Health solutions for the poor

Activity report
2008

International Union Against Tuberculosis and Lung Disease
The Union brings innovation, expertise, solutions and support
Table of Contents

| 4 | Message from the President |
| 6 | Message from the Executive Director |
| 9 | Our Mission, Vision and Values |

**The Union Departments**

| 10 | The Scientific Departments |
| 12 | Tuberculosis |
| 14 | HIV |
| 16 | Tobacco Control |
| 18 | Lung Health |

**Promoting Lung Health Worldwide**

| 20 | Map of Global Activities |
| 22 | Africa |
| 25 | Asia Pacific |
| 28 | South-East Asia |
| 32 | Latin America |
| 34 | Middle East |
| 36 | Europe |
| 38 | North America |

**Education**

| 40 | Union Technical Courses |
| 42 | International Management Development Programme |

**Sharing Scientific Knowledge**

| 44 | The 39th Union World Conference |
| 46 | Union Awards |
| 48 | Scientific Sections |
| 50 | Publications |
| 52 | Union Research Published in 2008 |
| 54 | The Union Membership |

**Finance**

| 56 | Report of the Treasurer |
| 60 | Balance Sheet |
| 62 | Income/Expenses |
| 64 | Acknowledgements |

* Approved April 2009
It is a pleasure and privilege to have been elected as President of The Union in 2008 after serving as an Individual Member on the Board since 2003 and as Vice-President since 2007. During my years on the Board, a great deal of time and consideration has been given to the question of the overall strategic direction of The Union, starting with the external review conducted by HLSP in 2003 under the visionary presidency of Asma El Sony.

It has been a period of extraordinary progress and expansion. The Union now has a broader engagement in the field of public health, while retaining a core focus on tuberculosis and lung health. The overall operating budget has increased from approximately €8 million in FY 2002 to more than €37 million in FY 2008. The driving force behind this change has been the Secretariat, now fully fledged as an international Institute thanks to the energetic leadership of Nils Billo and the dedicated hard work of both technical and administrative members of his highly skilled and experienced team.

This progress is extremely welcome and it gives The Union as a whole a vigorous core around which its other elements have the potential to further grow and flourish. One of the unique features of The Union – and one that marks it out amongst the many international organisations and agencies working to promote health – is the fact that it remains a membership organisation – one that is vitally supported by its constituent, organisational, and individual members. Along with the Institute, these pillars of The Union continue to give our organisation its international reach, guard its independence and sustain its deep understanding of local issues through roots that reach far out into communities throughout the world.

If The Union is to continue as a force for good, it needs strength in all of its pillars. During this time of international financial recession, every organisation and individual is looking to cut budgets in order to survive. Many valued members, particularly constituent members, are struggling to pay their fees to The Union, which brings challenges to our organisation’s overall economic health.
It is precisely during difficult periods such as these that the world most needs The Union to be strong, in order to be able to speak and act for those who will suffer most from the economic downturn – namely, the poor. This is the time to recall the original sense of international solidarity that was the impetus behind the foundation of The Union in 1920. It is appropriate, therefore, that, in this last phase of strategic renewal, The Union has clarified its mission and vision, both clearly aligned to the needs of the poor, as you will read in this report. I urge all of our members, partners and donors to unite strongly behind this vision and support The Union in all possible ways.

**S Bertel “Bertie” Squire**
MB BChir FRCP MD (Research)
Union President 2008
Lack of access to health care is a problem that appears in the news almost daily in both developing and industrialised countries. This demonstrates that the issue is of widespread concern and not only for poorer countries. There are heated debates on how we can finance the growing cost of health care systems and offer health insurance for all. Unfortunately, it is always the poorest segments of the population who suffer most because they cannot afford to get proper treatment or pay for medicine. It is very obvious that in some countries the health systems are weak and deficient; in other countries, these systems function, but they are so expensive that only privileged people can access them.

The Board of Directors together with the staff of The Union has held discussions over the last several years about how we can better serve the poor and make our vision and mission more visible. These discussions have led to the formulation and confirmation of our core values (quality, accountability, independence and solidarity) and a clear vision “Health solutions for the poor”. In order to implement these values across the whole organisation, in late 2008 we launched “The Union Moves Ahead Initiative”.

However, health solutions cannot be defined by those based at our Paris Headquarters alone. Therefore in 2008 we accelerated the decentralisation process begun a few years ago to bring The Union closer to those in need and to strengthen our dialogue with those affected on how we can improve access to health care for tuberculosis, asthma, HIV, pneumonia in children and other related diseases. Union region and country offices are now operational in New York, Mexico City, Edinburgh, Moscow, Mandalay, Cairo, Kampala, Delhi and
Beijing. Additional offices will also be opened during 2009 and 2010 to create a strong and well-functioning Union network.

It is impossible to summarise all of the activities of more than 250 staff and consultants, as well as many of our constituent, organisational and individual members in this short message. However, you will see in this Activity Report that The Union has a multitude of activities aimed at improving health worldwide. A few highlights:

The **Asthma Drug Facility** is now fully operational and able to receive orders for medicines used in the management of asthma. This will allow many countries to offer affordable inhalers at a yearly cost of less than €40 per patient. Projects in countries such as El Salvador, Sudan, China and Benin are underway. This is an encouraging model as it is contributing to a reduction of costs for each patient who is requested to pay for medicines not covered by an insurance scheme.

The **FIDELIS** granting mechanism funded by the Canadian International Development Agency (CIDA) came to an end in 2008, but this successful initiative clearly showed that the most cost-effective way to improve case finding for smear-positive tuberculosis cases is to strengthen health systems. Many countries have now taken up ideas generated by FIDELIS projects and are applying these innovative models to their own health care systems using funds from their own resources or external donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

FIDELIS also served as the model for the tobacco control granting system managed by The Union and its partners with funds from the Bloomberg Initiative to Reduce Tobacco Use. The **tobacco control grants** awarded to governments and organisations have contributed to the implementation of elements of the World Health Organization’s anti-tobacco MPOWER strategy in 38 countries. Policy changes will lead to a reduction in the deaths and morbidity caused by tobacco use, and The Union is proud to participate in this important battle to curb the tobacco epidemic.

The Union’s **Integrated HIV Care** for TB Patients Living with AIDS (IHC) Programme addresses another epidemic that has a disproportionately heavy impact on the poor: HIV/AIDS. This model for collaborative services provided by national TB and AIDS programmes is operational in Benin, Uganda, DR Congo, Zimbabwe and Myanmar. In 2008 the programme in Myanmar received an award for business excellence from the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria. This award exemplifies the commitment to both high-quality care and well-designed systems for which all Union programmes strive.

All of these activities and achievements are made possible by the dedication of The Union’s staff and consultants, the collaboration of our members and partners and the generosity of our donors who work with us to find “Health solutions for the poor”. Thank you.

*Nils E BiIlo, MD, MPH
Executive Director, International Union Against Tuberculosis and Lung Disease*
Our Mission, Vision and Values

The Union’s mission is to bring innovation, expertise, solutions and support to address health challenges in low- and middle-income populations.*

Collaboration and innovation have been central to The Union’s mission since it was established by 31 national lung health organisations in 1920. These organisations were joined by the common purpose of fighting tuberculosis, a global challenge, then as now.

The founders of The Union recognised that individually they could not defeat TB. They needed a central organisation to act on their behalf: to organise international conferences, to disseminate the latest research, to develop educational tools and materials, to go into the field and facilitate the transfer of knowledge between countries, and to synthesize all of this experience into innovative approaches to an age-old disease.

Today tuberculosis is curable. Since 1995, more than 32 million people in 184 countries have been treated using the Stop TB strategy, based on a model developed through Union research. But the TB-HIV co-epidemic and the increasing incidence of multidrug- and extensively drug-resistant TB have shown that tuberculosis remains a formidable threat. The Union, on behalf of its members and other stakeholders, is working hard to address these new challenges.

Since lung diseases are often linked to each other and other conditions, as well as driven by underlying factors such as poverty, The Union has expanded its scope. Over the past two decades, it has brought its expertise to bear on problems such as tobacco control, asthma, childhood pneumonia and HIV.

From its roots as a small secretariat in Paris, The Union has grown into an Institute with more than 200 staff and consultants working out of a network of regional offices in Africa, Asia, Europe, Latin America, the Middle East and North America. Members, colleagues and partners respect and rely upon its technical assistance, education and research promoting lung health in low- and middle-income populations.

The distinguishing qualities of The Union, besides its universality, spirit of solidarity and tolerance, are its continual striving for quality and its independence. Thanks to these, it provides the international community with an invaluable asset: a pioneer in devising, encouraging and testing innovations in the delivery of health services and a neutral platform for international collaboration, the exchange of information, friendship and esteem.

THE UNION’S VISION*
Health solutions for the poor

CORE VALUES

- Quality. We deliver our services and products to the highest possible standards.
- Accountability. We are responsible stewards of resources and deliver on our commitments.
- Independence. We maintain the freedom to pursue innovation and are guided by the best evidence to improve the health of the poor.
- Solidarity. We stand together as one Union to overcome the greatest challenges to improve health among the communities we serve.

* approved by the Board of Directors in April 2009
The Union Institute has four scientific departments: Tuberculosis, HIV, Tobacco Control and Lung Health. Each has a team of staff and affiliated consultants that provides technical assistance, offers training, conducts research and carries out other related activities at the request of members, governments, non-governmental organisations and other agencies.

In 2008, The Union was active in more than 75 low- and middle-income countries around the world.

**Principal projects and donors: 2008**

- **Laboratory Strengthening Programme** provides technical assistance and conducts training and operational research to improve key TB diagnostic services, with the main focus on meeting External Quality Assurance (EQA) standards and building capacity to prevent and control drug-resistant TB. Funded by TB CAP with funds from the US Agency for International Development (USAID) and the Canadian International Development Agency (CIDA).

- **TREAT TB** (Technology, Research, Education and Technical Assistance for Tuberculosis) is a new USAID Cooperative Agreement awarded to The Union and its partners for a comprehensive programme of TB-related research. The Agreement for up to US$ 80 million over five years will focus on both centrally led research efforts and country-specific research funding and support. Funded by USAID.

- **Integrated HIV Care for Tuberculosis Patients Living with HIV/AIDS (IHC) Programme** is building partnerships between national TB and AIDS programmes to serve TB-HIV patients in Benin, Democratic Republic of Congo, Myanmar, Uganda and Zimbabwe. Funded by the European Commission, Ligue Pulmonaire Suisse, USAID and the Yadana Consortium operated by TOTAL/MGTC.

- The Union coordinates the **TB Control Assistance Program (TB CAP)** activities in the Democratic Republic of Congo, Mexico, Uganda and Zimbabwe. TB CAP is USAID’s centrally funded project supporting the implementation of the international Stop TB strategy. The Union also acts as a collaborating partner in other countries and participates in several core-funded TB CAP activities at the global level – all as a member of the Tuberculosis Coalition for Technical Assistance, which oversees TB CAP. Funded by USAID.

- **Bloomberg Initiative (BI) activities include a grants programme** that gives competitively awarded grants to develop and deliver high-impact tobacco control interventions in low- and middle-income countries and a series of courses to build the management capacity of tobacco control organisations. BI’s aim is to reverse the global tobacco epidemic through specific key interventions. Funded by the World Lung Foundation with support from the Bill and Melinda Gates Foundation as part of the Bloomberg Initiative to Reduce Tobacco Use.
Child Lung Health Programme in Malawi has reduced the pneumonia case fatality rate in children under five by more than 50% since 2000. Funded by the Scottish Government and The Union with initial funding from Bill and Melinda Gates Foundation.

Asthma Drug Facility is a purchasing mechanism that makes it possible for low- and middle-income countries to obtain quality-assured essential asthma medicines at affordable prices. Funded by The Union Constituent and Organisational Members.

Comprehensive Approach to Lung Health looked at lung health from an interrelated and holistic perspective. The project focused on asthma, child lung health and smoking cessation in Benin, China and Sudan. Funded by the World Bank.

Kigoma Child Lung Health project in Tanzania addresses the problem of neonatal and young infant mortality from pneumonia and sepsis. Funded by the Norwegian Agency for Development (Norad).
The Union has been at the centre of international efforts to prevent, treat and control tuberculosis since 1920. Today the Tuberculosis Department supports the efforts of national tuberculosis programmes (NTPs) to attain high-quality, countrywide DOTS coverage and to meet global targets for TB control in low- and middle-income countries.

**TB research**

- **USAID awards up to $80 million**
  In September 2008 the United States Agency for International Development (USAID) awarded The Union a five-year Cooperative Agreement for up to US$ 80 million for TB research. The programme, now under implementation by The Union, key technical partners and several regional coordinating partners, is entitled TREAT TB: Technology, Research, Education and Technical Assistance for Tuberculosis.

  TREAT TB is expected to address six main technical areas:
  1. Laboratory research with field evaluation of new/adapted diagnostic tools
  2. Clinical trials to improve patient management, treatment efficacy and disease prevention
  3. Operational research and epidemiological studies to overcome constraints to implementing current or new tools and approaches
  4. Technical assistance to USAID missions for field trials, operational research and implementation evaluations
  5. Infection control research to evaluate infection control strategies
  6. Evaluation of new approaches to monitor the impact of new tools and approaches.

- **Fixed-doses may be invaluable MDR tool**
  With the urgent need to find solutions for the emergence of MDR-TB, fixed-dose combination drugs may prove to be invaluable tools. The efficiency, acceptability and toxicity of fixed-dose combination drugs during the intensive phase of treatment have been evaluated by The Union’s clinical trial, Study C. The five-year trial, now in its 24-month follow-up period, involved more than 1,700 participants enrolled at 11 centres worldwide.

  The use of fixed-dose combination tablets has been recommended by both The Union and the World Health Organization since 1994. This trial is one of the first to systematically evaluate them on a large scale. The follow-up period will end early in 2009. Funding for the clinical trial has been provided by the United States Agency for International Development (USAID) and the Global Alliance.

**TB technical assistance**

- **Technical assistance in 32 countries**
  In 2008 the Tuberculosis Department provided technical assistance to 32 countries in Asia, Africa and Latin America. Technical assistance in tuberculosis control and prevention is provided at the request of governments, partner organisations or agencies.
Through both long- and short-term consultations, Union consultants help NTPs evaluate their programmes and policies, monitor progress and develop plans to strengthen their programmes both clinically and administratively. This support is critical to efforts to control drug-resistance because every level of the health system has a role to play in addressing this crisis.

