The Union
HEALTH SOLUTIONS FOR THE POOR

International Union Against Tuberculosis and Lung Disease
ACTIVITY REPORT 2012
The mission of the International Union Against Tuberculosis and Lung Disease (The Union) is to bring innovation, expertise, solutions and support to address health challenges in low- and middle-income populations.
MESSAGE FROM THE PRESIDENT

This is the first annual report to appear under my presidency. In reading it, I continue to be struck by the breath and diversity of work performed under the aegis of The Union. I, like so many Union members, work daily with patients affected by TB, lung diseases and poverty, and I can see how many of the programmes described in this report touch my patients directly.

The MDR short-course treatment trials – both the STREAM clinical trial in Africa and Asia and the pilot programmes in francophone Africa – will produce key information. During a recent MDR cohort review with colleagues in western Kenya, I heard again what a difficult challenge it is to administer and monitor a highly toxic 20-month regimen in a rural setting.

In India, Project Axshya continues to provide inspiring examples of what can be accomplished on a large-scale to provide access to TB information, diagnosis and care for the most marginalised and hard-to-reach populations.

2012 also saw the dissemination of the results of nine years of work exploring the best way to integrate care for the millions of people with both TB and HIV – another high priority with TB continuing to be the leading cause of death among people with HIV.

Since 2009, the Centre for Operational Research (COR) has trained researchers from around the world who have studied not only TB and HIV, but also a wide range of other public health challenges. As a result, COR’s affiliated staff, consultants, fellows and course participants have published hundreds of papers in peer-reviewed journals that have contributed to important changes in policy and practice.

New projects, such as The Union’s bidirectional screening projects for diabetes and TB are teaching us not only about the risk that diabetes represents for TB control, but also the critical importance of primary health care strengthening. We can no longer afford (either fiscally or effectively) to silo public health diseases, such as TB, from the non-communicable chronic diseases, such as diabetes. And, just as The Union’s DOTS TB strategy evolved into a public health strategy applicable other diseases, our emphasis on healthcare systems strengthening coupled with public health disease interventions will also have broad applicability.

The war against tobacco continues – and I do believe that war is the critical wording here. Years after the acknowledgement of the deadly effects of smoking, we continue to struggle to provide smoke-free environments and to limit the sale of tobacco products to children. This report illustrates the progress made by the countries working with The Union in 2012; but the recent rise in e-cigarette sales, use and promotion is just one example of the battles still ahead.

These are but a few of the highlights of The Union’s work in 2012. I cannot ever write about The Union and its work without returning to the fact that it is a member organization. This fact not only defines The Union, but also drives its work and direction. A high point of my 2012 presidency year was the overwhelming response to my first letter to the membership. In that letter I talked about the importance of The Union membership to me in my day-to-day work and in my career – the camaraderie of the meetings, the mentorship I received, the home I found with others sharing the same goals. Not a day goes by that I don’t reread a message from you, to be inspired by you and to be reminded of what The Union means – and what it does.

I know you will be inspired by the many initiatives described in this 2012 Activity Report. I look forward to 2013 and beyond – to hearing from you and about you and your work as we go forward to fulfill The Union’s vision “health solutions for the poor.” Thank you all for your daily efforts.
MESSAGE FROM THE EXECUTIVE DIRECTOR

“Run for your lungs”

Over the past 30 years The Union has enlarged its areas of interest and intervention to include not only tuberculosis, but also HIV, child lung health and non-communicable diseases (NCDs), such as asthma, and major issues related to lung health, such as tobacco control. The lungs remain the primary focus of our attention as can clearly be seen in this 2012 Activity Report. The Union was active in 125 countries, with projects implemented through our region and country offices, scientific departments and many partners and grantees.

In Kuala Lumpur, during the 43rd Union World Conference on Lung Health, we collaborated with our Malaysian constituent member – the Malaysian Association for the Prevention of TB (MAPTB) – to organise two very successful “Run for your lungs” events with more than 1,200 runners from all age groups. These events were designed to raise awareness about all the diseases that can affect the lungs, and it is The Union’s responsibility to take advantage of every such opportunity to advocate for action and funding to tackle tuberculosis and lung disease.

While TB and HIV have both been high public health priorities, today there are many additional competing health issues burdening low- and middle-income countries. The United Nations, the World Health Organization and many governmental development agencies are now focusing their attention more and more on NCDs. Unfortunately for lung health advocates, the ones most frequently mentioned are diabetes, cardiovascular disease and cancer, with chronic respiratory disease receiving little attention.

In 2012 The Union delivered high-quality technical assistance, education and research serving 125 countries. It is not possible to mention all these activities in this short message, but we can be proud of the broad scope of our work, and the fact that, in a very difficult economic environment, The Union has continued to deliver excellent work. A few highlights are the launch of a study introducing short-course MDR-TB treatment regimens in several francophone countries in Africa, the successful completion of a project showing that integrated TB-HIV care can be provided at primary health care level, and the launch of the Global Asthma Network (GAN). In several countries, such as Turkey, Viet Nam and Indonesia, progress towards the reduction of tobacco use has been very encouraging. New laws have been introduced to offer smokefree environments to these populations.

The fiscal year 2012 ended with a surplus of 480,000 euros – a continuation of the positive financial results of 2010 and 2011. This is very encouraging, but it is important to note that we need to continue our efforts to work in a cost-efficient way to reduce our debts from previous years. I would like to thank all the staff and consultants for their excellent work, which has allowed us to report on so many positive results and to help save millions of lives around the world.

We at The Union need to continue providing innovative tools through technical assistance, education and research to benefit our members, governments, other NGOs and civil society and to ensure that poor populations in low- and middle-income countries are fit to live and “run” with healthy lungs, vital organs that do not always get the attention they deserve.

Let us run.
Two “Run for your lungs” events were held during the 2012 World Conference in Kuala Lumpur, Malaysia to raise awareness of lung health. They were organised by The Union and the Malaysian Association for the Prevention of Tuberculosis (MAPTB).
The Union Institute’s 396 staff and consultants offered technical assistance, provided education and training and conducted research in 125 countries in 2011. With headquarters in Paris, The Union also has offices close to the people we serve in Africa, Asia, Europe, Latin America, the Middle East and North America.

In addition, The Union’s network of 15,000 members and subscribers were active in more than 150 countries around the world, working towards our common vision: health solutions for the poor.

14 Headquarters and offices
103 Union constituent and organisational members
Technical assistance projects in 54 countries
Education activities in 48 countries
Research projects in 51 countries
Tobacco control grants in 33 countries
TB-HIV programmes and courses in 10 countries
TREAT TB partners projects in 10 countries
NCD advocacy and activities in 5 countries
ADF clients in 9 countries
In 2012, The Union had three offices serving Africa – in the DR Congo, Uganda and Zimbabwe – as well as partnerships with both francophone and anglophone countries throughout the continent. In addition to its technical assistance, education and research programmes in tuberculosis, multidrug-resistant TB and TB-HIV, The Union assists these countries to improve their management of asthma, child pneumonia, and other lung diseases. Tobacco control has become another growing area of Union activity.

**Health challenges in the Africa Region**

— 24% of all TB cases are in Africa, which has the highest rates of cases and deaths per capita.

— Only 69% of TB patients were tested for HIV in 2011, but this is up from 3% in 2004.

— 90% of rural households in sub-Saharan Africa use biomass fuel for cooking and heating.

*Sources: see page 71*
Addressing TB control issues in collaboration with francophone Africa

The Union continued its close collaboration with francophone Africa in 2012, providing technical assistance to the national tuberculosis programmes in eight countries – Benin, Cameroon, Central African Republic, Djibouti, the Democratic Republic of Congo (DRC), Madagascar, Niger and Togo. Programme reviews covered issues such as child TB, multidrug-resistant TB (MDR-TB), TB-HIV, infection control, laboratory services, first- and second-line drug supplies, monitoring and evaluation (M&E), government support and funding issues.

In Benin, Cameroon and Niger, a special focus was the pilot programmes testing the nine-month regimen for MDR-TB. The Union also conducted two reviews of the MDR-TB programme in Djibouti on behalf of the Green Light Committee (GLC).

Technical assistance was provided to the laboratory networks of Cameroon, DR Congo, Niger and Senegal.

Courses in French this year included bacteriology and laboratory courses tailored to sub-Saharan Africa and the 20th offering of the international TB course. All were held in Cotonou, Benin.

Funding for these activities is provided by the Agence Française de Développement.

SPARK-TB improves TB case detection and care in Uganda

With more than 50% of Kampala’s population living in slums, The Union saw the need to improve TB services at the widely used private-for-profit (PFP) clinics serving these areas and developed partnerships with 100 of them in 2012. Through SPARK-TB (Slum Partnerships to Actively Respond to Tuberculosis in Kampala), The Union built the clinics’ capacity by providing training and support supervision, as well as disseminating national TB guidelines and M&E tools. In addition, all laboratories were enrolled into the national External Quality Assurance (EQA) scheme. To build public awareness, the project also included advocacy, communication and social mobilisation (ACSM) activities.

In 2012, 633 TB cases were detected that would otherwise have been missed, and all patients received either community-based directly observed treatment (DOT) or health facility-based DOT. In addition, some of the clinics are now able to access anti-TB medications directly from the National Tuberculosis and Leprosy Programme, which had not been possible before the inception of SPARK-TB. Funded by TB-REACH, SPARK-TB received a grant to continue for 2013.

TB CARE project prepares Uganda to serve as an SRL

As part of the TB CARE I project “Strengthening TB laboratory networks in preparation for the creation of a new TB Supranational Reference Laboratory (SRL) in East Africa”, The Union’s laboratory experts visited Uganda’s candidate SRL at Kampala to review possible SRL activities and links with other countries. This led to official links with South Sudan and Zambia, a condition for the lab to become recognised as a full SRL. However, it was found that the lab lacked
the resources to meet all the requirements for a national reference laboratory (NRL) and SRL, in spite of newly acquired support from WHO Geneva. The focus of the visit was thus shifted to meetings with the Ministry of Health and other partners to lobby for semi-autonomy, in addition to working on strategic and management planning.

**Motorcycle fleet transports sputum samples in rural Zimbabwe**

A sputum transport system in five districts and three cities of Zimbabwe now uses motorcycles to deliver sputum samples from both remote villages and urban areas to the lab. The project funded by TB CARE I will eventually be scaled up to cover 32 districts and nine urban areas.

By the end of 2012, 62% of new sputum-positive patients in the five districts had used the transport system, significantly improving universal access to TB diagnosis and care.

The transport system is one of several TB CARE I projects in Zimbabwe designed to strengthen TB control by supporting the National Tuberculosis Programme through policy direction and build capacity to provide TB and TB-HIV services in the country.

The Union through The Union Zimbabwe Office is the lead partner, with the World Health Organization (WHO) and the KNCV Tuberculosis Foundation (KNCV) as collaborating partners. Funding is provided by the United States Agency for International Development (USAID).

**STREAM recruits for study of nine-month MDR-TB regimen**

TREAT TB and the UK’s Medical Research Council (MRC-UK) began recruitment for the STREAM study (Standardised Treatment Regimen of Anti-TB Drugs for Patients with MDR-TB) in 2012. Patient enrolment for the trial of a nine-month MDR-TB regimen began at South Africa’s King George V Hospital in Durban in July and the Sizwe Hospital in Johannesburg in August. To prepare for the study launch, staff and partners were trained in good clinical practice and effective laboratory methods, in partnership with the Institute for Tropical Medicine in Belgium. The team also ensured that all pharmaceutical and other procurement needs were met.

TREAT TB staff also worked with in-country study staff and officials from Ethiopia’s Ministry of Health and the Armauer Hansen Research Institute (AHRI) to prepare for the implementation of the STREAM study at St. Peter’s Hospital in Addis Ababa in November. The study also began at Phan Ngoc Thac Hospital in Viet Nam in November and is expected to begin in India in 2013.
Francophone countries pilot a nine-month regimen for MDR-TB

On 1 March 2012, The Union and the Cameroon Ministry of Health convened a meeting of international TB experts and representatives from the TB programmes of 10 francophone African countries to discuss “Short-course treatment for multidrug-resistant TB: what are the hopes?” in Yaoundé, Cameroon. The event provided a forum to compare and discuss the results of the WHO-recommended MDR-TB regimen, which lasts more than 20 months, versus a nine-month regimen and to clarify steps forward.

Over the prior year, a Cameroon test of the short-course regimen resulted in a 90% cure rate with no treatment failures or relapses. One factor contributing to this success was that this treatment is easier on both patients and health care systems. It also costs dramatically less. Bangladesh, Benin and Niger, who have also tested this regimen, presented similar results. Based on the gathering evidence, the WHO agreed that countries could further test the nine-month regimen under carefully monitored conditions.

The ethics committees of Benin, Burundi, Cameroon, Central African Republic, Côte d’Ivoire, DR Congo, Niger and Rwanda gave their approval for this study, as did The Union Ethics Advisory Group.

Courses and technical assistance build capacity for managing DR-TB

The Union offered its International Comprehensive Course for Clinical and Operational Management of MDR-TB in Namibia for the third time in 2012. The five-day course was attended by 19 participants.

An MDR-TB course that emphasised the training of trainers was held in South Africa. After the course, the National TB Programme and the TB CARE project of the University Research Co, LLC committed to repeat the training locally, in a cascade manner, with technical support from The Union. As a result, the training material was adapted; and local facilitators, who had been trained in Union courses, offered MDR-TB courses in three different South African provinces.

All of The Union’s MDR-TB courses cover the epidemiology of DR-TB, DR-TB case finding, drug susceptibility testing, multidrug- and extremely drug-resistant TB (MDR/XDR-TB) treatment, adverse drug reactions, infection control and contact management and treating MDR-TB under special circumstances. In the courses held in Africa, special attention was given to the needs of HIV co-infected patients.

In addition, The Union participated in a joint international mission on programmatic management of MDR-TB in Uganda. Online clinical technical assistance on managing difficult MDR-TB cases was provided to Botswana, Namibia, South Africa and Zimbabwe.

PROVE-IT: Analysing LPA and Xpert MTB/RIF as MDR-TB diagnostic tools

TREAT TB’s PROVE IT study is assessing line probe assay and Xpert MTB/RIF as tools to diagnose TB and MDR-TB. Since implementing these new tools requires the involvement and collaboration of several parts of the health system, PROVE-IT, which stands for Policy Relevant Outcomes from Validating Experience on Impact, weighs all of these elements in its evaluation.

Since the study began in South Africa in 2011, the team has analysed the records of 652 patients who received treatment at one of the study sites between 2005 and 2010. The team has also conducted 38 interviews with health officials for the policy transfer analysis track of the study and 83 patients to analyse the financial impact of these tools on them. The study, which is also being conducted in Brazil and Russia, will continue through 30 September 2013.

MDR-TB in brief

— PMDT review: The Union participated in a joint international mission on programmatic management of MDR-TB in Uganda.

— MDR-TB course: Zimbabwe offered The Union course on the clinical management of MDR-TB for the first time, training 30 participants from across the country.
Successful TB-HIV care can be offered by PHC facilities

Pilot TB-HIV programmes run by The Union and its partners in Benin, DRC and Zimbabwe have demonstrated that it is feasible and effective to provide integrated TB-HIV care through primary health care (PHC) facilities, using paramedical staff.

The 59 clinics participating in the Integrated HIV Care for Patients Living with HIV/AIDS (IHC) Programme were in both large cities and rural areas in DRC (2006–2012), Benin (2006–8) and Zimbabwe (2007–12). Between 2006 and 2012, they provided care for 26,372 TB patients, of whom 5,791 were found to be HIV positive, including 14,025 TB patients (1,683 HIV+) in DRC, 8,368 TB patients (1,255 HIV+) in Benin and 3,979 TB patients (2,853 HIV+) in Zimbabwe.

The IHC Programme aimed not only to bring quality integrated care to patients, but also to improve patient education and reduce the stigma associated with both diseases and to address issues such as training staff in PHC settings, providing accurate diagnoses, ensuring the supply of medicines and obtaining financing for free care – an especially challenging task for chronic diseases such as HIV/AIDS.

