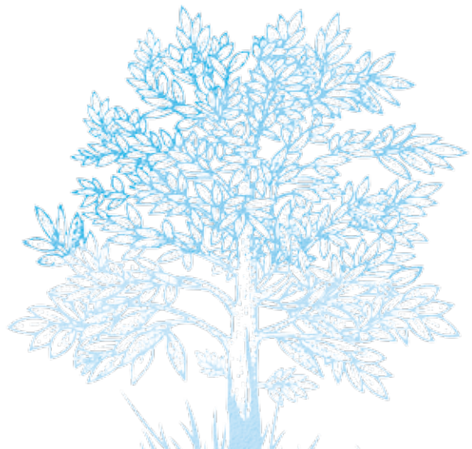


arc
australian respiratory council
prevention and cure of respiratory illness

2014 ANNUAL REPORT

NO. 101

australian respiratory council
prevention and cure of respiratory illness



www.thearc.org.au

arc

arc australian respiratory council
prevention and cure of respiratory illness

OUR MISSION

A global community with universal and high quality management of respiratory diseases.

OUR VISION

ARC is a Charitable, Non-Government Organisation that continues to build expertise and sustainable capacity in respiratory health by:

- Fostering innovative research to promote respiratory health
- Improving lung health in communities with an emphasis on disadvantaged groups and Indigenous people
- Actively seeking sustainable solutions through partnerships with like organisations such as the Australian Lung Health Alliance, World Health Organisation, the Stop TB Partnership, Secretariat of the Pacific Community and the US Centers for Disease Control and Prevention
- Bringing focus to and investment in TB and respiratory health
- Respecting relationships with and the contributions of stakeholders and staff.

OUR PATRONS



His Excellency General The Honourable David Hurley AC DSC (Ret'd) Governor of New South Wales.



Mrs Linda Hurley

ARC confirms that in the pursuit of its mission and vision it has no tobacco exposure in regard to direct stocks or managed funds exposures held within its Investment Portfolio.

ARC welcomes feedback. Please send any feedback or complaints to arc@thearc.org.au or write to Executive Officer, Australian Respiratory Council, GPO Box 102 Sydney, NSW 2001.

ARC confirms its commitment to full adherence to the ACFID Code of Conduct. Complaints relating to a breach of the ACFID Code can be made to the ACFID Code of Conduct Committee www.acfid.asn.au

ACFID

Australian Respiratory Council (ARC) is a member of the Australian Council for International Development (ACFID) and is a signatory to the ACFID Code of Conduct. The Code requires members to meet high standards of corporate governance, public accountability and financial management.

The Union
International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

Australian Respiratory Council (ARC) is a Constituent Member of the International Union Against Tuberculosis and Lung Disease (IUATLD). The mission of the Union is to bring innovation, expertise, solutions and support to address health challenges in low and middle income populations.

PRESIDENT'S REPORT

Emeritus Professor J. Paul Seale AM



I am pleased to report on the activities and outcomes of the Australian Respiratory Council (ARC) in 2014. From this report you will see that there has been a significant amount of work undertaken by our organisation over the past twelve months.

ARC's Patrons

After thirteen and a half years as Governor of New South Wales, Her Excellency Professor The Honourable Dame Marie Bashir AD CVO retired from Office on the 1st October, 2014. During her tenure as Governor The Honourable Dame Marie Bashir AD CVO and Sir Nicholas Shehadie AC OBE served as ARC's Patrons.



Her Excellency Professor The Honourable Dame Marie Bashir AD, CVO Governor of New South Wales



Sir Nicholas Shehadie AC, OBE

On behalf of ARC's Board of Directors I would like to extend our deepest gratitude to our former Vice-Regal Patrons during their term in office. In particular, I would like to note the engagement and commitment of our Patrons to three significant milestones for our organisation; ARC's Centenary Celebration in 2013, the launch of ARC's new identity in 2006 and the release of our 90 Year History in 2003. We would like to thank our former Patrons for their participation and contribution at each of these events.

Continuing ARC's history of Vice-Regal Patronage we are fortunate to have His Excellency General The Honourable David Hurley AC DSC (Ret'd) and Mrs Linda Hurley appointed as our Vice-Regal Patrons. We look forward to a long and productive association with our new Patrons.

Finances

Once again in 2014, our Finance team, led by, Robert Horsell OAM and supported by Peter Gianoutsos, David Macintosh AM, Robyn Johnson and the staff of the ARC worked to ensure the wise investment and continuation of funding for operational, research and project activities. I would like to acknowledge the diligence and commitment of the Finance team, your work and commitment is greatly appreciated.

The operating loss in 2014 was $141,203 against a projected budgeted loss of $291,626 with an asset revaluation of $16,953 (compared to $340,662 in 2013). The strategic management of the investment portfolio has resulted in the investments delivering a cash flow of $245,804 in 2014 (compared to $252,543 in 2013). The Australian Respiratory Council reported a Net Loss of $124,250 in 2014 (compared to a profit of $198,029 in 2013).

Further information on ARCs financial statements are detailed on pages 33 to 48 in this report.

Strategic Plan

This year, ARC's Board of Directors took time to review, reflect and update the organisation's strategic plan. A five year plan has been developed to guide the organisation's direction and activities over the coming years. The updated vision and mission is included in this report on page 1. The ARC is a Charitable, Non-Government Organisation supporting prevention, treatment and research into tuberculosis (TB) and respiratory disease at a national and international level. ARC is the Australian Constituent member of the International Union of TB and Lung Disease (The Union) and the Union Asia Pacific Region.

ARC focuses its activity on the Asia Pacific Region and around marginalised communities within Australia. It is a self-funding organisation and does not rely on the provision of government grants to pursue its activities.

Within our organisation we strive to reflect and embody the following values: accountability to stakeholders, ethical and sustainable practice, credibility and professionalism and leadership in respiratory health.

Building health system research capacity in Vietnam, Cambodia, Laos and China

In 2014, ARC funded for the fourth year the Methods in Clinical and Operational Research (MECOR) Program. The MECOR Program lead by Professor Guy Marks was held in Ha Noi, Viet Nam in January, 2014. This year participants from Viet Nam, Cambodia, Laos and China attended the course.

Through this project we are working in partnership with the Ministry of Health and National TB Programs in each of these countries, the Woolcock Institute, the American Thoracic Society, Viet Nam Lung Association against Tuberculosis and Lung Diseases and the Viet Nam National Lung Hospital.

The primary objective of the MECOR project is to develop capacity in future leaders in respiratory public health. This capacity will include the ability to interpret and use published evidence to guide policy development and disease management and generate research ideas and to design and implement studies to investigate these ideas.

A more detailed report has been provided by Professor Marks on pages 16 and 17 of this report.

ARC Nurse Consultants activities within the Region

Work continues by ARC's Nurse Consultant Group in the provision of training and technical support, clinical mentoring, the development of educational tools and resources for nurses and related workers within the Pacific Island countries and territories. This work is undertaken in collaboration with the US Centers for Disease Control and Prevention and the Pacific Island Health Officers Association.

This year, Chris Lowbridge and Flora Van der Heide from the NSW TB Program assisted the Nurse Consultants group in their work and activities. I would like to thank both Chris and Flora for their contributions.

In August 2014, Amanda Christensen and Flora Van der Heide travelled to Hawaii to provide training and technical support at the first Pacific Island Program Collaboration and Service Integration (PCSI) Workshop held August 11th –15th, at The Queen's Conference Center in Honolulu.



Participation included TB Program staff and public health workers from the six US affiliated Pacific Islands (American Samoa, Commonwealth of the Northern Mariana Islands, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) as well as public health experts from the US Centers for Disease Control and Prevention, World Health Organization, Australian Respiratory Council and other partner agencies.

This workshop featured a number of cross-cutting and hands-on training activities on diseases that burden Pacific Islanders. Diseases such as HIV/AIDS, viral hepatitis, sexually transmitted diseases, TB, Hansen's disease, and diabetes. There were dedicated training sessions for program managers, clinicians, laboratory technicians, nurses and related health workers. The multi-disciplinary workshop provided participants the opportunity to learn about many different topics within disease-specific areas and learn ways to collaborate between programs and integrate services at the point of care to address the public health challenges within the respective jurisdictions. In addition, the ability to be able to network with public health colleagues and experts from across the Pacific to share information, ideas, and strategies was invaluable.

A range of ARC resources were distributed to the TB Program Staff and conference participants. These resources included: the revised ARC TB Training Modules, updated TB Flip Charts and a new sputum collection poster. Positive feedback has been received on each of these resources.

I would like to thank ARC's Nurse Consultant Group; Pam Banner, Kerrie Shaw and Amanda Christensen for their continued enthusiasm and commitment. Their long standing and ongoing work to provide technical support, mentoring and capacity building for the Pacific Island countries and territories is an important activity.

Research activities

ARC continues a commitment to fund research activities in TB and respiratory disease. In 2014, research funding was awarded under the Ann Woolcock Fellowship Program and The Harry Windsor Research Grant Scheme.

Dr Jodie Simpson completed her tenure as the ARC Ann Woolcock Fellow in July, 2014. Dr Simpson, from the Hunter Medical Research Institute commenced her fellowship on "Characterisation and treatment of innate immune dysfunction in older people with obstructive airway disease" in 2010.

During the fellowship Dr Simpson conducted, supervised, and collaborated on a series of important studies exploring the role of the innate immune system in older people with obstructive airways disease (asthma and/or COPD). A detailed report on Dr Simpson's research is included in the annual report on pages 10 and 11.

I am pleased to report that as a result of the fellowship Dr Simpson has had considerable grant success in obtaining three new NHMRC project grants and will now work to translate the discoveries made during her fellowship project into clinical practice in severe asthma and COPD.

I would like to take this opportunity to wish Dr Simpson well in her future career and research activities.

Associate Professor Daniel Chambers was awarded the Harry Windsor Research Grant in 2014. The research project titled "Disease tolerance and transplant tolerance – two sides of the same coin?" was undertaken by Associate Professor Chambers and his team at the Queensland Lung Transplant Service, at the Prince Charles Hospital in Brisbane. A detailed report on the research project is included in the annual report on pages 12 and 13.

Acknowledgement and thanks

A continued strength of the ARC is the contribution that our Directors each make. I extend my personal thanks to each Director in this regard. Many of our Directors have been with the ARC for over a decade and continue with great generosity to provide expertise and wisdom to our organisation. Without the individual contributions that each person brings the success of our organisation would not be so great.

On behalf of Professor Iven Young, Chair of ARC's Research Committee. I would like to acknowledge the contribution of the Research Committee. Thank you for your support and time in assisting ARC to achieve our research goals.

Thank you to the staff of ARC, Amanda Christensen, Judy Begnell and Miranda Juhl for your commitment and enthusiasm to the work of our organisation over the past year. I would like to acknowledge Amanda and Judy's efforts in putting together the annual report that describes the achievements and outcomes of ARC. For a small staff the outcomes and achievements are significant.

The continued contribution of our volunteer Audrey Tonkin is also noted. Audrey has been a volunteer with ARC for the past eight years. Audrey's contribution and assistance is greatly valued.

In addition, my thanks and those of the Board are extended to Heath McLaren and his team at Macquarie Bank for their financial guidance in 2014 and to David Conroy and Roy Chong for their expertise and assistance in meeting our annual auditing responsibilities.

Finally, I extend my sincere thanks and gratitude to ARC's donors without whom we would not be able to continue our work. The loyalty and generosity of our donors, many of whom have been supporting our work for many years is greatly valued by everyone involved with our organisation as well as the recipients of our research and project funding. I hope through this report, our publications and website that you can learn about how your donations contribute to the work of ARC.

The year ahead

Looking to the year ahead there is much excitement and enthusiasm within our organisation. As the host of the 5th Conference of The Asia Pacific Region we will continue to work with The Union to develop a program that encompasses the domains of research, technical assistance and advocacy, to raise the profile of global health issues in general and focus the attention of regional governments and other key regional participants on the problems of TB, other lung diseases, tobacco control and non-communicable diseases among the poor within our Region.

The conference will showcase up-to-date information and feature many of our Region's leading researchers and clinicians in the area of TB and lung disease. The conference program will inspire solutions for the pressing challenges for the future management of TB and respiratory disorders in our neighbouring countries.

5th Asia Pacific Region Conference of the International Union Against Tuberculosis and Lung Disease

Sydney August 2015

Further information on the conference can be found on the conference website www.aprunion2015.com and on pages xx and xx of this report.

In 2015, through the Harry Windsor Research Grant Scheme ARC will support two research projects. The first grant has been awarded to Dr Brian Oliver from the Woolcock Institute and University of Technology, Sydney. Dr Oliver will undertake a research project on "Understanding the aetiology of small airway fibrosis in COPD". The second research grant has been awarded to Associate Professor Harin Karunajeewa from the Walter and Eliza Hall Institute, Victoria. Associate Professor Karunajeewa's research project is "Getting the dose right in Tuberculosis: Pharmacokinetics to improve outcomes in Tuberculosis".

Project work will continue for Dr Peter Massey and the team from the Solomon Islands. The ARC has agreed to fund an additional project to build on the success of previous projects and work – the project "Supporting TB treatment supporters Solomon's style" will work with women and other key people in East Kwaio to explore practical issues for TB treatment supporters.

In the year ahead ARC will co-ordinate and fund a project that will explore the framework for education for TB Nurses in Australia. The ARC Nurse Consultants Group in collaboration with a project officer and stakeholders will explore the options and develop a report with recommendations on potential provider institutions, as well as likely viability and sustainability of various models of education for TB Nurses. The development of a dedicated training course acknowledges that TB nursing requires a unique skill set and creates opportunities for advanced training for nurses throughout Australia and the Asia Pacific Region.

My sincere thanks to the many people involved with ARC in 2014. I look forward to my continued relationship with you all in the coming year.

Emeritus Professor J. Paul Seale AM
MB BS, PhD, FRACP
President

PRESIDENTS AND LIFE GOVERNORS

The National Association for the Prevention and Cure of Consumption

Year	President
1913 - 1917	Sir Phillip Sydney Jones
1918 - 1922	Dr Frederick Sobieski Vladimir Zlotkowski
1922 - 1928	Hon. George Frederick Earp MLC
1929 - 1930	Thomas Ernest Rofe

Anti-Tuberculosis Association of NSW (from 1931)

Year	President
1931 - 1934	Thomas Ernest Rofe
1935 - 1941	William Grazebrook Layton CBE
1941 - 1942	Phillip Lazarus JP
1942 - 1944	Sir Ernest Thomas Fisk
1944 - 1953	Zade Lazarus
1954 - 1955	Hon. Justice Edward Parnell Kinsella CBE
1955 - 1959	Ebenezer Richard Bagery-Parker
1959 - 1960	Harold Bruce Gibson
1960 - 1967	Hon. Justice Edward Parnell Kinsella CBE
1967 - 1972	Professor Noel Desmond Martin AM

Community Health and Anti - Tuberculosis Association (from 1973)

Year	President
1973 - 1994	Professor Noel Desmond Martin AM
1995 - 1999	Professor Ann J Woolcock AO
1999 - 2000	Dr Gregory Joseph Stewart
2000 - 2001	David Hugh Macintosh AM

Community Health and Tuberculosis Australia (from 2001)

Year	President
2001 - 2006	David Hugh Macintosh AM

Australian Respiratory Council (from 2006)

Year	President
2006 - 2013	David Hugh Macintosh AM
2013 - Present	Emeritus Professor J. Paul Seale AM

Year	Life Governors
1932	Honourable George Frederick Earp MLC, CBE (C)
1934	Sir John Sulman
1934	Sir Kelso King and Lady King
1966	Sir Harry Wyatt Wunderly
1996	Dr Keith Wellington Hills Harris AM
2003	Professor Noel Desmond Martin AM
2003	Clinical Professor Iven Young
2003	Emeritus Professor Ian W Webster AO
2007	Emeritus Professor Charles Baldwin Kerr AM
2007	Emeritus Professor J. Paul Seale AM
2009	David Hugh Macintosh AM
2011	Amanda Christensen
2011	Professor Gavin Frost
2012	Robert Horsell OAM
2012	Clinical Associate Professor Peter Gianoutsos



Photograph courtesy Rob Tuckwell Photography

EMERITUS PROFESSOR J. PAUL SEALE AM RECOGNISED FOR SIGNIFICANT SERVICE TO MEDICINE

Emeritus Professor J. Paul Seale was awarded a Member of the Order of Australia (AM) in the Queen's Birthday 2014 Honours List for his significant service to medicine as a clinical pharmacologist, particularly in the field of respiratory illnesses.

