The International Union Against Tuberculosis and Lung Disease promotes lung health in middle- and low-income countries through technical assistance, education and research.
Activity Report of the International Union Against Tuberculosis and Lung Disease

1 January – 31 December 2004

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The Millennium Development Goals commit the international community to specific targets that will promote human development and stimulate social and economic progress in the world. But without good health, there can be no sustainable development among the peoples of the world. Unless we can reduce child mortality, improve the health of parents and combat diseases such as tuberculosis, asthma and HIV/AIDS, the Millennium Development Goals will remain a dream for many countries, especially the poorest.

A special focus of The Union Board of Directors, Secretariat and members during 2004 has been The Union’s role in achieving the Millennium Development Goals. At the 35th World Conference on Lung Health, more than 1,700 participants from 120 countries gathered to discuss the theme: ‘Millennium Development Goals: what is in store for The Union?’

The Union is in a unique position to facilitate progress towards the Millennium Development Goals. Our global membership and our mission to improve lung health in low- and middle-income countries through technical assistance, education and research with currently — 197 projects in 71 countries around the world — give The Union unusual synergy in this effort. The many projects highlighted in this 2004 Activity Report are testimony to that.

However, like any well-functioning organisation, The Union must be guided by a clear vision and strategy for the future. To this end, The Union is developing a long-term strategic plan to ensure that the grants we receive fit not only a particular project, but also the overall plan and the mission of the organisation. The Board of Directors has commissioned an independent evaluation of The Union for the period 1992–2004, and the findings of this evaluation will then form the basis for the development of a strategic plan for 2005–2009.

As we build towards the future, The Union should be guided by its proven successes to strengthen its mission and help bring the vision of the Millennium Development Goals closer to reality for some of the world’s least advantaged people. There are four areas where I believe we can focus:

**Extend The Union’s successful model of TB treatment to other lung health problems**

The Union’s most important achievement is the model of TB control, now known as the DOTS strategy, that has become the worldwide standard for diagnosing, treating and controlling tuberculosis. This successful and proven public health model can be applied to other lung health problems in developing countries. The success of The Union’s Child Lung Health Project in Malawi is a powerful demonstration of this.

**Develop the human resources necessary to carry out our mission**

The demand for trained, experienced public health consultants in countries with a high burden of disease is great, but the pool of trained consultants is small.

There is a very interesting story in this Activity Report on The Union’s Junior Consultant Programme, a pilot project in which three consultants are being trained to provide leadership and expertise to national tuberculosis programmes in high-burden countries. Unfortunately, this is only a pilot project, and, unless further funding is found, these consultants will be the only ones trained. But it is an example of the type of programme that should be developed, not only in tuberculosis, but also in all areas of lung health. We need to build a pool of public health consultants who are able to provide technical assistance to all lung health programmes.
The Union’s capacity-building research, laboratory training and management courses already bring new expertise and skills to low-income countries each year. But we should strive to do more by facilitating links to universities, expanding our courses and workshops, providing further technical and managerial assistance and developing links between consultants and databases of trained personnel.

Create and strengthen internal and external partnerships

Individual countries must set their own goals and develop their own strategies, but they need global partners like The Union to ensure that the poorer people of the world are included in the benefits of development. The Union is already partners with a variety of national and international organisations and government agencies that share our mission to improve lung health.

But internal partnerships can be just as important as external partnerships. Our broad worldwide membership — ministries of health, national tuberculosis programmes, lung associations, professional societies, patient advocacy groups and individuals — is our greatest strength, and we must continually invigorate our membership network with a spirit of participation and partnership to further our mission. We can do this through mechanisms such as an expanded network of collaborating centres that actively involve countries and regions in Union activities, centres of excellence to improve and increase the capacity of our members, in-country Stop TB partnerships that could strengthen the country coordinating mechanisms, and a strong interregional council and other regional bodies to improve communication between the Secretariat and the six Union regions.

Disseminate and promote knowledge about lung health

Advocacy and social mobilisation to improve government accountability and raise public awareness have proven to be crucial tools in bringing public health agendas to the forefront. Advocacy can increase awareness of the social, economic and political impact of TB and other lung diseases, and keep these issues high on the public health agenda in countries around the world. Awareness is the first step toward action, and it is essential at every level – from individual patients, family members and healthcare workers to health ministers and government, business and opinion leaders. In particular, politicians and those controlling budget decisions at the district, state, national and international level need to understand that only sufficient funding will lead to sustainable improvement in TB and other health services.

The Union has advocacy programmes – from world health day events and social mobilisation forums to our global communications programmes – but we could and should do more, and we should seek additional funding to expand these activities.

Broaden our funding base

Adequate funding is critical to the success and sustainability of any public health initiative. While The Union receives funds from many donors and organisations, much of this money is earmarked for specific projects and sometimes does not give us the flexibility to respond to developing situations or new opportunities. As a scientific, technical and educational organisation, The Union has great resources and strengths, which we must be able to direct to the areas where our long years of experience show us the need is greatest. We must not become a service organisation working for grant givers.

As you read this 2004 Activity Report, I think you will agree that The Union is doing outstanding work. Our challenge is to remain strong, communicative, competitive and resilient as we grow and move forward.

Dr Asma El Sony
President
International Union Against Tuberculosis and Lung Disease
Contributing to the Millennium Development Goals

The Union has long been recognised as one of the leading players in tuberculosis control, yet in recent years, it has broadened its scope to give increased attention to other areas of lung health. Through projects in a few pilot countries, The Union has developed and successfully tested standardised approaches to reduce mortality from pneumonia in children, manage asthma and control tobacco use. These approaches are now ready to be expanded to other countries, ultimately reaching millions of patients.

In 2004, The Union managed 197 projects in 71 low- and middle-income countries. It provided technical assistance to 70 projects in 44 countries; organised 25 educational courses attended by 685 health professionals in 18 countries; and conducted 65 research projects in 45 countries, thereby increasing global knowledge of tuberculosis, child lung health, asthma, tobacco control, nursing and health policy.

These impressive achievements could not have been accomplished without the hard work and unconditional dedication of the 75 Union staff members and consultants. My sincere thanks go to all of them.

This Activity Report highlights these achievements and The Union’s contributions to global lung health in 2004. It also documents our efforts to reach the United Nations’ Millennium Development Goals (MDGs) for 2015.

How is the Union contributing to the MDGs?

At the United Nations Millennium Summit in September 2000, world leaders agreed to a set of measurable goals for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women by the year 2015. These Millennium Development Goals provide a framework in which world governments and international organisations can work together towards a common end. The Union has chosen to work within this framework and is contributing significantly to five of its goals.

Millennium Development Goal 1: Eradicate extreme poverty and hunger

Today 1.2 billion people still live on less than $1 a day. In many low- and middle-income countries, the poor do not have access to healthcare services. This creates a vicious cycle: sick people cannot work; without work, they cannot buy medication; without medication, they cannot recover and return to work. The Union is striving to develop and implement strategies that will allow everyone access to adequate health care.

Tuberculosis: Controlling a disease of poverty

TB has been called a disease of poverty, and 80% of today’s cases are concentrated in 22 low-income countries. The DOTS strategy for TB treatment and control, developed by The Union, has now been adopted by 182 countries worldwide. The Union’s technical assistance, capacity-building network, educational programmes and clinical trials all contribute to improve TB services, while the FIDELIS project specifically aims at improving case finding among the poorest of the poor with inadequate access to health care.

Tobacco Prevention: Stopping the waste of money and lives

Tobacco use is a major contributor to poverty and disease. As more poor people use tobacco and suffer the health consequences, available family resources for food, education and medications diminish. Given the current levels of use, tobacco-related diseases in low-income countries will soon overwhelm already overburdened healthcare systems. The Union has developed model interventions for tobacco control in low-income countries, provides educational materials to countries seeking to implement tobacco control, participates in international tobacco prevention research and actively supports the Framework Convention on Tobacco Control.

Asthma: Seeking solutions to a chronic problem

More than 300 million people worldwide now suffer from asthma – a chronic and sometimes life-threatening condition. Although effective treatments are available, the cost of obtaining them is often prohibitive for families...
and governments. Inhaled corticosteroids and bronchodilators are extremely expensive in many countries, and the majority of sufferers in developing countries do not have access to treatment. The Union has started an initiative to create a global Asthma Drug Facility that will improve patient access to affordable generic drugs.

**Millennium Development Goal 2: Achieve universal primary education**

Approximately 113 million children do not attend school. Many of these children may be caring for sick family members, or may themselves have TB, asthma or some other lung disease. Only healthy children can attend school and receive a primary education, and The Union advocates and supports good health programmes for adults and children, thus contributing to the right and ability of every child to attend school.

**Millennium Development Goal 4: Reduce child mortality**

Every year nearly 11 million children die before their fifth birthday, mainly from preventable illnesses. Two million of those die from pneumonia, over 90% of whom are from developing countries. It is the youngest, those under 1 year of age, in the poorest communities, who most often suffer and die from this condition. The Union’s Child Lung Health Division is dedicated to improving these children’s chances at life. Its model project in Malawi reduced the pneumonia fatality rate in children under 5 by an average of 40%, and plans are now underway to replicate this successful project in other countries.

**Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases**

It is extremely unfortunate that TB is not explicitly mentioned in this goal. However, the Stop TB Partnership, of which The Union is a member, has developed TB-specific language used in all relevant documents, such as the second Global Plan to Stop Tuberculosis. In addition, the Partnership is committed to meeting the target in the MDG relevant to TB ‘to have halted and begun to reverse the incidence [of TB] by 2015’. The general interpretation of this target is that the incidence rate of all forms of TB should be falling by 2015.

As this Activity Report shows, tuberculosis is The Union’s principal field of activity. Most of The Union’s resources over the next 10 years will be used to achieve these TB-specific targets. TB and HIV are closely linked in many high-burden countries, and The Union is now gaining experience in tackling both diseases using an Integrated Health Care approach through projects in Myanmar, DR Congo and Benin.

**Millennium Development Goal 8: Create a global partnership for development**

Through its membership network of individuals and organisations, The Union builds partnerships that help fulfill our mission to promote lung health in low- and middle-income countries through technical assistance, education and research. The Union is a founding member of The STOP TB Partnership and the International Non Governmental Coalition against Tobacco, both partnerships aiming to develop capacity in low- and middle-income countries. The Union’s capacity-building research, laboratory training and management courses bring new expertise and skills to low-income countries each year.

**Looking Ahead: Finances**

Despite the reduction of certain grants and the decline in the US dollar, the accounts for 2004 closed with a small positive balance. This was the result of rigorous budget control and efficient management of all Union departments. Closing the accounts with a positive balance will remain a challenge as The Union expands its activities and benefits from new funding opportunities. Earmarked funding has increased over the last few years, yet non-designated general funding — which is necessary to develop new projects and ideas — unfortunately decreased in 2004. This reduces our flexibility to undertake new innovative projects. It is therefore critical that we continue to receive support from donors and all constituent, organisational and individual members to increase the proportion of non-designated funds.

On behalf of The Union and those who benefit from our work around the world, I would like to thank our donors and members for the support they have given us in 2004. This support has been a great motivation for us all to do the best possible job to improve lung health globally.
Tuberculosis
Tuberculosis: a curable disease that kills two million people each year

Two billion people — one third of the world’s population — are infected with the bacterium that causes tuberculosis, and someone in the world is newly infected every second of every day. Left untreated, a person who develops active TB will infect an average of 10 to 15 other people every year. Effective drugs to treat and cure active tuberculosis have been available for more than 50 years, yet nearly two million people a year still die of the disease.

Eighty percent of the world’s tuberculosis cases are concentrated in 22 high-burden developing countries, yet no corner of the world is safe from TB. Mobile populations, the HIV/AIDS epidemic and an alarming increase of multidrug-resistant strains of tuberculosis prompted the World Health Organization (WHO) to declare TB a global emergency in 1993.

Halving TB prevalence and death rates by 2015 is among the United Nations Millennium Development Goals. Working in close collaboration with government agencies, national TB control programmes, the WHO, the STOP TB Partnership, and other national and international agencies, The Union assisted 64 countries to move towards this goal in 2004.
Tuberculosis Technical Assistance

The Union provides three types of technical assistance:

■ Intensive, in which the contracting agency requests long-term support
■ Contractual, which is limited to specific, usually short-term, tasks
■ Other related activities, such as project evaluation, site evaluation and research support.

In 2004, the Tuberculosis Division provided technical assistance to 38 countries:
16 in Africa, 11 in Asia, 2 in Europe, 7 in Latin America and 2 in the Middle East.

Featured Projects

FIDELIS launches projects in 11 developing countries

An innovative programme managed by The Union and funded by the Canadian International Development Agency (CIDA) has launched innovative projects to find and cure new smear-positive TB patients in 11 developing countries. Focusing on communities with little or no access to modern TB health care, projects are currently underway in 31 regions, ranging from urban slums in Kenya to remote rural provinces in China.

Known as FIDELIS – Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB – the programme improves access to TB diagnosis and treatment for hundreds of millions of people in poor and remote areas, where 5% of the undetected cases of tuberculosis are found. The goal is to detect at least 200,000 new cases of TB over the grant period.

To be eligible for FIDELIS funding a country must have a per capita GNI of less than US $1,000. In four rounds of funding, 99 applications were submitted, giving the programme an acceptance rate of approximately 33%.

The first three FIDELIS projects were funded in October 2003. By the end of 2004, a total of 25 projects had been launched: 10 in China, 3 in Pakistan, 2 each from Bangladesh, Kenya, Tanzania, and 1 each from Indonesia, Nigeria, Sri Lanka, Sudan, Tajikistan and Uganda.

‘We’re very pleased with the range of projects that have been approved and the efficiency with which we have been able to get them up and running,’ says Prof Donald A Enarson, The Union coordinator of FIDELIS. ‘The need is definitely there.’

Each project contract is for a 12-month period, with budgets ranging from US $150,000–$250,000. If a project is successful – able to achieve treatment success for less than $80 per case – it will become eligible to apply for further funding.

FIDELIS-funded projects include the introduction of DOTS services in army, police and prison health services in 16 northern states of Sudan, and mobilising 2.34 million primary and secondary school students in 24 counties in Anhui Province, China to detect possible tuberculosis cases in their family.

‘We believe that solutions to delivering TB treatment in poor and remote areas can best be found locally,’ says Prof Enarson. ‘What FIDELIS does is offer local groups needed funds, while The Union provides the technical and management support to help them implement their solutions.’

Case detection results are now available for the three projects launched in 2003. Of the 21,717 total new smear-positive cases detected to date, 16,577 (76%), were patients who had limited access to care and might otherwise not have been diagnosed. The estimated cost per treatment success averaged below the $80 goal of the FIDELIS initiative. Some of the projects have led to permanent policy and programme changes.

Following validation of their Phase I results by the Independent Results Assessment Group, successful projects may be eligible for funding to scale up activities in the final 6 months of the grant period. Three projects in China have received Phase II funding, and an additional seven to nine projects are expected to be funded.

Union consultant: Prof Donald A Enarson (Coordinator)
Funding Agency: CIDA
**FIDELIS in China: expanding TB diagnosis and treatment**

An individual with untreated active tuberculosis can spread the disease to 10 to 15 other people every year. As the country with the world’s largest population, China is a critical mass of potential TB infection. Working closely with China’s Centre for Disease Control and Prevention, FIDELIS has invested more than $1.25 million in local projects covering more than 85 million people in the provinces of Hunan, Hubei, Gansu, Hebei and Anhui. Additional projects are underway in Sichuan, Guizhou, Hubei and ShanXi.

**EXPANDING CASE FINDING IN GANSU PROVINCE**

Gansu is a remote province of hilly highlands and desert that stretches through western China. Nearly one-third of Gansu’s 26 million population live in poverty, and the province has the lowest GDP per capita of any in China.

In an effort to improve case detection in Gansu, a FIDELIS project was launched in 2003 to identify suspected TB cases and collect sputum at the village level. Under the project, villagers were made aware of the programme and suspected TB cases were referred to the local village doctor or township health centre for collection of a sputum sample. Slides were then transported to the county TB dispensary to be examined by technicians trained under the project. Poor patients who tested positive for tuberculosis were provided with money for transportation to the county TB dispensary where they received treatment.

The results in the first year of the programme far exceeded expectations, according to Dr Shiwen Jiang, one of the project’s coordinators. ‘We identified 8,212 new sputum smear-positive cases,’ says Dr Jiang. ‘This is almost double the figure of the previous year, before the project started.’ Perhaps most important, according to Dr Jiang, was the fact that, of the 8,212 new sputum smear-positive cases identified, 6,533 patients – more than 80% – had limited access to health care and would probably not otherwise have been diagnosed.

The success of the project is already having an impact on tuberculosis control in China. The approach has been adopted as policy by China’s National Tuberculosis Programme, and microscopy sites are being established in many townships in rural areas in China.

**STRENGTHENING THE REFERRAL SYSTEM IN HUNAN PROVINCE**

The 2000 National Tuberculosis Prevalence Survey in China’s southern Hunan Province found that 93% of suspected TB cases were going to county general hospitals for diagnosis, but only 30–50% of those were being referred to county TB dispensaries for treatment under the DOTS strategy.

To strengthen the referral of TB cases to TB dispensaries, a pilot FIDELIS project was conducted in 38 of Hunan’s 122 counties.

As a first step, the Hunan Health Bureau issued a directive that all TB patients must be referred from county hospitals to county TB dispensaries. Training workshops were held in each county, and a doctor in each hospital was designated to be responsible for finding and reporting TB suspects, and referring them to the appropriate dispensary. Each dispensary disseminated information throughout the county about its services. Staff of the county TB dispensary were charged with the follow-up of all patients who had been referred but had not turned up.

A system of incentives was implemented in which the referring doctor received a payment, while hospitals that did not implement the referral system risked a fine and reduced funding.

Between October 2003 and August 2004, a total of 47,847 suspected TB cases were screened, of which 11,179 were smear-positive. Of these, 88% were new cases with limited access to health care who might not have been diagnosed otherwise.

‘More than 4,000 new smear-positive cases were referred from the county hospitals during the project period,’ says Shiming...
Cheng, a project coordinator. ‘This compares with just over 500 referrals the year before. Equally important is the fact that 95% of the patients referred to the TB dispensary actually arrived there. And all of this was done at a cost that was about one third less than our target.’

SOCIAL MOBILISATION IN HEBEI PROVINCE
Hebei Province lies in northern China, extending into the Inner Mongolian Plateau. Most of Hebei’s 66 million people live in rural areas, 27% of them in poverty. According to a government survey, approximately 370,000 people in Hebei have active pulmonary TB, with an estimated incidence rate of 44 per 100,000 population.

A primary obstacle to diagnosis and treatment of tuberculosis in Hebei is a lack of knowledge among the people about TB. To address this, a FIDELIS project was begun in January 2004 in 45 counties to raise public awareness and increase the number of cases seeking treatment at TB dispensaries. Project organisers used a number of different strategies:

■ Health promotion leaflets and materials were developed and distributed in each project county, and TV and radio spots about TB were placed in the local media.
■ Wall slogans about TB and its treatment were painted on village walls, including the address and telephone number of the nearest TB dispensary.
■ Village leaders advocated TB control in their villages.
■ Students were recruited to inform their families and neighbours about TB.
■ TB information was incorporated into local drama performances and rural folk dances, and a major health promotion campaign was undertaken for World TB Day.

In the first 9 months of the programme, 6,648 new smear-positive cases were detected, and the case notification rate reached 44/100,000, a significant increase over the rate of 19/100,000 in 2002. Nearly 80% of the new smear-positive cases detected were among people with limited access to health care who might not have been treated otherwise.

What were the most effective public awareness strategies?
According to Guangxue He, a project coordinator, wall slogans seemed to reach the most people.

‘We asked 5,799 patients how they had acquired their information,’ he says, ‘and 43% said that they had learned about TB from wall slogans, 21% said they saw it on TV and 17% saw government notices. This will help us prioritise our health promotion activities next time.’

STRENGTHENING RELATIONSHIPS IN HUBEI PROVINCE
Hubei is a mountainous province in south-central China where one third of the 60 million people live below the poverty line. Although DOTS has been in place there for 10 years, the number of TB cases remained high in 2000.

County TB dispensaries are responsible for TB treatment and case management in Hubei, but many patients default between the time of their diagnosis at a general hospital and treatment. Among cases diagnosed in some county general hospitals, only 22% made it to the county TB dispensary to which they were referred. In addition, most general hospitals in Hubei had no designated staff responsible for TB control and lacked the capacity to conduct sputum examinations of suspected cases.

The FIDELIS project in Hubei was designed to provide a new approach to the collaboration between county hospitals and TB dispensaries. Sputum-microscopy units were set up in 40 county general hospitals, operating under a new laboratory quality assurance system, and 170 medical and paramedical staff and 80 laboratory technicians were trained.

A TB clinic was established in each general hospital, and referrals of suspected or diagnosed cases to county TB dispensaries were increased.

In the first year of the project, the number of general hospitals doing sputum examinations increased from none to 28. Thirty hospitals had established TB clinics, compared with two the year before; and 35 had a designated staff member for TB.

Between September 2003 and June 2004, 10,037 suspected TB cases were seen at the country general hospitals. Of these, 3,892 received a sputum examination. Two thirds of the new patients had limited access to health care and probably would not have been diagnosed otherwise.

‘Local situations should dictate the approach,’ says Hongyan Yao, one of the project coordinators. ‘But we have learned that, in all cases, establishing a TB clinic within a general hospital and appointing staff who are responsible for TB greatly strengthens the referral mechanism.’

Union consultants: Prof Donald A Enarson (Coordinator), Dr Chen-Yuan Chiang
Local partner: Prof Li-xing Zhang
Funding Agency: CIDA
Improving smear microscopy in low-income countries

Laboratories that can provide accurate diagnosis based on sputum-smear microscopy are a principal component of a successful tuberculosis control programme. To attain a high level of performance, these laboratories need not only to be properly equipped and staffed by well-trained technicians, but also provided with clear standards for judging their work.

