KNCV
To eliminate TB

TUBERCULOSISFOUNDATION

ANNUAL REPORT 2014

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Dutch KNCV Ambassador Peter Faber

Dutch KNCV Ambassador Imanuelle Grives

DIRECTORS' REPORT

The year 2014 has been one of transition and new ambitions– for global TB control as well as for KNCV. In May, the United Nations World Health Assembly adopted the new post-2015 Global TB Strategy. This "End TB" strategy sets highly ambitious targets: to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB. For the first time, the global ambition is not just to control TB, but to eliminate it as a (public) health problem. In adopting these new ambitions, KNCV developed a new Strategic Plan for the period 2015-2020, closing our current plan in 2014.

Successes and contributions

This year has once again seen important steps towards our mission of eliminating TB. The 2015 Millennium Development Goal of halting and reversing TB incidence has been achieved in all six WHO regions around the world. The number of people dying from TB, in particular from HIV-associated TB, continues to fall. Over 85% of patients newly treated for TB in DOTS programs have been cured. More than three-quarters of TB patients in Africa know their HIV status, and more than 70% of these have begun antiretroviral treatment. The roll-out of the new drug *bedaquiline* for treatment of MDR- and XDR-TB has started, and the scale-up of new rapid diagnostic tests is accelerating. The quality and completeness of data on TB have improved worldwide, thanks to strengthened surveillance and TB prevalence surveys. In The Netherlands, the reported number of TB patients in 2014 remained low at 823, with no more than 6 cases of MDR-TB.

Many of these successes were achieved thanks to KNCV's continued contributions. We advised National TB Programs in countries in Europe, Africa and Asia. We supported TB control activities on the ground through our offices in nine countries. We helped developing necessary guidelines, both national and international, as well as tools for training and implementation. We have been actively involved in research projects, strengthened surveillance, analyzed countries' epidemiological situation and assisted in TB prevalence surveys. To improve access to quality TB care, we have initiated and enhanced many programs relating to the programmatic management of MDR-TB, TB/HIV, vulnerable populations and infection control. We have also worked on the scale up of responsible use of new medicines and diagnostic tools, and have contributed to countries developing National Strategic Plans and submitting Concept Notes for funding to the Global Fund. We firmly believe that the only way to ultimately eliminate TB is to embed TB control into national health programs, involving all relevant parties. That is why we will keep investing in engaging the private sector and civil society organizations and empower patients to help themselves and others.

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We did this work out of our central office in The Hague, Netherlands, and our Central Asia regional office in Almaty, Kazakhstan, with many activities implemented through our country offices. As in previous years, the majority of the activities were carried out as part of the U.S. Agency for International Development (USAID)-funded 5-year TB CARE I program, for which KNCV has been the prime contractor. Through this extensive program, the lives of 4 million people have been saved. Having achieved TB CARE I's targets one year ahead of schedule, we completed the program in 2014 and will close it formally in 2015. Subsequently, this year we were awarded the prime contract for the new USAID flagship TB program, Challenge TB. With a financial ceiling of US $ 525 million, it is once again the largest multi-partner, multi-country TB program in the world, encompassing 18 countries in Africa, South and Central Asia and Eastern Europe by the end of 2014. We are very proud to have been selected for the fourth consecutive time to head this program as lead partner of an international coalition of nine organizations. We are also extremely pleased that the Dutch Ministry of Foreign Affairs (DGIS) has issued a five-year grant to KNCV to support our work under the Challenge TB umbrella, in particular for making the Global Fund money work to combat TB/HIV co-infection. Having been without DGIS funding for several years, we welcome the Netherlands Government's commitment to global TB-HIV control, as well as this clear sign of confidence in our abilities and vision.

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Step up on research

Although steps forward are being made, the challenges of fighting this disease of poverty remain: inadequate health services, poor patients and generally poor tools for diagnosis, treatment and prevention. Since 2000 the global incidence of TB has fallen by about only 1.5% per year. In order to meet WHO's ambition of cutting the number of new TB cases by 90% by 2035, incremental improvements won't be enough - we must take unprecedented steps, develop new approaches to TB control and massively scale up those that promise to be successful.

> We are proud to have contributed to saving more than 4 million lives as leader of the TB CARE I program.

This requires breakthroughs in diagnosis and improving access to diagnosis– we need to find the 3 million "missing TB cases" that, according to WHO estimates, exist worldwide but are not diagnosed, treated or reported to national TB programs. And we need to find them earlier – there is increasing consensus that with current diagnostic delays TB transmission will remain largely uncontrolled. Better access to existing diagnostics, better tests that can be brought "nearer to the patient" and better understanding of the dynamics of TB transmission in high-incidence communities are urgently needed. We also need to simplify and shorten treatment, allowing better access and lower costs for patients. Unfortunately, three large clinical trials of shortened first-line TB treatment based on addition of a fluoroquinolone antibiotic have all showed disappointing results, indicating an urgent need, not only for new TB drugs but also for better drug targets that allow killing persisting TB bacilli.
This is particularly acute for second-line

treatment of MDR-TB: the current 20-24 month treatment courses are simply too long, too complex and too toxic to be truly scalable.