The programme’s results were reported at a meeting of international partners and stakeholders in TB-HIV care in Paris, France on 18 December 2012. Other key findings were that strong microscopy services remained the cornerstone of TB diagnosis; patients were retained on anti-retroviral therapy (ART) after TB treatment; and thorough recording and reporting were essential. The IHC programme was funded by the European Union.

Improving the management of TB-HIV co-infected persons

In Zimbabwe, following on the successful IHC pilot, 13 sites received technical assistance in the integrated care of TB-HIV co-infected patients, including infection control. As part of the same TB CARE I and PEPFAR project, The Union also collaborated with the National AIDS Programme to introduce Isoniazid Preventive Therapy (IPT) in Zimbabwe. Of 10 pilot sites, three offer integrated TB-HIV services. Funding is from the US President’s Emergency Plan for AIDS Relief (PEPFAR).

TB-HIV in brief

— **TB-HIV technical assistance:** Namibia’s TB-HIV collaborative services are at an advanced stage, with steady, yearly improvement according to a technical assistance visit in September.

— **TB-HIV research:** A study of patient perceptions of TB and HIV led to improved services in Zimbabwe. Results were published in the *African Journal of AIDS Research*.

— **TB-HIV course:** 49 health care workers from Botswana participated in The Union TB-HIV course, held in that country for the first time.

KEY LESSONS LEARNT FROM IHC ACTION RESEARCH (2004–2012):

— TB clinics are important HIV testing points and major portals to HIV care

— Strong microscopy remains the cornerstone for TB diagnosis

— Paramedical and primary healthcare staff can provide high-quality care

— Patients are retained on care after TB treatment

— Thorough recording and reporting are essential
Asthma project in Benin continued despite challenges

Since completing a pilot funded by The Union in 2011, Benin has continued its asthma project. With support from a revolving fund, the National Tuberculosis Programme purchased quality-assured essential medicines at reduced cost from The Union’s Asthma Drug Facility for the fifth time since 2009. They also placed a third order for related medical devices.

A review of the project in September 2012 found that the number of patients served had increased; the number of emergency room visits and hospitalisations was down; and the revolving fund was working well as a funding mechanism. However, the rate of patients lost to follow-up was high, and maintaining standardised care at all sites was challenging. A planned nationwide expansion had to be cancelled due to lack of human resources and because the Global Fund decided that Practical Approach to Lung Health (PAL) activities would not be covered.

Lung Health in brief

— **ADF in Burundi:** Burundi placed its first order for asthma medical devices through the Asthma Drug Facility (ADF); Burundi first ordered quality-assured essential asthma medicines from ADF in 2010.

— **Child TB:** Representatives from 12 African countries participated in a “train the trainers” course on child TB led by Dr Steve Graham of The Union’s Child Lung Health Division.

— **Child pneumonia:** The Union’s successful Malawi Child Lung Health Project was the subject of an article in *The Lancet* in August 2012.
Gaining support for tobacco control in Africa

The Union worked with the governments of nine African countries to support their efforts to implement tobacco control measures: Benin, Burkina Faso, Chad, Guinea, Kenya, Madagascar, Mauritania, Niger and South Africa.

These measures included new graphic health warnings for Burkina Faso, Madagascar and Niger; smokefree policies in Burkina Faso; and point-of-sale regulations in Niger. Burkina Faso established both a budget and a national inter-ministerial committee for tobacco control, while Niger incorporated tobacco control into its national non-communicable diseases (NCD) plan. In Benin, a comprehensive tobacco control bill was adopted by the Ministers’ Council on 18 July 2012.

South Africa’s National Council Against Smoking (NCAS) worked with the government to develop regulations requiring all indoor public places to be 100% smokefree and restricting smoking in selected outdoor areas.

NCAS also supported the campaign that led to the Supreme Court’s dismissal of an appeal brought by British American Tobacco South Africa (Batsa), which sought to overrule a ban on tobacco advertising. This was a huge win for public health in Africa – and elsewhere.

RESEARCH

Managing diabetes and hypertension in Malawi

The Union’s Department of Research has demonstrated that the DOTS model can be used to manage diabetes mellitus (DM) patients through a pilot project in Malawi. By 31 December 2012, there were 6,387 DM patients registered in Queen Elizabeth Central Hospital, Blantyre; Zomba Central Hospital and Kamuzu Central Hospital, Lilongwe.

Care of the DM patients has been tracked by an electronic medical record system set up through a related Union collaboration with Malawi’s Baobab Health Trust. With additional support from the World Diabetes Foundation in 2012, The Union also established “Chronic-Disease-Care” Clinics in one of the health centres in Lilongwe, where patients will be collectively managed for DM, hypertension, cardiovascular disease, asthma and epilepsy.

Operational Research Assistance Project in South Africa

TREAT TB and the Desmond Tutu TB Centre (DTTC) at South Africa’s Stellenbosch University developed the Operational Research Assistance Project (ORAP) to train new researchers and support the use of OR as an integral part of the National TB Control Programme at national, provincial and local levels. As of December 2012, 88 scientists and health professionals had received training and support; and their research had resulted in 11 poster presentations, eight oral presentations, and one journal publication. In addition, 14 new OR studies were launched by ORAP trainees in 2012.

Research in brief

— OR fellows: 11 Operational Research fellows in Kenya, Malawi, South Africa and Zimbabwe completed their mandates from The Union’s Centre for Operational Research (COR) in 2012.

— Tracking ART: The Union supported national supervision, monitoring and evaluation of 560,325 patients ever initiated on antiretroviral therapy in Malawi in both the public and private sectors.

This project pioneers using the “DOTS” framework to track patients on ART.
THE UNION AFRICA REGION

755 members in 2012

The members of the Africa Region held their annual meeting during the World Conference in Kuala Lumpur on 16 November 2012. Current officers were introduced, and members were reminded that elections for new officers would take place in early 2013. The region charter was formally adopted. The main focus of the meeting was the 2013 region conference in Kigali, Rwanda. A local organising committee had been selected, and the conference theme chosen – “TB and other lung diseases: successes and challenges” – but the dates were not yet confirmed. Members were urged to support the conference by serving on the scientific committee and reviewing abstracts. Other issues discussed were region finances, the need for more formal records of meetings and the feasibility of a permanent secretariat.

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

Organisational member
Desmond Tutu HIV Foundation (South Africa)

Officers
President: Michel Gasana (Rwanda)
Vice President: Martin Gninafon (Benin)
Secretary General & Board Representative: Osséni Tidjani (Togo)
Treasurer: Genevieve Dorbayi (Ghana)
The Union in

Asia Pacific

The Union Asia Pacific Office (UAP) in Singapore supports technical assistance, research and training programmes throughout the region. With 12 employees and close to 30 consultants, it also serves as the office of International Union Against Tuberculosis and Lung Disease Asia Pacific Ltd, an independent charity in Singapore and an organisational member of The Union.

Major activities of the UAP in 2012 included coordinating seven International Management Development Programme (IMDP) courses in Kuala Lumpur and three IMDP courses for tobacco control in Indonesia, supporting the World Conference on Tobacco or Health organised by the Health Promotion Board of Singapore, and advising the regional Green Light Committee of the Western Pacific.

The Union China Office in Beijing coordinates The Union’s tobacco control activities in China, as well as offering expertise in tuberculosis and TB/diabetes.

Health challenges in the Asia Pacific Region

— Cambodia, China, Indonesia, Philippines and Thailand are among the 22 high-burden TB countries.

— 51% of men from the Western Pacific Region use tobacco – the highest rate in the world.

— In China, asthma among children 0–14 years increased more than 50% in 1990–2000. Lifetime prevalence is as high as 11% in Hong Kong.

Sources: see page 71
TOBACCO CONTROL

Smokefree cities in China: updates

— Smokefree laws went into effect in Harbin and Tianjin; and Guangzhou amended its law in 2012.

— Smokefree laws proposed in Shenzhen, Shenyang, Nanchang, Lanzhou, Chongqing and Jinan were submitted to municipal governments for review during 2012.

— Funds for tobacco control in Guangzhou have nearly tripled from RMB 1.1 million (about US $200,000) to RMB 2.95 million (around US $500,000) since its tobacco control law went into force in September 2010.

— Harbin and Guangzhou set up tobacco control offices; and Harbin, Tianjin and Guangzhou have established smokefree enforcement mechanisms.

Educating medical students in China about tobacco control

A tobacco control curriculum has now been introduced at 19 universities as part of a Bloomberg Initiative project to raise awareness about tobacco control. Faculty from 60 participating medical schools attended training organised by Zhejiang University on how to implement the curriculum. The Chinese Ministry of Health (MOH) has also incorporated tobacco control into the current qualification examination for doctors to ensure that these issues are addressed consistently within the clinical community.

Indonesia passed national tobacco control laws

On 24 December 2012, the President of Indonesia passed a new health law with tobacco control provisions calling for 40% pictorial health warnings on tobacco packages by June 2014; smoke-free environments; a ban on selling cigarettes to minors (under 18) and pregnant women; and a partial ban on tobacco advertising, promotion and sponsorship. The Union worked with the governmental Indonesian Public Health Association and civil society organisations to support this legislative development. Delegates who attended a Union training on graphic health warnings also met with and petitioned the President for the change.

The Philippines adopts Sin Tax to fund national health coverage

The Union has been working with the Philippines Department of Health since July 2010 to develop national tobacco control legislation and policies, including tax and price measures to reduce the demand for tobacco. On 20 December 2012, the Philippines President signed a Sin Tax reform bill into law. 68% will go towards universal healthcare coverage. 17% will be allocated for medical assistance and health enhancement facilities as determined annually by the Department of Health. 15% of the projected revenue raised from the tax will go to affected tobacco farmers and workers.
Omnibus tobacco control law enacted in Viet Nam

The Viet Nam National Assembly passed the nation’s first comprehensive tobacco control legislation in June 2012, and it will come into force on 1 May 2013. The law mandates smokefree public places; graphic health warnings on all tobacco packaging; a ban on certain forms of tobacco advertising, promotion and sponsorship; and creation of a fund directing mandatory contributions from tobacco manufacturers and importers towards tobacco control. The law is not comprehensive because it allows smoking rooms in hotels, ships, trains and airports, which is not best practice.

Since 2008, The Union has worked with the Viet Nam Steering Committee on Smoking and Health (VINACOSH), the government body that coordinated drafting of the new law, advocated for its adoption and paved the way for effective implementation by co-ordinating national and local bodies.

Tobacco Control in brief

— **China:** The State Administration of Traditional Chinese Medicine added smokefree hospital requirements to the Accreditation Standards for Tertiary TCM Hospitals in July.

— **Bali:** Bali’s sub-national legislation making public places, workplaces, including hotels and restaurants, and public transport 100% smokefree went into effect in May 2012.

— **Indonesia:** 59 mayors have now joined the Mayors’ Alliance for tobacco control, and 11 cities have adopted smokefree legislation.

**TOBACCO CONFERENCE HELD IN SINGAPORE**

The Union Asia Pacific Office supported the Singapore Health Promotion Board in putting on the 15th World Conference on Tobacco or Health (WCTOH) held in Singapore on 20–24 March. The Union Department of Tobacco Control exhibited at this major tobacco control conference, which is held every three years. At the conference, Michael Bloomberg, Mayor of New York City, announced that he will commit a further US$220 million to the Bloomberg Initiative to Reduce Tobacco Use (BI) and presented the 2nd Bloomberg Awards for Global Tobacco Control.

Current and former BI grantees received awards: Prof Elif Dagli of the Turkish National Coalition on Tobacco and Health received both a Bloomberg Award and the 2012 Lifetime Achievement Award from the International Network of Women Against Tobacco. Dr Yussuf Saloogee of South Africa and Dr Mira Aghi received Luther L. Terry Awards from the American Cancer Society.
**First TB-diabetes bi-directional screening pilot project completed**

China completed the first pilot project testing bi-directional screening for TB and diabetes mellitus (DM) within the routine health system in May 2012. Eleven hospitals and clinics participated in the 12-month project, which was based on the WHO/Union Collaborative Framework for the Care and Control of TB and Diabetes published in 2011.

Following the pilot, participants agreed that the screening approach works and should be expanded to other facilities in the country. Scientific papers describing the project from both the DM and TB perspectives were published in *Tropical Medicine and International Health*. This project was also featured in a *Lancet* news story.

**The Union and ISAAC form Global Asthma Network (GAN)**

“A world where no one suffers from asthma” is the ultimate vision of the Global Asthma Network (GAN) established by The Union and the International Study of Asthma and Allergies in Childhood (ISAAC) in November 2012. ISAAC began in 1991 and has studied asthma, rhinitis and eczema in almost two million children in more than 300 centres in 105 countries; The Union has worked to improve asthma management for nearly 20 years and founded the Asthma Drug Facility in 2005. By joining forces, the partners bring together a unique range of resources to improve asthma care through global monitoring and surveillance on the one hand, and through management, policy and advocacy on the other.

**TUBERCULOSIS**

**Building capacity for DR-TB management**

The Union’s comprehensive course on the clinical management of drug-resistant tuberculosis (DR-TB) was offered twice in China and once in Indonesia in 2012. The three five-day courses were attended by a total of 116 participants, all actively involved with the treatment of DR-TB patients.

The courses covered the epidemiology of DR-TB, DR-TB case finding, drug susceptibility testing, multidrug- and extremely drug-resistant TB (MDR/XDR-TB) treatment, adverse drug reactions, infection control and contact management. The Indonesia course also stressed treating MDR-TB under special circumstances, such as in children or people co-infected with HIV.

In addition, an international version of this course was offered in Thailand in November with participants from 11 countries.
Research on topics from TB to nutrition conducted in Fiji course

Nine Fijian health professionals completed a three-module course in operational research on 1 October 2012. They conducted studies on TB, congenital rubella syndrome, maternal health, cervical cancer, nursing human resources and nutrition, which were submitted to peer-reviewed journals for publication. As of the end of December 2012, two out of the 10 papers submitted to journals had been accepted for publication. Jointly run by The Union; Médecins Sans Frontières; Fiji School of Medicine, Nursing and Health Sciences; WHO; and the Fiji National TB Control Programme, this course was supported by The Global Fund.

Pacific regional course designed to build OR capacity

The Union and regional partners offered the first module of a three-module operational research course for the Pacific region in 2012; the course will continue in 2013. Participants came from the Marshall Islands, Federated States of Micronesia, New Caledonia, Solomon Islands, Tonga and Vanuatu. The Pacific course was organised jointly by The Union and the Secretariat of the Pacific Community (SPC), with funding by SPC through The Global Fund and WDF.

Pharmacokinetic study of rifabutin with ART underway in Viet Nam

The Union conducted a phase II pharmacokinetic (PK) study assessing different doses of rifabutin in combination with protease inhibitor-based antiretroviral therapy (ART) for HIV-infected patients with TB in 2012. The trial, which involved 33 enrolled patients at Pham Ngoc Thach Hospital in Ho Chi Minh City, Viet Nam, was designed to determine which of two doses of rifabutin (150 mg three times a week or 150 mg daily) produced better pharmacokinetic profiles when used in combination with an ART regimen that included lopinavir/ritonavir.

Results of the trial are expected in 2013. The Union’s PK trial was funded by the Agence Nationale de Recherche sur le Sida et les hépatites virales (ANRS) and Fondation Total.

TB-HIV collaboration strengthened through Union course

Representatives from TB and HIV/AIDS programmes in 16 provinces across China took part in The Union course “Working Together: Strengthening the Implementation of Collaborative TB-HIV Activities”, held in Guiyang, China. The four-day course covered the 12 components of collaborative TB-HIV activities recommended by WHO. Taught by Chinese and international faculty, the sessions were simultaneously translated in Chinese and English. This was the second time this course was offered in China. Funding was provided by the National Centre for TB Control and Prevention (NCTB) with a grant from the Global Fund to Fight HIV/AIDS, TB and Malaria (The Global Fund).

APR in brief

— TB-HIV: The China CDC and the NCTB arranged for The Union to share its experiences with developing TB-HIV collaborative activities in Africa at a seminar in Beijing attended by 30 representatives from the TB and HIV/AIDS programmes.

