For nearly 100 years, The Union has drawn from the best scientific evidence and the expertise, experience and global reach of our staff, consultants and members to advance solutions to the most pressing public health challenges affecting people living in poverty around the world. KNOW. SHARE. ACT.
I frequently like to point out that The Union touches individual lives every day in the 156 countries where we work. But reading this 2013 annual report, I am still amazed by the enormous impact of our organisation on some of the most critical issues in public health today. I am sure that you – our members, colleagues, donors and friends – will feel the same way when you read it too.

The spread of multidrug-resistant tuberculosis (MDR-TB) represents a major barrier to the dream of elimination, which inspired the founding of our organisation nearly 100 years ago. The Union’s MDR short-course treatment trials in francophone Africa and the STREAM clinical trial are going to revolutionise both our knowledge of – and approach to – MDR care globally.

The Union also continues to support health systems innovation and strengthening, as evidenced by the use of M-health in India, electronic medical records systems in Malawi for TB, HIV and NCDs, and the installation of solar panels at HIV clinics in Zimbabwe. Clinical ‘best practices’ must go hand-in-hand with innovations to the health system’s delivery of care, and The Union is there.

We have long been a leader in global tobacco control, and The Union’s statement on e-cigarettes was the first scientific statement warning of the dangers of these new products. It has since served as a rallying point for the world’s respiratory societies and other groups. In HIV, ‘prevention is key’ is the new mantra, and this is equally true for tobacco control. Preventing tobacco use is essential if we hope to improve global lung health.

Through The Union’s Operational Research courses, now branded “SORT IT” in conjunction with Médecins Sans Frontières and WHO, we are building the capacity of low- and middle-income countries to identify issues, conduct research and disseminate critical knowledge. The bidirectional screening programme for TB and diabetes mellitus in India is just one of many outcomes from this programme.

The launch of the Roadmap for Childhood TB has spotlighted the plight of the most vulnerable – and oft forgotten – population in TB control, the children. Justifications based on the challenge of diagnosing TB in children or these cases’ lack of public health impact can never be used to ignore children affected by TB again. The Roadmap for me exemplifies The Union’s vision of Health solutions for the poor.

There are many more initiatives I could highlight, but let me end this year’s remarks from the President by focusing on the conference and the membership. I have noted often that the World Conference is the first item placed on my annual calendar with my own Union region conference next to appear – and that is because these meetings are where I interact with and network with each of you. It is where I learn and where I gain strength from my colleagues, our patients and our activists, and where I take away inspiration and energy for another year. I believe others feel this too – which is why our conferences continue to grow.

I am awed to read about the work of The Union in this year’s annual report, and I look forward to the opportunity to hear more from you all in person. The power to achieve our mission lies in each of us – and in the power generated by our coming together for a common goal.

Dr E Jane Carter
President, The Union
MESSAGE FROM THE EXECUTIVE DIRECTOR

We are living in a moment of rapid, even seismic, change. We’re seeing the limited arsenal of TB medicines lose its potency as drug resistance intensifies and spreads. The global rise of non-communicable diseases means diabetes and TB are increasingly working together, comprising a looming co-epidemic poised to heavily affect people in low- and middle-income countries. After years in which we have seen unprecedented progress against tobacco use in many countries, the tobacco industry, ever innovative, has completely changed the game with the invention and aggressive marketing of e-cigarettes.

These are just a few of the dynamic challenges we face. How will we solve them?

As a global scientific organisation, The Union’s approach starts with evidence. We conduct research so that we can know the nature of the challenges we face and their most effective solutions. Through our peer-reviewed journals, our global and regional conferences, and through training courses and technical assistance, we provide platforms for sharing scientific knowledge with stakeholders around the world. And by directly delivering health services and advocating on behalf of those affected by tuberculosis and lung disease, we directly act on the best available scientific knowledge.

Know. Share. Act. These principles have driven The Union’s work since its founding nearly 100 years ago.

The French philosopher Jean-Francois Lyotard wrote that “scientific knowledge is a kind of discourse.” Discourse is essential for knowing, sharing and acting. As you’ll see when reading this report, The Union’s members, consultants and staff are advancing health solutions through discourse with literally millions of constituents and stakeholders across every region of the world.

If you’re reading this report, we would value having a discourse with you, too. There are many ways for us to engage. If you’re a clinician or researcher, submit your research for publication in the IJTLD or Public Health Action. Attend one of our global or regional conferences where you’ll interact with friendly colleagues and leaders in the field. Join The Union by becoming a member, whether you’re a seasoned expert or a student just starting out in public health.

I hope you enjoy reading about The Union’s efforts this past year. And when you’re finished, I hope we hear from you.

José Luis Castro
Executive Director, The Union
The Union

The Union institute provides our stakeholders with a full range of services and products that span from generating evidence to taking action to improve public health.

“Know. Share. Act. These principles have driven The Union’s work since its founding nearly 100 years ago.

José Luis Castro, Executive Director, The Union
Health Solutions for the Poor

The Union Institute’s 463 staff and consultants offered technical assistance, education and training and conducted research in 87 countries in 2013. In addition, Union members in 156 countries work to fulfill our common vision: health solutions for the poor.
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EVIDENCE IS THE FIRST STEP

The Union conducts research that advances knowledge and leads to changes in public health policy and practice that strengthen health systems and save lives. Our emphasis is on operational research and clinical trials.

SHORTENED REGIMEN IS A “REVOLUTION” FOR MDR-TB TREATMENT

96% of patients with MDR-TB showed no evidence of live TB bacteria in their sputum by the fourth month

First-year results from research studying a nine-month treatment for multidrug-resistant tuberculosis (MDR-TB) demonstrated that this new regimen is effective. Of the first 208 patients recruited for the study, 96 per cent had no evidence of live TB bacteria by the fourth month of treatment.

The goal of this research is to dramatically improve the treatment options for 450,000 people suffering from MDR-TB. The current standard treatment is too long, too expensive and too grueling for everyone involved. In addition, keeping patients alive without curing them may promote transmission of the disease.

The study, which will involve 1,000 patients, is taking place in nine francophone African countries. The Union and the national TB programmes are testing a nine-month course of treatment that had an 89 per cent success rate when previously tested in Bangladesh, Cameroon, Niger and Benin. By comparison, the standard 20–24 month regimen has a 53 per cent treatment success rate.

The World Health Organization, The Union’s Ethics Advisory Group and each country’s national ethics committee approved use of the shortened regimen for this study.

The participating countries are Benin, Burundi, Burkina Faso, Cameroon, Central African Republic, Côte d’Ivoire, Democratic Republic of Congo, Niger and Rwanda.

Project funding comes from each country, with coordination funded by France Expertise Internationale and Agence Française de Développement.

“ That’s a revolution. That’s a lot of hope for a lot of countries.”

Dr Arnaud Trebucq, Head, TB Technical Assistance Division, on the first-year results of a shortened MDR-TB regimen
TRIAL TO DETERMINE A NEW STANDARD TREATMENT FOR MDR-TB

STREAM data will show the shortened treatment’s performance in varied settings

While the results of observational studies indicate that a shortened MDR-TB regimen is highly effective, its validity has remained in question due to a lack of randomised data from a head-to-head comparison with the current standard 20–24 month regimen. The Union’s STREAM (Standardised Treatment Regimen of Anti-TB drugs for patients with MDR-TB) clinical trial is making that comparison.

With sites in South Africa, Ethiopia and Viet Nam, STREAM is testing a regimen modeled on one previously tested in Bangladesh that achieved an 87.9 per cent treatment success rate. Patient recruitment began in 2012 with half of the projected 400 patients enrolled by 31 December 2013. Mongolia is scheduled to become the fourth participating country in 2014.

The goal is to determine whether the Bangladesh regimen is effective in other settings and whether the results are at least as good as the current standard 20–24 month regimen. If the data confirm its effectiveness, the shortened regimen will then become the new standard against which other new or modified regimens will be measured.

The principal funder of the STREAM clinical trial is the US Agency for International Development (USAID). Additional funding is provided by the United Kingdom Medical Research Council and the UK Department for International Development (DFID).

UNION TRIAL PROVIDES SOLUTION FOR TB-HIV DRUG INTERACTION

Phase II pharmacokinetic study finds alternative TB drug produces better outcomes

Interactions between anti-tuberculosis drugs and antiretroviral therapy (ART) can be a serious problem for patients with HIV-associated tuberculosis. A randomised phase II pharmacokinetics study conducted by The Union and its partners in Viet Nam assessed different doses of the antibiotic rifabutin in combination with protease inhibitor-based ART to see whether patients tolerated it better than the more commonly prescribed antibiotic, rifampicin.

Rifabutin has been proposed as an alternative, and the trial data showed that a dose of 150 mg of rifabutin once daily produces the best treatment outcomes. The study’s results were accepted by *Plos ONE* in November 2013 for publication in early 2014.

The French National Institute for Health and Medical Research-French National Agency for Research on AIDS and Viral Hepatitis (INSERM-ANRS) sponsored and funded this study. Additional support and donations came from Fondation Total and Laboratoires SERB.

POLICY CHANGE AIDS TO HEAD OFF DIABETES/TB CRISIS

Operational research (OR) in India demonstrated value of bidirectional screening for TB and diabetes

The growing burden of non-communicable diseases (NCDs) in low- and middle-income countries is now recognised as a major threat to both public health and sustainable development.

In India, the country with the highest TB burden in the world, The Union and its research partners successfully tested the use of routine health services to

87.9% TREATMENT SUCCESS RATE achieved in Bangladesh tests

382 MILLION PEOPLE WITH DIABETES are at greater risk for TB
cross-screen people with diabetes for TB and TB patients for diabetes to address this potentially serious co-epidemic.

The success of this research has led to changes in India’s national policy and practice that also point a way forward for other countries.

The new policies include:

- New public policy requiring all registered TB patients to be screened for diabetes with appropriate changes to recording and reporting tools
- New Ministry of Health training manual for health workers in the field
- New public policy linking the TB and NCD national programmes so that data on TB patients are shared with both programmes, easing collaboration
- Suggestion that the new NCD programme collect and monitor patient data, using the DOTS principles developed by The Union for monitoring TB.

Results of these OR projects were summarised in eight papers published as a supplement to the November 2013 issue of *Public Health Action*, which is available at no charge. Two additional papers were published in May 2013 in *Tropical Medicine and International Health*.

The World Diabetes Foundation funded this project, as well as a similar pilot study conducted in China in 2012.

**TB KNOWLEDGE NEARLY DOUBLED AMONG THE PUBLIC**

Survey studied the results of India’s Project Axshya at the mid-point of a five-year grant

The Union South-East Asia Office conducted a Knowledge, Attitude and Practice (KAP) Survey to measure the effectiveness of advocacy, communication and social mobilisation activities conducted by its Project Axshya across 21 states of India. The “midline” survey measured data at the mid-point of the five-year project as compared to the baseline survey done when Project Axshya began.

**ONLY 18% KNEW BASIC TB FACTS when Project Axshya started**

Results showed that basic knowledge of TB among 4,804 members of the general public rose to 32 per cent, compared to 18 per cent at the baseline. There were also gains in TB knowledge among important stakeholders: those affected by TB, opinion leaders, representatives of non-governmental and community-based organisations and health service providers.

Project Axshya is funded by The Global Fund to Fight AIDS, Tuberculosis and Malaria.

**E-CIGARETTE BOOM REQUIRES EFFECTIVE REGULATION**

Official Union statement advocates further research – and provokes strong response

In the 11 years since e-cigarettes were invented in China, the market for these products has grown to US$ 3 billion a year. Variously promoted as safer than smoking and a quit-smoking aid, e-cigarettes urgently require regulation, according to a review of scientific evidence conducted by Union experts.

The conclusion was that the safety of these products has not been proven and that the rapid growth in the use of e-cigarettes demands immediate action from the health community. Specific problems range from the undisclosed amounts of nicotine and other chemicals delivered by the products to the marketing of flavours such as bubble gum that target children and adolescents.