FIDELIS initiative winds down
The Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB (FIDELIS) implemented 51 projects in 18 countries between 2003 and 2008. The projects were designed by the contractors to address local needs and conditions. Emphasis was placed on improving TB control and prevention in remote and underserved areas. The interventions fell into six main categories: social mobilisation and information, education and communication (IEC); involvement of the private sector; innovative microscopy services; semi-active case finding; health systems strengthening; and the use of incentives. A final project exploring the case-finding yield of a ‘best practice’ project based on the experiences of previous FIDELIS projects was initiated in Bangladesh in October 2008.

Laboratory strengthening in Africa and Asia
The Union’s laboratory strengthening unit helps laboratories in Asia and Africa to improve case detection and drug-susceptibility testing, implement external quality assurance (EQA) standards and conduct operational research. In 2008, Union consultants participated in preparing for the creation of a TB Supranational Reference Laboratory for East Africa, giving intensive support to the TB National Reference Laboratories and laboratory networks in Tanzania and Uganda. Laboratory activities also included training and preparation for implementation of molecular testing techniques in several countries.

Monitoring second-line TB drugs
Through its participation in the Green Light Committee (GLC), The Union is active in monitoring and addressing problems of drug-resistance. The GLC helps countries gain access to high-quality second-line anti-TB drugs so they can provide treatment for people with multidrug-resistant tuberculosis (MDR-TB). GLC-approved programmes in Burkina Faso, El Salvador, Dominican Republic, Nicaragua, Peru and Tunisia were reviewed by The Union in 2008.

TB education
MDR-TB training on four continents
In 2008 The Union offered tuberculosis courses around the world, including MDR-TB courses in China, Dominican Republic, Mexico, Philippines and at the World Conference in Paris. Programmes are offered in English, French and Spanish. In addition to offering formal courses, Union TB experts disseminate their knowledge and experience by participating in conference symposia, lecturing at universities and medical schools, and publishing books and articles.

TB HIGHLIGHTS: 2008
TREAT TB initiative was launched with the signing of a 5-year Cooperative Agreement funded by USAID for up to US$ 80 million.
Agreement signed with the Agence Française de Développement (AFD) to support TB control in several French-speaking sub-Saharan African countries.
MDR-TB courses and technical assistance projects took place in China, Dominican Republic, El Salvador, France, Mexico, Nicaragua, Peru, the Philippines and Tunisia.
Study C, the 5-year clinical trial of fixed-dose versus individual formulations, neared the end of its 24-month follow-up period.

“Basic TB control is more essential than ever with extensively drug-resistant TB now reported in 55 countries and territories and more than 500,000 cases of MDR-TB worldwide.”
I.D. Rusen, MD, MSc
Director, Department of Tuberculosis
The IHC programme works with national TB and AIDS programmes to strengthen their collaboration and build the capacity of the countries’ general health systems to deliver high-quality HIV and TB care. The goals of the programme are to:

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

**IHC highlights: 2008**

- **Benin:** The early success of the programme in the 20 pilot sites planned for the project encouraged the NTP to expand TB-HIV activities to all NTP sites nationwide. Today 95% of TB patients in Benin know their HIV status. Funded by the European Commission and Ligue Pulmonaire Suisse.

- **Democratic Republic of Congo (DRC):**
  The increased collaboration of the National Tuberculosis Programme (NTP) with the National AIDS Programme (NAP) has inspired them to examine means to accelerate HIV care/ART in DRC. Based on epidemiological and economic results, the IHC programme provides a concrete example that TB, HIV and other chronic diseases can be managed in the context of primary health care in DRC. Funded by the European Commission.

- **Myanmar:** The IHC programme was commended by the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria, receiving an award for Business Excellence in the Tuberculosis category in May 2008. Funded by the Yadana Consortium, operated by Total/MGTC.

- **Uganda:** The Union supported the Ministry of Health in the development of a joint TB and HIV managers’ course for TB-HIV, which was held in March 2008. Funded by USAID through TB CAP.

- **Zimbabwe:** All three project sites were accredited as antiretroviral treatment initiation centres in 2008, and the first co-infected TB patients started on ART from August 2008. Funded by the European Commission.

**TB-HIV CHALLENGES**

- 1/3 of people infected with HIV are also latently infected with TB.
- TB is the number one cause of death among people infected with HIV.
- One out of four TB deaths is HIV-related.

Source: WHO TB/HIV Facts 2009

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“There are an estimated 1.37 million people now co-infected with HIV and TB. One of the biggest obstacles in treating TB and HIV co-infection is lack of coordination between HIV and TB programmes at international, national and community levels.”

Paula I Fujiwara, MD, MPH
Director, Department of HIV
Benin IHC project provides a model for collaboration

When The Union’s HIV Department began collaborating with Benin in 2005, the goal was to support integrated TB and HIV care at the general health services level and improve the quality of care provided to TB-HIV patients. Partners in the project were the Benin Ministry of Health, the National Tuberculosis Programme (NTP) and the National AIDS Programme (NAP). With a population of 7.6 million inhabitants, Benin has approximately 3,700 cases of TB per year and an HIV seroprevalence rate of 1.7%. There are about 650 cases of TB-HIV co-infection each year.

100 health care workers trained
To address the needs of these co-infected patients, IHC activities were initially implemented in 20 TB diagnostic and treatment centres (CDTs) located throughout the country. Specific HIV training was provided to 100 health care workers, including doctors, nurses and laboratory technicians, who would be participating in the programme.

At the pilot CDTs, TB patients were then routinely offered HIV testing, and those diagnosed with HIV were placed on cotrimoxazole prophylaxis (CPT). The project also provided laboratory equipment, supplies, and training to perform CD4 measurement. When eligible, patients were started on antiretroviral therapy (ART) during the course of TB treatment. ART was provided either on site (if the health centre was accredited by the NAP to provide HIV care) or at a NAP-accredited site nearby.

Over the past three years, the IHC programme screened a total of 7,787 TB patients for HIV (93% of all TB patients registered in the project) of which a total of 1,255 (16%) were found to be HIV positive. Seventy percent of the patients were tested at the time of TB diagnosis, and the remainder were known people living with HIV/AIDS who were referred by an NAP site for TB evaluation and treatment. CPT was prescribed to 1,137 patients, and 456 started or continued ART during TB treatment.

In Benin, 95% of TB patients know their HIV status
The early success of the programme in the 20 pilot sites encouraged the NTP to expand TB-HIV activities to all NTP sites nationwide immediately. IHC activities have been successfully scaled up to all 54 CDTs, resulting in a situation whereby 95% of TB patients in Benin know their HIV status.

Although The Union’s role in the Benin IHC project ended in November 2008 due to the completion of funding for that particular phase, the sustainability of activities has been ensured. HIV testing and treatment are now part of the NTP’s routine activities, and subject to regular, formative supervision. The NAP will continue to provide rapid tests and antiretroviral drugs. An ongoing dialogue has now been established between the NTP and NAP, and the IHC programme demonstrated that quality HIV care can be delivered by non-specialist staff with minimal access to technology in first- and second-line health care facilities.

LESSONS LEARNED: WORKING TOGETHER TO FIGHT BOTH HIV AND TB

- TB clinics can play an important role in extending access to HIV diagnosis and care to TB patients. This helps NAPs to roll out HIV care.
- TB services can provide good-quality HIV services. Non-specialist health workers staffing TB (general health) services with minimum access to sophisticated technology can provide essential HIV-related services after initial and refresher training, and with regular supervision.
- Increased workload can be absorbed by TB clinics.
- The IHC project fostered new collaboration between the national TB and AIDS programmes.
- Better information was generated about HIV epidemiology in partner countries.
- The project identified ways to ensure that integrated HIV care for TB patients with HIV would be sustained.
- The project confirmed the need for all staff to be knowledgeable in both TB and HIV.
- The project facilitated collaboration between TB and HIV laboratories.
The mission of The Union’s Tobacco Control Department is to promote effective tobacco control policy through technical assistance; train a new generation of managers and practitioners; support effective programmes through grants; and build knowledge for action through research.

**Offices supporting tobacco control now established in 5 countries**
The Union now supports tobacco control through its regional and country offices in China, Egypt, India, Mexico and Russia. Union teams provide access to expertise in law, management and leadership, policy and technical issues. They give advice on specific issues and regions. Their familiarity with the political landscape and policy issues and relationships with local communities, coupled with their local access and networks, are invaluable in providing assistance in tobacco control.

**Building capacity through training**
In 2008 26 management training courses were offered to tobacco control organisations in eight top-priority countries. More than 500 training places were filled. The Union’s International Management Development Programme has developed four courses to build capacity in tobacco control organisations: Management and Leadership, Human Resources Management, Budget and Financial Management and Management of Managers. The Union also collaborated with the World Health Organization to complete MPOWER training packages on smoke-free policies and effective tobacco pack warnings.

**Grants programme active in 38 countries**
In 2008 the Bloomberg Initiative (BI) grants programme continued under the management of The Union and its US partner, The Campaign for Tobacco-Free Kids. More than 1,200 project ideas have been processed since the programme began, and 120 grants are now active in 38 countries. Grants were given to national governments in 13 of 15 countries identified by the BI as top priorities due to their level of tobacco use. Round 5 was launched in 2008.

Priority for funding is given to projects that lead to a sustainable improvement in tobacco policies, such as tax/price measures, smoke-free environments, and advertising bans. The grants programme and grantees in the recipient countries are supported by a team of international experts in tobacco control with diverse experience in governmental and non-governmental agencies.

The BI grants programme focuses most strongly on the 15 countries in which approximately two-thirds of the world’s tobacco users live. Grants are one to two years in duration and range from US$ 10,000 per year for a short-term advocacy campaign to US$ 500,000 per year for a comprehensive tobacco control programme, supporting national governments.

**Studies document the impact of interventions**
The Union commissioned a series of economics reports on tobacco taxation in high priority countries, documenting how tobacco taxes could be restructured and raised to reduce tobacco use and save lives. In addition, The Union is a partner in international research projects that focus on tobacco pack warnings and taxes across Europe; that seek to ascer-
The Union China Office continued to provide intensive support for smoke-free policies in six cities during the run up to the Olympic and para-Olympic games.

The Union Middle East Office opened in Cairo and established a coalition of NGOs that have agreed to work together to ensure effective implementation of tobacco control policies.

The Union Latin America Office, which opened in Mexico City this year, conducted a case study of how Mexico City went smoke-free.

In India, The Union provided technical assistance to cities seeking BI funding, supported smoke-free initiatives and organised workshops for enforcement officials and NGOs.

Technical guides on tobacco-free health care, sports venues and educational campuses were published and are available for free from www.tobaccofreeunion.org.

How does a city of 15 million go smoke-free?

In February 2008 Mexico City approved legislation requiring that all indoor workplaces and public places, including restaurants and bars, become 100% smoke-free. This legislation was designed to help protect the health of the 15 million residents and workers in Mexico City. In Mexico approximately one-quarter of those over the age of 12 smoke.

In 2008 The Union Latin America Office drafted a comprehensive study of Mexico City’s smoke-free experience. The study includes both extensive research and face-to-face interviews. Staff identified key players involved in the development, campaigning, research, implementation and enforcement of the law that has made Mexico City one of the world’s biggest cities to go smoke-free.

This study will highlight the success factors and tactical lessons that made this experience possible, measuring the impact of and compliance with the law. The case study could become a tool for those people who wish to promote a smoke-free environment in their own cities.

“Despite significant challenges in tobacco control, The Bloomberg Initiative to Reduce Tobacco Use has catalysed early progress in low- and middle-income countries. The Union Tobacco Control Department is rising to the challenge of supporting civil society and governments to achieve effective policy change, curb tobacco use and save lives.”

Sinéad Jones, PhD, MPH
Director, Department of Tobacco Control

“Tobacco Control Highlights: 2008

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- The Union Latin America Office, which opened in Mexico City this year, conducted a case study of how Mexico City went smoke-free.
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- Technical guides on tobacco-free health care, sports venues and educational campuses were published and are available for free from www.tobaccofreeunion.org.
The Lung Health Department uses the framework developed by The Union for tuberculosis services as a model for developing innovative approaches to child lung health, asthma and smoking cessation, and also participates in international initiatives that promote lung health. The Department provides technical assistance, holds training sessions, develops guides and other publications and conducts operational research.

**Asthma Division**

**Standardised case management for asthma**

An estimated 300 million people worldwide suffer from asthma, an increasing number of them in low-income countries. More than 30 million people with asthma live in Africa alone. Health services in these countries are hard-pressed to provide adequate care for this chronic condition, and the high cost of medication is a major obstacle.

The Asthma Division focuses on improving asthma management in low- and middle-income countries and has developed guidelines based on The Union model for tuberculosis and the Global Initiative for Asthma (GINA) guidelines. In 2008, The Union published the 3rd edition of *Management of Asthma: a guide to the essentials of good clinical practice*, which recommends the standardised case management of asthma using essential medicines.

Technical assistance in asthma management continued through the World Bank-funded Comprehensive Approach to Lung Health project in Benin, China, and Sudan. Monitoring visits focused on capacity building in standardised case management of asthma and critical issues such as the availability of drugs and supplies, the quality of recordkeeping, patient education and staff motivation.

**Asthma Drug Facility (ADF)**

**ADF quality assurance system in place**

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

In 2008 the ADF finished the revision of its quality assurance system with the support of pharmacists and WHO’s 2007 guidelines ‘Model Quality Assurance System for Procurement Agencies’. Standard Operating Procedures were developed to assess the quality of medicines offered by manufacturers and to assure quality during procurement. The ADF had to pay particular attention to the definition of quality requirements for the HFA (CFC-free) inhalers. This is because WHO does not pre-qualify

"The ADF will allow governments to save millions in the cost of medicines, unnecessary emergency room visits and hospitalisations – and above all, improve the quality of life for asthma patients in low- and middle-income countries.”

Chiang Chen-Yuan MD, MPH
Director, Department of Lung Health
inhalers; markets are still transitioning between CFC and HFA formulations; and regulatory requirements are not yet fully defined, even in highly regulated countries.

With its quality assurance system in place, ADF published an Invitation for Expression of Interest for potential suppliers. ADF assessed the quality of manufacturers and their products and then launched a limited competitive bid among qualified suppliers for their qualified products. Thus, ADF prepared to receive orders from countries in early 2009. The products to be supplied by ADF are in line with the WHO's Essential Medicines List and the recommendations of The Union's Asthma Guide.

With affordable medicines and standardised case management of asthma, countries can work towards the objectives defined in the WHO plan for Non Communicable Diseases 2008–2013.

**Child Lung Health Division**

**Tanzania – Kigoma Child Lung Health project**
The Child Lung Health component of the Kigoma Project began in late 2008. The project addresses the problem of neonatal and young infant mortality from pneumonia/sepsis in conjunction with a maternal survival programme. Funding for the Kigoma Project comes from the Norwegian Agency for Development (Norad).