The award is recognition of Emeritus Professor Seale's leadership, professional achievements and contribution to respiratory health, pharmacology, education, research and meritorious service to the community.

Emeritus Professor Seale's achievements are acknowledged by his peers, he is recognised as an eminent international leader in respiratory health and pharmacology and is held in very high regard by all those who have had the good fortune to be associated with him. His professional and voluntary life demonstrate a strong, lifelong commitment to both leadership and meritorious service.

ARC is proud to acknowledge the contribution of Emeritus Professor Seale AM over a number of years. Paul joined ARC's Board of Directors in 1997, served as a Vice President for a number of years and elected as the President in 2013.

ARC's Board of Directors and staff congratulate Emeritus Professor Seale AM for this well-deserved award.

GOVERNANCE

BOARD OF DIRECTORS

AMANDA CHRISTENSEN
Dip Nursing



NSW TB Program Manager 1997- 2013; various positions in public health for over twenty one years including; clinical nurse consultant in public health Corrections Health Service and Tuberculosis Control for the NSW Ministry of Health. Appointed to the Board in 2001. Elected as a Life Governor in 2011. Employed as the ARC Executive Director from April 2008 to May 2009 and April 2013 - present.

CLINICAL ASSOCIATE PROFESSOR PETER GIANOUTSOS
MB, ChB (Univ of Otago), FRACP, FCCP



Appointed Emeritus Consultant Physician RPAH, 1 January 2014; Senior Consultant Thoracic Physician (VMO) Dept of Thoracic Medicine RPAH 1971-2013; Member TSANZ, ATS, ACCP, BTS, ALF, MLS(NSW); Chairman RPA Medical Board 1989-1991; Member of Medical Board of NSW 1978-1982; Chairman UMPS Medical Expert Panel 2002 – 2007; Member of Board of Directors UMP 2000-2003. Appointed to the Board of ARC in 2006. Vice President 2008 - Present. Elected Life Governor of ARC in 2012.

ROBERT HORSELL OAM
CPA



Medal of the Order of Australia 2012; Proprietor, R E Horsell & Co Public Accountants 1978-; Former Director, Cricket Australia 1997-2004, 2005- 2008; Former Chairman, Cricket NSW 1997-2008; Former Director, Bradman Foundation 1999-2005. Appointed to the Board in 1999; Chair of Finance Committee. Elected Life Governor of ARC in 2012.

ROBYN JOHNSON
GAICD



Conference Organiser with more than 21 years experience managing National and International conferences for not-for-profit associations, corporations and universities. Currently General Manager, Event Delivery at Business Events New South Wales. Appointed to the Board in 2012.

DAVID MACINTOSH AM
BBS (UTS), FCA



Member of the Order of Australia 2011, awarded National Medal for Service 2014, Chairman, The Macintosh Foundation, Macintosh Chair of Paediatric Respiratory Medicine - Endowed Chair 29 November 2005 in perpetuity; Founder since 2013 and Benefactor since 2007, Royal Alexandra Hospital for Children - The Children's Hospital at Westmead; Member of Board of Governors and Chairman of the Finance Committee, Woolcock Institute of Medical Research 2000-2011; Previous Director, The Australian Lung Foundation; Managing Director, Paynter Dixon Construction Group 2001- Present; Director, Ainsworth Game Technology Limited 2013 – 2015. Director of numerous private companies; thirty four years of senior management and director level in the transport and construction industries in Australia and Europe; Chairman, actively involved in the Surf Life Saving movement for over forty eight years; Life Member, Long Reef Surf Life Saving Club Inc.; Distinguished Service Member and Chairman of the Expenditure Review Committee, Collaroy Surf Life Saving Club Inc. Appointed to the Board in 1997; President 2000 -2013. Vice President 2013 -; Elected Life Governor of ARC in 2010.

IAN W. RAMSAY
LL.,B



Solicitor, Supreme Court of NSW; General Manager and Board Director, WorkCover NSW (1988-1997); Chairman, Dust Disease Board of NSW (1988-1997); Member, National Occupational Health and Safety Commission (1988-1997); Chairman, Sporting Injuries Committee (1988-1997); Member, Joint Coal Board Health and Safety Trust (1993-1997). Appointed to the Board in November 2008 - 2012. Chair, of Centenary Celebration Committee. Reappointed to the Board 2012.

EMERITUS PROFESSOR J. PAUL SEALE AM
MB BS, PhD, FRACP



Member of the Order of Australia, 2014 Professor of Clinical Pharmacology, University of Sydney 1992- 2014; Pro-Dean, Faculty of Medicine, University of Sydney 1997-2003; Consultant Physician, Royal Prince Alfred Hospital 1980-2013; Deputy Director, Woolcock Institute of Medical Research; Member 2003-2012, former member, Australasian Society for Clinical and Experimental Pharmacologists and Toxicologists; Past President, Thoracic Society of Australia and New Zealand; former Congress President, Asia Pacific Society of Respirology; former Chairman, NSW Therapeutics Advisory Group; former Chair TB Committee, Sydney South West Area Health Service; former Member of NSW Health TB Advisory Committee, Appointed to the Board in 1997; Vice-President 2003 - 2012. President 2013 - Present; Elected Life Governor of ARC in 2007.

RESEARCH COMMITTEE

KERRIE SHAW
Dip Nursing



TB Coordinator South Eastern Sydney Local Health District (Northern Sector) 2013; Executive Officer Australian Respiratory Council 2009-2013; Manager Department of Respiratory Medicine, TB Coordinator, TB and Respiratory Clinical Nurse Consultant 1998-2009; Asthma Coordinator and TB Clinical Nurse Specialist South Eastern Sydney and Illawarra Area Health Service (Southern Sector) 1992-1998; Chair and Program Secretary, Nurses and Allied Health Subsection International Union Against TB and Lung Disease 2009-2013; Appointed to the National Asthma Expert Advisory Group 2006; Appointed to the Board Asthma Educators Association (NSW) 1992 and Board Australian Asthma and Respiratory Educators Association 2006, Life Member 2011; Member, Thoracic Society of Australia and New Zealand 1992; Appointed to ARC Board 2013.

CLINICAL PROFESSOR IVEN YOUNG
BSc (Med), MBBS, PhD FRACP



Senior Physician, Department of Respiratory and Sleep Medicine, Royal Prince Alfred Hospital (RPAH) 1991- 2009; Visiting Medical Officer, RPAH 1979-1985; Senior Staff Specialist in Respiratory Medicine, RPAH 1985-; Post Doctoral Fellow, University of California, San Diego 1976-1978; Research Fellow, University of Sydney 1974-1976; Respiratory Physician 1975-; Member, Thoracic Society of Australia and New Zealand; Member, American Thoracic Society; Member, European Respiratory Society; Senior Examiner, Australian Medical Council 1997-; elected to the Adult Medicine Division, Royal Australasian College of Physicians 2000-2001; Chairman, Division of Medicine, RPAH 2001-2009; Chair, Physicians Training Council, HETI 2010 - Present. Appointed to the Board in 1998. Elected Life Governor of ARC in 2003. Chair of Research Committee.



Professor Carol Armour
Executive Director, Woolcock Institute of Medical Research
Professor of Pharmacology & Associate Dean (Career Development & Research), Sydney University.



Professor Judith Black AO
Research Adviser Health & Medical, Sydney University,
Woolcock Institute of Medical Research.



Professor Peter Gibson
Senior staff specialist & Director of Ambulatory Care & Sleep Medicine at the John Hunter Hospital, Conjoint Professor of Medicine in Faculty of Health, Newcastle University, Co-Director of the VIVA Programme, Hunter Medical Research Institute.



Emeritus Professor J. Paul Seale AM
ARC President (ex officio).



Clinical Professor Iven Young (Chair)
Chair, Physicians Training Council.



Dr Greg Fox
Post-doctoral Fellow, Montreal Chest Institute, McGill University, Canada.

SUPPORTERS OF ARC

BREATH OF LIFE

During 2014 despite uncertain economic times ARC's loyal supporters have continued to show their generosity and support by contributing to our two regular appeals. This ongoing commitment ensures that ARC is able to continue to fund researchers in Australia and project work with a focus on the Asia Pacific Region.

What is extremely rewarding is to see that our supporters are also wishing to make a lasting impact on respiratory disease by advising of their intention to leave a bequest in their Will.

Breath of Life Club and Honour Roll

Members of the Breath of Life are supporters who have made a commitment to leave a bequest to ARC in their Will. They are acknowledging that they wish to continue to support the projects and research aimed at fulfilling the vision of a community free of respiratory illness.

The Honour Roll is a way ARC can publicly acknowledge the incredible act of kindness and generosity of our supporters who take this decision.



Why leaving a gift in your will matters

It is our vision that together we can beat respiratory disease. When people like you trust us with a gift in your will we make sure your money matters.

What type of gift can I leave in my Will?

Being wealthy is not a prerequisite and a desire to look after your family does not have to preclude you from leaving a bequest. The value of such bequests is immeasurable. Regardless of their size, bequests are always gratefully received. It does not matter how large or how small your estate, or the size of the bequest you choose to make, it will be a gift that allows you to continue your generous support and make a difference over time.

Making a bequest to ARC is very easy. After taking into account the needs of your family, you can choose to gift a specific asset, a certain amount, a percentage or residue of your estate to ARC. We would suggest that you instruct your solicitor about making a new Will to include a gift to ARC or updating your existing Will to make a simple amendment that designates your desired gift to ARC.

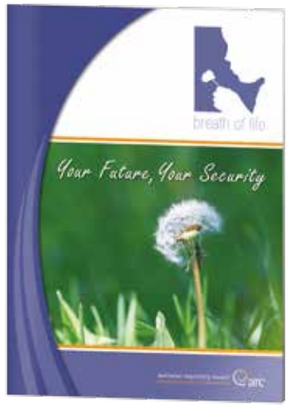
Notifying us about your bequest

For many people a Will is an intensely private thing; its contents are not something they choose to talk about. That's why so many acts of great generosity remain a well-kept secret. Over many years, people from all walks of life have chosen to leave bequests of varying sizes.

Whilst it would be good to be able to thank all our supporters for this incredible step, we understand some prefer to remain anonymous. Many longtime supporters have chosen to remain anonymous during their lifetime. It is not until after we receive notification that they have left ARC a bequest that we can publicly thank them for their generosity and add their names to the Breath of Life Honour Roll to thank them in perpetuity.

Communicate your wishes to your loved ones and please consider telling us about your bequest. Notifying us does not alter your right to change or update your wishes if circumstances change but it does help us plan for the future.

Please call us for a copy of our "Your Security, Your Future" booklet if you are considering leaving a bequest to ARC.



"A bequest to ARC provides a way to continue a lifetime of generous giving"

INVESTING IN THE FUTURE THROUGH RESEARCH

ANN WOOLCOCK FELLOWSHIP



This award was established in 2004 and is named in honour of the late Professor Ann Woolcock AO, former head of the Institute of Respiratory Medicine at the University of Sydney and Royal Prince Alfred Hospital. Professor Woolcock was a strong supporter of trainee scientists and physicians.

This is a 4 year full time postdoctoral fellowship in biomedical, clinical or public health research and is valued at approximately $100,000 per year. The Fellowship aims to encourage people of outstanding ability to develop research as a significant component of their career.

The Fellowship will support research relating to tuberculosis, respiratory diseases due to other infections, or respiratory diseases related to tobacco use, community issues or the health of disadvantaged groups.

Ann Woolcock Fellowship

2005 - 2009 The genetic influences on causal pathways of acute lower respiratory tract infections (ALRIs) in highly susceptible infants in PNG

Dr Ingrid Laing
Telethon Institute for Child Health Research, Perth

2010 - 2014 Characterisation and treatment of innate immune dysfunction in older people with obstructive airway disease

Dr Jodie Simpson
University of Newcastle

HARRY WINDSOR RESEARCH GRANTS SCHEME



These grants are named in honour of the late Dr Harry Windsor, a leading Australian heart surgeon who played a key role in ARC for many years.

Dr Windsor performed the first heart transplant operation in Australia and was a prominent cardiothoracic surgeon at Sydney's St Vincent's Hospital.

He was actively involved with ARC and its Board from 1955 until his death in 1987.

These awards are being offered nationally to support research in:

- Tuberculosis
- Respiratory diseases related to other infections
- Smoking-related respiratory diseases

Research which also address community issues or the health of disadvantaged groups are particularly encouraged.

Grants of approximately $50,000 are offered each year. Grants are available for projects submitted to the National Health and Medical Research Council (NHMRC) which are considered fundable but which do not reach the cut-off mark for funding in any one year. An information sheet and grant conditions can be found and downloaded from ARC's website: www.thearc.org.au

Harry Windsor Research Grants
2014 Recipient

2014 Disease tolerance and transplant tolerance – two sides of the same coin?

Associate Professor Daniel Chambers,
The Prince Charles Hospital, Qld Lung Transplant Service, Qld

DR JODIE SIMPSON

Australian Respiratory Council Ann Woolcock Research Fellow 2010 - 2014



Characterisation and treatment of innate immune dysfunction in older people with obstructive airway disease

During my Ann Woolcock Research Fellowship I have conducted, supervised, and collaborated on a series of important studies exploring the role of the innate immune system in older people with obstructive airways disease (asthma and/or COPD). I have examined a novel mechanism leading to neutrophilic inflammation in obstructive airways disease which is a key discovery in this area and will be generalisable to other neutrophilic airway diseases such as non-CF bronchiectasis, protracted bacterial bronchitis in children, and post-transplant bronchiolitis obliterans.

Since commencing my fellowship I have had considerable grant success with 3 new NHMRC project grants since 2010 resulting from my fellowship work and will now seek to translate the discoveries into clinical practice in severe asthma and COPD. I have also written a chapter The Biology of Neutrophils in the prestigious text book "Middleton's Allergy Principles and Practice". In March 2014, I submitted an NHMRC project grant investigating a novel therapeutic target for neutrophilic asthma which is the result of a new collaboration with Associate Professor Sandy Hodge in Adelaide and Associate Professor Johan Bylund in Sweden.

The ARC Fellowship has significantly advanced my career development. In 2013, I was promoted to Associate Professor (research only) at the University of Newcastle and named the Elsevier Scopus Young Researcher of the Year for Medicine and Medical Sciences. I was appointed the chair of the awards committee for the Thoracic Society of Australia and New Zealand. In 2014, I was appointed the Research Higher Degree Coordinator for the School of Medicine and Public Health.

Research Program

Obstructive airways diseases in the older age group are increasingly common, and the distinction between different diseases can be blurred. In clinical practice distinguishing asthma from COPD in adults older than 55 is problematic because of overlap of many of the features of both diseases. This overlap may result from altered pathophysiology in the elderly, where the underlying inflammatory reaction in the airways becomes similar in the different conditions as people age.

Ageing is associated with a range of immune system changes. There are well-described changes in both innate and adaptive immunity with ageing. Important inflammatory cells called neutrophils, exhibit decreased capacity to perform some of their vital functions with ageing, which may lead to persistence of infection. Neutrophil responses are typically associated with activation of the innate immune system. The development of age related airway neutrophilia implicates a role for the innate immune response being responsible for this effect.

During my fellowship I have investigated how alterations in the innate immune response in older people with airways disease can potentiate the effects of ageing and compare these results with older and younger healthy controls. I have also been examined the effect of a new treatment to determine its ability to reduce airway neutrophils in older people with COPD.