— MDR-TB: The Union served on the faculty of a course on the Programmatic Management of MDR-TB (PMDT) designed to build a cadre of skilled consultants for the Western Pacific Region.
THE UNION ASIA PACIFIC REGION

298 members in 2012

The Union Asia Pacific Region’s principal task this year was preparing for the 4th region conference to be held in Hanoi, Viet Nam in April 2013. Organised by the Vietnam Association Against Tuberculosis and Lung Diseases (VATLD), the conference theme will be “Optimal Use of New Technology and Approach”. Central Organising and Scientific Committees made up of members now provide ongoing support and “institutional memory” for APR region conferences. Dr Ral Antic was elected as Chair of the Scientific Committee for a three-year term starting 2012 and new officers will be elected for a four-year term at the Hanoi conference in 2013.

With the World Conference held in Kuala Lumpur (KL), the Malaysian Association for the Prevention of Tuberculosis (MAPTB) was an important partner for the conference team in Paris throughout the year and co-sponsored the “Run for your lungs” as well as hosting a dinner for The Union’s Board of Directors.

At the annual meeting in KL, The Union offices in Singapore and Beijing gave reports. Members also discussed the region’s finances and selected the Australian Respiratory Council to host the 5th region conference in 2015.

**Constituent members**

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

**Organisational members**

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

**Officers**

President & Board Representative:
Camilo Roa Jr (The Philippines)
Conference President:
Dinh Ngoc Sy (Viet Nam)
Vice President:
Wang Xie Xiu (China)
Secretary General:
Elizabeth Cadena (The Philippines)
Treasurer:
Simon Yat-Wa Chan (Hong Kong)
Established in 2003, The Union South-East Asia Office was The Union’s first region office. Today it provides public health expertise to the region’s governments, civil society, corporations and international agencies.

While Project Axshya remained USEA’s focus for TB control in 2012, tobacco control efforts advanced through several initiatives including support of 16 Bloomberg Initiative grantees. USEA also conducted operational research, coordinated capacity-building programmes and provided grant-monitoring services.

Two secretariats are housed at USEA – The Partnership for TB Care and Control, India, and the TB & Poverty Sub-Working Group of the Stop TB Partnership.

In 2012, The Union received its registration as an international non-governmental organisation in Myanmar. The Union Office in Myanmar located in Mandalay provides HIV and TB-HIV programmes, working in close partnership with the Ministry of Health and the health services at every level.

**Health challenges in South-East Asia**

— In South-East Asia, 40% of TB deaths are linked to smoking.

— 71.4 million people in South-East Asia with diabetes are at increased risk for developing active TB.

— In Myanmar, only 40% of the people with HIV who need antiretroviral treatment are receiving it.

Sources: see page 71
**Tuberculosis**

**In Year 3, Project Axshya reaches full strength serving 300 districts**

The Union’s Project Axshya focuses on strengthening India’s TB services through advocacy, communication and social mobilisation (ACSM) and community engagement.

Funded by The Global Fund, Axshya’s prime objective is to enhance access to TB services for the most vulnerable and marginalised populations across the country. Its activities include high-level advocacy for political and administrative support; implementation of the ACSM strategy of Revised National TB Control Programme (RNCTP); and social mobilisation to build demand for TB services.

The goal is to strengthen the engagement of all healthcare providers with the RNTCP, improve access to diagnostics, increase commitment to fighting drug-resistant TB (DR-TB) and TB-HIV, build awareness and broaden civil society involvement in TB control.

In its third year, Axshya has now covered 300 districts, reaching out to women, children, tribals, migrants, prisoners, slum dwellers and other vulnerable and marginalised people whose access to TB services Axshya was designed to ensure.

This objective has been reached by increasing their knowledge of TB and empowering them to obtain care through awareness campaigns; by establishing sputum collection and transport mechanisms to facilitate diagnosis; and by building teams of volunteers called ‘Axshya Mitras’ who carry on these campaigns and also serve as DOTS providers. The creation of ‘District TB Forums’ has also provided a platform for affected communities to voice their needs and challenges.

The numbers involved reflect the complexity both of the project – and India. Nearly 1,200 non-governmental organisations, 3,000 civil-society based organisations, and 21,000 rural healthcare providers have joined Axshya in the fight against TB.

The Union South-East Asia Office (USEA) manages Axshya through a dedicated Project Management Unit, which coordinates with the RNCTP and nine sub-recipient partner organisations. The Global Fund has accorded an ‘A’ rating to the grant for the period October 2011 to March 2012 (Year 2).

**Project Axshya at a glance. Summary of achievements of The Union and its nine sub-recipient partners against project targets (2 Apr 10-31 Dec 12)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>New partners in the Partnership for TB Care and Control, India</td>
<td>43</td>
<td>58</td>
</tr>
<tr>
<td>People trained at the state-level Training-of-Trainers for NGOs/CBOs/PPs</td>
<td>499</td>
<td>468</td>
</tr>
<tr>
<td>People from District-Level Networks sensitised on TB</td>
<td>855</td>
<td>783</td>
</tr>
<tr>
<td>NGOs sensitised at state-level to register under RNTCP schemes for sputum collection/transport/microscopy</td>
<td>1,404</td>
<td>1,295</td>
</tr>
<tr>
<td>Rural healthcare providers sensitised on referral, DOT provision and other RNTCP schemes</td>
<td>20,390</td>
<td>18,959</td>
</tr>
</tbody>
</table>
Building capacity through TB training in India

The Union offered its intensive five-day course on the clinical and operational management of MDR-TB course to 24 participants from across India at the Lala Ram Swaroop TB Institute in Delhi in November. In addition, a 12-day comprehensive TB course was offered at the same location in March.

The Eli Lilly partnership on MDR-TB also continued to provide training for health professionals in collaboration with The Union.

Use of FDA aids TB treatment monitoring in Bangladesh

For patients with increased risk of treatment failure or relapse, TB treatment monitoring is critical to provide early recognition of developing problems and adaptation of the treatment. With guidance from The Union, projects run by the Damien Foundation Bangladesh piloted the use of vital staining with fluorescein diacetate (FDA) on referred sputum from various types of retreatment cases, as well as in patients with delayed conversion of routine smears.

A retrospective analysis of the results over the last four years showed that this test was very useful to avoid unnecessary culture and rapid drug susceptibility tests, as well as the false declaration of treatment failure. The technique is safe and simple, but still requires a light-emitting diode (LED) fluorescent microscope and cold storage of the reagent, limiting its decentralisation in resource-poor settings.

Support for the Bangladesh laboratory network

The Union provided technical assistance to Bangladesh’s laboratory services in 2012 under an agreement with the World Health Organization (WHO) and the Antwerp Supranational Reference Laboratory. The mission included an evaluation of the network at national, divisional and regional levels. Issues of quality and safety, supply and demand, were carefully considered. In many areas, new equipment and technologies, such as LED fluorescent microscopy and Xpert MTB/RIF, and new diagnostic tools, such as line probe assay and mycobacterial growth indicator tube (MGIT), have been introduced. Challenges in using these systems ranged from the need for more training to the need for more electricity. However, the National Tuberculosis Programme’s adoption of a two-sputum collection strategy, rather than three, is expected to greatly reduce the excess workload and support quality work.

TB CARE review of the Pakistan laboratory network

The Union conducted a review of Pakistan’s TB laboratory network as part of the TB CARE project “Microscopy network accreditation tool”. Pakistan has participating in the pilot testing of this approach. The review found that the network, which hardly existed 10 years ago, has developed very well. Coverage is complete and efficient with few exceptions, and the intermediate level is well developed. However the network still faces serious challenges in maintaining the quality of its work, due to problems ranging from procurement of essential supplies and the stability of the electrical supply to high turnover of staff. These issues resulted in the conclusion that AFB microscopy services in Pakistan are not yet at the level required for accreditation of the network.

TB in brief

India: Project LIGHT, which introduced LED fluorescent microscopes in 200 Indian medical colleges, resulted in the notification of more than double the number of TB cases than the previous year at an average cost of US $175 per additional case detected.
PICTS programme launched in Mandalay

On 15 January 2012, The Union launched a new TB case-finding programme in Myanmar known as PICTS – Programme to Increase Catchment of Tuberculosis Suspects. Funded by TB REACH, the goal of the programme was to double the number of TB cases identified within one year.

PICTS implemented activities in seven townships of Mandalay in collaboration with township health centres. Key staff were supported by teams of 30 volunteers from each township, who were primarily persons living with TB or who had experience with TB-related issues.

Case detection strategies included encouraging general practitioners and drugstores to refer people with possible TB to PICTS; dissemination of Information Education Communication (IEC) materials; health education sessions in factories, schools and other public places; technical support for the public sector to improve TB diagnosis; placement of sputum collection points where they could be easily accessed; and collaboration with other health sectors. To build a network of TB “ambassadors”, groups of People Affected by TB (PATB) were formed that met monthly in each PICTS township.

**PICTS ACTIVITIES: 2012**

**ACSM**
- Community health education (HE) sessions held: 2,319
- Special outreach programmes (SOP) in factories, schools, etc: 302
- Total reached through HE and SOP: 131,821
- Information, Education, and Communication (IEC) materials distributed: 1,666,932

**Screening and testing**
- People screened verbally for TB symptoms: 131,821
- People screened using smear microscopy (new and old patients): 16,615
- Total chest X-rays taken: 8,566 (including 1,851 at mobile clinics).
- GeneXpert tests done: 2,776 (including 106 at mobile clinics)
- Other tests offered included fine-needle aspiration cytology (277 since Q3) additional tests for extra-pulmonary TB (106).
- 13% (2,123) came from outside of Mandalay and were registered at their respective townships for treatment.

**TB cases identified**
- Total smear-positive cases identified: 1,825 (about 10% of the total screened)
- New smear-positive bacteriologically confirmed cases in Mandalay townships: 1,064
- All forms of TB / Mandalay townships only: 3,758
Close to 13,000 patients in Myanmar on ART through The Union’s “4P” approach:

The Union Office in Myanmar, the Myanmar Ministry of Health and their partners passed a milestone in 2012 that once seemed impossible: 10,000 people living with HIV (PLHs) receiving antiretroviral treatment (ART) and other services through the Integrated HIV Care (IHC) Programme. By the year’s end, the total number of patients served reached 12,906.

The IHC Programme began in 2005 with funding from the Yadana Consortium operated by Total/MGTC. The overarching goal was to scale-up access to ART, but progress was slow at first. After five years, 2,000 patients were on ART. Then The Global Fund and the Three Diseases Fund (3DF) became involved, and 8,000 more patients started on ART between January 2010 and June 2012.

The IHC model is based on The Union’s “4P” approach – a partnership between patients, the public sector and the private sector. The private sector is represented by The Union, which facilitates the integration of HIV care into existing public health services on behalf of the patients.

IHC services are now offered in 14 townships to any HIV patient (with or without TB); and patients no longer have to prove they reside in the catchment area. These changes have greatly increased the project’s scope.

IHC works not only with Myanmar’s National AIDS (NAP) and National TB (NTP) Programmes, but also hospitals, township health centres, laboratories, social service departments, pharmacies and patient self-help groups. The Union provides technical, human resources and financial support to enhance their performance and increase their reach.

The Union also assists with monitoring and evaluation, identifying opportunities to use operational research to improve the programme.

Mandalay lab offers high-tech diagnostic services with The Union’s support

With support from The Union Office in Myanmar, Mandalay’s Public Health Laboratory (PHL) was extensively renovated and equipped with a fully automatic CD4 machine, hematology and biochemistry machines and a molecular laboratory in 2012. A team of pathologists and technicians was trained to use the new equipment, which will enable advanced HIV testing for both diagnosis and treatment monitoring. The PHL serves the estimated 8,000 HIV-infected patients followed by the hospitals in Mandalay’s seven districts.

Funding for the equipment, renovations and training came from grants to The Union from the Global Fund to Fight AIDS, TB and Malaria (The Global Fund) and the Fondation Mérieux.
RESEARCH

Revised operational research course offered in Nepal

Increasing demand for the operational research course developed by The Union and Médecins Sans Frontières (MSF) led to the need to increase the number of courses and offer them regionally, rather than bring participants to The Union headquarters in Paris.

In February 2012, USEA, in partnership with Union faculty from Paris and MSF-Luxembourg, coordinated the first regional Asian course in Kathmandu. The 12 competitively selected participants came from nine countries across the region.

LUNG HEALTH & NON-COMMUNICABLE DISEASES

Pilot project tests bi-directional screening for TB and diabetes

The estimated 61 million people with diabetes mellitus (DM) in India have a two to three times greater risk of developing active TB than those without DM, and evidence suggests that the disease also adversely affects TB treatment outcomes.

In 2012, The Union and its partners implemented a pilot project providing bi-directional screening for the two diseases. TB patients in seven tertiary centres and more than 60 peripheral health facilities were screened for DM; and DM patients were screened for TB at six clinics in tertiary hospitals across the country. The findings were published in peer-reviewed international journals.

Findings indicated that DM screening was feasible using existing TB services and led to earlier identification of DM and better management of co-morbidity. As a result the RNCTP instituted a national policy calling for all TB patients to be screened for DM and linked to appropriate services.

The Central TB Division, Ministry of Health and Family Welfare and the WHO collaborated with The Union on this project, which was modeled on the Collaborative Framework for Care and Control of TB and Diabetes, published by WHO/The Union in 2011.

Final results for Bangladesh smoking cessation project

Using The Union’s ABC approach (A = ask, B = brief advice, C = cessation support) Bangladesh’s BRAC supported TB patients at 17 peri-urban DOTS centres in their efforts to quit smoking beginning in 2011. Cohort results collected in 2012 for the 239 new sputum-smear positive TB patients registered for smoking cessation between May and August showed that 80% of them successfully had quit smoking by the end of their six-month TB treatment. This demonstrated that brief advice and cessation support given by DOT providers at each visit can result in a remarkable quit rate among TB patients. The ABC approach comes from The Union guide Smoking Cessation and Smoke-free Environments for Tuberculosis Patients.

Research in brief

— India: As part of TREAT TB, a national version of The Union/MSF operational research course was organised by USEA and held in Chennai.

Lung health in brief

— Asthma in Vanuatu and Indonesia: The Ministry of Health of Vanuatu and the Principal Recipient of the The Global Fund in Indonesia placed their first orders for quality-assured essential asthma medicines through the Asthma Drug Facility (ADF).

— Occupational lung disease in India: The Union helped raise awareness of the occupational lung disease silicosis by bringing representatives of several NGOs to an Indian rock phosphate mine. The visit included a tour and training session for mine workers and managers on the disease and how to reduce the risks.
In India, 29 jurisdictions go smokefree – and other advances

With support from several different Bloomberg Initiative grants, India’s progress in implementing the national tobacco control law (COPTA) continued in 2012.

• 29 jurisdictions (districts, towns and cities) with a combined population of 37 million went smokefree.
• The ban on sale of tobacco to minors progressed in parts of Rajasthan, Uttar Pradesh, Jammu and Kashmir and Madhya Pradesh, as well as several individual cities.
• Mandatory pictorial warnings were placed on tobacco products produced in Mizoram.
• Bans on gutka products were introduced in Punjab, Himachal Pradesh, Rajasthan, Bihar and Mizoram following a Union workshop.

These milestones demonstrated that enforcement of the national law is strengthening. Smokefree implementation alone now protects 160 million people in 15 states.

International collaboration curbed tobacco advertisements at cricket tournaments

The Union supported Action on Smoking and Health (ASH) Australia in responding to illegal tobacco ads at a televised cricket match. In Australia, the incident resulted in media coverage, an investigation by the Australian Department of Health and removal of the ads. Similar occurrences during India-South Africa and Sri Lanka matches; and The Union coordinated with 17 national cricket boards to ensure that tobacco ads were not seen during matches or broadcasts.

Sri Lanka’s new pictorial warnings cover 80% of tobacco packaging

As of November 2012, Sri Lanka adopted some of the world’s largest pictorial health warnings on tobacco packaging. The new warnings in Sinhala, Tamil and English cover 80% of the package. The Union has worked with Sri Lanka’s National Authority on Tobacco and Alcohol (NATA) since January 2009 to strengthen legislation and improve implementation of the country’s tobacco control law.