Based on the evidence collected during the review, the Department of Tobacco Control developed an official Union statement on e-cigarettes and electronic nicotine delivery.
systems (ENDS). It was launched during the 44th Union World Conference on Lung Health in Paris and published in the *International Journal of Tuberculosis and Lung Disease* in November 2013.

The statement was widely cited in the press and provoked an outcry from “pro-vapers” on social media. Subsequently the Forum of International Respiratory Societies (FIRS) used the document as the foundation for their own position statement on e-cigarettes.

**TOBACCO CONTROL COULD SAVE 3.7 MILLION RUSSIAN LIVES BY 2055**

Union research examines long-term benefits of tobacco control in Russia

A Union study of the long-term effects of tobacco control policies on smoking rates and attributable deaths in Russia was published *Tobacco Control* in 2013, adding momentum for the country’s new comprehensive law. This study revealed that a full range of public policies that help reduce the demand for tobacco would save up to 3.7 million lives by 2055.

The Union Russia Office has worked with governmental and non-governmental supporters of tobacco control since 2008. With 43.9 million smokers, Russia is one of the top 15 tobacco-using countries, but awareness of the devastating impact of tobacco on health has led to strong new policies at the national level.

**SURVEY SHOWS STRONG SUPPORT FOR TOBACCO CONTROL IN INDONESIA**

Public opinion survey on tobacco control generates regional support from health ministers

A public opinion survey conducted in 11 cities across Indonesia by Union grantees, the Indonesian Institute for Social Development and Muhammadiyah, found strong support for tobacco control. Of the 1,444 respondents, 91 percent supported adopting the WHO Framework Convention on Tobacco Control (FCTC), and 95 per cent supported the introduction of comprehensive tobacco control laws.

These data were used by the Ministry of Health and the Indonesian Tobacco Control Network to generate support among policymakers and the media for signing the Framework Convention on Tobacco Control (FCTC). They were also used to draft an academic paper to advance tobacco control policy debate at ministerial and presidential levels.

The paper was published, and survey data released to the media, to coincide with the first day of the 4th Islamic Conference of Health Ministers (OIC), which was held in Jakarta in October 2013. Resulting national media coverage reinforced the need to enhance tobacco control in Indonesia and across the OIC region.

**91% OF INDONESIANS SURVEYED SUPPORT ADOPTION of the Framework Convention on Tobacco Control (FCTC)**

The conference concluded with several strong resolutions on tobacco control that urged all OIC Member States to ratify the FCTC and implement the WHO-recommended MPOWER measures, to battle together against the region’s illicit tobacco trade and to prohibit tobacco trade fairs.
The Union facilitates global sharing of expertise by providing advice and assistance to countries at their request, convening international and regional conferences, training health professionals and publishing peer-reviewed journals and technical guides.

NEW TOBACCO CONTROL LEGISLATION SET TO COVER THE WORLD’S MOST POPULOUS NATION

Success in China at city-level sets stage for introduction of national law

While several Chinese regions have comprehensive and well-enforced tobacco control laws, a national policy framework has yet to be developed. In 2013, The Union signed a contract to assist the Chinese authorities with this process. The Union is working with key stakeholders in the National Health and Family Planning Commission and the State Council to provide technical support for the design and implementation of a national smokefree law, and a strategy for raising public awareness about the impact of tobacco use on health.

The new policies will draw on international best practice for tobacco control, as well as the success of city-level strategies in Tianjin, Shanghai, Harbin and Guangzhou. In these jurisdictions alone, 40 million people are now protected from tobacco smoke. Once in place, the new legislation will cover the world’s most populous nation, which is currently home to 300 million smokers. The annual death toll due to smoking-related disease in China now stands at one million; without the introduction of effective tobacco control, this figure is estimated to rise to three million by 2050.

“We have reached the tipping point in China. Strong growth in smokefree law at city-level has built momentum for creating a national policy.”

DR EHSAN LATIF, Director, Department of Tobacco Control
ADVISE

PUBLIC-PRIVATE PARTNERSHIP LEADS TO QUALITY TB SERVICES IN KAMPALA’S SLUMS

SPARK-TB improves TB services in clinics used by 60% of Ugandans in the capital’s slums

A Union project in Uganda has developed a successful approach to improving TB services in the slums of the capital city, Kampala. Over the past two years, SPARK-TB (Slum Partnerships to Actively Respond to Tuberculosis in Kampala) has fostered ties between the public health sector and the private clinics that are a major source of health care for people living in Kampala’s slums.

About 60 per cent of the population uses these clinics first when they become ill, because they are more convenient than public health facilities. Unfortunately, before SPARK-TB, most of them lacked the capacity for TB diagnosis, so patients with TB went home undiagnosed, spreading the disease and coming back much sicker than before.

60% OF URBAN POOR VISIT PRIVATE CLINICS FIRST

Through SPARK-TB, the Union Uganda Office has worked with 70 private clinics, the National TB and Leprosy Programme and the Kampala City Council Authority to build a successful public-private partnership that has enabled some clinics to receive free TB medicines and have the quality of their laboratories assessed. The Union has also provided training, mentoring and supervision to develop the capacity of all clinic staff and establish links between community health workers and the clinics.

These clinics now provide quality TB diagnosis and care with support from the project, and in 2013, some 1,500 TB patients were detected and started on treatment.

The Stop TB Partnership TB-REACH Initiative is funded by the Government of Canada and UNITAID.

TB IN BRIEF

Uganda’s national lab becomes Supra National Reference Laboratory for East Africa

Ten years of collaboration between Uganda, The Union and other partners culminated in 2013, when the National Reference Laboratory was granted the status of Supra National Laboratory (SRL) by the World Health Organization. Uganda is only the fourth SRL in Africa and will serve East Africa.

Redefinition of MDR-TB outcome failure proposed by The Union is adopted by WHO

The World Health Organization adopted a proposal from The Union to redefine the meaning of outcome “failure” in the management of MDR-TB in its “Definitions and reporting framework for tuberculosis – 2013 revision”. The Union felt that the previous definition was not practical and could not be used to guide clinical management of MDR-TB. The new definition was originally proposed in a 2011 article written by several Union consultants and published in the International Journal of Tuberculosis and Lung Disease.

Mobile technology reduces delay in diagnosis of TB patients in tribal district of India

In a remote tribal district of Jharkhand, India, rural health care providers and lab technicians were trained and equipped with Android-based mobile phones pre-loaded with a mobile application to create a real-time central database of persons with symptoms of TB. The database includes both those who have been referred for testing and the results of their tests. Updated and monitored in real time, the system helps improve follow up on referred individuals and reduces delays in getting test results.

The Union implemented this pilot project in collaboration with Dimagi and the Lilly Foundation of Eli Lilly & Company.

PRIMARY CARE CLINICS CAN PROVIDE FULL RANGE OF TB-HIV SERVICES

76% of TB-HIV patients receive antiretroviral treatment (ART) at pilot clinics in Zimbabwe

In Zimbabwe, an estimated 74 per cent of tuberculosis patients – some 30,000 people – are co-infected with HIV. As a result, they need to be able to obtain care for both diseases at the same facility, close to where they live. In October 2011, The Union Zimbabwe Office began work with 13 primary care clinics in 9 urban areas to strengthen their capacity to both diagnose and treat patients in their catchment areas with these linked diseases. The project expanded to 23 clinics in 17 urban areas in 2012, and these clinics have shown they can offer the full range of collaborative TB-HIV services, as recommended by the World Health Organization.

96% OF TB PATIENTS RECEIVED HIV TESTS at primary care clinics in Zimbabwe pilot project
Results achieved from October 2012 to September 2013 compared very favourably to national averages, which report data from 2012. For example:

- HIV testing for TB patients: 96% (national average: 91%)
- Cotrimoxazole preventive therapy (CPT) for TB patients living with HIV: 89% (national average: 94%)
- ART for TB patients living with HIV: 76% (national average: 74%)

The Union project has also improved the clinic facilities by building open-air pavilions to serve as waiting areas and help prevent the spread of TB and by adding solar panels to reduce the problems caused by Zimbabwe’s frequent power outages. All of which means patients consistently receive the care they need.

This project is funded by TB CARE I, implemented by the Tuberculosis Coalition for Technical Assistance (TBCTA) with funds from USAID.

ELECTRONIC REGISTERS USED TO MONITOR PATIENTS IN MALAWI

High-tech monitoring system provides critical data on HIV/AIDS, TB and non-communicable diseases in Malawi

Electronic registers in 36 clinics run by the Malawi government now monitor half of the 640,000 HIV/AIDS patients who have been enrolled and registered for antiretroviral therapy. Using the same type of electronic registers, the government also monitors over 10,000 patients with diabetes mellitus at three hospital clinics in the country.

The Union’s Centre for Operational Research is partnering with Malawi and the US Centers for Disease Control and Prevention in implementing the use of an electronic medical records system to track patients with infectious and non-infectious diseases.

PROGRESS OF 320,000 HIV/AIDS PATIENTS ON ART monitored electronically

This high-tech application of cohort reporting, monitoring and evaluation has made it possible for the Ministry of Health to collect critical data on efforts to manage patients with diseases as diverse as tuberculosis, HIV/AIDS, hypertension and diabetes mellitus.

The electronic medical record system was developed by the Baobab Health Trust in Malawi. In 2013, 108,975 new patients on antiretroviral therapy were added to this system. The data collected through this project are essential for effective evaluation, future planning and budgeting, as well as providing the basis for operational research leading to improved health policy and practice.

MODEL “CHRONIC-DISEASE-CARE” CLINIC IN MALAWI USES DOTS MONITORING APPROACH

Clinics in Lilongwe will manage non-communicable diseases from asthma to epilepsy

The successful application of the quarterly cohort reporting used by The Union and Malawi for TB, and subsequently for HIV/AIDS and diabetes, led the World Diabetes Foundation to fund expansion of the concept.

As a result, a pilot “Chronic-Disease-Care” Clinic to manage diabetes, hypertension, cardiovascular disease, asthma and epilepsy opened at Lilongwe’s Kamuzu Central Hospital in 2013, and a second will open in the Area 25 Health Centre in 2014.

BENIN OFFERS MODEL FOR FINANCING ASTHMA MEDICINES

Grant from The Union helped launch the fund in 2008

In 2008, the Benin National Tuberculosis Programme (NTP) established a revolving fund to finance the purchase of essential asthma medicines. In 2013, a Union team evaluated the operation of this project over the past five years – and its potential as a model for other countries.

Benin’s revolving fund was launched with a grant, primarily from The Union, that enabled the NTP to purchase quality-assured essential asthma medicines at reduced cost. The medicines were distributed at the NTP’s asthma pilot project sites, where patients were charged a nominal fee that was used to replenish the fund.

The Union team assessed all aspects of the project from the purchase price of the medicines and costs such as shipping and printing asthma treatment cards, versus the revenue generated by sales of medicines to patients. While they found that there was a slight decrease in the capital as of 31 January 2013, this was due mainly to the number of inhalers provided free of charge and expenses related to managing the programme.
Despite these additional costs, the figures showed that the revolving fund did make it possible for the NTP to maintain an uninterrupted supply of essential asthma medicines over the past five years.

TOBACCO CONTROL ENFORCEMENT EVOLVES

Early FCTC adopters pass more stringent tobacco control laws

The experience of many early adopters of the WHO Framework Convention for Tobacco Control (FCTC) has shown that revising and building on initial legislation and enforcement policies can speed their progress towards the full implementation of the treaty.

For example, Bangladesh was the first signatory of the FCTC and its original tobacco control laws came into force in 2005. But lack of human resources and infrastructure to support and implement these laws meant their impact was eroded over time.

In 2013 The Union worked with the country to develop new long-term strategies, including building collaborative relationships with the Ministry of Health and Family Welfare and civil society; smokefree monitoring programmes; and training for capacity building. Bangladeshi tobacco control law is now fully aligned with FCTC recommendations.