1. Characterisation of immune dysfunction in older people with obstructive airways disease

The obstructive airway diseases COPD and asthma are now major health issues for Australia's ageing population. COPD is a disease of global significance that is a major contributor to mortality and morbidity in older people. The airflow obstruction that characterises COPD is progressive and incompletely reversed by current therapy. This underscores the need to better understand disease mechanisms which would facilitate the search for new treatment modalities in COPD. Airway inflammation is a key element of COPD, and typically involves neutrophilic infiltration of the airways. Neutrophilic bronchitis in COPD is persistent, and remains after the removal of stimuli such as tobacco smoke. The role of airway inflammation in obstructive airway disease of older people is poorly understood. It is likely to be important but also different to younger people because of life-long exposures to particulates such as cigarette smoke or other immune stimuli such as infections.

Persistent neutrophilic bronchitis is also a feature of other chronic airway diseases; bronchiectasis, allergic bronchopulmonary aspergillosis, and the neutrophilic subtype of asthma. This suggests there may be a common mechanism contributing to persistent airway neutrophilia in these diseases. I have previously described a self-perpetuating neutrophil activation cycle (NAC) in neutrophilic asthma and hypothesised its existence and the involvement of an important immune system receptor (toll like receptor 2) in other obstructive airway diseases characterised by neutrophilic inflammation. This cycle is activated by toll like receptor 2 stimulation and persists *via* positive feedback interactions between important neutrophil proteins (CXCL-8, NE, and MMP-9) all of which levels are significantly elevated in the airways of patients with neutrophilic asthma.

Other factors known to influence airway neutrophilia are ageing, smoking, airflow obstruction, infection and corticosteroid use, and these factors are also associated with neutrophilic airway diseases. However, it is unclear to what extent factors such as age and past smoking impact on the persistent neutrophilic bronchitis and NAC in COPD. I have investigated these issues by assessing components of the NAC, and controlling for the effects of age, smoking and airway obstruction in patients with COPD. I have recruited 118 adults and collected induced sputum for bacterial culture and measurement of key inflammatory proteins and genes.

The NAC was enhanced with age, smoking and most significantly in those with COPD. TLR2 gene expression was significantly elevated in those with COPD and was a significant independent predictor of neutrophils in sputum after correcting for age, smoking and airflow obstruction. TLR2 activation led to increased gene expression for TLR2 and the induction of the components of the NAC. The results of this study have been accepted for publication in Mediators of Inflammation.

2. Treatment of immune dysfunction in older people with obstructive airways disease

While effective treatments are well established to treat some types of inflammation in asthma and COPD, there are no treatments targeting neutrophilic inflammation. The anti-inflammatory effects of macrolide antibiotics are well-established. Macrolide antibiotics such as azithromycin have separate and distinct antibiotic and anti-inflammatory actions. There is extensive *in vitro* evidence of anti-inflammatory activity of macrolides, and some evidence that they may be efficacious in the treatment of neutrophil mediated airway diseases.

A randomised placebo controlled trial of azithromycin therapy for 12 weeks was undertaken to determine the ability of macrolide treatment in reducing the NAC components as well as bacterial load. This study screened 77 participants and randomized 30 people for the clinical trial of azithromycin therapy in older patients with airways disease.

Nine participants with neutrophilic bronchitis had a potentially pathogenic bacteria isolated and the median total bacterial load of all participants was $5.22x10^7$cfu/ml. Azithromycin treatment resulted in a non-significant reduction in sputum neutrophil proportion, CXCL8 levels and bacterial load. The mean severe exacerbation rate was 0.33 per person per 26 weeks in the azithromycin group compared to 0.93 exacerbations per person in the placebo group (incidence rate ratio (95%CI): 0.37 (0.11, 1.21), P=0.062). For participants who underwent chest CT scans, no alterations were observed. In stable COPD with neutrophilic bronchitis, add-on azithromycin therapy reduced severe exacerbations with a non-significant reduction in sputum neutrophils, CXCL8 levels and bacterial load

RESEARCH TRAINING

Student Supervision 2013-2014

- 2007-2014: Ms Hayley See is investigating the *in vitro* response of bronchial epithelial cells and the activation of lymphocytes from COPD patients by infection with rhinovirus, respiratory syncytial virus and *Haemophilus influenza*.
- 2008-2014 Mr Heng Zhong commenced his PhD in October 2008 studying the *in vitro* response of bronchial epithelial cell and neutrophils to infection with rhinovirus: a comparison of patients with COPD, healthy smokers and healthy non-smokers
- 2009-2014 Mr Lakshitha Gunawardhana, is studying the epigenetic regulation of airway inflammation in non-eosinophilic asthma
- 2014-2016 Ms Melanie Erriah will be studying mast cells and eosinophilic COPD.

RESEARCH OUTPUT 2013-2014

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4. **Simpson JL,** Baines KJ, Ryan NM, Gibson PG. Neutrophilic asthma is characterised by increased rhinosinusitis with sleep disturbance and GERD. APJAI Accepted January 2013.
5. Baines KJ, **Simpson JL,** Gibson PG**.** The Biology of Neutrophils. Middleton's Allergy- Principle and Practice 7th Edition Volume 1; Chapter 17 2013: Editors Adkinson NF, Bochner BS, Busse WW, Holgate ST, Lemanske RF, Simons FER. Mosby Elsevier ISBN 978-0-323-05659-5.
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11. Gunawardhana, LP, Baines, KJ, Mattes, J, Murphy, VE, **Simpson, JL**, Gibson, PG. Differential DNA Methylation Profiles of Infants exposed to Asthma during Pregnancy. Paediatric Pulmonology. 2013 Oct 25. doi: 10.1002/ppul.22930. [Epub ahead of print]
12. **Simpson JL**, Phipps S, Baines KJ, Oreo K, Gunawardhana, LP, Gibson PG. Elevated expression of the NLRP3 inflammasome in neutrophilic asthma. Eur Resp J 2013 Oct 17. [Epub ahead of print]
13. **Simpson JL**, Gibson PG, Yang IA, Upham JW, James A, Reynolds PN, Hodge S. AMAZES Study Research Group. Altered sputum granzyme B and granzyme B/PI-9 in patients with non-eosinophilic asthma. Respirology. 2013 Dec 23. doi: 10.1111/resp.12213. [Epub ahead of print]
14. Oreo K, Gibson PG, **Simpson JL**, Wood LG, McDonald VM, Baines KJ. Sputum ADAM8 expression is increased in severe asthma and COPD. Clinical Experimental Allergy. 2013 Oct 22. doi: 10.1111/cea.12223. [Epub ahead of print]
15. G Peng, **Simpson JL**, Z Jie, Gibson PG. Galectin-3: its role in asthma and potential as an anti-inflammatory target. Respiratory Research accepted December 4th 2013.
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ASSOCIATE PROFESSOR DANIEL CHAMBERS

The Prince Charles Hospital, Qld Lung Transplant Service, Qld



Disease tolerance and transplant tolerance – two sides of the same coin?

As the 2014 Harry Windsor Research Grant recipient I am delighted to be able to provide an update on the progress of the above project.

This grant application was prompted by our observation that re-colonisation of the transplanted lung by the same bacterial species with which the patient was colonised pre-transplant (a 'concordant microbiome') was associated with less chronic rejection. We speculated that these patients had developed a tolerogenic pulmonary environment which translated into better lung transplant outcomes.

Since our last report we have expanded the study in response to advances in the field (see below re the macrophage work), and simultaneously increased the number of samples that we are studying to include a longitudinal component to ensure stability of the immune environment over time in addition to the planned cross-sectional study. We are now studying 40 concordant and 20 discordant in the cross-sectional arm and studying 30 patients at 3 time points (20 concordant and 10 discordant) in the longitudinal arm. While these are positives, unfortunately our work has been delayed somewhat due to the lack of sensitivity of some of our ELISAs. For IL-10 and TNFalpha we found that many of the samples had values below the limit of detection. It was felt that pursuing ELISAs would not generate meaningful results and we instead made the decision to determine RNA expression in the BAL. We did find that IL-8 and mannose binding lectin could be detected at the protein level and have now completed all the ELISAs for this outcome (see Figure 1). Preliminary analysis would suggest that IL-8, but not MBL, is higher in BAL where a concordant microbiome exists. This is an interesting finding, and suggests active immunity where concordance exists. We have now extracted RNA from all the samples, converted this to cDNA and are optimising the real-time PCR assays to measure cytokine gene expression.

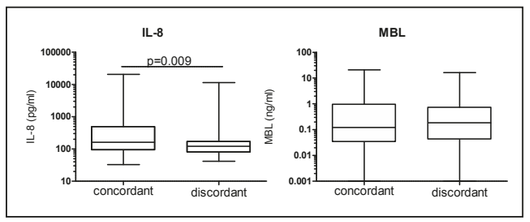


Figure 1. IL-8 and mannose binding lectin by microbiome concordance.

Meanwhile we have assessed bacterial biomass as planned using 16S rRNA RT-PCR and linked this data to BAL neutrophil count (Figure 2). As expected, we found that bacterial biomass was unrelated to the neutrophil count (consistent with a tolerogenic environment) but surprisingly it didn't seem to matter whether the microbiome was concordant or discordant.

Figure 2

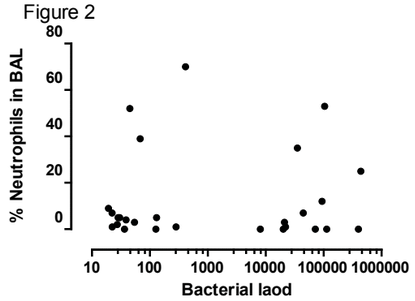


Figure 2. Bacterial biomass is dissociated from neutrophilia in lung allografts, consistent with a tolerogenic environment

Finally, recent literature has suggested that macrophages are important in tolerance and that macrophages can be divided into M1 and M2 subsets. Furthermore, animal models have suggested, in paradigm changing studies, that tissue-derived macrophages are self-replicating, long lived and present in the steady state. We are uniquely positioned to study both macrophage subtype and whether they are tissue-derived (ie from the donor) or circulating (ie from the recipient), and how this then relates to microbiome and allograft tolerance. We firstly used flow cytometry and stained macrophages (CD68) with markers suggestive of an M1 (HLA-DR) or M2 (CD163 and CD206) phenotype. Interestingly we found that all lung macrophages were of an M2 phenotype (Figure 3, macrophages (blue line) stain for the M2 markers CD163 and CD206 but not the M1 marker HLA-DR). We are now furthering this with our cytokine PCRs by measuring IL-1 and TNFalpha (M1) and IL-10, TGFbeta and arginase (M2). Additionally, we are exploiting the fact that most lung transplants are HLA mismatched and are using flow cytometry with antibodies against mismatched donor and recipient HLA A or HLA B antigens to determine, for the first time in humans whether alveolar macrophages are tissue resident or bone-marrow derived or both. The hypothesis here is that alveolar macrophage chimerism may be linked to both allograft and disease tolerance. We are approximately half

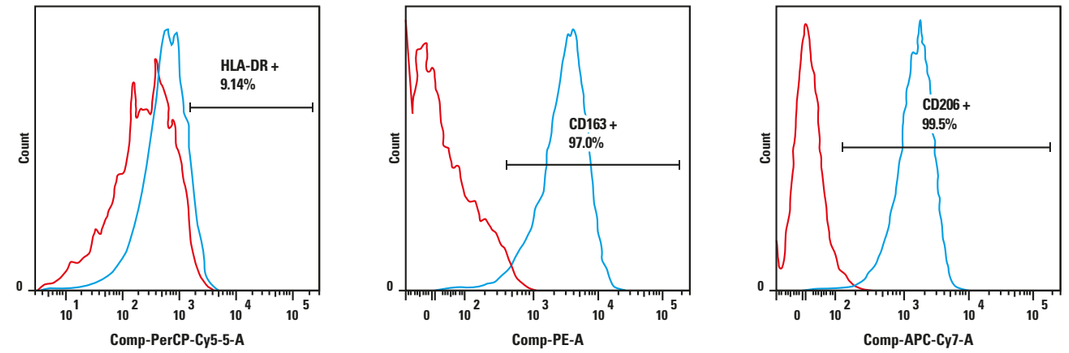


Figure 3, macrophages (blue line) stain for the M2 markers CD163 and CD206 but not the M1 marker HLA-DR)

way through this but initial observations would suggest that the early post-transplant period has a mix of donor and recipient derived macrophages, whereas by 3 months post-transplant most macrophages are of recipient origin (Figure 4, blue line indicates positive staining). This data will nicely round out and complement the other innate immune work.

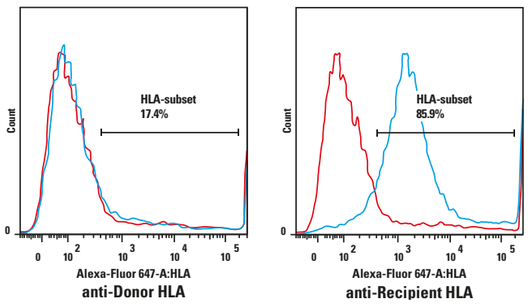
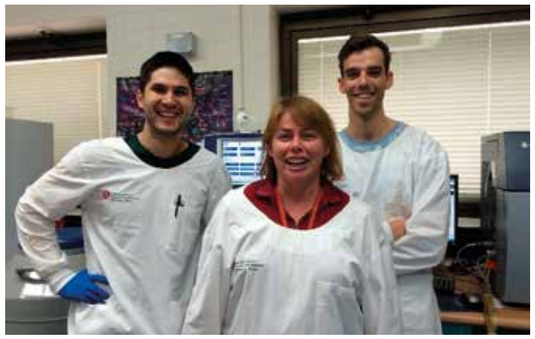


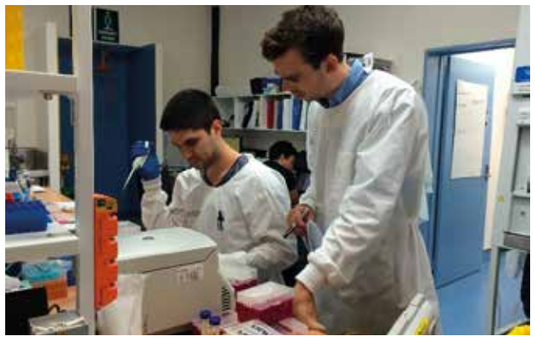
Figure 4, blue line indicates positive staining

This study has been a team effort and will also contribute to a MBBS Honours project for my student Ricky Nelles. Ricky is the top student in his class and is in his final year of medical studies at University of Queensland. Ricky has been ably helped by my Research Assistants Maxine Tan and Luke Samson, with the laboratory work overseen by my Chief Scientist Stephanie Yerkovich.

Thank you once again for supporting our work. It is anticipated that the project will be fully completed by mid 2015, and an updated report with the final results will be forwarded.



L-R; Luke, Maxine and Ricky in the laboratory



L-R; Luke and Ricky at work

DR ANN MITROVIC

The University of Sydney



Australia's Lyme-Like Illness: a focus on north-eastern NSW and south-eastern Queensland

Background

Lyme borreliosis (including Lyme disease) is a tick-borne infection due to a spirochetal (spiral) bacteria called Borrelia. Several species of Borrelia bacteria are known to cause disease globally, in USA (Lyme disease & relapsing fever borreliosis), Europe & Asia (Lyme borreliosis & relapsing fever borreliosis), Africa (relapsing fever borreliosis) as well as South America (Baggio-Yoshinari Syndrome & relapsing fever borrelia).

Borreliosis, when disseminated as a multi-system infection, has a broad clinical presentation. Symptoms can be neurological, musculo-skeletal, systemic, fatigue, cardiac and arthritic. These symptoms can overlap with other conditions making diagnosis difficult outside well characterised endemic areas such as regions of USA and Europe.

The study

Tick bites in Australia particularly from the paralysis tick are increasingly causing concern, mainly due to possible infection and also acute allergic reactions following tick bites, occasionally requiring hospitalisation. More recently a delayed allergic reaction to red-meat associated with a prior tick bite has been described.