A new Union activity, funded through a 5-year Cooperative Agreement from the United States Agency for International Development (USAID), will establish a network of expert laboratories to support and monitor the work of national tuberculosis programmes (NTPs) in low-income countries and help them achieve and maintain external quality assessment (EQA) standards.

The Union recognised the need for such standards as a result of conducting training programmes and in-country technical assistance. Techniques and standards of practice, the consultants learned, varied widely from country to country, lab to lab and technician to technician.

Initial efforts to establish EQA through training sessions alone, however, proved to be ineffective in producing long-term change. ‘Implementing an EQA programme is a new idea in TB control,’ says Dr Armand Van Deun, Senior Microbiologist in charge of the project. ‘We now know that expert support is required to sustain the standards, and that’s what this new laboratory network will provide.’

LABORATORY NETWORK SUPPORTS EQA AND CAPACITY BUILDING

The first laboratory was established in January 2004 at the Mycobacteriology Unit of the Institute of Tropical Medicine in Antwerp, Belgium, where Dr Van Deun is based. Other staff include a second bacteriologist, Dr Gabriela Torrea, responsible for francophone Africa and Latin America; Mourad Gumusboga, a multilingual laboratory technologist who consults on missions and courses in Africa; and administrative staff. Dr Sang Jae Kim from The Union’s Clinical Trials Division is also assisting with this project, coordinating work in the Pacific, Far East and South-East Asia regions.

Initially support visits to field labs and research will be managed through Antwerp, but over time, these activities will shift to regional laboratories that will support neighbouring countries and also serve as centres for operational research activities.
FIRST REGIONAL LABORATORIES ESTABLISHED

The first regional laboratory services were established in Bangkok, Thailand, in April 2004. Union support has enabled the National TB Reference Laboratory of the Thai NTP to take on the role of a regional lab, expanding its services to become a consultant to and resource for other countries. This arrangement will provide services to Bangladesh, Indonesia, Nepal, Pakistan and other countries as needed.

The second regional lab is located in Cotonou, Benin and will serve francophone Africa. Contracts for that facility were finalised in July 2004, with regional activities scheduled to begin in early 2005. The location of a third lab, serving anglophone Africa, has not yet been determined.

In addition, The Union has created a special agreement with India’s Revised National Tuberculosis Control Programme and the Tuberculosis Research Centre (TRC) in Chennai, Tamil Nadu, designed to improve microscopy services throughout India. In the first phase, Dr Selvakumar, Senior Microbiologist at the TRC, will monitor the implementation of EQA in six states. While his joint monitoring visits with Union consultants will prepare Dr Selvakumar to become a regional consultant, he will initially only provide services within India, due to the magnitude of the work to be performed there.

SERVICES FROM ASSESSMENT AND TRAINING TO MONITORING

Countries in need of assistance will be identified through a variety of contacts, such as technical assistance projects, courses, training programmes and qualifying reviews for participation in clinical trials. At the request of an NTP, consultants from the regional lab will review the country’s AFB-microscopy network and quality-assessment system, and make suggestions for improving it. The regional lab can also assist with individual training and will monitor progress, help with interpretation and suggest corrective measures, as needed. The regional labs may also assist countries by manufacturing sets of slides with known bacillary content for panel testing. Supervision visits began soon after the project was launched, and 17 countries took part in 2004.

‘In the past, NTPs have never been pushed to give due attention to improving their microscopy,’ says Dr Van Deun. ‘Now we’re making them rethink the methods and techniques they have traditionally used. Overall the countries we’ve talked to have shown great interest in the development of EQA.’

Overall the countries we’ve talked to have shown great interest in the development of EQA for microscopy”
Dr Armand Van Deun

OPERATIONAL RESEARCH PROJECTS FOSTERED BY THE LABORATORY STRENGTHENING PROJECT

- **Solubility and shelf life of basic carbol-fuchsin**
  - Participating labs: Antwerp, Belgium and Bangladesh
  - Status: ongoing

- **Yield of fluorescence microscopy versus culture in middle-income countries**
  - Participating lab: Lima, Peru
  - Status: ongoing

- **Identification of quality indicators extractable from lab registers**
  - Participating lab: Kinshasa, DR Congo
  - Status: ongoing

- **Correlation between yield of bleach method and baseline direct AFB-microscopy quality**
  - Participating lab: Bangladesh
  - Status: in preparation

- **Yield of bleach method in HIV-positive versus negative**
  - Participating lab: Pasteur Yaounde, Cameroon
  - Status: in preparation

- **Yield and primary default using two morning sputa versus classical spot-morning-spot collection strategy**
  - Participating lab: West Cameroon
  - Status: in preparation

- **Incremental yield and reliability of fluorescence microscopy in routine clinics and evaluation of cheap commercial fluorescence systems (FluoreslenS)**
  - Participating lab: Nairobi, Kenya
  - Status: in preparation

LABORATORIES ALSO PARTICIPATE IN OPERATIONAL RESEARCH

In addition to supporting high standards of practice, the regional labs are expected to foster research that may help improve both TB diagnosis and control. Research projects underway or in the planning stage range from a study of the solubility and shelf life of carbol-fuchsin to identification of quality indicators extractable from lab registers.

The new network established through the lab-strengthening project interfaces with other resources, such as the Supranational Reference Laboratory (SRL) Network of the WHO/Union Drug Resistance Surveillance Project, training programmes provided through the Tuberculosis Coalition for Technical Assistance (TBCTA) and The Union’s Clinical Trials Division.

Union consultants: Drs Armand Van Deun, Sang Jae Kim

Funding agency: USAID
Latin American TB Nurses and Allied Professionals gain strength and visibility

In less than 2 years, The Union’s Nursing Division and the Nurses and Allied Professionals (NAPS) Scientific Section have created a network, which is starting to bring together the diverse group that makes up 85% of the people involved in tuberculosis care and control. Where once they worked in isolation, TB frontline care providers from Uganda to Peru have begun to connect through conferences and meetings, and to plan presentations, brainstorm research ideas and discuss best practices for TB care.

While the network now has representatives in The Union’s Africa, Eastern and Europe regions, the Latin America network has grown the most quickly. Coordinated by Edith Alarcón, a Union consultant with expertise in both TB and nursing, the Latin America and Caribbean network now has members in more than 10 countries.

The network in Mexico is particularly strong, with more than 7,000 nurses currently active. Members are making an impact on their TB programmes that has improved not only technical skills, but also the human side of patient care. They are a committed group of people who are working with their institutions and the community, stressing the importance of innovative strategies and methods, along with personal growth and continuing education.

The NAPS network in Brazil has delved into research, conducting a survey of the curricula on tuberculosis in Brazilian nursing schools, which they presented at the 35th World Conference on Lung Health.

Members of the Latin America network also contributed to a nurses’ guide for the implementation and expansion of the DOTS strategy, which was published in Spanish in 2004.

Alarcón says, ‘Latin American and Caribbean nurses have developed a strong network because they are motivated; now they feel important and taken into account. The support of the NTP managers in their countries has also been critical to the success of their projects.’

Members of the Latin American network held their third meeting in Honduras in 2004. Several members also attended the North America Region Conference in Texas and the World Conference in Paris. Their goals are to consolidate the networks in each country and to involve health professionals at each level. Alarcón also hopes to see members conduct operational research in TB nursing care that will improve the experience of TB patients. Expansion of the network to include the Asia and Middle East regions is in the planning stages.

Union consultants: Gini Williams, MSc BNurs RGN HV, Edith Alarcón, RN
Funding agency: TBCTA
Uganda expands its community-based DOTS strategy

The Union continues its collaboration with Uganda’s National Tuberculosis and Leprosy Programme (NTLP), and in August 2004, Union consultants visited the country to meet with officials of the Ministry of Health, district officials and health facility staff.

The main focus of Uganda’s NTLP continues to be the expansion of its model of community-based DOTS strategy implementation. Under this model, when a person is hospitalised with tuberculosis, a local health worker visits the patient’s community to educate and sensitise the community and family members about the disease, and to help the community choose a treatment supporter for the patient. This community volunteer becomes responsible for the patient’s directly observed treatment and coordinating with the health worker responsible for reporting outcomes to the district health services.

Implementation of this community-based DOTS strategy has now been extended to 46 of the 56 districts in the country, an increase from 34 in September 2003.

Union consultants found significant improvement over the past year in human resources within Uganda’s NTLP and increased district commitment to improving tuberculosis performance indicators. Nevertheless, the NTLP is still significantly understaffed for the task at hand.

Union consultants also reported that approximately 15% of new pulmonary TB cases were beginning treatment without a sputum examination, and 53% of the new smear-positive cases who completed treatment did not have confirmation of cure by sputum examination. They recommended that NTLP staff at all levels promote a policy of diagnosis by sputum-smear microscopy to ensure that healthcare facilities use this technique to identify and confirm cure of infectious cases.

In addition, the consultants found a lack of routine HIV counselling and testing capacity, and no approved policy or technical guidelines to enable the NTLP and the National AIDS Control Programme to perform joint HIV/AIDS and TB activities. They recommended that the Director General of Health Services work with the Commissioner of National Disease Control to appoint a national TB and HIV coordinating committee to help develop national policies and technical guidelines to promote joint activities. The recent appointment of a medical officer as the TB/HIV point person should help move these activities forward.

The consultants also recommended that the NTLP develop an updated multi-year strategic plan and detailed operational plans to better allocate human and material resources to achieve internationally recognised case finding and treatment outcome targets.

In December 2004, the Uganda Stop TB Partnership was launched, bringing the NTLP together with local and international NGOs; private and faith-based groups, which provide a significant proportion of care for persons with TB; donor and technical communities; and HIV/AIDS organisations. The stage has now been set for a comprehensive approach to tuberculosis in Uganda.

Union consultant: Dr Paula I Fujiwara
Local partner: Uganda NTLP
Funding agency: CIDA and the French Ministry of Foreign Affairs
Continuing progress in the Republic of Senegal

The Union has supported Senegal’s anti-tuberculosis efforts since 1984. Much of this support has been in partnership with the Norwegian Association of Heart and Lung Patients (LHL), which has provided financial aid since 1986. In 2003, Senegal also signed a contract for technical assistance with USAID.

In September 2004, an LHL consultant and a Union technical consultant visited Senegal to assess progress since the last visit in 2003. The consultants visited several health centres in Dakar, assessed the management of anti-tuberculosis drugs by the central unit, and followed up on the management of LHL- and USAID-funded projects.

The review team found many positive developments since its last visit.

More health centres are now using directly observed treatment, and there has been an increase in the number of regional and district head doctors who are actively involved in the NTP. The treatment success rate for new smear-positive cases has improved slightly to 69%.

Senegal’s established leprosy programme is now active in staff training and supervision of NTP activities, and the training guide for treatment unit staff, developed in 2003, is now in widespread use.

Among the problems the team found were that nurses in charge of treatment and supervisors at all levels lacked sufficient training for their jobs; not all regional and district head doctors were actively involved in the NTP; data were not regularly analysed in most districts; and the data of quarterly reports were not always reliable.

The team recommended that the Minister of Health and Disease Prevention organise better management of medication at the regional and district levels, and help strengthen the commitment of regional and district head doctors.

The government should also provide financial support to the NTP for purchasing laboratory products and fund two more doctors at the NTP’s central unit.

The team also recommended the development of an action plan for collaboration between the NTP and the National AIDS Programme.

Union consultant: Prof Nadia Aït-Khaled
Local partner: National Tuberculosis Programme
Funding agencies: USAID-Dakar office via TBCTA, Norwegian Association of Heart and Lung Patients (LHL) and The Union

Benin NTP shows good results

Benin is one of the countries where the DOTS strategy was first tested, and it is often used as an example of good implementation. The Union has been supporting Benin’s NTP since the beginning of the 1980s.

Benin’s TB programme is well integrated into the country’s health structure, and each health zone contains a TB detection and treatment centre with laboratory, case recording and registration facilities. The microscopy network is well managed, and drug supplies are constant. Patients taking medication are strictly supervised during the initial phase of treatment, and the rate of multidrug-resistant TB has been low.

Programme supervision is regular and of high quality, explaining, to a certain extent, Benin’s good results. According to the WHO Global TB Control Report 2004, Benin now detects 98% of new smear-positive cases, and treatment success rates reached 80% in 2003, close to the WHO target of 85%.

Since 2003, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been financing many of the Benin NTP activities, including laboratory equipment, vehicles, motorbikes and new staff. The Global Drug Facility (GDF) has agreed to supply all medications, beginning in 2005 and continuing for the next 2 years.

Decentralisation of patient care is continuing, and a home tracing system for irregular patients has been introduced in several places. The sputum of retreated patients is being systematically cultured to survey drug resistance. To date, 10% have tested positive for multidrug-resistant strains.

The Union is collaborating with Benin on a TB-HIV pilot project that will enable screening of new TB patients for HIV and offer those who are HIV-positive simultaneous treatment with antiretroviral drugs.

Union consultants: Dr Arnaud Trébucq
Local partner: Benin National Tuberculosis Programme
Funding agency: Swiss Pulmonary League, French Ministry of Foreign Affairs
Training new consultants to provide technical assistance

A lack of trained consultants to provide leadership and expertise to national tuberculosis programmes contributes to the problem of tuberculosis control in many high TB burden countries. Responding to a need expressed by ministries of health and other health providers, The Union has developed a consultant training programme in which participants work closely with Union senior consultants, who serve as their mentors.

Funded by a grant from the USAID, a pilot phase of this Junior Consultant Programme began with three participants in 2004. At the end of the 18-month programme, the junior consultants should be able to provide quality technical support to high-incidence countries and be capable of conducting training, undertaking technically relevant operational research and acting as preceptors to others wishing to become consultants.

‘There is a great need for more experienced TB consultants,’ says Dr Paula I Fujiwara, Senior Technical Advisor to The Union. ‘However, you cannot create a pool of qualified consultants by just sending them to a few training courses based on a general training plan. Junior consultants need the guidance and mentoring of experienced consultants and hands-on experience in the field to acquire the knowledge, skills and attitudes necessary to become competent consultants.

‘We believe that trained people from high TB burden countries will have on-the-ground experience relevant to other countries in similar situations and may be more useful than consultants from low TB burden countries where the focus is different.’

The individualised training programme of each junior consultant is designed to fill gaps in their knowledge, experience, competencies and understanding of the role of a consultant. During the 18-month training period, participants:

■ Attend one of The Union’s 3-week international tuberculosis control courses. They are also expected to teach in one of the courses during the latter half of training.

■ Work with an experienced consultant on multiple field trips to a country where The Union, or a similar organisation, provides intensive technical assistance. The junior consultants help draft and ultimately take full responsibility for field reports.

■ Conduct operational research on an issue relevant to their own country or one where The Union provides intensive technical assistance.

■ Interact with peers and colleagues at international and regional conferences and meetings, and during visits to The Union Secretariat in Paris.

“This is a wonderful opportunity to work with some of the world’s best TB epidemiologists and assist TB programmes. I hope to contribute to a significant drop in the burden of HIV and TB before my retirement.”

Dr Jean-Louis Abena Foe,
Junior Consultant from Cameroon

“I have been armed with so much tuberculosis information from my mentor that I feel comfortable advising from an informed point of view on a wide range of tuberculosis issues.”

Dr Panganai Dhliwayo,
Junior Consultant from Zimbabwe
Candidates for the Junior Consultant Programme are expected to be a citizen or permanent resident of a country with a high or intermediate burden of tuberculosis; hold a medical or graduate public health degree; have verbal and written proficiency in English and either French, Spanish, Mandarin Chinese or Russian; and have 2 years of experience in clinical and programmatic issues related to TB control in high- or intermediate-burden countries.

While Union officials believe that the Junior Consultant Programme can have a major impact on tuberculosis programmes in high-burden countries, future funding will determine its sustainability.

‘At this point we only have enough funds to train three consultants,’ says Dr Fujiwara. ‘If no other funds are forthcoming, and we only train these three, we will have obviously made a contribution, but it is a tiny fraction of what is needed. If we can bring this method of training to more people – combining technical assistance, training and operational research in a way that is tailored to the specific needs of the individual and situation – it could have a positive impact on tuberculosis control.’

Union consultants: Drs Paula I Fujiwara, Arnaud Trébuq, Hans Rieder

Funding agency: USAID

TB nursing workshops build skills and much more

A series of workshops for nurses and allied professionals (NAPS) offered by The Union at its regional and international conferences is having far-reaching effects on these frontline patient care providers. For many, the workshops are the first opportunity they have ever had to share their experiences with colleagues from different healthcare settings and different countries.

Until 4 years ago, there were few programmes specifically designed for NAPS at Union conferences, and few people from low-income countries could afford to attend.

Members of the NAPS Scientific Section worked with The Union to apply for a grant from the TBCTA and received sufficient funds not only to launch the workshops, but also to provide a number of scholarships for those who needed them.

Since then, there have been workshops on nursing at Union conferences in the Africa, Eastern, Europe and Latin America regions, with up to 10 NAPS funded to participate in each. Representatives elected by the regions have also received support to attend the World Conference on Lung Health for the past 3 years.

The initial workshops provided a review of the DOTS strategy and the frontline care providers’ role, followed by discussion of their personal experience in implementing DOTS. The participants also talked about training issues, their ideas and hopes for research projects, their priorities and their plans. Subsequent workshops have been planned and organised by the nurses and allied professionals themselves, according to their identified priorities.

As a result of the connections made through the workshops, nurses and allied professionals have contributed to manuals on best practices in TB nursing and ways for them to contribute to DOTS expansion; conducted research projects and presented their results at conferences; and supported each other through networking.

Gini Williams, head of The Union’s Nursing Division, hopes to see the role of NAPS continue to expand, especially in areas such as operational research and policymaking, so that their knowledge and experience can become fully integrated into tuberculosis prevention, treatment and control.

‘The workshops were the beginning,’ she says. ‘But the workshops are about so much more than education.’

“This programme has been a unique opportunity. The Union has a reputation for training, and this has allowed me to assess my existing skills and build on them to become competent as an international tuberculosis consultant.”

Dr Nevin Wilson, Junior Consultant from India
Workshop studies the challenge of TB in large cities

Tuberculosis control in large cities requires special attention as the incidence of the disease is higher in urban areas, and many different stakeholders are involved in treatment and control services. In May 2004, The Union sponsored a workshop in Bangkok, Thailand to assess the status of urban TB control. The discussion was based on sample cities in the countries represented by workshop participants: Bangladesh, Cambodia, Egypt, Indonesia, Nepal, Pakistan, the Philippines, Thailand and Vietnam.

Participants developed a variety of recommendations for improving administrative, diagnostic and treatment services in large cities:

**ESTABLISH A TB CONTROL COMMITTEE**
In cities with a population of five million or more, appoint a TB control management committee including, at minimum, a doctor, a nurse and a laboratory specialist. Define the committee’s terms of reference precisely to obtain the widest support from politicians and other stakeholders. Their mandate will be to develop TB control guidelines for their city, based on those established by their NTP, and to participate in developing a multi-year strategic plan for TB control in the city as part of the national plan.

**DEVELOP A COMPREHENSIVE BUDGET AND FUNDING PLAN**
Develop a comprehensive budget for the programme, including costs for personnel, human resource development, supervision, transport, drugs and supplies, and other necessities. Request government funds specifically designated for improving TB control in cities. Incorporate the special needs of cities into applications to the Global Fund to Fight AIDS, TB and Malaria (GFATM) and other donors.

**INVENTORY AVAILABLE RESOURCES**
Obtain a full picture of available TB control resources by inventorying all of the TB diagnostic and treatment centres in the city. Make this information available to all those involved in TB control and health care, and to TB patients who may be seeking a convenient facility for their treatment.

**MAKE SERVICES WIDELY ACCESSIBLE**
Provide TB diagnosis and treatment services free of charge. Give attention to providing TB services near patients’ homes; if this is not possible, make transportation to treatment centres affordable to the poorest patients. Work to convince local authorities to introduce TB services based on NTP guidelines in the facilities under their jurisdiction.

**BUILD BROAD AWARENESS AND COMMITMENT**
Integrate social and administrative mobilisation into the strategic plan. While administrative mobilisation seeks to convince directors, administrators, health policy specialists and other professionals to participate in TB control activities, social mobilisation activities aim to inform the general public about TB services available in the city and the need to visit a diagnostic centre when they observe the signs and symptoms of TB.

**INVOLVE BOTH PUBLIC AND PRIVATE HEALTH CARE**
Enlist in the TB control effort all public-sector institutions that can potentially contribute additional TB patients, and encourage them to record and report their data according to NTP guidelines. Emphasise public institutions, such as hospitals; medical colleges; social security; and the military, railway, police and prison systems; but also encourage NGOs and other community-based organisations, such as churches and schools, to assist in implementing the DOTS strategy.

Work to persuade private hospitals and clinics of the importance of participating in TB control following NTP guidelines. Approach them about how they might improve TB control by finding and diagnosing TB patients. Develop collaborations that are adapted to the local situation, but be sure they follow NTP guidelines and monitor them closely.

**STRENGTHEN HUMAN RESOURCES**
Sufficient skilled personnel are essential to the success of the TB control programme. Plan and budget carefully to ensure that the TB control committee has the resources to implement its strategic plan. Make human resource development a priority, and offer regular training to build the skills of both new and experienced personnel. Collaborate with local professional societies and encourage them to put TB control on their meeting agendas, so that they are fully informed and up to date.

Union consultants: Drs Chen-Yuan Chiang, Arnaud Trébucq, Nils E Billo
Funding agency: USAID, French Ministry for Foreign Affairs

18 Tuberculosis / Tuberculosis Education
The Union launches international randomised clinical trial

The Union’s Clinical Trials Division launched a major international clinical trial in early 2004 entitled ‘Study C’. This randomised trial will compare outcomes among patients treated with a four-drug fixed-dose combination vs. individual medications. The study regimen will consist of an initial intensive phase of 2 months of daily ethambutol, isoniazid, rifampicin and pyrazinamide, in a fixed-dose combined tablet, followed by 4 months of rifampicin and isoniazid in a fixed-dose combined tablet three times a week. The control regimen will consist of the same drugs, but they will be given in separate formulations in the initial intensive phase.