Amended tobacco control law endorsed by Bangladesh Cabinet

After more than a year of opposition from the Ministry of Finance, the Cabinet of Bangladesh endorsed the Smoking and Using of Tobacco Products (Control) (Amendment) Act 2012. The draft amendment expands smokefree areas to restaurants, workplaces and all other public places and transport and requires graphic health warnings covering 50% of tobacco packaging.

The Union supported the Ministry of Health and Family Welfare and the National Tobacco Control Cell’s preparation of the amendment, and met with Cabinet members.

Pakistan fights back against tobacco industry interference

In 2012, Pakistan’s Tobacco Control Cell (TCC) registered cases against both tobacco manufacturers and retailers for violating point-of-sale advertisement guidelines. In Quetta, the court fined retailers and issued a summons to the Pakistan Tobacco Company. In the Lahore High Court. The TCC also won court cases against sheesha cafes.

To further monitor tobacco industry interference, The Union and the TTC developed a management information system that enables real-time, online data collection to monitor industry tactics and violations of the laws against tobacco advertising, promotion and sponsorship (TAPS) at subnational level.

Tobacco Control in brief

— Nepal: The comprehensive Tobacco Control Act went into force in May 2012.
— Bangladesh: A Union economic report showed tobacco use continues to increase, largely due to a taxation system that has allowed real prices of tobacco products to drop steadily over recent years.
— India: The Australia-India Institute’s Taskforce on Tobacco Control released a report recommending use of plain packaging in India.
The Union South-East Asia Region (SEAR) used its annual meeting at the World Conference in Kuala Lumpur as an opportunity for the constituent members to present their achievements, challenges and future plans. Afghanistan, Bangladesh, India, Nepal and Pakistan made presentations at the 2012 meeting, demonstrating the considerable impact of these organisations on the fight against TB through direct care, technical assistance, advocacy, education and research. In addition, a representative from USEA updated them on the work of this office over the past year. The members also discussed their 2014 conference to be held in Dhaka, Bangladesh and arranged to hold the first Core Committee meeting in March 2013.

Constituent members
National Tuberculosis Control Program (Afghanistan)
National Anti-TB Association of Bangladesh (NATAB) (Bangladesh)
The Tuberculosis Association of India (India)
Myanmar Medical Association (Myanmar)
Nepal Anti-Tuberculosis Association (Nepal)

Officers
President:
Mozaffar Hossain Paltu (Bangladesh)
Vice President:
Devendra Bahadur Pradhan (Nepal)
Editor, SEAR Bulletin:
Chaudhary Muhammad Nawaz (Pakistan)
Board Representative:
Khairuddin Ahmed Mukul (Bangladesh)
Scientific Committee Chair:
Rohit Sarin (India)

Organisational members
Pakistan Anti-Tuberculosis Association (Pakistan)
Ceylon National Association for the Prevention of Tuberculosis (CNAPT) (Sri Lanka)
SAARC Tuberculosis and HIV/AIDS Center (STAC) (Nepal)
Sandoz Private Limited (India)
The Union offices in Mexico and Peru are becoming increasingly well known as resources for the Latin America region. Through the Bloomberg Initiative to Reduce Tobacco Use, The Union Mexico Office (UMO) supports governments and non-governmental organisations working in tobacco control and manages grants projects to promote key interventions, such as tax increases and smoke-free environments. In 2012 UMO managed seven grants in five countries: Argentina, Brazil, Colombia, Chile and Mexico.

The Union Peru Office in Lima provides a base for TB, MDR-TB, HIV and lung health technical assistance and training, as well as other coordinating services for The Union’s Spanish-speaking constituents.

HEALTH CHALLENGES IN LATIN AMERICA

— 1.7 million people with HIV live in Latin America and the Caribbean.

— An estimated 60,000 TB cases went undetected in 2011, mostly in urban areas.

— Tobacco use is a major risk factor for ischaemic heart diseases, the leading cause of death in the region.

*Sources: see page 71*
**TB risk study in Peru to test more than 7,000 children**

In 2012 The Union Peru Office managed a study designed to measure TB prevalence and estimate the annual risk of TB infection (RAIT) among schoolchildren. The results will be used to monitor the RAIT trend. To prepare for the study, The Union coordinated with the Ministry of Health to train 200 people to give tuberculin skin tests to 7,740 school children in cities with populations over 20,000 across nine selected regions. The training was designed to ensure the validity of the testing and other data. The study funded by the Ministry of Economy began in August, with completion scheduled for February 2013.

**Improving services to disadvantaged communities in the Dominican Republic**

The Union collaborated with the Dominican Republic Ministry of Health to improve the extent and quality of health care and social services offered to low-income communities, including women, children, minorities and disabled people. The project provided training and technical assistance to health organisations and other groups to ensure that their services are provided in a culturally sensitive and appropriate way. Funding was provided by The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (The Global Fund).

**TB in brief**

- **TB:** The Union is working with Ecuador’s National Tuberculosis Programme (NTP) to improve the TB multidisciplinary approach through training on MDR-TB and TB-HIV.

- **TB infection control:** A new three-day course in infection control (IC) was held in Ecuador. Two months after the course, representatives of The Union and the NTP visited nine facilities to evaluate the IC plans made by course participants and advise on their implementation.
**Capacity building through MDR-TB training**

The Union offered several courses on managing multidrug-resistant tuberculosis (MDR-TB) in the Latin America region during 2012. The three-day intensive course on the clinical management of MDR-TB was held in Colombia, Ecuador and Dominican Republic.

In each case, The Union worked with the national TB programme to customise the course to their needs, with the goal of creating a critical mass of well-trained doctors and nurses dedicated to MDR-TB to serve that country. The comprehensive curriculum covered topics from clinical and operational techniques for prevention and control for drug-resistant TB to the implications of TB-HIV coinfection. Participants also learned how to develop a business plan to improve their TB programmes.

In addition to the national courses, the Xth international course on the clinical and operational management of MDR-TB was held in the Dominican Republic in June. Funding for the MDR-TB courses came from the Pan American Health Organisation (PAHO) and The Global Fund.

**Intensive MDR-TB support for Colombia**

The Union collaborated with the National Tuberculosis Control Programme (NTP) and PAHO to support Colombia’s MDR-TB programme through technical assistance and training. Activities included a one-day intensive update in Cali City attended by 120 respiratory physicians and other healthcare professionals; a three-day national clinical course; a full day of reviewing difficult cases; and site visits to laboratory and treatment facilities. The mission concluded with planning sessions to discuss how lessons learnt could be incorporated into Colombia’s MDR-TB policies and programme.

**Bolivia PMDT plan evaluated**

The Union led a mission to evaluate the expansion of Bolivia’s Programmatic Management of Drug-Resistant TB (PMDT) in 2012. The goal was to identify successes and gaps, particularly in relation to infrastructure, human and financial resources and supplies management. Recommendations included steps to improve case finding and timely diagnosis; encouragement to provide greater support for patients, such as food baskets; and emphasis on the need for stronger collaboration with the HIV/AIDS programme.

**Ecuador to establish a reference and training centre in Guayas**

In Ecuador, approximately 85% of MDR-TB patients are concentrated in the province of Guayas. The main facility for treating them is the Valenzuela Hospital, which was approved in 2006 for a Green Light Committee project. In 2012, the National TB Programme and the hospital asked The Union to assist in expanding the hospital’s remit to become a national MDR-TB reference centre and clinical training facility for Ecuador and the region.

As a result, The Union offered MDR-TB training for specialists and nurses, as well as infection control (IC) courses and technical assistance for IC and MDR-TB management. In addition, The Union visited peripheral centres in the provinces of Guayas and Los Rios.

Challenges included an MDR-TB detection rate of about 51% and a treatment success rate of only 50-60% due to deaths and dropouts. Stakeholders from patients to programme managers were interviewed as part of the planning process for the centre.

Steps forward include the introduction of Gene Xpert machines and new diagnostic algorithms, as well as more frequent meetings of the MDR-TB committee.
New clinical TB-HIV course offered in three countries

The Union offered a new clinical TB-HIV course in Latin America in 2012. The course attended by a total of 133 physicians was presented once in both Colombia and Ecuador and twice in the Dominican Republic. The intensive three-day course is designed for clinicians who work in both TB and HIV care and emphasises the management of co-infected patients with serious complications. The curriculum presents the most up-to-date evidence base and experience gathered by Union consultants, and participants reported that it strengthened their understanding of the need for collaborative and comprehensive management of patients with these two conditions. Funding was provided by PAHO.

In brief
— MDR-TB and TB-HIV: The Union has been working with the Colombia’s NTP to standardise MDR-TB and TB-HIV treatment and procedures.

PROVE-IT in Brazil

In Brazil, TREAT TB’s PROVE-IT study recruited 121 patients into the line probe assay arm of the study and 62 into the Xpert MTB/RIF arm in 2012. The study, which is evaluating the efficacy and cost-effectiveness of these new tools, was conducted at multiple sites across the country by Rede-TB, a TREAT TB partner. There is a large community activity board (CAB) component in Brazil, with local CABs for each PROVE-IT site. They bring together a diverse range of participants and perspectives to ensure the community has a voice in and understanding of the research.

LUNG HEALTH & NCDs

ADF supports asthma projects in El Salvador and Honduras

El Salvador’s asthma control project, which uses medicines purchased through the Asthma Drug Facility (ADF), continued at the three initial pilot project sites in 2012. Assessment of the cohort of patients participating in the project has generated data that will be used for a publication describing the first achievements. Organisers hope this publication will help build the case for expanding the project to more locations in the country.

With the support of the International Medical Assistance Foundation, Honduras received its first order of quality-assured essential medicines through the ADF in 2012.
Brazil passes world’s strongest ban on tobacco additives

Brazil adopted the world’s strongest ban on additives in 2012. The ban covers all tobacco flavourings and additives, including menthol, honey, fruit essences, colours and other sweeteners. According to the Global Youth Tobacco Survey (GYTS), 13–15 year olds are the most attracted to flavoured tobacco.

The new initiative was put forward by ANVISA, the regulatory health agency, and faced many obstacles, including tobacco industry opposition. Manufacturers will have 18 months to comply with the new law. The Union has partnered with ANVISA in several initiatives, including the campaign for the additives ban; and several ANVISA staff have participated in The Union’s International Management Development Programme (IMDP).

Ecuador’s tobacco control law strengthened

Ecuador strengthened its 2011 National Law for Tobacco Control, passing Decree 1047 in February 2012. The new regulation is designed to ensure that public enclosed spaces are 100% smokefree. It bans point-of-sale advertising, increases graphic warnings to cover 60% of tobacco packages and categorises electronic cigarettes as tobacco products. The Union Mexico Office provided legal support throughout this campaign, collaborating with partners such as the Ministry of Health and PAHO.

Legal workshops build capacity for fending off legal challenges to tobacco control

Implementation of the Framework Convention on Tobacco Control (FCTC) in Latin America has reached the stage where some stakeholders have begun lodging appeals against tobacco control laws. The Union has provided 15 countries with technical and legal advice on addressing these challenges.

More than 50 lawyers from South and Central America have attended legal workshops designed to help them analyse the legislative and judicial processes involved. With lawyers from both governments and non-governmental organisations, the workshops have provided an opportunity for networking as well as learning from each other’s experiences.

Tobacco Control in brief:

— Argentina: In 2012, the Ministry of Health (MOH) of Buenos Aires, a BI grantee supported by The Union, launched a campaign to strengthen smokefree compliance with the city’s smokefree law. The MOH also played a critical role in the passage of these regulations.

— Brazil: The Brazilian subsidiary of British American Tobacco legally challenged ACT’s media campaign against tobacco use. ACT responded with support from The Union and the Campaign for Tobacco-Free Kids, and the court ruled against the tobacco industry.

— Chile: Congress approved legislation that bans smoking in all enclosed public places and prohibits all forms of tobacco advertising. The Union supported the Ministry of Health throughout this long campaign.

— Costa Rica: Comprehensive tobacco control legislation was approved. The Union provided legal assistance and participated in the public consultation.

— Mexico: The third and fourth rounds of graphic health warnings were successfully implemented.

— Mexico: The capital of Baja California went smokefree and Tabasco State developed and implemented an inspection programme to ensure compliance with its law.
THE UNION LATIN AMERICA REGION

153 members in 2012

The principal activity for members in 2012 was organising the 16th Conference of The Union Latin America Region. This was a one-day event held within the framework of the 26th Caribbean and Central American Congress of Pneumology and Thoracic Surgery in Panama, on 29 March 2012. Respiratory physicians, nurses, doctors and practitioners from several countries participated in the conference and attended The Union’s sessions on tuberculosis, asthma and tobacco control. There was also a booth that showcased The Union’s activities in the region and promoted Union membership. The region’s annual meeting was held at the World Conference in Kuala Lumpur in November.

Constituent members

Ministerio de Salud y Deportes (Bolivia)
Fundaçao Ataulpho de Paiva (Brazil)
Ministerio de Salud (Chile)
Programa Nacional de Control de Tuberculosis (Cuba)
Fundacion Ecuatoriana de Salud Respiratoria (FESAR) (Ecuador)
Ministerio de Salud Publica y Asistencia Social (El Salvador)
Liga Nacional Contra la Tuberculosis (Guatemala)
Programa Nacional de Tuberculosis (Honduras)

Comite National de Lucha Contra la Tuberculosis y Enfermedades del Aparato Respiratorio (Mexico)

Officers

President: vacant
Vice President: Regiane Cardoso De Paula (Brazil)
Secretary General & Board Representative: Jesús Felipe González Roldán (Mexico)
Treasurer: Miguel Angel Lindero Olalde (Mexico)
The Union in

the Middle East

The Union Middle East Office (UME) based in Cairo, Egypt manages Bloomberg Initiative grants, provides technical assistance and works with its partners to build national and regional capacity for tobacco control policies. In 2012, the UME worked with close to 50 organisations and key focal points at the national and sub-national levels in the Middle East region. The UME also coordinated and/or collaborated on seven tobacco control technical trainings in the region.

The Union’s technical departments also work closely with Epilab in Sudan and other partners, including national tuberculosis programmes throughout the region. TB technical assistance in 2012 focused on building capacity for managing MDR-TB. A new website in English and Arabic, including news and resources, launched in 2012 at www.theunion.org/Regions/Middle East.

Health challenges in the Middle East

- More than 700,000 Syrians and 569,000 Sudanese became refugees in 2012.
- The Eastern Mediterranean Region is experiencing the fastest increase in HIV infections in the world.
- “Under 5” deaths fell below 1 million for the first time in 2011; child mortality remains high in 7 countries.

Sources: see page 71
**Egypt continues to improve tobacco control at national and subnational levels**

Egypt made two important steps at the national level with the introduction of the country’s third set of graphic health warnings in January and a further tax increase on imported and local cigarettes in February 2012. The Ministry of Health in collaboration with The Union and Johns Hopkins School of Public Health conducted air monitoring baseline surveys to support the implementation of smokefree policies in Egypt. The results were disseminated through various media channels and presented at the World Lung Conference in Kuala Lumpur.

The smokefree cities project also advanced. In Alexandria, Port Said and Luxor, The Union collaborated with local partners, World Lung Foundation and the World Health Organization (WHO) to create taskforces, train inspectors and develop guidelines for implementing smokefree policies in healthcare facilities, workplaces and educational facilities. In 2012, the Ministry of Health and Population expanded the project to three more cities – Ismailia, Minia and Cairo.

**Lebanon’s smokefree law went into effect and survived industry challenges**

Lebanon’s National Tobacco Control Law came into effect on 3 September 2012, mandating that all indoor public places, including hospitality venues, such as hotels, restaurants, cafes and cigar lounges, be smokefree. The tobacco industry challenged the ban, which created confusion and protests, but, following a request for clarification from The Union, the Ministry of Justice ruled to uphold the ban in full, both indoors and outdoors.

To build stronger support for the new law, the National Tobacco Control Programme (NTCP) developed an infographic-style booklet on secondhand smoke and the importance of tobacco control laws in saving lives. A media campaign was also launched in December.