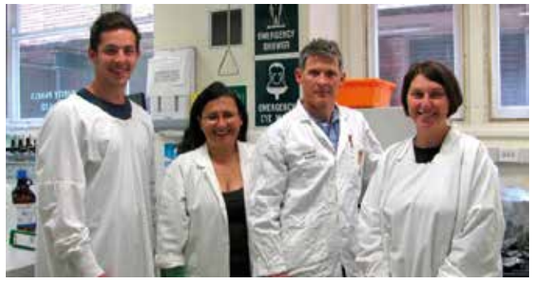


Adult paralysis tick (Ixodes holocyclus)

Our group is interested in a tick bite related syndrome that has been described since 1982 where multiple non-specific systemic symptoms develop usually beginning as a flu-like illness following a tick bite. The syndrome has many similarities with the northern hemisphere Lyme disease, an infection caused by the spiral bacteria called Borrelia and hence the syndrome is referred to as an Australian Lyme-like illness. A causative agent/s has not yet been identified for our Australian Lyme-like illness. There appear to be clusters of this illness mainly on the east coast of Australia and one of the clusters is located in north-eastern NSW & south-eastern Queensland and this region is the focus of the Australian Respiratory Council grant which forms part of a greater national study.

Our research aims to identify the causative agent of this Lyme-like illness and further to develop sensitive and specific diagnostic tests to detect Australians with the illness. We are using different methods to investigate whether the causative agent is a Borrelia species:

1. DNA technology to detect the presence of Borrelia DNA, as evidence of a current or recent exposure to Borrelia species
2. Diagnostic blood tests to detect antibodies against Borrelia proteins in clinical patient samples and
3. Culture of salivary glands and mid-gut contents of ticks to isolate spirochetal bacteria.



Members of the Tick-borne Diseases Unit, The University of Sydney, left to right, Will Shirvington, Ann Cincotta, Brent McParland & Ann Mitrovic

The hypothesis we have focussed on in the first year of the grant is that if Australian Lyme-like illness is caused by a Borrelia bacteria then an immune response against the Borrelia would have resulted in antibodies being formed. These antibodies should be detected to some extent on a diagnostic test designed for European and American Lyme disease. This part of our research is conducted by Will Shirvington a PhD Candidate. Will's initial results have shown that of the 35 participants tested from the region, 74% had evidence of antibodies that bound to specific Borrelia proteins. This result implies exposure to Borrelia bacteria but cannot define which species of Borrelia. We are continuing to recruit participants from the NE NSW & SE QLD region and have recently had an increase in interest about the study following an article in the Coffs Harbour advocate.

The study also focusses on isolating and identifying pathogens from ticks. Mees Barak, a Masters student is working on detection of Borrelia species in Australian ticks. We are also interested in other micro-organisms that may cause the symptoms of an Australian Lyme-like illness. Brooke Storey-Lewis, a PhD student is investigating Babesia, a tick transmitted micro-organism which causes serious illness in USA and Europe and which may also contribute to the symptoms of Australian Lyme-like illness. The first reported Australian case of babesiosis believed to be acquired in Australia was published in 2012. There is always the possibility of Australians returning from overseas with babesiosis acquired in an endemic region. Brooke has employed a diagnostic kit to test the blood for antibodies against 2 types of Babesia species. To date she has tested 26/35 participants and found that 34% had antibodies against Babesia; this requires further investigation.

Field work is required to collect tick samples and in February Brooke Storey-Lewis, Dr Brent McParland and Dr Ann Mitrovic visited a field site in Morisset NSW. Further field work to collect tick samples will be held in NE NSW and SE QLD and is planned for later in the year.

Will Shirvington & Brooke Storey Lewis will be presenting their preliminary data at the 3rd Tick-borne Diseases Conference being held at Charles Perkins Centre, The University of Sydney, 7-8 March, 2015.



Mees Barak Masters student



Brooke Storey-Lewis PhD student



Eastern Grey Kangaroos at Morisset during tick collection fieldwork

Acknowledgement: ARC is able to provide funding for this project as a result of a generous donation from the Twin Towns Services Community Foundation Limited.

PROJECT FEEDBACK



PROFESSOR GUY MARKS

Training Vietnamese doctors and public health professionals in research methods for lung health

Viet Nam, and its neighbours Cambodia and Laos, face many lung health challenges including tuberculosis, asthma and COPD, air pollution, occupational lung disease, lung cancer, pneumonia and acute respiratory illness in children. They face these problems with limited physical and human resources. An important step in finding locally relevant to solutions to health problems is conducting local research and for this they need research enabled and empowered key individuals within the health sector. Since 2011, the Australian Respiratory Council (ARC) has been supporting the development of this capacity by contributing towards the annual Methods in Epidemiological, Clinical and Operational Research (MECOR) course in Viet Nam.

MEKONG MECOR is a one week, full-time residential course designed to build a diverse range of research enabling skills in a cohort of future lung health leaders in Vietnam and its neighbours. Participants are selected from government programs and hospitals, universities, institutes and NGOs. All are engaged in clinical or public health work, in research and/or in teaching in fields relevant to lung health: TB prevention and care, clinical respiratory medicine, laboratory medicine, environmental health, cancer medicine, child health or other related fields. Most are in their 30s or early 40s – at early to middle stages of their career – and all are able to communicate in English. We select people who will be capable of using what they learn at MECOR to good effect in leading research and in teaching others. The MECOR



program is supported by the American Thoracic Society, the Viet Nam Association for Tuberculosis and Lung Disease, Woolcock Institute of Medical Research, and USAID, as well as the Australian Respiratory Council.

During their first year (Level 1), participants learn the basics of research design, including some key epidemiological and biostatistical principles. They also learn about ethical issues in medical research, how to prepare a research protocol and a questionnaire, and how to present at scientific meetings. The teaching is highly interactive and features an emphasis on questioning (the Socratic approach). They work in small groups to develop and present a protocol for research study. From this they learn some of the pitfalls to avoid but also gain confidence and the ability to work with others.

Those who are successful in Level 1 are invited back the following year for the Level 2 course, in which they learn more about a research design and develop their own research protocol (individually). The final level in Viet Nam is Level 3, where participants analyse data from their research projects and prepare a manuscript for publication. Some of the Level 3 participants have gone on to attend a global (level 4) course where they meet MECOR trainees from around the world and learn more about data analysis and writing research reports.



In January 2014, all participants in all three levels of MECOR gathered at the Trade Union Hotel near West Lake in Hanoi. These consisted of 18 Level 1 participants, eight Level 2 participants and four Level 3 participants. They were taught by a faculty of 17 teachers and assistants including four from USA, two from Australia (Guy Marks and Michael Abramson) and 11 from Viet Nam. The teams worked hard all day and most of the evenings from Monday morning to Saturday lunchtime. They had one night "off" for the favourite social activity: karaoke! At the end of the week (Saturday morning), all the students presented their projects to the assembled MECOR family. We had a wonderful array of exciting projects presented as seen from the table listed below.





Research Proposals Developed and Presented at MEKONG MECOR 2014

1	The value of CAT score to predict the exacerbation of COPD outcome
2	Relation between metabolic syndrome and obstructive sleep apnea in Vietnamese patients
3	The prevalence of MDR-TB among adult TB suspects living with HIV in HCMC, Viet Nam
4	Value of impulse oscillometry in children with cough-variant asthma
5	Prevalence of poor sleep quality and day time sleepiness in COPD patients at National Lung Hospital
6	Knowledge, Attitudes and Practices of Tuberculosis among Ethnic Minority Groups in the Central Highlands of Viet Nam
7	Incidence of hospital acquired pneumonia at Respiratory Center - Bach Mai Hospital
8	Evaluation the differences of clinical and outcome characteristics between MDR vs. non MDR Klebsiella pneumonia among hospitalised pneumonia patients
9	The impact of active case finding on rates of recurrent TB in Ca Mau, Viet Nam
10	The association between anxiety and depression symptoms and dyspnea in adult asthma patients
11	Prevalence of modifiable risk factors for poor outcomes in patients admitted with acute exacerbations of COPD
12	Evaluation the agreement of cTNM and pTNM of NSCLC patients in Bach Mai Hospital
13	Association of BMI with survival in TB/HIV co-infected patients
14	Universal GenXpert testing in HIV infected patients for improving case detection

PROJECT FEEDBACK



DR PETER MASSEY

East Kwaio, Solomon Islands: Community based stories for TB education and evaluation

Completing TB treatment is a vital aspect of the control of TB, or as it is described in the East Kwaio area of Solomon Islands, "*drinkim gud TB meresin fo 6 manis*". The model of care in most Pacific countries and territories is to admit people with TB to the hospital for the intensive phase of treatment for 2 months and then discharge the patient. A mixture of treatment follow-up methods then occurs for patients during the continuation phase of the treatment of 4 months, from no follow-up, to daily contact. But many people do not complete TB treatment "*gud*".

With support from the ARC, Hunter New England Population Health and James Cook University, the Atoifi Adventist Hospital (AAH) set out to develop a better understanding of the issues with completing TB treatment. The AAH employed a project officer, and with the TB team consulted and discussed treatment issues with patients, families and communities.

Initially there were some delays in getting the consultation parts of the project underway due to a natural disaster in the Solomon Islands – cyclone, flood and earthquake. But when the team was able to safely move about, consultation with ten villages and communities across the East Kwaio area occurred. This involved many days walking and boat rides to reach communities.



Photo taken at Ngarinasuru in Sinalagu - with Chiefs, leaders, women and children after the TB talk.

People in the communities spoke about a number of important issues in relation to TB treatment. One man said, "*It is our duty and obligation to look and take care for the patient. Family is the priority and it* [the care] *was culturally instructed.*" A Chief explained that: "*a family member is a blood* [relative]*, whether the patient is at the hospital or at home they have the total responsibility to help that person get his or her treatment until it is completed.*"

Chiefs and members of a community a long way from the Hospital suggested the following strategies: "*It is better for the TB patient to stay at the hospital under the care of nurses and doctors until he or she is fully recovered*"; "*While in the hospital they should receive good care and also provide food for the patient*"; "*If the TB patient should return to his home, it is the responsibility of the family members and close relatives to monitor its improvement and making sure the treatment is completed*"; and "*it is the duty of the nurse to visit the TB patient monthly to know the progress.*"



Esau Kekeubata (TB Project Officer) giving TB awareness talk at Kwainaa'isi in the mountains, an area with a lot of TB.

Based on these findings and other similar stories and suggestions the AAH initiated a number of changes and recorded a DVD to explain treatment to patients and families. The Hospital is now providing food for all TB patients while they are admitted. This has helped the patient's recovery, and supported their families by reducing the financial pressure and burden of travel to care for their relative. Some families needed to travel a long way to bring food from their gardens and this is difficult on a daily basis. TB Patients are now getting nutritious food and re-building their strength, which was taken away by TB. People are now staying in hospital instead of "running away" to be with family.

Utilising the skills of the health workers at AAH, and local people in acting, recording and editing a DVD was developed to address some of the issues about TB treatment. The DVD was made using equipment purchased with a previous ARC grant and has resulted in a high quality and interesting resource.

The DVD is recorded in the local Kwaio language and this is a highlight. As the previous projects have found, health stories in local language connect with people in a way that using English or



Esau Kekeubata (TB Project Officer) giving TB awareness talk at Kwainaa'isi in the mountains, an area with a lot of TB.





New TB Ward at Atoifi Adventist Hospital, showing culturally appropriate separate roof lines for male and female wards

even Pijin will not. The 2014 DVD includes information about TB and about the importance of completing TB treatment. Sharing this information through a story on the DVD aligns closely with the oral story traditions of the area and thus is very engaging for patients and families.

All TB patients and families are now shown the DVD on a number of occasions. Over time the full impact of this community-based resource will be seen, but for now we have already seen a better approach to TB treatment for patients, treatment supporters and staff.

The new TB Ward is now admitting patients though the ward is not yet complete. This shows how acceptable the new ward is and will be. Patients from all parts of East Kwaio can now be cared for in this ward as many cultural issues have been addressed. A separate study by the Director of Nursing looked at the local responses by health workers and communities have helped to inform policy and protocols of the new TB Ward.

The TB team has three publications about the work in East Kwaio. The publications will help others in the Pacific to see the work and become more aware of other options for the control of TB in a more culturally acceptable way.

- Massey PD, Asugeni R, Wakageni J, Kekeubata E, Maena'adi J, Laete'esafi J, Waneagea J, Asugeni V, MacLaren D, Speare R. TB stories in local language on DVD: steps on a journey to TB control in Solomon Islands. BMC International Health and Human Rights 2015; 15:1
- Massey PD, Asugeni R, Wakageni J, Kekeubata E, Maena'aadi J, Laete'esafi J, Waneagea J, Harrington H, Fangaria G, MacLaren D, Speare R. Progress towards TB control in East Kwaio, Solomon Islands. *Rural and Remote Health* 2013: 2555.
- Massey PD, Wakageni J, Kekeubata E, Maena'adi J, Laete'esafi J, Waneagea J, Fangaria G, Jimuru C, Houaimane M, Talana J, MacLaren D, Speare R. TB questions, East Kwaio answers: community-based participatory research in a remote area of Solomon Islands. *Rural and Remote Health* 2012; 12: 2139.

The TB awareness DVD and the TB treatment DVD were shown at the inaugural Atoifi Research Symposium and were widely acclaimed. This excellent resource is being used for TB awareness in the AAH. The DVDs will continue to be shown in villages, hamlets and at community events. This will further embed the messages about TB in this remote area of Solomon Islands where TB is a daily struggle for many. The AAH team looks forward to sharing this resource with others in the Solomon Islands. Also the AAH team look forward to continued work with the ARC, and partners, in addressing TB using a community-based grass-roots approach.

More information is available at: www.atoifiresearch.org.sb

Reports of ARC TB Projects in the news:

12 February 2015.	TB prevention story published. www.atoifiresearch.org.sb/node/84
31 October 2014.	TB project progresses: A second set of TB videos in Kwaio Language. www.atoifiresearch.org.sb/node/61
6 August 2014.	Australia saintis i laik halvim PNG na Solomon Islands long sait long helt. Radio Australia interview. http://www.radioaustralia.net.au/tokpisin/2014-08-06/australia-saintis-i-laik-halvim-png-na-solomon-islands-long-sait-long-helt/1353200
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PROJECT FEEDBACK

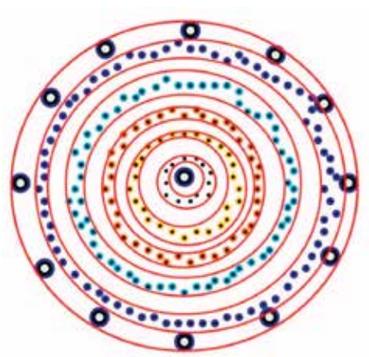


DR JENNY HUNT

BREATHE: Building Research Evidence to address Aboriginal Tobacco Habits Effectively

The name of the project, BREATHE, is an acronym for **B**uilding **R**esearch **E**vidence to address **A**boriginal **T**obacco **H**abits **E**ffectively.

The artist's statement about the BREATHE logo is explained below:



"The BREATHE logo – the imperfect concentric circles loosely resemble the cartilage rings in a person's windpipe; the larger dark dots in the outer rim represent the 12 services participating in the project, and the dark dot in the middle represents the AH&MRC."

Introduction

The Aboriginal Health and Medical Research Council (AH&MRC) was funded by the Australian Respiratory Council, the Cancer Council of NSW, and the Heart Foundation to design, implement and evaluate a project to enhance tobacco control in NSW Aboriginal communities. The project came to be known as the BREATHE Project, and was undertaken between 2007 and 2011. The BREATHE project involved the AH&MRC working with 12 member NSW Aboriginal community controlled health services (ACCHSs) and a range of organisations and individuals.

Aims, objectives and overall design

The aims and objectives of the BREATHE project were:

- To trial the impacts of employing, training and supporting a tobacco control worker within an ACCHS setting
- To increase tobacco control capacity of ACCHSs
- To improve smoking related outcomes in NSW Aboriginal communities
- To contribute to the evidence base.