**Malawi’s CHAM hospitals show gradual improvement**
In 2008, Union consultants continued to give technical support to the Integrated Child Lung Health Project in the Christian Hospital Association of Malawi (CHAM) hospitals. This is phase two of a project that saw the case fatality rate for children under five with pneumonia treated in district hospitals drop by more than 50%. The inclusion of CHAM hospitals began in May 2006 and 11 CHAM hospitals now participate. The Union review team found highly motivated staff, a gradual improvement of treatment and a decreasing death rate for pneumonia. This project is funded by the Scottish Government.

**Comprehensive Approach to Lung Health**

**Three-year project addressed lung health comprehensively**
A three-year project in Sudan, China and Benin took a comprehensive – rather than disease-specific – approach to improving the quality of lung health services at the first referral care level. The objectives were to:

- Demonstrate an effective and feasible means to prevent deaths from pneumonia in children under five years of age
- Address adult respiratory diseases by using holistic policies, services and interventions to reduce the impact of tobacco smoking and improve the management of asthma
- Conduct a case-control study of the link between indoor air pollution and tuberculosis in Benin and China
- Publish a monograph outlining steps to address the lung health consequences of indoor air pollution caused by the use of solid fuel in low-income countries
- Prepare a CD containing guidelines and training materials for distribution.

Funding for the project has been provided by the World Bank.

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**LUNG HEALTH HIGHLIGHTS: 2008**

- The Child Lung Health Division sponsored a workshop on guidelines for prevention, diagnosis and treatment of TB in HIV-infected children.
- Researchers conducted a case-control study of the link between indoor air pollution and TB in Benin and China.
- Tobacco cessation interventions for tuberculosis patients: a guide for low-income countries was published.
- A third edition of *Management of Asthma: a guide to the essentials of good clinical practice* was published.
- Steps to address the lung health consequences of exposure to smoke from domestic use of solid fuels were outlined in a new monograph.
The Union Institute conducted technical assistance, education and research activities in more than 75 countries in 2008. With headquarters in Paris, The Union also has 9 regional and country offices in China, Egypt, India, Mexico, Myanmar, Russia, Uganda, the United Kingdom, and the United States. In addition, Union members working towards global lung health are affiliated into seven regions that hold conferences and carry out other joint projects. The regions are Africa, Asia Pacific, Europe, Latin America, Middle East, North America and South-East Asia.

- **Headquarters and offices** in 10 countries
- 98 Union constituent and organisational member countries
- **Technical assistance projects** in 43 countries
- **Education** (courses, conferences, etc) in 30 countries
- **Research projects** in 18 countries, including clinical trials in 12 countries
- **IHC TB-HIV programmes** in 5 countries
- **FIDELIS TB case-finding projects** in 7 countries
- **TI tobacco control projects** in 38 countries
Promoting Lung Health Worldwide
Monitoring MDR-TB a high priority

The Tuberculosis Department offers both short- and long-term technical assistance at the request of governments and other agencies. In 2008 ongoing technical assistance was provided to Benin, Burkina Faso, Cameroon, the Democratic Republic of Congo, Côte d'Ivoire, Madagascar, South Africa, Sudan, Togo, Uganda and Zimbabwe.

Management of MDR TB is a major priority in DR Congo and work in this area started in five provinces in 2008. These activities were funded by TB CAP. Union consultants reviewed several request from the Green Light Committee and visited Burkina Faso, DR Congo, Côte d'Ivoire, Cameroon and Benin to evaluate their multi-drug-resistant TB management programmes.

Technical assistance and training for francophone Africa

The “Projet d’appui technique à la lutte contre la tuberculose” assists mainly French-speaking countries in sub-Saharan Africa, including Benin, Burkina Faso, Côte d’Ivoire, the Democratic Republic of Congo and Togo. The NTPs of these countries receive intensive supervisory visits from The Union twice each year; and international courses and academic training are sponsored. The project also helps to develop French-language scientific documents related to tuberculosis control. Funded by the Agence Française de Développement (AFD).

Benin TB programme a model for the region

The National Tuberculosis Programme in Benin is considered a model for the region, with an 86% TB treatment success rate as well as an 86% detection rate. There are few cases of MDR-TB, despite the fact that Benin has been one of the first countries in sub-Saharan Africa to use rifampicin in treating TB patients with positive microscopy. This reflects the high quality of their programme.

HIV testing is offered to all TB patients, and 95% of patients were tested in 2007. That is the highest acceptance rate of the test in Africa. TB patients eligible to receive antiretroviral therapy are identified and enrolled in the programme according to their clinical status and the absorption capacity of the National Programme for the Fight Against AIDS.

Drug costs a challenge for Benin project

A site visit to the Comprehensive Approach to Lung Health project in Benin in July 2008 found the work plan from the previous visit had been implemented in large part.

A training module for treating pneumonia in children had been developed and finalised. The training was conducted in June 2008. Six oxygen concentrators had arrived. Because antibiotics are unavailable for budgetary reasons, treatment of children depends on parents’ ability to buy the drugs.
A pocket guide for the management of asthma had been prepared and distributed. The intervention began in various locations in February 2008. Supervision of sites is performed regularly. The cost of drugs may be an obstacle for the poor to continue their regular treatment. All of the monitoring and reporting documents for the smoking cessation intervention had been put in place. This project was funded by the World Bank.

For a story about the Benin IHC programme, please turn to page 15.

**DR Congo TB programme contributes to AIDS strategy**

The first phase of The Union’s Integrated HIV Care for Tuberculosis Patients Living with HIV/AIDS (IHC) Programme funded by the European Commission ended in November 2008. In the two project sites in DR Congo, more than 800 TB-HIV patients were followed during the 27 months of the project. The results demonstrated that:

- Quality HIV care is achievable in primary health clinics using TB staff (private/public, hospital/health centre).
- The National Tuberculosis Programme (NTP) can significantly contribute to access to HIV care and hence to the National AIDS Programme (NAP) strategy.
- HIV testing and care is very acceptable to patients and health care workers.

The second phase of the project is taking place in the Province of North Kivu, also with financing from the European Commission.
Zimbabwe finds up to 80% TB patients are HIV+

In Zimbabwe, up to 80% of TB patients are co-infected with HIV. While the health services have made progress towards providing HIV care to patients with TB, several challenges remain. In September 2007, The Union received funding from the European Commission to support Zimbabwe’s efforts by introducing the IHC programme. Three pilot implementation sites were established in municipal primary health clinics – two in Bulawayo and one in Harare – and they registered close to 800 patients. These centres are equipped with a supply of rapid HIV tests, equipment and consumables for providing cotrimoxazole and antiretroviral medications. The main objective is to develop innovative strategies for feasible and sustainable TB-HIV services that can be replicated by other local authority health departments and district health services in the country and outside Zimbabwe.

In 2008, every effort was made to maintain the activities despite the cholera epidemic and the challenges of working in the current setting. In this year the pilot sites registered 754 TB patients of which 531 (70%) were HIV tested. Four hundred and fifty two (85%) TB patients were found to be HIV-infected and were offered enrolment into HIV care. A total of 324 (72%) individuals were started on antiretroviral treatment (ART): 234 in Bulawayo and 90 in Harare. These figures incorporate co-infected TB patients from clinics situated near the pilot sites. These clinics refer both patients and family contacts who are eligible for ART to the pilot sites for ART initiation.

New TB control project in Zimbabwe

The Union is collaborating with the National Tuberculosis Programme and other partners on a new programme to strengthen TB control in Zimbabwe. Initiated in the last quarter of 2008, the programme has set as its first-year goals the strengthening of leadership, management and human resource capacity at all levels, and the improvement of capacity to scale up TB-HIV services.

Midlands Province and the City of Gweru were chosen to be the first demonstration sites. Consultants making the initial site visit found many challenges to TB control in Zimbabwe. These included lack of coordination among the organisations involved, lack of TB training and supervision, and limited TB diagnostic and treatment facilities. Despite these challenges, progress has been made and a work plan developed for implementation in 2009.

The Mission of United States Agency for International Development (USAID) to Zimbabwe provided funds to the Tuberculosis Control Assistance Program (TB CAP) to support this programme.

TB CAP in Uganda provides training and assistance

In Uganda, the Tuberculosis Control Assistance Program (TB CAP) is coordinated by The Union. In 2008, the programme provided training to 1,827 health workers in TB-HIV collaborative services, 398 in CB-DOTS (community-based TB care) and 167 in TB infection control. A TB-HIV managers course was developed for managers at the national and district levels, and was delivered in March 2008.

TB CAP also provided technical assistance to five President’s Emergency Plan for AIDS Relief (PEPFAR) partners supported through USAID. Results from the 12 TB CAP-supported districts showed great improvement in the treatment success rate, HIV counselling and testing, and cotrimoxazole preventive therapy for TB patients.

For an update on the Child Lung Health Programme in Malawi, please turn to page 19.
Managing adverse reactions to MDR-TB treatment

About one-quarter of the world’s multidrug-resistant tuberculosis (MDR-TB) cases are in China. In 2008, the National Tuberculosis Programme requested that The Union provide on-site technical support and education to its clinicians. The mission focused on managing adverse reactions to the drug regimens required to treat MDR-TB.

FIDELIS projects increased TB case finding by up to 60%

China was the site of 15 innovative TB case finding projects between 2003 and 2008, including several that went into second-phase activities. The projects were funded by the Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB (FIDELIS) and focused on reaching people in remote and underserved areas. In China FIDELIS projects covered 415 million people in 700 counties, who were offered improved TB services and training over the five years. Examples of some new successful approaches to TB case finding include:

- People with newly diagnosed sputum smear-positive TB were offered transportation fees to reach treatment sites. Other TB patients were also offered transportation fees if they provided a ‘poverty certificate’. Case finding increased 43%.
- Schoolchildren were taught about TB and asked to report anyone in their homes with a cough to their teachers. Teachers referred these TB suspects to a diagnostic facility with microscopy services. The project detected 4,617 new sputum smear-positive cases, 3,939 more than the previous year – an almost seven-fold increase.

LUNG HEALTH CHALLENGES: CHINA

- No. of TB cases/2007: 1.3 million
- MDR-TB cases/2007: 112,000
- TB deaths/2007: 201,000
- No. of smokers: 325 million
- Adult male deaths from smoking: 15–19.9%

New microscopy centres were established in 40 county hospitals to strengthen the referral of TB suspects and patients to county TB dispensaries where treatment was offered using the DOTS strategy. This project increased case finding by 38%.

New microscopy centres were established in township hospitals. The centres developed routines for reporting smear results to the TB dispensaries where the cases were managed. The centres also provided training and involved village doctors in case finding and management. Case finding increased 60%.

FIDELIS was funded by the Canadian International Development Agency (CIDA).

**Smoke-free TB centres in Hunan**

A Bloomberg Initiative project in Hunan Province aims to improve the health of TB patients and their families by establishing smoke-free TB centres and encouraging smoke-free families. The project also seeks to promote smoking cessation among medical staff and increase awareness of the dangers of tobacco use among the general public. The project is being implemented in seven prefectures by the National Centre for Tuberculosis Control and Prevention.

The project in Shaodong, managed by the Shaoyang City CDC, has become a model. Within three months of the launch, the TB centre was 100% smoke-free. All staff members are now smoke-free, and the doctors have been trained in smoking cessation. Patients who smoke are given advice about quitting. The TB centre has excellent smoke-free signage throughout the facility. There is also information displayed both inside and outside the TB centre that details the harm caused by tobacco use.

**Tobacco-free Olympic/Para-Olympic cities**

The 2008 Olympic and Para-Olympic Games held in China offered a tremendous boost to public awareness of the problems caused by air pollution, tobacco use and secondhand smoke. The Union-managed Bloomberg Initiative grants programme has funded projects in China that worked closely with the Chinese Centre for Disease Control and Prevention and its partners towards the goal of creating tobacco-free environments in Beijing, Shanghai, Qingdao, Shenyang, Qinhuangdao and Tianjin.

**Tobacco Control: More highlights**

The Union China Office also supported the **Building Advocacy Capacity for Tobacco Control among the Public Health Workforce Project**. This project included a variety of activities at seven universities including advocacy activities, meetings on anti-smoking practices and policies, development of a guide for implementing tobacco-free campuses, designation of outdoor areas for smoking and development of no-smoking signs. In addition, The Union China Office produced publicity materials for the Office of Beijing Patriotic Health Campaign Committee: Smoke-Free Beijing.

**Asthma a ‘hidden disease’ in China**

Union experts monitoring the Comprehensive Approach to Lung Health project in China found that there were no asthma patients diagnosed before the project. With assistance from the project, doctors have improved their ability to diagnose and treat asthma. The finding confirmed that asthma has been a “hidden” disease in China, and that consistent use of standardised case management for asthma is needed.

Monitors also found that since the project started there had been a significant improvement in the classification of the severity of pneumonia in children. In addition, facilities participating in the project now consistently provide brief advice for smoking cessation. The Comprehensive Approach to Lung Health project was funded by the World Bank.

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**OTHER UNION ACTIVITIES IN THE ASIA PACIFC**

- The Union provided technical assistance to the TB programme of the Democratic People’s Republic of Korea.
- Union management and technical courses were offered in China, Indonesia, Mongolia and the Philippines.
- The Union South-East Asia Office provided technical and financial support for tobacco control activities in Indonesia — a priority country identified by the Bloomberg Initiative to Reduce Tobacco Use (BI).
In 2008, the Singapore Antituberculosis Association expanded its mission and vision to include lung health and will fund up to $350,000 annually in research on lung health and tuberculosis. Taipei held a Tuberculosis Control Training Programme for six Vietnamese physicians. In partnership with the Tropical Disease Foundation, the Philippine Tuberculosis Society conducted a joint research project on multidrug-resistant TB. The Hong Kong Tuberculosis, Chest and Heart Diseases Association administers several clinics and facilities, including the Ruttonjee Hospital and the Grantham Hospital.

Joint activities of the region in 2008 focused on early planning for the 2nd Union Asia Pacific Region Conference to be held in Beijing, China in September 2009.

**THE UNION ASIA PACIFIC REGION**

In 2008, the Singapore Antituberculosis Association expanded its mission and vision to include lung health and will fund up to $350,000 annually in research on lung health and tuberculosis. Taipei held a Tuberculosis Control Training Programme for six Vietnamese physicians. In partnership with the Tropical Disease Foundation, the Philippine Tuberculosis Society conducted a joint research project on multidrug-resistant TB. The Hong Kong Tuberculosis, Chest and Heart Diseases Association administers several clinics and facilities, including the Ruttonjee Hospital and the Grantham Hospital.