Similarly, Chile’s tobacco control laws came into force in 2005. In 2011 The Union launched a two-year project with the Ministry of Health to assess how well legislation was being enforced and to identify elements of the strategy that could be strengthened.

As a result, the law was amended to progress more swiftly towards a 100 per cent smokefree Chile. New specifications on graphic health warnings, tobacco taxes and advertising, promotion and sponsorship were also introduced. The new tighter tobacco control legislation is being monitored countrywide to ensure implementation levels remain high.

This year, Pakistan, Russia and Viet Nam also worked with Union teams to upgrade legislation and improve enforcement.

Preparing for 2014’s smokefree winter Olympics in Sochi

The Union Russia team helped build foundations for a smokefree winter Olympic Games in Sochi. Working with local government stakeholders, they offered technical assistance to the Sochi Olympic Games Organising Committee (SOGOC) on creating 100 per cent smokefree environments at all official venues and offered training for Games volunteers on how to effectively implement the ban. The goal was to protect sports fans, as well as 155,000 athletes, sports delegation representatives and volunteers, from the harmful effects of smoking and second-hand smoke.

Smokefree movement hits the beach in Mexico

Cozumel’s San Martin beach became Mexico’s first smokefree beach – and only the third in Latin America – thanks to local government and partners, supported by the Pan-American Health Organization (PAHO) and The Union Mexico Office.
The 44th Union World Conference on Lung Health in Paris was the largest international Union conference in its history. The theme of “Shared Air, Safe Air?” offered a platform for discussing issues from clean air and infection control to secondhand smoke and air pollution.

The five-day scientific programme included 182 sessions in different formats and more than 700 posters presented by researchers from around the world. Highlights included:

- Intense discussion of new TB treatment options, including bedaquiline, the first new drug approved for TB in 40 years, and a shortened 9-month MDR-TB regimen
- A plenary session on tobacco control in Africa, featuring Léné Segbo, Minister of Health, Burkina Faso; and Elioda Tumwesigye, Honorable Minister of State for General Duties, Uganda
- TB and TB-HIV late-breaker sessions showcasing the latest research
- Plenary sessions on air pollution and asthma, and child pneumonia
- Release of an official Union statement calling for regulation of e-cigarettes and electronic nicotine delivery systems (ENDS).

MORE THAN 2,100 ATTEND UNION REGIONAL MEETINGS

Union Region Conferences were held in Rwanda, Viet Nam and Canada

Members of The Union’s Africa, Asia-Pacific and North America Regions organised conferences in 2013. These events focused on TB, lung disease, shared air, new technologies and other issues, attracting over 2,100 delegates from across the three regions.

INTERNATIONAL TOBACCO CONTROL CONFERENCE NOW MANAGED BY THE UNION

Plans are underway for the World Conference on Tobacco or Health in March 2015

As the newly appointed permanent secretariat for the tri-annual World Conference on Tobacco or Health, The Union began preparations for the 2015 event during 2013. Advance promotional materials and a website were developed and plans laid for the online submission of session proposals in early 2014. The conference, which is expected to attract 3,000 delegates, will take place on 17–21 March 2015 in Abu Dhabi, UAE.

TRAIN

DEVELOPING PUBLIC HEALTH LEADERS

Union courses develop clinical expertise, management savvy and the ability to solve problems through research

The demands of working in public health today are greater than ever – from managing weak health systems and burgeoning caseloads to keeping abreast of new technologies and evolving diseases. That is why The Union’s courses address:

- Clinical and operational management
- Management and leadership
- Operational research

CLINICAL AND OPERATIONAL MANAGEMENT

Clinical and operational expertise is fundamental to good public health – and it requires continually refreshing knowledge, sharing experiences
and analysing results. The Union’s international and national technical courses have played a critical role in training public health leaders for more than 30 years. In 2013, courses taught in a variety of formats and languages focused on:

- Tuberculosis
- Multidrug-resistant tuberculosis
- TB-HIV clinical management
- TB-HIV collaboration
- Tobacco control

**2013 Technical Courses at a glance**

- 152 participants from 51 countries took international TB and MDR-TB courses
- 13 countries sponsored national TB and MDR-TB courses with 431 participants
- 132 participants from 4 countries attended TB-HIV courses
- 327 participants in 7 countries received tobacco control technical training

In 2013 alone, their improved skills in leadership, strategic planning, budgeting, supply-chain management, human resource development and communication helped to strengthen the ministries of health in 23 countries, as well as 102 non-governmental organisations.

In addition to its 9-course core curriculum, this year the IMDP offered training with a tobacco control focus for the Bloomberg Initiative to Reduce Tobacco Use; provided management courses for the Stop TB Partnership’s TB TEAM; and presented post-graduate courses for several conferences.

**2013 IMDP Courses at a glance**

- 125 participants from 47 countries took 9 core and specialised management courses
- 198 participants from 7 countries attended management courses with a tobacco control focus

Over its first decade, The Union’s International Management Development Programme (IMDP) has trained some 4,000 health managers from 45 countries.

*THE INTERNATIONAL MANAGEMENT DEVELOPMENT PROGRAMME (IMDP)*

COR has trained more than 150 researchers and taken on 19 Operational Research Fellows since 2009. In this year alone, COR-affiliated researchers published 96 research papers; 16 viewpoint, opinion or review papers; and six chapters, books and citable talks.

In January 2013, COR joined SORT IT (Structured Operational Research Training Initiative), a collaboration between The Union, Médicins Sans Frontières and WHO; as a result, The Union OR courses are now branded “SORT IT”.

**2013 OR Courses at a glance**

- 72 course participants from Africa, Asia, Latin America and Oceania in 7 courses
- 71 research projects in press or published
- 13 Operational Research Fellows working in Africa, Asia and Europe
- 79 OR Fellow research projects completed with papers published

In 2013 alone, their improved skills in leadership, strategic planning, budgeting, supply-chain management, human resource development and communication helped to strengthen the ministries of health in 23 countries, as well as 102 non-governmental organisations.

The courses emphasise the practical, real-world orientation of operational research, sometimes called “the science of doing better”. This focus also addresses the need to both disseminate the knowledge gained – and foster change.

THE UNION’S Centre for Operational Research (COR) teaches public health professionals to conduct a research project from developing a protocol to submitting the results for publication. Publication and attention to the effects of research on changing policy and practice are key to the COR philosophy.

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**2013 OR Courses at a glance**

- 72 course participants from Africa, Asia, Latin America and Oceania in 7 courses
- 71 research projects in press or published
- 13 Operational Research Fellows working in Africa, Asia and Europe
- 79 OR Fellow research projects completed with papers published

The Union’s Centre for Operational Research (COR) teaches public health professionals to conduct a research project from developing a protocol to submitting the results for publication. Publication and attention to the effects of research on changing policy and practice are key to the COR philosophy.

The courses emphasise the practical, real-world orientation of operational research, sometimes called “the science of doing better”. This focus also addresses the need to both disseminate the knowledge gained – and foster change.

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In 2013 alone, their improved skills in leadership, strategic planning, budgeting, supply-chain management, human resource development and communication helped to strengthen the ministries of health in 23 countries, as well as 102 non-governmental organisations.

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The Union not only conducts research, but also publishes two peer-reviewed scientific journals that provide a forum for research being conducted in countries around the globe. Dedicated to the continuing education of physicians and health personnel, they disseminate the latest information on tuberculosis, lung health and other public health issues affecting low- and middle-income countries.

**The Union Journals**

In 2013, the IJTLD published studies from 59 countries on issues from TB prevention and control in prisons to the need for new drugs and new diagnostics. Highlights included:

- A State of the Art series on active case finding/screening for tuberculosis, which resulted in record downloads
- A supplement on “Achieving patient-centred care for people affected by tuberculosis”, sponsored by Jhpiego and the International Council of Nurses

The quarterly Public Health Action attracts more submissions and readers in its 2nd full year

Open-access online journal *Public Health Action* (PHA) expanded its scope in 2013 to include studies on such diverse issues as nutrition services, emergency room care, sexual and gender-based violence, occupational health, antenatal care, tobacco control and ethics.

After 10 issues, PHA has close to 3,000 readers, and the number of articles submitted for each issue continued to grow throughout the year. The journal’s first supplement, published in November 2013, was devoted to the challenge of identifying and managing care for the increasing number of patients with TB and diabetes in low-income countries.

**Technical Guides**

The Union distills its extensive clinical, management and field experience into practical guides for use by public health professionals in limited-resource settings around the world. In 2013, our 68 new and backlist guides were downloaded more than 54,000 times at no charge.

*NEVER SAY A TB PATIENT IS INCURABLE!*

The Union guide to MDR-TB published in 2013

The Union’s guide to the clinical and operational management of multidrug-resistant TB is the culmination of 10 years of teaching courses on this subject in widely diverse settings, as well as the accumulated experience of close to 100 years of working with TB in the field. While emphasising the necessity of well-managed basic TB control to prevent the development of drug resistance, the guide also covers the new tools and resources available today and tackles the challenges of fulfilling each patient’s potential for cure from the perspectives of both clinicians and programme managers.

*74,000 CHILDREN DIE NEEDLESSLY FROM TB EACH YEAR* 

A guide for reaching the forgotten children with TB

The first-ever comprehensive plan to address the hidden TB epidemic among children was published in 2013 by seven partners, including The Union. The Roadmap for Childhood TB: Towards
Zero Deaths provides a 10-step plan for addressing the needs of the half million children who develop TB each year – and for preventing some 74,000 deaths. Child TB experts from The Union served as lead writers on this document cosponsored by the World Health Organization, UNICEF and other key stakeholders in efforts to integrate TB into other health services for children and families.

Roadmap for Childhood TB: Towards Zero Deaths
World Health Organization, et al.
(Geneva, Switzerland: WHO, 2013)

The Union also released a French edition of its popular Desk Guide for Diagnosis and Management of TB in Children in 2013.

Desk-Guide for Diagnosis and Management of TB in Children
SM Graham, et al.
French ed.
(Paris, France: The Union, 2013)

GOOD-QUALITY MICROSCOPY WILL IDENTIFY 95-98% OF SMEAR-POSITIVE TB PATIENTS

Updated laboratory guide presents latest techniques in a practical, readable format

Sputum microscopy remains a primary – and indispensable – tool for diagnosing TB and monitoring patients’ response to treatment in thousands of laboratories around the world.

In 2013, members of the Global Laboratory Initiative, including The Union, published Laboratory Diagnosis of TB by Sputum Microscopy, a practical, readable guide that incorporates techniques and strategies developed over the past decade.

Laboratory Diagnosis of Tuberculosis by Sputum Microscopy
Global Laboratory Initiative (Adelaide, South Australia: SA Pathology, 2013)

Other 2013 publications

Implementing Collaborative TB-HIV Activities: A Programmatic Guide
PI Fujiwara, et al.
French, Spanish and Portuguese eds.
(Paris, France: The Union, 2013)

DR-TB Drugs under the Microscope: The Sources and Prices of Medicines
The Union/MSF Access Campaign, 3rd ed.
(Brussels: MSF, 2013)

Respiratory Diseases in the World: Realities of Today – Opportunities for Tomorrow
Forum of International Respiratory Societies (FIRS), 2013
The Union delivers essential health services and advocates for public health policies and resources necessary for safeguarding people’s health.

17,000+ PATIENTS RECEIVE ART IN MYANMAR AS IHC PROGRAMME GROWS

One year on, 93 per cent of patients in the Integrated HIV Care (IHC) Programme have an undetectable viral load and are not contagious

More than 17,000 HIV-positive patients received antiretroviral treatment (ART) through The Union’s Integrated HIV Care (IHC) Programme in Myanmar in 2013. And after more than one year, 93 per cent of IHC patients have an undetectable viral load and are not contagious.

The Union Office in Myanmar collaborates on the IHC Programme with the national AIDS and TB programmes, providing technical, human resources and financial support to the hospitals, township health centres, laboratories, social service departments, pharmacies and patient self-help groups that are part of IHC’s network serving 14 townships.