‘This trial is essential for studying the efficacy of using a regimen of fixed-dose combination medications throughout the treatment course,’ says Prof Donald A Enarson, Director of The Union’s Department of Scientific Activities. ‘If efficacy can be demonstrated, this simplified treatment regimen could become the recommended standard of practice.’

The study began enrolling patients in 2004 and will eventually involve approximately 2,000 patients at 10 sites in Africa, Asia and Latin America.

Global partnership works to stop TB

Partnerships create strength, and The Union collaborates with a wide variety of partners, including foundations and other donors, universities, government agencies and NGOs.

The Stop TB Partnership is a global partnership with 400 members designed to accelerate social and political action to stop the spread of tuberculosis around the world. The Union was a founding member in 1998, and the Executive Director serves on the Stop TB Coordinating Board.

The Stop TB mission is to 1) increase access, security and support to ensure that every TB patient has access to treatment and cure, 2) stop transmission of the disease, 3) protect vulnerable populations, and 4) reduce TB’s social and economic toll on families, communities and nations.

To achieve this mission, the Partnership has set the following strategies and priorities:

- Accelerate DOTS expansion by increasing access to accurate diagnosis, effective treatment, and affordable quality TB drugs
- Adapt existing strategies to address the challenges posed by emerging threats, such as MDR-TB and HIV-related TB
- Promote research to develop new and improved diagnostic tests, drugs and vaccines, and promote adoption of these new and improved tools by ensuring access and affordability
- Develop advocacy and resource mobilisation strategies in support of these priorities.

The Union actively contributes to the Partnership through its technical assistance, education, research and advocacy programmes. Union staff serve on the DOTS Expansion Working Group, the DOTS Plus Working Group, the Green Light Committee, the TB-HIV Working and Core Groups, as well as participating in other activities.

Among the Partnership’s major achievements are the establishment of the Global Drug Facility, which has already provided nearly two million patients with treatment at no cost; and the Green Light Committee which has significantly improved MDR-TB treatment.
Tuberculosis and HIV

Each year, nearly three million people die from HIV and two million by tuberculosis, despite the fact that HIV infection can be managed with antiretroviral (ARV) medications, and tuberculosis is curable. Almost one third of HIV-infected individuals are also infected with Mycobacterium tuberculosis. Because HIV infection progressively impairs cell-mediated immunity, people infected with both HIV and TB are 30 times more likely to develop active tuberculosis. HIV is the main reason that many high-burden countries, especially those in sub-Saharan Africa, have been unable to meet international tuberculosis control targets.

TB and HIV: The Union’s coordinated approach to a co-epidemic

Tuberculosis is the leading cause of death among HIV-positive individuals and accounts for 30–40% of AIDS deaths in Africa and Asia. The rapidly increasing HIV epidemic in Eastern European countries and Asia could also increase the number of HIV-related TB cases.

Fortunately, TB treatment is just as effective for people infected with HIV as it is for those who are not, and antiretroviral treatment (ART) reduces the risk of active TB developing in HIV-positive individuals infected with Mycobacterium tuberculosis. Thus, TB treatment is a key part of HIV/AIDS care, and prevention of HIV is crucial to the control of TB. It is essential to find new approaches that tackle both of these diseases in a coordinated way.

To address this issue, The Union has established an HIV Department and is in the process of launching several coordinated TB-HIV control activities under grants from USAID, the European Commission and TOTAL and its partners Unocal, PTTEP and MOGE in the Yadana project.

Programme implementation has started in Benin, the Democratic Republic of Congo and Myanmar, and other countries are being assessed for possible inclusion in the project.

The key criteria for qualification are that countries have a well-functioning national tuberculosis programme with good DOTS coverage and a relatively high rate of HIV infection; national tuberculosis and AIDS control programmes that are able to collaborate with each other. The key criteria for qualification are that countries have a well-functioning national tuberculosis programme with good DOTS coverage and a relatively high rate of HIV infection, and national tuberculosis and AIDS control programmes that are able to collaborate with each other.

Under the programme, patients who come into a national tuberculosis control programme for evaluation or treatment will also be offered HIV testing and counseling, and if found to be positive, they will be offered integrated HIV care, including ART.

“We will offer testing to patients for HIV during their TB treatment, and if they are HIV positive, we will link them to HIV care and treatment with ARV drugs,” says Dr Paula I Fujiwara, Senior Technical Advisor to The Union.

“The idea is to make the existing TB programme an entry point for HIV care.”

Dr Paula I Fujiwara, Senior Technical Advisor to The Union
The programme will use a country’s existing healthcare system, rather than specialised HIV clinics or the tuberculosis control programme itself, for HIV care and administration of ARV drugs.

‘We are not creating a new programme,’ says Dr Fujiwara. ‘We want to make use of the facilities and experience that already exist and reinforce them. Although small pilot projects with intensified support show that treatment of HIV is possible in low-income, high-burden settings, the use of the general health services will be needed to cover an entire country. The key is to put in place the same systems of registration and monitoring that have made the DOTS strategy so successful worldwide in tuberculosis control.’

‘The DOTS strategy is also applicable to HIV,’ says Dr Fujiwara, ‘except that it is a lifelong treatment, not just 6 to 8 months.’

‘We will have to train staff in the general health services to handle this,’ she says. ‘We will start in one place, and then use those members of staff as trainers. It is an ever-widening circle. Eventually every country with an HIV programme would have laboratory services capable of accurate and rapid diagnosis, an adequate supply of quality drugs, and a standardised registering and reporting system.’

Treating TB–HIV in Myanmar

Myanmar is one of the poorest and most isolated countries in the world, yet it has a very successful NTP and is one of the only high-burden countries that is on schedule to reach the WHO goal of detecting 70% of smear-positive TB cases and curing 85% of those by 2005.

Among the reasons for this success are the strong administrative structure of Myanmar’s healthcare system and the government’s strong commitment to the TB programme, with infrastructure and staff costs borne entirely by the national budget. The Union has provided technical support to the country’s NTP for a number of years. Tuberculosis control is managed at the township level, and TB treatment is supervised by trained volunteers at rural health centres and in patients’ homes. According to a recent programme review, TB staff are meticulous in their adherence to the principles of the DOTS strategy. The country’s drug and diagnostic supply management, case finding, treatment, recording and reporting, and evaluation of programme performance were found to be of the highest quality.

HIV/AIDS is a national priority in Myanmar and one of three priority communicable diseases identified by the Ministry of Health. This, combined with its record of excellence in treating tuberculosis, made Myanmar an ideal site for The Union’s first pilot project to implement HIV care for dually infected tuberculosis patients.

In May 2004, Union staff, with Dr Odile Picard of Saint Antoine Hospital in Paris, travelled to Myanmar to establish a framework for the pilot project. Dr Picard has provided training on HIV care to Myanmar physicians for more than 10 years. The contract for the project has been signed with government officials in Myanmar, and training of clinical staff has commenced. Dr Picard will remain in Myanmar for several months to oversee the initiation of the programme, starting in January 2005.

The TB-HIV project has received strong support from Myanmar’s National Tuberculosis and AIDS Control Programmes, the WHO in Myanmar and Yadana project, operated by TOTAL, which will support the purchase of ARV drugs and medicines for treatment and prevention of opportunistic infections.

‘Myanmar will give us valuable experience in treating patients who are infected with both TB and HIV, and in managing a coordinated TB-HIV programme,’ said Union Executive Director Dr Nils E Billo. ‘We can then use that experience in other countries that have expressed an interest in this project.’

Union consultants: Drs Philippe Clevenbergh and Nevin Wilson
Local partner: Myanmar National TB and AIDS Programmes
Funding agency: Yadana project, operated by TOTAL
Child Lung Health
Each year more than two million children die before the age of five from lung diseases. Most of these deaths are due to severe and very severe pneumonia, which is five times more common in developing countries than in industrialised countries, with a death rate 10 to 50 times higher.

Yet pneumonia is curable with cheap and effective antibiotics, and its incidence in children could be reduced by 10–20% through immunisation with available vaccines. For countries with limited resources, however, these drugs are prohibitively expensive, and many developing countries are unable to provide immunisation services due to both funding and distribution problems. A further difficulty is that, although proven strategies and regimens for treating pneumonia are in place, they are not effectively implemented by the few health services available.

The Union’s Child Lung Health Division was created in 1996 to improve healthcare services for children with pneumonia and other acute respiratory infections, tuberculosis, HIV-related lung disease and asthma through technical assistance, education and research. The division’s Child Lung Health Project in Malawi, which was launched in 2000, has become a model for health service delivery in low-income countries that has dramatically improved treatment for childhood pneumonia. The division also conducts international training courses, develops technical guides and conducts operational research related to child lung health.
Malawi Child Lung Health Project’s success leads to expansion

The Union’s highly regarded Malawi Child Lung Health Project (CLHP) continued in 22 districts and three regional hospitals across the country in 2004. In addition, Malawi’s Ministry of Health and Population (MOHP) requested that nongovernmental hospitals become incorporated into the project and designated the CLHP as part of its Essential Health Package.

Before the CLHP, pneumonia was the second leading cause of death for children under the age of 5 in Malawi, with an estimated case fatality rate of 20–25%. During the first 3 years of the project (September 2000–December 2003), 24,743 hospitalised children were treated for pneumonia, with a recorded case fatality rate of 10.3%.

To achieve these favorable results, the project introduced standard case management, provided ongoing training and active supervision for healthcare workers, directed limited resources to the children at most risk, ensured an adequate supply and rational use of antibiotics, and carefully documented practices and procedures to improve quality of service.

Expansion into hospitals run by the Christian Health Association of Malawi (CHAM) would eventually bring the CLHP’s approach to the 37% of the population treated at those facilities. The MOHP already funds the healthcare staff at CHAM hospitals, and new service agreements will eliminate the service fee they formerly charged for children to receive health care. A pilot project will be conducted in two hospitals in 2005 to establish the feasibility of including all CHAM hospitals in the CLHP.

Inclusion in the Essential Health Package is an important indicator of the government’s regard for the CLHP’s success. Government commitment is further demonstrated by the fact that the project has been incorporated into the national planning sector-wide approach (SWAP). However, since funding for health services in Malawi depends substantially on donor grants, securing funds for the CLHP will remain a significant challenge. Although the MOHP is the second largest recipient of funds in the government’s 2004–2005 budget, donor assistance will be required if all of the programmes included in the Essential Health Package are to receive adequate funding from the regular budget under the sector-wide approach.

In another new development, the CLHP has concluded that further reductions in the case fatality rate for pneumonia may depend on introducing standard case management to children with malaria. Malaria is endemic in Malawi – and remains the number one cause of death for children under 5 – so children with severe malaria are frequently admitted to the same pediatric wards as those with pneumonia, and many children suffer from both.

Although a standard case management strategy exists for treating malaria, it has not been efficiently applied. Using the model developed for CLHP, standard case management would be supported by the ongoing training and supervision of staff, careful documentation of practices and procedures, and other features that have contributed to the CLHP’s good results.

Begun as a collaboration between the Government of Malawi and The Union, with funding from the Bill and Melinda Gates Foundation, the Child Lung Health Project has developed into a model programme that can be implemented with immediate effect in other resource-poor countries. In addition to applying the CLHP model to malaria, plans are also underway to replicate the project in other sub-Saharan countries.

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Union consultant: Penny Enarson, BSN
Local Partner: Acute Respiratory Infection Programme of the Ministry of Health and Population
Funding agency: Bill and Melinda Gates Foundation, ITF

Sudan prepares to replicate child pneumonia project

Health officials in Sudan began preparations to replicate The Union’s Child Lung Health Project in 2004. Sudan’s Federal Minister of Health requested that The Union consider the feasibility of assisting with implementation of the project. A Union consultant visited and discussed the proposal with people from the Ministry, and with Union President Dr Asma El Sony, Director of the Epilab at the University of Khartoum’s Academy of Medical Science and Technology.

The Child Lung Health Division is now assisting with the preparation for a second visit from The Union consultant in September 2005. These preparations include assembling extensive information on the country and the health status of the population, details about the health system and available health services, and specific information about the incidence of childhood lung disease, especially pneumonia in children under 5 years. This information is essential for planning how the project will be implemented in Sudan and for funding applications.

‘Childhood pneumonia is one of the major causes of death for Sudanese children under 5,’ says Dr El Sony. ‘We’re very pleased that The Union is working with us to replicate a programme that has made such a positive impact on this problem in Malawi.’
**Information management system aids project evaluation**

Consistent collection of reliable data is critical to determine whether a programme is meeting its goals for the quality and cost effectiveness of care and services. In countries where the healthcare staff is burdened with high patient-to-staff ratios and chronic shortages of both personnel and supplies, keeping data accurate and up to date is especially challenging.

In 2000, The Union’s Child Lung Health Division developed an information system and has shown that it is feasible to implement such a system within the CLHP in Malawi.

The division and its partner, the Ministry of Health and Population’s Acute Respiratory Infections (ARI) Control Programme, first identified a set of measurable indicators that would be monitored on a regular basis. They developed a plan that specified when these indicators would be evaluated, where the information would be recorded and how frequently results would be reported. Criteria for the epidemiological and operational indicators were that they be measurable, valid, reliable and easy to interpret.

Documents used to record and report data are simple, clear and kept to the absolute minimum required for adequate monitoring and evaluation of the programme, such as monthly reports on cases of pneumonia and treatment outcomes. Evaluating the success of pneumonia case management required three main pieces of information: data on individual in-patients, a register of the number of in-patient pneumonia cases at each hospital, and a record of the drugs and other supplies used. To keep track of this data, three forms were developed: a monthly report on the number and classification of cases diagnosed, their treatment outcomes and a monthly order form for treatment supplies.

Following the first training course for participants in the CLHP in 2000, the project partners determined that the ARI coordinator and pharmacy technicians would need further training on how to monitor the project correctly. An additional 5-day training session was planned for them; and since then, this training in project monitoring has been offered 4 to 6 weeks prior to each new session of the clinical training course.

‘Although the Child Lung Health Project was not designed to be a research study that evaluates a new intervention, we have wanted to provide data on the feasibility and effectiveness of the project,’ says Penny Enarson, head of the Child Lung Health Division. ‘The information about our successes and failures – and the experience we gained – will be important to those who want to replicate the project elsewhere.’

The Union provided funds and resources for a person to enter the aggregate data collected in the field using a specifically designed computer programme. All Malawi CLHP Monthly Reports from October 2000 to December 2003 were entered. A summary of the initial findings based on this aggregate data was presented in a preliminary report to Malawi’s Ministry of Population and Health in September 2004.

The next step will be an analysis of the individual health service records of the children treated for pneumonia during the CLHP. All the data included on the In-patient Pneumonia Recording Forms from September 2000 through June 2003 (approximately 17,500 records) have been double-entered and cleaned, and are ready to be analysed.

The data are expected not only to provide information about the current project, but also to help identify areas for future research that could lead to further reduction in the fatality rate for children with pneumonia in resource-poor countries.

**New resources for treating lung disease in children**

One of the Child Lung Health Division’s priorities is to increase awareness of the special needs of children under 5 years of age from low-income countries, who are being diagnosed and treated for pneumonia, tuberculosis and other lung diseases. Most training courses, manuals and drug protocols, especially for the management of tuberculosis, emphasise care of adults and leave it to physicians to determine how to apply the information to their paediatric patients.

In the developing world, the problem is exacerbated by the fact that many young children present with multiple problems (comorbidity), such as pneumonia and malaria or tuberculosis and HIV/AIDS, and these diseases have overlapping symptoms that make diagnosis more complicated.

To address this problem, the Child Lung Health Division developed the technical manual, *Management of the Child with Cough or Difficult Breathing: A Guide for Low-Income Countries*. First published in 1997, the guide focused on the management of severe and very severe pneumonia at the first referral level paediatric in-patient ward. This manual was revised and expanded in 2004 to include the management of HIV complications of pneumonia, tuberculosis and asthma. It will be published in 2005.

*The Diagnostic Atlas of Intrathoracic Tuberculosis in Children*, published in English in 2003, was translated into French in 2004 and will be available in early 2005. An edition in Arabic is also underway.

‘Union guides, which members and other interested people can download free of charge from The Union website, are invaluable tools for health professionals struggling to provide good care in isolated and resource-poor environments,’ says Penny Enarson. ‘One of the quickest and most far-reaching interventions we can offer to improve child lung health is to put these guides into the hands of all who need them.’
Asthma
Asthma is a disease in which chronic bronchial inflammation causes recurrent attacks of breathlessness and wheezing. A worldwide public health problem, asthma afflicts nearly 300 million people and causes more than 200,000 deaths each year. It affects people of all ages in all countries, but the majority of patients are children and young adults. Although the prevalence of asthma is highest in industrialised countries, it is a greater economic and public health burden in the developing world.

There has been an alarmingly constant increase in asthma in the last two decades. In Western Europe, asthma has doubled in 10 years and in the United States it has increased by more than 60% since the early 1980s.

Asthma takes an enormous human and economic toll on both families and governments. Worldwide, its economic costs are estimated to exceed those of TB and HIV/AIDS combined; and in the United States alone, the annual direct and indirect costs of asthma exceed $6 billion.

Persistent asthma requires long-term treatment, usually with short-acting bronchodilators which, when inhaled, dilate the bronchial tubes in a matter of seconds, and inhaled corticosteroids, which treat the bronchial inflammation. However, both of these treatments are relatively expensive, and the majority of sufferers in developing countries cannot afford them.

National and international action is necessary to improve patient access to good quality generic asthma drugs and to reduce health costs for both patients and governments.
Managing asthma: The Union’s approach

In 1995, The Union created an Asthma Division whose first objective was to apply The Union framework for the delivery of TB services as a model for asthma management in low- and middle-income countries.

In 1996, The Union published *Management of Asthma in Adults: A Guide for Low-Income Countries*, which outlines the most effective and least costly diagnostic methods to treat asthma, and recommends essential drugs to manage it. Work on an updated version of the guide, including management of children with asthma, was undertaken in 2004.

The Asthma Division’s second objective is to develop an operational research programme to evaluate and sustain best treatment practices in developing countries. Early studies demonstrated that one of the principal barriers to effective asthma management in low-income countries is the high price of inhaled steroids. The Union is studying the feasibility of improving access to treatment and reducing the cost of medication through the group purchase of generic asthma drugs. By coordinating and pooling the procurement of drugs and providing technical assistance in storage and distribution, a coordinated asthma drug programme could play a crucial role in getting treatment to the majority of asthma patients in developing countries.

In 2003, The Union initiated the Global Asthma Survey of Practice (GASP) to assess an audit procedure for use in emergency rooms. This audit procedure can help local health services identify improvements needed in asthma care and develop targets for the future.

The Asthma Division collaborates with international research groups, such as the International Study of Asthma and Allergies in Childhood (ISAAC) and the Allergic Rhinitis and its Impact on Asthma (ARIA) project.

For many years, the division has also collaborated with the WHO on the Practical Approach to Lung Health (PAL) project, which aims to integrate standardised management of asthma with other acute respiratory infections and chronic respiratory diseases.

Studies reveal need for a national asthma programme in Sudan

In collaboration with Sudan’s Epilab Research Centre, the Asthma Division has been following a number of studies to evaluate asthma prevalence and management in that country.

The International Study of Asthma and Allergies in Childhood (ISAAC) revealed a high prevalence of asthma symptoms in children 13-14 years old in Sudan, with 15% in Khartoum, vs 5% in one rural area.

Another survey of emergency rooms in Sudan revealed that improper management of asthma was common and that asthma morbidity had increased sharply over the past 4 years.

‘These studies revealed a need for a national asthma control programme,’ says Dr Asma El Sony, Director of the Epilab at the University of Khartoum’s Academy of Medical Science and Technology. ‘We therefore decided to develop a national guideline based on The Union guideline, and initiated an asthma pilot project in four centres. The number of patients is now approaching 1,000.’

Dr El Sony and her colleagues in Sudan have been actively fund-raising to improve the affordability of asthma drugs for patients. She believes that the expansion and the sustainability of the programme will be directly linked to the affordability of the drugs.

Union staff made a technical assistance visit to each of the four centres in January 2004.
Improving access to essential asthma medications

Over the last decade, highly effective international guidelines for the standardised management of asthma have been developed that could improve asthma treatment worldwide. Several studies have demonstrated that implementation of these guidelines, including treatment with inhaled corticosteroids and bronchodilators, could control asthma in most countries and dramatically reduce emergency room visits, days spent in hospital and overall health costs.

But in most low-income countries, the high cost of essential asthma drugs remains a major obstacle to effective asthma treatment. Today, the minimum annual drug costs for treatment of a case of moderately persistent asthma range from US $52 to more than $200, depending on the country. To be affordable for the majority of patients in the developing world, drug prices need to be reduced to less than $30 annually.

The cost of asthma treatment worldwide could be dramatically decreased by following a regimen of standardised treatments using only two cost-effective drugs: inhaled salbutamol, 100 µg; and inhaled beclomethasone, 250 µg.

A recent Union survey found that the price of one inhaler of 200 doses of beclomethasone was $62 in Kuwait, $25 in Sudan, $32 in France and $4 in Algeria. It would be possible to purchase a generic version of the same drug at $3.40 per inhaler if they were purchased in lots of 20,000.

Pooled procurement of TB drugs and the establishment of the Global Tuberculosis Drug Facility by the Stop TB Partnership have produced significant reductions in the cost of anti-tuberculosis drugs over the last 10 years. This has led to rapid expansion of the DOTS strategy in most high-burden countries. The same approach could work for asthma, according to Union Executive Director Dr Nils E Billo.

‘It is time for us to undertake similar efforts for asthma control, so that the majority of asthma patients will be able to benefit from current standards of therapy rather than continuing to be treated with inadequate, ineffective drugs,’ he says. ‘An Asthma Drug Facility (ADF) run along similar lines to the Global Tuberculosis Drug Facility may be a solution.’

By coordinating and pooling procurement for interested developing countries, an ADF could ensure purchase of essential drugs at a lower price and guaranteed quality. The price of 1 year of treatment could be reduced to an average of $30 per patient, which would play a crucial role in getting treatment to the majority of asthma patients in these countries.