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**2008 OFFICERS**

President: Dato' Seri Yeop Jr (Malaysia)
Vice President: vacant
Secretary General: Sahul Hamid (Malaysia)
Treasurer: BabeYing-Yee (Hong Kong)
Board Representative: Camilo Roa (The Philippines)
In South-East Asia, India alone bears 20% of the global TB burden. Nevertheless the Revised National Tuberculosis Control Programme (RNTCP) has made great strides, achieving 100% DOTS coverage in this country of one billion. The tobacco epidemic is another major problem in the region. There are an estimated 241 million tobacco users in India, of whom 800,000 die each year. Bangladesh and Thailand are also among the top 15 tobacco-using countries.

In 2004, The Union opened the India Resource Centre in New Delhi to support its activities in India and the region. Renamed in 2008, The Union South-East Asia Office (USEA) offers expertise in TB control, tobacco control, programme logistics and financial management.

**ACSM activities in Orissa**

The Indian state of Orissa is home to the largest tribal population in the country. In 2008, The Union continued to provide technical support to Advocacy, Communication and Social Mobilisation (ACSM) programmes in Orissa with support from a round 4 Global Fund grant from the Ministry of Health. Union consultants suggested interventions to optimise the National TB Programme for tribal and other people living in geographically difficult areas. Emphasis has been placed on 16 of the state’s 31 districts, which have been identified by the state Department of Health as ‘low performing’ in TB control. The Union also coordinated activities including leadership and management training and a survey that will guide adaptation of the state’s TB programme policies to the special needs of this population. For example, the TB Patient’s Charter has been translated into the Oriya language and is now available in all primary health care facilities in the state.

**TB-HIV workshop held in Delhi**

From 22–23 July 2008, The Union organised a workshop on promoting the implementation of collaborative TB-HIV activities in New Delhi, India. This workshop was the first activity under the TB CAP TB-HIV Public/Private Mix Project, in which The Union is leading the implementation of two pilot projects to field test guidelines developed by the World Health Organization. The objectives of the workshop were to examine the applicability of the protocol, hear presentations on public/private and public/public activities for TB-HIV at selected pilot sites and to develop action plans for implementing the pilots. Four participants from the pilot site in Namibia and three participants from the pilot site in India participated in the workshop. Presentations on public/private and public/public activities for TB-HIV were made by implementing partners. Pilots promoting collaborative TB-HIV activities through public/private mix will be implemented over a nine-month period ending May-June 2009.

**Civil society partnership formed**

The Union South-East Asia Office coordinated the development of a Partnership of Civil Society at the national level with support from a large number of non-governmental organisations (NGOs), the corporate sector, bilateral partners, the Ministry of Health and professional groups. By November 2008, the Partnership included 24 members and had established links with a network of similar national partnerships across the world. The Secretariat of the Partnership is housed at The Union office and is currently funded by a USAID grant through World Vision.

**Smoking banned in public places**

India announced comprehensive smoke-free rules that effectively prohibit smoking in public...
places across the country in October 2008. These rules mandate all “public places” to display specific “No Smoking” signage. To increase public awareness of the new rules, as well as to support enforcement, The Union South-East Asia Office coordinated with the World Lung Foundation and the Ministry of Health of India to develop and distribute 400,000 ‘No Smoking’ signs for display in public offices in all 610 districts of 35 states and union territories in the country. The Union is also working with state governments in Delhi, Gujarat, Tamil Nadu and Mizoram on the implementation of smoke-free environments.

**Bidi taxation study published**

Increased taxes on hand-rolled bidis would reduce the estimated number of smokers in India by 18 million and save at least six million lives, according to a study commissioned by The Union and published in 2008. The Union South-East Asia Office coordinated the dissemination of the report across the country targeting the Ministry of Finance, the Planning Commission, the Prime Minister’s Economic Advisory Group, Departments of Finance in 35 states and union territories, economists, national institutes of public policy and finance and members of parliament. The report was also translated and made available in Hindi. The report recommends that the excise rate on bidis be increased to a tax rate identical to that for micro non-filter cigarettes. It also proposes that the distinction between handmade and machine-made bidis be eliminated, and that tax exemptions be limited or eliminated entirely. A copy of the study can be downloaded from www.tobaccofreeunion.org.

**WORLD NO TOBACCO DAY MEDIA CAMPAIGN**

The USEA coordinated with the World Lung Foundation, the Public Health Foundation of India (PHFI) and the Ministry of Health India to launch an eight-week media campaign over television and radio around World No Tobacco Day 2008. The campaign was estimated to cover about 72 percent of the geographic spread of the population. The subsequent evaluation revealed that about 20 percent of the respondents spontaneously reported seeing or hearing the radio or TV spots about the dangers of smoking.
Promoting Lung Health Worldwide

Myanmar

The Union’s Integrated HIV Care for Tuberculosis Patients Living with HIV/AIDS (IHC) Programme is implemented in 8 townships and supported by The Union Myanmar Office in Mandalay.

The IHC programme in action

Since 2005 more than 6,599 or >73% of the registered adult TB patients have been tested for HIV infection. Of these one-third have been diagnosed as HIV positive. When a person tests positive for HIV, their spouse and children are also offered testing through the programme. More than 1,500 co-infected persons identified through the programme have been enrolled in a comprehensive package of care, including access to full laboratory examination, diagnosis and treatment of opportunistic infections and access to antiretroviral therapy (ART). The inclusion rate is 60-80 new patients per month. During the three years in which the programme has been implemented, over 1,135 patients have been put on ART, of which 1,031 (<90%) were still alive at the end of 2008.

In May, the programme was commended by the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria for Business Excellence for Tuberculosis.

Expanding facilities and resources for TB-HIV integrated care

The increasing commitment to and acceptance of the IHC programme in Myanmar are expressed by a number of changes that took place in 2008. For example, a third HIV outpatient clinic was opened at a 300-bed hospital, and this facility also now has a fully equipped laboratory. Condoms are now distributed at HIV out-patient departments, and infection control activities have increased with clinics providing information, posters and face masks for patients, as needed.

Outreach has improved too. HIV testing has become more decentralised so that it is available in two township health centres and the TB hospital. Financial support was provided for building a counseling room in two TB outpatient departments, and case finding for HIV among spouses and children of TB-HIV patients has intensified. Formal financial support is also now provided to two advocacy and support groups for People Living With HIV (PLWH), Spectrum in Mandalay and Hope Alive Pakokku.

In addition, 50 patients were provided with second-line drugs. Overall, the budget of the IHC programme in Myanmar has tripled since it began in 2005.

THE UNION SOUTH-EAST ASIA REGION

The 1st Union South-East Asia Region Conference was held in New Delhi, India on 8-10 September 2008. It was organised jointly with the 63rd National Conference on Tuberculosis and Chest Diseases (SEAR-NATCON 2008). The theme of the conference was “TB, HIV and Lung Health in Resource Limited Countries”. More than 580 delegates came from Bangladesh, Bhutan, Germany, India, Myanmar, Nepal, Norway, Pakistan, Sri Lanka, the United Kingdom and the United States.

2008 OFFICERS

President: MM Singh (India)
Vice President: Irwin Jayasuriya (Bangladesh)
Secretary General: Chaudhary Muhammad Nawaz (Pakistan)
Treasurer: SC Goyal (India)
Board Representative: MM Singh (India)
OTHER UNION ACTIVITIES IN SOUTH-EAST ASIA

- The Union South-East Asia Office (USEA) coordinated four international courses for TB control and 19 courses for tobacco control attended by 196 intermediate- and senior-level managers from governments, NGOs, academia and civil society in 30 countries.

- USEA carried out procurement valued at US$ 923,292 including drugs valued at $631,033 and laboratory items worth $292,259 for countries including Vietnam, Myanmar, Democratic Republic of Congo and Benin.

- USEA also provided technical and financial support for tobacco control activities in India and Bangladesh – priority countries identified by the Bloomberg Initiative to Reduce Tobacco Use (BI).

- The Union continued to provide technical assistance to TB programmes in the region including Afghanistan and Bangladesh.

- Union management and technical courses were offered in Bangladesh, India, Thailand and Vietnam.

- Three interns worked with the USEA on projects related to research in health systems, tobacco control and tuberculosis control.
The Union has provided TB technical assistance and education in Latin America for nearly two decades. There has been special emphasis on training doctors, medical students, and nurses in this region, and on addressing the growing problem of multidrug-resistant TB. The high-burden TB country Brazil is also on the list of the top 15 tobacco-using countries.

Collaboration key to Mexico’s TB control programme

In 2008, The Union participated in evaluating a TBCAP programme in Mexico which ran from 2005-2008. Partners in the project were Alianza SALUD, USAID and PPCT (Programa de Prevención y Control de la Tuberculosis). The reviewers concluded that the collaboration between the three organisations had contributed significantly to improving the coverage and quality of interventions for TB control in Mexico. The evaluation also noted that sustainability of this progress is the most important challenge facing the Secretary of Health and the National Tuberculosis Programme.

Union experts participate in MDR-TB project reviews

The Union participated in Green Light Committee (GLC) reviews of several Latin American MDR-TB projects in 2008. Reviewers for both the El Salvador and Peru MDR-TB Projects found these programmes to be excellent: GLC’s recommendations made in previous visits had been followed, and they received high marks both in clinical management and the case finding performed by the National Tuberculosis Programmes (NTP).

A review of the Nicaragua MDR-TB Project found important weaknesses, and the team developed recommendations to try to improve the functioning of this project over the coming months. In the Dominican Republic, reviewers found positive and steady progress, with the potential to reach high-quality levels with many lives saved. Impediments to success included weakness in the laboratory networks, delays in diagnosis and the low number of hospital beds.

Tuberculosis: Other highlights

- Guatemala, Dominican Republic and Mexico: National MDR-TB intensive training courses
- El Salvador: International course on Epidemiology and Control of TB
- Mexico: International course on Clinical and Operational Management of Patients with MDR-TB
- Mexico: Technical assistance in the development of Nursing Networks in Mexico

Mexico City Office focuses on tobacco control

The Union opened a Latin America Office in Mexico City in May 2008. The main objective of this regional centre is to strengthen the capacity of tobacco control professionals in Latin America through effective interventions, such as development of capacity-building activities, legal assistance, administration of the Bloomberg Initiative grants programme and technical support to public and non-governmental organisations. The team of six works closely with a diverse group of partners to broaden the network of tobacco control in the region.

Management courses build capacity

The Union Latin America Office coordinated and executed the first series of four tobacco control management courses offered in the
region in 2008. Eighteen governmental agencies and non-governmental organisations from Argentina, Brazil, Guatemala, Honduras, Mexico, Paraguay, Peru and Uruguay participated in courses on management, leadership, human resources, budget planning and other skills. The four courses have not only provided an opportunity for capacity building in key organisations, but also have served as a platform for sharing experiences, building meaningful partnerships and strengthening the Latin American tobacco control network. The courses were developed by The Union’s International Management Development Programme and funded by the Bloomberg Initiative.

**Tobacco grants focus on Brazil and Mexico**

The Union Latin America Office supports the work of Bloomberg Initiative (BI) grantees in the region, particularly in Brazil and Mexico, two of the top 15 tobacco-using countries in the world. The National Council Against Addictions (CONADIC) in Mexico received a Union grant that allowed the creation of the National Office for Tobacco Control. Also in Mexico, the National Institute of Public Health (INSP) and the Inter-America Heart Foundation (FIC-Mexico) have been funded to develop programmes in support of change in the national legislation, communication campaigns and the implementation of smoke-free environments in Mexico City.

In Brazil, The Alliance for Tobacco Control (ACT) currently holds two BI grants. The National Institute Against Cancer (INCA) also has a BI grant that supports the promotion of smoke-free environments in Brazil.

**Tobacco Control: Other highlights**

- **Mexico**: Provided legal support to the National Office for Tobacco Control and FIC-MEXICO in several projects related to the drafting of regulations of the tobacco control law, and the developing of pictorial warnings on tobacco products.
- **Panama**: Carried out a fact-finding mission to assess compliance with the advertising ban on tobacco products and the smoke-free legislation in Panama.
- **Costa Rica, Ecuador, Guatemala, Honduras, Paraguay**: Provided technical assistance and legal advice to these countries where comprehensive tobacco control legislation is being passed, discussed or approved.
- **Mexico**: Conducted a study of their smoke-free experience (see story, page 17).
Lung associations in the Middle East were among the founders of The Union in 1920, and The Union Middle East Region has organised 26 conferences — more than any other. The 22 countries in the region are highly diverse in their development, economic power and health indicators.

The Union Middle East Office in Cairo, Egypt opened in January 2008. Its work focuses on providing technical assistance, building national capacity, managing the Bloomberg Initiative grants programme for the Middle East and fostering effective partnerships for tobacco control.

**Addressing MDR-TB in Tunisia and Jordan**

Tunisia is one of five countries in the Middle East that has achieved 100% DOTS coverage. The NTP has outstanding results with a 90% cure rate and high levels of detection. Nonetheless the increase of MDR-TB is a serious challenge. A Union MDR-TB expert has been working with them since 2004, and they were approved for assistance from the Green Light Committee (GLC) in 2006. The Union participated in a GLC review in 2008 and found many earlier recommendations had not yet been followed. Major problems include a lack of staff trained in and dedicated to treating MDR-TB, drug shortages and inadequate monitoring of these patients. The review team concluded that the clinical and operational management can be improved since there are still relatively few cases and the country has a good DOTS baseline, strong infrastructure, motivated staff and political will.
32 organisations attend management courses in Cairo

To build national capacity in tobacco control, The Union Middle East Office coordinated five management courses in 2008. The courses attended by 70 participants from 32 organisations were adapted from a series developed by The Union’s International Management Development Programme (IMDP). As a result of what they learned, 18 NGOs made tobacco control a priority in their work plans, and two formally added it to their mission statements.

Tobacco control materials translated into Arabic

The Union Middle East Office collaborated with Tobacco Control Department staff in Edinburgh to produce fact sheets on tobacco control in Arabic. They also assisted in preparing translations of a range of other materials issued by The Union and other Bloomberg Initiative partners. The office now has an excellent library of management course materials and presentations in Arabic.

NGO coalition formed in Egypt

In 2008, The Union Middle East Office assisted tobacco control organisations in Egypt to create an NGO coalition established to join forces with the government on its tobacco control measures.