The IHC Programme was launched as a pilot project in 2005 to serve patients with TB and HIV. But based on the heavy demand for services, The Union sought increased funding to include patients regardless of TB status. Programme services now include the availability of high-tech HIV diagnostic and monitoring systems at Mandalay Public Health Laboratory, which was renovated by the Fondation Mérieux in collaboration with The Union in 2012.

The IHC Programme is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Yadana Consortium operated by Total/MGTC.

“The success of the IHC programme stems from a collaborative approach with the public sector and the patients.”

DR BALATHANDAN THANUMALAYA
Assistant Country Director and Representative, The Union Office in Myanmar
LARGE POPULATIONS CALL FOR LARGE CAMPAIGNS

Project Axshya reaches 1.4 million households with TB messages and sensitisises rural health care providers about TB

Some 70 per cent of India’s 1.21 billion people live in rural areas far from its teeming cities. Reaching this population is the goal of Project Axshya, a landmark civil society initiative that is supporting the Revised National TB Control Programme’s efforts to provide all Indians with access to TB information and services.

Active in 300 districts across 21 Indian states, Axshya entered Phase II in April 2013 with new approaches to intensify outreach to those with the greatest difficulty accessing diagnosis and treatment; strengthen the engagement of community groups and health care providers; and establish sputum collection/transportation and directly observed treatment (DOT) services in vulnerable and marginalised areas.

Through Axshya SAMVAD (Sensitisation and Advocacy in Marginalised and Vulnerable Areas of Districts), a unique intervention around intensified outreach, community volunteers reached over 1,400,000 households in vulnerable areas with information on TB. Apart from raising awareness about the disease, volunteers identified people with TB symptoms in each household, referring them for diagnosis, while also transporting sputum samples and results between laboratories and households, when necessary.

In the same year, Project Axshya also trained 6,500 Rural Health Care Providers (RHCP), who are the first point of contact for health care in rural populations. Over 4,200 of them are now engaged in referrals, sputum collection and transportation and acting as directly observed treatment (DOT) providers.

In 2013, over 217,000 people with TB symptoms were referred and over 181,206 sputum samples were transported through these initiatives. This has led to 21,793 TB patients being diagnosed and put on treatment. The Global Fund awarded Axshya an A rating for its consistently excellent performance and committed US$ 30.45 million in funding for Phase II (Years 3–5).

Project Axshya is implemented in partnership with eight sub-recipient organisations and funded by The Global Fund to Fight AIDS, Tuberculosis and Malaria.

VOLUNTEERS REACH 170,000 PEOPLE IN MANDALAY

PICTS sets out to find TB across Myanmar’s capital city

In Myanmar, the campaign to diagnose and treat TB launched by The Union and the Ministry of Health has proven it will stop at nothing – not even a lack of funding. The Program to Increase Catchment of TB Suspects (PICTS) started in 2012 with a TB REACH grant and deployed thousands of volunteers across the seven townships of Mandalay. The project’s goals were to reinforce case finding and access to diagnosis through mass communications; decentralise symptom screening; collect the sputum samples needed to diagnose TB from convenient locations; and make referrals to Township Health Centres (TSHC).

In 2013, PICTS was funded by TB REACH and The Union headquarters.

14% MORE TB identified in Mandalay in one year

FOR CHILDREN AFFECTED BY HIV/AIDS, LAUGHTER IS A VITAL PRESCRIPTION

The Union supports the paediatric ART programme in Myanmar

By December 2013, 1,254 HIV-infected children were on antiretroviral therapy (ART) at sites supported by The Union Office in Myanmar. This paediatric ART programme includes not only medical care, but also psychosocial support for the children and their families, including a popular holiday party.
CAMPAIGN FOR CHILDHOOD TB LAUNCHED

“Roadmap” for addressing TB is the work of seven organisations

With a high-profile press conference, workshop and congressional visits in Washington, DC, The Union and its partners in developing the Roadmap for Childhood TB: Towards Zero Deaths signaled that children with TB now have a powerful group of advocates who will ensure that their voices are heard.

The 1 October launch began with a press conference announcing the 10-step “roadmap” for addressing the hidden epidemic of childhood TB that generated over 130 stories in the media. Speakers from the World Health Organization, The Union and other agencies outlined their call to action for preventing 74,000 children under 15 years of age from dying needlessly each year.

Central to the partners’ approach is the integration of childhood tuberculosis into broader maternal and child health activities. The collaboration of UNICEF is therefore very beneficial, since it will help build the widespread support from for all stakeholders in child health that is essential to the roadmap’s success.

An afternoon workshop detailed recommendations for implementing the plan. Workshop speakers included representatives from TB, HIV and maternal and child health organisations, as well as a family affected by TB.

74,000 CHILDREN DIE NEEDLESSLY from TB each year

Despite the US government shutdown, the workshop was very well attended, and the following day Union leaders and other partners were able to meet with US members of Congress to educate them about these issues and advocate for increased TB funding.

SUPPORTING CHINA’S EFFORTS TO CHANGE

After seven years of advocacy, public support for tobacco control in China is strong

Since 2007, The Union China Office in Beijing has worked closely with governmental and non-governmental tobacco control advocates across China to build a foothold for change.

Through the “Seven Cities Project” – which focused on seven cities with populations of more than 10 million – four cities have now shown the way forward by implementing strong smokefree legislation, including effective smoking bans in workplaces, health care facilities, schools and on public transport in these cities. By 2013, there was increasingly strong public support for tobacco control.

Political will for national tobacco control is also building. In December 2013, the Communist Party’s Central and State Council Offices took an important step forward when they issued a notice that requested officials not to smoke in public places or use public funds to buy cigarettes and to ensure that government buildings are smokefree.
PHILANTHROPIST
MICHAEL R. BLOOMBERG
MEETS UNION EXPERTS

Bloomberg has committed more than US$ 600 million to global tobacco control since 2007

The world’s most influential tobacco control advocate, Michael R Bloomberg, came to Paris on 23 September to join staff from The Union and the Campaign for Tobacco Free Kids (CTFK) in selecting the Round 14 Bloomberg Initiative grants. For several hours, the CEO of Bloomberg Philanthropies and then Mayor of New York participated in weighing the relative impact that each proposal would have on tobacco use and the pandemic of disease it causes. He was so engaged that he stayed long past the time originally allotted by his accompanying team.

The visit to The Union was Bloomberg’s first public international visit on behalf of his philanthropy, through which he has committed more than US$ 600 million for the Bloomberg Initiative to Reduce Tobacco Use. As part of the initiative, The Union and CTFK manage the $109-million grants programme, which has awarded 556 grants for projects that will develop and deliver high-impact, evidence-based tobacco control interventions.

Bloomberg also attended a breakfast at the Union headquarters, where he met with the heads of the French Committee Against Tobacco, CTFK and The Union. A reporter from Time magazine, who was writing a cover story on Bloomberg’s global advocacy and influence, followed his activities throughout the day.

80% OF NCD BURDEN is now in low- and middle-income countries

NON-COMMUNICABLE DISEASES (NCDs) SCORE VICTORY AT UN

Critical step in four-year campaign to address the growing NCD crisis

The Union and its partners in the NCD Alliance saw the campaign for non-communicable diseases achieve a major victory when the UN Member States unanimously adopted an omnibus resolution on NCDs at the 66th World Health Assembly on 27 May 2013. The resolution fulfilled commitments made in 2011’s UN Political Declaration on NCDs and signaled consensus on the three pillars of the global NCD architecture — action, accountability and coordination. The key decisions in the resolution were:

• To endorse the WHO global action plan for the prevention and control of NCDs 2013–2020
• To adopt the global monitoring framework on NCDs, including nine global targets and 25 indicators
• To develop a global coordination mechanism by the end of 2013 to coordinate activities and promote engagement of all actors in the global NCD response.

The adoption of the global action plan moves the campaign for NCDs from the political to the practical realm. For the first time, all governments are accountable for progress on NCDs, which cause some 36 million deaths each year — 80 per cent in low- and middle-income countries.

These achievements are the outcome of lengthy and complex consultations, many of which were initiated in 2011 as a follow-up to the UN Summit on NCDs. As a principal partner of the NCD Alliance, The Union was involved throughout the campaign that helped make this bold UN resolution a reality.

ACT

80% OF NCD BURDEN is now in low- and middle-income countries

Annual Report 2013

21
The Union was founded as a federation of member organisations in 1920. Today both organisations and individuals may join – and they form an international network of influential public health experts in more than 150 countries. This federation also governs The Union through the General Assembly and the Board of Directors, which is elected by the members. Below are highlights of the federation’s activities.

THE CENTENNIAL CAMPAIGN 2012-2020

The Union Centennial Campaign, launched in 2012, honours the lead up to The Union’s 100th anniversary on 20 October 2020. Led by the Union President and the Board, the campaign is raising unrestricted funds to support The Union’s independent and innovative research and education programmes. These programmes have been the hallmark of The Union’s contribution to the global fight against tuberculosis and lung disease since its founding and continue to be core activities serving 150 countries today.

CAMPAIGN RAISES MORE THAN $500,000 IN FIRST TWO YEARS

Launched in Kuala Lumpur in November 2012, the campaign grows in 2013

The Centennial Campaign was launched in November 2012 with the 1st President’s Centennial Dinner in Kuala Lumpur, Malaysia. Envisioned as a series of dinners held each year in conjunction with the World Conference, this first event raised US $140,000, creating momentum for 2013. At the Board Retreat in April, the Communications, Fundraising and Membership Committee voted to accumulate and hold all campaign funds until 2020, giving these gifts the maximum impact on The Union’s programmes.

THE 2ND PRESIDENT’S CENTENNIAL DINNER DRAWS CAPACITY CROWD

Centennial Dinner in Paris was an event not to be missed

The reputation of the President’s Dinner as an event not to be missed during the World Conference is already growing. The second dinner in Paris, France attracted a capacity crowd of 200 to the elegant Cercle National des Armées on Wednesday, 30 October 2013 and raised US $300,000. Long-time member Prof Lee B Reichman welcomed the guests and President E Jane Carter spoke about the importance of continuing research and education to fulfill The Union’s vision of health solutions for the poor. Among the guests from some 50 different countries were Union leaders going back 20 years and representatives from more than 20 corporations, universities, international agencies, non-governmental organisations and health institutes.

FIRST REGIONAL CAMPAIGN EVENT HELD IN SCOTLAND

Ben Nevis Challenge invited participants to “Climb for Your Lungs!”

The Union Europe Office in Edinburgh, Scotland was the first Union office to plan a regional fundraising event for the Centennial Campaign. On Friday, 6 September 2013, Union staff, family and friends participated in the Ben Nevis Challenge — Climb for Your Lungs, an eight-hour hike on Ben Nevis, the highest mountain in the British Isles. Led by a qualified mountain leader, the intrepid climbers reached the summit and raised £1,000 for the campaign.
Union members with shared professional interests collaborate on projects through the Scientific Sections – Tuberculosis, HIV, Adult & Child Lung Health and Tobacco Control – as well as more specialised sub-sections and working groups. Planning the scientific programme for the annual World Conference is a responsibility shared by all the sections. Examples of member projects in 2013 follow.

PAEDIATRIC TB draws standing-room-only crowd at World Conference

Child TB topics ranged from estimating the burden to using the new Roadmap

With child TB as the focus of events from World TB Day on 24 March to the high-profile launch of the Roadmap for Childhood TB on 1 October, it’s not surprising there was strong interest in this issue at the World Conference in Paris. The Adult & Child Lung Health Section organised well-attended sessions on estimating the burden of child TB, paediatric TB surveillance and epidemiology, diagnosis and the use of the new Roadmap and MDR-TB in children. Some 300 delegates participated in these sessions, including a standing-room-only crowd at the surveillance and epidemiology symposium.