The overall design of the BREATHE project was to use a culturally informed action research approach to conduct a community randomised trial. Twelve ACCHSs were recruited to participate in the BREATHE project, of which six were randomly selected to receive the 'intervention'. The intervention consisted of ACCHSs receiving funding for 12 months to contribute to employing a tobacco control worker (BREATHE worker), and the provision of a program of tailored training and support. The project was undertaken by a small AH&MRC project team, supported by a Project Management Group of external organisations and individuals. Assistance at various stages of the project was also provided by a range of people employed by and associated with the AH&MRC. The organisations and individuals who contributed to the BREATHE project are listed in Appendix 1 of the Project Report posted on ARC's website www.thearc.org.au

The BREATHE project was evaluated through the collection and analysis of a broad range of information about the implementation of the project, as well as about smoking and tobacco control activities in the 12 participating ACCHSs and the Aboriginal communities they serve. Information was collected by the BREATHE project team and locally employed research assistants before and after the intervention period. The collected information included assessing smoking prevalence, knowledge and behaviours among Aboriginal community members attending each ACCHS, as well as ACCHS policies and activities, staff knowledge and attitudes, as they related to smoking and tobacco control. In addition, after the intervention period, interviews were conducted with the BREATHE workers and ACCHS managers in intervention sites to gain their perspectives of the achievements and challenges of the project.

Between 2011 and the preparation of this report in 2015, the AH&MRC has continued to use and disseminate information about lessons learnt through the BREATHE Project. At the time of writing, work by the AH&MRC towards publishing several journal articles to disseminate BREATHE Project findings is ongoing.

Key activities

Selection and randomisation of ACCHSs

AH&MRC member ACCHSs were invited to express interest in participating in the project at the time of the original funding application and then followed up after the project was funded. ACCHSs were eligible to participate if they did not have an existing tobacco control program. The AH&MRC actively followed up with member ACCHSs to identify 12 services that were interested in participating in the project, and to include small and large ACCHSs in urban, rural and remote locations.

Participation in the project was negotiated with each ACCHS over several months, through a series of discussions, including at least one face to face meeting. Community consent forms were signed by participating ACCHSs and the AH&MRC, to document points of agreement in these areas.



The AH&MRC BREATHE Project Team with representatives of participating ACCHSs and partner organisations after the randomisation event at the AH&MRC Annual General Meeting, October 2008

Funding, recruitment and employment of BREATHE Workers within ACCHSs

The six intervention site ACCHSs received funding from the BREATHE project for employment of a BREATHE worker to focus on tobacco control within the ACCHS. The AH&MRC BREATHE Project Team provided support for recruitment, training, and activities. A draft position description was developed by the AH&MRC team, describing the proposed role and activities of the position.

BREATHE worker training and support

At the beginning of the intervention period, an induction workshop for the BREATHE workers and their managers was held in Sydney by the AH&MRC Project Team. As well as providing information about the project, and delivering training on smoking and tobacco control strategies, BREATHE workers and their managers were supported to develop a shared workplan, based on a workplan template drafted by the Project Team, based on a review of evidence based approaches to Aboriginal tobacco control and knowledge about ACCHS operations.

Three subsequent workshops for BREATHE workers were held in Sydney during the 12 month intervention period, with a focus on training, information sharing, peer support, and networking. Content was specifically designed to meet the BREATHE worker needs. The training sessions included:

- Training about tobacco addiction, brief intervention (including Smokecheck), smoking cessation, tobacco control strategies, the use of smokerlysers, environmental tobacco smoking
- Health promotion, social marketing, cannabis use and interventions
- Sharing information about the BREATHE Project and BREATHE worker roles and activities.

Training was delivered by individual trainers with specific expertise in the relevant area, including the NSW Quitline trainer, the Smokecheck team, external consultants, organisations such as the National Cannabis Prevention and Information Centre, and members of the Project Management Group with relevant expertise.

In feedback at the end of the intervention period, the BREATHE workers provided positive feedback about the value of training that had been delivered through the BREATHE Project, saying that it had provided them with the information, knowledge and skills they needed to undertake tobacco control activities within their ACCHS.

Throughout the intervention period, and in particular between workshop and training blocks, the BREATHE workers were primarily supported by the BREATHE Project Manager through frequent email and telephone exchanges, site visits, and other means.

BREATHE worker areas of focus and activities

A generic workplan template for BREATHE workers was developed by the Project Team. The workplan template identified six areas of focus for BREATHE worker activities:

1. Increase focus and profile of ACCHS tobacco control and smoking cessation activities
2. Improve ACCHS workplace tobacco control and smoking cessation policies
3. Increase delivery of brief interventions to ACCHS clients
4. Increase support for ACCHS clients interested in quitting
5. Act and advocate for increased tobacco control and smoking cessation in the community
6. Build evidence, research and reporting.

Each BREATHE worker and ACCHS was able to adapt and customise the local work plan, to reflect local ACCHS circumstances and priorities.

BREATHE workers were all active in promoting a focus on addressing smoking and tobacco control within their ACCHS, using a range of strategies including: presentations to staff, collecting, adapting and disseminating resources, establishing a committee to focus on tobacco issues within the ACCHS, and linking with other programs within the ACCHS.

BREATHE workers focusing on ACCHS policy development were able to establish new ACCHS tobacco control policies where these were not already in place, re-develop existing policies to be stronger and more detailed, and take action to support the implementation and enforcement of policies. Areas of focus included smoke free areas within the ACCHSs, signage, staff smoking, smoking around children, smoking in ACCHS cars, and cessation support for ACCHS staff.

As well as being active within the local ACCHS, BREATHE workers were active in other locations within the community, including through developing and distributing resources such as posters and fact sheets to Aboriginal organisations, Aboriginal land councils, local hospitals, and local pubs and clubs.

BREATHE workers spent a lot of their time talking with and providing information to community members about smoking, quitting and strategies to address environmental tobacco smoke,

both within the ACCHS and in the community. They engaged with individual ACCHS clients, and also with groups such as mums and bub, and men's health groups. The BREATHE workers actively participated in community events such as NAIDOC week, family fun days, youth days, and career days, and distributed resources such as posters, fact sheets, leaflets and marketing materials as well as using Smokerlysers during these events to engage community interest in talking about smoking.

Baseline and end of trial data collection

The AH&MRC BREATHE Project Team and locally employed research assistants collected data at all 12 ACCHSs, including intervention and control sites, before and after the intervention period.

Data gathering tools and methods were specifically developed for the BREATHE Project by the AH&MRC BREATHE Project Team with support from Project Management Group members, drawing on questions and data gathering instruments used in other settings, both Aboriginal specific and mainstream. The different methods used to gather information and data from participating ACCHSs were:

- A survey of community members about smoking attitudes, knowledge and behaviours
- Contextual information about ACCHS tobacco control activities was collected through a semi structured interview with one or more staff members, and this information was supplemented with a local environmental scan to document signage and health promotion displays relating to smoking
- ACCHS staff views were assessed through self-administered surveys and a staff focus group being held at each participating ACCHS.



BREATHE workers, the AH&MRC BREATHE Project Team and colleagues at the Oceania Tobacco Conference, Darwin 2009

Impacts, achievements and outcomes

The BREATHE Project was able to document a range of project impacts, achievements and outcomes at four different levels:

- Individual: BREATHE workers and research assistants. The four individuals who were in BREATHE worker positions at the end of the project all continued employment at the ACCHS after the project ended
- Participating ACCHSs
- Aboriginal communities served by participating ACCHSs
- The AH&MRC.

Individual: BREATHE workers and research assistants

The BREATHE Project directly provided new employment opportunities. The AH&MRC BREATHE Project Team and others observed significant growth in BREATHE worker knowledge, skills, and confidence during the course of the project. The BREATHE workers each became effective advocates for tobacco control at their ACCHS and in their communities.

Experience gained by BREATHE workers during the project included: working with health and community organisations developing ACCHS policy, program development, implementation and research skills. These skills have built the capacity of individuals to undertake future work in these related areas, hence making an important contribution to the positive impacts of the BREATHE Project.

Participating ACCHSs

Employing and supporting BREATHE workers within intervention site ACCHSs delivered increased ACCHS capacity around tobacco control during the life of the BREATHE Project. BREATHE worker interviews and staff focus group results provided similar perspectives on the outcomes of the BREATHE Project relating to changes in ACCHS staff knowledge, attitudes and behaviours. These were:

- More ACCHS staff were aware of brief intervention strategies and were incorporating these into their practice
- Increased staff confidence in talking with clients about smoking and in delivering brief interventions was reported
- More ACCHS staff were asking for assistance with addressing smoking
- Demand for training about addressing smoking amongst ACCHS staff was greater
- No-smoking areas were being better observed and respected by ACCHS staff.

Analyses assessed the proportions of survey participants who smoked reporting they had been advised to quit, referred to the Quitline, or referred to a quit support worker. These proportions were compared for the groups of participants attending intervention site ACCHSs with those attending control site ACCHSs, before and after the intervention period. At baseline, the proportions of regular smokers reporting they had been advised to quit in the previous six months was similar for intervention (39.1%) and control (43.6%) groups. Post-intervention, the proportion of control group regular smokers advised to quit was similar (41.8%), but in the intervention group a statistically significantly higher proportion of smokers reported being advised to quit (57.5%, $P<0.001$). This pattern of increased levels of ACCHS tobacco control activity being observed for intervention site ACCHSs was similar for regular smokers reporting they had been referred to the Quitline and to a quit worker.

ACCHS staff reported in post intervention interviews that the BREATHE worker model worked for ACCHSs and had been well received by communities. There was significant interest amongst both intervention and control site ACCHSs in funding for dedicated, specialist Aboriginal tobacco control positions being ongoing.

Aboriginal communities

BREATHE workers reported in post intervention interviews that they had received increasing requests for assistance to quit from community members who smoked over the timeframe of the project, and that they had observed a greater awareness of and understanding about the effects of smoking on the health of individuals and family members, including children, through environmental tobacco smoke exposure in the home and in cars. The views of BREATHE workers that the BREATHE Project had raised the profile of tobacco control within the local community, and contributed to de-normalising smoking was shared by participants in intervention site ACCHS staff interviews and focus groups.

Analyses of exit survey data relating to Aboriginal community members smoking related behaviours and attitudes was also undertaken to assess potential impacts of the BREATHE Project.

Analyses also compared the rates of quit attempts and successful quit attempts before and after the intervention, for participants who smoked that attended intervention site ACCHSs with those attending control site ACCHSs. Amongst regular smokers, the proportions of exit survey participants who reported a quit attempt in the previous 12 months (33-40%), or a successful quit attempt (13-18%), were similar in both time periods and groups, with differences not being statistically significant.

Smoking prevalence was also assessed amongst intervention and control groups, before and after the intervention. Between the baseline and post-intervention time periods, there was a statistically significant decrease in smoking prevalence amongst ACCHS exit survey participants for both intervention (50.2% at baseline compared to 42.9% post-intervention) and control (55.9% at baseline compared to 49.7% post-intervention) groups. This suggests a secular trend of decreasing prevalence of smoking amongst NSW ACCHS attendees over the intervention period.

In summary, the findings of analyses of exit survey responses suggested the BREATHE Project intervention contributed to an increase in help seeking behavior amongst smokers, and reduced smoking in cars. While impacts on quit rates and smoking prevalence were not demonstrable, a secular trend of reduction in smoking prevalence in both intervention and control groups is encouraging.

AH&MRC

The knowledge and experience that the AH&MRC gained about Aboriginal tobacco control has been a major positive outcome of the BREATHE Project. Through the literature reviews and other research conducted at the outset of the BREATHE Project, the AH&MRC gained a sound understanding of the existing body of evidence about effective strategies to address Aboriginal smoking. The experience of designing, implementing and evaluating the BREATHE Project provided the AH&MRC with an in depth understanding of the strengths and challenges ACCHSs experienced in taking action on Aboriginal tobacco control, and enabled successful strategies to be identified as well as opportunities for lessons to be learnt from those activities that were less successful.

The BREATHE Project has been the foundation for the establishment and operation of an ongoing program of support for NSW ACCHSs around tobacco resistance and control – the AH&MRC Tobacco Resistance and Control (A-TRAC) Program.

The AH&MRC has been enabled through the BREATHE Project and subsequent work to provide well informed contributions to policy and program development in the key priority area of Aboriginal tobacco control at both a national and state level. As well as participation on a broad range of committees and advisory groups relating tobacco control, the AH&MRC was able to draw on the experience of BREATHE in preparing written submissions to the National Preventive Health Authority and to contribute to the National Tobacco Strategy. The AH&MRC also provided advice to the Commonwealth government in their development and roll out of the Tackling Indigenous Smoking initiative that formed part of the COAG Indigenous Chronic Disease package, through participation on the Tobacco Technical Reference Group and through other communications. At the NSW State level, as well as providing advice and input to NSW Health into various policy and strategy documents with coverage of tobacco control over the years, the AH&MRC has more recently worked in partnership with the NSW Ministry of Health to develop a strategic framework for Aboriginal tobacco resistance and control, the ATRAC Framework, that aims to guide and support coordinated action by all NSW stakeholders into the future.

Reflections and conclusions

The BREATHE Project was a major undertaking for the AH&MRC, and provided the AH&MRC with a focus for establishing a program of work to support Aboriginal tobacco resistance and control in NSW and nationally that has been continued since the project was completed.

The AH&MRC designed and implemented the BREATHE Project in ways that maximized opportunities for Aboriginal community and ACCHS capacity building and strengthening throughout the process of conducting the project. As outlined in the previous section, the BREATHE Project was able to achieve a range of positive impacts for individuals, participating ACCHSs and the Aboriginal communities they serve, and the AH&MRC, throughout its life and these benefits have extended beyond the life of the project.

The AH&MRC has presented about different aspects of the BREATHE Project at a range of meetings, symposia and conferences, including two Oceania Tobacco Control Conferences, the annual conference of the Public Health Association of Australia, the Coalition for Research to Improve Aboriginal Health Research Conference and others .

The AH&MRC greatly appreciates the opportunity provided by the Australian Respiratory Council in funding the BREATHE Project and the additional funding and support of the Heart Foundation and the Cancer Council that made the BREATHE Project possible.

ADVOCACY

WORLD TUBERCULOSIS DAY (TB) - 24 MARCH 2014

The "missed" 3 million

In 2014, the slogan for World TB Day was "Reach the 3 million".

TB is curable, but current efforts to find, treat and cure everyone who gets ill with the disease are not sufficient. Of the 9 million people a year who get sick with TB, a third of them are "missed" by health systems. Many of these 3 million people live in the world's poorest, most vulnerable communities or are among marginalized populations such as migrant workers, refugees and internally displaced persons, prisoners, indigenous peoples, ethnic minorities and drug users.

WHO and the Stop TB Partnership, hosted at WHO, are together promoting World TB Day. World TB Day provides the opportunity for affected persons and the communities in which they live, governments, civil society organizations, health-care providers, and international partners to call for further action to reach the 3 million. All partners can help take forward, innovative approaches to ensure that everyone suffering from TB has access to diagnosis, treatment and cure.

The burden of TB

World TB Day is an opportunity to raise awareness about the burden of TB worldwide and the status of TB prevention and control efforts. The Day is also an occasion to mobilize political and social commitment for further progress.

Progress towards global targets for reductions in TB cases and deaths in recent years has been impressive: TB mortality has fallen over 45% worldwide since 1990, and incidence is declining. New tools such as rapid diagnostics are helping transform response to the disease and new life-saving drugs are being introduced.

But the global burden remains huge and significant challenges persist.

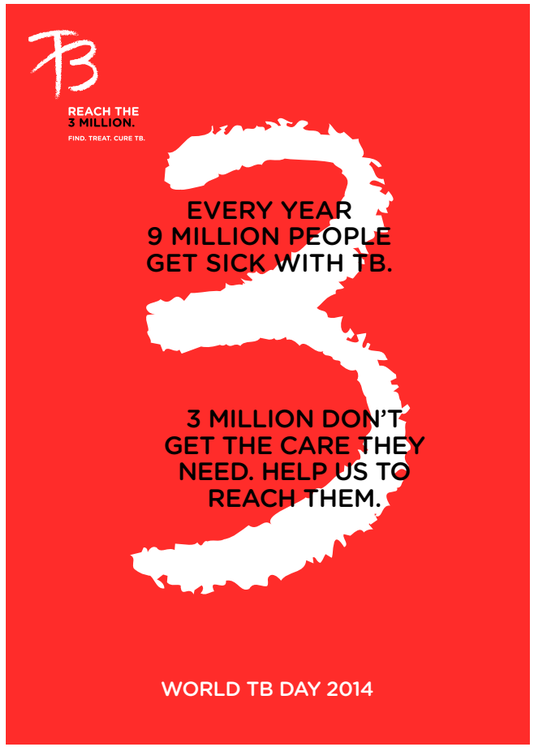
- In 2012, there were an estimated 8.6 million new cases of TB and 1.3 million people died from TB.
- Over 95% of TB deaths occur in low- and middle-income countries. Poor communities and vulnerable groups are most affected, but this airborne disease is a risk to all.
- TB is among the top 3 causes of death for women aged 15 to 44.
- There were an estimated 500 000 cases and 74 000 deaths among children in 2012.