Treating child pneumonia in Sudan

Ten hospitals in Sudan were enrolled in The Union’s child lung health programme (CLHP) as part of the Comprehensive Approach to Lung Health project. The CLHP is a proven approach to managing severe and very severe pneumonia in children under five years of age based on standardised case management. Local partner EpiLab and The Union, working closely with the Sudanese Pediatric Association, established agreed policies on diagnosis and treatment regimens following standardised case management recommendations and procedures. After a situation analysis, a training programme was developed for pediatric staff. Wards were then provided with recording materials and equipment, such as oxygen concentrators. The CLHP was introduced first in five hospitals in Khartoum State, then five hospitals in Gezira State. Lessons learned included the importance of involving local experts and the need for a clear Memorandum of Understanding with each participating hospital. Staff turnover and the inability of the children’s parents to pay for medication were two challenges. A new policy offering free care for children under five within the public sector of Sudan resolved the latter problem. The Comprehensive Approach to Lung Health project was funded by the World Bank.

Grants in Egypt, Pakistan and Lebanon

In 2008, five BI grant-funded projects were underway in Egypt, Pakistan and Lebanon. The projects are designed to strengthen tobacco control programmes by focusing on policies known to have high impact and to affect a considerable portion of the population.
Europe includes countries with both low and medium-high incidence of tuberculosis. Each year about 431,000 new TB cases and 63,000 deaths are reported in the region, which includes Central Asia. The high prevalence of drug resistance and MDR-TB coupled with high rates of TB-HIV co-infection is the most alarming epidemiological problem. While many European countries have passed tobacco control legislation, tobacco use continues to be a major public health threat.

The Union’s headquarters have been in Paris since 1920. Today it also has offices in the UK and Russia. The Union United Kingdom Office in Edinburgh, Scotland is the administrative headquarters of the Tobacco Control Department and oversees activities related to the Bloomberg Initiative to Reduce Tobacco Use.

The Union Russia Office was established in 2008. This year its staff assisted WHO EURO and Russia with the organisation of a regional planning meeting to develop sub-national programmes for tobacco control.

**Grants support Russia’s tobacco control movement**

Russia has one of the highest burdens of tobacco-related disease in the world. More than 60% of men smoke, and almost half of male deaths are caused by smoking. In 2008, two grant-funded projects aimed to reduce the toll of tobacco in Russia. Open Health Institute / Russian FCTC Coalition’s NGO Coalition for Tobacco Control secured media coverage on the avoidable toll of tobacco-related disease in Russia, the actions of the industry in promoting smoking and blocking tobacco control, and the need for effective government responses. A separate project aims to strengthen the capacity of the Ministry of Health and Social Development to initiate and propose effective national tobacco control policies and legislation in the Russian Federation.

**More tobacco control highlights: 2008**

- Prepared documents for establishing an Interagency Coordinating Council for Tobacco Control. The project monitored and supported the readings of the draft bill to accept the Framework Convention on Tobacco Control submitted to the Duma.
- Supported development of a comprehensive National Tobacco Control Strategy for the Russian Federation consistent with the provision and guidelines of the FCTC.
- Assisted in securing and obtaining sustainable funding for future tobacco control strategies, programmes and measures in the Russian Federation.

**Union expertise serving Europe**

The Union participates in a wide variety of activities based in Europe. Staff and consultants serve on national and international advisory committees of the World Health Organization, the Stop TB Partnership and other related organisations, such as EURO TAG, the technical advisory group of The European Region of WHO. They are affiliated with leading institutions such as the Institute of Tropical Medicine in Belgium and Hôpital Lariboisière in Paris. They serve on boards, lecture at universities and present research at conferences. In 2008, they conducted courses and workshops in Belgium, Estonia, France, Moldova, Norway, Spain, Sweden, Switzerland and Turkey.

### LUNG HEALTH CHALLENGES: EUROPE

- TB cases/2007: 431,500
- TB deaths/2007: 63,765
- % of MDR-TB/2007: 17
- High-burden tobacco countries: 4


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The Union Russia Office was established in 2008. This year its staff assisted WHO EURO and Russia with the organisation of a regional planning meeting to develop sub-national programmes for tobacco control.

**Grants support Russia’s tobacco control movement**

Russia has one of the highest burdens of tobacco-related disease in the world. More than 60% of men smoke, and almost half of male deaths are caused by smoking. In 2008, two grant-funded projects aimed to reduce the toll of tobacco in Russia. Open Health Institute / Russian FCTC Coalition’s NGO Coalition for Tobacco Control secured media coverage on the avoidable toll of tobacco-related disease in Russia, the actions of the industry in promoting smoking and blocking tobacco control, and the need for effective government responses. A separate project aims to strengthen the capacity of the Ministry of Health and Social Development to initiate and propose effective national tobacco control policies and legislation in the Russian Federation.

**More tobacco control highlights: 2008**

- Prepared documents for establishing an Interagency Coordinating Council for Tobacco Control. The project monitored and supported the readings of the draft bill to accept the Framework Convention on Tobacco Control submitted to the Duma.
- Supported development of a comprehensive National Tobacco Control Strategy for the Russian Federation consistent with the provision and guidelines of the FCTC.
- Assisted in securing and obtaining sustainable funding for future tobacco control strategies, programmes and measures in the Russian Federation.

**Union expertise serving Europe**

The Union participates in a wide variety of activities based in Europe. Staff and consultants serve on national and international advisory committees of the World Health Organization, the Stop TB Partnership and other related organisations, such as EURO TAG, the technical advisory group of The European Region of WHO. They are affiliated with leading institutions such as the Institute of Tropical Medicine in Belgium and Hôpital Lariboisière in Paris. They serve on boards, lecture at universities and present research at conferences. In 2008, they conducted courses and workshops in Belgium, Estonia, France, Moldova, Norway, Spain, Sweden, Switzerland and Turkey.

### LUNG HEALTH CHALLENGES: EUROPE

- TB cases/2007: 431,500
- TB deaths/2007: 63,765
- % of MDR-TB/2007: 17
- High-burden tobacco countries: 4

Despite increased investment from the international community, TB control programmes in many parts of Europe are still characterised by sub-optimal standards of diagnosis and treatment, leading to low success rates and high default rates. The misuse of second-line drugs, now more accessible than in the past, generates more and more super-resistance, with alarming rates of extensively drug-resistant (XDR) TB. This is why WHO has declared TB as a regional emergency in Europe.

Several activities of The Union Europe Region in 2008 aimed to improve this situation:

- The Region actively supported the Stop TB Partnership for Europe, which had to interrupt its activities for lack of funding.
- On World TB Day 2008, events took place in Rome, Berlin, Brussels and other cities to increase the awareness of TB at the EU level.
- The Europe Region joined initiatives aimed at a better control of tobacco use in Europe and developed a strategic plan.
- The Europe Region of The Union began planning its 5th Congress to be held in Dubrovnik, Croatia (27-30 May 2009). Training activities were conducted in Sondalo (Italy), Riga (Latvia) and Tallin (Estonia) with facilitators from the Region.

### 2008 OFFICERS

**President:** Giovanni Battista Migliori (Italy)

**Vice President:** Jean-Pierre Zellweger (Switzerland)

**Secretary General:** Maryse Wanlin (Belgium)

**Treasurer:** vacant

**Board Representative:** Maryse Wanlin (Belgium)
The strong lung health associations of North America have been key supporters of The Union since its inception. The governments of these countries have also been deeply committed to improving lung health not only for their own citizens, but also for the low- and middle-income populations that are the focus of The Union’s mission.

The Union North America Office opened in New York City in late 2008. It is The Union’s first field office in the United States and is charged with the following roles:

- Oversee and manage complex national and international assistance and research projects of relevance to the region and globally
- Strengthen ties between The Union and key partners in North America including governments, donors and technical agencies
- Support the work of other Union offices in the region, Union Regions, constituent and organisational members and the work of the scientific sections.

**TREAT TB to be managed from New York office**

The new North America Office will be managing an ambitious initiative for The Union. TREAT TB – Technology, Research, Education and Technical Assistance for TB – was launched in October 2008 with funding from the United States Agency for International Development (USAID). Supported by a five-year Cooperative Agreement for up to US $80 million, TREAT TB aims to build a successful research partnership model with the potential to stimulate changes in international standards and practice in ways that serve country needs. For further details, please see page 12.

**LUNG HEALTH CHALLENGES: NORTH AMERICA**

- 1 in 6 US deaths is from lung disease
- 1 in 5 Canadians smoke.
- More than 3 million Canadians have lung disease.
- TB rates remain high among Canadian Aboriginal people.
- 60% of Americans are endangered by air pollution.
- 22 million Americans have asthma.

Sources: American Lung Association, Canadian Lung Association

**THE UNION NORTH AMERICA REGION**

The 12th Annual Conference of The Union’s North America Region was held from 28 February to 1 March in San Diego, California. The combined meeting of STOP TB USA and STOP TB Canada also took place as part of the conference and was attended by more than 185 people who participated in a half-day of presentations and networking.

**2008 OFFICERS**

President: Kevin Elwood (Canada)
Vice President: Charles Wallace (USA)
Secretary General and Treasurer: Michael Lauzardo (USA)
Board Representative: Kevin Elwood (Canada)
Union technical courses provide the theoretical and practical knowledge required for both the clinical and management aspects of tuberculosis control. The curricula developed by Union experts and consulting faculty are offered in various formats, and for audiences ranging from laboratory technicians and nurses to specialist physicians and administrators. Each presentation is customised to meet the needs of the host country or region, in collaboration with the national tuberculosis programme (NTP) or other local partners.

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

Funding for Union courses and sponsorship of individual participants is provided by a variety of international agencies, sponsors, and local partners.

More than 1,000 NTP managers have completed The Union’s International Tuberculosis Course. This flagship programme covers modules on the bacteriologic basis of TB control, clinical presentation and diagnosis of TB, epidemiologic basis of TB control, interventions for TB control and elimination, the principles of TB control in a national programme and the elements of DOTS expansion. Teaching methods include lectures, discussion, group work, laboratory bench work and field visits to local NTP facilities. International Tuberculosis Courses are offered in three languages. The English and French courses are three weeks long. The Spanish version (Curso Internacional de Epidemiología y Control de la Tuberculosis) is presented in an intensive 9-day format.

For a complete schedule of upcoming technical courses, please visit The Union website at www.theunion.org or email technical-courses@theunion.org
COURSES IN ENGLISH

International Course on Clinical Management of Drug-Resistant TB
The Philippines: Manila
5–9 May 2008
Participants: 22
Coordinators: José A Caminero, I.D. Rusen
Donors: The Union, Action Damien, Norad

EpiData Software for Operations Research in TB Control: From Paper to Computer Records
Mongolia: Ulaanbaatar
16–20 June 2008
Participants: 11
Coordinator: Hans L Rieder
Donors: The Union, Action Damien, Norad

National Intensive MDR-TB Course
China: Nanjing
7–13 September 2008
Participants: 35
Coordinator: José A Caminero
Donors: The Union, World Health Organization, China GFATM

Course on Efficient Data Capture and Management
Uganda: Kampala
6–10 October 2008
Participants: 10
Coordinator: Hans L Rieder
Donor: TB CAP

COURSES IN FRENCH

Cours International de Management appliqué aux PNT
Benin: Cotonou
10–15 March 2008
Participants: 18
Coordinator: Arnaud Trébucq
Donor: Agence Française de Développement (AFD)

Cours de Mycobactériologie appliquée aux besoins des PNT
Benin: Cotonou
9–20 June 2008
Participants: 13
Coordinator: Armand Van Deun
Donors: The Union, Action Damien, Agence Française de Développement (AFD)

Cours International sur la lutte contre la Tuberculose
Benin: Cotonou
1–19 September 2008
Participants: 25
Coordinator: Arnaud Trébucq
Donor: Agence Française de Développement (AFD)

Cours sur la Microscopie à fluorescence, les tests phénotypiques rapides de détection de la résistance aux antituberculeux et la détermination de la viabilité des bacilles de la tuberculose
Benin: Cotonou
17–28 November 2008
Participants: 7
Coordinators: Aysel Gumusboga, Mourad Gumusboga
Donor: CIDA

COURSES IN SPANISH

XVII Curso Internacional de Epidemiología y Control de la TB
El Salvador: San Salvador
31 March–8 April 2008
Participants: 30
Coordinator: José A Caminero
Donor: The Union

Curso Internacional de Manejo Clínico y Operativo de MDR-TB
Mexico: Mexico City
30 June–4 July 2008
Participants: 25
Coordinator: José A Caminero
Donor: TB CAP

Curso Nacional de Manejo Clínico y Operativo de MDR-TB
Mexico: Mexico City
3–4 July 2008
Participants: 30
Coordinator: José A Caminero
Donor: TB CAP

Curso Nacional de Manejo Clínico y Operativo de MDR-TB
Dominican Republic: Boca Chica
1–2 August 2008
Participants: 30
Coordinator: José A Caminero
Donor: Green Light Commithe (GLC)
Building capacity in low- and middle-income countries through education is central to The Union’s mission. The International Management Development Programme (IMDP) facilitates this mission by delivering high-quality education and training to both individuals and groups from health ministries to non-governmental organisations.

The International Management Development Programme courses help managers acquire and improve the skills they need to run effective national health programmes. Knowledge of how to obtain funding, create and manage a budget, work with basic financial concepts, and coordinate services and tasks are vital to a programme’s success.

The IMDP advances careers and delivers lasting value to the organisations that sponsor participants. The IMDP’s learning environment is widely recognised for its rigorous yet highly participative atmosphere. IMDP participants enjoy many opportunities to share and expand on their personal experiences in an open setting.

Emphasis is placed on linking classroom training and real-world situations, developing action plans to apply what participants learn when they return to work, integrating supervisors into the process to further facilitate cooperative learning and networking, and access to continuing education after the course has ended. The small class size and extensive experience of the faculty are also key features of the programme.

To help improve educational development, the IMDP has teamed up with Harvard Business Publishing to offer IMDP participants the latest in educational tools and resources. Harvard Business Publishing’s online educational tools greatly facilitate the ongoing educational process by providing information and answers to critical implementation questions. IMDP participants may also be eligible for European continuing medical education credits (CME) that can be applied at various international institutions.