TB LABORATORIES improve quality with revised GLI tool

2013 edition is more user-friendly and detailed

A revised version of the Global Laboratory Initiative (GLI) tool was launched in 2013 with the assistance of The Union’s Working Group on TB Laboratory Accreditation. The new edition of the tool, which helps TB laboratories implement quality management systems, was adapted to the new ISO 151-89:2012 quality standard. It is both more user-friendly and more detailed and enables users to construct their own focused laboratory assessment checklists. Funding for the GLI tool update was provided by TB CARE I.

INCIDENCE OF TB IN PRISONS IS 5 TO 70 TIMES HIGHER THAN AMONG GENERAL PUBLIC

Public health experts are concerned that 9.8 million incarcerated people around the world are at risk

Through a global consultation and review of evidence, the TB in Prisons Working Group finalised an official Union statement outlining key recommendations for preventing risk and providing care that was published in the International Journal of Tuberculosis and Lung Disease in January 2013. Members also contributed a chapter on TB in a guide to health for European prisons and helped several countries conduct studies of TB in their prison facilities this year.

HIV/TB LATE-BREAKER SHOWCASES RECENT RESEARCH IN PARIS

Presentations limited to research completed as of May 2013

The HIV Section organised the first-ever HIV/TB Late-Breaker Session at the World Conference in 2013. The presentations of recent research included a study that found an increase in TB diagnoses among HIV-infected patients when a novel urine-based test was used; an analysis of the impact of Xpert on TB case finding among people with HIV; and a first report on using directly observed therapy – in which a health worker supervises every dose of medicine – for heroin-injectors with TB. Based on expressed demand, this session will be offered again at the World Conference in 2014.

TOBACCO INDUSTRY MANOEUVERS REQUIRE NIMBLE RESPONSE FROM PUBLIC HEALTH ADVOCATES

Prevention of industry interference in public health policies is critical

Less than two years after the Working Group on Countering Tobacco Industry Interference in Public Health Policies launched a toolkit for countries facing these challenges, the group has observed that countries may require further tools to address both new and longstanding industry strategies.

At their annual meeting during the World Conference, the Working Group discussed this issue and possible ways forward. The toolkit, developed by the Working Group and the Department of Tobacco Control, outlines ways for governments to prevent industry interference and fulfil Article 5.3 of the WHO Framework Convention on Tobacco Control. It has been distributed widely and used as the basis for the department’s training programmes.
THE UNION REGIONS

Union members affiliate by geographic region and work together to solve regional issues. Union region conferences, organised by the members, provide important opportunities to showcase region-focused research and programmes.

ASIA-PACIFIC CONFERENCE HELD IN HANOI

Close to 1,000 delegates attended 4th Union Asia-Pacific Region Conference

The 4th Conference of The Union Asia-Pacific Region was held in Hanoi, Viet Nam on 10–13 April 2013. The scientific programme provided a balanced look at the current status, on-going challenges and future opportunities in the region regarding TB, smoking, HIV/AIDS, non-communicable diseases, operational research and health promotion.

Eminent international and local experts spoke and 190 posters were presented, making the four-day programme a stimulating experience for close to 1000 delegates. The sponsoring member was the Viet Nam Association Against Tuberculosis and Lung Diseases, and Prof Dinh Ngoc Sy was conference president.

"TB: THE AIR WE SHARE" WAS THEME IN VANCOUVER

Six awards presented this year

The 17th Conference of The Union North America Region took the theme “TB: The Air We Share”. Held on 28 February–2 March 2013 in Vancouver, BC, Canada, the conference focused on childhood TB, TB in urban areas, TB transmission and TB among Canada’s indigenous people.

Awards are a high point of this annual event. In 2013, Lifetime Achievement Awards were presented to Dr Ed Ellis (Canada) and Dr Fordham von Reyn (USA); and Dr C Crane (USA), Dr R J McDonald (USA), Dr V Hoeppner (Canada) and Dr M E Villarino (USA) received Service Awards. The British Columbia Lung Association served as secretariat for the conference.

19TH AFRICA REGION CONFERENCE HELD IN RWANDA

Regional meeting attracted more than 600 delegates

More than 600 delegates gathered in Kigali, Rwanda for the 19th Conference of The Union Africa Region on 20–22 June 2013. The theme was “Tuberculosis and Other Lung Diseases: Successes and Challenges”. The discussion of regional issues included a declaration from civil society organisations, who requested greater involvement in the region and future conferences. Dr Michel Gasana, then President of The Union Africa Region, and the Rwanda TB Forum coordinated this conference for the region.

GENERAL ASSEMBLY

The General Assembly is the annual meeting of The Union membership, which is the governing body of the organisation.

The Union General Assembly 2013 was held on Sunday, 3 November in Room 342A, Palais des Congrès, Paris, France from 08:00 to 09:00. Dr E Jane Carter, The Union President, welcomed constituent, organisational, honorary and individual members and scientific section chairs.

ELECTIONS

The Nominating Committee received nine applications for three vacant individual member positions on the Board. Two were candidates for re-election and seven were new. In seeking nominations, the committee in particular sought to broaden representation from civil society. Informed by the committee’s
recommendations, the General Assembly elected the following individual members:

Ms Siphiwe Ngwenya (Swaziland), Ms Carole Nyirenda (Zambia) and Ms Laia Ruiz Mingote (Spain).

The General Assembly validated the appointment of the two regional representatives: Dr Cuthbert Kanene (Zambia) for the Africa Region and Dr Xiexiu Wang (China) for the Asia-Pacific Region.

RESOLUTIONS

The General Assembly unanimously approved the Activity Report, treasurer’s report and the audited accounts for the period of 1 January to 31 December 2012 and the budget for Fiscal 2014.

The General Assembly also delegated authority to the Board of Directors to authorise the leaseback of the office located at 68 Boulevard Saint-Michel in Paris for at least 1,853,000 euros over 12 years.

DISCHARGE AND POWER

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

WORLD CONFERENCE 2015

José Luis Castro, Interim Executive Director, reported that bids from three locations were being considered – Cape Town (South Africa), Hyderabad (India) and Liverpool (UK). After the sites have been evaluated, the Board will receive a report and recommendation.

STRATEGIC PLAN

Dr E Jane Carter reported that the Strategic Plan was in process and the Board of Directors and Institute were moving along these lines.

AWARDS

Prof Donald A Enarson (Canada) was awarded The Union Medal and Dr Thelma E Tupasi (The Philippines) was made an Honorary Member.

The Vice President, Dr Dean Schraufnagel, presented the results of the Christmas Seal Contest and congratulated the winners:

- 3rd Prize: The Hong Kong TB Chest & Heart Diseases Association (Hong Kong)
- 2nd Prize: Comité Nacional de Lucha Contra la Tuberculosis (Mexico)
- 1st Prize: Philippine Tuberculosis Society, Inc (PTSI) (Philippines)

OTHER BUSINESS

Discussion points included the importance of the Board being members of The Union and the need for representation from civil society and tobacco control. The point was made that the Board is elected by the membership, but that the President may appoint one or two members based on their expertise who do not have to be Union members.

Other members spoke about the need for solidarity and transparency during a period of change, the Executive Director search, avenues for communication outside the General Assembly, declining membership and the new student membership campaign.

THANK YOU!

Dr E Jane Carter thanked the General Assembly, and the meeting was adjourned at 09:00.
HONOURS

THE UNION MEDAL

The Union Medal, the organisation’s highest honour, is awarded to members who have made an outstanding contribution to the control of tuberculosis or lung health by their scientific work and/or actions in the field.

Prof Donald A Enarson, long-time Scientific Director, received Union Medal

Prof Donald A Enarson, who served as The Union’s Director of Scientific Activities from 1991 to 2009, received The Union Medal in recognition of his central role in overseeing the expansion of The Union’s TB technical assistance, education and research activities to include other major public health challenges, including HIV, tobacco control, asthma and child lung health. Under his leadership, The Union TB clinical trials Study A and Study C were completed, and he fostered the growth of operational research as a means of finding local solutions to local problems.

One of the most distinguished lung health experts globally, Prof Enarson continues to serve as Adjunct Professor, Department of Medicine at the University of Alberta. He is also editor of The Union’s open-access journal, Public Health Action, and has served as Associate Editor of the IJLTD since 1997.

He has published more than 20 books on issues such as tuberculosis, lung cancer and asthma, as well as hundreds of chapters and articles. He is a Fellow of the Royal College of Physicians and Surgeons of Canada; a Member through Distinction of the Faculty of Public Health Medicine, Royal Colleges of Physicians, UK; and a Fellow of the Royal College of Physicians of Edinburgh.

HONORARY MEMBER

The title of Honorary Member of The Union is granted to a person who has become distinguished through active participation in The Union’s activities and the fulfillment of its goals.

Dr Thelma E Tupasi of The Philippines awarded Honorary Membership

Dr Thelma E Tupasi was made Honorary Member of The Union in 2013 – a well-deserved title recognising her distinguished career, which has included founding the Tropical Disease Foundation in Manila and creating one of the first DOTS clinics in The Philippines. Dr Tupasi has published extensively on infectious diseases; and she was named one of the Ten Outstanding Scientists in 1980 and one of the Ten Outstanding Women in the Nation’s Service in 1983. She received the Centennial Award for Research from the University of The Philippines College of Medicine in 2005.

CONSTITUENT MEMBERS

Each country is represented by one constituent member, which plays an important leadership role in The Union.

Afghanistan: National Tuberculosis Control Programme
Algeria: Comité Algérien de Lutte contre la Tuberculose et les Maladies Respiratoires (CALTMR)
Angola: Programa Nacional de Controlo de Endemias
Australia: Australian Respiratory Council
Austria: Verein Heilanstalt Alland
Bangladesh: National Anti-TB Association of Bangladesh (NATAB)
Benin: Ministère de la Santé
Bolivia: Ministerio de Salud y Deportes
Brazil: Fundaçao Ataúlpho de Paiva
Burkina Faso: Ministère de la Santé
Cameron: Ministre de la Santé Publique
Chile: Ministerio de Salud Pública
China: Chinese Anti Tuberculosis Association (CATA)
Croatia: Pulmonary Outpatient Center
Cuba: Programa Nacional de Control de Tuberculosis
Democratic Republic of Congo: Programme National de Lutte Contre la Tuberculose
Denmark: Danmarks Lungeforening
Ecuador: Fundacion Ecuatoriana de Salud Respiratoria (FESAR)
Egypt: The Egyptian General Association Against Smoking, TB and Lung Disease
El Salvador: Ministerio de Salud Publica y Asistencia Social
Equatorial Guinea: Ministerio de Sanidad y Bienestar Social
Eritrea: Ministry of Health
Estonia: Tartu University Clinics, Lung Clinic
Finland: Finnish Lung Health Association – Filha Ry
Georgia: National Centre of Tuberculosis & Lung Diseases
Germany: Deutsches Zentralkomitee Zur Bekämpfung der Tuberkulose (DZK)
Ghana: Ghana Society for the Prevention of Tuberculosis and Lung Disease
Guatemala: Liga Nacional Contra la Tuberculosis
Guinea Conakry: Ministère de la Santé et de l’Hygiène Publique
Guyana: The Guyana Chest Society
Haiti: Programme National de lutte contre la Tuberculose
Honduras: Programa Nacional de Tuberculosis
Hong Kong: The Hong Kong TB Chest and Heart Diseases Association
Iceland: Reykjavik Health Care Services
India: The Tuberculosis Association of India
Indonesia: The Indonesian Association Against Tuberculosis
Islamic Republic of Iran: Iranian Charity Foundation for Tuberculosis and Lung Disease
Ireland: Tobacco Free Research Institute
Israel: Israel Lung and Tuberculosis Association
Japan: Japan Anti-Tuberculosis Association
Jordan: Jordanian Society Against Tuberculosis and Lung Disease
Kenya: Kenyan Association for the Prevention of Tuberculosis and Respiratory Disease
Korea: Korean Institute of Tuberculosis (KIT)
Lebanon: Ministry of Public Health
Luxembourg: Ligue de Prévention et d’Action Médico-Sociale
Madagascar: Institut d’Hygiène Sociale
Malawi: Ministry of Health and Population
Malaysia: Malaysian Association for the Prevention of Tuberculosis
Mali: Comité Anti Tuberculeux de Lutte contre les Maladies Respiratoires du Mali (CAMM)
Mexico: Comité Nacional de Lucha Contra la Tuberculosis
Mongolia: Mongolian Anti-Tuberculosis Association
Mozambique: Ministerio de Saúde
Republic of the Union of Myanmar: Myanmar Medical Association
Nepal: Nepal Anti-Tuberculosis Association
Netherlands: Royal Netherlands Tuberculosis Foundation (KNKV)
Nigeria: National TB and Leprosy Control Programme
Norway: Nasjonalforeningen for Folkehelse
Pakistan: Pakistan Anti Tuberculosis Association
Philippines: Philippine Tuberculosis Society, Inc (PTSI)
Portugal: Associação Nacional de Tuberculose e Doenças Respiratórias
Rwanda: Programme National Intégré de lutte contre la Lèpre et la Tuberculose
Saudi Arabia: Ministry of Health
Senegal: Ministère de la Santé
Singapore: SOTA CommHealth
South Africa: South African National Tuberculosis Association (SANTA)
South Korea: Ceylon National Association for the Prevention of Tuberculosis (CNAPT)
Sudan: Federal Ministry of Health
Sweden: Swedish Heart Lung Foundation
Switzerland: Ligue Pulmonaire Suisse
Syrian Arab Republic: Comité Syrien de Défense Contre la Tuberculose
Taipei, China: National Tuberculosis Association Taipei, China
United Republic of Tanzania: Ministry of Health
Thailand: The Anti-Tuberculosis Association of Thailand
Togo: Comité National Anti-Tuberculeux (CNART)
Tunisia: Ligue Nationale Contre la Tuberculose et les Maladies Respiratoires
Turkey: Turkish Anti-Tuberculosis Association
Uganda: National Tuberculosis and Leprosy Programme
Viet Nam: National Hospital of Tuberculosis and Respiratory Disease
Yemen: National TB Control Programme