Challenges

- Globally, around 3 million people (equal to 1 in 3 people falling ill with TB) are currently being 'missed' by health systems.
- There is slow progress in tackling multi-drug resistant TB (MDR-TB): 3 out of 4 MDR-TB cases still remain without a diagnosis, and around 16 000 MDR-TB cases reported to WHO in 2012 were not put on treatment.
- Provision of antiretroviral therapy (ART) for TB patients known to be living with HIV needs to increase to meet WHO's recommendation that all TB patients living with HIV promptly receive ART.

Article reprinted from
http://www.who.int/mediacentre/factsheets/fs104/en/

Further information on World TB Day can be found at the Stop TB Partnership website:
http://www.stoptb.org/events/world_tbday/2014/resources.html



5TH CONFERENCE OF THE UNION ASIA PACIFIC REGION

SYDNEY 2015

In August 2015, ARC in collaboration with The International Union Against Tuberculosis and Lung Disease (The Union) will hold the 5th Conference of The Union Asia Pacific Region in Australia. The conference will address respiratory health issues in the Asia Pacific Region including: TB, smoking-related diseases, respiratory viruses, air pollution and lung disease.

While these diseases are significant problems worldwide, they pose particular problems in the Asia Pacific Region due to increasing smoking rates in a number of countries, the high burden of TB, recent viral outbreaks, antibiotic resistance of bacterial organisms, and socio-economic factors that have produced rising levels of air pollution, often in areas that are the most impoverished. The health, social and economic impact for these diseases are significant.

It is the intention of ARC and The Union to develop a program that encompasses the domains of research, technical assistance and advocacy to raise the profile of global health issues in general and focus the attention of regional governments and other key regional actors on the problems of tuberculosis, other lung diseases, tobacco control and non-communicable diseases among the poor within our Region.

The Union Asia Pacific Conferences are held every two years and this will be the first time the conference is held in Australia. The conference will showcase up-to-date information and feature many of our Region's leading researchers and clinicians in the area of tuberculosis and lung disease. The conference program will inspire solutions for the pressing challenges for the future management of tuberculosis & respiratory disorders in our neighbouring countries.

In October 2014, Emeritus Professor J. Paul Seale, Robyn Johnson and Amanda Christensen travelled to Barcelona to attend the 45th Union World Conference on Lung Health to promote the Asia Pacific Regional Conference. Emeritus Professor Seale reported to the Union Executive on the progress of the Scientific Program and Conference planning and activities. Amanda Christensen and Robyn Johnson met with potential sponsors and delegates to promote interest and engagement in the Conference.





Terri Growcott, Amanda Christensen, Robyn Johnson and Paul Seale







Reducing the Burden of TB and Lung Disease by Increasing and Expanding Regional Partnerships

Hosted by:

The Union
International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

arc
australian respiratory council
prevention and cure of respiratory illness

5th Conference of The Union Asia Pacific Region

Sydney, Australia
31 August – 2 September 2015

On behalf of The Union and the Australian Respiratory Council, it is our great pleasure to invite you to attend the 5th Conference of The Union Asia Pacific Region, which will be held in Sydney, Australia, 31 August to 2 September 2015.

We are looking forward to an exciting and stimulating scientific program which will enable delegates to learn from our Region's leading researchers and clinicians in the area of TB and Lung Disease.

The three day scientific program will provide a wide range of forums for participants to hear about new developments, present their work, to meet with colleagues and to explore new partenrships. The Conference program will inspire solutions for the pressing challenges for the future management of TB & respiratory disorders in the Asia Pacific Region.

The following global experts will be presenting keynote addresses in featured plenary sessions:

Dr Mario C Raviglione
WHO's new End TB Strategy for the prevention and control of TB and MDR TB - Adoption and adaptation to Asia & The Pacific

Professor David Shu-Cheong Hui
Influenza and novel respiratory viral infections of global concern

Professor Leon Guo
Role of environmental factors in asthma

Dr Dick Menzies
Diagnosis and treatment of Latent TB Infection as a Strategy for TB Control

Dr Becky Freeman
Tobacco control: success and future challenges

Professor Philip Hill
Building TB research capacity in an Asian setting

Dr Paul Douglas
Eliminating TB in low burden countries through immigration TB control strategies

Australia is home to a range of pre-eminent international experts in TB, lung disease (asthma, COPD, smoking cessation) and HIV, who are looking forward to engaging with the Asia Pacific and international communities at this conference.

We invite you to connect and collaborate with clinicians, academics, researchers, field workers across multi-disciplines, social advocates and the public from within our region and beyond.



Emeritus Professor J. Paul Seale AM
MB BS, PhD, FRACP
President Australian Respiratory Council
Conference President



Professor Xie Xiu Wang
Chairman, The Union Asia Pacific Region, Executive Committee
President, Chinese Anti-Tuberculosis Association



Professor Guy Marks
MB BS, PhD, FRACP,
Chair of the Scientific Committee

Visit the conference website for updates
www.aprunion2015.com

RESOURCES

Launch and release of the ARC TB Training Modules

The ARC Nurse Consultants Group completed the review of the ARC TB Training Modules developed for the nurses and related workers of the Northern Pacific TB Programs.

The ARC TB Training Modules package is made up of a series of modules that are clinically based and cover TB symptoms, disease process, diagnosis, treatment and management and modules that focus on counselling and communication skills, education and working with communities.The Modules were launched and distributed at the Pacific Island Program Collaboration and Service Integration Workshop, held in Hawaii in August, 2014.

Positive feedback was received on the resources from the Nurses working within the Northern Pacific TB Programs, the CDC, WHO and SPC. Additional copies of the training modules were requested for the seven Nursing Schools of the Northern Pacific. The ARC Nurse Consultants Group has been invited to meet with the respective Nursing Schools with the aim of developing an education and training curriculum for TB nurses and related workers.



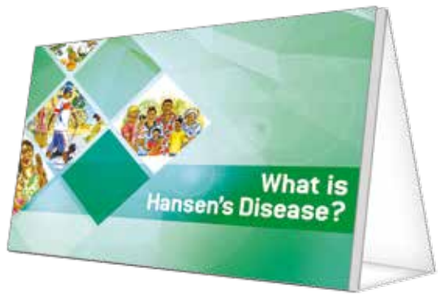
Development of Sputum Collection Poster

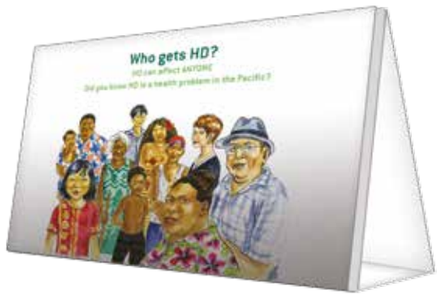
Collecting Sputum is one the most important activities for a TB Program. Analysing sputum enables the confirmation of diagnosis, ensures that the patient is on the appropriate medications and is used to monitor the patients' response to treatment. ARC has developed a poster entitled Collecting Sputum to Diagnose TB as a resource tool.

Hansen's Disease Flipchart currently under development

The ARC Nurses Consultant Group is in the final stages of developing a Hansen's Disease Flipchart. Hansen's Disease (also known as leprosy) was once feared as a highly contagious and devastating disease in many countries. Now, however, in many countries the disease is rare. A number of countries within the Pacific are yet to eradicate Hansen's Disease. Work continues with communities to raise awareness and provide care and treatment to people with this disease.

It is anticipated that this resource will be launched at the 5th Conference of the Union Asia Pacific Region in August 2015.





SCHOLARSHIPS, FELLOWSHIPS

A HISTORY

ARC Ann Woolcock Fellowship Awards (2005 - Present)

Date	Recipient	Subject	Award
2010-2014	Jodie Simpson *Newcastle University, NSW*	Characterisation and treatment of innate immune dysfunction in older people with obstructive airway disease	$258,763
2005-2009	Ingrid Laing *Telethon Institute for Child Research, Perth,WA*	Genetic Influences on causal pathways of ALRIs in highly susceptible infants	$285,000

ARC Ann Woolcock Biomedical and Postgraduate Research Scholarship Awards (2002 - 2004)

Date	Recipient	Subject	Award
2003-2004	Corrina Parker *Australian National University, Canberra, ACT*	Detection, isolation and characterisation of novel anti-effective agents from cultured micro-fungi	$40,143
2003-2004	Kylie Turner *University of Sydney, NSW*	Investigation of the structure of cryptococcal phospholipases	$40,143
2002- 2004	Zoe Barker-Whittle (McKeough) *Royal Prince Alfred Hospital, Sydney, NSW*	Evaluation of lung volume reduction surgery in patients with chronic airflow limitation	$59,214
2002-2003	Shoma Dutt *Westmead Hospital, Sydney, NSW*	Biliary lipids in liver disease and interstitial phospholipid metabolism in children with cystic fibrosis	$41,793
2002-2003	Rita Machaalani *University of Sydney, NSW*	Neurone receptor systems in sudden infant death and piglets exposed to hypercapnic-hypoxia	$29,214
2002- 2003	Anup Desai *University of Sydney, NSW*	The contribution of obstructive sleep apnoea to driver fatigue in transport drivers	$55,793

ARC Harry Windsor Biomedical and Postgraduate Research Scholarship Awards (1999 - 2001)

Date	Recipient	Subject	Award
2001	Anup Desai *University of Sydney, NSW*	Interaction of mild obstructive sleep apnoea, sleep deprivation and circadian factors in cognitive function	$27,793
2000-2001	Shoma Dutt *Westmead Hospital, Sydney, NSW*	Biliary lipids in liver disease and interstitial phospholipid metabolism in children with cystic fibrosis	$40,311
2000-2001	Rita Machaalani *University of Sydney, NSW*	Neurone receptor systems in sudden infant death and piglets exposed to hypercapnic-hypoxia	$37,454
1999-2001	Anna Hansen *University of Sydney, NSW*	The role of cytokines in the immunity and pathology of malaria	$56,703
1999-2001	Rosemary Santangelo *Westmead Hospital, Sydney, NSW*	Phospholipases of Cryptococcus neoformans	$63,498
1999-2001	George Latouche *University of Sydney, NSW*	Phopholipases as potential virulence factors of Cryptococcus neoformans variety Gattii	$55, 089

RESEARCH GRANTS arc

RESEARCH GRANTS

A HISTORY

ARC Harry Windsor Medical Research Grants (1999 - Present)

Date	Recipient	Subject	Award
2014	Associate Professor Daniel Chambers *The Prince Charles Hospital, Qld* *Lung Transplant Service, Qld*	Disease tolerance and transplant tolerance – two sides of the same coin?	$50,000
2013	Brian Oliver *University of Sydney, NSW*	Why do fibroblasts from people with COPD produce extracellular matrix proteins in response to ciagraette smoke?	$50,000
2012	Bernadette Saunders *Centenary Institute, Sydney, NSW*	Microparticles and microRNA as biomarkers of TB disease	$50,000
2011	Ross Coppel, Paul Crellin et al *Monash University, Melbourne*	Identification of inhibitors of PimA, a new target for tuberculosis therapy	$50,000
2010	Peter Bye *Royal Prince Alfred Hospital, Sydney, NSW*	Novel interventions for the diverse population of Australia with bronchiectasis	$50,000
2010	Peter Bye *Royal Prince Alfred Hospital, Sydney, NSW*	Novel interventions for the diverse population of Australia with bronchiectasis	$50,000
2009	Sandra Hodge *Hanson Institute, Adelaide, SA*	Investigation of macrophage function as a therapeutic target in chronic obstructive pulmonary disease/emphysema (COPD)	$50,000
2008	Jenny Alison *University of Sydney, NSW*	Optimising mucus clearance with exercise in cystic fibrosis	$50,000
2008	Stephen Stick, Anthony Kicic & Siobhan Brennan *University of WA, Perth, WA*	A randomised controlled trial of L-arginnine or vitamin D to improve outcomes in pulmonary tuberculosis	$50,000
2007	Siobhain Brennan and Anthony J Kettle *Telethon Institute for Child Health Research, Perth, WA*	Investigating markers of oxidative stress in young children with cystic fibrosis: a driving mechanism of pulmonary investigation	$50,000
2007	Stephen Bozinovski and Ross Vlahos *University of Melbourne, Melbourne, VIC*	Cigarette smoke chemically modifies and inactivates lung innate immunity mediated by the bacterial receptor, TLR4	$50,000
2006	Paul Kelly, Graeme Maguire, Peter Morris, Ivan Bastian & Nicholas Anstey *Menzies School of Health Research, Darwin, NT*	Nutritional intervention to improve tuberculosis treatment outcome in Timika, Indonesia: the NUTTS study	$50,000
2006	David Jans *Monash University, Melbourne, VIC*	Role of phosphorylation in regulating nuclear trafficking during infection of respiratory syncitial virus matrix protein	$50,000
2006	Robert Capon *University of Queensland*	A new non-toxic approach to controlling bacterial infection	$49,000
2005	Paul Reynolds, Gregory Hodge, Sandra Hodge, Mark Holmes *Royal Adelaide Hospital, Adelaide, SA*	Infection versus rejection in lung transplant related bronchiolitis obliterans syndrome: can intracellular cytokines help?	$50,000
2005	Kwung Fong & Annalese Semmler *Prince Charles Hospital*	Novel methylated genes in lung cancer	$52,250
2004	Warwick Britton, Guy Marks and Bernadette Saunders *Centenary Institute of Cancer Medicine & Cell Biology , Sydney, NSW*	Evaluation of genetic and environment risk factors for progression to active tuberculosis in the Liverpool cohort	$44,701
2004	Paul Kelly, Nick Anstey, Graeme Maguire et al *Menzies School of Health Research, Darwin, NT*	Pulmonary Function in Tuberculosis patients in Timika District, Papua Province, Indonesia	$43,267
2002 -2003	James Triccas & Warwick Britton *Centenary Institute of Cancer Medicine & Cell Biology, Sydney, NSW*	New strategies to vaccinate against Mycobacterium tuberculosis	$112,588
2002	Amanda Leach, Heidi Smith-Vaughan Marius Puruntamerri, Ross Baillie & Peter Morris *Menzies School of Health Research*	Improved hygiene measures for reduced infection in Australian Aboriginal Children: a randomised controlled trial	$48,424
2002	Evangelia Daviskas, Sandra Anderson & Iven Young *Royal Prince Alfred Hospital*	Effect of mannitol on the clearance of mucus in patients with COPD	$38,593
2001	Amanda Baker and Vaughan Carr *University of Newcastle*	Randomised controlled trial of a smoking cessation intervention among people with a mental illness	$63,370
2001	Terence Amis and John Wheatley *Westmead Hospital*	The role of snoring and obstructive sleep apnoea in the pathogenesis of hypertension	$45,665
2001	James Wiley and Tania Sorrell *University of Sydney, NSW*	The monocyte-macrophage P2x7 receptor and susceptibility to tuberculosis	$45,000
2000-2001	John Wiggers, Afaf Girgis, Robyn Considine, Jenny Bowman *University of Newcastle*	Preventing infant exposure to tobacco smoke: evaluation of an early childhood intervention	$53,006
2000	Peter Bye, Iven Young, Jenny Alison and Marney Isedale *Royal Prince Alfred Hospital*	Evaluation of lung volume reduction surgery in patients with chronic airflow limitation	$38,000
2000	Warwick Britton and James Triccas *Centenary Institute of Cancer Medicine & Cell Biology*	Interlukin-18 as an adjuvant for DNA Immunisation against Tuberculosis	$26,500
2000	Peter Gibson *John Hunter Hospital*	Quality of Life in Chronic Cough	$25,500
1999	Guy Marks *Institute of Respiratory Medicine*	Does BCG vaccination in infancy prevent allergy	$5,000
1999	Graeme Maguire, Norma Benger and Bart Currie *Menzies School of Health Research*	Chronic Lung Disease in Aboriginal Australians: factors in aetiology and treatment	$69,136
1999	Bernadette Saunders and Helen Briscoe *Centenary Institute of Cancer Medicine & Cell Biology*	Apoptosis in the control of Mycobacterial infection	$38,000
1999	Peter Bye, Stefan Eberl and Jenny Alison *University of Sydney, NSW*	Pharmacological and Physical Therapies to enhance mucociliary clearance in chronic lung disease and mucus hypersecretion	$39,000
1999	Evangelica Daviskas *Royal Prince Alfred Hospital*	Effects of beta2-adrenceptor agonists on mucociliary clearance in persons with asthma	$5,000
1999	Karen Waters *University of Sydney, NSW*	Potential neurotoxicity of repetitive hypercapnic hypoxia during early treatment	$10,000
1999	Ronald Grunstein *Royal Prince Alfred Hospital*	Sleep Apnoea and Cytokines	$22,000