We need better ways to prevent TB disease. With no effective vaccines on the horizon, prophylactic drug treatment, which is becoming more effective and less burdensome to the patient, is our most important weapon. However, this weapon can only be deployed in a feasible and affordable way if we are better able to identify those individuals infected with TB bacilli who have the highest risk of getting the disease. Again, this requires better diagnostics, and better understanding of the biological mechanisms that define people's risk of becoming ill once infected.
And finally, we need better approaches that maximize the yield of our efforts, improving access, strengthening the health service response, and engaging the private health sector in TB control. We need to try out creative solutions, learn from them as we go in a systematic manner, and scale up what works.

All of this calls for stepping up investments in focused research. However, research funding for TB has been falling over recent years, and pharmaceutical companies are withdrawing from the field of antibiotics – including antimicrobial drug development. Although two new drugs have recently been approved, and a few candidates are in late-stage development, the R&D pipeline for new TB drugs starts to look depleted. If these developments are not reversed soon, the struggle will be hard to win.

It also calls for a stepped up role for KNCV to advocate for and conduct research. In line with WHO's End-TB strategy, KNCV has therefore made research (generating a solid evidence base) one of the three pillars of its new Strategic Plan 2015-2020. Moreover, within the Challenge TB program, USAID explicitly aims to support operational/implementation research to find local solutions to local problems and to invest in multi-year, multi-country studies to test new interventions for curbing TB transmission.

"We pledge our commitment to eliminate this deadly disease, and are thankful for your continuing support."

Organizational internal developments

For KNCV, 2014 has also been a year of transition. We geared up to new developments, reorganizing ourselves to be fit for future challenges.

Continuing the revision of our decentralization strategy, we decided, after reviewing needs and demands of countries and donors, to close our African regional office located in Kenya. Instead, we increased our focus on where our efforts are needed most, i.e. in the countries where we work, by strengthening our country offices through clearer lines of management and decentralized capacity building.

We also revised our internal organizational structure and modus operandi. Aiming to let people do what they do best, to optimally support high-quality technical output, and to maximize efficiencies, we replaced the geographically oriented units with a separation into an Operations and Technical Division operating alongside a Finance Division and supportive units. Central to this structure are crosscutting country teams, in which the different disciplines work closely together with the country office. The Project Management Unit for Challenge TB, which also oversees activities in countries that are led by our coalition partners, is fully embedded in this structure, with clear internal lines of reporting. KNCV's Technical Division has been divided into thematically oriented teams that are meant to further enhance knowledge and develop new approaches. Also, we strengthened the Communications and Private Fundraising Unit to help raise awareness about TB among the general public and to sustain and strengthen the funding base for KNCV's activities in TB control. A small Resource Mobilization Unit was set up to focus on acquiring project grants to broaden and diversify our funding base. Following almost a year of preparations, the new structure became operational as of 1 January 2015.

Looking both back and forward, we wish to thank everyone who has made and will be making a difference in the fight against TB. Our work is not possible without the contribution of you all: the governments in the countries we assist, our partners, donors, community and patient organizations, Board of Trustees and staff. We pledge our commitment to eliminate this deadly disease, and are thankful for your continuing support.

Prof. dr. Frank Cobelens,
Chief Scientific Officer

Dr. Kitty van Weezenbeek,
Chief Executive Officer

KNCV TUBERCULOSIS FOUNDATION
IN KEY FIGURES

Income from third party activities **€ 1,075,270**

95.7% Spent on mission related goals

Income from private fundraising **€ 1,593,139**

209 Number of staff worldwide

25,436 Number of private donors

% of expenses to fundraising **24.6%**

2.5% of expenses to administration and control

Income from government grants **€ 42,051,486**

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COUNTRIES WHERE KNCV WORKED
AND CORE COUNTRY HIGHLIGHTS IN 2014

Africa

Botswana	Working on the development of tele-audiology services to combat one of the most notorious side effects of treatment for MDR-TB: deafness
Ethiopia	Successfully building up sustainable operational research capacity
Namibia	Launch of national TB infection control guidelines
Nigeria	Innovative TB case finding, using religious outlets for community awareness campaigns and referral.
Mozambique	Supporting the national TB program in strategic planning and developing patient centered approaches
Rwanda	Providing technical support for the implementation of the National TB Prevalence Survey
Zambia	Technical support and capacity building for the first fully digital National TB Prevalence Survey
Zimbabwe	Training Zimbabwean Community Health Workers in TB control, working on three levels: strategy, curriculum development and cascade training