The NTCP assigned enforcement and monitoring responsibilities across several government bodies, non-governmental organisations and coalitions. The Union provided training that led these groups to develop a strategic plan for implementing and enforcing the law.
Sudan’s Epi-Lab moves to optimal use of this research centre

The annual Technical Assistance Committee (TAC) review of the Epi-Lab in Khartoum took place in June. The goal is to make optimal use of this research centre, which conducts operational research, cultivates Young Investigators and has sections focusing on tuberculosis, TB in animals, child lung health, asthma and tobacco. The Epi-Lab is both a WHO and a Union Collaborating Centre.

The review found that pilot activities such as the asthma project are being mainstreamed into the public health services, thanks to stronger partnerships with ministries, medical schools and other stakeholders. Data management has improved and the core staff has become more stable. Next steps are to develop a business plan and to prevent a backlog of unpublished research.

Asthma project advances in Sudan

Sudan’s pilot asthma project progressed in 2012. The Hasa Heisa Hospital held a weekly asthma clinic with 10–15 patients each week. Through the Asthma Drug Facility, patients were provided with inhalers at the cost of SP 8.50, rather than the much higher price of SP 140 charged in the private market. The challenge of clearing the inhalers through customs, which delayed the start of the project, was resolved once the drug had been registered in the country.

A further hurdle is lack of patient education. Patients fear the label “asthma” due to persistent stigma. In addition, many patients whose asthma improves with treatment do not see a need to continue follow up. One positive sign of progress has been that the number of patients served in the “asthma room” of the emergency department has dropped dramatically in the past three years.

Morocco’s MDR-TB programme improves dramatically

Morocco has an estimated 300 new MDR-TB cases per year, but in 2011 only four were enrolled in the Green Light Committee (GLC) programme. A Union review found that the obstacles to treatment ranged from the patients’ reluctance to accept in-hospital care to lack of training and effective drug susceptibility testing.

The 2012 review found the situation greatly improved with 79 patients on treatment and the expectation that the cohort would increase to 100. Information about the total number of MDR-TB patients and their outcomes is still incomplete, but advances have been made. For example, the country now has written guidelines and an MDR-TB committee and communication has improved between the laboratories, clinicians and the national TB programme. Despite continuing challenges related to data management and human resources, the reviewers felt that foundation for a successful MDR-TB programme has been laid.

Morocco’s MDR-TB programme improves dramatically

— The Union also offered technical assistance to the MDR-TB programmes in Djibouti, Jordan, Lebanon and Tunisia in 2012.
THE UNION MIDDLE EAST REGION

86 members in 2012

The high point of 2012 was the 27th Conference of The Union Middle East Region, which was held in conjunction with the Egyptian Society of Chest Diseases and Tuberculosis conference in Cairo, Egypt on 27–30 March 2012. The four-day programme included sessions on the global and regional tuberculosis situation, multidrug-resistant TB, indoor air pollution and lung cancer. The UME provided two sessions on tobacco-free healthcare facilities and also had a booth at the conference, which showcased Union publications and promoted membership. Union members also took part in the Egyptian-African Congress of Healthcare and the 20th Annual Congress on Bronchial Asthma on World Asthma Day. At the annual meeting in Kuala Lumpur, members discussed ways to increase communication across The Union and encourage new members as well as plans for the next Middle East Region conference in 2014.

Constituent members

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

Organisational member

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

Officers

President: Hani Algouhmani (Syria)
Vice President: Georges Saade (Lebanon)
Secretary General & Board Representative: Mohammed Awad Tag Eldin (Egypt)
Treasurer: Nehad Saleh (Egypt)

Meeting of The Union, Epilab, and the Minister of Health, Gezira State, Sudan
The Union in Europe

Europe is the home of The Union’s headquarters in Paris and two other offices. The International Union Against Tuberculosis and Lung Disease – United Kingdom is located in Edinburgh, Scotland and is an independent charity working towards lung health in the UK and internationally. Also known as The Union Europe Office, this office houses the Department of Tobacco Control, the hub of our international efforts to halt the tobacco pandemic. The Union Russia Office in Moscow is dedicated to tobacco control and lung health in that country and Eastern Europe.

**Health challenges in the Europe Region**

- There are 18 high-priority MDR-TB countries in the Europe Region.
- Over 50% of people are overweight or obese; over 20% are obese making them more susceptible to chronic lung diseases, cardiovascular disease, diabetes and cancer.
- Europeans are the world’s biggest smokers and drinkers.

*Sources: see page 71*
TUBERCULOSIS

Preliminary findings from PROVE-IT study in Russia completed

The records of 250 TB patients from Russia’s Arkhangelsk district were analysed as part of TREAT TB’s Policy Relevant Outcomes from Validating Evidence on Impact (PROVE-IT) study. In addition, 74 patients participated in interviews. The study is evaluating the impact of the line probe assay test on patients and health systems. PROVE-IT team members from the Arkhangelsk Regional Anti-Tuberculosis Dispensary and the Arkhangelsk State University presented a preliminary analysis of their findings in November at The Union World Conference in Kuala Lumpur, Malaysia.

RESEARCH

Operational research (OR) courses held in Paris and Luxembourg

In June 2012, participants from Africa, Asia and South America completed the final two modules of an eight-month OR course offered in Paris and then in Luxembourg by The Union and Médecins sans Frontières submitted their research papers to peer-reviewed journals. In July, 24 participants began the three-module OR course, the first 12 starting the course in Paris, and then the next 12 in Luxembourg. The participants’ studies related to TB, HIV/AIDS, non-communicable diseases, maternal and child health and neglected tropical diseases.

TOBACCO CONTROL

Campaigns to support a smokefree Euro 2012 football competition

With support from The Union, Bloomberg Initiative (BI) grantees in Poland developed targeted campaigns to coincide with the Euro 2012 football competition held in that country. The Chief Sanitary Inspectorate launched the health promotion campaign ‘Cheer your health’ which provided information on smokefree legislation and advice on tobacco, alcohol, drugs and sexual health. They also worked with MANKO, another BI grantee, on training local tobacco control coalitions in the four match cities. MANKO and the Polish Society for Health Programmes reported violations of the Tobacco Act by British American Tobacco, which – despite tobacco-free policies at the mega event – conducted promotional activities in and around Euro 2012 venues.

The UK considers plain packaging for tobacco products

On 31 May 2012, The Union hosted a World No Tobacco Day event in conjunction with ASH Scotland and the University of Edinburgh in support of a UK government consultation on plain tobacco packaging. Union consultant Anne Jones gave a talk on Australia’s experience with plain tobacco packaging and interference from the tobacco industry attempting to prevent adoption of this measure. The event coincided with a UK government consultation on the introduction of plain packaging for which The Union drafted a consultation paper.

The Union’s FCTC Article 5.3 Toolkit: Guidance for Governments on Preventing Tobacco Industry Interference was also launched at the event and is available online at www.theunion.org

New tobacco control law in Bulgaria

On 1 June 2012, a revised law went into effect in Bulgaria that bans smoking in all enclosed public spaces – a considerable achievement since a complete smoking ban passed in 2009 and was repealed in 2010 due to tobacco industry interference. The Union supported The Bulgarian National Tobacco Control Coalition to have the law reintroduced under a plan conceived during a Union tobacco control technical training in March 2011.
World Health Assembly sets “25 x 25” target for NCDs

At the 65th World Health Assembly, held in Geneva, Switzerland in May 2012, UN Member States agreed to an historic target to reduce premature deaths from non-communicable diseases (NCDs) by 25% by 2025. As a principal partner of the NCD Alliance, The Union joined in a major lobbying campaign to ensure this target was secured.

The major NCDs, which cause 60% of global deaths each year, are cardiovascular diseases, diabetes, cancer and chronic respiratory diseases. Formerly associated with high-income settings, 80% of these deaths now occur in low- and middle-income countries, which have become increasingly influenced by the main risk factors: tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity.


Europe in brief


— HIV/AIDS: Prof AD Harries, Senior Advisor, chaired the Strategic and Technical Advisory Committee that oversees the HIV/AIDS activities of WHO’s HIV Department and also the Consolidated ARV Guidelines Group, which is developing new guidelines on the use of antiretroviral drugs for publication in June 2013.

— Child TB: Dr Stephen Graham of The Union’s Child Lung Health Division contributed to a child TB roadmap and new guidelines as chair of the Childhood TB Subgroup of the Stop TB Partnership.

— Tobacco control: The Union, WHO Russia and the Sochi 2014 Olympics Committee organised a workshop on implementing smokefree environments attended by representatives for 13 Russian regions.

— Tobacco control: Ongoing monitoring shows smokefree compliance remains high in Georgia since healthcare and education facilities were covered by the ban in 2010.
THE UNION EUROPE REGION

518 members in 2012

Nearly 450 delegates from 61 countries attended the 6th Conference of The Union Europe Region, which took place at Imperial College London on 4–6 July 2012. The theme of this first region conference to be held in Western Europe was “TB and Lung Disease: threats and promises”.

Keynote speaker Lord Boateng, the former Chief Secretary to the UK Treasury and High Commissioner to South Africa, encouraged The Union to continue the fight for public health using “a response based on the principle of partnership.” Other plenary speakers were Ajit Lalvani from Imperial College, Christopher Dye from World Health Organization and David Heymann from the UK Health Protection Agency, in addition to more than 40 speakers from across Europe and beyond. Organisers were pleased that close to 100 delegates from Eastern Europe attended, and simultaneous translation was offered in Russian at many sessions.

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

Organisational members
Alter Santé Internationale et Développement (France)
Comité National contre les Maladies Respiratoires (France)
Kuratorium Tuberkulose In Der Welt E.V. (Germany)
CheckTB (The Netherlands)
Norwegian Association of Heart and Lung Patients (LHL) (Norway)
King Oscar II Jubilee Foundation (Sweden)
TB Alert (United Kingdom)
The International Union Against Tuberculosis and Lung Disease, Inc (United Kingdom)

Officers
President & Board Representative: Peter Davies (UK)
Vice President: Ivan Solovic (Slovakia)
Secretary General: Zohar Mor (Israel)
Treasurer: vacant
The Union in North America

The Union North America Office in New York is the home of The Union North America, a U.S. non-profit, tax-exempt organisation and organisational member of the federation in its own right. This office works closely with Union members throughout the region and supports fundraising efforts for The Union internationally. In 2012, the New York office served as a base for staff and consultants working on the TREAT TB initiative, provided administrative support to the Ethics Advisory Group, and housed the marketing and communications unit for the International Management Development Programme (IMDP).

Health challenges in North America

— TB case detection averaged 86% in the US and 89% in Canada in 2011. Both countries reported cases of extremely drug-resistant (XDR)-TB.

— Only 26 out of 50 US states have passed comprehensive smokefree laws.

— In the US 18.1% of all high school students smoke; studies show 80% will continue as adults.

— In Canada, 19.9% of those age 12 and older smoke.

Sources: see page 71
TUBERCULOSIS

TREAT TB Initiative successes in 2012

The Union’s TREAT TB Initiative (Technology, Research, Education and Technical Assistance for Tuberculosis) is administered by a North America-based team working with partners around the world. It is funded by the US Agency for International Development (USAID).

Key outcomes this year:

The STREAM clinical trial testing a nine-month MDR-TB treatment began patient enrolment in South Africa and Ethiopia. The regimen to be tested is modeled on one used in a non-randomised observational study in Bangladesh, which demonstrated an 87% cure rate.

The Operational Research Assistance Project (ORAP) developed by TREAT TB and the Desmond Tutu TB Centre (DTTC) at Stellenbosch University in South Africa has supported 88 scientists and health professionals new to operational research. In 2012, these trainees launched 14 new OR studies.

Several partners in the TREAT TB Diagnostic Tools Initiative worked together to create a comprehensive modeling approach called virtual implementation. It can be used to address the “what if?” questions about new TB diagnostic tools by virtually projecting the performance, resource requirements and costs associated with using the tools in real-world settings.

Teams working on the PROVE-IT study in Russia, Brazil and South Africa analysed the records of hundreds of patients and conducted interviews with patients and health care providers to help determine the efficacy and cost-effectiveness of line probe assays as a TB diagnostic tool.
COR research led to 90 publications

The Union’s Centre for Operational Research had a very successful year in 2012, generating research that led to 90 publications, including 70 research papers, 19 opinion/review papers and one document authored by staff, fellows and course participants.

By December, 11 of The Union/Médecins sans Frontières three-module training courses had been started and/or completed with 129 participants enrolled. These took place in Fiji, France, India, Kenya, Luxembourg, Nepal and the South Pacific Islands. Of the eight courses completed by the end of the year, 89% of the participants completed all of the course milestones from developing a research protocol to submitting a paper for publication.

COR also supports the work of its Operational Research Fellows in seven countries. The fellows conduct self-defined research projects and also facilitate training courses. By the end of 2012, the research of the OR fellows had led to 73 research projects, of which 56 were published or in press.

Other COR projects included conducting bilateral TB-diabetes screening in India and China; using the DOTS framework to track different diseases, such as diabetes, HIV/AIDS and hypertension; and piloting the use of electronic village registers and other electronic monitoring systems.

COR is funded by Bloomberg Philanthropies and the UK Department for International Development (DFID).

COR SUPPORT BROUGHT POLICY CHANGE IN MALAWI

With COR providing indirect technical assistance, Malawi implemented a “test and treat” approach for HIV-infected pregnant women, which provides them with antiretroviral therapy for life regardless of their CD4 cell count. This so-called Option B+ went into effect nationwide in July 2011, and results for the first 12 months showed that 37,000 women had accessed Option B+ and 31,000 (84%) were retained in care at six months.

NORTH AMERICA IN BRIEF


— HIV: Prof AD Harries, Director of the Department of Research, gave a plenary lecture on “TB and HIV: Science and Implementation to Turn the Tide on TB” at the XIX International AIDS Conference in Washington, DC in July.

— TB: The TREAT TB virtual implementation approach was presented at the 2012 Global Health Mini-University in Washington, DC in September.
355 members in 2012

The main activity of The Union North America Region in 2012 was the annual conference. One goal this year was to encourage other countries in the region to be more actively involved, e.g., the French-speaking Caribbean countries, Haiti, Guyana and Belize. The next conference will be in Vancouver, BC from 28 February to 2 March 2013.

The NAR annual meeting in Kuala Lumpur covered reports from the Institute, regional activities, the region charter, membership and a financial report. Action points included the need to cultivate constituent members from the region and plans for forthcoming conferences. In addition, the NAR has identified an “ambassador” to encourage students and trainees to join The Union in the new student category.

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

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

Officers
President/Board representative: E Jane Carter (USA)
Vice President/Programme Chair: Kevin Schwartzman (Canada)
Secretary/Treasurer: Alfred Lardizabal (USA)

The 16th Conference of The Union North America Region was held in San Antonio, Texas in February 2012. It proved a success both in terms of the 280 participants and the well-balanced programme. Dr Nils Billo presented the “Beyond TB” lecture, and Dr Gerry Friedland gave the George Comstock Lecture on community-based strategies to address the TB, HIV, and M/XDR-TB epidemics in South Africa. The Union’s Senior Advisor Prof Don Enarson (Canada) and Dr Sue Etkind, Executive Director of Stop TB USA, were honoured with Lifetime Achievement Awards.
Since 2003, The Union’s International Management Development Programme (IMDP) has provided health programme management training for health professionals in limited-resource settings. The IMDP builds capacity by addressing common problems in health programmes, such as ineffective budgeting, inconsistent access to medicines and other supplies and inadequate communication strategies.

The IMDP aims to bridge these gaps by educating clinicians and others working in health programme management and by facilitating the transfer of their new skills to the programmes and the staff they manage. The IMDP does not in itself empower people; it provides them with the knowledge, skills and tools to empower themselves.

In 2012, the IMDP trained close to 300 professionals working in a variety of positions in more than 40 countries. They attended 15 courses held in 10 countries on the following management topics:
• Budget and Finance
• Project Management
• Leadership
• Communications and Mass Media

IMDP courses are customised. For international audiences, they are customised according to the topic and current issues and challenges. For national training, they are customised to address the priority issues in the host country. Courses consist of five to six full-day sessions involving expert presentations, case studies, group exercises and action planning. Participants work with IMDP faculty to create post-course action plans that are tailored to their own programme’s needs and priorities.