The Union published a statement of need and outlined the concept for an ADF in 2004. This was followed by several presentations at WHO meetings in Geneva, Switzerland, The Union’s Africa Region Conference and the 35th World Conference on Lung Health.

The next steps involve an international campaign to develop support among governments, NGOs, patients and consumers; discussions with the pharmaceutical industry to encourage a public-private mix; fund-raising to support the creation and administration of an ADF; and technical assistance for implementation of standardised asthma management.

As Dr Billo wrote in a 2004 editorial in *The International Journal of Tuberculosis and Lung Disease*, ‘If the cost of essential asthma drugs is beyond the reach of most patients in developing countries, international guidelines are probably only valid for industrialised countries, and physicians in developing countries will continue to prescribe medicines that are the most affordable, but not the most effective. This must change – all possible efforts must be undertaken by the international community to ensure that we are able to provide essential asthma drugs of good quality to all patients in all countries. We all have the responsibility to ensure that international guidelines are valid for all citizens of the world and not only for a minority of wealthy countries.’
Poor asthma management overburdens emergency services

In 2003, The Union’s Asthma Division commissioned a Working Group of the Respiratory Disease Scientific Section to conduct an audit of asthma treatment in emergency rooms and casualty departments. The goal of the Global Asthma Survey of Practice (GASP) is to improve the management of asthma as a chronic disease and thus reduce the need of patients to visit emergency rooms.

According to Prof Peter Burney, coordinator of the survey, GASP is based on the premise that asthma care in the developing world is compromised by a number of factors:

■ lack of continuous care appropriate to such a chronic disease
■ poor understanding of asthma therapy
■ lack of available drugs
■ lack of access to drugs and/or care because of high cost.

The initial survey involved 15 centres in Algeria, Bosnia, Canada, Chile, Kuwait, Palestine, Sudan, Syria, Tunisia and the United Kingdom, and the results were presented at the 35th World Conference on Lung Health.

One of the first things the survey found is that many patients come to emergency rooms because they are undertreated. They are not receiving a steroid dosage appropriate to the severity of their case, and consequently have an asthma attack that requires emergency treatment.

The survey also found that few of the people going to emergency rooms were receiving other sources of care; they were relying on emergency room care to treat a chronic disease.

In addition, the survey found that patients who consulted private specialists for their asthma received better care than those who sought treatment in the public sector. Public sector patients were less likely to be put on proper steroid treatment.

‘This tells us that we really need to do something about the quality of asthma care being provided in the public sector,’ says Prof Burney. ‘If everyone with a chronic disease like asthma has to go to a specialist for appropriate care, that does not bode well for the financial well-being of the overall healthcare system. Better education, better training and better facilities need to be established in the public sector, where most patients usually go.’

One of the other major conclusions from GASP – as most other studies of asthma have shown – is that drug affordability is critical to providing adequate treatment.

‘One of the most important things that needs to be done is some sort of intervention on drug availability and costs.’

The second part of the GASP study – a more formal trial – is to be designed according to results from the first part of the study. A small sub-group of the Working Group will meet in 2005 to review what needs to be done and to seek funds for the work to be completed.

Union consultant: Prof Nadia Aït-Khaled

Partners in asthma research: ISAAC

The International Study of Asthma and Allergies in Childhood (ISAAC) was established in 1991 to facilitate an international collaboration to study asthma, allergic rhinitis and eczema in children from different populations around the world using standardised methodologies.

The Union has been an active supporter of ISAAC for many years. Prof Nadia Aït-Khaled, head of The Union’s Asthma Division, serves on the ISAAC steering committee and is also the Regional Coordinator for francophone Africa.

‘The concept of ISAAC was very simple – to develop a simple framework using standard, straightforward techniques that could be undertaken at any location and with limited financial resources, enabling truly global participation across geographic, cultural and linguistic boundaries,’ says Prof Donald A Enarson, Director of The Union’s Department of Scientific Activities. ‘It operated with a decentralised structure that permitted the addition of any number of local questions that needed to be addressed, varying in complexity according to the skills and resources of the centre involved.’

Phase One of ISAAC (1992–1996) involved more than 700,000 children from 156 centres in 56 countries. The results, published in four leading medical journals, found worldwide variations in the prevalence of symptoms of asthma, allergic rhinoconjunctivitis, and atopic eczema that could not be explained by current understanding of these diseases.

ISAAC Phase Two (1998–2004) used intensive investigations in 36 centres in 22 countries to further examine the potential role of risk and protective factors that may contribute to the international differences observed in Phase One.

Phase Three, involving 1.2 million children and adolescents from 286 centres in 106 countries, uses the potential of the Phase One study design to comprehensively determine the prevalence of symptoms of asthma and allergic disease world-

“This highlights the need for some sort of coordinated approach to the purchase and distribution of asthma drugs in low-income countries”

Prof Peter Burney
wide, explore recent time trends in these symptoms and cast new light on the aetiology of asthma and allergic disease. The results of ISAAC Phase Three, including a comprehensive ‘world map’, are in preparation or have been submitted to research journals.

Phase Four will be discussed during the next ISAAC Steering committee in Hong Kong in November 2005.

‘ISAAC has been a tremendous development in encouraging participation in research across the world,’ says Prof Enarson. ‘A major barrier to realising many public health objectives is a lack of confidence among healthcare workers in involving themselves in research. By ‘democratising’ critical thinking, ISAAC has been able to engage people not previously involved in research in an exercise in disciplined measurement and critical thinking.’

‘Through open-minded, inclusive collaboration, ISAAC has produced a base of knowledge that is used globally to inform policy. It is a model that should be followed by all those of us who are committed to improving public health in low-income countries.’

Asthma
Tobacco Prevention
Tobacco is the leading cause of preventable deaths worldwide, responsible for about five million deaths each year. If current trends in tobacco use continue unchecked, that number will double by the year 2020. Of the 1.3 billion people who smoke today, half will eventually die from the direct or indirect effects of tobacco.

A 1994 report estimated that tobacco use resulted in an annual global net loss of $200 thousand million – one third of this in developing countries. Close to 60% of the 5.7 billion cigarettes smoked each year and 75% of tobacco users are in the developing world.
The Union approach to tobacco control and prevention

The Union formed a scientific committee dedicated to tobacco control in 1988, cofounded the International Non Governmental Coalition Against Tobacco (INGCAT) in 1995 and established a Tobacco Prevention Division in 1996. The division’s mission is to develop practical strategies for tobacco control in low-income countries and to disseminate this information through education, technical assistance and applied research.

The Union guide *Tobacco Control and Prevention: A Guide for Low-Income Countries* was published in 1998, and the division has also prepared a collection of free downloadable fact sheets and presentations that provide Union members and others with up-to-date information on tobacco-related issues.

Current research projects include studies of the feasibility and efficacy of routine brief cessation advice in low-income countries, the relationship between smoking and tuberculosis, and the impact of national legislation on public awareness about tobacco. The division has also joined INGCAT coalition members in promoting the passage of the international Framework Convention on Tobacco Control (FCTC).

The Union is committed to reducing the burden of disease and death caused by tobacco. The sooner countries are able to strengthen their tobacco control programmes and policies, the sooner the tobacco pandemic will be brought to an end.

Research studies use of 'brief advice' in low-income countries and other issues

Evidence collected in the industrialised world over the past 25 years has demonstrated that a measurable number of patients will stop smoking if their healthcare practitioner discusses their tobacco use with them. These interventions build awareness of the health risks of tobacco, and the benefits of cessation, and may motivate patients to quit.

To test this technique in limited-resource settings, The Union’s Tobacco Prevention Division is working with the Finnish Lung Association and Sudan’s Epidemiological Laboratory, in collaboration with its national tuberculosis programme. Their research is evaluating the feasibility and efficacy of brief advice in various settings and with populations ranging from Laplanders, treated through general healthcare services in Finland, to people from Nile Valley tribes undergoing tuberculosis treatment in Sudan.

The studies are providing information about where, and under what conditions, brief advice will work best. For example, early results have shown that in areas where anti-smoking campaigns and tobacco control legislation have been in place for a long time, the effects of brief advice are measurable only in a large-scale trial. In areas where people have not been exposed to as much information about tobacco, the effect is measurable in a much smaller sample.

A Union study in Morocco is seeking to determine if the technique can be integrated into busy tuberculosis treatment services. This feasibility and cohort study has resulted in a network of chest physicians who are interested in applying the technique. The next step will be to look at ways to integrate brief cessation advice into other healthcare services.

The Tobacco Prevention Division is also studying the effect of international tobacco control strategies, such as the new FCTC. In one such project, the division is working with the Department of Epidemiology and Public Health at Morocco’s University of Fez to measure changes in attitudes and practices concerning tobacco in a country that is experiencing not only expansion of the tobacco industry’s presence, but also efforts to influence national tobacco control legislation and ratification of the FCTC.

Union consultant: Karen Slama, PhD
Local partners: Finnish Lung Association, Sudan Epilab, Faculty of Medicine and Pharmacy, University of Fez, Morocco
Educating the healthcare community about teenage smoking

One of the most alarming trends in tobacco use is adolescent smoking. A behaviour once adopted more widely by boys, today in many countries a higher percentage of teenage smokers are girls. A 1999 study of 15–16 year olds who smoked showed that girls outnumbered boys in richer countries, including Denmark, France, Iceland, Ireland, Norway and the United Kingdom. The same trend has also appeared in studies of adolescent tobacco use in low- and middle-income countries such as Barbados, Bulgaria, Chile, Cuba, Greenland, Uruguay and Venezuela.

The Union’s Tobacco Prevention Division has made it a priority to build awareness of the factors that contribute to adolescent smoking and to publicise the approaches that have been most effective in helping them to quit. In 2004, Dr Karen Slama, head of the division, made presentations to healthcare practitioners on these and other related topics at conferences and courses in Algeria, Australia, France, Ireland and Sudan.

According to Dr Slama, healthcare practitioners need to view adolescents as a high-risk group for tobacco use and its significant health consequences.

‘Teens are very vulnerable to the message that being a smoker is cool,’ she says. ‘They experience smoking as a way to bond with friends and ease their transition from child to adult.’

Once they’ve started, young smokers become dependent more quickly than adults, and the health consequences of their tobacco use are not all in the far-off future. Nicotine affects the developing brain, causes reduced growth in lung function and increases the risks of respiratory illnesses. Like adult smokers, adolescents experience deterioration in their ability to perform tasks when they ‘need a smoke.’

Brief advice, which involves healthcare practitioners opportunistically talking to patients about their smoking, can be effective with adolescents as well as other tobacco users.

Age, level of self-esteem, the length of time the teen has smoked and external factors, such as whether parents and friends smoke, also influence the outcome of treatment.

‘Reducing the number of teens who smoke will require more than a targeted effort at young smokers,’ says Slama. ‘Since society sets the rules and determines the norms of behaviour, adolescents will continue to use tobacco as long as adults do.’

Union consultant: Karen Slama, PhD

Malcolm Gladwell, The Tipping Point

"Teenage smoking: “Smoking was never cool. Smokers are cool.”"
International coalition cofounded by The Union active in tobacco control

In 1995, The Union’s Tobacco Prevention Division joined with the International Union Against Cancer and the World Heart Federation to found a coalition of NGOs that could coordinate and leverage their efforts in international tobacco control. By 2004, the International Non Governmental Coalition Against Tobacco (INGCAT) had 34 member organisations and a track record of significant accomplishments in the fight against the global health, environmental and societal effects of tobacco use.

ADVOCA CY

One of INGCAT’s most important achievements has been its effective role in the campaign for the FCTC, which was adopted by the World Health Assembly in May 2003. INGCAT represented the coalition’s members during the 4 years of negotiations in Geneva, ensuring that they were kept fully informed about the proceedings and that their views were made known. INGCAT has also supported the passage of a variety of other tobacco control measures.

INFORMATION AND RESOURCES

To provide coalition members with up-to-date information, and resources for their advocacy campaigns and education programmes, INGCAT prepares downloadable resources, such as sample research presentations and referenced professional briefings on tobacco-related issues. Members may use these in full or adapt them to their own local needs. The coalition also assists members to plan projects, access funding and technical assistance, or create partnerships.

ADVICE ON POLICY

To assist members lobbying for or developing tobacco control policies, INGCAT provides advice and guidance, drawing on its knowledge of evidence-based international and national tobacco control policies. The Tobacco Prevention Division also helps members to craft position papers on tobacco-related issues.

Other activities of INGCAT members in 2004 ranged from the American Lung Association’s Hackademy Awards, which rated Hollywood movies based on the messages they project about smoking, to Indonesia’s ‘Quit and Win’ contest.

Collaborations expand reach of The Union’s tobacco prevention efforts

The Tobacco Prevention Division was established to provide expert technical and educational resources for Union members and others interested in lung health. To increase the impact of its work, the division frequently collaborates with other international and national health organisations that have similar objectives for their members.

In addition to its advocacy work through INGCAT, the division collaborates with other organisations to provide technical and educational support. For example, the division worked with the French League Against Cancer and the International Union Against Cancer to develop a handbook on cancer prevention for NGOs. Now published in several languages, this handbook includes an in-depth look at tobacco control and an overview of the behavioural elements in lifestyle change developed by The Union.

Union expertise on brief cessation advice in general practice led to collaboration with French researchers who are surveying general practitioners’ practices and attitudes toward their patients who smoke. The division is also working with the International Union for Health Promotion and Education (IUHPE) on a manual about creating legislation that meets the FCTC criteria for national tobacco control programmes.

In addition, the division worked closely with the Netherlands Institute of Health and the IUHPE to determine best practices in health promotion for tobacco control as part of the European project ‘Getting evidence into practice’. The division is also represented on a variety of advisory committees for international meetings and standards.
WHAT IS THE FRAMEWORK CONVENTION ON TOBACCO CONTROL?

The Framework Convention on Tobacco Control (FCTC) is the world’s first public health treaty. Developed by the 192 member states of the WHO, this legally binding treaty required nearly 4 years of negotiations before a final agreement was reached in May 2003. The Union and other tobacco control advocates worked tirelessly to ensure passage of a treaty with provisions in line with best practice in tobacco control.

By 31 December 2004, 168 countries had signed the treaty and 49 had ratified it, with many more countries expected to join their ranks. The treaty’s provisions became law on 27 February 2005.

While the framework convention and protocols are binding only on countries that ratify them, The Union sees the treaty as a critical step toward reducing the devastating health and economic impacts of tobacco, and will continue to support efforts to strengthen the role of the FCTC in international tobacco control.

OVERVIEW OF THE FCTC

Provisions of the treaty
The goal of the FCTC is to provide basic tools for countries to pass comprehensive tobacco control legislation. Key provisions encourage countries to:

■ Enact a comprehensive ban on tobacco advertising, promotion and sponsorship
■ Obligate placement of health warnings on tobacco packaging
■ Ban use of misleading and deceptive terms such as ‘light’ and ‘mild’
■ Protect citizens from exposure to tobacco smoke in workplaces, indoor public places and on public transportation
■ Combat smuggling
■ Increase tobacco taxes.

The process of negotiating the FCTC has already strengthened tobacco control efforts in scores of countries by:

■ Giving governments greater access to scientific research and best practices
■ Motivating national leaders to rethink priorities
■ Engaging ministries, such as finance and foreign affairs, in tobacco control
■ Raising public awareness about the tactics of multinational tobacco companies
■ Mobilising technical and financial support for tobacco control
■ Making it politically easier for developing countries to resist the tobacco industry
■ Mobilising NGOs and other members of civil society in support of stronger tobacco control.

Once the treaty is in effect, the onus will be on national governments to implement the FCTC and its protocols. How effective the FCTC will be in reversing the tobacco epidemic will be determined by how fully governments implement its provisions.
The Union’s Health Policy Unit, established in 2001, researches factors that influence the formulation and implementation of policies relating to lung health.

The unit is currently conducting a four-country study to examine the impact of sub-national policy processes on the success of DOTS implementation and expansion, as well as the transfer of the DOTS strategy from global to regional to national and sub-national levels.
DOTS expansion: examining district-level policy processes

Beginning in June 2002, the Health Policy Unit held a series of regional workshops to examine district-level policy processes involved in DOTS expansion. Workshops have been held in Durban, South Africa (June 2002), Punta del Este, Uruguay (December 2002), Paris, France (October 2003) and Moscow, Russian Federation (June 2004). The workshops bring together the NTP manager and a district-level tuberculosis programme team of three people (e.g., a medical doctor, nurse and laboratory technician) from four to six countries each time.

The questionnaires and discussions do not deal with the technical content of the DOTS strategy or tuberculosis policy. Instead, they explore factors, such as political, social, financial and organisational factors, that might affect the success of implementing and adapting the DOTS strategy at the district level. The research is generating a series of regional pictures of policy processes based on the perceptions of personnel at different levels in the programmes (national and district) and from different disciplinary perspectives (doctor, nurse, laboratory technician).

Preliminary results revealed the importance of the management of innovation and adaptation at district level. It is also clear that all levels need to focus much more on understanding how social and political commitment to TB is gained and maintained at this level. Districts are calling for greater knowledge transfer about strategies for improvements in: management and organisational skills of TB programme staff; communication with non-health entities for collaboration and coordination; managing resources for social support of TB patients; finding non-financial means to motivate health staff and community volunteers; working with the media; and using TB data more creatively and for a wider audience.

Selected conclusions follow:

1. Techniques of advocacy, marketing and the management of innovations can be used successfully at all levels to bring about changes in TB control policy and practice, and to overcome resistance to such change.

2. The global DOTS strategy was used as an innovation to break from past programme styles, moving from a) vertical, non-integrated programmes to integrated programmes; and b) technical guidelines under the control of specialist clinicians, to a public health ‘policy package’ with components that reflected the work of the whole multidisciplinary team and emphasised the interdependence of technical, political and management components.

3. The building of new partnerships and networks, as well as the mobilisation of existing networks, led to greater uptake of the strategy; increased consultation and adaptation; greater resources and accountability; and integration of the strategy into broader agendas and initiatives.

4. Mexico confronted three major challenges for policy transfer: a fragmented health system; decentralising systems; and a long history of policy, practices and perceptions about TB. Each exerted a multiplying effect on the amount of learning, persuasion and adaptation that had to occur for the strategy to transfer. Mexico’s strategies for facilitating policy transfer included a focus on networks and partnerships; human resource development; management and communication skills; political commitment; social mobilisation; marketing; and sector-wide approaches.

5. In addition to political commitment to DOTS, it is necessary to seek commitment from social, professional and institutional actors; to determine what type of evidence and style of communication suits these actors; and to negotiate their role in the TB policy network.

6. Explicit and innovative strategies should be developed to allow not only policymakers but also policy implementers

Study examines DOTS policy transfer in four countries

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

The Health Policy Unit is coordinating this collaborative research, which also involves the London School of Hygiene and Tropical Medicine and researchers from institutions in the four participating countries: Brazil – University of Rio De Janeiro State; Federal University of Rio de Janeiro; Mexico – Mexican Health Foundation (FUNSALUD); Malawi – Equi-TB; Chancellor College, University of Malawi; and Zambia – INESOR; Demography Department, University of Zambia. After a workshop in February 2004, the researchers began fieldwork, which consists of in-depth, semi-structured interviewing and document review. Findings will be disseminated in 2005 in the form of country reports as well as comparative reports and a synthesis report.

Results on the global-regional-national transfer of the DOTS strategy in Mexico are already available as a doctoral thesis on the topic and a poster publication presented at the Global Forum on Health Research in Mexico City, November 2004.

Union consultant: Karen Bissell, MA, DrPH
Funding agency: TBCTA
to examine lessons from other settings, apply the strategy flexibly to their settings and create new knowledge through implementing.

7. Improved information systems and dynamic exchange between levels about information, not simply of information, facilitates transfer.

8. A fundamental challenge throughout the levels is achieving a mixture of directive approaches that impose enough accountability and provide impetus for change and expansion with approaches that inspire more voluntary motivations for adoption and lead to greater ownership and adaptation of the strategy.

9. Scaling-up of a health programme or strategy should involve an analysis of its location within the health system; the perceived authority of the policy-making entity; where different actors are looking for policy options; and what would bring different actors to adopt the policy in question.

Union consultant: Karen Bissell, MA, DrPH

Funding agencies: UK DFID, The Union, Norad

Union-supported research is exposing British American Tobacco’s secrets

A highly confidential international project that has been securing public access to nearly eight million pages of British American Tobacco (BAT) documents was made public on World No Tobacco Day 2004.

The Guildford Archiving Project (GAP) was initiated by the London School of Hygiene and Tropical Medicine (LSHTM) and is being driven by a consortium of researchers from the LSHTM, the University of California, San Francisco (UCSF) and the Mayo Clinic.

GAP is compiling a publicly accessible Internet copy of the contents of an archive that contains BAT’s internal and formerly secret documents dating from the early 1900s to the mid-1990s. These documents are invaluable for understanding how the tobacco industry has operated in the past, as well as its future strategies, especially in the developing world.

The depository was established in 1998 under the terms of a legal settlement between tobacco companies and the state of Minnesota (USA). The settlement stipulated that the public should be allowed access to documents produced during litigation against the tobacco industry for 10 years. As a result, two depositories were created, one in Minnesota, where an independent paralegal firm ensures public access to the internal documents of leading US tobacco companies, and the second in Guildford, UK, which is managed by BAT itself. The US companies subsequently made the majority of their documents available on the Internet in fulfillment of the Minnesota Master Settlement Agreement. The UK-based BAT, however, imposed obstructive conditions of access and complied minimally with the requirement to make the documents publicly available. Among the numerous obstacles are no Internet site, poor indexing systems and a response time of more than a year for photocopy requests.

GAP raised multi-million pound funding from a consortium of donors including the Wellcome Trust, the Flight Attendant Medical Research Institute, Cancer Research UK, Health Canada and the American Heart Association. This has allowed the LSHTM and its international colleagues to order a photocopy of every document in the Guildford archive. Documents are being scanned, indexed and hosted on the UCSF library website. For the first time, systematic and comprehensive searching of these documents will be possible. By the end of 2004, some 1.5 million pages in more than 400,000 documents had been placed online at www.bat.library.ucsf.edu. The entire 6-8 million page collection will be available by 2007.