Asia

Indonesia	Introduction of Xpert MTB/RIF technology, thereby considerably enhancing screening of drug-resistant TB, dramatically boosting the number of rifampicin-resistant TB cases being diagnosed
Kazakhstan	Working on National PMDT policies, which were adopted by the Ministry of Health and are now available to clinicians, researchers and all medical staff nationwide
Kyrgyzstan	Developing a palliative care guideline
Tajikistan	Improving the quality of TB services among all care providers
Vietnam	Implementing and successfully scaling-up of a new strategy on management of TB in children

Europe

The Netherlands	New edition Handbook TB 2015 published both digitally and in print

Other countries where we worked

ACTIVITIES AND RESULTS IN 2014

Ladies waiting at a hospital in Zimbabwe photo by Jeroen van Gorkom

- POLICY & GUIDELINES
- EVIDENCE
- ACCESS TO CARE
- SUSTAINABILITY

Alies de With tuberculosis nurse, The Netherlands

"The Dutch TB Handbook is an excellent reference book,"

The updated Dutch Tuberculosis 2015 Handbook was approved by the Committee for Practical TB Control Netherlands (CPT) at the end of 2014. KNCV led the initiative for this new edition, which is available in print and online. Dutch TB nurse Alies de With talks about why this handbook is important for her daily practice.

Alies de With has been a TB control nurse since 1993. She works for the Community Health Services, supporting TB patients and advising their caregivers, including regular visits to TB patients in the asylum-seekers' centers and in urban settings. In addition, she gives preventive health advice to people who travel overseas and also represents TB nurses in various national working groups.

"It is very good to have such a compact handbook", says Alies de With. "This gives a complete insight into the field, without going into too much detail. The content is precisely what I need: it gives an overview of how TB control is organized in our country, as well as specific practical information and relevant references."

Today, with the decline in the number of TB patients in the Netherlands, there are only about 60 TB nurses remaining, and many of them work only part-time. Under these circumstances, it is a challenge to maintain a high level of up-to-date knowledge and experience regarding TB in the healthcare services.

The new TB 2015 Handbook serves a wider readership than its predecessor, which was published in 2008. In addition to TB professionals in the Netherlands, the new Handbook is designed to inform students and healthcare staff in other fields. The Handbook is an essential reference: even seasoned practitioners like Alies de With still use it regularly. "TB control practice is always changing, and the guidelines are regularly amended", she says. "Sometimes I need to refresh my memory on what is currently recommended practice. I find the Handbook an excellent reference book: it is ideal for using online. It nicely brings together all that we need to know, and for more details there is a reference to the relevant guideline or regulation at the top of each paragraph. For instance, if we need to organize a contact investigation, we can easily to refer to the Handbook for a reminder of the criteria for determining the first and second rings of contact. The Handbook is also convenient when we need to explain the contact investigation procedure."

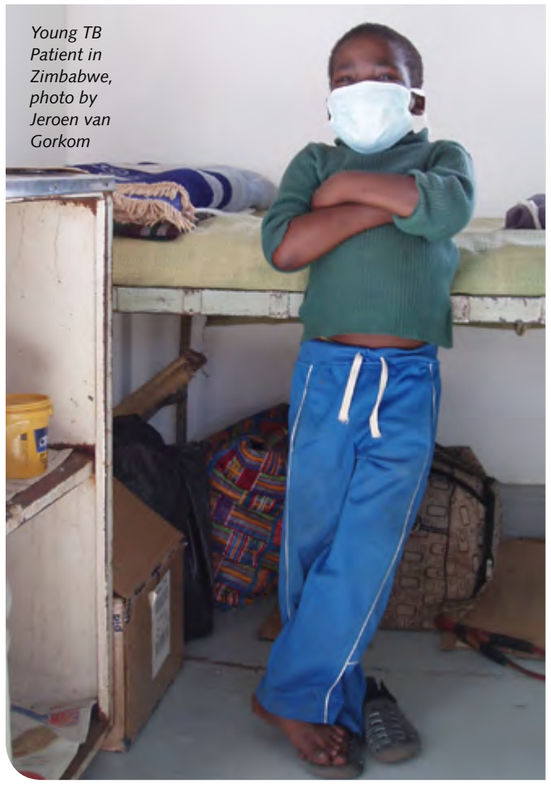
TB 2015 Handbook

The TB 2015 Handbook reflects policies approved by the CPT and other health profession representative bodies. It is an example of a successful collaboration under the auspices of the Committee for Practical TB Control Netherlands (CPT) between KNCV, the National Institute for Public Health and the Environment (RIVM), and the Municipal Health Services (GGD). KNCV led the initiative in its role as coordinator of the CPT. The Handbook, which was written in 2014 and approved by the CPT in December 2014, was published by KNCV in January 2015.

> "TB control practice is always changing, and the guidelines are regularly amended."