For more information, please visit “Courses” at www.theunion.org or www.union-imdp.org.
**TECHNICAL COURSES**

**Technical training builds capacity to address critical challenges**

Key challenges addressed in 2012 through The Union’s technical courses included managing multidrug-resistant TB (MDR-TB), improving TB-HIV collaborative programming, developing operational research capacity and implementing smokefree legislation.

**Tuberculosis:** With the increasing incidence of MDR-TB, 19 courses were offered in various formats this year. Teaching methods range from lectures to site visits and discussions about difficult cases. In addition, the number of comprehensive TB courses increased with the addition of a course held in India; and the number of national TB courses rose as well. A new course on TB infection control was offered for the first time in 2012.

**TB-HIV:** The Union’s TB-HIV collaborative programming course has now been offered several times in Africa and Asia. The curriculum aims to help countries plan collaborative TB-HIV activities that meet key indicators outlined in the Global Plan to Stop TB. In 2012, a new course on the clinical management of TB-HIV patients was offered in Latin America.

**Operational Research:** Our operational research courses, which take participants from the development of a protocol to submission of their results for publication, have been very successful. In the eight courses completed by December 2012, 89% of the participants completed all milestones, with 81 papers submitted and 52 published or in press.

**Tobacco Control:** The Union and the World Health Organization developed a new course in 2012: ‘Protect people from tobacco smoke: Smoke-free environment’. It aims to address the challenges that have arisen as countries have enacted and begun to enforce national or local smokefree laws. Other courses focused on the MPOWER measures, tobacco-free health care facilities and building legal skills for tobacco control.

**Other:** Courses were also offered on topics such as child lung health, laboratory skills and chest x-ray reading.

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**Technical courses and workshops in 2012**

- TB: 14
- MDR-TB: 19
- Laboratory skills: 5
- TB-HIV: 10
- Child lung health: 1
- Tobacco control: 11
- Operational research: 10
- Other topics: 3
- Country locations: 32
The Kuala Lumpur Convention Centre in Malaysia, with its lush garden and skyline views, proved a congenial setting for the 43rd Union World Conference on Lung Health. More than 2,600 delegates from 122 countries attended the conference on 13–17 November 2012, which focused on “Driving Sustainability through Mutual Responsibility”. In her welcome address, Union President Dr E Jane Carter said the theme described not only the goal for global health, but also The Union and the way its members support and sustain each other.

The conference’s five-day scientific programme involved presenters from 65 countries offering more than 150 postgraduate courses and workshops, symposia, plenary sessions, abstract-driven and poster-related sessions, meet-the-experts and a late-breaker session on TB research.

Special events included:

- Welcome address by Datuk Dr Lokman Sulaiman Bin Hakim, Deputy Director General Ministry of Health Malaysia
- Sir John Crofton Memorial Lecture by Prof Lee Reichman (USA) on “Timebomb Revisited 10 Years Later: Can we sustain progress or are we losing the war?”
- The Stop TB Symposium (organised by the Stop TB Partnership and the World Health Organization) on “Accelerating Impact: Developing post-2015 TB strategy and targets”
- Plenary lectures by Prof Guy Marks (Australia) on “The Global Burden of Respiratory Disease”; Dr Sheila Tlou (Botswana) on “Preparing the Workforce for the Responsible Rollout of New Tools”; and Dr Anneke Hesseling (South Africa) on “Childhood TB: We need to do more”
- Demonstrations promoting The Kuala Lumpur Civil Society Declaration on Tuberculosis, which called for actions leading to zero TB deaths
- A summary of the scientific outcomes prepared by 27 rapporteurs and presented at a standing-room-only Closing Ceremony.

Run for your lungs!

The Union and the Malaysian Association for the Prevention of Tuberculosis (MAPTB) co-sponsored two events designed to build awareness of the need for lung health: a 5km run held on 11 November for the local population, and a 1.5 km family fun run in the KLCC Park on 17 November. More than 1,200 children, families and conference delegates put on their running shoes for these two very enjoyable events.
2012 AWARDS

Union awards
The Inaugural Session of the conference included the traditional Union awards ceremony honouring outstanding contributions to the fight against tuberculosis and lung disease.

The Union Young Investigator Prize acknowledges a researcher for work on tuberculosis or lung health published in the past five years, when 35 years and younger. Dr David Dowdy (USA) was honoured for his work on modeling the impact and cost-effectiveness of diagnostic interventions for TB.

The Union Scientific Prize acknowledges researchers at any stage of their career for work on tuberculosis or lung health published in the past five years. Dr Dick Menzies (Canada) was recognised for his long and well-known history with TB from his years in Lesotho to his research programme at the Montreal Chest Institute.

The Karel Styblo Public Health Prize acknowledges a health worker (physician or lay-person) or a community organisation for contributions to tuberculosis control or lung health over a period of 10 years or more. Dr Karin Weyer (South Africa) was honoured for her work as Coordinator of Laboratories, Diagnostics and Drug Resistance (LDR) at the WHO Stop TB Department.

Other awards presented at the conference
The Stop TB Partnership-Kochon Prize
South Africa’s Desmond Tutu TB Centre received this award for their work on childhood tuberculosis.

The Princess Chichibu Memorial TB Global Award
Dr Marcos A Espinal (Dominican Republic) of the Pan American Health Organisation received this award from the Japan Anti-Tuberculosis Association (JATA).

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

In 2012, 11 constituent and organisational members from the following countries participated: Canada; France; Hong Kong; India; Japan; Malaysia; Republic of Korea; Singapore; Taipei, China; The Philippines; and the USA.

The 2012 Christmas Seals Contest winners were:

1st prize: Japan Anti-Tuberculosis Association (JATA)
2nd prize: Philippine Tuberculosis Society, Inc
3rd prize: SATA CommHealth (Singapore)
In 2012 the main focus in the IJTLD, now in its 16th volume, was to reduce article backlogs to manageable levels to speed up publication times. Average submissions to the IJTLD have now reached 80 per month, compared to 68 per month in 2011, resulting in high workloads for editors and staff. To deal with this continued increase, the Board reinforced its policy of immediate rejection, whereby authors whose articles are deemed unsuitable for sending for review are informed within two days of submission. Thus, 18% of submissions in 2012 were immediately sent back to the authors as unsuitable, contributing to a rejection rate for original articles of 76%.

The above measures, along with the increased e-publication of original articles and the requirement for pre-submission queries for review and perspective articles, will aid in finetuning the journal’s overall performance.

The State of the Art (SoA) series in 2012, with Wing-Wai Yew as series editor, consisted of five articles on New Tools (diagnosis, new drugs, biomarkers, programme issues and retooling). In addition, two stand-alone SoA articles were published, one by Denis Mitchison on chemotherapy and the other by Tom Ottenhoff on the immunopathogenesis of TB.

Full-text downloads from the Ingenta site increased again, to 15,800 per month, and the Impact Factor increased from 2.557 in 2011 to 2.753, confirming once again its close parallel with the download rate (see figure).
In its first full year of publication, The Union’s new online journal, Public Health Action (PHA), saw an increase in content from eight articles in the March issue to 23 in the December issue. In its focus on operational research, the new journal continues to publish thought-provoking articles both on TB and on subjects that are not generally covered in other journals, including its sister journal, the IJTLTD. For example, 2012 saw articles on ethics in operational research, neglected tropical diseases, child malnutrition in Bangladeshi slums, the use of bed nets to prevent malaria in Liberia and paediatric and maternal health — all discussing how to improve the quality of health services and systems for the poor.

Some 40% of published articles came from authors not directly engaged in The Union training programmes, indicating that the journal is fast acquiring a niche in public health research.

The e-alert for each new issue is distributed to The Union’s mailing list of 35,000 contacts (on 21 March, June, September and December). By December 2012, the PHA’s full-text downloads from Ingenta had classed the new journal in the top 100 of 12,000 titles, in only its second year.

Although The Union had hoped that sponsorship for a low €500 publication fee could be maintained, this has not been the case, necessitating a higher fee to cover the actual costs of publication and make PHA sustainable. The Editorial Board, which met in Kuala Lumpur in November, reluctantly endorsed the increase in publication charge to the €1,500 cost that had originally been calculated as the real cost, to be applied for all papers submitted as of 1 January 2013.

Clare Pierard
Managing Editor

THE ETHICS ADVISORY GROUP (EAG)

The EAG’s role is to support and advise The Union in its quest to meet ethical standards in its activities. The six-member team is composed of people from different geographic regions and different professional backgrounds. The work is managed through e-mail communication and by an annual meeting at the time of the World Conference on Lung Health.

At the 2012 World Conference, two sessions were organised by the EAG, both of which highlighted ethical issues in lung health. A workshop focused on the stigma associated with various lung diseases and HIV; and a symposium examined who has the right to health care and who is responsible for ensuring its provision. The EAG was also invited to present at a symposium on MDR-TB treatment. Organising and presenting at conference sessions gives the EAG an opportunity to raise issues and to be available for discussion and debate.

Ethics review by the EAG is required from researchers associated with The Union in various roles (staff members or consultants, collaborators or sponsored by The Union). In 2012 the number of applications increased substantially to 123. This number was 42% of all the applications reviewed since the inception of the EAG in 2005. Most (86%) of the 123 applications were from participants in The Union-MSF operational research (OR) courses (70), TREAT TB-sponsored OR courses (15 from ORAP in South Africa, 13 from India) and other SE Asia OR courses (14). The remainder were from Union or TREAT TB staff (11).

The standardised application process has been simplified by creating two forms, one for research on existing records, the other for research with direct participant contact.
The Union is committed to disseminating its latest research, policy and practice to the widest possible audience. Most Union publications are available as PDFs at no charge from the website. Print copies may be ordered from documents@theunion.org.

TECHNICAL GUIDES
Implementing Collaborative TB-HIV Activities: A Programmatic Guide
PI Fujiwara, RA Dlodlo, O Ferroussier, et al
English; print or PDF

ADVOCACY RESOURCES
DR-TB drugs under the microscope: sources and prices of medicines
The Union/Médecins Sans Frontières
2nd ed; English, Spanish; print or PDF

FCTC Article 5.3 Toolkit: Guidance for Governments on Preventing Tobacco Industry Interference
The Union
English; print or PDF

The Economics of Tobacco and Tobacco Taxation in Bangladesh
Abul Barkat, et al
English; PDF

TRAINING RESOURCES
Training and Capacity Building for Operational Research
The Union/Médecins Sans Frontières
English, French; print or PDF

The Health Manager
International Management Development Programme
An online magazine that addresses a different health management topic in each issue
English; online

PROJECT REPORTS
Project Axshya Annual Report 2011–12
The Union South-East Asia Office
English; print or PDF

ECONOMIC REPORTS
The Economics of Tobacco and Tobacco Taxation in Bangladesh
Abul Barkat, et al
English; PDF
Research is one of The Union’s primary activities, essential to testing health solutions and fostering policy changes that can lead to better prevention, treatment and control of lung and other diseases. In 2012, Union staff, consultants, operational research fellows and operational research course participants published 128 research, viewpoint, opinion or review papers in peer-reviewed journals; two documents; and one book chapter. In addition, staff and consultants were involved in writing Union technical guides on TB-HIV (published in 2012) and MDR-TB (scheduled for 2013).

Peer-reviewed journals in which Union research was published in 2012 included:

- Africa Health
- African Journal of AIDS Research
- AIDS
- AIDS Behaviour
- AIDS Research and Treatment
- American Journal of Respiratory and Critical Care Medicine
- BMC Health Services Research
- BMC Infectious Diseases
- BMC Public Health
- BMC Research Notes
- Bull Epidemio; Hebd
- Central African Journal of Medicine
- Clinical Infectious Diseases
- Current Science
- Emerging Infectious Diseases
- European Respiratory Journal
- European Respiratory Monograph
- Health Education Journal
- Indian Journal of Medical Research
- International Health
- International Journal for Equity in Health
- International Journal of Tuberculosis and Lung Disease
- Journal of Acquired Immune Deficiency Syndrome
- Journal of Clinical Microbiology
- Journal of the International AIDS Society
- Journal of Infectious Diseases
- Journal of Tropical Medicine
- Lancet
- Lancet Infectious Diseases
- Lancet Respiratory Medicine
- Med Clin (Barc)
- Paediatric Infectious Diseases
- PloS Medicine
- PloS One
- Public Health Action
- South African Medical Journal
- Transactions of the Royal Society of Tropical Medicine and Hygiene
- Tropical Medicine and International Health

Unpublished research did not happen and therefore does not exist. A crucial milestone in any operational research endeavor is to ensure publication in a peer-reviewed journal

Prof AD Harries
Director, Department of Research

Highlights of the issues covered in Union research

- Drug-resistant TB transmission and resistance amplification in families
- Screening patients with diabetes mellitus for TB in China
- HIV prevalence among persons suspected of TB: policy implications for India
- Attributable deaths from smoking in the last 100 years in India
- Mortality and loss to follow-up in the first year of ART: Malawi national ART programme
- Mycobacterium TB transmission in a country with low TB incidence: role of immigration and HIV
- Effective interventions and decline of anti-TB drug resistance in Eastern Taiwan, 2004-08
- Asthma as a hidden disease in rural China
- European Union standards for TB care
- An incentivised HIV counseling and testing programme targeting hard-to-reach unemployed men in Cape Town, South Africa
- Severe malnutrition in children presenting to facilities in an urban slum in Bangladesh.
- Why ethics is indispensable for good-quality operational research
New Honorary Members of The Union named in Kuala Lumpur

Two Honorary Members were named at the 2012 General Assembly in Kuala Lumpur, in recognition of their distinguished contributions to the fight against tuberculosis and lung disease. Honorary membership is a lifetime award, and these special colleagues provide their wisdom and experience to help to guide The Union in its mission.

The new Honorary Members are:

Prof Asma El Sony (Sudan)

Prof Asma El Sony was born and raised in Sudan. After six years of medical training, she worked in hospitals in Sudan and the UK. She taught at Juba and Khartoum universities while joining the Federal Ministry of Health. As National TB Programme Manager, she worked with consultants from The Union and WHO, the Central Unit and State Coordinators to achieve 100% DOTS coverage for Sudan in 2002.

Prof El Sony is a co-founder and has been Director of the Epidemiological Laboratory (Epi-Lab) in Khartoum since 2005. She has collaborated with The Union on many projects, including smoking cessation, child pneumonia and asthma management. Author of numerous books and book chapters, she serves as a consultant for WHO, TDR, The Global Fund and others. Long active in The Union, she served on the Board for 12 years with terms as President (2003-07) and Past President (2008-11), where she oversaw its expanded scope and decentralisation, as well as the increase in its budget by nearly 300%.

Dr Richard O’Brien (USA)

Dr Richard O’Brien served as Chief of the Clinical Research Branch of the US CDC Division of Tuberculosis Elimination (DTBE) from 1982 to 1991. He was seconded to the WHO until 1996 to reestablish and head TB research in the Global Tuberculosis Programme. Following his return to the CDC DTBE, he oversaw the establishment of the TB Trials Consortium for therapy trials of new TB drugs and expanded research on new TB diagnostics.

In January 2004, Dr O’Brien joined the Foundation for Innovative New Diagnostics (FIND) as Head of Product Evaluation and Demonstration. In 2011, he returned to the US and now works as an independent consultant. He is board-certified in Internal Medicine, Pulmonary Disease and Preventive Medicine/Public Health and has more than 100 publications in peer-reviewed medical journals. In May 2010, he also received the prestigious World Lung Health Award from the American Thoracic Society.
TB in prisons:
Official statement of The Union
The TB Control In Prisons Working Group developed a position statement on TB prevention and control for the 9.8 million people in prisons that was adopted by the Board of Directors as an official statement of The Union and scheduled for January 2013 publication in the *IJTLD*. To download the full statement, please go to www.theunion.org and click on Resources/Official statements.

QMS Guide for TB laboratories
The TB Laboratory Accreditation Working Group helped launch a Quality Management System (QMS) implementation guide for national TB laboratories seeking accreditation that provides step-by-step guidance for the laboratories and is available electronically with links to resources and templates at www.gliquality.org. As part of the Global Laboratory Initiative (GLI), it also helped develop a microscopy network accreditation assessment tool.