The Union supported the LSHTM’s Guildford-related research projects from their planning stages in 1999. It endorsed LSHTM funding applications as vital research of global public health interest. The Union also provided essential expertise from its Health Policy Unit, which has a close research link with the LSHTM’s Centre on Global Change and Health. The Health Policy Unit contributed substantially to the writing of the first successful LSHTM bid to the US National Cancer Institute for funds to investigate the Guildford archives, prior to the GAP project. With these early funds secured, the LSHTM team was able to start using Guildford documents to compile profiles of tobacco industry activity in 14 countries.
The Union as an Educational Resource
Education is central to The Union mission. Educational services are provided in formats ranging from 3-week residential courses to posters and downloadable manuals that meet the needs of the healthcare community at every level.

Union courses are renowned for their instructors, who are experts with extensive experience in both theory and practice. Courses are offered in English, French and Spanish in locations around the world.

Union conferences are a primary opportunity to network with colleagues, share experiences, refresh one’s skills and gain new insights. In addition to the annual World Conference on Lung Health, each of The Union’s six regions holds regular conferences.

The Union also provides educational opportunities through publications, such as its technical guides. These guides are written for middle- and low-income countries, but the same principles very often apply to industrialised countries, too. Most guides and manuals can be downloaded free of charge from The Union’s website or purchased by contacting the Secretariat.

Our peer-reviewed journal, *The International Journal of Tuberculosis and Lung Disease*, is distributed monthly to approximately 2,000 individuals and libraries, and is the best publication for keeping up to date with tuberculosis and lung disease.

Other resources include presentations, slide shows, CDs and videos. The Union’s website also provides information on all areas of Union activity and links to other informative sites.
Union Courses

Union courses offer opportunities for participants to gain thorough understanding of both the theoretical basis and practical challenges of tuberculosis control and the promotion of lung health in low-income settings. Recently The Union’s course offerings have expanded to stress not only technical knowledge, but also administrative expertise. This reflects the reality that the clinical effectiveness of an NTP or other public health programme, is ultimately dependent on its administrative effectiveness.

Courses are developed by the technical staff of the Department of Scientific Activities and conducted in close coordination with the NTP or other local sponsor in the country where the course is held. Faculty are renowned experts in their fields, guaranteeing high scientific standards and up-to-date curricula. The content is designed to meet the needs of the different groups involved in TB and lung health, such as NTP personnel, NTP managers, specialist physicians, and university and medical school faculty.

Union course objectives are to:

- increase the knowledge and expertise of healthcare workers and managers
- create local capacity to conduct health systems and services research that is designed to meet their needs
- strengthen relationships and understanding between NTPs and other sectors of the healthcare system, including physicians in private practice
- increase the management capacity and human resources of the NTP
- identify individuals who may pursue careers in public health.

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

In 2004, The Union offered 25 courses, attended by 675 people in 18 countries. In addition, Union consultants facilitated or taught courses for a wide variety of other institutions and organisations.
Innovative management course fills gap in TB control resources

For many years, the emphasis of tuberculosis prevention, treatment and control has been on clinical issues and health service delivery. But managerial tasks, from staff supervision to budgeting, can also make or break a TB programme. Therefore The Union has now developed a new course that addresses the need for skill in these areas.

The 2-week International Course in Management, Finance and Logistics for TB Control was offered for the first time in February 2004 at the Indian Institute of Health Management in Jaipur, India. An international faculty from The Union and the Institute taught the course, including Professor Uday Pareek, a highly regarded management professor and author of more than 50 books on human resource development.

Thirty-four participants from 22 countries attended the course, which was designed to:

- help participants appreciate the importance of good management in TB control
- identify the management issues that can arise in a TB control programme
- examine different approaches to dealing with them.

TOPICS FROM LEADERSHIP STYLES TO MANAGING RESOURCES

The first few days of the demanding curriculum covered an introduction to management; the need for leadership in an organisation and the impact of different leadership styles; management styles and personal effectiveness; team building and creating strong partnerships; and increasing patient and community motivation for TB control. As part of this section of the course, participants examined the structure of their own programme and the effectiveness of its various components.

The focus then shifted to intensive study of strategic planning, quality assurance and financial management. Two days were devoted to mechanisms of funding TB control and the role of financial managers, along with accounting systems and procedures, budgetary control, and systems for internal checks and controls.

Finally the programme covered the importance of building ongoing training into an organisation’s mission: the principles of adult learning that contribute to a successful training programme; management of logistics, such as supply chains, facilities and human resources; and the procurement system for drugs and supplies for TB treatment and control.

Teaching methods included lectures, demonstrations, discussion, participant presentations, case studies, small-group projects and individual assignments. Each small group was assigned a resource person who could be called upon to work individually with participants, and interpreters were available at every session to assist as needed.

ACTION PLANS FOLLOW COURSE

A special feature of the course was the action plan that participants drew up to solve a problem in their programme. After the course was over, the instructors monitored the process as the participants moved through the milestones of their plan to help ensure their success.

Feedback from the participants was very positive. As the focal person for TB-HIV in Nigeria, Dr Amos F Omoniyi reported that he applied what he learned to the development of national TB-HIV guidelines. ‘The aspects on feedback and managerial style have also been very helpful to me,’ he said.

Ellen Stamhuis, TB Programme Manager for the Swiss NGO Medair in Kabul, Afghanistan, calls the course ‘one of the best’ she has taken. ‘Most management courses are more general,’ she said, ‘but this was all related to TB, which was very useful for my work.’ The analysis she did of her programme as part of the course led to many team discussions and improvements when she returned home.

‘We were very pleased with the outcome of the first course,’ says José L Castro, The Union’s Director of Development and Finance and a lead instructor. ‘These management techniques are the basic tools that organisations all over the world use to be successful, and we wanted to ensure that TB programmes also have access to them.’

Due to the popularity of the International Course in Management, Finance and Logistics for TB Control, the programme was offered a second time in India in August 2004. An additional course, Management of Managers, was offered in Bangkok in September.
The cornerstone of any successful public health programme is quality data collection. Without it, there can be no reliable reports or analyses of health studies or interventions.

For many years, the standard database software used in international public health has been a programme called Epi Info, developed by the CDC and supported by the WHO.

In the late 1990s, however, the CDC decided to apply a different strategy and adapted Epi Info to the Windows environment. ‘The CDC’s move to the Microsoft Access platform led to greater rather than less dependence on proprietary software compatibility’ says EpiData developer and coordinator Dr Jens Lauritsen.

As a result, in 1999 Lauritsen conceived the EpiData application. The basic strategy was to maintain compatibility with the logic of the well-tested original Epi Info programme, but adapted to the Windows operating system. Working with others who shared his interest, Lauritsen began to develop EpiData as a freely available database programme. The developers worked with standard formats to create a simple-to-use, independent application that would not interfere with or require any special database system drivers or interfere with other applications. This allows users all over the world to download the programme and share data. EpiData is a relatively small programme – it will fit on a 1.44 MB floppy disk – and it can be translated into another language in approximately 2 days.

The first version of EpiData was released in late 2000 and more than 200 users around the world helped to debug the programme and suggest extensions. But Lauritsen and his colleagues faced a big problem: they lacked money for further development.

‘In 2001 we formed an international group called “Friends of EpiData” to secure further funding,’ says Lauritsen. ‘The Union gave us a small amount of funding at that time, which was very crucial to our development.’

Today, EpiData has evolved to version 3.1, and it is a very mature programme that has been tested in a multitude of settings. With approximately 200,000 users, it is increasingly becoming the software of choice for frontline epidemiologists throughout the world. The use of EpiData is taught in The Union’s international training courses on tuberculosis, and each month the free programme is downloaded by people from about 100 countries.

Ten organisations now support the continuing development of EpiData, but Lauritsen is concerned about its long-term sustainability as no major funding source has yet been identified that would allow it to be converted from freeware to open-source software and to make it available for other operating systems, such as Linux. Discussions regarding its future are in progress with The Union and other sponsoring organisations.

‘Without support from The Union, a number of universities and some other funding bodies, the development of EpiData would have stopped,’ says Lauritsen. ‘Now we need to ensure its viability for the future.’

For more information about EpiData, visit their website: www.epidata.dk.

“The use of EpiData is taught in all of The Union’s international training courses on tuberculosis.”
INTERNATIONAL TUBERCULOSIS CONTROL

The Union’s international tuberculosis control course is a 3-week programme for 25 participants. The curriculum covers five modules: bacteriological basis of tuberculosis control, clinical presentation and diagnosis, epidemiologic basis of tuberculosis control, interventions for tuberculosis control and elimination of TB, and principles of tuberculosis control in a national programme. Teaching methods include lectures, discussion, group work, laboratory bench work and field visits. Practical exercises are based on reviewing data from a real country, which is fictitiously named Asiam. Participants work in groups to review Asiam’s TB programme, draw conclusions and make recommendations.

OPERATIONS RESEARCH TO PROMOTE LUNG HEALTH

The operations research course is a 2-week course designed to enable countries to develop and implement their own national health research programmes. The premise is that all NTPs have access to sufficient data to show them how they need to improve, but lack the skills to collect and analyse the information. This course provides these skills by taking participants through all the stages of a research project. Since data processing is essential to research, basic computer knowledge is a prerequisite, and participants are trained to use EpiData and Epi Info software. The course material, Research Methods for Promotion of Lung Health: Guide to Protocol Development for Low-Income Countries, was developed and published by The Union.

MANAGEMENT, FINANCE AND LOGISTICS FOR TB CONTROL

This international course for senior managers of NTPs was developed in 2004 in collaboration with the Indian Institute of Human Resource Management. It offers a 2-week intensive overview of the principles of management, finance and logistics with emphasis on their application to tuberculosis control.

INTENSIVE COURSE FOR CHEST SPECIALISTS

Enlisting the participation of chest specialists in TB control is important to the success of all NTPs. This course is designed to refresh chest specialists’ knowledge of tuberculosis, and introduce them to the DOTS strategy and the principles of TB prevention, treatment and control within the context of an NTP. Offered only in Spanish, the course is presented in 1-, 2- and 3-day formats.

MANAGEMENT OF MULTIDRUG-RESISTANT TUBERCULOSIS

MDR-TB has become a significant threat to the future of TB control in many parts of the developing world. This course is offered in Spanish only in a 2-day national and a 5-day international format. Designed for both TB managers and clinicians, it covers all aspects of prevention, treatment and control of MDR-TB.
**COURSES IN ENGLISH**

- **International Tuberculosis Course**
  Vietnam: Ho Chi Minh City
  12–30 April 2004
  Participants: 25
  Coordinator: Dr Hans L Rieder
  Donor: The Netherlands Medical Committee (MCNV)
  Vietnam: Hanoi
  30 August–17 September 2004
  Participants: 24
  Coordinator: Dr Hans L Rieder
  Donor: TBCTA, The Netherlands Medical Committee
  Tanzania: Arusha
  8–26 November 2004
  Participants: 24
  Coordinator: Dr Hans L Rieder
  Donor: TBCTA

- **Advanced Course on AFB-Microscopy and EQA**
  Kenya: Nairobi
  3–14 May 2004
  Participants: 13
  Coordinator: Dr Armand Van Deun
  Donor: TBCTA

- **Social Mobilisation of NGOs in TB Control**
  Thailand: Bangkok
  18–19 September 2004
  Participants: 13
  Coordinator: Dr Nils E Billo
  Donor: TBCTA

- **Applied Epidemiology for Operations Research in Tuberculosis Control**
  France: Paris
  12–23 January 2004
  Participants: 10
  Coordinator: Dr Hans L Rieder
  Donor: TBCTA

- **XIII Curso Internacional de Epidemiologia y Control de la Tuberculosis**
  Nicaragua: Granada
  29 March–6 April, 2004
  Participants: 39
  Coordinator: Dr José A Caminero
  Donor: TBCTA

- **Clinical and Operational Management of MDR-TB Patients**
  El Salvador: San Salvador
  1 April 2004
  Participants: 44
  Coordinator: Dr Jose A Caminero
  Donor: WHO and The Union

- **Curso Intensivo para Medicos Especialistas**
  Ecuador: Cuenca
  19 July 2004
  Participants: 45
  Coordinator: Dr José A Caminero
  Donor: The Union
  Argentina: Buenos Aires
  12–13 October 2004
  Participants: 45
  Coordinator: Dr José A Caminero
  Donor: The Union
  Argentina: Santa Fe
  14–15 October 2004
  Participants: 45
  Coordinator: Dr José A Caminero
  Donor: The Union

- **Curso de Especializacion de Gestion en Acciones de Control de Tuberculosis**
  Brazil: Sao Paulo
  14–16 October 2004
  Participants: 42
  Coordinator: Edith Alarcón, RN
  Donor: TBCTA

- **Curso de Supervision en las Acciones del Programa de Control de Tuberculosis**
  Brazil: Sao Paulo
  18–20 October 2004
  Participants: 19
  Coordinator: Edith Alarcón, RN
  Donor: TBCTA

**COURSES IN FRENCH**

- **Cours International sur la Lutte Antituberculeuse**
  Benin: Cotonou
  16 August–3 September 2004
  Participants: 34
  Coordinator: Mr José L Castro
  Donor: TBCTA and the US CDC

- **Cours Avancé sur la Microscopie Appliquée aux BAAR et son Assurance de Qualité**
  Senegal: Dakar
  15–26 March 2004
  Participants: 13
  Coordinator: Dr Armand Van Deun
  Donor: TBCTA

**COURSES IN SPANISH**

- **Curso de Especializacion de Gestion en Acciones de Control de Tuberculosis**
  Brazil: Brasilia
  28–31 July 2004
  Participants: 40
  Coordinators: Dr José A Caminero, Edith Alarcón, RN
  Donor: TBCTA

- **Movilización Social: Partipación activa de las ONGs y sociedades profesionales en el movimiento Alto a la Tuberculosis (Stop TB) en Latino América**
  Brazil: Brasilia
  29–30 June 2004
  Participants: 18
  Coordinator: Dr Nils E Billo
  Donor: TBCTA
The Union as an Educational Resource

World Conference looks at The Union’s role in meeting Millennium Development Goals

The UN Millennium Development Goals were the theme for The Union’s 35th World Conference on Lung Health. More than 1,700 tuberculosis and lung health professionals from 115 countries attended the annual scientific event, which was held at the Palais des Congrès in Paris.

Participants spent 4 days discussing issues such as the challenge of meeting the WHO’s 2005 goals for tuberculosis control – to detect 70% of smear-positive TB cases and cure 85% of them – and the UN’s Millennium Development Goals for 2015.

The scientific programme amply demonstrated the vigour and creativity with which the TB community is seeking solutions. With seven postgraduate courses, 31 symposia, nine workshops, 13 meet-the-expert sessions and hundreds of poster displays and slide shows, the conference showcased a host of presentations on topics such as new diagnostics and the possibility of vaccines; progress reports on new treatment regimens; behavioural studies of patients and healthcare workers; analyses of innovative healthcare delivery schemes involving such non-traditional participants as village grocers, family members and employers.

Time and again, however, sessions concluded that advocacy and social mobilisation are a major missing link in TB control. Tools that have been used to build prevention awareness and generate resources for other diseases, such as HIV/AIDS, must also be put to work for TB.

In his keynote speech, Salil Shetty, Director of the UN’s Millennium Development Goals (MDG) Campaign, pointed out that public mobilisation can help to ensure that governments fulfill their promises. The MDGs, which were endorsed by 147 heads of state in the autumn of 2000 and later adopted by the UN General Assembly, set an ambitious agenda that includes beginning to reverse the spread of AIDS, malaria and other diseases, such as TB. ‘To achieve these goals by 2015,’ he said, ‘we need commitment at the highest level and action at the local level.’

Union President Dr Asma El Sony agreed. ‘Activism needs to be brought into the mix more strongly. To have patients and communities also fighting TB is a huge advantage because they are a voice that is constantly there. They are much more motivated than anyone else who is less involved and affected,’ said Dr El Sony, who also heads Sudan’s National Tuberculosis Programme.

In keeping with this new emphasis, patient activists had a more visible role than ever before. The Union facilitated the conference participation of 60 members of the patient organisation Treatment Action Group (TAG) and 12 members of the patient-support network TBTV.

Other special features of this year’s conference were the incorporation of a 2-day meeting of the Stop TB Partnership’s DOTS Expansion Working Group and the celebration of the 10th anniversary of the Nurses and Allied Professionals Scientific Section.

Conferences
TECHNICAL GUIDES

CONTROLLED CLINICAL TRIALS IN TUBERCULOSIS: A GUIDE FOR MULTI-CENTRE TRIALS IN HIGH-BURDEN COUNTRIES

Authors: Amina Jindani, Andrew Nunn, Donald A Enarson

This new guide is part of The Union’s strategy for increasing high-burden countries’ capacity to participate in clinical trials. It is a compendium of information on how to conduct controlled clinical trials in tuberculosis, covering design and the statistical, operational and laboratory aspects of clinical trials, as well as ethical considerations, examples of trial forms and other practical information. It also includes a brief history of past clinical trials in tuberculosis.

GUIDE FOR NURSES ON THE IMPLEMENTATION AND EXPANSION OF THE DOTS STRATEGY

Authors: Edith Alarcón, with revisions by José A Caminero

Nurses are an essential component of tuberculosis care within public health services. This technical guide is designed to enable them to implement and expand the DOTS strategy. It includes strategies for disease prevention; basic measures to guarantee supervised treatment and follow-up of patients; guidelines, information and data management; and a description of Latin American and Caribbean achievements in tuberculosis control. This manual follows the official guidelines of the DOTS strategy, but does not replace norms and directives of individual countries.

RESEARCH METHODS FOR THE PROMOTION OF LUNG HEALTH

Authors: Donald A Enarson, Susan M Kennedy, David L Miller, Per Bakke

The effective use of research is crucial to building strong lung health and tuberculosis control programmes. This guide builds on the information provided in The Union research methods course, designed to assist health workers and investigators to develop research protocols relevant to low-income countries. The guide has two parts: course notes and practical exercises that can be expanded and/or adapted for local use, and it also includes instructions on how to use the recommended Epi Info software.

A TUBERCULOSIS GUIDE FOR SPECIALIST PHYSICIANS

Author: José A Caminero

This innovative guide discusses the clinical and epidemiological aspects of tuberculosis in the context of national tuberculosis programmes in 18 illustrated chapters. It is designed as a stand-alone reference for anyone involved in the treatment, control and prevention of tuberculosis, and is especially valuable for specialist physicians working in developing countries.

EPIDEMIOLOGICAL BASIS FOR TUBERCULOSIS CONTROL

Author: Hans L Rieder

This guide, based on material presented in The Union’s international tuberculosis course, deals with the epidemiology of tuberculosis and delineates the determinants of exposure, infection, disease and death from the disease. A selection of pertinent examples drawn from biomedical literature is included. The international TB control course is intended for healthcare personnel with responsibility at the regional or national level within their national tuberculosis programmes.
In 2004, *The International Journal of Tuberculosis and Lung Disease* (IJTLD) fulfilled its goals to launch a special educational series and to include at least one ‘State of the Art’ and/or review article and an editorial in every issue. The *Journal* also increased in size from 100 to 120 pages.

Key State of the Art articles appeared on severe acute respiratory syndrome (SARS), chronic obstructive pulmonary disease (COPD), environmental tobacco smoke, bronchiectasis, lung cancer, tobacco control and indoor air pollution. The educational series began with a six-part serialisation of The Union technical guide *Research Methods for Promotion of Lung Health*. In addition, special sections on the Stop TB Partnership (sponsored by the WHO) and childhood TB (sponsored by the US CDC) appeared in January and May.

The latest Science Citation Index, published for 2003, gave the *Journal* an impact factor of 1.634, slightly down from the previous year (1.888), but still good for a specialist journal. Submissions continued to increase, rising from 38 articles per month in 2003 to 40/month in 2004. With separate Editors-in-Chief for tuberculosis and lung disease, the number of lung disease articles doubled to 16% of journal content, meeting targets set in 2003.

The backlog of accepted articles continues to cause delays in publication despite the increase in pages and shorter article lengths. The plan is to increase the rejection rate, which remained low at 47% – although this was higher than in 2003. Steps are being taken to tighten acceptance standards. Of the average 40 articles received per month in 2004 (total 474), 223 were published.

Distribution of the English print version of the *Journal* increased slightly, from 2,080 in 2003 to 2,134 copies sent to members and subscribers, 244 of which were institutional members.

Usage of Ingenta, the UK-based service that hosts the online version of the *Journal*, nearly doubled in 2004 to an average of 1,300 articles downloaded per month. All issues back to Volume 1 (1997) are now online and available through Ingenta. More than 180 *Journal* articles are now available in French on The Union website. Emphasis is placed on TB articles that are of use to health personnel working in the field, particularly in French-speaking sub-Saharan Africa.

The Chinese edition of the *Journal* is still being published and distributed three times a year to 4,000 colleagues in China. A second edition of the Russian version and a new Spanish version are planned for 2005.

In addition to the two Editors-in-Chief, based in South Africa and Hong Kong, and the three-person editorial staff based in Paris, the *Journal* is the collective project of 54 associate editors from 23 countries – 42 for tuberculosis and 12 for lung disease – and all experts in their respective fields.
JOURNAL ARTICLES


Caminero J A. Number of drugs to treat multidrug-resistant tuberculosis. [Correspondence]. Am J Respir Crit Care Med 2004; 169: 1337.


BOOKS AND CHAPTERS


Expanding the Reach of The Union
The Union continually seeks new ways to expand the reach of its expertise and services to low- and middle-income countries. For example, the new India Resource Centre in New Delhi is a hub for Union activity in Asia, providing services ranging from procurement, course management and programme development to advocacy and public relations.

Partnerships with other organisations that become ‘collaborating centres’ combine Union and local resources to carry out activities from developing new technical guides and research projects to planning and implementing workshops designed specifically for local needs.