For further information please visit the International Management Development Programme web site at www.union-imdp.org or email imdp@theunion.org.
International Management Development Programme for TB Control

Management, Finance and Logistics
India: Jaipur
4-16 February 2008
Participants: 23
Coordinator: José Luis Castro
Donors: The Union

Leading Management Teams
Thailand: Bangkok
14-26 July 2008
Participants: 13
Coordinator: Jamshed Chhor
Donors: The Union

Human Resources Development and Management
Thailand: Bangkok
17-28 November 2008
Participants: 24
Coordinator: Jamshed Chhor
Donors: The Union

Budget Planning and Project Management
Thailand: Bangkok
1-13 September 2008
Participants: 34
Coordinator: Jamshed Chhor
Donors: The Union

Cours International de Management de l’Union appliqué aux programmes de lutte contre la tuberculose
Benin: Cotonou
10–5 March 2008
Participants: 18
Coordinator: Arnaud Trébucq
Donor: Agence Française de Développement (AFD)

International Management Development Programme for Tobacco Control

The following courses were funded by the Bloomberg Initiative:

Management and Leadership
Egypt: Cairo
26 January–2 February 2008
Participants: 22
Coordinator: Gihan El Nahas

Indonesia: Makassar
Participants: 27
Coordinator: Partha Pratim Mandal

Bangladesh: Dhaka
15-22 March 2008
Participants: 25
Coordinator: Partha Pratim Mandal

China: Yinchuan
25 June–2 July 2008
Participants: 16
Coordinator: Lin Yan

Mexico: Cuernavaca
25 September–2 October 2008
Participants: 17
Coordinator: Mirta Molinari

Egypt: Cairo
23–30 November 2008
Participants: 17
Coordinator: Gihan El Nahas

Russia: Moscow
15–22 December 2008
Participants: 15
Coordinator: Tuija Tengvall

Human Resources Management
Bangladesh: Dhaka
5-9 January 2008
Participants: 30
Coordinator: Partha Pratim Mandal

Indonesia: Bekasi
12–16 May 2008
Participants: 24
Coordinator: Partha Pratim Mandal

Bangladesh: Dhaka
7–11 June 2008
Participants: 22
Coordinator: Partha Pratim Mandal

Egypt: Cairo
24–20 June 2008
Participants: 20
Coordinator: Gihan El Nahas

India: Kolkata
26–30 August 2008
Participants: 19
Coordinator: Rana J Singh

Management of Managers
India: Bengaluru
16–20 February 2008
Participants: 13
Coordinator: Partha Pratim Mandal

Indonesia / Bangladesh: Dhaka
18–22 February 2008
Participants: 14
Coordinator: Partha Pratim Mandal

China: Xian
15–19 December 2008
Participants: 20
Coordinator: Gihan El Nahas

China: Haiku
21–25 June 2008
Participants: 15
Coordinator: Rana J Singh

In-Country Custom-Designed Courses

Change Agents and Role Clarity Workshop (Tropical Disease Foundation)
Philippines: Manila
6–15 March 2008

Participants: 58
Coordinator: Jamshed Chhor
Partner: Tropical Disease Foundation

Mentoring Workshop (Tropical Disease Foundation)
Philippines: Manila
15–20 September 2008
Participants: 16
Coordinator: Jamshed Chhor
Partner: Tropical Disease Foundation

Train the Trainer (in collaboration with PMU-TB CAP / KNCV)
Indonesia: Yogyakarta
7–11 July 2008
Participants: 13
Coordinators: Ineke Huitema (PMU); Jamshed Chhor (The Union); Ieva Leimane (KNCV)
Donor: TB CAP USAID

Budget and Financial Management
Egypt: Cairo
31 March–4 April 2008
Participants: 20
Coordinator: Gihan El Nahas

Indonesia: Bali
12–16 August 2008
Participants: 23
Coordinator: Tara S Bam

Bangladesh: Dhaka
25–29 October 2008
Participants: 22
Coordinator: Nevin Wilson

Egypt: Cairo
26–30 October 2008
Participants: 25
Coordinator: Rana J Singh

India: Goai
4–8 November 2008
Participants: 23
Coordinator: Gihan El Nahas

Mexico: Cuernavaca
1–5 December 2008
Participants: 17
Coordinator: Gihan El Nahas

China: Xian
15–19 December 2008
Participants: 20
Coordinator: Gihan El Nahas

Management of Managers
India: Bengaluru
16–20 February 2008
Participants: 13
Coordinator: Partha Pratim Mandal

Indonesia / Bangladesh: Dhaka
18–22 February 2008
Participants: 14
Coordinator: Partha Pratim Mandal

China: Xian
15–19 December 2008
Participants: 20
Coordinator: Rana J Singh

Budget and Financial Management
Egypt: Cairo
31 March–4 April 2008
Participants: 20
Coordinator: Gihan El Nahas

Indonesia: Bali
12–16 August 2008
Participants: 23
Coordinator: Tara S Bam

Bangladesh: Dhaka
25–29 October 2008
Participants: 22
Coordinator: Nevin Wilson

Egypt: Cairo
26–30 October 2008
Participants: 25
Coordinator: Rana J Singh

India: Goai
4–8 November 2008
Participants: 23
Coordinator: Gihan El Nahas

Mexico: Cuernavaca
1–5 December 2008
Participants: 17
Coordinator: Gihan El Nahas

China: Xian
15–19 December 2008
Participants: 20
Coordinator: Gihan El Nahas

Management of Managers
India: Bengaluru
16–20 February 2008
Participants: 13
Coordinator: Partha Pratim Mandal

Indonesia / Bangladesh: Dhaka
18–22 February 2008
Participants: 14
Coordinator: Partha Pratim Mandal

China: Xian
15–19 December 2008
Participants: 20
Coordinator: Rana J Singh
The 39th Union World Conference on Lung Health was held 16-20 October 2008 in Paris, France. The theme was “Global Threats to Lung Health: The Importance of Health System Responses.” The conference was attended by 2,600 delegates from 125 countries who took part in a scientific programme that included 90 sessions (postgraduate courses, workshops, symposia, meet-the-experts and plenary sessions) as well as 45 sessions based on abstracts (thematic slide presentations, poster discussions and poster displays).

**Conference highlights**

- Dr Nils E Billo, Executive Director of The Union, called for wealthy countries to put together a “Rescue Plan” for TB to fund human resources, new diagnostics, new treatment regimens and drugs, clinical trials for MDR-TB, an effective vaccine and management training.

- Prof Rifat Atun, Director of the Strategic Policy and Performance Cluster of The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)’s Executive Management Team, outlined the Global Fund’s contributions to health systems and human resources.

- At a symposium on re-imaging tobacco, more than 60 delegates heard about strategies for changing the attractive image of smoking created by the tobacco industry.

- Ambassador Mark Dybul, US Global AIDS Coordinator, leading the implementation of the President’s Emergency Plan for AIDS Relief (PEPFAR), told delegates that HIV and TB programmes have an obligation to work together because the diseases are inextricably linked.

- Dr Zhenkun Ma, Head of Research for the Global Alliance for TB Drug Development, gave an overview of the global TB drug pipeline. Five new drugs are in the late stages of development, and two or three new drugs should be registered by 2015.

- A capacity crowd turned out for a workshop on tuberculosis and HIV care in prisons which explored a host of medical, political, ethical and management issues.

- The interrelationship between the TB and tobacco epidemics was discussed at a briefing announcing the publication of *A WHO/The Union Monograph on TB and Tobacco Control*.

- In a one-day “Stop TB Symposium” led by Dr Marcos Espinal, Executive Secretary of the Stop TB Partnership, speakers stressed that good TB control is integral to – and dependent on – a health system that provides effective patient care.
Region conferences are organised by The Union members and provide an opportunity to present research, conduct training and explore lung health issues from a specific regional perspective. Most regions convene every other year. In 2008, two conferences were held:

- 12th Union North America Region Conference, 28 February–1 March 2008 (San Diego, California)
- 1st Union South-East Asia Region Conference, 8–10 September 2008 (New Delhi, India)
**Union Awards**

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

**Union Scientific Prize**
The Union Scientific is awarded to a scientist under 45 years of age for research on tuberculosis or non-tuberculous lung disease published during the past two years.

Recipient: **Dr Rony Zachariah** (Belgium) is general coordinator for operational research and documentation for Médecins sans Frontières. His work on the delivery and monitoring of ART in a district setting paved the way for Malawi’s national ART system. Since 2001, he has published close to 65 papers, including many on joint TB-HIV interventions.

**Karel Styblo Award for Public Health**
The Karel Styblo Award for Public Health is given to a health worker (physician or lay person) for contributions to tuberculosis or non-tuberculous lung disease.

Recipient: **Chief Austin Arinze Obiefuna** (Ghana) is founder and President of the Afro Global Alliance International, the National Coordinator of Stop TB Partnership Ghana, National Coordinator for the International AIDS Candlelight Memorial and a member of the Country Coordinating Mechanism for the Global Fund. In 2007 he founded the TB Voice Network and Global TB Candlelight Meditation.

**Other Awards**

**Princess Chichibu Global Memorial TB Award**
This prize is awarded annually by the Japan Anti-Tuberculosis Association (JATA) to raise awareness, recognise excellence and encourage those at the forefront of the campaign to accelerate the battle to stop TB.

Recipient: **Anne Fanning**, MD, FRCP (Canada) is an Emerita Professor, University of Alberta, Canada and served as President of The Union from 2000 to 2003. She has been designated as a ‘physician of the century’ in her home province of Alberta and is a recipient of the Order of Canada, the highest civilian honour for a Canadian.

**Stop TB Partnership Kochon Prize**
The Stop TB Partnership Kochon Prize is awarded annually to persons, institutions, or organisations that have made a highly significant contribution to combating TB. Winners share a US$ 65,000 award and they each receive the Kochon Medal.

Co-Recipient: **Dr Jaime Bayona** (Peru), founding director of Socios En Salud Sucursal Perú (SES), a Lima-based organisation that has had an important impact on policies for the prevention and treatment of drug-resistant TB and HIV.

Co-Recipient: **Prof Denis Mitchison** (UK) engaged in pioneering studies of streptomycin in the late 1940s. In 1956 he became the director of the Medical Research Council Unit for Research on Drug Sensitivity in TB at what is now Imperial College. In that role, he designed the first groundbreaking studies comparing inpatient and outpatient TB treatment in Madras, India.
**2008 UNION CHRISTMAS SEALS CONTEST**

The Union holds a Christmas Seals Contest each year at the World Conference, honouring the commemorative stamps that have helped raise money for tuberculosis and lung disease for more than 100 years. Union members vote for their favourite seals, and the winners are announced at the General Assembly.

The winners of the 2008 contest were:

- **1st prize:** National Tuberculosis Association, Taipei, China.
- **Ex-Aequos 2nd prize:** Comité Nacional de Lucha Contra la Tuberculosis y Enfermedades del Aparato Respiratorio, Mexico.
- **Ex-Aequos 2nd prize:** Philippine Tuberculosis Association, Inc.
The Union’s Scientific Sections offer members an opportunity to affiliate with others who share the same interests and collaborate on research, publications and projects. Their principal responsibilities are to plan the scientific programme for Union conferences and to participate in the governance of The Union through the General Assembly.

Sub-Sections and Working Groups are sub-committees of the Scientific Sections that take on specific projects. All hold their annual meetings at the World Conference. Following are summaries of their 2008 activities.

**Tuberculosis Scientific Section**
2,208 members in 2008

**Chair:** M Amir Khan (Pakistan)*  
**Vice Chair:** Peter Davies (UK)*  
**Programme Secretary:** Fraser Wares (India)*  
**Secretary:** Edward Nardell (USA)*  

In September 2008, Digambar Behera was elected as Vice Chair and C N Paramasivan as Secretary of the Tuberculosis Section. Peter Davies and Edward Nardell became Chair and Programme Secretary respectively. At the annual meeting symposia proposed for the 2009 World Conference covered a range of topics including ethical issues in TB control and clinical trials, childhood TB in high-burden countries, developments in MDR-TB treatment, diabetes and tuberculosis and TB-HIV.

* Officers until September 2008

**Working Groups**
- **TB education** (Leader: M Amir Khan)  
- **TB control in prisons**  
  (Leader: Michael Kimerling)  
- **Trans-border migration and TB**  
  (Leaders: Fraser Wares and Deliana Garcia)  
- **TB infection control**  
  (Leader: Edward Nardell)  
- **TB in big cities** (Leader: Arnaud Trébucq)  
- **TB social determinants and ethics**  
  (Leader: Anne Fanning)  
- **Health systems strengthening**  
  (Leader: M Amir Khan)  
- **TB-HIV data management**  
  (Leader: Rory Dunbar)

**TB Bacteriology and Immunology Sub-Section**
508 members in 2008

**Chair:** C N Paramasivan (Switzerland)*  
**Programme Secretary:** Knut Feldman (Germany)*  

The TB Bacteriology and Immunology Sub-section met during the 2008 World Conference. Symposia topics proposed for 2009 included the contribution of microbiology to the therapeutic management of TB, advances in TB diagnostic tests, closing the gap towards optimal AFB microscopy and laboratory systems to implement new capacities.

*These officers were replaced in late 2008 by Christopher Gilpin and Rumina Hasan.

**TB Nurses and Allied Professionals Sub-Section**
112 members in 2008

**Chair:** Mariam Walusimbi (Uganda)  
**Programme Secretary:** Rajita Bhavaraju (USA)  

The TB Nurses and Allied Professionals (NAPs) Sub-Section met together with members of the HIV, Lung Health and Tobacco Control NAPs Sub-Sections this year. A mission statement was
crafted: “The Nursing and Allied Professionals Sub-Section aims to ensure that quality patient care receives the same level of attention as diagnostics and treatment.”

Symposia proposed for 2009 included implementing and evaluating best practice for patient care in low-income countries and patient and provider education.

**Working Groups**

**Regional mobilisation**
(Leader: Maruschka Sebek)

**Best practice for patient care,**
formerly Case management
(Leaders: Gini Williams and Inge Schreurs)

**Education and training**
(Leaders: Nisha Ahamed and Amera Khan)

**Zoonotic Tuberculosis Sub-Section**
25 members in 2008

**Chair:** Claude Turcotte (Canada)
**Programme Secretary:** John Kaneene (USA)

During 2008, the Zoonotic TB Sub-Section’s *M. bovis* Working Group conducted a survey of the available laboratory techniques as well as molecular typing of *Mycobacterium spp.* in humans and animals. They proposed a symposium for 2009 on public health and socioeconomic challenges.

**Working Group**
*M. bovis*
(Leaders: Claude Turcotte and John Kaneene)

**HIV Scientific Section**
92 members in 2008

**Chair:** Renée Ridzon (USA)
**Vice Chair:** Reuben Granich (Switzerland)
**Programme Secretary:** Nickolas DeLuca (USA)
**Secretary:** Alasdair Reid (Switzerland)

At the HIV Scientific Section annual meeting special emphasis was placed upon the need to ensure and improve information sharing about Section activities. Symposia proposed for 2009 focused on an integrated approach to primary health care, controversies in HIV and ‘hot’ topics, such as prevention, discordant couples and IPT. In 2008 members collaborated with TB professionals on joint symposia on implementation of the three Is of HIV-TB, joint TB-HIV services, community advocacy and HIV and TB in prisons.

**Tobacco Control Scientific Section**
350 members in 2008

**Chair:** Javaid Khan (Pakistan)
**Vice Chair:** Chakib Nejjari (Morocco)
**Programme Secretary:**
Jacques Prignot (Belgium)

The Tobacco Control Scientific Section proposed various symposia for 2009 at its annual meeting. The themes were tobacco and poverty, tobacco and TB, the tobacco industry and the impact of mass media in the fight against tobacco.