Tobacco cessation interventions for TB patients average 69.25% success rate
The Tobacco Cessation Interventions for TB Patients Working Group developed the ABC approach (A=ask, B=brief advice, C=cessation support) to support smoking cessation among TB patients. Four pilots that started in 2010-11 have shown an average quit rate of 69.25%. The WG’s guide *Smoking Cessation and Smokefree Environments for Tuberculosis Patients* (available at www.theunion.org) is now used at universities in eight countries. The WG presented its results at both the 15th World Conference on Tobacco or Health in Singapore and The Union World Conference in Kuala Lumpur in 2012.

Toolkit outlines how to counter tobacco industry interference
The Countering Tobacco Industry Interference in Public Health Policies Working Group collaborated with The Union Department of Tobacco Control in developing the Article 5.3 toolkit published in 2012. The toolkit offers practical guidance to countries faced with industry interference in the development and implementation of tobacco control legislation. The WG organised symposia on this issue at the 2011 and 2012 World Conferences and is now helping to develop a training package.

Active NAPs networks
The Regional Mobilisation of Nurses and Allied Professionals (NAPs) Working Group has established six regional networks of NAPs. This year the Europe network organised a symposium for the 6th Conference of The Union Europe region in London and a lung health programme for nurses offered in Sweden. Members of the South America NAPs network in Brazil continue to be involved in operational research focused on patient-centred care for people affected by TB and HIV/AIDS and is collaborating with the Ministry of Health to develop a multicentre study on health services evaluation for TB control.

New membership categories reach out to low-income organisations and students
New categories of membership launched in 2012 aim to give organisations from low-income countries the opportunity to become part of The Union as associate organizational members and to reach students in training under the age of 35. Both options are for first-time members only. For details about eligibility, please write to membership@theunion.org

Membership team decentralised across the regions
While the Membership Unit continues to be led from the Paris HQ, staff in the India and Singapore offices now handle the database and the members-only space at Union Services. In addition, staff from the US, Peru, UK and Egypt offices have been designated to support member cultivation and member activities in The Union regions. This process of decentralisation will continue in an effort to provide more local support to members and build stronger partnerships and opportunities for collaboration between the Institute and the Federation.
SCIENTIFIC ACTIVITIES

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

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

TUBERCULOSIS SCIENTIFIC SECTION
2,128 active members in 2012
Chair: Richard Zaleskis (Latvia)
Vice Chair: Edward Nardell (USA)
Programme Secretary: Bonita Mangura (USA)
Secretary: Kevin Schwartzman (USA)

The Tuberculosis Section is a large and active section, playing an important role in the Coordinating Committee of Scientific Activities and organising many conference events. The challenge for this section is not to increase membership numbers, but membership participation. The goal is to ensure the diversity of voices heard at section meetings and in conference offerings. One proposed strategy is to communicate more fully about the working groups’ activities throughout the year.

At the annual meeting these issues were discussed; working groups gave presentations on their work during 2012; and participants proposed ideas for 2013 conference sessions. Of note, the Working Group on TB-HIV Data Management asked to disband.

Working Groups
- Global Indigenous Stop TB Initiative (Leader: Anne Fanning) – 139 members
- TB Infection Control (Leaders: Matsie Mphahlele, Rose Pray, Grigory Volchenkov) – 772 members
- TB Control in Prisons (Leaders: Masoud Dara, Sarabjit Chadha) – 199 members
- TB and Migration (Leader: Deliana Garcia) – 257 members
- TB Social Determinants and Ethics (Leaders: Carlton Evans and Delia Boccia) – 303 members
- TB-HIV Data Management (Leader: Rory Dunbar) – 248 members

TB BACTERIOLOGY AND IMMUNOLOGY SUB-SECTION
412 active members in 2012
Chair: Rumina Hasan (Pakistan)
Programme Secretary: Marina Shulgina (Russian Federation)

This sub-section was responsible for five symposia, one oral abstract session and eight poster sessions at the 2012 conference. At the annual meeting in Kuala Lumpur, the members discussed topics proposed for 2013. Other topics of discussion were changes in leadership in 2013, the low level of participation in the sub-section meeting and the need for greater representation for immunology, as well as bacteriology in its activities. The Working Group also presented its report.

Working Groups:
- TB Education and Training (Leaders: Allison Maiuri, Ahmed Al-Kabir) – 643 members
- Regional Mobilisation of Nurses and Allied Professionals (Leader: Tiemi Arakawa) – 38 members
- Best Practice for Patient Care (Leaders: Gini Williams, Inge Schreurs) – 442 members

TB NURSES AND ALLIED PROFESSIONALS (NAPS) SUB-SECTION*
117 active members in 2012
Chair: Kerrie Shaw (Australia)
Programme Secretary: Stacie Stender (South Africa)

This sub-section held its annual meeting in Kuala Lumpur and reviewed activities at the 2012 conference, including post-graduate courses, symposia, oral presentations and poster discussion sessions. Other topics of discussion were plans for 2013, proposals to change the name of the sub-section and ways to involve members of the other NAPS sub-sections.

Working Groups:
- TB Education and Training (Leaders: Allison Maiuri, Ahmed Al-Kabir) – 643 members
- Regional Mobilisation of Nurses and Allied Professionals (Leader: Tiemi Arakawa) – 38 members
- Best Practice for Patient Care (Leaders: Gini Williams, Inge Schreurs) – 442 members

* The HIV, Tobacco Control and Lung Health Sections also have small NAPS sub-sections.

ZOONOTIC TB SUB-SECTION
22 active members in 2012
Chair: Alejandro Perera (Mexico)
Programme Secretary: Francisco Olea-Popelka (USA)

The Zoonotic TB Sub-Section grew by 38% in 2012, thanks to the efforts of its members. They also organised a symposium for the World Conference and proposed a new Working Group on Creating Global Awareness of Zoonotic TB.
**HIV SCIENTIFIC SECTION**

120 active members in 2012  
**Chair:** Soumya Swaminathan (India)  
**Vice Chair:** Anand Date (USA)  
**Programme Secretary:** Alasdair Reid (South Africa)  
**Secretary:** Sandya Wellwood (Namibia)

The very active HIV Scientific Section fulfilled important goals in 2012. The mentorship programme for new researchers that they proposed was launched this year, and, thanks in part to their advocacy, the number of abstract-driven sessions at the 2012 World Conference rose to 12. The section organised 16 sessions for the World Conference and put together a roadmap of these events. In addition, Alasdair Reid coordinated a team of 27 rapporteurs who covered close to 80% of the core symposia and all but one of the oral abstract sessions. They then helped prepare the summary of scientific outcomes presented at the Closing Ceremony. This work was greatly appreciated by the standing-room-only audience.

At their annual meeting during the World Conference, the Section discussed upcoming elections in 2013; other proposals for the conference, such as new formats for the sessions and a new HIV/TB latebreaker session; and recommendations for the membership programmes, such as permitting people to belong to more than one section.

**LUNG HEALTH SCIENTIFIC SECTION**

82 active members in 2012  
**Chair:** Guy Marks (Australia)  
**Vice Chair:** Gregory Erhabor (Nigeria)  
**Programme Secretary:** Anneke Hesseling (South Africa)  
**Secretary:** Andrew Steenhoff (USA)

The Lung Health Section was very well represented at the 2012 World Conference, with officers Guy Marks and Anneke Hesseling invited to give plenary lectures on lung health and childhood TB. In addition, the section organised seven symposia, two workshops, one postgraduate course, five poster discussion sessions, two abstract-driven oral sessions and a meet-the-expert session.

The name of this section was a major topic of discussion at the annual meeting in Kuala Lumpur. The final recommendation to put to the Board in 2013 was a change to Adult and Child Lung Health. The three Working Groups gave reports on their activities over the year, and other issues, such as changes in leadership and proposals for 2013 conference sessions were discussed.

**Working groups**
- Childhood TB (Leaders: Anne Detjen, James Seddon) – 219 members
- COPD in low- and middle-income countries (Leader: Peter Burney) – 105 members
- Tobacco Cessation Interventions for TB Patients (Leader: TS Bam) – 79 members

**TOBACCO CONTROL SCIENTIFIC SECTION**

138 active members in 2012  
**Chair:** Wang Jie (China)  
**Vice Chair:** Xiaolin Wei (Hong Kong)  
**Secretary:** E Vidhubala (India)  
**Secretary:** Ehab Asaad (Egypt)

The Tobacco Control (TC) Section has three active working groups and organized 13 symposia and other events for the 2012 World Conference. At their annual meeting, they not only heard the working group reports, but also used the opportunity for small-group discussion of issues ranging from the environmental impact of tobacco to methods of enforcing smokefree legislation. These discussions led to several ideas for new working groups. Other issues discussed included the possibility of sponsoring a Union award for tobacco control, ways to increase the number of posters presented onsite at the World Conference and other strategies for increasing the visibility of tobacco control activities. The Department of Tobacco Control has offered to coordinate a membership campaign to increase the number of TC organisations in The Union.

**Working Groups**
- Strengthening NCD Prevention through Tobacco Control (Leader: Trish Fraser) – 82 members*  
- Getting Research into Tobacco Control Policy at Regional and Country Level (Leader: Md Akramul Islam) – 71 members  
- Countering Tobacco Industry Interference in Public Health Policies (Leader: Anne Jones) – 52 members

* This WG asked to be dissolved. They will finalise a technical briefing paper, which they hope will be published in 2013.
The Union General Assembly was held on Saturday, 17 November from 16:00 to 17:00 in Conference Hall 1, Kuala Lumpur Convention Centre, Kuala Lumpur, Malaysia. Dr E Jane Carter, The Union President, welcomed constituent, organisational, honorary and individual members and scientific section chairs.

**Elections**

Based on the Nominating Committee’s recommendations, the General Assembly elected the following individual members: Dr E Jane Carter (USA), Dr Guy Marks (Australia), Mr James De Viel Castel (Switzerland) and Dr Akira Shimouchi (Japan).

The General Assembly also validated the appointments to the Board of two regional representatives: Dr Pamela Orr (Canada) for the North America Region and Prof Peter Davies (UK) for the Europe Region.

**Resolutions**

The General Assembly unanimously approved the Activity Report, treasurer’s report and the audited accounts for the period of 1 January to 31 December 2011 and the budget for fiscal 2013.

The General Assembly also approved the sale of the offices located at 109 Boulevard St-Michel (BSM), and 1 avenue Observatoire, (Obs) both in 75006 Paris. If 109 BSM was sold at auction, it must be sold for at least €1,040,000 confirmed by the fiscal department (France Domaine). If 1 ave Obs was sold at auction, it must be sold for at least €1,200,000 confirmed by the fiscal department (France Domaine) or the price reached at public auction.

**Discharge and power**

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

**World conferences**

Dr Nils E Billo reminded members that the 2013 conference would be in Paris, while the venue for 2014 was still to be decided between Barcelona and Dubai, as recommended by the Board of Directors.

**Strategic plan**

Dr Nils E Billo presented the main lines of the draft strategic plan approved by the Board of Directors.

**Awards/remembrance**

Prof Asma El Sony (Sudan) and Dr Richard O’Brien (USA) were made Honorary Members of The Union. Several members who passed away in 2012 were remembered (see below); and the results of the annual Christmas Seals contest were announced (see page 49).

**Thank you!**

Dr E Jane Carter thanked everyone for their participation and commitment to The Union. The General Assembly closed at 17:00.

**In Memoriam**

The Union honours the passing in 2012 of the following members who made vital contributions to our organisation and our cause:
- Pierre Chaulet (Algeria)
- Moti Lall (Guyana)
- Joseph Adera Odhiambo (Kenya)
- Knut Ovreberg (Norway)
The Union supports the Kuala Lumpur Civil Society Declaration on Tuberculosis which calls for actions leading to zero TB deaths.
I am pleased to submit the Report of the Treasurer of the International Union Against Tuberculosis and Lung Disease (The Union) for the fiscal year ended 31 December 2012.

2012 was a year of progress in a challenging economic environment for The Union. In the aftermath of the economic crisis that began in early 2008, The Union faced a difficult financial environment; however, we took effective action to reduce costs and operate on a balanced budget.

During the past three years, The Union experienced revenue surpluses that helped us mitigate the operating losses of Fiscal 2008 and 2009. We need to continue to manage our resources all the more prudently, and we therefore need to redouble our efforts at fiscal discipline and high productivity, two hallmarks of The Union’s operating philosophy. Perhaps, like successful non-profit organisations, we at The Union know how to do more with less.

One of the measures we implemented was the decentralisation of administration and activities from 2003 onwards. This process has not only helped the organisation grow, but also has allowed The Union to be closer to its beneficiaries, collaborators and members. It will be important that all The Union offices become more self-sustainable. Three of the offices are already managing a substantial portfolio of activities and are able to meet almost all of their operating costs.

In 2012 we launched The Union Centennial Campaign to raise unrestricted funds for research and education. The 1st President’s Centennial Dinner, a key campaign event, was held in Kuala Lumpur and raised $140,000, which will be placed in a specially designated Centennial Fund.

The Union also received a legacy from Madame Suzanne Horvais of France, who bequeathed her entire estate in recognition of timely and thoughtful advice provided by The Union in 1952. The contributions to The Union Centennial Campaign, as well as this significant legacy, are important and have helped the organisation maintain its commitment to its vision and mission.

**Fiscal 2012 highlights**

- Total net financial result for the year was a surplus of 0.480 million euros compared to a surplus of 0.346 million euros in 2011. Total revenue was 32.6 million euros compared to 30.1 million euros in 2011.
- Revenue from grants, gifts and operating grants amounted to 29.4 million euros, compared to 27.1 million euros in 2011.
- Total expenditure was 30.1 million euros, compared to 31.7 million euro in 2011.
- The current bank advances (overdraft) stood at 1.23 million euros compared to 0.260 million euros in 2011.
- The operating result was a surplus of 0.66 million euros (deficit 0.277 million euro in 2011), along with an exceptional result of 0.558 million euros (surplus 0.682 million euros in 2011).

The Union has great strength in the way it provides its technical assistance, educational and operational research activities and how each of these are interlinked and contribute to its core competency. The key to The Union’s success, and essential to maintaining a leadership position in global health, will be maintaining a keen focus on our areas of strength. We will need to adjust budgets prudently and proactively, always aware of the need to protect our gains and ensure pursuit of our strategic priorities.

The Union’s management is already factoring tighter economic conditions into the budgets for Fiscal 2013 and beyond. The premium on prioritising wisely and judiciously is even greater in times such as these, when
we face not only challenges, but also opportunities as well. It is imperative that The Union focus on those areas in which it has expertise so that it continues to provide its beneficiaries with high-quality products.

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. The management and staff are working closely with the Board and our auditors to 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 2013 and beyond.

Financial statements

This report describes the financial position of The Union. The document on the following pages consists of the audited financial statements for Fiscal Year 2012 audited by KPMG.

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

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

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

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

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

Thank you.

Louis-James de Viel Castel
Treasurer
Opinion sur les comptes annuels

Nous avons effectué notre audit selon les normes d’exercice professionnel applicables en France ; ces normes requièrent la mise en œuvre de diligences permettant d’obtenir l’assurance raisonnable que les comptes annuels ne comportent pas d’anomalies significatives. Un audit consiste à vérifier, par sondages ou au moyen d’autres méthodes de sélection, les éléments justifiant des montants et informations figurant dans les comptes annuels. Il consiste également à apprécier les principes comptables suivis, les estimations significatives retenues et la présentation d’ensemble des comptes. Nous estimons que les éléments que nous avons collectés sont suffisants et appropriés pour fonder notre opinion.

Nous certifions que les comptes annuels sont, au regard des règles et principes comptables français, réguliers et sincères et donnent une image fidèle du résultat des opérations de l’exercice écoulé ainsi que de la situation financière et du patrimoine de l’association à la fin de cet exercice.

Justification des appréciations

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

Compte d’emploi annuel des ressources

Dans le cadre de notre appréciation des principes comptables suivis par votre association, nous avons vérifié que les modalités retenues pour l’élaboration du compte d’emploi annuel des ressources, décrites dans la note 6 page 42 de l’annexe, font l’objet d’une information appropriée, sont conformes aux dispositions du règlement CRC n°2008-12 et ont été correctement appliquées.