Workshops hosted by The Union, such as this year’s social mobilisation workshops, provide a forum for colleagues from across a region to gather and focus intensively on issues that affect the work of all of us.

The Union’s communications programme also reaches out to link the farflung network of members and other TB advocates through print and electronic communications, advocacy programmes and publicity.

All of these activities have one ultimate goal: to empower local tuberculosis programmes and provide them with the tools and information they need to become more effective in preventing, controlling, and treating tuberculosis and other lung diseases in their countries.
Social mobilisation brings new energy to the fight against TB

The DOTS strategy is now being implemented in 182 countries, but as 2005 approaches, most of the 22 high-burden countries have not achieved the WHO’s global targets of detecting 70% of smear-positive cases and curing 85% of them. In 2004, The Union organised two workshops for NGOs, one in Bangkok, Thailand and one in Brasilia, Brazil to explore how social mobilisation campaigns can bring new energy, commitment and resources to the fight against TB.

The objectives of the workshops were for participants to exchange experiences and study examples of effective social mobilisation, explore ways to increase social mobilisation regarding TB, propose ways to keep TB a high priority within the framework of the Millennium Development Goals, and develop recommendations for global TB social mobilisation.

Fifteen participants from Brazil, Peru, Panama, Guatemala and France attended the Brasilia workshop, and after 2 days of sometimes heated discussion, they came up with recommendations to be widely disseminated in Latin America and elsewhere.

First they identified a wide variety of groups to be incorporated into a mobilisation network. These ranged from the media, NGOs and government agencies to community-based organisations, professional societies and TB patient groups. This network would be used to build awareness about tuberculosis, to work together in stronger partnerships and to participate in strategic planning for TB control.

Among the specific goals of the network would be to:

- tackle the stigma of tuberculosis
- ensure that information about the disease reaches all sectors of the community
- improve the visibility of TB and understanding of its importance.

Participants in the workshop discussed ways in which the fight against tuberculosis is linked to other critical problems, such as poverty and the HIV/AIDS epidemic, and the need to make politicians and other groups aware that these issues cannot be addressed in isolation from each other. They also discussed how to measure the impact of social mobilisation activities and ways to sustain the network politically, financially and technically. Success, they concluded, will depend on activities that reinforce the value of networking and coordination between health professionals and civil society to the creation of a stronger, healthier community.

The Bangkok workshop was attended by representatives from 10 countries: Bangladesh, India, Indonesia, Iraq, Japan, Kenya, Mexico, Nepal, Thailand and the Philippines. They heard regional presentations from India, Japan, Kenya and Mexico; and discussed topics such as TB in large cities, TB and poverty, TB and HIV and the role of the media in increasing public attention. A session on funding highlighted the importance of budgeting for a social mobilisation campaign. By the end of the 2 days, they too had developed recommendations to be disseminated.

A website detailing the recommendations from these workshops is under construction. Both workshops were funded by the TBCTA.

“Social mobilisation is essential for achieving the full benefit of DOTS. NTPs need to cultivate interest and commitment from all segments of the community to control TB.”

Niels E Billo, MD, MPH
Executive Director, The Union

Union establishes a resource centre in India

The Union’s India Resource Centre, established in 2003, held a grand opening for its offices in New Delhi on World TB Day in March 2004. The Centre supports the work of The Union by fostering collaborations between organisations and scientific institutions working on tuberculosis and lung disease control in South and South-East Asia.

EDUCATION AND TRAINING PROGRAMMES

With the Centre’s assistance, The Union is becoming an important provider of public health management education in developing countries. The Centre has been active in raising funds for these courses, developing partnerships with local management training institutes, and assisting with organisation and implementation. In 2004, four courses in management, finance and logistics were offered in India and Thailand, and attended by more than 90 TB managers from 26 countries. Taught by faculty from The Union Secretariat and local institutions, the courses are designed to strengthen the ability of national TB control programmes to assess their needs, develop budgets and procurement plans, monitor costs and design systems that will improve their managerial capacity.
The Centre also helped to organise The Union’s international workshop on ‘Social Mobilisation of NGOs for DOTS Expansion’ held in Bangkok in May. This event was attended by heads of several leading NGOs from Africa, Asia and South America. Other regional activities supported by the Centre this year included a workshop for nurses at the Eastern Region Conference in Nepal and a meeting of leading Indian experts in respiratory medicine.

CONFERENCE ACTIVITIES
The Resource Centre has also made it possible for The Union to increase its presence in the region in other ways. Centre staff attended and disseminated information at five national and international conferences on TB, HIV and lung disease in India, and at two regional conferences in Nepal. They also organised The Union’s booth at the Stop TB Partnership Forum in New Delhi in March.

COMMUNICATIONS AND PUBLICATIONS
The Centre has proved to be an excellent new resource for Union communications and publications. Centre staff coordinated production, printing and distribution of The Union’s updated clinical trials and asthma guides, and the English and Spanish versions of the AFB smear staining poster. They advised India’s Revised National Tuberculosis Control Programme (RNTCP) on their Information, Education and Communication (IEC) strategy and website, and participated in a DANIDA-funded media training workshop in the state of Orissa.

PROCUREMENT FOR NTPS
Procurement is another area where the India Resource Centre has been very active. In 2004, the Centre managed purchasing and shipping of anti-tuberculosis drugs, laboratory supplies, vehicles, computers and other items valued at US $4 million on behalf of The Union for the NTPs in Benin, DR Congo, Myanmar, Nicaragua, Panama, Senegal and Sudan. The Centre also managed an emergency procurement of drugs for the RNTCP valued at GBP 1.7 million.

PROGRAMME DEVELOPMENT
In June 2004, Dr Vishnuvardhan Kamineni was hired to join the Centre staff as a programme development officer based in India. With his assistance, The Union raised $1.6 million to finance activities including the World Conference, courses and publications.

AWARDS PROGRAMME
In addition, the Centre has established two new awards to build awareness of The Union in the region. The awards recognise outstanding medical students from the Universities of Mumbai and Gujarat, and will be awarded at commencement each year.

The India Resource Centre is managed by Sunita Kripalani, under the direction of José L Castro, The Union’s Director of Development and Finance.

Mongolia collaborates with The Union on TB education
One of the ways The Union has broadened the reach of its services and programmes is by entering into formal agreements with other organisations, which become known as collaborating centres. Status as a collaborating centre is limited to organisations that share The Union’s goals and are able to meet specific qualifying criteria. The number of centres is limited to two or three in each of the six Union regions, and, in 2004, there were 5 such agreements in place.

The Mongolia National Programme for Combating Tuberculosis (NPCT) was appointed a collaborating centre for the Eastern Region in 2000. The first joint project was the presentation of an AFB microscopy course taught in Russian for medical personnel, doctors and laboratory technicians.

In 2001, the Mongolia National Tuberculosis Centre organised the first Russian language course for TB managers. Held in Ulaanbaatar, the 2-week course was attended by 16 managers from the Russian Federation and taught by instructors from England, Japan, Mongolia, Nepal, and The Union Secretariat.

These successful collaborations led to further projects and the NPCT’s 2-year remit was renewed for another 2 years. In 2003, the NPCT worked with The International Journal of Tuberculosis and Lung Disease to create a Russian version of the Journal that was printed and distributed to 1,500 doctors and other healthcare professionals. This publication was so well received that work began on a second edition in 2004.

‘Mongolia has demonstrated the value of collaborating centres,’ says Dr Nils E Billo, Union Executive Director. ‘By working with them, The Union has been able to educate and assist doctors and healthcare workers not only in Mongolia, but also across the whole Russian Federation.’

Drs GR Khatri and Nils E Billo, Mampreet Kaur, Sunita Kripalani, Amit Gordon and Dr Vineet Bhatia in front of the India Resource Centre.
Communications Unit increases Union visibility

The Union’s communications programme creates links between members around the world, helping them stay abreast of the activities of the Secretariat and other members; developments in tuberculosis and lung disease prevention, treatment and control; opportunities for advocacy; upcoming courses, conferences and events; and other issues.

The Union website and principal newsletter are available in English, French and Spanish – the three official languages of The Union. Other publications, such as a monthly e-newsletter and the annual Activity Report, are produced in English.

The Union’s website provides extensive information for members and other interested persons. The Union’s series of technical guides on tuberculosis and other lung diseases may be downloaded at no charge, and it is also the home site of The International Journal of Tuberculosis and Lung Disease. Full details about conferences and courses, membership, recent news and making a donation are all online.

The Union builds visibility within the TB and lung disease community by bringing an information booth to conferences hosted by other organisations. In 2004, The Union participated in lung health conferences in France, India, Scotland, Thailand and the United States, as well as in its own Africa, Europe and North America Region Conferences and World Conference on Lung Health.

Media relations are also an important part of The Union’s communications strategy. Press releases in English, French and Spanish are distributed to the international media for major advocacy events, scientific gatherings and other significant activities. Press events held in Paris for the opening of the World TB Day photography exhibition and the 35th World Conference on Lung Health generated a variety of coverage. A press briefing on the Child Lung Health Project in Malawi for the UN Correspondents Association in New York generated an Associated Press story that was picked up internationally. Innovative Union courses on international TB control and financial management attracted media coverage in India and Pakistan. Coverage in France included interviews on Radio France Internationale and a programme organised and broadcast by France Culture and Le Monde, which was also posted on the Internet.

Stop TB Image Library faces uncertain future

The Stop TB Image Library continued to grow in its second year, adding hundreds of new images to the collection from China, Ghana, India and other countries. It served as a resource for many websites and documents, including those of The Union, which managed the library for the Stop TB Partnership for 2 years. Other users ranged from the WHO and the US CDC to Westcare in Perth, Western Australia and Médecins Sans Frontières – Indonesia. In April, an Image Library bulletin was distributed to Union members and the Stop TB Partners to promote the use of the collection.

As part of World TB Day 2004, The Union organised a photography exhibition on ‘TB in Paris and the World’ using images from the Stop TB Image Library and library manager Gary Hampton’s private collection. This exhibit was also displayed during the 35th World Conference on Lung Health at the Town Hall of Paris’s 1st district.

Although the library’s content and use increased substantially, The Union and the Stop TB partnership decided that it would not be able to continue to provide the staffing and technical support needed to keep it in operation after the end of 2004. Alternate plans for hosting the library are under discussion.
World Days bring fresh attention to TB and lung disease

‘World Days’ provide important occasions for raising public awareness about public health issues. The organisation of a World Day event, such as a public meeting, spectacle or press conference, creates synergies and unites those involved in public health, from government ministers and donor agencies to the staff of local health centres, patients and their families.

While The Union’s advocacy and social mobilisation efforts continue on throughout the year, World Days offer opportunities to highlight members’ efforts and carry the message to the media about the global public health challenges of tuberculosis and lung disease.

World Tuberculosis Day: 24 March

Every breath counts. Stop TB now!

Laugh, cry, shout, sing, whisper: to do all of these, you first have to breathe

World Tuberculosis Day 2004 coincided with the 2nd Stop TB Partnership Forum held in New Delhi, India on 24–25 March. This forum convened delegations from the 22 highest TB burden countries, representatives from the G-8 countries and all of the Stop TB Partners. As a founding member of the Partnership, The Union was well represented at this important event, which generated considerable media interest for efforts to stop TB.

In Paris, The Union commemorated World TB Day 2004 by holding a photography exhibition entitled ‘TB in Paris and the World.’ The selection of colour and black and white photographs was drawn from the Stop TB Image Library and the private collection of photographer Gary Hampton. It was displayed in La Maison du Poumon from 24 March to 30 June.

In addition, The Union distributed press releases and background information to members and the media.

World Asthma Day: 4 May

The burden of asthma

World Asthma Day was created in 1998 to highlight the growing increase in asthma across both the industrialised and developing worlds. In conjunction with this global awareness-raising event, The Union initiated a campaign to improve access to essential asthma medication, which is prohibitively expensive for the majority of asthma sufferers in low-income countries. Working with the WHO, and other organisations, The Union hopes to establish a Global Asthma Drug Facility, modeled on the successful Global TB Drug Facility, to reduce the costs of inhaled corticosteroids to asthma patients in low-income countries.

World No Tobacco Day: 31 May

Tobacco and poverty

World No Tobacco Day 2004 emphasised not only the toll in ill-health and human lives caused by tobacco use, but also the poverty-causing, poverty-sustaining and exploitive labour practices of the transnational tobacco countries. The Union disseminated information about World No Tobacco Day through its print and e-newsletters, website and other information distributed to members and the media.

Tobacco control advocacy was an important activity throughout 2004. The Union called on members to support the Framework Convention on Tobacco Control (FCTC) and to encourage both their own countries and others to ratify the treaty.

The Union also participated in an important meeting organised by the WHO Tobacco Free Initiative, which gathered representatives of health professional organisations to establish a code of practice in tobacco control. Health professionals are essential partners in successful tobacco control activities, and this code of practice has been distributed to Union members.
Union Member Activities
The International Union Against Tuberculosis and Lung Disease was established in 1920 by 31 national lung associations to provide much-needed centralised services and resources, including scientific conferences and education programmes, publications, research and technical assistance. Over the past 84 years, The Union has become widely regarded as one of the most effective organisations dedicated to the prevention, treatment and control of tuberculosis and other lung diseases.

While many Union activities are managed through the Secretariat in Paris, the 1204 members around the world also play a critical role. Today’s members include not only lung associations, but also national tuberculosis programmes, ministries of health, physicians’ associations, patient advocacy groups and individuals.

“Through active involvement in The Union, people who care about lung disease can make a real difference in the lung health of their own communities and around the world.”

Scott McDonald
Executive Director
British Columbia Lung Association

Nurses and allied professionals gather together in Honduras after a workshop.
Union members form a vital network

Organisational and constituent members work together by affiliating with one of The Union’s six regions – Africa, Eastern, Europe, Latin America, Middle East and North America. The regions provide a focus for advocacy and social mobilisation efforts, and members address TB and lung health issues from their regional perspective through conferences and other activities. The regions meet annually at The Union’s World Conference on Lung Health and at other times throughout the year as needed to carry out their plans.

Individual members may also join one of The Union’s six scientific sections: bacteriology and immunology, nurses and allied professionals, respiratory disease, tobacco prevention, tuberculosis and tuberculosis in animals. Through these sections, members have an opportunity to share their expertise and experience. The sections are responsible for planning and presenting the scientific content of Union regional and international conferences; and other activities range from preparing manuals and training materials to sponsoring advocacy events.

Within the sections, working groups (WGs) take on specific projects. Typically these groups hold annual meetings at the World Conference to summarise the activities of the previous year, hear reports from members and plan activities for the coming year. Some tasks require WGs from different sections to collaborate, further increasing the opportunity for members to gain new experience and contacts. The scientific sections also occasionally collaborate with the Secretariat’s scientific divisions. Officers of the scientific sections report to the Chair of the Scientific Coordinating Committee, who is an elected member of the Board of Directors.

With its strong Secretariat, the global reach of its regions and the depth of experience in its scientific sections, The Union provides a powerful network of public health experts to meet the challenge of tuberculosis and lung disease around the world.

**Union Member Activities**

**BENEFITS OF UNION MEMBERSHIP**

Both organisations and individuals may become members of The Union.*

**Outstanding resources**

Union membership includes:
- A subscription to the peer-reviewed *International Journal of Tuberculosis and Lung Disease*
- Free technical guides, advocacy materials and other resources
- A subscription to The Union’s monthly e-newsletter and other publications.

**Professional opportunities**

Union member activities include:
- Networking with colleagues from other countries
- Participating in research projects with other members
- Presenting results at conferences
- Attending regional and international conferences at a discounted rate.

**Make a difference in the global fight for lung health**

Union members help support:
- Experts in the field serving national tuberculosis programmes around the world
- Research on prevention, treatment and control of TB, HIV, asthma, child pneumonia, tobacco-related conditions and other lung diseases in low- and middle-income settings
- Education and training in clinical practice and patient care, research methods, programme management and other key issues
- Advocacy efforts to keep TB and lung diseases high on the public health agenda.

* Individual and organisation benefits vary. For full details, consult The Union website at [www.iuatld.org](http://www.iuatld.org)

**Bacteriology and Immunology Scientific Section**

Chair: Chinnambedu N Paramasivan, India
Vice chair: Kai Man Kam, Hong Kong
Secretary: Catherine Mundy, USA
Programme secretary: Knut Feldmann, Germany

The Bacteriology and Immunology Section sponsored four sessions at the 35th World Conference: a workshop on practical laboratory issues in low-resource settings and symposia on the value of measuring drug resistance; the bacterial virulence of tubercle bacilli and genetic susceptibility in humans; and microscopy and culture. They also presented a symposium jointly with the Nurses and Allied Professionals Section on ensuring quality care in DOTS implementation/integrating laboratory, NTPs and organisation.

At their annual meeting during the World Conference, the section validated statements on drug resistance, surveillance of drug resistance, drug susceptibility testing, and External Quality Assessment for AFB smear microscopy. They heard a report from the International Laboratory Training Opportunities Working Group and discussed renewing the Non-Tuberculous Mycobacteria (NTM) Working Group. Nuria Martin Casabona offered to serve as this WG’s leader. The section also proposed activities for the next World Conference.
Working Group
INTERNATIONAL LABORATORY TRAINING OPPORTUNITIES
Leader: Salman Siddiqi, USA

This working group has met several times in the last few years. Its discussions have helped to generate interest in the various mechanisms to recruit laboratory consultants to help in laboratory training in developing countries. There was great interest in this activity among experts, and several volunteered their services. The WG also developed an application form. This WG may be discontinued because The Union Bacteriology Section does not have the resources to carry out these training activities, and no support could be obtained from outside.

Nurses and Allied Professionals Scientific Section (NAPS)
Chair: Chantelle Allen, Nepal
Vice chair: Evita Berga, Latvia
Secretary: Rajita Bhavaraju, USA
Programme secretary: Helen Wallstedt, Sweden

NAPS officers serve a 3-year term, which for current officers expires on 31 October 2005. At the annual meeting, the working groups made presentations. There were no new section statements or documents produced in 2004.

Working Group
EDUCATION AND TRAINING
Leaders: Nick Deluca, USA and Nisha Ahamed, USA

The objectives of this working group are to develop, improve and maintain access to training and educational resources, and to assist Union members to build their skills and participate in NAPS activities.

For the 35th World Conference on Lung Health, the WG sponsored a postgraduate course on adapting educational materials to local contexts, and organised a display and discussion session where members presented materials including videos, training guides and databases that they had developed during the year.

At their annual meeting, members discussed their education and training needs. In 2005, the WG will plan activities and training targeted to members’ needs and offer them guidance in locating or developing training and educational materials.

Working Group
CASE MANAGEMENT
Leader: Gini Williams, UK

This Working Group completed the first draft of its patient care manual in February 2004. The manual includes more than 40 case studies/stories drawn from the four regions participating in the NAPS regional network – Africa, Eastern, Europe and Latin America.

A meeting in April was canceled due to lack of funds, which has delayed publication of the complete manual. Nevertheless, a short version entitled TB Guidelines for Nurses in the Care and Control of Tuberculosis and Multidrug Resistant Tuberculosis was published by the International Council of Nurses in October.

Four WG members attended the 35th World Conference on Lung Health with funding from the Tuberculosis Coalition for Technical Assistance (TBCTA). There they discussed the current draft and plan to have the complete manual revised and ready for publication by July 2005. TBCTA will fund the printing and distribution.
Respiratory Disease Scientific Section
Chair: Isabella Annesi-Maesano, France
Vice chair: Steve Graham, Malawi
Secretary: Gregory Erhabor, Nigeria
Programme secretary: Christer Janson, Sweden

The Respiratory Disease Scientific Section meeting, held at the 35th World Conference, was attended by 15 members. Prof Peter Burney chaired the meeting in the absence of Dr Isabella Annesi-Maesano.


Elections were held for 2005. Elected officials are listed above.

Working Group
EMERGENCY ROOM TREATMENT OF ASTHMA IN LOW-INCOME COUNTRIES
Leader: Peter Burney, UK

This Working Group has completed a descriptive study of acute severe asthma patients visiting emergency rooms (ER) in 13 centres in 11 countries. Patients were examined and interviewed about the severity and treatment of their disease in the 4 weeks prior to their ER visit. Data collected between 1 March 2003 and 6 November 2004 were analysed across centres.

The data showed that only 36% of patients with persistent asthma had been prescribed an adequate dose of inhaled corticosteroids (ICS). The percentage was higher among those receiving regular care from the same doctor and at least as good for the 10% of patients receiving private health care. Those with health insurance were more likely to be receiving adequate ICS and reported good adherence with their medication. Patients on adequate medication were much less likely to have lost work in each of the 4 previous weeks than those two or three treatment steps below the recommended dose. Access to adequate treatment appears to be critical in better management of asthma. The WG has submitted a paper for publication.

Working Group
AIR QUALITY AND LUNG HEALTH IN DEVELOPING COUNTRIES
Leader: Noureddine Zidouni, Algeria

The aim of this Working Group is to promote Union members' awareness of indoor and outdoor atmospheric pollution in low-income countries. Consequently, the group proposes to establish adequate surveillance indicators for pollution and associated health risks.

After a workshop at the 34th World Conference on Lung Health, the group organised symposia that were presented at the Africa Region Conference and the 35th World Conference in 2004.

Tobacco Prevention Scientific Section
Chair: Javaid Khan, Pakistan
Vice chair: Chakib Nejjari, Morocco
Secretary: Lee Abdelfadil, Sudan
Programme secretary: Stefano Nardini, Italy

The Tobacco Prevention Scientific Section meeting at the 35th World Conference was attended by a dozen members. They thanked outgoing officers Jacques Prignot (Belgium) and Elif Dagli (Turkey) and elected new officers: see list above.

The Section also formed a new Working Group on smoke-free universities and tobacco issues in medical school curricula, which will be coordinated by Chakib Nejjari.

Tuberculosis in Animals Scientific Section
Chair: Claude Turcotte, Canada
Vice chair: Reinhard Weiss, Germany
Secretary: Giuliana Moda, Italy
Programme secretary: John Kaneene, USA

In 2004, The Union confirmed the status of the Tuberculosis in Animals Scientific Section as separate from the Tuberculosis Scientific Section. Members of Tuberculosis in Animals held their annual meeting at the 35th World Conference. New officers are Chair Claude Turcotte (Canada) and Secretary Giuliana Moda (Italy). Past Chair Charles Thoen (USA) will continue his active role in the section.