ORGANISATIONAL MEMBERS

Any not-for-profit organisation may apply to join as an organisational or associate organisational member.

Canada: British Columbia Lung Association (BCLA)
France: Comité National contre les Maladies Respiratoires (CNMR)
Germany: Kuratorium Tuberkulose In Der Welt E.V.
Islamic Republic of Iran: Tobacco Prevention and Control Research Center (TPCRC)
Nepal: SAARC Tuberculosis & HIV/AIDS Centre (STAC)
Norway: LHL International Tuberculosis Foundation (LHL International)
Philippines: Tropical Disease Foundation
Singapore: The International Union Against Tuberculosis and Lung Disease, Asia Pacific Ltd
South Africa: Desmond Tutu HIV Foundation
Sweden: King Oscar II Jubilee Foundation
United Kingdom: The International Union Against Tuberculosis and Lung Disease – United Kingdom
United Kingdom: TB Alert
USA: American College of Chest Physicians
USA: American Lung Association
USA: American Thoracic Society Inc (ATS)
USA: Population Services International
USA: Project HOPE
USA: The Union North America
USA: World Lung Foundation

ASSOCIATE ORGANISATIONAL MEMBERS

Brazil: Alliance for the Control of Tobacco Use (ACT)
Democratic Republic of Congo: Equilibre International – Equinte
India: ARASMIN
India: The Catholic Health Association of India
REPORT OF THE TREASURER: FISCAL YEAR 2013

I am pleased to submit the annual Report of the Treasurer of the International Union Against Tuberculosis and Lung Disease (The Union) for the fiscal year ended 31 December 2013.

The year 2013 was a year of transition, where in June 2013 an interim team under the leadership of José Luis Castro took over the management of The Union in a very challenging economic environment. The Board of The Union tasked the new management with three priorities: to stabilise the finances, revamp communications and ensure strong human resources. I am pleased to report that the management performed beyond expectation on all three counts.

Through continued support from our donors and efforts from staff, The Union in 2013 was able to provide a positive result, as in the past years. The total net surplus amounted last year to € 367,000. This has firmly put the organisation in a position of financial strength. This has been accomplished mainly through new revenues of approximately US$ 55 million, as well as effective action to reduce costs and operate on a balanced budget. The Union since 2010 has managed to continuously post a surplus, which helped to mitigate the large operating losses from Fiscal 2008 and 2009 and also to reduce our bank debt. We need to continue to manage our resources all the more prudently, and we therefore need to continue to focus on fiscal discipline and high productivity, two hallmarks of The Union’s operating philosophy.

In order to strengthen our human resources and ensure that innovation and creativity are nurtured at The Union, we appointed a new human resources director. It is envisaged that our greatest and strongest asset, our staff, will, through an effective and efficient human resource department, make The Union an organisation that people will dream of working for.

A new communications strategy and team have been put in place, and this has, among other things, resulted in a complete change of the website, which is now available in the three official languages of The Union: English, French and Spanish.

FISCAL 2013 HIGHLIGHTS

- Total net result for the year was a surplus of 0.367 million euros compared to a surplus of 0.480 million euros in 2012. Total revenue was 34.3 million euros compared to 32.6 million euros in 2012.
- Revenue from grants, gifts and operating grants amounted to 31.2 million euros compared to 29.4 million euros in 2012.
- Total expenditure was 31.3 million euros compared to 30.1 million euros in 2012.
- The current bank advances (overdraft) stood at 0.795 million euros compared to 1.230 million euros in 2012.
The Union has great strength in the way it provides its technical assistance, educational and operational research activities and how each of these are interlinked and contribute to its core competency. The key to The Union’s success, and essential to maintaining a leadership position in global health, will be maintaining a keen focus on our areas of strength. We will need to adjust budgets prudently and proactively, always aware of the need to protect our gains and ensure the pursuit of our strategic priorities. The Union’s management is already taking into consideration tighter economic conditions for the budgets for Fiscal 2014 and beyond. The premium on prioritising wisely and judiciously is even greater in times such as these, when we face not only challenges, but also opportunities. It is imperative that The Union focuses on those areas in which it has expertise and resources, so that it continues to provide its beneficiaries with high-quality products.

With the breadth of resources entrusted to The Union by donors, government agencies, members and other supporters, the need for prudent fiscal oversight is great. 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 2014 and beyond.

FINANCIAL STATEMENTS

This report describes the financial position of The Union. The document on the following pages consists of the audited financial statements for Fiscal Year 2013 audited by KPMG.

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

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

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

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

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

Thank you.

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

Rapport du commissaire aux comptes sur les comptes annuels
Exercice clos le 31 décembre 2013

Mesdames, Messieurs,

En exécution de la mission qui nous a été confiée par votre Assemblée générale, nous vous présentons notre rapport relatif à l’exercice clos 31 décembre 2013, sur :
• le contrôle des comptes annuels de l’Association Union Internationale Contre la Tuberculose et les Maladies Respiratoires, tels qu’ils sont joints au présent rapport;
• la justification de nos appréciations;
• les vérifications et informations spécifiques prévues par la loi.

Les comptes annuels ont été arrêtés par le Conseil d’administration. Il nous appartient, sur la base de notre audit, d’exprimer une opinion sur ces comptes.

1 Opinion sur les comptes annuels

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

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

2 Justification des appréciations

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

Compte d’emploi annuel des ressources


Dépréciations d’actifs

Nos travaux ont consisté à analyser les actifs à risques, tels que mentionnés en note n°3-l-4-2 de l’annexe des comptes sociaux, et à vérifier que ces actifs ont été dépréciés en conséquence.

Provisions pour risques

Nos travaux ont consisté à revérifier les calculs effectués par l’Association, à comparer les estimations, à revoir par sondages les calcules effectués par l’Association, à comparer les estimations comptables des périodes précédentes avec les réalisations correspondantes. Les auditeurs ainsi investis, en conformité avec la méthode de contrôle duissu d’audit du compte annuel de la situation financière en tenant compte des variations des fonds dédiés du bilan avec celle du compte de résultat.

Estimation Comptables

Votre Association dispose des informations nécessaires à la validation de votre ordonnance et de votre déploiement d’opérations de l’exercice écoulé ainsi que de la situation financière et du patrimoine de l’Association à la fin de cet exercice.

3 Vérifications et informations spécifiques

Nous avons également procédé, conformément aux normes d’exercice professionnel applicables en France, aux vérifications spécifiques prévues par la loi.

Nous avons procédé à l’analyse des informations qui ont été clairement et concrètement exposées dans le rapport financier du Trésorier et dans les documents adressés aux membres sur la situation financière et les comptes annuels.

Paris La Défense, le 1er septembre 2014

BI/MA/MPSK - Exercice clos le 31 décembre 2013
in accordance with, French law and professional auditing standards applicable in France. This report also includes information relating to the specific verification of information given in the management assurance on individual account balances, transactions, or disclosures.

auditor’s assessments of certain significant accounting and auditing matters. These assessments were considered presented below the audit opinion on the financial statements and includes an explanatory paragraph discussing the

of its operations for the year then ended in accordance with French accounting principles.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide

includes evaluating the appropriateness of accounting policies used and the reasonableness

performing procedures, using sampling techniques or other methods of selection, to obtain

about whether the financial statements are free of material misstatement. An audit involves

those standards require that we plan and perform the audit to obtain reasonable assurance

1 Opinion on the financial statements
We conducted our audit in accordance with professional standards applicable in France; these standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit involves performing procedures, using sampling techniques or other methods of selection, to obtain audit evidence about the amounts and disclosures in the financial statements. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made, as well as the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion. In our opinion, the financial statements give a true and fair view of the assets and liabilities and of the financial position of the Organisation as at December 31st, 2013 and of the results of its operations for the year then ended in accordance with French accounting principles.

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

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

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

Contingent and loss provisions
Your organization sets up provisions against exchange losses and provisions for dispute, such as mentioned in note n°5-2-2 of the appendix of the social accounts.

Wear and tear allowances
Your organization sets up provisions to cover the depreciations natural or envisaged on assets, such as mentioned in note n°5-3-4-2 of the appendix of the social accounts.