Estimations Comptables

Fonds dédiés

Votre association comptabilise en fonds dédiés, tel que présenté en note n°3-2-3 de l’annexe des comptes sociaux, les financements externes reçus et affectés à un projet spécifique répondant aux critères prévus par les règles et principes comptables français.

Nos travaux ont consisté à revoir par sondages les calculs effectués et àvalider la cohérence des variations des fonds dédié du bilan avec celles du compte de résultat.

Provisions pour risques

Votre association constitue des provisions pour couvrir les risques liés aux pertes latentes sur opérations en devises et pour litiges prédant homaux, telles que mentionnées en note n°3-2-2 de l’annexe des comptes sociaux.

Provisions pour dépréciations

Votre association constitue des provisions pour couvrir les dépréciations constatées ou prévues au titre des actifs de l’entreprise, telles que mentionnées en note n°3-1-4-2 de l’annexe des comptes sociaux.

Paris La Défense, le 26 août 2013

KPMG Audit NM

Bernard Gauillon
Associé
Opinion on the financial statements

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

In our opinion, the financial statements give a true and fair view of the assets and liabilities and of the financial position of the Company as at December 31, 2012 and of the results of its operations for the year then ended in accordance with French accounting principles.

Justification of our assessments

In accordance with the requirements of article L.833-9 of the French Commercial Code (Code de commerce), we bring to your attention the following matters:

Annual resources use account

As part of our assessment of the accounting principles applied by your organization, we have verified that the methods used to prepare the annual account of resource use, as described in note 6 on page 42 of the appendix, subject appropriate information, comply with the provisions of CRC Regulation 2008-12 (French accounting regulation) and have been properly applied.

Accounting estimations

Dedicated funds

Your organization sets up dedicated funds, such as presented in note n°3-2-2 of the appendix of the social accounts, external funding received and allocated to a specific project meets the criteria laid down by the French accounting rules and principles.

Our audit includes review by sampling tests the calculations made and validate the coherence of variation in dedicated funds of Balance Sheet and those in the Income Statement.

Contingencies and loss provisions

Your organization sets up provisions against exchange losses and provision for disputes, such as mentioned in note n°3-2-1 of the appendix of the social accounts.

Wear and tear allowances

Your organization sets up provisions to cover the depreciations noticed or envisaged on assets, such as mentioned in note n°3-1-4-2 of the appendix of the social accounts.
## Net Amount

### ASSETS

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<td><strong>Total Fixed Assets</strong></td>
<td>6 911 488</td>
<td>9 119 018</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constituent members</td>
<td>505 906</td>
<td>667 492</td>
</tr>
<tr>
<td>Suppliers advance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Managed funds receivable</td>
<td>2 312 579</td>
<td>3 051 217</td>
</tr>
<tr>
<td>Receivable on committed grants</td>
<td>-1</td>
<td>-1</td>
</tr>
<tr>
<td>Inter-offices accounts</td>
<td>29 257</td>
<td>38 602</td>
</tr>
<tr>
<td>Other receivables</td>
<td>190 591</td>
<td>251 466</td>
</tr>
<tr>
<td>Sundry debtors</td>
<td>203 941</td>
<td>269 080</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>3 242 273</td>
<td>4 277 856</td>
</tr>
<tr>
<td><strong>Bank &amp; Cash</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial investment for managed funds</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash and bank for managed funds</td>
<td>4 664 317</td>
<td>6 154 100</td>
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<tr>
<td>Cash and bank of the Union</td>
<td>432 888</td>
<td>571 152</td>
</tr>
<tr>
<td><strong>Total Bank &amp; Cash</strong></td>
<td>5 097 205</td>
<td>6 725 252</td>
</tr>
<tr>
<td><strong>Prepaid Expenses</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Total Prepaid Expenses</strong></td>
<td>217 715</td>
<td>287 253</td>
</tr>
<tr>
<td><strong>Foreign Exchange Unrealised Losses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Exchange Losses</strong></td>
<td>1 233 059</td>
<td>1 626 898</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>16 701 740</td>
<td>22 036 276</td>
</tr>
</tbody>
</table>

2011: 1 € = 1.2939 US$
2012: 1 € = 1.3194 US$
## Equity

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td>Reserves</td>
<td>2 287 820</td>
<td>3 018 550</td>
</tr>
<tr>
<td>Result carried forward</td>
<td>-4 366 275</td>
<td>-5 760 863</td>
</tr>
<tr>
<td>Result from the financial year</td>
<td>479 718</td>
<td>632 940</td>
</tr>
<tr>
<td>Restatement reserve on premises</td>
<td>1 887 396</td>
<td>2 490 230</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td><strong>288 659</strong></td>
<td><strong>380 857</strong></td>
</tr>
</tbody>
</table>

## Contingency Reserves

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Total Contingency Reserves</strong></td>
<td><strong>494 802</strong></td>
<td><strong>652 842</strong></td>
</tr>
</tbody>
</table>

## Dedicated Funds

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Total Dedicated Funds</strong></td>
<td><strong>6 342 934</strong></td>
<td><strong>8 368 867</strong></td>
</tr>
</tbody>
</table>

## Debts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td>Grants to be paid</td>
<td>2 532 690</td>
<td>3 341 631</td>
</tr>
<tr>
<td>Committed grants related to future budget years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inter-offices accounts</td>
<td>1 059 561</td>
<td>1 397 985</td>
</tr>
<tr>
<td>Borrowing from credit institutions</td>
<td>1 781 279</td>
<td>2 350 220</td>
</tr>
<tr>
<td>Current bank advances</td>
<td>1 230 810</td>
<td>1 623 931</td>
</tr>
<tr>
<td>Suppliers and similar accounts</td>
<td>432 412</td>
<td>570 524</td>
</tr>
<tr>
<td>Tax and social security</td>
<td>518 970</td>
<td>684 729</td>
</tr>
<tr>
<td>Charges to be paid (accrued expenses)</td>
<td>210 252</td>
<td>277 406</td>
</tr>
<tr>
<td>Other creditors</td>
<td>479 909</td>
<td>633 192</td>
</tr>
<tr>
<td><strong>Total Debts</strong></td>
<td><strong>8 245 883</strong></td>
<td><strong>10 879 618</strong></td>
</tr>
</tbody>
</table>

## Deferred Income

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Total Deferred Income</strong></td>
<td><strong>552 899</strong></td>
<td><strong>729 495</strong></td>
</tr>
</tbody>
</table>

## Foreign Exchange Unrealised Gains

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Total Exchange Gains</strong></td>
<td><strong>776 563</strong></td>
<td><strong>1 024 597</strong></td>
</tr>
</tbody>
</table>

## Grand Total

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€</td>
<td>US $</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>16 701 740</strong></td>
<td><strong>22 036 276</strong></td>
</tr>
</tbody>
</table>

2011: 1 € = 1.2939 US$  
2012: 1 € = 1.3194 US$
Financial Report

Income/Expenses

In euros - 1 January 2012 – 31 December 2012

<table>
<thead>
<tr>
<th>INCOME STATEMENT (in €)</th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>307 704</td>
<td>446 336</td>
<td>754 039</td>
<td>603 347</td>
</tr>
<tr>
<td>Operating grant</td>
<td>2 925 791</td>
<td>-2 922 428</td>
<td>3 364</td>
<td>2 840 090</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>2 495</td>
<td>29 441 389</td>
<td>29 443 884</td>
<td>24 266 912</td>
</tr>
<tr>
<td>Write back of provisions and transferred charges</td>
<td>177 427</td>
<td>356 146</td>
<td>533 573</td>
<td>482 517</td>
</tr>
<tr>
<td>Other income</td>
<td>466 333</td>
<td>1 442 656</td>
<td>1 908 990</td>
<td>1 918 964</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>3 879 750</td>
<td>28 764 099</td>
<td>32 643 850</td>
<td>30 111 830</td>
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<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>External charges</td>
<td>-1 437 112</td>
<td>-12 091 502</td>
<td>-13 528 613</td>
<td>-15 377 801</td>
</tr>
<tr>
<td>Taxes</td>
<td>-27 469</td>
<td>-120 446</td>
<td>-147 915</td>
<td>-26 789</td>
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<tr>
<td>Wages and salaries</td>
<td>-644 319</td>
<td>-2 859 738</td>
<td>-3 504 057</td>
<td>-3 316 828</td>
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<tr>
<td>Social contributions</td>
<td>-389 771</td>
<td>-932 692</td>
<td>-1 322 463</td>
<td>-1 426 088</td>
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<tr>
<td>Depreciation charges and addition to provisions</td>
<td>-664 394</td>
<td>-6 410</td>
<td>-670 803</td>
<td>-664 440</td>
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<tr>
<td>Other expenses</td>
<td>-556 286</td>
<td>-10 410 318</td>
<td>-10 966 604</td>
<td>-10 883 462</td>
</tr>
<tr>
<td><strong>Total Operating Expense</strong></td>
<td>-3 719 351</td>
<td>-26 421 106</td>
<td>-30 140 455</td>
<td>-31 695 408</td>
</tr>
<tr>
<td>Write back of dedicated funds</td>
<td>0</td>
<td>2 405 984</td>
<td>2 405 982</td>
<td>3 183 013</td>
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<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>-4 843 911</td>
<td>-4 843 913</td>
<td>-1 877 144</td>
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<tr>
<td><strong>Operations on Dedicated Funds</strong></td>
<td>0</td>
<td>-2 437 927</td>
<td>-2 437 931</td>
<td>1 305 869</td>
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<tr>
<td><strong>Operating Result</strong></td>
<td>160 399</td>
<td>-94 934</td>
<td>65 464</td>
<td>-277 709</td>
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<tr>
<td><strong>Financial Result</strong></td>
<td></td>
<td></td>
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<tr>
<td>Foreign exchange difference</td>
<td>-123 927</td>
<td>-5 222</td>
<td>-129 149</td>
<td>246 228</td>
</tr>
<tr>
<td>Interest and financial income</td>
<td>-98 201</td>
<td>88 418</td>
<td>-9 783</td>
<td>40 189</td>
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<tr>
<td>Financial provisions</td>
<td>1 119</td>
<td>0</td>
<td>1 119</td>
<td>-329 301</td>
</tr>
<tr>
<td><strong>Total Financial Result (+Gain /-Loss)</strong></td>
<td>-221 009</td>
<td>83 196</td>
<td>-137 813</td>
<td>-42 884</td>
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<tr>
<td><strong>Exceptional Result</strong></td>
<td>546 906</td>
<td>11 738</td>
<td>558 644</td>
<td>682 733</td>
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<tr>
<td><strong>Income Tax</strong></td>
<td>-6 577</td>
<td>0</td>
<td>-6 577</td>
<td>-15 712</td>
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<tr>
<td><strong>Net Result for Financial Year</strong></td>
<td>479 718</td>
<td>0</td>
<td>479 718</td>
<td>346 428</td>
</tr>
</tbody>
</table>

Aid in kind (Drugs) | 1 394 659
Free use of goods and services | -1 394 659

2011: 1 € = 1.2939 US$
2012: 1 € = 1.3194 US$
In US$ - 1 January 2012 – 31 December 2012

<table>
<thead>
<tr>
<th>Operating Income</th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>405 985</td>
<td>588 896</td>
<td>994 879</td>
<td>780 671</td>
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<tr>
<td>Operating grant</td>
<td>3 860 289</td>
<td>-3 855 852</td>
<td>4 438</td>
<td>3 674 792</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>3 292</td>
<td>38 844 969</td>
<td>38 848 261</td>
<td>31 398 957</td>
</tr>
<tr>
<td>Write back of provisions and transferred charges</td>
<td>234 097</td>
<td>469 899</td>
<td>703 996</td>
<td>624 329</td>
</tr>
<tr>
<td>Other income</td>
<td>615 280</td>
<td>1 903 440</td>
<td>2 518 721</td>
<td>2 482 948</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>5 118 942</strong></td>
<td><strong>37 951 352</strong></td>
<td><strong>43 070 296</strong></td>
<td><strong>38 961 697</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>External charges</td>
<td>-1 896 126</td>
<td>-15 953 528</td>
</tr>
<tr>
<td>Taxes</td>
<td>-36 243</td>
<td>-158 916</td>
</tr>
<tr>
<td>Wages and salaries</td>
<td>-850 114</td>
<td>-3 773 138</td>
</tr>
<tr>
<td>Social contributions</td>
<td>-514 264</td>
<td>-1 230 594</td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>-876 601</td>
<td>-8 457</td>
</tr>
<tr>
<td>Other expenses</td>
<td>-733 964</td>
<td>-13 735 374</td>
</tr>
<tr>
<td><strong>Total Operating Expense</strong></td>
<td><strong>-4 907 312</strong></td>
<td><strong>-34 860 007</strong></td>
</tr>
</tbody>
</table>

| Write back of dedicated funds | 3 174 456 | 3 174 453 | 4 118 501 |
| Obligations for projects | -6 391 056 | -6 391 059 | -2 428 837 |
| **Operations on Dedicated Funds** | **-3 216 600** | **-3 216 606** | **1 689 664** |

| Operating Result | 211 630 | -125 255 | 86 374 | -359 328 |

Financial Result

| Foreign exchange difference | -163 509 | -6 890 | -170 399 | 318 594 |
| Interest and financial income | -129 566 | 116 659 | -12 908 | 52 001 |
| Financial provisions | 1 476 | 0 | 1 476 | -426 083 |
| **Total Financial Result (+Gain /-Loss)** | **-291 599** | **109 769** | **-181 830** | **-55 488** |

| Exceptional Result | 721 588 | 15 487 | 737 075 | 883 388 |

| Income Tax | -8 678 | 0 | -8 678 | -20 330 |
| **Net Result for Financial Year** | **632 940** | **0** | **632 940** | **448 243** |

Aid in kind (Drugs) 1 804 550
Free use of goods and services -1 804 550

2011: 1 € = 1,2939 US$
2012: 1 € = 1,3194 US$
The Union gratefully acknowledges the following governments, agencies, foundations and corporations that supported The Union’s work in 2012.

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Agence Française de Développement
Agence Nationale de Recherche sur le Sida et les hépatites virales (ANRS)
Commune de Premier Fait, France
Department for International Development (DFID) of the British Government
Economic Development Board of Singapore
European Commission, Democratic Republic of Congo
Family Health International with funds from the United States Agency for International Development (USAID)
France Expertise Internationale (FEI) Initiative 5% Sida, Tuberculose, Paludisme
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Global Fund To Fight AIDS, Tuberculosis and Malaria (Global Fund) through a grant managed by the United Nations Office Project Services (UNOPS) in Myanmar
Institut Pasteur, France
International Federation of Red Cross and Red Crescent societies with funds from the Bloomberg Philanthropies
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Malaysian Association for the Prevention of Tuberculosis (MAPTB)
Ministry of Economy and Finance, Government of Peru
Ministry of Health, Dominican Republic
MISEREOR
Norwegian Association of Heart and Lung Patients (LHL)
PAHO Ecuador
Research Institute for a Tobacco-Free Society LBG with funds from the Commission of the European Communities
Secretariat of the Pacific Community, New Caledonia
Stop TB Partnership
TBCARE I and II implemented by the Tuberculosis Coalition for Technical Assistance (TBCTA) with funds from the United States Agency for International Development (USAID)
Three Diseases Fund through a grant managed by the United Nations Office Project Services (UNOPS) in Myanmar
Tuberculosis Coalition for Technical Assistance (TBCTA) with funds from the US President’s Emergency Plan For Aids Relief (PEPFAR)
USAID
US Department of Health and Human Services Centers for Disease Control and Prevention (CDC)
University Research Co, LLC funded by USAID
World Health Organization (WHO) through a grant managed by EnCompass LLC
WHO through grants managed by the Stop TB Partnership

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Schwab Charitable Fund
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The Union Centennial Campaign

honours the 100th anniversary of the International Union Against Tuberculosis and Lung Disease (The Union) by raising unrestricted funds to support its independent and innovative research and education programmes. These programmes have been the hallmark of The Union’s contribution to the global fight against tuberculosis and lung disease since its founding in 1920 and continue to be core activities serving 150 countries today.

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Maurice Oliver Nunn, UK

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Jeremiah Chakaya Muhwa, Kenya
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Clare Pierard, France
Antic Ral, Philippines
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