5 QUESTIONS ABOUT OUR INVOLVEMENT IN POLICY AND GUIDELINE DEVELOPMENT

KNCV plays an important role in determining, with partners, authorities and stakeholders, the national and international policies with regard to TB control and research underpinning these policy adaptations. It contributes to defining the directions for the short, mid and long term, and the conditions needed to realize these ambitions (such as funding, political commitment and capacity development). In addition, KNCV is involved in the development of international guidelines for TB control practice. These guidelines are important instruments for translating policy into action and cover a variety of areas, such as TB diagnosis, treatment and surveillance, but also involvement of private practitioners in TB control.



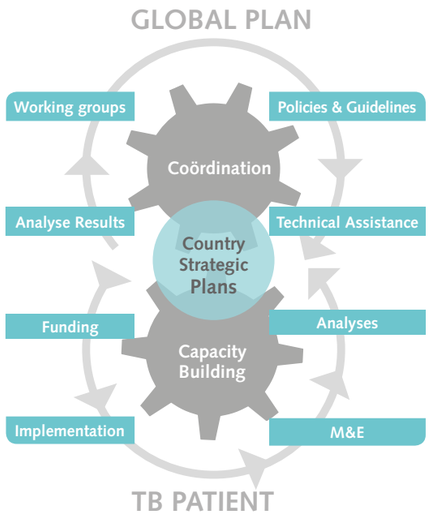
Young TB Patient in Zimbabwe, photo by Jeroen van Gorkom

1 What policy-making bodies was KNCV part of in 2014?

As a leading TB agency with global expertise, KNCV is an active member of many policy-making bodies at both an international and a national level. These include virtually all Dutch TB control bodies, as well as a wide variety of working groups, strategic fora, expert committees and guideline committees under the umbrella of the World Health Organization (WHO), the Stop TB Partnership, the Union and other international organizations. See the insert for an overview.

2 Why does KNCV participate in these sort of bodies?

Because of our active involvement around the globe we use our insights and are at the forefront of international policy and guideline development. The combination of this involvement with our on-the-ground experience in TB control places us in an unique position. When working within the framework of countries' policies, we gain input that is valuable for developing WHO guidelines, for example. This in turn forms the basis for national policy adjustments and new regulations for better TB control. We help countries implement these adjustments and regulations, gaining new input for improvement – and so on.



In 2014, KNCV was actively involved in:

- Important WHO fora, such as: Strategic Technical Advisory Group on TB (STAG-TB); Global Task Force on TB Impact Measurement; European Technical Advisory Group on Tuberculosis Control (TAG-TB);
- Several regional WHO TB Technical Advisory Groups
- Stop TB Partnership's Coordinating Board;
- Several Stop TB Partnership working groups and task forces, such as: Global Drug-resistant TB Initiative (GDI)*, TB/HIV Working Group *, Global Laboratory Initiative (GLI)*, TB Infection Control sub-group**, Childhood TB subgroup; DOTS Expansion Working Group;
- The Union's Executive Committee in Europe;
- The Union's HIV Working Group**;
- The NGO Developed Country Delegation to the Global Fund Board;
- The Country Coordinating Mechanism of Kazakhstan; the Global Fund Technical Review Panel (as expert);
- Regional meetings of NTP managers;
- The Tuberculosis Surveillance and Research Unit (TSRU), as the secretariat and convener of annual meetings;
- The TB Alliance Stakeholders Association;
- The TB Europe Coalition*;
- The Global Health Workforce Alliance;
- The Wolfheze Program Committee and Working Groups;
- The Dutch Association of Medical Doctors in TB control (VvAwT)*;
- The Eijkman Foundation*;
- The Steering Committee of the Amsterdam Institute for Global Health and Development;
- Steering committee of the RESIST TB initiative;
- Steering committees of various research projects, as independent/external members;
- The Dutch Tuberculosis Steering Committee of the GGD (municipal health services);
- Virtually all other Dutch TB committees and working groups.

KNCV staff are also on the editorial team of:

- The International Journal of Tuberculosis and Lung Disease;
- The Dutch periodical Tegen de Tuberculose ("Against Tuberculosis").

*CORE GROUP OR BOARD MEMBER. **CHAIR OR CO-CHAIR.

3 How did KNCV support policy and guideline development in 2014?

Among other things, we contributed to:

- Almost 20 international TB guidelines, manuals and tools, including the majority of WHO TB and TB CARE I guidelines and tools;
  - TB CARE I publications, such as:
    - Compendium of Tools & Strategies – To achieve universal access to TB care for at risk and vulnerable groups;
    - Xpert MTB/RIF Training Package – Training course designed for health care workers, laboratory officers, clinicians and TB program staff;
    - Handbook for interpretation and and use of TB data.
  - WHO guidelines and tools, including:
    - Guidelines on the management of latent tuberculosis infection;
    - Framework towards tuberculosis elimination in low-incidence countries;
    - WHO interim guidance on the use of delamanid in the treatment of MDR-TB.
- 35 scientific TB publications, to share and disseminate knowledge and lessons learned.
- In The Netherlands, we are responsible for all TB guidelines. In 2014 for example, we completed the Richtlijn bron- en contactonderzoek ("source and contact investigation guideline). In other countries, we help adapt and implement international guidelines to local countries' contexts.