**Working Groups**
**Evaluation of different forms of tobacco use** (Leader: Jacques Prignot)

**Standards for smoking cessation programmes in low-income countries** (Leader: Kristen Hassmiller)

**Lung Health Scientific Section**
79 members in 2008

**Chair:** Stephen Graham (Australia)
**Vice Chair:** Christer Janson (Sweden)

**Programme Secretary:**
Gregory Erhabor (Nigeria)

**Secretary:** Simon Schaaf (South Africa)

Three Lung Health Section Working Groups completed key objectives in 2008: A consensus statement on the risk of BCG in HIV-infected infants was published in the IJTLD (BCG Safety Working Group); training courses for doctors and TB administrators were held (Childhood TB Working Group); and a pilot prevalence survey of COPD was conducted in Annaba, finding a prevalence of 17% for COPD (COPD Maghreb Working Group).

At the annual meeting symposia proposed for 2009 address lung health in relation to poverty and resource-limited settings, childhood TB and the inclusion of children in TB trials and the COPD epidemic.

**Working Groups**
**BCG safety** (Leader: Anneke Hesseling)
**Childhood TB** (Leader: Ben J Marais)
**COPD in Maghreb** (Leader: Rachid Benali)
Submissions to the IJTLD continued to increase in 2008, with more than 57 articles received per month. Even with a rejection rate of 70% for original articles and shorter article lengths, there were more than enough to fill 120 pages each month. So as not to impact on the very satisfactory average time from submission to publication (<9 months) and from acceptance to publication (<4 months), we decided to increase the size of the Journal periodically to accommodate the excess.

In July 2008 we further improved access on Ingenta by allowing free access to editorials and States of the Art each month and bringing open access to the Journal forward from 12 to six months. Article downloads soared to more than 10,000 per month in the first half of 2008, and further increases were seen immediately after July. The Impact Factor also improved, with an IF of 2.240 announced in June.

Two changes in 2008 were made in response to requests from authors and readers. First, the possibility of publishing online supplementary material, such as raw data and appendices, was instigated in October in return for a handling fee. Second, an institutional repository policy was established. Internationally, many research councils now require that public-funded research should be made freely available (or at least within six months of publication). We therefore established the following policy: six months after publication, authors may self-archive a copy of the final version of the paper accepted for publication, which includes all modifications from the publishing peer-review process (post-print), but not the publisher’s pdf. There are no associated charges, but authors should notify the Editorial Office on submission, the IJTLD reference should be included in the archived paper and copyright should be acknowledged.

In March, we migrated to Manuscript Central Version 4 and took advantage of this transition to move away from double-blind reviewing – a decision made two years previously. Users seem to have taken this in their stride. An average of two editorials and two States of the Art (SoA) or Review articles were published in each issue in 2008. The SoA series on chronic obstructive pulmonary disease ran from January to July, and one on tuberculosis commenced in November. In the two Educational series we serialised guides on best practice for the care of patients in low-income countries and guidelines on prevalence surveys. A supplement on HIV-TB, sponsored by the US Centers for Disease Control and Prevention, was published in March, and a special series on gender and TB, sponsored by the World Health Organization, appeared in July.

Exposure to tobacco smoke has been shown to cause or exacerbate a wide variety of cancers, infections, cardiovascular and respiratory diseases. This new Union Guide addresses the association between tobacco smoke and tuber-

### Tobacco cessation interventions for tuberculosis patients: A guide for low-income countries, 2008
Authors: K. Slama, Chiang C-Y, D Enarson
ISBN : 978-2-914365-31-4
Quantities printed: 3,000

NULDA BEYERS
Editor, Tuberculosis - South Africa

MOIRA CHAN-YEUNG
Editor, Lung Disease - Hong Kong

CLARE PIERARD
Managing Editor
The third edition of this guide addresses issues raised at the launch of The Union’s Asthma Drug Facility (ADF): treatment guidelines have been updated, given the availability of chlorofluorocarbon-free (CFC-free) metereddose inhalers; and simpler tools, including an electronic database, have been developed to monitor patients treated with asthma medicines purchased through the ADF. It also incorporates findings gained through evaluating the use of the previous edition. Training materials (instructor manual, participant manual and slide presentations) are also available. Publication of the new edition and the associated training materials was funded by the World Bank.

Guides now in French, Spanish and Chinese

Priorities for tuberculosis bacteriology services in low-income countries
2007, 2nd edition
French and Chinese translations, 2008
Authors: H L Rieder, A Van Deun, K M Kam, S J Kim, T M Chonde, A Trébucq, R Urbanczik
Quantities printed: 2,000 copies in French, 1,500 in Chinese

Best practice for the care of patients with tuberculosis: a guide for low-income countries
Authors: G Williams, E Alarcón, S Jittimanee, M Walusimbi, M Sebek, E Berga, T Scatena Villa
ISBN: 978-2-914365-33-8 (French), 978-2-914365-37-6 (Spanish). Quantities printed: 2,000 copies in French, 2,000 copies in Spanish

The Best Practice guide has been translated into French thanks to the support of the French Ministry of Foreign Affairs, and into Spanish thanks to the support of the US Centers for Disease Control and Prevention (CDC). This guide was developed by members of the Case Management Working Group of Nurses and Allied Professionals Scientific Section of The Union, in collaboration with the Nursing Division. It gives detailed guidance on practical aspects of patient care from the onset of symptoms to the completion of treatment, aiming to provide health care workers with the tools to ensure the highest possible quality of care whatever their role or circumstances. Based largely on evidence gathered from experts in the field, the guide has been developed in partnership with the type of health care providers who will be using it in practice.
Sharing Scientific Knowledge

Union Research Published in 2008

Union staff and consultants published 4 books and 58 manuscripts in peer-reviewed journals in 2008.

Peer-reviewed journals


Ngoma D, Makombe SD, Kamoto K, Harries AD. WHO Clinical stage 3 disease conditions in HIV-infected patients who start antiretroviral therapy in Malawi. Tropical Doctor 2008; 38: 159–160:

From the 31 national lung associations that became the International Union Against Tuberculosis (IUAT) in 1920, The Union has grown into an international network of nearly 3,000 non-governmental organisations, government agencies, world-renowned experts and committed individuals all working towards global lung health.

**Governance**

The Union is a not-for-profit organisation based in France. Union members govern the organisation through the Board of Directors and the General Assembly, which meet regularly to discuss strategies, set policies and approve plans, budgets and reports.

**Financial support**

Each country may have one organisation designated as its constituent member of The Union; additional organisations wishing to join become organisational members. Constituent members contribute a yearly fee based on the World Health Organization (WHO) indicators related to their country’s level of development. These contributions are essential to maintain the momentum of The Union’s activities.

While membership fees are no longer the sole source of revenue, as they were in the early years, these fees provide The Union with **vital unrestricted funds used as seed money for innovative approaches** to research, education and technical assistance.

Recent successful ventures funded by The Union members include:

- **Child Lung Health Programme**, which has been subsequently funded by the Bill and Melinda Gates Foundation, the Scottish Government and the World Bank.
- **Asthma Drug Facility**, which is now poised to begin generating orders in 2009.

**Scientific activities**

Union members affiliate with both their geographic region and the Scientific Section of their choice (Tuberculosis, HIV, Lung Health or Tobacco Control). The principal responsibility of the regions is to organise conferences around specific regional themes and issues. The Scientific Sections, Sub-Sections and their Working Groups organise sessions for the World Conference and carry out other projects such as conducting operational research, developing technical guides and training materials and advocating for global lung health.

As of 31 December 2008, the membership of the Scientific Sections stood at:

- Tuberculosis: 2,208
- HIV: 92
- Tobacco Control: 350
- Lung Health: 79

**Membership benefits**

By joining The Union, countries, organisations and individuals receive many benefits:

- Up to five subscriptions to the monthly peer-reviewed *International Journal of Tuberculosis and Lung Disease* (print and/or online edition)
- Opportunity to participate in the activities of a Scientific Section, Sub-Section or Working Group
- Free technical publications and other resources
- Discounts on registration for the World Conference and some Union regional conferences
- Professional experience through networking and collaboration
- Professional exposure through The Union’s e-newsletters, website, Activity Report, scientific publications and conferences
2008 news from the Membership Unit

Individual membership expands in all regions
The Union expanded its individual membership in all regions in 2008, and particularly in Africa, Latin America and South-East Asia. New physicians, microbiologists, researchers, epidemiologists, veterinarians, nurses, laboratory staff, students, teachers, trainers, activists and others joined The Union and its Scientific Sections, Sub-Sections and Working Groups. Some of these newcomers initiated new Working Groups in their fields of interest.

Benefactors and 15-year members sponsor 40 colleagues
The dynamic growth of the individual members resulted in many Benefactors choosing to demonstrate their trust in The Union by increasing their financial support. The contributions of these longstanding friends provided direct sponsorship to more than 40 colleagues from developing countries around the world.

Tobacco control groups and others become organisational members
The Union’s shift to a broader focus on lung health has led to the establishment of several key partnerships and coalitions. As a result, three new organisational members joined The Union. Two of these operate in the tobacco control field; the third one is in laboratory equipment activities.

Constituent membership increases
In 2008 eight former constituent members decided to revive the partnerships between their organisations and The Union. In return, The Union is granting some sponsored access to Union technical and management courses. These sponsorships will continue in 2009 and will be granted at the discretion of The Union.

General Assembly endorses WHO scale for constituent members
The 2008 General Assembly of The Union unanimously endorsed the resolution to calculate the constituent members’ yearly fees on the basis of the latest World Health Organization (WHO) scale of national assessments. There were two reasons for this simplified assessment scheme: to remain consistent with the universally known metrics of the WHO; to establish a scale that is easily understandable, applicable and communicable.

The new Union constituent membership fees will be implemented starting 1 January 2009.

The Union General Assembly 2008

The Union General Assembly was held on Sunday, 19 October 2008 at the Palais des Congrès in Paris. President Dr S Bertel Squire welcomed the constituent, organisational, honorary and individual members, and Scientific Section chairs.

Elections
Based on the Nominating Committee’s recommendations, the General Assembly elected Dr Muhammad Amir Khan (Pakistan) and Prof Felix Salaniponi (Malawi) as individual members of the Board. The Latin America and Middle East representatives completed their terms, but the regions did not put forward nominees, so these seats will remain vacant.

Resolutions
The General Assembly unanimously approved the 2007 Activity Report, Treasurer’s Report and audited accounts. The Assembly also unanimously approved new membership fees for constituent members, effective 1 January 2009, and the budget for FY 2009. The bye-laws were modified as follows: 1) the Treasurer will sit on the Board; and 2) the President will nominate the Treasurer on the recommendation of the Nominating Committee. He or she may be re-nominated from year to year.

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

JOIN THE UNION TODAY
You may now join The Union online and pay your fee with Visa, MasterCard or American Express using our secure network. For more information, please go to www.theunion.org and click on Membership Services.
I am pleased to submit the annual report of the Treasurer of the International Union Against Tuberculosis and Lung Disease (The Union) for the fiscal year ended 31 December 2008.

During this year The Union has made significant progress in examining its operations, charting new areas of growth and planning for the future. While making advances in these and other important areas, The Union has maintained financial strength and achieved new heights in programme funding. Donors continued their generous financial support for our programmes and activities. The value of our fixed assets is higher by (59%) € 2.75 million (US $2.8 million) than it was in Fiscal 2007 and operating income grew by (46%) €11.75 million (US$16.3 million).

Of course, growth does not come without challenges. During Fiscal 2008, The Union experienced a negative operating result of € 826,727 (US $ 1,150,556). Exceptional, one-time project-related expenditures amounting to € 426,000 (US $592,000) were incurred in Fiscal 2008, and a provision for risk of losses related to foreign exchange fluctuations in the amount of € 262,000 (US $364,000) had to be recorded as required by French law. This is not an actual loss because the currencies were not sold in 2008, but a provision for risk and this provision will be cancelled in 2009.

Because of the substantial growth in activities and identification of new opportunities, we invested in new essential personnel which resulted in an operating deficit of €139,000 (US $193,210). This investment has already benefited The Union by generating new grants totaling € 2.5 million (US $3.4 million) in 2009 and 2010.

The exceptional expenditure of € 426,000 (US $592,000) is justified as follows:

- The Integrated HIV Care (IHC) Programme funded by the European Commission requires cost-participation with eligible projects from The Union. In 2008, despite best efforts, The Union was not able to find € 274,000 (US $380,860) in eligible projects during 2007 and 2008 in its portfolio to satisfy this cost-participation requirement and had to finance it with the General Fund.

- The USAID Cooperative Agreement, which started in 2003, had in some previous years, spent more than the funding available to it and therefore The Union in 2008 needed to support the project with funding of € 108,000 (US $150,120) from the General Fund.

- The TBCTA project (2003-2007) had a € 44,000 (US $61,160) deficit resulting from essential activities that were not eligible for USAID funding. The final amount of these costs was determined upon the completion of the final USAID audit of TBCTA in 2008.

The world financial crisis of 2008 stirred a collective energy to approach our mission with greater dedication, creativity and focus than ever. The Union took numerous steps to increase revenue, reduce costs and manage more efficiently. The past year saw a major review of our policy for management of foreign currencies to minimise the risk of losses due to foreign exchange fluctuations. In addition, new financial management systems improved The Union’s ability to control expenditures and take corrective action when necessary.

With the breadth of resources entrusted to The Union by donors, government agencies, members and other supporters, the need for prudent fiscal oversight is great. Working closely with our Board of Directors and our auditors, we continue to review and improve our financial policies, procedures and practices. Such oversight will ensure the continued financial strength needed to pursue The Union’s agenda in Fiscal 2009 and beyond.

The activities described in this Activity Report provide evidence that The Union, by almost any measure, is better-positioned today than last year, or the year before.

Financial highlights

- The Union’s operating income was € 37.1 million (US $51.7 million).
Grants and managed funds, as a percentage of total revenue, represent 90 percent of total income.

The Union received new grants totaling €7.9 million (US $11 million) from the World Lung Foundation and USAID respectively.

The Union’s General Fund, which accounts for 10 percent of total income, includes unrestricted funds received from members, donors and friends of The Union. The General Fund underwrites most administrative activities, the cost of publications and the core scientific activities of The Union.

Approximately €400,000 (US $556,000) of funds owed by constituent members were written off as members indicated their inability to pay.

We reduced our short-term bank advances by €410,000 (US $570,000) (22%) from 2007.

The amount borrowed long-term from financial institutions increased by €1.59 million (US $2.11 million) (46%) for the purchase of new office space.

