<td>US$ 133 004</td>
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<tr>
<td>Other unliquidated obligations</td>
<td>€ 484 929</td>
<td>US$ 610 865</td>
</tr>
<tr>
<td><strong>Total 5</strong></td>
<td>€ 5 126 464</td>
<td>US$ 6 457 807</td>
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<tr>
<td><strong>Deferred income</strong></td>
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<td></td>
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<tr>
<td><strong>Total 6</strong></td>
<td>€ 66 264</td>
<td>US$ 83 473</td>
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<tr>
<td><strong>Realisable exchange profit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total 7</strong></td>
<td>€ 86 831</td>
<td>US$ 109 381</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>€ 31 911 305</td>
<td>US$ 40 198 670</td>
</tr>
</tbody>
</table>

NB: 2002 1 € = 0.9856$  
2003 1 € = 1.2597$
## Income/Expenses

1 July 2002 - 31 December 2003 in Euros

### Income Statement (in €)

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>1 253 634</td>
<td>1 253 634</td>
<td>751 783</td>
<td></td>
</tr>
<tr>
<td>Operating grant</td>
<td>1 331 733</td>
<td>1 331 733</td>
<td>307 628</td>
<td></td>
</tr>
<tr>
<td>Grants and gifts (1)</td>
<td>2 071 345</td>
<td>30 439 111</td>
<td>6 636 510</td>
<td></td>
</tr>
<tr>
<td>Write back of provisions</td>
<td>226 120</td>
<td>108 423</td>
<td>328 543</td>
<td></td>
</tr>
<tr>
<td>and transferred charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Write back of dedicated</td>
<td>7 344 222</td>
<td>7 344 222</td>
<td>653 601</td>
<td></td>
</tr>
<tr>
<td>funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other income</td>
<td>1 212 583</td>
<td>130 275</td>
<td>1 342 858</td>
<td>119 557</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6 095 415</td>
<td>38 022 031</td>
<td>44 117 445</td>
<td>8 751 734</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External charges</td>
<td>3 625 354</td>
<td>5 705 977</td>
<td>9 331 331</td>
<td>2 435 771</td>
</tr>
<tr>
<td>Taxes</td>
<td>179 441</td>
<td>179 441</td>
<td>102 405</td>
<td></td>
</tr>
<tr>
<td>Wages and salaries</td>
<td>1 764 632</td>
<td>1 764 632</td>
<td>790 458</td>
<td></td>
</tr>
<tr>
<td>Social contributions</td>
<td>740 148</td>
<td>740 148</td>
<td>466 024</td>
<td></td>
</tr>
<tr>
<td>Depreciation charges and</td>
<td>280 933</td>
<td>280 933</td>
<td>79 790</td>
<td></td>
</tr>
<tr>
<td>addition to provisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations for projects</td>
<td>29 296 485</td>
<td>29 296 485</td>
<td>4 654 607</td>
<td></td>
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<tr>
<td>Other expenses</td>
<td>406 494</td>
<td>3 019 568</td>
<td>3 426 062</td>
<td>113</td>
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<tr>
<td><strong>Total</strong></td>
<td>6 997 002</td>
<td>38 022 031</td>
<td>45 019 033</td>
<td>8 529 168</td>
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<tr>
<td><strong>Operating Result</strong></td>
<td>-901 587</td>
<td>0</td>
<td>-901 587</td>
<td>222 566</td>
</tr>
<tr>
<td>Foreign exchange profits</td>
<td>368 985</td>
<td>368 985</td>
<td>-5 126</td>
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<tr>
<td>Write back of financial</td>
<td>176 629</td>
<td>176 629</td>
<td>-18 808</td>
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<tr>
<td>provisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest and financial</td>
<td>-76 431</td>
<td>-76 431</td>
<td>-177 661</td>
<td></td>
</tr>
<tr>
<td>charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Provision of risk for</td>
<td>-637 387</td>
<td>-637 387</td>
<td>-177 661</td>
<td></td>
</tr>
<tr>
<td>foreign exchange losses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net financial income</strong></td>
<td>-168 205</td>
<td>0</td>
<td>-168 205</td>
<td>-201 595</td>
</tr>
<tr>
<td><strong>Net result for financial year</strong></td>
<td>1 069 793</td>
<td>0</td>
<td>1 069 793</td>
<td>20 971</td>
</tr>
</tbody>
</table>

(1) The amount in column managed funds includes 12,212,562 € receivables

---

NB: 2002 1 € = 0,9856$  
     2003 1 € = 1,2597$
### Income Statement (in US$)