4 What did that adaptation and implementation look like?

To translate international guidelines and policy to local contexts, we use a country specific approach, as these examples from 2014 show:

Introducing a new TB drug for multidrug-resistant (MDR) TB treatment

A fundamental aspect of the rational introduction of new TB drugs in countries is to ensure that the national authorities establish the necessary conditions for optimal and responsible use of new TB drugs/

regimens. In 2013, KNCV therefore contributed – within the framework of the TB CARE I program – to the development of a protocol for the rational and safe introduction of bedaquiline, a new TB drug for MDR-TB treatment. In 2014, we supported Indonesia, Kazakhstan and Vietnam in the development of country-specific versions of this protocol. These countries are now implementing their plans to systematically collect information on drug safety ("pharmacovigilance"), as well as on the feasibility and effectiveness of its implementation.

Laboratory Kampala, Uganda, photo by Tristan Bayly

STRATEGIC LABORATORY PLANNING

Laboratories are essential for the diagnosis of TB and for monitoring TB treatment. In low-and middle-income countries, it is often a challenge for TB laboratories to provide the appropriate level of services. Laboratory work is also becoming progressively complex, with increasingly widespread use of quality-assured diagnostics in smear microscopy, culture and drug-susceptibility testing, as with the introduction of new laboratory tests (including line probe assays and the Xpert MTB/RIF test).
TB laboratory plans are new to most countries. The countries need TB-specific laboratory strategic plans to help determine which laboratory interventions are required for the overall national TB control strategy over a 5-year period.
The TB CARE I Practical Handbook for National TB Laboratory Strategic Plan Development is a practical guide for conducting a TB-specific laboratory planning process. The second English edition of the handbook, published in February 2014, was produced under coordination by KNCV.
The Practical Handbook has been endorsed by the Global Laboratory Initiative. It is found to be very useful and is being used in the supra-national reference laboratory in Uganda, for example. There is also an accompanying Participants' Manual and a Facilitators' Manual.

Introducing a new WHO reporting framework and revised definitions

KNCV helped review the WHO reporting framework and definitions in 2013. In follow-up, this year we supported Tajikistan and Kyrgyzstan's National TB Programs (NTPs) in introducing the new WHO recommendations and definitions into their local contexts. We also conducted a workshop in Kazakhstan to this end.

Introducing a new guide to monitor TB incidence among health care workers

In Kazakhstan, Kyrgyzstan and Tajikistan, KNCV educated national teams of trainers on TB infection control. During these sessions, we introduced the TB incidence monitoring guide that we helped develop. We also helped Zambia to apply the guide. Furthermore, we assisted Indonesia in using it to develop a pilot involving the screening of health workers in ten Programmatic Management of Drug-resistant TB (PMDT) hospitals. As a supplement to the guideline, special posters, booklets and videos were made for health care workers and patients.

Introducing a new guideline to build infrastructure for airborne infection control in Indonesia, KNCV collaborated with DG Medical Services to develop a technical guideline on building infrastructure for primary health care facilities to prevent and control airborne infection. This guideline will provide standards for all airborne infection control, including TB, varicella and measles. Architectural, mechanical and electrical engineering consultants were contracted to provide technical input and designs for health facilities. The guideline was printed in September 2014 for distribution to the relevant stakeholders.

Introducing public-private mix (PPM) guidelines and standards in Indonesia

To effectively enhance the quality of TB care in private practices, KNCV in Indonesia worked with the Ministry of Health and professional societies to develop and legalize National Guidelines for Medical Practice Standards for TB care, based on the International Standards for Tuberculosis Care (ISTC). These standards are essential to ensure quality of TB care delivered by private providers. They are also important to establish a legal basis and foundation for certification by the Indonesian Medical Association. We then went on to assist 141 hospitals in ten provinces in developing their own Clinical Pathways and Clinical Practice Guidelines, based on the National Guidelines. The next step is to link those pathways and guidelines to the National Health Insurance System (JKN), thereby ensuring the necessary transparency and accountability for reimbursement of costs by health insurance providers. This will ultimately enable health care facilities to provide everyone in Indonesia with access to quality TB care.

DATA DICTIONARY FOR SECOND-LINE TB DRUGS FORECASTING

With support from the Eli Lilly and Company Foundation, we developed a generic data dictionary as part of the E&M (online and mobile) Health project. The generic data dictionary describes the essential data needed for second line drugs forecasting. This is important because of the often limited supply, short shelf-lives and high sales prices for these drugs needed to treat MDR-TB.
Harmonization of data dictionaries for treatment of MDR-TB patients across countries allows for better prediction of the second line drugs needed, enabling countries and pharmaceutical companies to improve their planning. The dictionary is currently used in Kenya, Nepal and Tajikistan. It is a guide for IT developers in building drug management components into their electronic patient information systems. The data dictionary is freely available on the E&M Health web forum that is hosted and facilitated by KNCV and MSH. The project core team exists of staff from KNCV, MSH, IRD, PiH, Abt Associates WHO and PATH.