The M. bovis Working Group continued its work in 2004. New information about the contribution of M. bovis to human tuberculosis has come from studies underway in Europe, Africa and Latin America.

The section expects to establish a new M. avium Working Group in 2005 to better understand how to identify M. avium and the risks it presents.

Other goals are to disseminate copies of the symposium sponsored by the section entitled ‘Can You Get TB from Your Food?’ and to contribute appropriate images to the Stop TB Image Library.
Tuberculosis Scientific Section

Chair: Sue Wang, China
Vice chair: M Amir Khan, Pakistan
Secretary: Fraser Wares, India
Programme secretary: Michael E Kimerling, USA

The Tuberculosis Scientific Section meeting was attended by 48 members, and the vice chair, secretary and programme secretary. The section voted on eight General Assembly resolutions and heard a presentation on the 2005 Union budget. They also endorsed nominees for the Board of Directors and the 2005 Union Medal.

New officers were elected for 2-year terms: see list above. Members thanked outgoing Chair Dr Paula Perdigao (Mozambique) and Programme secretary Dr Ian Smith (Switzerland) for their contributions.

Members also discussed the proposed reorganisation of the scientific sections and heard reports from the TB working groups.

Working Group
TB-HIV
Leaders: Renee Ridzon, USA and Bess Miller, USA

At the 35th World Conference, the TB-HIV Working Group sponsored two sessions. The first described the antiretroviral (ARV) programmes in Khalitsha Cape Town and Malawi. Speakers discussed how TB is being addressed within the 3 x 5 programme and TB-HIV projects funded by the Bill and Melinda Gates Foundation. The second session focused on integration of TB and HIV activities and programmes, the operational research agenda for TB and HIV, drug-drug interactions between antituberculosis and ARV drugs, and intensified TB case finding and isoniazid preventive therapy in HIV care settings.

At the WG meeting, representatives from the WHO, the CDC and The Union also presented updates on current TB-HIV-related activities.

In 2005, the WG expects to continue presenting TB-HIV-related data at relevant TB and HIV meetings, and providing a forum for discussion of these topics at Union conferences.

Working Group
TRANS-BORDER MIGRATION AND TB
Leaders: Fraser Wares, India and Deliana Garcia, USA

At a well-attended annual meeting at the 35th World Conference, members heard reports on a variety of activities including the collection, review and dissemination of existing practices, policies and guidelines for trans-border migration, recent initiatives on trans-border TB control; and the establishment of an electronic communication network (www.migrantclinician.org). The WG presented a symposium on TB in mobile populations and in persons with illegal residence status at the conference.

In 2005, WG members plan to contribute to a paper on migrants’ access to TB care and an editorial on the issue of TB in persons with undocumented residence status. Both will be submitted to The International Journal of Tuberculosis and Lung Disease. The WG will also explore the possibility of joint activities with the TB in Prisons WG.

Working Group
TB EDUCATION
Leader: M Amir Khan, Pakistan

The TB Education Working Group sponsored a postgraduate course on multimethod research in DOTS expansion at the 35th World Conference. The course was attended by 19 participants and taught by Dr Aime De Muynck, Prof Odd Morkve, Dr Charles Yu, Dr John Walley, Dr M Amir Khan and Dr Rose Liefooghe. Morning sessions covered an introduction to research methods used in DOTS expansion, use of research methods in educational interventions, case studies, a group exercise and a panel discussion. In the afternoon, there was a technical session on the use of research evidence for enhanced educational interventions and a second panel discussion. Participants rated the course as interesting, well presented and relevant.
Union Member Activities
Reports from the Regions

Africa Region
President: Dr Felix Salaniponi, Malawi
Secretary General: Dr Angelica Salomão, Mozambique

The Africa Region is comprised of 22 member organisations in 45 countries across the continent. Members include lung health organisations, national tuberculosis programmes and ministries of health. Members of the Africa Region have been sponsoring conferences to share their research and experience since the late 1960s. The 15th Africa Region Conference was held in Algeria in 2004.

22 AFRICAN COUNTRIES REPRESENTED AT CONFERENCE IN ALGERIA

The 15th conference of The Union Africa Region was held in Algiers, Algeria from 9–12 February 2004 under the patronage of the President Abdelaziz Bouteflika. Prof Djilali Larbaoui, President of the Conference and Organising Committee, proudly welcomed delegates from 22 African countries: Algeria, Benin, Burkina Faso, Cameroon, DR Congo, Egypt, Ghana, Guinea, Ivory Coast, Kenya, Madagascar, Malawi, Morocco, Nairobi, Niger, Senegal, South Africa, Tanzania, Togo, Tunisia, Uganda and Zambia. They were joined by colleagues from Belgium, Canada, France, Switzerland, the United States and the United Kingdom.

Highlights of the scientific programme included a full-day session on TB control and the community, and a workshop for nurses and allied professionals on poster production aimed at increasing their participation in conferences. DOTS expansion in Africa, multidrug resistance treatment in sub-Saharan Africa and HIV/AIDS were among the TB-related symposia topics. Other sessions were devoted to the tobacco epidemic, occupational lung disease and air pollution, lung health in children and asthma management, including a presentation on the International Study of Asthma and Allergies in Childhood (ISAAC) in Africa.

During a session on the Practical Approach to Lung Health (PAL) strategy where access to essential drugs was raised, Dr Nils E Billo, Executive Director of The Union, introduced the concept of a global Asthma Drug Facility, initiated by The Union and several partners. This new facility would be modeled on the Global Tuberculosis Drug Facility (GDF), which has been instrumental in reducing the cost of TB treatment to US $10 per patient.

In his opening speech, President Bouteflika described the devastating impact of tuberculosis and lung disease in Africa, and reiterated his country’s willingness to collaborate with other African countries to combat these diseases.
The Europe Region includes representatives from 37 lung health associations, hospitals, government agencies and patient advocacy organisations in 40 countries.

Members of the Europe Region met several times to plan the 4th Europe Region Conference in June 2006. The conference will be held in Latvia, and the scientific committee will include not only Europe Region members, but also representatives from Scandinavian countries and the European Respiratory Society (ERS). Organisers plan to explore the possibility of the event becoming a pan-Baltic congress, jointly sponsored by Latvia, Estonia and Lithuania.

Members also agreed that contributing to new ERS guidelines would be an official activity of the Europe Region. The document is the joint project of the ERS, The Union, The Royal Netherlands Tuberculosis Association (KNCV) and the WHO.

EUROPE REGION CONFERENCE DRAWS RECORD NUMBER OF DELEGATES
The Union’s 3rd Europe Region Conference was held this year in conjunction with the Russian Respiratory Society’s 14th National Congress on Lung Diseases. The joint conference brought together pulmonologists and phthisists for the first time in Russia and attracted 4,671 delegates, making it the largest Union meeting ever to be held in Europe. Participants came from Russia (60%), Eastern Europe (25%) and other Western countries (15%). More than half of the delegates were pulmonologists, 30% were TB specialists, and 15% were from other specialties.

The scientific programme included 17 postgraduate courses in Russian and 11 international postgraduate courses in English. Nine international symposia examined issues in tuberculosis treatment and control, ranging from TB in large cities and MDR-TB to TB in children. A symposium organised by the Nurses and Allied Professionals Scientific Section (NAPS) explored the challenge of implementing the DOTS strategy in different parts of Europe.

A ‘pro and con’ session chaired by Dr Hans L Rieder of The Union looked at the controversy over radiological screening – which in Russia is preferred over sputum-smear microscopy – for active TB case finding. A second ‘pro and con’ session debated the question of vaccination and revaccination.

The opening ceremony held at the Kremlin attracted more than 4,000 people. Many delegates also enjoyed the cultural programme, which offered tours of historic sites in Moscow and St Petersburg.

Although the North America Region (NAR) comprises only three member countries – the United States, Canada and Haiti – it includes some of the largest and most influential organisations in lung health in the world and also some of The Union’s strongest advocates. The American Lung Association (ALA), the American Thoracic Society (ATS) and the British Columbia Lung Association have made invaluable contributions to the fight against tuberculosis and lung disease through their support of research and their advocacy and education programmes. In 2004, the ALA received The Union Medal in recognition of its longstanding support.

The NAR sponsors an annual conference, which is held alternately in the United States and Canada.

NORTH AMERICA AND LATIN AMERICA REGIONS DISCUSS CROSS-BORDER ISSUES AT CONFERENCE
The theme of the 2004 NAR Conference was ‘Crossing Borders to Eliminate TB’, and a principal objective was to foster and strengthen ties with the Latin America Region.

While the NAR conference usually alternates between Chicago, Illinois, USA and Vancouver, British Colombia, Canada, the NAR decided to hold this meeting in Austin, Texas to encourage participation from Mexico and Latin America. The TBCTA and the International Tuberculosis Foundation provided scholarships for 19 people from Latin America and other countries.

More than 350 people attended the meeting, which included 30 workshops, lectures and symposia and more than 80 poster presentations. For the first time, the conference was simultaneously translated into Spanish.

A highlight was a full-day assembly for nurses, which was attended by nurses from North America and members of The Union’s Latin America Region nurses and allied professionals network.

The ALA of Metropolitan Chicago and the Chicago Thoracic Society (a chapter of ATS) collaborated with the ALA of Texas/Texas Thoracic Society and the Texas Department of Health to organise and host the conference.
General Assembly and Board of Directors

Report from the General Assembly

The annual meeting of the General Assembly was held at the World Conference on Lung Health on 1 November 2004. All fully paid members of The Union were invited to attend and vote on issues pertaining to The Union’s management and direction.

RESOLUTIONS
The General Assembly approved the Activity Report, the Treasurer’s Report and the audited accounts for 1 July 2002–31 December 2003. They also unanimously approved the budget for the financial year 2005 and the purchase of office space at 72 boulevard Saint Michel in Paris. They voted to change the bye-laws so that the Treasurer may be re-elected from year to year for a maximum of 9 years.

BOARD OF DIRECTORS: ELECTIONS
Dr Ahsan Ali of Bangladesh and Dr Dean Schraufnagel of the United States were elected to fill seats for individual members that became open in 2004. Two regional representatives also ended their terms this year. The Eastern Region nominated Dr Tao Ping Lin of Taipei, China, who was confirmed; the Latin America Region will nominate a candidate at a later date.

CHANGING VENUE OF WORLD CONFERENCE
The Assembly approved a plan to hold the World Conference outside of France in 2007 as it is more consistent with The Union’s mission to alternate the location between Paris and its six regions.

HONORARY MEMBERSHIPS
The Nominating Committee and the Board of Directors were pleased to award honorary memberships to:
- Prof Li-xing Zhang from China for his long-standing support of The Union and his contribution to tuberculosis control in China
- Dr Rodolfo Rodriguez from Cuba for his outstanding contribution to the implementation of DOTS in the Latin America Region as TB advisor to PAHO and for his excellent collaboration with The Union
- Prof Hans Waaler from Norway for his long-standing support of The Union as an tuberculosis advocate in Norway and for chairing the Finance Committee for many years.

AWARDS
Winners of the 2004 Christmas Seals contest received their award certificates (see page 71 for details). The General Assembly approved the nominee for the 2005 Union Medal.

Report from the Board of Directors

The Board of Directors held its annual retreat from 7–9 May 2004 in Paris to review the progress of various Secretariat activities; discuss the experiences of Stop TB Partnerships at national, regional and international levels; and make recommendations for future directions. The Board also discussed ways to strengthen Union Regions through regional bodies and an inter-regional council.

In her presentation, President Asma El Sony stressed the importance of sustaining, improving and promoting Union activities, in particular by building on the success of the TB model and by exploring its application to other lung diseases and public health problems. She also presented a vision of The Union for feedback from the Board. The final document will be presented to the General Assembly at the World Conference.

Executive Director Nils E Billo and Director of Scientific Activities Donald A Enarson presented highlights of 2004 activities. Other topics discussed included the progress of the TB-HIV pilot projects; the need to continue and expand Union contributions to human resource development; the importance of creating a stronger network among people who have taken Union courses; the high priority that should be given to tobacco prevention and control; the value of expanding the reach of Union activities through collaborating centres; ways to disseminate experience with Stop TB campaigns; personnel issues at the Secretariat; and the need for a long-range strategic plan.
The International Union Against Tuberculosis and Lung Disease presents awards at its annual World Conference on Lung Health to individuals and organisations that have made an outstanding contribution to tuberculosis or non-tuberculous lung disease. A nominating committee of Union members studies the proposals and selects candidates.

Scientific Prize

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

Dr Igor Mokrousov (Russia) received the 2004 Scientific Prize for his analysis of the genome polymorphism of *Mycobacterium tuberculosis* based on insertion and repetitive sequences, and the molecular basis of drug resistance. At age 37, he is a senior researcher at the St Petersburg Pasteur Institute and author of 40 published journal articles, including a dozen articles on tuberculosis in the past 2 years.

The Karel Styblo Public Health Prize

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

Dr Jaap Broekmans (The Netherlands) received the 2004 Karel Styblo Public Health Prize for his contributions to TB control and his indefatigable support of the DOTS strategy. Director of the Royal Netherlands Tuberculosis Association (KNCV) since 1987, he has developed KNCV into an organisation that is currently active in 35 countries.

Dr Broekmans began his career in the 1970s in Tanzania, where he was greatly inspired by Dr Karel Styblo. He went on to work for TB control in The Netherlands, China, Vietnam and Tanzania.

He has served as Chair of the WHO’s Strategic Technical Advisory Group – Tuberculosis since 2001 and was a founding member of the Stop TB Initiative, forerunner of the Stop TB Partnership. He serves on the Partnership’s Coordinating Board.

He has chaired the Board of Directors of the Tuberculosis Coalition for Technical Assistance (TBCTA) since 2001; serves as the UN Millennium Project’s TB Taskforce Coordinator; and is an ex-officio member of the Technical Evaluation Reference Group for the Global Fund to Fight AIDS, TB and Malaria (GFATM). A long-time Union member, he served on the Executive Committee for 10 years and was a member of the Board of Directors from 1999 to 2004.

The Union Medal

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

Dr Jacob Kumaresan (India) was honoured with The Union Medal for his work with the Stop TB Partnership as a founding member and Executive Secretary (2000-2003). During that time, he oversaw the creation of the Global TB Drug Facility (GDF), which coordinates the bulk purchase of TB drugs, reducing the cost of treatment to $10 per patient.

Dr Kumaresan received his MD degree from Kilpauk Medical College, University of Madras, India, and later earned MPH, TM and DrPH degrees from Tulane University (USA). During his 20-year career in public health, he also managed infectious disease programmes in Botswana and currently serves as President of The International Trachoma Initiative in New York.

On the occasion of its 100th anniversary, the American Lung Association (United States) received The Union Medal for its long-standing support of The Union. The ALA and its forerunners have supported The Union throughout its history, and delegates from North America have helped shape The Union’s mission and programmes since the 1920s.

In 1947, the ALA proposed to match the existing budget of The Union to support its revival after World War II, and the ALA has continued to maintain a high level of support, even during their own difficult periods.
We are grateful to our American constituent member whose sustained support included such specific initiatives as publishing a bulletin in English and French, the appointment of a full-time Executive Director, Union-managed multi-country studies — the first of their kind in the world, and the work of the Tuberculosis Surveillance Research Unit (TSRU), headed by then Director of Scientific Activities Dr Karel Styblo. This research provided vital information for TB prevention that formed the basis of today’s DOTS strategy.

With the backing of constituent members such as the ALA, The Union is able to pursue its pioneering studies of disease patterns and tests of new diagnostics, treatments and prevention methods. Their support is irreplaceable in developing mutual respect and stimulation, attenuating prejudices and in creating solidarity, friendship and peace.

Princess Chichibu Memorial Award

This annual award memorialises Princess Chichibu of Japan (1909–1995), who was active for many years in the Japan Anti-Tuberculosis Association (JATA) and served as its president. The $10,000 award is given in recognition of outstanding achievement in anti-tuberculosis activities. Candidates are recommended by the Awards Committee of The Union, irrespective of their nationality, and the winner is selected by JATA. The President of JATA presents the award at the World Conference on Lung Health.

Dr Hans L Rieder (Switzerland) received the 2004 Princess Chichibu Memorial Award for his contributions to tuberculosis education. Trained in Switzerland and the United States, Dr Rieder began his career working in infectious diseases at Zurich’s University Hospital and then directed a TB programme for Cambodian refugees in Thailand. He also worked for the US Centers for Disease Control for 4 years before returning to Switzerland’s Public Health Service.

A full-time Union consultant since 1993, Dr Rieder has conducted international TB courses in Africa, Asia and Europe, and also teaches courses on operational research. He is author of more than 200 articles, and author or co-author of several monographs on TB control.

PAST WINNERS OF UNION AWARDS SINCE 1998

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<th>Karel Styblo Public Health Prize</th>
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<td>1998 Dr Dirgh Singh Bam, Nepal</td>
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<td>2002 Dr Anne Horgheim, Norway</td>
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<td>2003 Dr Oumou Bah-Sow, New Guinea</td>
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<td>2004 Dr Jaap Broekmans, The Netherlands</td>
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**NEIL WALTON WHITE**  
1954–2004

Professor Neil Walton White was born on 15 May 1954 in Edinburgh, Scotland, and died peacefully on 6 November 2004 in Cape Town, South Africa. He was a remarkable man and will be remembered fondly by his colleagues and all those whose lives he touched during his short life.

Neil held numerous degrees and diplomas, earned in an education that took him from the United Kingdom and Canada to South Africa. At the University of Cape Town, he was an Associate Professor and head of the Occupational Medicine Unit and the Lung Institute.

A lifelong human rights activist, Neil devoted his academic career to the epidemiology of lung diseases affecting the people of Africa, and he always made sure that his findings were embedded in guidelines and regulations to improve the lives of the very people used in his research. His published work led to the exposure of occupational lung diseases, including pneumoconiosis, byssinosis, silicosis and asbestosis caused by South African industry, and he campaigned for the fair compensation of workers affected by these diseases.

Neil was also a devoted member of The Union. He served on the faculty of courses in Africa, and one of his early studies of pneumoconiosis in miners working in South African mines was initiated at a Union conference in Maputo. He was a member of the Working Group on Asthma and the Respiratory Disease Committee, both of which contributed to the development of *A Guide to the Management of Asthma in Low-Income Countries*.

But what we’ll all remember best about Neil will be his ever-present laugh, his remarkable sense of justice and his amazing good nature. He never compromised on principles and, although he was investigating unfair practices, he brought about change by fairness and not by anger.

Neil is survived by his wife Justine Quince and their two sons, Kim Jabulani and Joseph Douglas Mandla.

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

This Activity Report covers the accounting period from 1 January – 31 December 2004. During that time, the department prepared 130 financial reports for donors, prepared accounts for seven external audits and organised the disbursement of per diem to approximately 500 individuals. In order to further strengthen National TB Programmes, the department also assisted several countries by procuring drugs, laboratory supplies and equipment valued at almost four million euros.

To meet the reporting requirements of our principal donors, the department hired two financial project managers and support staff. The department was also actively involved in designing and teaching the new international financial and management training courses offered in 2004.

All activities of the Department of Finance and Development support the mission of The Union by providing efficient and effective financial and administrative services, by enabling access to information and resources and by promoting the financial health and security of each unit and The Union as a whole.
I am pleased to submit the annual report of the Treasurer of the International Union Against Tuberculosis and Lung Disease for the fiscal year ended 31 December 2004. During this year The Union has made significant progress in examining its operations, charting growth and planning for the future. While making advances in these and other important areas, we have also maintained financial strength and realised a modest operating surplus. The economic challenge The Union faced in Fiscal 2003, stirred a collective energy to approach our mission with greater-than-ever dedication, and creativity, including numerous steps to increase revenue, reduce costs, and manage more efficiently. After a major review of our policy for managing foreign currencies. The Union engaged currency experts to monitor the fluctuations of the Canadian dollar, the US dollar and the euro and to advise management on strategies for reducing the risk of foreign-exchange losses. In addition, the introduction of new financial management procedures improved The Union’s ability to control expenditures and take corrective action when necessary.

With the breadth of resources entrusted to The Union by donors, government agencies, members, and other supporters, the need for prudent fiscal oversight is great. Working closely with our Board of Directors and our auditors, we continue to review and improve our financial policies, procedures, and practices. Such oversight will ensure the continued financial strength needed to pursue The Union’s agenda in Fiscal 2005 and beyond.

Financial highlights

- The Union ended the year with an operating surplus of EUR 4,813 (US $6,557).
- Grants and managed funds, as a percentage of total revenue, represented 72% of total revenue. The Union received new grants totaling EUR 6.7 million (US $9.1 million) from the European Commission and USAID respectively.
- The Union’s General Fund accounted for 28% of total revenue, and included unrestricted funds received from members, donors, and friends of The Union. The General Fund underwrites most administrative activities, the cost of publications and core scientific activities of The Union. Unrestricted expenses exceeded revenue by EUR 365,400 (US $497,711) due to a reduction of the grant from the Royal Norwegian Ministry of Foreign Affairs.
- Approximately EUR 148,000 (US $201,000) of funds owed by constituent members were written off as members indicated their inability to pay.
- The Union’s assets increased during Fiscal 2004 with the purchase of a new premise that will provide 110 m² of office space in close proximity to the main Secretariat office. Staff from the Department of Scientific Activities currently working in leased premises will relocate to the new office in Fiscal 2005. A policy of developing our assets as well as our programmes will allow The Union to maintain its existing strengths and develop in new and exciting areas.

We enter Fiscal 2005 with improved financial results, but with continued concerns for both revenues and expenditures. Changes in the way funding agencies support projects, and the declining number of paying constituent members, are areas that pose significant challenges.