PROJECTS

A HISTORY

ARC Project Awards (1999 - Present)

Date	Recipient/Project	Award
2013-2014	Solomon Islands Improving TB control in remote area of Solomon Islands	$37,950
2012	Bangladesh Bangladesh MDR-TB Project, an investigation into risk factors for MDR-TB in communities in Bangladesh	$10,000
2011	Kimberley Aboriginal Medical Services Council(KAMSC) Cultural exchange of Be Our Ally Beat Smoking Study(BOABS) workers to visit Maori Tobacco Control Programs in New Zealand	$10,000
2011-2014	Vietnam MECOR Course - Level 1, Level 2 and Level 3 workshops	$50,000
2010	Secretariat of Pacific Community Evaluation of the effectiveness of the Community Component of the Kiribati Quality TB Epidemic Control Project	$4,800
2010	Menzies School of Health Research Development of educational resources, 3 Talking posters and 3 flipcharts on pneumonia, bronchiolitis and bronchiectasis	$35,000
2009	Federated States of Micronesia Capacity Building for TB nurses and related health workers in the Federated States of Micronesia (FSM) – Partnership Eli Lilly	$31,424
2009-2012	Cambodian Anti-Tuberculosis Association Cambodia: TB control in elderly and vulnerable groups and in factories	$110,637
2008-2009	Secretariat of Pacific Community TB Drama Video Production in Kiribati	$35,000
2007-2009	Aboriginal Health Council of Western Australia (AHCWA) Beyond the Big Smoke: a clear vision for Aboriginal tobacco control in Western Australia	$200,000
2007-2009	Aboriginal Health and Medical Research Council (AH&MRC) BREATHE: Project. This project aims to reduce smoking-related disease and morbidity for Aboriginal people in NSW communities	$490,200
2007-2008	Secretariat of Pacific Community Enhancing Community involvement in TB control through Theatre in Kiribati	$40, 926
2006-2014	PITCA Training of nurses and related workers in the Northern Pacific Funding	$114,004
2006	TB Nurse Training in Kiribati	$41,699
2006	Building of TB Laboratory at Tunguru Hospital Kiribati	$30,000
2005	Maningrida Lung Health Community Awareness Raising Pilot Project Funding (James N Kirby Foundation $12,000)	$20,000
2002 - 2006	TB laboratory Training Tonga, Samoa, Kiribati and the Cook Islands	$189,231
2001	Distribution of books: Clinical Tuberculosis and Tobacco or Health: A Global Threat through Teaching Aids at Low Cost.	$2,000
2000	Sponsored Professor Don Enarson, Scientific Director of IUATLD, to be guest speaker at the NSW Health Department TB Nurses Conference	$3,000
2000	Participation in the WHO, “First Stop TB Meeting in the Pacific Islands” in Noumea	$4,000
1999	Provided funding for the translation of “Tobacco or health: A Global Threat” through Teaching Aids at Low Cost	$3,000
1999	Visit to Port Moresby & Lae to evaluate the DOTS TB Programme	$4,000
1999	Funded purchase of course textbooks for Epidemiology Workshop in Port Moresby	$1,000

2014 FINANCIALS AND ACFID SUMMARY FINANCIALS

DIRECTORS' REPORT

Your Directors present their report on the Company for the financial year ended 31 December 2014.

Australian Respiratory Council
(A Company Limited By Guarantee)
A.B.N. 11 883 368 767

Directors

The Directors at any time during or since the end of the financial period are:

Amanda Julie Christensen
Dip Nursing
Appointed to the Board on 22 January 2001
Interest in contracts: Nil

Clinical Associate Professor Peter Gianoutsos
MB CHB(Univ of Otago), FRACP FCCP
Appointed to the Board on 15 May 2006
Vice President
Interest in contracts: Nil

Robert Eric Horsell OAM
CPA
Appointed to the Board on 24 June 1999
Finance Director
Interest in contracts: Nil

Robyn Johnson
GAICD
Appointed to the Board on 5 November 2012
Interests in contracts: Nil

David Hugh Macintosh AM
BBS(UTS), FCA
Appointed to the Board on 19 June 1997
Vice President

Ian W Ramsay
LL.,B
Board Member 2008 - February 2012
Reappointed to the Board 5 November 2012
Interest in Contracts: Nil

Emeritus Professor John Paul Seale AM
MB BS PhD FRACP
Appointed to be the Board on 19 June 1997
President
Interest in contracts: Nil

Kerrie Shaw
Dip Nursing
Appointed to the Board on 4 Febraury 2013
Interest in contracts: Nil

Professor Iven Young
BSc(Med), MB BS, PhD, FRACP
Appointed to the Board on 6 August 1998
Interest in contracts: Nil

Meetings of Directors

The number of Directors' meetings held during the financial period and the number of meetings attended by each Director were:

Name Of Director	Number Held while in Office	Number Attended
Amanda Julie Christensen	4	4
Peter Gianoutsos	4	3
Robert Eric Horsell	4	4
Robyn Johnson	4	4
David Hugh Macintosh	4	4
Ian Ramsay	4	4
John Paul Seale	4	4
Kerrie Shaw	4	2
Iven Hunter Young	4	4

Principal Activities

The principal activity of the Company during the financial year was to provide funding and expertise of research and projects aimed at improving lung health.

The Company's short term objectives are to:
- i) continue to build expertise in respiratory health.
- ii) foster innovation in respiratory health research.
- iii) deliver and measure positive impacts to communities and research.
- iv) enhance ARC's role in the country as a unique non-government organisation in the area of lung health.
- v) advocate to improve respiratory health, particularly in relation to TB and smoking at state, national and international levels.

The Company's long term objectives are to:
- i) develop and support innovative and effective approaches to research and development in lung health.
- ii) to improve lung health in communities, with an emphasis on disadvantaged groups.

To achieve these objectives, the Company has adopted the following Strategies:
- i) the Board strives to attract sustainable partnerships.
- ii) the Board undertakes fundraising.
- iii) the Board actively seeks funding.

The Company is incorporated under the Corporations Act 2001 and is a Company limited by guarantee. If the Company is wound up, the Constitution states that each member is required to contribute a maximum of $1.00 towards meeting any outstanding obligations of the company. At 31 December 2014 the collective liability of members was $44 (2013:$45).

AUDITORS' INDEPENDENCE DECLARATION UNDER SECTION 307C OF THE CORPORATION ACT 2001

A copy of the Auditor's Independence Declaration follows this Directors Report.

Signed in accordance with a resolution of the Board of Directors:

Professor J. Paul Seale
Director
Sydney, 15 April 2015

Robert Horsell OAM
Director
Sydney, 15 April 2015

Auditor's Independence Declaration Under section 307C of the Corporations Act 2001 to the Directors of Australian Respiratory Council

I declare that, to the best of my knowledge and belief, during the year ended 31 December 2014 there have been:
- i) no contraventions of the Auditor independence requirements as set out in the Corporations Act 2001 in relation to the audit; and
- ii) no contraventions of any applicable code of professional conduct in relation to the audit.

BRYAN RUSH & COMPANY
Chartered Accountants

D R Conroy FCA
Principal
Sydney, 15 April 2015

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
For the Year Ended 31 December 2014

	Note	2014 $	2013 $
Revenue	2	473,908	465,779
Depreciation and amortisation expense	3	(8,971)	(8,516)
Research grants, fellowships and scholarships		(78,622)	(116,675)
Project funding		(46,314)	(28,000)
Investment expense		(16,063)	(12,595)
Consultancy fees		(4,000)	(5,350)
Employee benefits expense		(223,383)	(218,333)
Other expenses		(237,758)	(218,943)
Loss before income tax		(141,203)	(142,633)
Income tax expense	1	-	-
Loss for the year		(141,203)	(142,633)
Other comprehensive income after tax:			
Net gain on revaluation of investment property		-	50,000
Net gain on revaluation of financial assets		16,953	290,662
Other comprehensive income for the year net of tax		16,953	340,662
Total comprehensive income for the year		(124,250)	198,029

STATEMENT OF FINANCIAL POSITION
As at 31 December 2014

	Note	2014 $	2013 $
ASSETS			
Current Assets			
Cash and cash equivalents	5	497,270	793,101
Trade and other receivables	6	93,779	9,248
Other current assets	7	7,851	3,925
Total Current Assets		598,900	806,274
Non-Current Assets			
Financial assets	8	2,527,481	2,410,528
Property, plant and equipment	9	48,838	57,809
Investment property	10	1,600,000	1,600,000
Total Non-Current Assets		4,176,319	4,068,337
TOTAL ASSETS		**4,775,219**	**4,874,611**
LIABILITIES			
Current Liabilities			
Trade and other payables	11	75,788	57,188
Employee entitlements	12	30,334	24,076
Total Current Liabilities		106,122	81,264
TOTAL LIABILITIES		**106,122**	**81,264**
NET ASSETS		**4,669,097**	**4,793,347**
EQUITY			
Reserves	13	2,881,383	2,864,430
Retained earnings		1,787,714	1,928,917
TOTAL EQUITY		**4,669,097**	**4,793,347**

STATEMENT OF CHANGES IN EQUITY
For the year ended 31 December 2014

	Capital Profits Reserves $	Asset Revaluation Reserves $	Retained Earnings/ (Accumulated Losses) $	Total $
Balance at 1 January 2013	2,411,980	38,359	2,152,070	4,602,409
Loss attributable to members	-	-	(142,633)	(142,633)
Total comprehensive income for the year	-	340,662	-	340,662
Transfers on sale of assets	-	73,429	(80,520)	(7,091)
Balance at 31 December 2013	**2,411,980**	**452,450**	**1,928,917**	**4,793,347**
Loss attributable to members	-	-	(141,203)	(141,203)
Total comprehensive income for the year	-	16,953	-	16,953
Transfers on sale of assets	-	-	-	-
Balance at 31 December 2014	**2,411,980**	**469,403**	**1,787,714**	**4,669,097**

STATEMENT OF CASH FLOWS
For the year ended 31 December 2014

	Note	2014 $	2013 $
Cash Flows From Operating Activities			
Receipts from customers		128,974	177,278
Payments to suppliers and employees		(586,960)	(604,566)
Interest received		16,351	42,884
Distributions received		245,804	252,543
Net cash provided by (used in) operating activities	**17**	**(195,831)**	**(131,861)**
Cash Flows From Investing Activities			
Proceeds from sale of available-for-sale investments		-	365,386
Payment for property, plant and equipment		-	(6,029)
Payment for available-for-sale investments		(100,000)	(497,128)
Net cash provided by (used in) investing activities		**(100,000)**	**(137,771)**
Net Increase/(Decrease) in Cash Held		(295,831)	(269,632)
Cash at beginning of financial year		793,101	1,062,733
Cash at end of financial year	**17**	**497,270**	**793,101**

NOTES TO AND FORMING PART OF THE ACCOUNTS
For The Year Ended 31 December 2014

Note 1 - Statement of Significant Accounting Policies

Basis of Preparation
Australian Respiratory Council applies Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: Application of Tiers of Australian Accounting Standards and AASB 2010–2: Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements.

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board (AASB) and the Corporations Act 2001. The company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements, except for the cash flow information, have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities. The amounts presented in the financial statements have been rounded to the nearest dollar.

Revenue
Revenues are recognised at fair value of the consideration received net of the amount of goods and services tax (GST) payable to the taxation authority. Exchanges of goods or services of the same nature and value without any cash consideration are not recognised as revenues.

Dividend revenue is recognised when the right to receive a dividend has been established. Interest revenue is recognised on a proportional basis taking into account the interest rates applicable to the financial assets. Revenue from investment properties is recognised on an accruals basis in accordance with lease agreements.

Donations and bequests are recognised as revenue when received.

Income from other sources is recognised when the fee in respect of other products or services provided is receivable.

Income Tax
The Company is registered as a charity and is not subject to income tax. Continued exemption for income tax is subject to the requirements for non profit organisations.

Property, Plant and Equipment
Each class of property, plant and equipment is carried at cost less, where applicable, any accumulated depreciation and impairment losses.

Plant and Equipment
Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses. In the event the carrying amount of plant and equipment is greater than its estimated recoverable amount, the carrying amount is written down immediately to its estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. A formal assessment of recoverable amount is made when impairment indicators are present.

Plant and equipment that have been contributed at no cost, or for nominal cost, are valued and recognised at the fair value of the asset at the date it is acquired.

Depreciation
The depreciable amount of all fixed assets, including buildings and capitalised lease assets, but excluding freehold land, is depreciated on a straight line basis and diminishing value basis over their useful lives to the Company commencing from the time the asset is held ready for use.

The depreciation rates used for each class of depreciable assets are:

Class of Fixed Asset	Depreciation Rate
Plant and Equipment	7.5% - 50%

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each balance sheet date.

An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are included in the statement of comprehensive income. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained earnings.

Impairment of Assets
At each reporting date, the Company reviews the carrying values of its tangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is expensed to the income statement.

Employee Benefits
Provision is made for the Company's liability for employee benefits arising from services rendered by employees to balance date. Employee benefits expected to be settled within one year together with benefits arising from wages and salaries, annual leave and sick leave which will be settled after one year, have been measured at the amounts expected to be paid when the liability is settled plus related on-costs. Other employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits.

Contributions are made by the Company to employee superannuation funds and are charged as expenses when incurred.

Goods and Services Tax (GST)
Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Tax Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the statement of financial position are shown inclusive of GST.

Cash and Cash Equivalents
For the purposes of the cash flows statement, cash includes cash on hand and at call deposits with banks or financial institutions, investments in money market instruments maturing within less than two months and net of bank overdrafts.

Comparative Figures
Where required by Accounting Standards comparative figures have been adjusted to conform with changes in presentation for the current financial year.

Financial Instruments
Recognition and initial measurement
Financial instruments, incorporating financial assets and financial liabilities, are recognised when the entity becomes a party to the contractual provisions of the instrument. Trade date accounting is adopted for financial assets that are delivered within timeframes established by marketplace convention.

Financial instruments are initially measured at cost plus transactions cost where the instrument is not classified as at fair value through profit or loss. Transaction costs related to instruments classified as at fair value through profit or loss are expensed to profit or loss immediately. Financial instruments are classified and measured as set out below.

1. Fair value estimation
   The fair value of financial assets and financial liabilities must be estimated for recognition and measurement or for disclosure purposes.

   The fair value of financial instruments traded in active markets such as trading and available-for-sale securities is based on quoted market prices at the balance sheet date. The quoted market price used for financial assets held by the Company is the current bid price; the appropriate quoted market price for financial liabilities is current ask price.

2. Loans and receivables
   Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost using the effective interest rate method.

3. Held to maturity investments
   Held to maturity investments are non-derivative financial assets with fixed maturities and fixed or determinable payments, and it is the entity's intention to hold these investments to maturity. They are subsequently measured at amortised cost using the effective interest rate method.

4. Available for sale financial assets
   Available for sale financial assets are non-derivative financial assets that are either designated as such or that are not classified in any of the other categories. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or determinable payments.