5 How does KNCV optimally fit guidelines and tools to practical usage?

To develop tools and approaches that work, it is of fundamental importance to combine policy-making and practical experience, while grounding our recommendations in operational research. This is the essence of the KNCV approach. A good example is the patient-centered approach (PCA) package, which was developed within the TB CARE I project. The package, which focuses on stimulating countries and health workers to organize their care around the patient, consists of five different tools. The entire package was piloted and evaluated in five countries: Cambodia, Indonesia, Mozambique, Nigeria and Zambia.
The PCA package tools fulfilled their promise: to provide practical suggestions for national programs and health facilities to take steps in improving patient-centered care and to empower patients to get organized and involved in TB care. In general, the tools were found to be easy to implement, with the exception of the Tool to Estimate Patients' Costs, which required more training and direction. This costing tool was then revised based on previous experiences. All five pilot countries reported plans to scale up their use of the PCA tools.

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POLICY TOOLS IN THE NETHERLANDS AND LOW-INCIDENCE COUNTRIES

KNCV, and The Netherlands in general, have an outstanding international track record in effectively fighting TB. This reputation was upheld in the findings of the 'Evaluation of TB source and contact investigation in The Netherlands 2006-2010', published in 2014. In another landmark, in 2014 KNCV's unique online registry for TB and latent TB infection in the Netherlands www.tbc-online.nl celebrated its 20th anniversary of operations.
We also participated in developing the WHO 'Framework towards TB elimination in low-incidence countries', which was also published in 2014. The Framework offers a coherent approach for eliminating TB in low-incidence countries. It is designed to guide national policy-makers and those responsible for technical aspects of the national effort to eliminate TB. Eliminating TB is possible, but there are huge challenges to be overcome. As the TB burden drops, it is increasingly difficult to keep TB on the public health agenda. Common challenges to the health system in low-incidence countries are diminishing political commitment, clinical and diagnostic expertise, and low general public awareness of TB.

Pascalina Chanda-Kapata Survey Coordinator National Tuberculosis Prevalence Survey, Ministry of Health, Zambia

‘Everybody felt a part of this’

In 2013-2014, the first fully digital national TB prevalence survey was conducted in Zambia. Such a population-based prevalence survey estimates the true burden of TB disease. Besides being innovative in using digital tools for collecting and processing data, the Zambia prevalence survey was also the first in surveying the estimated burden of both TB and HIV. Pascalina Chanda-Kapata, survey coordinator from the Ministry of Health, talks about how it came to be.

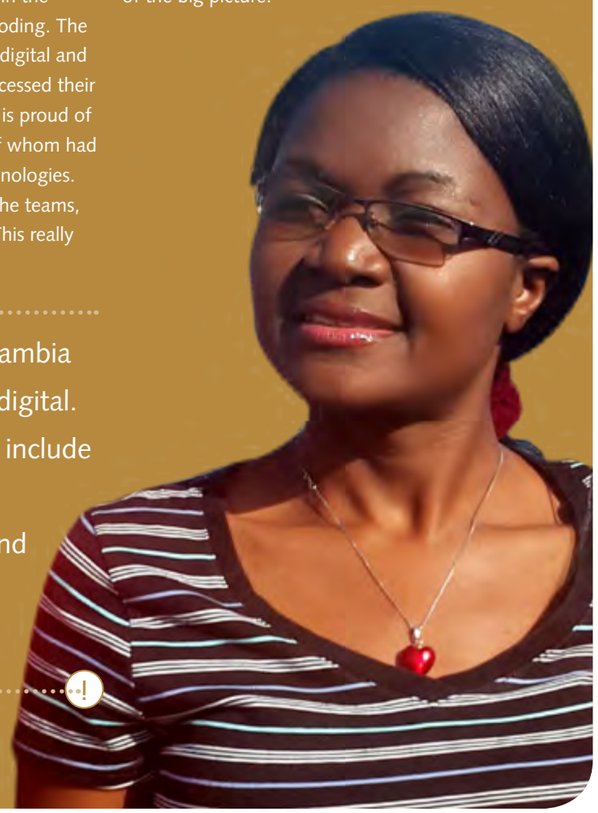
A prevalence survey provides a baseline to monitor progress and impact of interventions. That is why it is seen as an important tool in TB control policy making and financing. “It was an ambitious, innovative and in many ways a new process”, says survey coordinator Pascalina Chanda-Kapata. “It took a lot of people to make this happen and strong teamwork was a major ingredient to making it a success.”