#### Operating Income

<table>
<thead>
<tr>
<th>Source</th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>1,579,203</td>
<td>1,579,203</td>
<td>740,957</td>
<td></td>
</tr>
<tr>
<td>Operating grant</td>
<td>1,677,584</td>
<td>1,677,584</td>
<td>303,198</td>
<td></td>
</tr>
<tr>
<td>Grants and gifts (1)</td>
<td>2,609,273</td>
<td>38,344,148</td>
<td>40,953,421</td>
<td></td>
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<tr>
<td>Write back of provisions and transferred charges</td>
<td>284,843</td>
<td>136,580</td>
<td>421,423</td>
<td></td>
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<tr>
<td>Write back of dedicated funds</td>
<td>9,251,517</td>
<td>9,251,517</td>
<td>644,189</td>
<td></td>
</tr>
<tr>
<td>Other income</td>
<td>1,527,490</td>
<td>164,107</td>
<td>1,691,597</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,678,393</td>
<td>47,896,352</td>
<td>55,574,745</td>
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</tr>
</tbody>
</table>

#### Operating Expenses

<table>
<thead>
<tr>
<th>Source</th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External charges</td>
<td>4,566,858</td>
<td>7,187,820</td>
<td>11,754,678</td>
<td>2,400,696</td>
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<tr>
<td>Taxes</td>
<td>226,042</td>
<td>226,042</td>
<td>100,930</td>
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</tr>
<tr>
<td>Wages and salaries</td>
<td>2,222,906</td>
<td>2,222,906</td>
<td>779,075</td>
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</tr>
<tr>
<td>Social contributions</td>
<td>932,365</td>
<td>932,365</td>
<td>459,313</td>
<td></td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>353,891</td>
<td>353,891</td>
<td>78,641</td>
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<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>36,904,782</td>
<td>36,904,782</td>
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<tr>
<td>Other expenses</td>
<td>512,060</td>
<td>3,803,750</td>
<td>4,315,810</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>8,814,123</td>
<td>47,896,352</td>
<td>56,710,475</td>
<td></td>
</tr>
</tbody>
</table>

#### Operating Result

-1,135,729

#### Foreign exchange profits

464,810

#### Write back of financial provisions

222,499

#### Interest and financial charges

-96,281

#### Provision of risk for foreign exchange losses

-802,917

#### Net financial income

-211,889

#### Net result for financial year

-1,347,618

{(1) The amount in column managed funds includes 15,384,164 USD receivables}

---

**NB:**

- 2002 1 € = 0.9856$  
- 2003 1 € = 1,2597$
The work summarised in this Activity Report would not have been possible without the assistance and support of all our donors. We would like to express our sincere thanks to the following organisations and individuals for their financial support during this 18-month reporting period.

**DONOR ACKNOWLEDGEMENTS**

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aeras Global Tuberculosis Vaccine Foundation</td>
<td>Norwegian Agency for Development Cooperation (NORAD)</td>
</tr>
<tr>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>Norwegian Association of Heart and Lung Patients (LHL)</td>
</tr>
<tr>
<td>British Columbia Lung Association</td>
<td>NTP Bolivia</td>
</tr>
<tr>
<td>Canadian International Development Agency (CIDA)</td>
<td>NTP Costa Rica</td>
</tr>
<tr>
<td>Canadian Lung Association</td>
<td>NTP El Salvador</td>
</tr>
<tr>
<td>Chest Heart and Stroke Scotland</td>
<td>NTP Guatemala</td>
</tr>
<tr>
<td>Damien Foundation</td>
<td>NTP Honduras</td>
</tr>
<tr>
<td>US Department of Health and Human Services/Centers for Disease Control and Prevention (CDC)</td>
<td>Royal Ministry of Foreign Affairs of Norway</td>
</tr>
<tr>
<td>European Commission (EC)</td>
<td>Stichting Rotterdams TBC Fonds</td>
</tr>
<tr>
<td>Global Alliance for TB Drug Development</td>
<td>Stop TB Partnership</td>
</tr>
<tr>
<td>International Tuberculosis Foundation (ITF)</td>
<td>Swiss Agency for Development Cooperation</td>
</tr>
<tr>
<td>Japan Research Institute of Tuberculosis (RIT)</td>
<td>Swiss Pulmonary League</td>
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<tr>
<td>Japanese Anti-Tuberculosis Association (JATA)</td>
<td>The Conrad Hilton Foundation</td>
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<td>KNCV Tuberculosis Foundation</td>
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