While the financial picture is improving, The Union’s agenda is no less ambitious than in prior years. We must remain committed to the sound financial management needed to achieve The Union’s goals. Continued fiscal discipline and increased administrative efficiency are essential to make the most of the resources available to support our mission of research, education, and technical assistance.
Financial statements

This report describes the financial position of The Union. The document on the following pages consists of the financial statements for Fiscal 2004 audited by KPMG.

The audited financial statements present a snapshot of The Union’s entire resources and obligations at the close of the fiscal year. We have presented the accounts in euros and US dollars in order to facilitate comparison of accounts.

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

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

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

By almost any measure, The Union is better positioned today than last year, or the year before. Our success is the product of clear vision, unrelenting effort, a determination to honour our commitments, and the exercise of disciplined financial management. The Union staff is proud of what has been accomplished during Fiscal 2004 and looks forward to building on these achievements. I know the Board joins me in thanking them for their exemplary dedication, as we also thank you, the members of The Union, and our donor agencies for your confidence and continued support of The Union.

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

Dear Sir,

In compliance with the assignment entrusted to us by the Executive committee, we are pleased to submit our report concerning the audit of the accounts of the association International Union Against Tuberculosis and Lung Disease, for the period beginning January 1st 2004 and ended December 31st, 2004 as attached to the present report.

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

Opinion on the annual accounts

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

In our opinion, the financial statements give a true and fair view of the financial position and its assets and liabilities as of December 31st, 2004 and of the results of its operations for the year then ended in accordance with the accounting rules and principles applicable in France.

Levallois-Perret, August, 31st, 2005

KPMG Entreprises

François Kimmel
Partner

Union Budget
- Revenues
- Expenditures

Expenditure
- Courses
- Managed Funds
- Personnel
- Services and Publications
- Conferences
- Travel
- Other

Sources of Revenue
- Membership
- Grants and Gifts
- Managed Funds
- Conferences
- Courses
- Other Income
### Balance Sheet

1 January 2004 - 31 December 2004

#### Assets

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Software</td>
<td>€64,780 (88,237)</td>
<td>€62,224 (78,384)</td>
</tr>
<tr>
<td>Land</td>
<td>€500,000 (681,050)</td>
<td>€500,000 (629,850)</td>
</tr>
<tr>
<td>Building</td>
<td>€2,621,506 (3,570,753)</td>
<td>€2,070,000 (2,607,579)</td>
</tr>
<tr>
<td>Fixtures and equipments</td>
<td>€156,446 (213,095)</td>
<td>€73,417 (92,484)</td>
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<tr>
<td>Other tangible fixed assets</td>
<td>€195,336 (266,067)</td>
<td>€225,547 (284,122)</td>
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<tr>
<td>Financial fixed assets</td>
<td>€35,428 (48,256)</td>
<td>€34,119 (42,980)</td>
</tr>
<tr>
<td><strong>Total 1</strong></td>
<td>€3,573,496 (4,867,459)</td>
<td>€2,965,308 (3,735,399)</td>
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<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constituent members</td>
<td>€238,552 (324,932)</td>
<td>€292,099 (367,957)</td>
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<tr>
<td>Suppliers advance</td>
<td>€159,357 (217,060)</td>
<td>€222,568 (280,369)</td>
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<tr>
<td>Managed funds receivable</td>
<td>€10,565,203 (14,390,864)</td>
<td>€12,212,562 (15,384,164)</td>
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<tr>
<td>Other receivables</td>
<td>€309,455 (421,508)</td>
<td>€519,501 (654,415)</td>
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<tr>
<td>Sundry debtors</td>
<td>€735,998 (1,002,503)</td>
<td>€604,895 (761,986)</td>
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<tr>
<td><strong>Total 2</strong></td>
<td>€12,008,565 (16,356,866)</td>
<td>€13,851,625 (17,448,891)</td>
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<tr>
<td>Financial investment for managed funds</td>
<td>€3,866,191 (5,266,139)</td>
<td>€6,616,361 (8,334,630)</td>
</tr>
<tr>
<td>Cash and bank for managed funds</td>
<td>€4,079,350 (5,556,483)</td>
<td>€5,794,744 (7,299,639)</td>
</tr>
<tr>
<td>Cash and bank of The Union</td>
<td>€741,571 (1,010,094)</td>
<td>€1,947,436 (2,453,185)</td>
</tr>
<tr>
<td><strong>Total 3</strong></td>
<td>€8,687,113 (11,832,716)</td>
<td>€14,358,541 (18,087,454)</td>
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<tr>
<td><strong>Prepaid expenses</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Total 4</strong></td>
<td>€123,468 (168,176)</td>
<td>€94,230 (118,702)</td>
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<tr>
<td><strong>Realisable exchange losses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total 5</strong></td>
<td>€96,172 (130,996)</td>
<td>€641,601 (808,225)</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>€24,488,814 (33,356,214)</td>
<td>€31,911,305 (40,198,670)</td>
</tr>
</tbody>
</table>

**NB:**

2003 1 € = 1,2597$
2004 1 € = 1,3621$
### Liabilities

<table>
<thead>
<tr>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Equity</strong></td>
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<tr>
<td>Reserves</td>
<td>€429 820</td>
<td>€429 820</td>
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<tr>
<td></td>
<td>US$585 458</td>
<td>US$541 445</td>
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<tr>
<td>Result carried forward</td>
<td>-€946 524</td>
<td>-€1 289 260</td>
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<td>-US$1 289 260</td>
<td>-US$155 282</td>
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<td>Result from the financial year</td>
<td>€4 814</td>
<td>-US$1 069 793</td>
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<td></td>
<td>-US$6 557</td>
<td>-US$1 347 618</td>
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<td>Restatement reserve on premises</td>
<td>€1 887 396</td>
<td>€1 887 396</td>
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<tr>
<td></td>
<td>US$2 570 822</td>
<td>US$2 377 552</td>
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<td><strong>Total 1</strong></td>
<td>€1 375 507</td>
<td>€1 370 692</td>
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<tr>
<td></td>
<td>US$1 873 577</td>
<td>US$1 726 661</td>
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<td><strong>Contingent liability</strong></td>
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<td></td>
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<td><strong>Total 2</strong></td>
<td>€146 235</td>
<td>€637 387</td>
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<tr>
<td></td>
<td>US$199 187</td>
<td>US$802 917</td>
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<td><strong>Dedicated funds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total 3</strong></td>
<td>€18 510 745</td>
<td>€24 623 667</td>
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<td></td>
<td>US$25 213 487</td>
<td>US$31 018 433</td>
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<tr>
<td><strong>Debts</strong></td>
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<tr>
<td>Borrowing from credit institutions</td>
<td>€735 585</td>
<td>€162 349</td>
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<td></td>
<td>US$1 001 941</td>
<td>US$204 512</td>
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<td>Current bank advances (Short-term)</td>
<td>€2 128 837</td>
<td>€3 782 801</td>
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<td></td>
<td>US$2 899 688</td>
<td>US$4 765 195</td>
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<tr>
<td>Suppliers and similar accounts</td>
<td>€618 285</td>
<td>€304 841</td>
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<td></td>
<td>US$842 166</td>
<td>US$384 008</td>
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<tr>
<td>Tax and social security</td>
<td>€483 809</td>
<td>€285 960</td>
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<tr>
<td></td>
<td>US$658 996</td>
<td>US$360 223</td>
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<tr>
<td>Charges to be paid</td>
<td>€74 280</td>
<td>€105 584</td>
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<td></td>
<td>US$101 177</td>
<td>US$133 004</td>
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<tr>
<td>Other unliquidated obligations</td>
<td>€298 953</td>
<td>€484 929</td>
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<tr>
<td></td>
<td>US$407 204</td>
<td>US$610 865</td>
</tr>
<tr>
<td><strong>Total 4</strong></td>
<td>€4 339 749</td>
<td>€5 126 464</td>
</tr>
<tr>
<td></td>
<td>US$5 911 172</td>
<td>US$6 457 807</td>
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<tr>
<td><strong>Deferred income</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Total 5</strong></td>
<td>€105 646</td>
<td>€66 264</td>
</tr>
<tr>
<td></td>
<td>US$143 901</td>
<td>US$83 473</td>
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<tr>
<td><strong>Realisable exchange profit</strong></td>
<td>€10 932</td>
<td>€86 831</td>
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<tr>
<td></td>
<td>US$14 891</td>
<td>US$109 381</td>
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<tr>
<td><strong>Total 6</strong></td>
<td>€24 888 814</td>
<td>€31 911 305</td>
</tr>
<tr>
<td></td>
<td>US$33 356 214</td>
<td>US$40 198 670</td>
</tr>
</tbody>
</table>

Grand Total | €24 888 814 | US$33 356 214 |

NB: 2003 1 € = 1,2597$  
2004 1 € = 1,3621$
### Income Statement (in €)

#### Operating Income

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>824 601</td>
<td>0</td>
<td>824 601</td>
</tr>
<tr>
<td>Operating grant</td>
<td>1 663 319</td>
<td>0</td>
<td>1 663 319</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>2 097 701</td>
<td>5 323 546</td>
<td>7 421 248</td>
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<tr>
<td>Write back of provisions and transferred charges</td>
<td>603 701</td>
<td>96 710</td>
<td>700 411</td>
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<tr>
<td>Write back of dedicated funds</td>
<td>0</td>
<td>11 335 386</td>
<td>11 335 386</td>
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<tr>
<td>Other income</td>
<td>974 069</td>
<td>42 696</td>
<td>1 016 765</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6 163 391</td>
<td>16 798 339</td>
<td>22 961 730</td>
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</table>

#### Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>External charges</td>
<td>3 150 707</td>
<td>8 243 231</td>
<td>11 393 938</td>
</tr>
<tr>
<td>Taxes</td>
<td>211 623</td>
<td>0</td>
<td>211 623</td>
</tr>
<tr>
<td>Wages and salaries</td>
<td>1 700 981</td>
<td>0</td>
<td>1 700 981</td>
</tr>
<tr>
<td>Social contributions</td>
<td>679 056</td>
<td>0</td>
<td>679 056</td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>408 513</td>
<td>0</td>
<td>408 513</td>
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<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>5 222 464</td>
<td>5 222 464</td>
</tr>
<tr>
<td>Other expenses</td>
<td>81 709</td>
<td>3 327 451</td>
<td>3 409 159</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6 232 588</td>
<td>16 793 146</td>
<td>23 025 733</td>
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</table>

#### Operating result

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating result</td>
<td>-69 197</td>
<td>5 193</td>
<td>-64 003</td>
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</tbody>
</table>

#### Foreign exchange profit or loss

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign exchange profit or loss</td>
<td>-386 083</td>
<td>-5 163</td>
<td>-391 246</td>
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</tbody>
</table>

#### Write back of financial provisions

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write back of financial provisions</td>
<td>644 728</td>
<td>0</td>
<td>644 728</td>
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</tbody>
</table>

#### Interest and financial charges

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest and financial charges</td>
<td>-88 461</td>
<td>-31</td>
<td>-88 492</td>
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</tbody>
</table>

#### Provision of risk for foreign exchange losses

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of risk for foreign exchange losses</td>
<td>-96 172</td>
<td>0</td>
<td>-96 172</td>
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</tbody>
</table>

#### Net financial result

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net financial result</td>
<td>74 011</td>
<td>-5 193</td>
<td>68 818</td>
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</table>

#### Net result for financial year

<table>
<thead>
<tr>
<th></th>
<th>General Funds</th>
<th>Managed Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net result for financial year</td>
<td>4 814</td>
<td>0</td>
<td>4 814</td>
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</tbody>
</table>
### Income Statement (in US$)

#### Operating Income

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Funds</td>
<td>Managed Funds</td>
</tr>
<tr>
<td>Contributions</td>
<td>1 123 190</td>
<td>0</td>
</tr>
<tr>
<td>Operating grant</td>
<td>2 265 606</td>
<td>0</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>2 857 279</td>
<td>7 251 202</td>
</tr>
<tr>
<td>Write back of provisions and transferred charges</td>
<td>822 301</td>
<td>131 729</td>
</tr>
<tr>
<td>Write back of dedicated funds</td>
<td>0</td>
<td>15 439 930</td>
</tr>
<tr>
<td>Other income</td>
<td>1 326 779</td>
<td>58 157</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>8 395 155</strong></td>
<td><strong>22 881 018</strong></td>
</tr>
</tbody>
</table>

#### Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Funds</td>
<td>Managed Funds</td>
</tr>
<tr>
<td>External charges</td>
<td>4 291 578</td>
<td>11 228 105</td>
</tr>
<tr>
<td>Taxes</td>
<td>288 251</td>
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<tr>
<td>Wages and salaries</td>
<td>2 316 906</td>
<td>0</td>
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<td>Social contributions</td>
<td>924 942</td>
<td>0</td>
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<tr>
<td>Depreciation charges and addition to provisions</td>
<td>556 435</td>
<td>0</td>
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<tr>
<td>Obligations for projects</td>
<td>0</td>
<td>7 113 519</td>
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<tr>
<td>Other expenses</td>
<td>111 296</td>
<td>4 532 320</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>8 489 408</strong></td>
<td><strong>22 873 944</strong></td>
</tr>
</tbody>
</table>

---

#### Operating result

-94 253 7 074 -87 179 -1 135 730

---

#### Foreign exchange profit or loss

-525 884 -7 032 -532 917 464 810

#### Write back of financial provisions

878 183 0 878 183 222 499

#### Interest and financial charges

-120 493 -42 -120 535 -96 281

#### Provision of risk for foreign exchange losses

-130 996 0 -130 996 -802 917

---

#### Net financial result

100 810 -7 074 93 736 -211 888

---

#### Net result for financial year

6 557 0 6 557 -1 347 618

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**NB:** 2003 1 € = 1,2597$  
2004 1 € = 1,3621$
DONOR ACKNOWLEDGEMENTS

The work summarised in this Activity Report would not have been possible without the assistance and support of all our donors. We would like to express our sincere thanks to the following organisations:

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>PROJECTS FUNDED IN 2004</th>
</tr>
</thead>
</table>
| Bill & Melinda Gates Foundation | Child Lung Health Programme  
35th World Conference on Lung Health |
| British Columbia Lung Association (BCLA) | Core activities |
| Canadian International Development Agency (CIDA) | Fidelis, DOTS Expansion in Uganda and Myanmar, technical assistance (helping countries fill in GFATM proposals) |
| European Commission (EC) | HIV Programme  
Clinical Trials – Study C |
| Global Alliance for TB Drug Development | Clinical Trials – capacity building  
Publications |
| Green Light Committee (GLC) (WHO) | MDR-TB meeting support |
| International Tuberculosis Foundation (ITF) | Annik Rouillon Documentation Centre (ARDOC)  
Core activities  
Child Lung Health Project in Malawi |
| Medisch Comité Nederland–Vietnam (The Netherlands Medical Committee) | Vietnam International TB Course |
| Ministère de la Culture et de la Communication, France | Simultaneous translations for the 35th Union World Conference on Lung Health |
| Ministère des Affaires Etrangères, France | TB in large cities workshop  
Technical assistance in Benin and Uganda  
Cours international sur la lutte antituberculeuse  
French translations of Union communication documents (website, press, World Days) and technical publications |
| Norwegian Agency for Development Cooperation (Norad) | Core activities  
35th Union World Conference on Lung Health |
| Norwegian Association of Heart and Lung Patients (LHL) | Technical assistance in Senegal and Sudan |
| Service public fédéral, Affaires étrangères, Commerce extérieur et Coopération au Développement, Belgium | Africa Region Conference |
| Stop TB Partnership (STBP) | 35th Union World Conference on Lung Health |
| Swiss Agency for Development Cooperation | Core activities |
| Swiss Federal Office of Public Health | Core activities |
| Swiss Pulmonary League | Technical assistance in Benin |
| Tuberculosis Coalition for Technical Assistance (TBCTA) with financial support from USAID | Technical assistance in DR Congo and Senegal  
World and Regional Conferences  
Educational courses:  
• NAPS networks and education  
• International TB Course  
• International Course in Management, Finance and Logistics  
• International Course on Management of Managers for TB Control Programmes  
• Applied epidemiology for Operations Research in TB Control  
• Advanced course on AFB Microscopy and EQA  
• Social mobilisation of NGOs in TB Control  
• Workshop in Algeria December 2004  
• Curso Internacional de Epidemiologia y Control de la Tuberculosis  
• Curso de Especializacion de Gestion en Acciones de Control de Tuberculosis  
• Curso de Supervision en las Acciones de Programa de Control de Tuberculosis  
• Curso Intensivo; Teorica-Practico de Epidemiologia y Control de la TB  
• TB in large cities workshop  
• Junior consultants’ training  
• DOTS Expansion Workshop |
| United Kingdom Department for International Development (DFID) | Health Policy Research |
| US Agency for International Development (USAID) | Secondment of Dr Paula I Fujiwara  
Lab strengthening programme  
Clinical Trials – Study A and Study C  
TB/HIV  
Capacity building  
35th Union World Conference on Lung Health |
| US Department of Health and Human Services/Centers for Disease Control and Prevention (CDC) | Secondment of Dr Paula I Fujiwara  
International Course in Management, Finance and Logistics  
Technical guides  
Union North America Region Conference, TB Control Workshop, Mexico  
Workshops at 35th Union World Conference on Lung Health  
Technical Assistance to Brazil NTP |
| World Health Organization (WHO) | Stop TB Image Library  
International Course in Management of MDR-TB  
35th Union World Conference on Lung Health  
Technical Assistance to Brazil NTP |
| Yadana project, operated by TOTAL | HIV Programme in Myanmar |
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- American Lung Association (USA)
- Anti-tuberculosis Association of Thailand (THAILAND)
- Asociación Nacional de Tuberculosis e Doencas Respiratorias (PORTUGAL)
- Association Sénégalaise de Lutte Anti-tuberculeuse (SENEGAL)
- Belgian Lung and TB Association (BELGIUM)
- British Thoracic Society (UNITED KINGDOM)
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- Canadian Lung Association (CANADA)
- Central Association Against Tuberculosis and Lung Disease (EGYPT)
- Ceylon National Association for the Prevention of TB (SRI LANKA)
- Chest Disease Hospital (GREECE)
- Chinese Anti-tuberculosis Association (CHINA)
- Comité algérien de lutte contre la tuberculose (ALGERIA)
- Czech Pneumo & Phthisiologie Society (CZECH REPUBLIC)
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- Federation Nationale Tuberculose (FRANCE)
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- Philippine TB Society Inc (IRELAND)
- Programa Nacional de Controlo Endemias (ANGOLA)
- Programa Nacional de Tuberculosis (BOLIVIA)
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- Société Suisse de Pneumologie (SWITZERLAND)
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- Vereen Anstalt Alland (AUSTRIA)

**ORGANISATIONAL MEMBERS**

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- Kuratorium Tuberkulose in der Welt EV (GERMANY)
- SAARC Tuberculosis Centre (NEPAL)
- Norwegian Association of Heart & Lung Patients (NORWAY)
- TB Alert (UNITED KINGDOM)
- Chest, Heart & Stroke Scotland (UNITED KINGDOM)
- American College of Chest Physicians (USA)
- King Oscar II Foundation (SWEDEN)

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  - Mr Julian Vyas (FRANCE)
100 YEARS OF CHRISTMAS SEALS

The 2004 Christmas Seals contest held at the World Conference on Lung Health marked the centenary of the stamps that have been used to raise funds for TB and lung disease around the world. The idea for Christmas Seals originated with Enar Holbøll, a Danish postal worker, and the first stamps were issued bearing the Queen of Denmark’s image in 1904. In Denmark, the stamps generated funds to build several sanatoria for children with TB. The idea caught on quickly in Europe and North America, and eventually spread to countries around the globe. At the 35th World Conference, the private collection of Joseph Wheeler (USA) was on display. It included Christmas Seals from 130 countries, some dating back to 1904. Seals from The Union’s archive were also on exhibit.

The annual 2004 exhibit included Christmas Seals from 16 countries: Canada, France, Germany, Hong Kong, India, Korea, Mexico, The Netherlands, Norway, Pakistan, The Philippines, Portugal, Sudan, Taiwan, Thailand and Tunisia. Conference participants voted for their favorite Christmas seals. The 2004 winners were:

1st prize: Korean National Tuberculosis Association

2nd prize: Philippine Tuberculosis Society, Inc

3rd prize: Hong Kong Tuberculosis, Chest and Heart Diseases Association

AFB acid-fast bacilli
ADF Asthma Drug Facility
AIDS acquired immune-deficiency syndrome
ALA American Lung Association
ARDOC Annik Rouillon Documentation Centre
ARI acute respiratory infection
ART antiretroviral treatment
ARV antiretroviral
ATS American Thoracic Society
BCG bacille Calmette-Guérin
CDC United States Centers for Disease Control and Prevention
CIDA Canadian International Development Agency
CLHP Child Lung Health Project
COPD chronic obstructive pulmonary disease
DFID United Kingdom Department for International Development
DOTS directly observed treatment, short-course
EQA external quality assessment
ERS European Respiratory Society
FCTC Framework Convention on Tobacco Control
FIDELIS Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB
GASP Global Asthma Survey of Practice
GDF Global TB Drug Facility
GFATM Global Fund to Fight AIDS, TB and Malaria

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Lexic

HIV human immunodeficiency virus
ICRC International Committee of the Red Cross
INGCAT International Non Governmental Coalition Against Tobacco
ISAAC International Study of Asthma and Allergies in Childhood
ITF International Tuberculosis Foundation
JATA Japanese Anti-Tuberculosis Association
KNCV Royal Netherlands Tuberculosis Association
LHL Norwegian Association of Heart and Lung Patients
LSHTM London School of Hygiene and Tropical Medicine
MDR-TB multidrug-resistant tuberculosis
NAPS Nurses and Allied Professionals
NAR North America Region
NGO nongovernmental organisation
Norad Norwegian Agency for Development Cooperation
NTLP National Tuberculosis and Leprosy Programme
NTP National Tuberculosis Programme
PAHO Pan American Health Organization
PAL Practical Approach to Lung Health
TB tuberculosis
TBCTA Tuberculosis Coalition for Technical Assistance
UN United Nations
USAID United States Agency for International Development
WG working group
WHO World Health Organization

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