“It was a Zambian project, but designed to be globally applicable”, Chanda continues. “Our survey team learned by doing. The World Health Organization (WHO) Taskforce for Impact Measurement was involved from the beginning, giving technical advice on the preparatory process, field data collection and data analysis. The Taskforce also provided a platform for inter-country exchanges. We initially visited Rwanda and then Ghana, which were all at different stages of their prevalence surveys, and we also interacted with colleagues from Ethiopia, Nigeria, Malawi, Sudan, etc. KNCV’s epidemiologist and data management consultants participated at the various stages of the survey. The consultants were really part of the team, not afraid to get their hands dirty, and that is just what we needed.”

Also within the government system different expertise was brought in. “With such a large project, you can really optimize by working with what is already in the system” says Chanda. “We had a strong inter-ministerial cooperation, for instance the Ministry of Communication and Transport for courier of specimens, the Ministry of Home Affairs provided the security personnel and the Central Statistical Office for the Mappers/Listers.”

Full-scale field data collection started in September 2013, and the last cluster was surveyed by end of July 2014. Personal Digital Assistants (PDAs) with a Global Positioning (GPS) attached were used in the field for census enumeration and data collection. Records and samples from different steps in the survey were correctly linked through barcoding. The field- and central-level x-Ray system was digital and the central reference laboratories also processed their results digitally. Pascalina Chanda-Kapata is proud of the role of the local fieldworkers, many of whom had to overcome their phobia of a mix of technologies. “We took care to invest in the buy-in of the teams, making them part of the whole process. This really paid back in the commitment of people. We found that the fieldworkers started helping each other - when somebody was unable to do the work, another team member stepped in. Everybody felt part of the big picture.”

> The prevalence survey in Zambia was the first ever to be fully digital. Benefits of a digitized survey include efficient and quality data collection; timely reporting and improved ICT infrastructure at various levels.



5 QUESTIONS ABOUT OUR RESEARCH IN 2014 KNCV

INTRODUCING NEW DRUGS AND REGIMEN

Current treatment of multidrug-resistant forms of TB (MDR-TB) requires the use of multiple drugs with limited efficacy for a prolonged period of time (18-24 months). The treatment is complicated, costly and difficult for patients. Some patients may have highly resistant forms of TB that are even more difficult to treat. Fortunately, new TB drugs and treatment strategies for the management of MDR-TB are being approved and tested. This offers patients and their providers hope for shorter, better therapy for the first time in decades.

Pharmacovigilance is the collection, detection, assessment, monitoring and prevention of adverse effects with pharmaceutical drugs. In 2014, KNCV supported a pharmacovigilance project for new TB drugs in four pilot countries: Indonesia, Kazakhstan, Vietnam and Bangladesh. The data will be important to steer decisions in countries in implementing new drug regimens, and will help build the evidence base about safety of these drugs. KNCV is also involved in a WHO generic implementation plan for new drugs and regimens and in a WHO Expert group for bedaquiline and delamanid.

TB Medication, photo by Jeroen van Gorkom

KNCV does operational and implementation research, in order to find out to what extent tools, approaches, implementation methods and programs work or should be improved, and what is needed for successfully scaling up tools and interventions. We also assist National TB programs in epidemiological research, such as prevalence surveys to map the burden of TB in a country. These are very important as input for the National Strategic Plan and Concept Note, which are mandatory to apply for funding from the Global Fund. In addition to developing, implementing and directing research, we also work on building local research capacity.

1 In which countries did KNCV support epidemiology studies? How does that help?

In 2014 we supported epidemiological assessments in Afghanistan, Bangladesh, Rwanda, Tanzania and Zambia, in preparation for their Global Fund applications. Large prevalence studies took place in Indonesia, Tanzania, Nigeria and Zambia, among other countries.

In Rwanda, we worked on follow up epidemiologic research on the prevalence survey we helped to conduct there in 2011-2012. This prevalence study showed that Rwanda had a lower than anticipated prevalence, with a smear positive prevalence below 100 per 100,000. This lower burden is good news in itself, but could also pose challenges for the national Tb program, as it is more difficult and expensive to detect and treat the remaining cases. The results of the prevalence survey, combined with the epi assessment, shaped the development of the new strategic plan. The TB epidemic is becoming more concentrated, which supports the expanding focus on key populations in Rwanda and how to find the missing cases. The Rwanda TB program should maintain the current effort, but at the same time develop new strategies requiring more budget. A concerted effort is needed to move towards TB elimination in the decades to come. Rwanda is poised to move in line with the new post 2015 Global TB strategy, to reach less than 10 tuberculosis cases per 100 000 population by 2035 to pave the way for elimination by 2050.

Nurses in outdoor TB clinic, Zambia, photo by Suzanne Verver.