By almost any measure, The Union is better positioned today than last year, or the year before. Our success is the product of unrelenting effort, clear vision, a determination to honor our commitments and the exercise of disciplined financial management. We are proud of what we have accomplished during Fiscal 2008 as an organisation and look forward to building on these achievements as we strive to provide even more valuable services in the future. I would like to thank you, the members of The Union and our donor agencies, for your confidence in and continued support of The Union.

Thank you.

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

Siège social : 68 Boulevard Saint-Michel - 75006 Paris

Independent Auditor’s Report

For the year ended 31st December 2008

Dear Sirs,

We have audited the accounts of the Association International Union Against Tuberculosis and Lung Disease as of December 31, 2008. These financial statements are the responsibility of the Union’s Treasurer. Our responsibility is to express an opinion on these financial statements based on our audit.

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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Association’s internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statements presentation. We believe that our audit provides a reasonable basis for our opinion.
In our opinion, the financial statements referred to above presents fairly, in all material respects, the financial position of the Association as of December 31, 2008, in accordance with the accounting rules and principles applicable in France.

Levallois-Perret, le 9 juin 2009

KPMG Entreprises
Département de KPMG S.A.

[Signature]

Jérôme Eustache
 Associé
## Finance

### Balance Sheet

#### ASSETS

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<td>Software</td>
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<td>Constituent members</td>
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<td>231 501</td>
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<td>Financial investment for managed funds</td>
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<td>Cash and bank for managed funds</td>
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<td>Cash and bank of The Union</td>
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<td><strong>Total 3</strong></td>
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<td><strong>Realisable Exchange Losses</strong></td>
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<td>117 482</td>
<td>172 941</td>
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<td><strong>Total 4</strong></td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>18 254 959</td>
<td>25 405 425</td>
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<td>14 741 395</td>
<td>21 700 805</td>
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#### Conversion Rates

- 2008: 1 € = 1,3917 US$
- 2007: 1 € = 1,4721 US$

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>ASSETS</strong></td>
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<td></td>
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</tr>
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</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
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<tr>
<td>Constituent members</td>
<td>620 294</td>
<td>863 263</td>
</tr>
<tr>
<td><strong>Prepaid Expenses</strong></td>
<td></td>
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<tr>
<td><strong>Realisable Exchange Losses</strong></td>
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<tr>
<td></td>
<td>€</td>
<td>US $</td>
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<td><strong>Equity</strong></td>
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<td>Reserves</td>
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<td>Result carried forward</td>
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<td>-826 727</td>
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<td>Restatement reserve on premises</td>
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<td><strong>Total 1</strong></td>
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<td><strong>Contingent Liability</strong></td>
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<td><strong>Total 2</strong></td>
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<td>363 955</td>
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<td><strong>Dedicated Funds</strong></td>
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<td>9 658 782</td>
<td>13 442 128</td>
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<td><strong>Debts</strong></td>
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<td>Borrowing from credit institutions</td>
<td>2 938 500</td>
<td>4 089 510</td>
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<td>Current bank advances (Short-term)</td>
<td>1 483 859</td>
<td>2 065 087</td>
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<td>Suppliers and similar accounts</td>
<td>1 405 194</td>
<td>1 955 608</td>
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<tr>
<td>Tax and social security</td>
<td>556 329</td>
<td>774 243</td>
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<td>Charges to be paid (Accrued expenses)</td>
<td>14 717</td>
<td>20 482</td>
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<td>Other creditors</td>
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<td><strong>Total 3</strong></td>
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<td><strong>Total 4</strong></td>
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<td>866 369</td>
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<td><strong>Foreign Exchange Unrealised Gains</strong></td>
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<td><strong>Total 5</strong></td>
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<td><strong>Grand Total</strong></td>
<td><strong>18 254 959</strong></td>
<td><strong>25 405 425</strong></td>
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</table>

2008: 1 € = 1,3917 US$
2007: 1 € = 1,4721 US$
### INCOME STATEMENT (in €)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Contributions</strong></td>
<td>576 033</td>
<td>710 714</td>
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<tr>
<td><strong>Operating grant</strong></td>
<td>5 070 857</td>
<td>5 067 455</td>
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<tr>
<td><strong>Grants and gifts</strong></td>
<td>1 614 244</td>
<td>20 941 804</td>
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<td><strong>Write back of provisions and transferred charges</strong></td>
<td>173 349</td>
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<td><strong>Other income</strong></td>
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**Total 1** | 9 950 436 | 25 382 880 |

<table>
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<td><strong>External charges</strong></td>
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<td>13 069 630</td>
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<td><strong>Taxes</strong></td>
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<td><strong>Wages and salaries</strong></td>
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<td><strong>Social contributions</strong></td>
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<td>1 433 783</td>
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<td><strong>Depreciation charges and addition to provisions</strong></td>
<td>820 875</td>
<td>1 088 559</td>
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<tr>
<td><strong>Other expenses</strong></td>
<td>484 033</td>
<td>9 758 926</td>
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**Total 2** | 10 563 711 | 27 943 244 |

<table>
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<td>19 244 594</td>
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<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>-16 587 616</td>
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</tbody>
</table>

**Operating Result** | -613 275 | 96 614 |

| Foreign exchange profit or loss | 93 101 | -284 132 |
| Write back of financial provisions | 49 842 | 222 741 |
| Interest and financial charges | -94 875 | 18 842 |
| Provision of risk for foreign exchange losses | -261 520 | -49 842 |

**Net Financial Result** | -213 452 | -92 391 |

<table>
<thead>
<tr>
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<tr>
<td><strong>Net Result for Financial Year</strong></td>
<td>-826 727</td>
<td>4 223</td>
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*2008: 1 € = 1,3917 US$  
2007: 1 € = 1,4721 US$  
Note: External charges include € 425,988  
non-recurrent charges on Dedicated Funds*
## INCOME STATEMENT (in US $)

### Operating Income

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<th>General Funds</th>
<th>Managed Funds</th>
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<th>Total</th>
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<td>801,665</td>
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<td>-4,735</td>
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<td>39,378,113</td>
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<td>Write back of provisions and transferred charges</td>
<td>1,330,196</td>
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<td>1,749,587</td>
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</tr>
<tr>
<td><strong>Total 1</strong></td>
<td><strong>13,848,023</strong></td>
<td><strong>37,839,899</strong></td>
<td><strong>51,687,922</strong></td>
<td><strong>37,366,138</strong></td>
</tr>
</tbody>
</table>

### Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>External charges</td>
<td>6,441,791</td>
<td>21,487,416</td>
<td>27,929,207</td>
<td>19,239,802</td>
</tr>
<tr>
<td>Taxes</td>
<td>24,232</td>
<td>2,994</td>
<td>27,226</td>
<td>24,468</td>
</tr>
<tr>
<td>Wages and salaries</td>
<td>4,216,647</td>
<td>1,036,045</td>
<td>5,252,692</td>
<td>3,791,725</td>
</tr>
<tr>
<td>Social contributions</td>
<td>2,202,808</td>
<td>17,831</td>
<td>2,220,639</td>
<td>2,110,672</td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>1,142,412</td>
<td>0</td>
<td>1,142,412</td>
<td>1,602,468</td>
</tr>
<tr>
<td>Other expenses</td>
<td>673,629</td>
<td>15,119,728</td>
<td>15,793,357</td>
<td>14,366,115</td>
</tr>
<tr>
<td><strong>Total 2</strong></td>
<td><strong>14,701,519</strong></td>
<td><strong>37,664,014</strong></td>
<td><strong>52,365,533</strong></td>
<td><strong>41,135,250</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write back of dedicated funds</td>
<td>0</td>
<td>37,608,056</td>
<td>37,608,056</td>
<td>28,329,967</td>
</tr>
<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>-37,749,710</td>
<td>-37,749,710</td>
<td>-24,418,629</td>
</tr>
<tr>
<td><strong>Operations on Dedicated Funds</strong></td>
<td>0</td>
<td><strong>-141,654</strong></td>
<td><strong>-141,654</strong></td>
<td><strong>3,911,338</strong></td>
</tr>
</tbody>
</table>

### Operating Result

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>-853,496</strong></td>
<td><strong>34,231</strong></td>
<td><strong>-819,265</strong></td>
<td><strong>142,226</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign exchange profit or loss</td>
<td>129,568</td>
<td>-34,311</td>
<td>95,257</td>
<td>-418,271</td>
</tr>
<tr>
<td>Write back of financial provisions</td>
<td>69,366</td>
<td>0</td>
<td>69,366</td>
<td>327,897</td>
</tr>
<tr>
<td>Interest and financial charges</td>
<td>-132,038</td>
<td>80</td>
<td>-131,958</td>
<td>27,737</td>
</tr>
<tr>
<td>Provision of risk for foreign exchange losses</td>
<td>-363,955</td>
<td>0</td>
<td>-363,955</td>
<td>-73,373</td>
</tr>
<tr>
<td><strong>Net Financial Result</strong></td>
<td><strong>-297,059</strong></td>
<td><strong>-34,231</strong></td>
<td><strong>-331,290</strong></td>
<td><strong>-136,010</strong></td>
</tr>
</tbody>
</table>

### Net Result for Financial Year

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>-1,150,555</strong></td>
<td>0</td>
<td><strong>-1,150,555</strong></td>
<td><strong>6,216</strong></td>
</tr>
</tbody>
</table>

---

2008: 1 € = 1,3917 US$  
2007: 1 € = 1,4721 US$  
Note: External charges include US$ 592,847  
non-recurrent charges on Dedicated Funds
The members of The Union are part of an 89-year tradition of international lung health activism. Their membership fees provide much-needed unrestricted funds that provide The Union with the scientific independence to foster innovative health solutions for the poor. We gratefully acknowledge their support.

Constituent members
Each country is represented by one constituent member.

National Tuberculosis Control Programme, Afghanistan
Comité Algérien de Lutte contre la Tuberculose, Algeria
Programa Nacional de Controlo de Endemias, Angola
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Fonds des Affections Respiratoires, Belgium
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Ministerio de Salud Pública, Chile
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National Tuberculosis Association, Taipei, China
Programme National de Lutte Contre la Tuberculose, Democratic Republic of Congo
Comité Antituberculeux de la Côte d’Ivoire, Côte d’Ivoire
Pulmonary Outpatient Centre, Croatia
Programa Nacional de Lucha Contra la Tuberculosis, Cuba
Danish Lung Association, Denmark
Egyptian General Association Against Smoking, TB and Lung Disease, Egypt
Ministerio de Salud Pública y Assistencia Social, El Salvador
Ministerio de Sanidad y Bienestar Social, Equatorial Guinea
Ministry of Health, Eritrea
Tartu University Clinics, Lung Clinic, Estonia
Finnish Lung Health Association - Filha Ry, Finland
National Centre of Tuberculosis & Lung Disease, Georgia
Deutsches Zentralkomitee Zur Bekämpfung der Tuberkulose, Germany
Ghana Society for the Prevention of Tuberculosis and Lung Disease, Ghana
Liga Nacional Contra la Tuberculose, Guatemala
National Tuberculosis Programme, Guinea Bissau
Ministère de la Santé, Guinea Conorky
The Guyana Chest Society, Guyana
Unité de Coordination des Maladies Infectieuses et Transmissibles (UCMIT), Haiti
The Hong Kong TB Chest and Heart Diseases Association, Hong Kong
Semmelweis University/Hungarian Respiratory Society, Hungary
Reykjavik Health Care Services, Iceland
The Tuberculosis Association of India, India
The Indonesian Association Against Tuberculosis, Indonesia
Research Institute for a Tobacco Free Society, Ireland
Iranian Charity Foundation for Tuberculosis and Lung Disease, Islamic Republic of Iran
Israel Lung and Tuberculosis Association, Israel
Japan Anti-Tuberculosis Association, Japan
Jordanian Society Against Tuberculosis and Lung Disease, Jordan
Kenyan Association for the Prevention of TB and Lung Disease, Kenya
Korean Institute of Tuberculosis (KIT), Republic of Korea
Ministry of Public Health, Lebanon
Ligue de Prévention et d’Action Médico-Sociale, Luxembourg
Institut d’Hygiène Sociale, Madagascar
Ministry of Health and Population, Malawi
Malaysian Association for the Prevention of Tuberculosis, Malaysia
Direction Nationale de la Santé, Mali
Comité National de Lucha Contra la Tuberculosis, Mexico
Mongolian Anti-Tuberculosis Association, Mongolia
Ministerio de Saude, Mozambique
Myanmar Medical Association, Myanmar
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Royal Netherlands Tuberculosis Foundation, The Netherlands
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South African National Tuberculosis Association, South Africa
Ministerio de Sanidad y Consumo, Spain
Ceylon National Association for the Prevention of Tuberculosis, Sri Lanka
Federal Ministry of Health, Sudan
Swedish Heart Lung Foundation, Sweden
Ligue Pulmonaire Suisse, Switzerland
Comité Syrien de Défense Contre la Tuberculose, Syrian Arab Republic
Ministry of Health, United Republic of Tanzania
Anti-Tuberculosis Association of Thailand, Thailand
Ligue Nationale Contre la Tuberculose et Maladies Respiratoires, Tunisia
Turkish Anti-Tuberculosis Association, Turkey
National Tuberculosis and Leprosy Programme, Uganda
British Lung Foundation, United Kingdom
American Lung Association, USA
National Hospital of Tuberculosis and Respiratory Disease, Vietnam
Ministry of Health, Yemen

Organisational members
Any organisation may join as an organisational member.

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Kuratorium Tuberkulose in der Welt e.V., Germany
Sandoz Pvt. Ltd., India
Associazione Scientifica Interdisciplinare per lo Studio delle Malattie Respiratorie, Italy
South Asian Association for Regional Cooperation (SAARC) Tuberculosis & HIV/AIDS Centre, Nepal
Norwegian Association of Heart and Lung Patients (LHL), Norway
Tropical Disease Foundation, The Philippines
King Oscar II Jubilee Foundation, Sweden
Chest, Heart & Stroke, Scotland, United Kingdom
TB Alert, United Kingdom
American College of Chest Physicians, USA
American Thoracic Society Inc, USA
LW Scientific, Inc, USA
World Lung Foundation, USA

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Honorary members have been recognised by The Union for their distinguished contributions to the fight against tuberculosis and lung disease. Their wisdom and experience helps to guide The Union in its mission.

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Prof Li-Xing Zhang, China
Prof Abolhassan Zia Zarifi, Iran
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Agence Française de Développement (AFD)
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European Commission, DR Congo
Bill and Melinda Gates Foundation
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Norwegian Association of Heart and Lung Patients (LHL)
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World Bank
World Health Organization (WHO)
World Lung Foundation
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