5. Financial Liabilities
   Non-derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost using the effective interest rate method.

Critical Accounting Estimates and Judgments

TThe Directors evaluate estimates and judgements incorporated into the financial report based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economical data, obtained both externally and within the group.

Key Estimates - Impairment
The Company assesses impairment at each reporting date by evaluating conditions specific to the Company that may lead to impairment of assets. Where an impairment trigger exists, the recoverable amount of the assets is determined. Value in use calculations performed in assessing recoverable amounts incorporated a number of key estimates.

Key Judgments - Provision for Impairment of Receivables
The Directors believe that the amount included in accounts receivable is recoverable and non provision for impairment has been made at the end of the financial year.

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 31 December 2014

2. Revenue

	2014 $	2013 $
Operating Activities		
Net profit/(loss) on sale of investments	-	(4,095)
Rental revenue for property investment	49,197	51,544
Interest received	16,351	42,884
Fund distributions from investments	216,053	224,926
Legacies & donations	20,000	49,100
Member subscriptions	1,368	1,182
Miscellaneous income	44,861	4,712
Refund of franking credits	29,751	27,617
Appeals	74,718	67,909
Sundry income	21,609	-
Total Revenue	473,908	465,779

3. Profit From Ordinary Activities

Expenses		
Depreciation of Non-Current Assets:		
Plant and equipment	8,971	8,516

4. Auditor's Remuneration

Remuneration of the Auditor of the Company for:		
- Auditing the Financial Report	12,300	12,000

5. Cash and Cash Equivalents

Cash on hand	1,243	2,741
Cash at bank	496,027	790,360
	497,270	793,101

6. Trade and Other Receivables

Trade debtors	59,756	4,932
Other debtors	34,023	4,316
	93,779	9,248

7. Other Current Assets

Prepayments	7,851	3,925

8. Financial Assets

	2014 $	2013 $
Non Current		
Listed shares - at fair value	1,758,195	1,657,731
Managed funds - at fair value	769,286	752,797
Total financial assets	**2,527,481**	**2,410,528**

9. Property, Plant & Equipment

Non Current		
Plant & equipment at cost	133,707	133,707
Less: accumulated depreciation and impairment	(84,869)	(75,898)
Total property, plant and equipment	**48,838**	**57,809**

Movements in Carrying Amounts

Movement in the carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year:

	Plant and Equipment $	Total $
Balance at the beginning of year	57,809	57,809
Additions	-	-
Disposals	-	-
Depreciation expense	(8,971)	(8,971)
Adjustment	-	-
Carrying amount at the end of year	48,838	48,838

10. Investment Property

Non Current		
Investment property - at fair value	1,600,000	1,600,000
Total	**1,600,000**	**1,600,000**

11. Trade and Other Payables

Unsecured liabilities		
Trade payables	3,902	11,183
Sundry payables and accrued expenses	71,886	46,005
Total	**75,788**	**57,188**

12. Employee Entitlements

Provision for annual leave	18,067	12,598
Provision for long service leave	12,267	11,478
Total	**30,334**	**24,076**
Number of employees		
Number of employees at year end	3	3

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)
For the year ended 31 December 2014

13. Reserves

	2014 $	2013 $
Capital profits reserve	2,411,980	2,411,980
Asset revaluation reserve	469,403	452,450
Total	2,881,383	2,864,430
Nature and purpose of reserves		
(a) Capital Profits		
The capital profits reserve is used to accumulate realised capital profits		
Balance at end of year	2,411,980	2,411,980
(b) Asset revaluation		
The asset revaluation reserve is used to record increments and decrements in the value of non current assets		
Balance at beginning of year	452,450	38,359
Revaluation increment/(decrement)	16,953	340,662
Transfers	-	73,429
Balance at end of year	**469,403**	**452,450**

14. Members' Guarantee

The Company is limited by guarantee. If the Company is wound up, the Constitution states that each member is required to contribute a maximum of $1 each towards meeting any outstanding obligations of the Company. At 31 December 2014 the number of members was 44 (2013:45).

15. Financial Risk Management

(a) Interest Rate Risk

The Company's financial instruments consist mainly of deposits with banks, local money market instruments, short-term investments, accounts receivable and payable, and investment available for sale.

The carrying amounts for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

	2014 $	2013 $
Financial assets		
Cash and cash equivalents	497,270	793,101
Trade and other receivables	93,779	9,248
Other current assets	7,851	3,925
Financial assets at fair value through profit or loss	2,527,481	2,410,528
Total financial assets	**3,126,381**	**3,216,802**
Financial liabilities at amortised cost:		
– trade and other payables	75,788	57,188
Total financial liabilities	**75,788**	**57,188**

Net Fair Values

(i) For listed available-for-sale financial assets and financial assets at fair value through profit or loss the fair values have been based on closing quoted bid prices at the end of the reporting period.

In determining the fair values of the unlisted available-for-sale financial assets, the Directors have used inputs that are observable either directly (as prices) or indirectly (derived from prices).

(ii) Fair values of held-to-maturity investments are based on quoted market prices at the ending of the reporting period.

16. Key Management Personnel

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any Director (whether executive or otherwise) of that entity is considered key management personnel.

The totals of remuneration paid to key management personnel (KMP) of the Company during the year are as follows:

	2014 $	2013 $
Key management personnel compensation	131,358	106,310

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)
For the year ended 31 December 2014

	2014 $	2013 $

17. Cash Flows Information

(a) Cash at the end of the financial year as shown in the cash flow statement is reconciled to items in the balance sheet as follows:

Cash and cash equivalents	**497,270**	**793,101**
(b) Reconciliation of Cash Flow from Operations with Profit after Income Tax		
Net income/loss for the period	(141,203)	(142,633)
Cash flows excluded from profit attributable to operating activities		
Non cash flows in profit		
Depreciation	8,971	8,516
Net (gain)/loss on disposal of investments	-	4,095
Changes in assets and liabilities, net of the effects of purchase and disposal of subsidiaries		
(Increase)/decrease in trade and term receivables	(84,531)	(1,784)
(Increase)/decrease in prepayments	(3,926)	3,802
Increase/(decrease) in trade payables and accruals	18,600	(12,312)
Increase/(decrease) in provision for employee benefits	6,258	8,455
Net cash inflow/(outflow) from operating activities	**(195,831)**	**(131,861)**

Information and declarations to be furnished under the Charitable Fundraising Act 1991, Section 23

(a) Details of aggregate gross income and total expenses of fundraising appeals		
Gross proceeds from fundraising appeals	74,718	72,509
Less: Total direct costs of fundraising	29,462	29,612
Net surplus from fundraising activities	**45,256**	**42,897**

(b) Statement showing how funds received were applied to charitable purposes

This surplus is used for research grants, fellowships and scholarships.

(c) Fundraising appeals conducted during the financial period

Appeals only.

(d) Comparisons		
Total cost of fundraising/gross income from fundraising	39%	41%
Net surplus from fundraising/gross income from fundraising	61%	59%
Total cost of services/total expenditure	100%	100%
Total cost of services/total income received	39%	41%

SUMMARY FINANCIAL REPORT - BALANCE SHEET
Balance Sheet as at 31 December 2014

	Note	2014 $	2013 $
ASSETS			
Current Assets			
Cash and cash equivalents	5	497,270	793,101
Trade and other receivables	6	93,779	9,248
Other current assets	7	7,851	3,925
Total Current Assets		**598,900**	**806,274**
Non-Current Assets			
Financial assets	8	2,527,481	2,410,528
Property, plant and equipment	9	48,838	57,809
Investment property	10	1,600,000	1,600,000
Total Non-Current Assets		**4,176,319**	**4,068,337**
TOTAL ASSETS		**4,775,219**	**4,874,611**
LIABILITIES			
Current Liabilities			
Trade and other payables	11	63,042	45,980
Borrowings	11	800	1,594
Provisions	12	30,334	24,076
Other financial liabilities	11	11,946	9,614
Total Current Liabilities		106,122	81,264
TOTAL CURRENT LIABILITIES		**106,122**	**81,264**
NET ASSETS		**4,669,097**	**4,793,347**
EQUITY			
Reserves	13	2,881,383	2,864,430
Retained earnings		1,787,714	1,928,917
TOTAL EQUITY		**4,669,097**	**4,793,347**

At the end of the financial year the Australian Respiratory Council had no balances in the Inventories, Assets held for sale, Non current Trade and other receivables, Intangibiles, Current tax liabilities and Non Current Liabilities categories.

The above disclosures are prepared in accordance with the requirements set out in the ACFID Code of Conduct.

SUMMARY FINANCIAL REPORT - INCOME STATEMENT
For the year ended 31 December 2014

	2014 $	2013 $
REVENUE		
Donation and Gifts - Monetary & Non monetary	94,718	72,509
Bequests and Legacies	-	44,500
Grants		
AusAid	-	-
Other Australian	32,716	-
Other overseas	12,000	-
Investment Income	311,316	342,876
Other Income	23,158	5,894
TOTAL REVENUE	**473,908**	**465,779**
EXPENDITURE		
International Aid and Development		
International programs		
Funds to international projects	56,932	34,819
Program Support Costs	31,006	23,600
Community education	7,314	7,587
Fundraising Costs		
Public	29,462	29,612
Government, multilateral and private	-	-
Accountability and Administration	395,412	393,669
Non - Monetary Expenditure	-	-
Total International Aid and Development Programs Expenditure	**520,126**	**489,287**
Domestic projects	94,985	119,125
TOTAL EXPENDITURE	**615,111**	**608,412**
EXCESS/(SHORTFALL) OF REVENUE OVER EXPENDITURE	(141,203)	(142,633)
Net gain/(loss) on revaluation of financial assets	16,953	340,662
EXCESS/(SHORTFALL) OF REVENUE OVER EXPENDITURE	(124,250)	198,029

During the financial year the Australian Respiratory Council had no transactions in the Revenue or Expenditure for International Political or Religious Adherence Promotion Program categories.

The above disclosures are prepared in accordance with the requirements set out in the ACFID Code of Conduct.

SUMMARY FINANCIAL REPORT
ARC's Table of Cash Movements for Designated Purposes for the year ended 31 December 2014

Total for	Cash available at the beginning of the financial period $	Cash raised during the financial period $	Cash disbursed during the financial period $	Cash available at the end of the financial period $
Australia Research Grants & Fellowships	(114,823)	67,569	(94,985)	(142,239)
Australian Projects	34,064	32,716	-	66,780
International Projects	(168,197)	50,569	(87,938)	(205,566)
Community Education	(15,420)	-	(7,312)	(22,732)
Other Purposes	1,057,477	240,275	(496,725)	801,027
Total	**793,101**	**391,129**	**(686,960)**	**497,270**

NOTE: In the year ended 31 December 2014, the Board allocated an amount for international projects. The shortfall in cash reserves is compensated by cash raised from investment activities.

SUMMARY FINANCIAL REPORT - STATEMENT OF CHANGES IN EQUITY
For The Year Ended 31 December 2014

	Capital profits Reserves $	Asset Revaluation Reserves $	Retained Earnings/ (accumulated losses) $	Total $
Balance at 1 January 2013	2,411,980	38,359	2,152,070	4,602,409
Excess of revenue over expense	-	-	(142,633)	(142,633)
Total comprehensive income for the year	-	340,662	-	340,662
Transfers on sale of assets	-	73,429	(80,520)	(7,091)
Balance at 31 December 2013	2,411,980	452,450	1,928,917	4,793,347
Excess of revenue over expense	-	-	(141,203)	(141,203)
Total comprehensive income for the year	-	16,953	-	16,953
Transfers on sale of assets	-	-	-	-
Balance at 31 December 2014	**2,411,980**	**469,403**	**1,787,714**	**4,669,097**

The above disclosures are prepared in accordance with the requirements set out in the ACFID Code of Conduct.

DIRECTORS' DECLARATION

The Directors of the Company declare that:

1. The financial statements and notes are in accordance with the Corporations Act 2001:
   - **i.** comply with Australian Accounting Standards – Reduced Disclosure Requirements; and
   - **ii.** give a true and fair view of the financial position as at 31 December 2014 and performance for the year ended on that date of the Company;
2. In the Directors' opinion there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the Board of Directors.

Emeritus Professor J. Paul Seale AM
Director
Sydney, 15 April 2015

Robert Horsell OAM
Director
Sydney, 15 April 2015

INDEPENDENT AUDITOR REPORT
To The Members of the Australian Respiratory Council

Australian Respiratory Council
(A Company Limited by Guarantee)
A.B.N. 11 883 368 767

Report on the Financial Report

We have audited the accompanying financial report of Australian Respiratory Council, which comprises the statement of financial position as at 31 December 2014, the statement of profit or loss, statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the Directors' declaration.

Directors' Responsibility for the Financial Report

The Directors of the Company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the Corporations Act 2001 and for such internal control as the Directors determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Directors, as well as evaluating the overall presentation of the financial report.

"We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion."

Independence

In conducting our audit, we have complied with the independence requirements of the Corporations Act 2001.

Auditor's Opinion

In our opinion,

(a) the financial report of Australian Respiratory Council is in accordance with the Corporations Act 2001, including:

- **i.** giving a true and fair view of the Company's financial position as at 31 December 2014 of their performance for the year ended on that date;
- **ii.** complying with Australian Accounting Standards - Reduced Disclosure Requirements (including Australian Accounting Interpretations) and the Corporations Regulations 2001; and
- **iii.** complying with Div 60 of the ACNC Act 2012.

(b) We have also audited the summary financial reports of Australian Respiratory Council which in our opinion are in accordance with the requirements set out in the ACFID Code of Conduct.

BRYAN RUSH & CO
Chartered Accountants

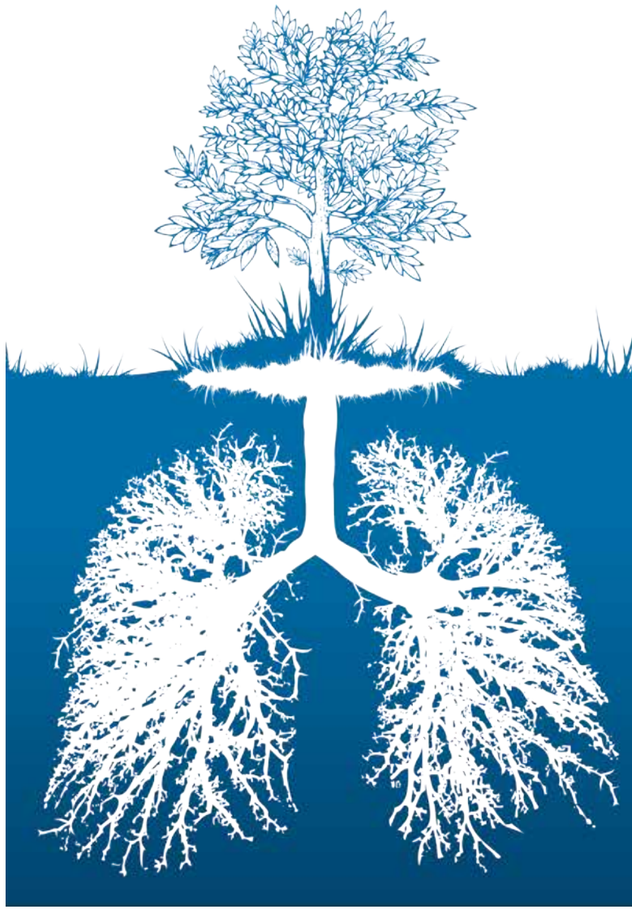


D R Conroy FCA
Principal
Sydney, 15 April 2015

BRYAN RUSH & CO
Chartered Accountants
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GIVING TOWARDS A COMMUNITY FREE OF RESPIRATORY ILLNESS



Lung disease affects many different people; an Australian war veteran with chronic lung disease, a person continually exposed to smoking, a young child in the Pacific with drug resistant tuberculosis.

The Australian Respiratory Council's vision is for a community free of respiratory illness.

A bequest, large or small, is a simple and enduring way you can help to improve people's quality of life. Give a gift towards a better Life.

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For more information or a copy of ARC's '*Your Future, Your Security*', contact us on (02) 9223 3144 or email arc@thearc.org.au

www.thearc.org.au



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