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

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

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

We have no matters to report as to the fair presentation and the consistency with the financial statements of the information given in the management report of the Board of Directors, and in the documents addressed to shareholders. This report should be read in conjunction with, and continued as an annex to with, French law and professional auditing standards applicable in France.
## ASSETS

<table>
<thead>
<tr>
<th></th>
<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EUROS</td>
<td>US DOLLARS</td>
<td>EUROS</td>
<td>US DOLLARS</td>
</tr>
<tr>
<td><strong>FIXED ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Software</td>
<td>107,192</td>
<td>147,828</td>
<td>123,797</td>
<td>163,338</td>
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<tr>
<td>Land</td>
<td>1,896,033</td>
<td>2,614,819</td>
<td>2,891,123</td>
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<td>Building</td>
<td>1,818,711</td>
<td>2,508,184</td>
<td>3,151,474</td>
<td>4,158,055</td>
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<tr>
<td>Fixtures and equipments</td>
<td>400,724</td>
<td>552,638</td>
<td>529,362</td>
<td>698,440</td>
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<tr>
<td>Other tangible fixed assets</td>
<td>101,078</td>
<td>139,397</td>
<td>140,708</td>
<td>185,650</td>
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<tr>
<td>Financial fixed assets</td>
<td>58,884</td>
<td>81,207</td>
<td>75,024</td>
<td>98,987</td>
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<tr>
<td><strong>TOTAL FIXED ASSETS</strong></td>
<td>4,382,622</td>
<td>6,044,073</td>
<td>6,911,488</td>
<td>9,119,018</td>
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<td><strong>CURRENT ASSETS</strong></td>
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<td>Constituent members</td>
<td>505,306</td>
<td>696,868</td>
<td>505,906</td>
<td>667,492</td>
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<td>Suppliers advance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Managed funds receivable</td>
<td>1,281,826</td>
<td>1,767,766</td>
<td>2,312,579</td>
<td>3,051,217</td>
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<tr>
<td>Receivable on committed grants</td>
<td>0</td>
<td>0</td>
<td>-1</td>
<td>-1</td>
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<tr>
<td>Inter-offices accounts</td>
<td>233,527</td>
<td>322,057</td>
<td>29,257</td>
<td>38,602</td>
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<tr>
<td>Other receivables</td>
<td>115,951</td>
<td>159,908</td>
<td>190,591</td>
<td>251,466</td>
</tr>
<tr>
<td>Sundry debtors</td>
<td>253,035</td>
<td>348,961</td>
<td>203,941</td>
<td>269,080</td>
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<tr>
<td><strong>TOTAL CURRENT ASSETS</strong></td>
<td>2,389,645</td>
<td>3,295,560</td>
<td>3,242,273</td>
<td>4,277,856</td>
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<tr>
<td><strong>BANK &amp; CASH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial investment for managed funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Cash and bank for managed funds</td>
<td>7,655,958</td>
<td>10,558,332</td>
<td>4,664,317</td>
<td>6,154,100</td>
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<tr>
<td>Cash and bank of The Union</td>
<td>579,264</td>
<td>798,863</td>
<td>432,888</td>
<td>571,152</td>
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<tr>
<td><strong>TOTAL BANK &amp; CASH</strong></td>
<td>8,235,222</td>
<td>11,357,195</td>
<td>5,097,205</td>
<td>6,725,252</td>
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<tr>
<td><strong>PREPAID EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL PREPAID EXPENSES</strong></td>
<td>211,413</td>
<td>291,560</td>
<td>217,715</td>
<td>287,253</td>
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<tr>
<td><strong>FOREIGN EXCHANGE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UNREALISED LOSSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL EXCHANGE LOSSES</strong></td>
<td>1,635,100</td>
<td>2,254,966</td>
<td>1,233,059</td>
<td>1,626,898</td>
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<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>16,854,002</td>
<td>23,243,354</td>
<td>16,701,740</td>
<td>22,036,277</td>
</tr>
</tbody>
</table>

2012: 1 euro = 1.3194 US$
2013: 1 euro = 1.3791 US$

From Evidence To Public Health Action
### LIABILITIES

#### EQUITY

<table>
<thead>
<tr>
<th></th>
<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EUROS</td>
<td>US DOLLARS</td>
</tr>
<tr>
<td>Reserves</td>
<td>2,287,820</td>
<td>3,155,133</td>
</tr>
<tr>
<td>Result carried forward</td>
<td>-3,886,556</td>
<td>-5,359,949</td>
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<tr>
<td>Result from the financial year</td>
<td>366,803</td>
<td>505,858</td>
</tr>
<tr>
<td>Restatement reserve on premises</td>
<td>1,887,396</td>
<td>2,602,908</td>
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<tr>
<td><strong>TOTAL EQUITY</strong></td>
<td><strong>655,463</strong></td>
<td><strong>903,950</strong></td>
</tr>
</tbody>
</table>

#### CONTINGENCY RESERVES

<table>
<thead>
<tr>
<th></th>
<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EUROS</td>
<td>US DOLLARS</td>
</tr>
<tr>
<td><strong>TOTAL CONTINGENCY RESERVES</strong></td>
<td><strong>666,076</strong></td>
<td><strong>918,585</strong></td>
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#### DEDICATED FUNDS

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<tr>
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<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EUROS</td>
<td>US DOLLARS</td>
</tr>
<tr>
<td><strong>TOTAL DED. FUNDS</strong></td>
<td><strong>8,559,461</strong></td>
<td><strong>11,804,353</strong></td>
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#### DEBTS

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<thead>
<tr>
<th></th>
<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants to be paid</td>
<td>1,049,416</td>
<td>1,447,250</td>
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<tr>
<td>Committed grants related to future budget years</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Inter-offices accounts</td>
<td>314,908</td>
<td>434,290</td>
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<tr>
<td>Borrowing from credit institutions</td>
<td>1,291,782</td>
<td>1,781,497</td>
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<tr>
<td>Current bank advances</td>
<td>795,931</td>
<td>1,097,668</td>
</tr>
<tr>
<td>Suppliers and similar accounts</td>
<td>603,254</td>
<td>831,948</td>
</tr>
<tr>
<td>Tax and social security</td>
<td>575,080</td>
<td>793,093</td>
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<tr>
<td>Charges to be paid (Accrued expenses)</td>
<td>216,491</td>
<td>298,563</td>
</tr>
<tr>
<td>Other creditors</td>
<td>395,598</td>
<td>545,565</td>
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<tr>
<td><strong>TOTAL DEBTS</strong></td>
<td><strong>5,242,460</strong></td>
<td><strong>7,229,874</strong></td>
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</table>

#### DEFERRED INCOME

<table>
<thead>
<tr>
<th></th>
<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL DEFERRED INCOME</strong></td>
<td><strong>535,937</strong></td>
<td><strong>739,111</strong></td>
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</tbody>
</table>

#### FOREIGN EXCHANGE

#### UNREALISED GAINS

<table>
<thead>
<tr>
<th></th>
<th>31 DECEMBER 2013</th>
<th>31 DECEMBER 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL EXCHANGE GAINS</strong></td>
<td><strong>1,194,605</strong></td>
<td><strong>1,647,480</strong></td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td><strong>16,854,002</strong></td>
<td><strong>23,243,353</strong></td>
</tr>
</tbody>
</table>

2012: 1 euro = 1.3194 US$  
2013: 1 euro = 1.3791 US$
## INCOME STATEMENT IN EUROS

<table>
<thead>
<tr>
<th></th>
<th>31 December 2013</th>
<th>31 December 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING INCOME</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>747,613</td>
<td>754,039</td>
</tr>
<tr>
<td>Operating grant</td>
<td>38,043</td>
<td>3,364</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>31,184,847</td>
<td>29,443,884</td>
</tr>
<tr>
<td>Write back of provisions and transferred charges</td>
<td>179,796</td>
<td>533,573</td>
</tr>
<tr>
<td>Other income</td>
<td>2,136,604</td>
<td>1,908,990</td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
<td>34,286,903</td>
<td>32,643,850</td>
</tr>
</tbody>
</table>

| **OPERATING EXPENSES** |                  |                  |
| External charges       | -12,191,771      | -13,528,613      |
| Taxes                  | -77,646          | -147,915         |
| Wages and salaries     | -3,718,231       | -3,504,057       |
| Social contributions   | -1,441,674       | -1,322,463       |
| Depreciation charges and addition to provisions | -425,829        | -670,803        |
| Other expenses         | -13,512,584      | -10,966,604      |
| **TOTAL OPERATING EXPENSE** | -31,367,735      | -30,140,455      |
| Write back of dedicated funds | 2,288,198       | 2,405,982        |
| Obligations for projects | -4,550,389      | -4,843,913       |
| **OPERATIONS ON DEDICATED FUNDS** | -2,262,191      | -2,437,931       |
| **OPERATING RESULT**   | 656,977          | 65,464           |

| **FINANCIAL RESULT**   |                  |                  |
| Foreign exchange difference | -243,299        | -129,149         |
| Interest and financial income | 13,785          | -9,783           |
| Financial provisions    | -204,226         | 1,119            |
| **TOTAL FINANCIAL RESULT** ( + GAIN / - LOSS ) | -433,740        | -137,813         |

| **EXCEPTIONAL RESULT** |                  |                  |
| Income tax             | -7,262           | -6,577           |
| **NET RESULT FOR FINANCIAL YEAR - EUROS** | 366,803          | 479,718          |

**Aid in kind (Drugs)** | 1,921,786 | 1,394,659 |
**Free use of goods and services** | -1,921,786 | -1,394,659 |

2012: 1 euro = 1.3194 US$  
2013: 1 euro = 1.3791 US$
## INCOME STATEMENT IN US DOLLARS

### OPERATING INCOME

<table>
<thead>
<tr>
<th></th>
<th>31 December 2013</th>
<th>31 December 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>1,031,033</td>
<td>994,879</td>
</tr>
<tr>
<td>Operating grant</td>
<td>52,465</td>
<td>4,438</td>
</tr>
<tr>
<td>Grants and gifts</td>
<td>43,007,023</td>
<td>38,848,261</td>
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<tr>
<td>Write back of provisions and transferred charges</td>
<td>247,957</td>
<td>703,996</td>
</tr>
<tr>
<td>Other income</td>
<td>2,946,591</td>
<td>2,518,721</td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
<td><strong>47,285,068</strong></td>
<td><strong>43,070,296</strong></td>
</tr>
</tbody>
</table>

### OPERATING EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>31 December 2013</th>
<th>31 December 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>External charges</td>
<td>-16,813,671</td>
<td>-17,849,652</td>
</tr>
<tr>
<td>Taxes</td>
<td>-107,082</td>
<td>-195,159</td>
</tr>
<tr>
<td>Wages and salaries</td>
<td>-5,127,812</td>
<td>-4,623,253</td>
</tr>
<tr>
<td>Social contributions</td>
<td>-1,988,213</td>
<td>-1,744,858</td>
</tr>
<tr>
<td>Depreciation charges and addition to provisions</td>
<td>-587,261</td>
<td>-885,057</td>
</tr>
<tr>
<td>Other expenses</td>
<td>-18,635,205</td>
<td>-14,469,337</td>
</tr>
<tr>
<td><strong>TOTAL OPERATING EXPENSE</strong></td>
<td><strong>-43,259,243</strong></td>
<td><strong>-39,767,316</strong></td>
</tr>
<tr>
<td>Write back of dedicated funds</td>
<td>3,155,654</td>
<td>3,174,453</td>
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<tr>
<td>Obligations for projects</td>
<td>-6,275,441</td>
<td>-6,391,059</td>
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<tr>
<td><strong>OPERATIONS ON DEDICATED FUNDS</strong></td>
<td><strong>-3,119,788</strong></td>
<td><strong>-3,216,606</strong></td>
</tr>
</tbody>
</table>

### OPERATING RESULT

- **906,037 USD** (2013)
- **86,374 USD** (2012)

### FINANCIAL RESULT

<table>
<thead>
<tr>
<th></th>
<th>31 December 2013</th>
<th>31 December 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign exchange difference</td>
<td>-335,534</td>
<td>-170,399</td>
</tr>
<tr>
<td>Interest and financial income</td>
<td>19,011</td>
<td>-12,908</td>
</tr>
<tr>
<td>Financial provisions</td>
<td>-281,648</td>
<td>1,476</td>
</tr>
<tr>
<td><strong>TOTAL FINANCIAL RESULT</strong></td>
<td><strong>-598,171</strong></td>
<td><strong>-181,830</strong></td>
</tr>
</tbody>
</table>

### EXCEPTIONAL RESULT

- **208,007 USD** (2013)
- **737,075 USD** (2012)

### Income tax

- **-10,015 USD** (2013)
- **-8,678 USD** (2012)

### NET RESULT FOR FINANCIAL YEAR - USD

- **505,858 USD** (2013)
- **632,940 USD** (2012)

### Notes

- Aid in kind (Drugs) 2,650,335 USD (2013), 1,840,113 USD (2012)
- Free use of goods and services -2,650,335 USD (2013), -1,840,113 USD (2012)

2012: 1 euro = 1.3194 US$
2013: 1 euro = 1.3791 US$
AKNOWLEDGEMENTS

The Union gratefully acknowledges the following governments, agencies, foundations and corporations that supported The Union’s work in 2013.

GOVERNMENTS AND AGENCIES

- Action Damien
- Agence Française de Développement (AFD)
- Agence Nationale de Recherche sur le Sida et les hépatites virales (ANRS)
- Alter Vida (Centro de Estudios y Formacion para el Ecodesarrollo)
- Baobab Health Trust, Malawi
- Commune de Premier Fait, France
- Department for International Development (DFID) of the British Government
- Economic Development Board of Singapore
- Family Health International with funds from the United States Agency for International Development (USAID)
- France Expertise Internationale (FEI)
- Initiative 5% Sida, Tuberculose, Paludisme
- Fondation Mérieux
- Fondo Financiero de Proyectos de Desarrollo (FONADE)
- Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) via Central Tuberculosis Division, Ministry of Health and Family Welfare, India
- Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) through a grant managed by the United Nations Office Project Services (UNOPS) in Myanmar
- Instituto Nicaragüense de Seguridad Social
- International Federation of Red Cross and Red Crescent societies with funds from the Bloomberg Philanthropies
- Jagran Pehel, India
- Ligue Pulmonaire Suisse
- Ministry of Economy and Finance, Government of Peru
- Ministry of Health, Dominican Republic
- MISEEROR
- National Cancer Institute (NCI) via Courtesy Associates Chicago LLC
- New Ways to Work for DWOI (Developing World Outreach Initiative)

- Norwegian Association of Heart and Lung Patients (LHL)
- PAHO Ecuador
- Programme National de Lutte contre la Tuberculose RDC
- Secretariat of the Pacific Community, New Caledonia
- TBCARE I and II implemented by the Tuberculosis Coalition for Technical Assistance (TBCTA) with funds from the United States Agency for International Development (USAID)

- United Nations Development Programme (UNDP Iran)
- USAID
- US Department of Health and Human Services Centers for Disease Control and Prevention (CDC)
- University Research Co, LLC funded by USAID
- World Health Organization (WHO) through a grant managed by EnCompass LLC
- WHO through grants managed by the Stop TB Partnership

FOUNDATIONS AND OTHER ORGANISATIONS

- Anonymous
- Bloomberg Philanthropies
- National Press Foundation
- Schwab Charitable Fund
- The Union North America
- World Diabetes Foundation
- World Lung Foundation with financial support from Bloomberg Philanthropies
- World Lung Foundation with financial support from the Bill and Melinda Gates Foundation

CORPORATIONS

- Eli Lilly and Company India Pvt Ltd
- The Yadana Consortium operated by Total/MGTC
- Longhorn Vaccines and Diagnostics LLC
- Qiagen/Cellestis
- Frequent Flyer Travel Paris
- Voxiva SRL

CENTENNIAL CAMPAIGN

The following individuals and organisations generously supported The Union Centennial Campaign 2012-2020.

President’s Circle (FROM 1500€)
- Anonymous
- AZApp, France
- Peter Baldini, United States of America (USA)
- E Jane Carter, USA
- José Luis Castro, France
- Louis James De Viel Castel, Switzerland
- Eli Lilly and Company India Pvt Ltd, India
- Fundacion Carlos J Finlay, USA
- Frequent Flyer Travel, France

Sponsors (700-1499€)
- Scott Halsted, USA
- Steve Lan, Hong Kong
- Shiu Hung Lee, Hong Kong
- Anna Mandalakas, USA
- Bruce Mandell, USA
- Diane Johnson Murray and John F Murray, USA

Supporters (350-699€)
- Ross Anderson, UK
- Chen-Yuan Chiang, Taipei, China
- Peter Davies, UK
- Asma El Sony, Sudan
- Glen Gormezano, USA
- L Masae Kawamura, USA
- Charles M Nolan, USA
- Renee Ridzon, USA
- Xiexie Wang, China

Contributors (150-349€)
- Jean-Louis Abena, Cameroon
- Michael Abramson, Australia
AKNOWLEDGEMENTS: CONTINUED

BENEFICTOR AND 15-YEAR MEMBERS

Benefactor and 15-year members are individuals who augment their memberships with gifts or take out long-term memberships.

**Platinum**
Louis-James de Viel Castel, Switzerland

**Gold**
Philip Hopewell, USA
Bess Miller, USA
Lee B Reichman, USA
Max Salfinger, USA

**Silver**
Margaret R Becklake, Canada
Nobukatsu Ishikawa, Japan
Seiya Kato, Japan
Hans-Joachim Lipp, Germany
Robert Loddenkemper, Germany
Guy Marks, Australia
Toru Mori, Japan
Jeremiah Chakaya Muhwa, Kenya
Edward Nardell, USA
Charles M Nolan, USA
Richard O’Brien, USA
Hans L Rieder, Switzerland
Dean Schraufnagel, USA
S Bertel Squire, UK
Armand Van Deun, Belgium

15-year members
Frank Adae Bonsu, Ghana
Nils E Billo, Switzerland
E Jane Carter, USA
Chen-Yuan Chiang, Taipei, China
Asma El Sony, Sudan
Donald A Enarson, France
Anne Fanning, Canada
Jean-William Fitting, Switzerland
Paula I Fujiwara, USA
Ludwing Gresely Sud, Ecuador
Anthony David Harries, UK
Joseph Ntaganira, Rwanda

INIVIDUAL DONORS
The Union also thanks the following who made gifts during the year.

Nils E Billo, Switzerland
Gilles Cesari, France
Anne Fanning, Canada
Elisabeth Joekes, UK
L Masae Kawamura, USA
Guy Marks, UK
John F Murray, USA
Mikkel Vestergaard Frandsen, Switzerland
Sarah Watson, UK

FINANCIAL REPORT

From Evidence To Public Health Action
**BOARD OF DIRECTORS**

The Board of Directors is elected by The Union federation of members at the General Assembly each year.

### THE BUREAU

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Dr E Jane Carter, USA</td>
<td>USA</td>
</tr>
<tr>
<td>Vice President</td>
<td>Dr Dean Schraufnagel, USA</td>
<td>USA</td>
</tr>
<tr>
<td>Secretary General</td>
<td>Dr Muhammad Amir Khan, Pakistan</td>
<td>Pakistan</td>
</tr>
<tr>
<td>Treasurer</td>
<td>Mr Louis-James de Viel Castel, Switzerland</td>
<td>Switzerland</td>
</tr>
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</table>

### REPRESENTATIVES OF THE REGIONS

<table>
<thead>
<tr>
<th>Region</th>
<th>Name</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Region</td>
<td>Dr Camilo Roa, Jr</td>
<td>Colombia</td>
</tr>
<tr>
<td>Asia Pacific Region</td>
<td>Prof Peter Davies, United Kingdom</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Europe Region</td>
<td>Dr Jesús Felipe González Roldán, Mexico</td>
<td>Mexico</td>
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<tr>
<td>Latin America Region</td>
<td>Prof Robert Loddenkemper, Germany</td>
<td>Germany</td>
</tr>
<tr>
<td>Middle East Region</td>
<td>Dr Reuben Granich, Switzerland</td>
<td>Switzerland</td>
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<tr>
<td>North America Region</td>
<td>Dr Muhammad Amir Khan, Pakistan</td>
<td>Pakistan</td>
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<tr>
<td>South-East Asia Region</td>
<td>Dr Reuben Granich, Switzerland</td>
<td>Switzerland</td>
</tr>
</tbody>
</table>

### MEMBERS REPRESENTING THE SCIENTIFIC SECTIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Name</th>
<th>Country</th>
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</thead>
<tbody>
<tr>
<td>Tuberculosis Section</td>
<td>Dr Richard Zaleskis, Latvia</td>
<td>Latvia</td>
</tr>
<tr>
<td>Adult &amp; Child Lung Health Section</td>
<td>Prof Simon Schaaf, South Africa</td>
<td>South Africa</td>
</tr>
<tr>
<td>HIV Section</td>
<td>Dr Soumya Swaminathan, India</td>
<td>India</td>
</tr>
<tr>
<td>Tobacco Control</td>
<td>Dr Wang Jie, China</td>
<td>China</td>
</tr>
</tbody>
</table>

### INDIVIDUAL MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Louis-James De Viel Castel, Switzerland</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Dr Reuben Granich, Switzerland</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Dr Muhammad Amir Khan, Pakistan</td>
<td>Pakistan</td>
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<tr>
<td>Dr Guy Marks, Australia</td>
<td>Australia</td>
</tr>
<tr>
<td>Dr E Jane Carter, USA</td>
<td>USA</td>
</tr>
<tr>
<td>Mr Khairuddin Ahmed Mukul, Bangladesh</td>
<td>Bangladesh</td>
</tr>
<tr>
<td>Prof S Bertel Squire, United Kingdom</td>
<td>United Kingdom</td>
</tr>
</tbody>
</table>

### MEMBERS NOMINATED BY THE PRESIDENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Rajita Bhavaraju, USA</td>
<td>USA</td>
</tr>
<tr>
<td>Ms Siphiwe Ngwenya, Swaziland</td>
<td>Swaziland</td>
</tr>
<tr>
<td>Ms Carol Nyirenda, Zambia</td>
<td>Zambia</td>
</tr>
<tr>
<td>Dr Dean Schraufnagel, USA</td>
<td>USA</td>
</tr>
<tr>
<td>Ms Tadeo Shimizu, Japan</td>
<td>Japan</td>
</tr>
<tr>
<td>Prof S Bertel Squire, United Kingdom</td>
<td>United Kingdom</td>
</tr>
</tbody>
</table>

### HONORARY MEMBERS

The Board confers Honorary Membership on individuals who have made outstanding contributions to TB and lung disease, and they play an important advisory role in The Union.

- Prof Margaret Becklake, Canada
- Dr Matthias Bleker, The Netherlands
- Dr H J Chum, United Republic of Tanzania
- Dr Valentin Cuesta Aramburu, Uruguay
- Prof Elif Dağlı, Turkey
- Prof Gunnar Dahistrohm, Sweden
- Dr Abbas Hassan El Masry, Sudan
- Prof Asma El Sony, Sudan
- Prof Anne Fanning, Canada
- Prof Victorino Farga, Chile
- Prof Rudolf Ferlinz, Austria
- Prof Martin Gninafon, Benin
- Dr Earl Hershfield, Canada
- Prof Michael Iseman, USA
- Dr James Kieran, USA
- Dr Arata Kochi, Switzerland
- Prof Robert Loddenkemper, Germany
- Dr Halfdan Mahler, Switzerland
- Prof David Miller, United Kingdom
- Prof Denis A Mitchison, United Kingdom
- Prof John F Murray, USA
- Dr Daniel Nyangulu, Malawi
- Dr Richard O’Brien, USA
- Dr Frances R Ogasawara, USA
- Dr Antonio Pio, Argentina
- Prof Françoise Portaels, Belgium
- Prof Jacques Prignot, Belgium
- Dr Rodolfo Rodríguez Cruz, Brazil
- Dr Annik Rouillon, France
- Dr A Samy, Egypt
- Dr Tadao Shimao, Japan
- Dr Sonkgram Supcharoen, Thailand
- Mr James Swomley, USA
- Prof Thelma Tupasi, The Philippines
- Prof Li-Xing Zhang, China

*Elected in Kuala Lumpur, Malaysia, 17th November 2012*
UNION OFFICES

Headquartered in Paris, The Union also has 11 offices in the Africa, Asia Pacific, Europe, Latin America, North America and South-East Asia regions.

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SouthEastAsia@theunion.org

THE UNION UGANDA OFFICE
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P.O. Box 16094 Wandegeya
Uganda
Uganda@theunion.org

THE UNION ZIMBABWE OFFICE
13 Van Praagh Avenue
Milton Park
Harare, Zimbabwe
Zimbabwe@theunion.org
Mario Vargas is a 46-year-old fisherman and coconut seller from Acapulco, Mexico. In April 2012, he was diagnosed with a form of multidrug-resistant tuberculosis (MDR-TB) that was resistant to five of the antibiotics commonly used to treat TB: isoniazid + rifampicin + pyrazinamide + ethambutol + streptomycin. Nevertheless he tolerated his treatment well, supported by his mother with whom he lives. Mario’s treatment took 18 months, but he is now completely cured and has been able to resume all the activities of his normal life.

Mario chose to help carry the message that MDR-TB is curable by participating in The Union’s exhibition of photos from Latin America by Javier Galeano.