2 What were the findings of KNCV-supported implementation research?

With the availability of new drugs and diagnostic tools, implementation research is essential for their scale up in a sustainable and safe way. For example, KNCV participated in a large-scale implementation trial of the Xpert MTB/RIF diagnostic tool in Brazil. The study took place in 2012, with four publications coming out in 2014. It proved the added value of Xpert MTB/RIF over smear microscopy in detecting TB and rifampicin-resistant TB cases, but also showed that doctors continued to treat patients for TB without any laboratory confirmation, and that additional training is needed to change clinical practice. Similarly, implementation studies of Xpert MTB/RIF in Indonesia and Kazakhstan showed a strong increase in the number of MDR-TB patients detected and a massive reduction in the delay between diagnosis and start of appropriate, second-line treatment.

3 What results stood out in operational research in 2014?

In 2014 we conducted or were involved in more than 15 operational research projects in, among others, Ethiopia, Tajikistan, Vietnam, Nigeria and Indonesia.

In recent years, KNCV has trained over 300 people in nine countries in operational research and analysis/publication skills.

These are a few of the many significant results:

- In Nigeria, we helped examine the role of community volunteers in TB detection. How could they improve referral of presumptive TB and TB case finding? Positive factors turned out to be knowledge of TB symptoms, hours spent on TB referral,

regular provision of compensation, involvement in treatment support, tracing patients lost to follow-up treatment and explicit referral targets;
- In Indonesia, a study examined the possibilities of increasing the role of nurses in identifying people with presumptive TB. It turned out that engaging family public health nurses in the identification and referral of presumptive TB cases increased referrals by a factor of four compared to control areas;

In Indonesia, a study showed that engaging family public health nurses in the identification and referral of presumptive TB cases increased referrals a factor of four.

Indonesia, District Health Facilty TB Control Supervisor

- In the Ethiopian Oromia region, the proportion of people with smear-positive pulmonary TB who completed treatment was higher among those who received decentralized care (at the community level) than among those who got centralized care. Decentralized care led to fewer patients defaulting and/or dying.
- In Kyrgyzstan, we found that patient delay in seeking health care for TB symptoms was on average a month, and increased delay was associated with migration, living in a rural area, older age and less awareness of symptoms.
- In Tajikistan, it was found that a majority of patients that did not complete TB treatment had moved to another place. We recommended expanding patient support packages to motivate patients to postpone migration until after they have completed treatment.

4 What is done with the results of this operational research?

In the majority of the countries KNCV supports, research results have found their way into strategic plans, annual plans, guidelines, codes of conduct and/or changed behaviors such as new habits. An evaluation study of operational research showed that of the 25 (measureable) recommendations resulting from that research, eleven (44%) had been adopted to shape new policies. For example, the results from the Xpert MTB/RIF trial in Brazil prompting the Brazilian government to replace smear examination by Xpert as the standard TB test in the country. In Ethiopia, the first results from the capacity-building initiative were used to confirm strategic directions and the need for enhanced roll out. For example, higher-level clinics were hesitant to decentralize to lower levels until the operational research showed that treatment results were as good for patients receiving care at health-post level, thereby confirming the strategic outline the Ministry of Health had defined.

5 How did we build research capacity?

Capacity building, or the transferring and building of knowledge, is a key element of the KNCV approach. Besides coaching on the job, as we did in the development and implementation of operational research and population epidemiology, we also guided PhD students and supported the writing of research papers. In 2014, three PhD students graduated and eight more continued on in PhD programs. Research papers were written with our support in Kyrgyzstan (sixteen researchers, three papers), Tajikistan (eleven researchers, two papers), Kazakhstan (three papers, partly to be published in 2015) and Nigeria (two operational research papers under submission). In Indonesia, we supported a researcher in writing a paper on patient costs and an Indonesian student in writing a paper on the quality of sputum smear microscopy. The student's paper will be submitted in 2015. We also developed a highly successful research capacity building program in Ethiopia (see highlight).

ETHIOPIA OPERATIONAL RESEARCH CAPACITY BUILDING INITIATIVE

Program-based operational research (OR) is instrumental for the enhancement of TB control. Ethiopia has a strong history of conducting operations research, but translating research results into policy or practice has been limited. In 2012, the Ethiopian Ministry of Health, together with USAID, KNCV and other partners, launched an initiative to develop sustainable capacity for operational research in Ethiopia. The results were published as a supplement to IUATLD's Public Health Action in December 2014.
Teams representing regions in Ethiopia conducted operational research, addressing national and regional priorities. To make use of local expertise and increase sustainability, a domestic mentor training program was included. Existing capacity was enhanced through a competitive grant scheme for TB researchers. The Ethiopian Tuberculosis Research Advisory Committee (TRAC) was also supported in its functions. Regional ethics review bodies were strengthened or established where they did not exist.
Using a 'learning by doing' approach, KNCV and TRAC conducted intensive modular training for regional OR teams of TB and TB/HIV program staff together with academia. Fifty-two people were trained and conducted 13 OR projects. In addition, eight protocols were supported through grants. Ethics review bodies were strengthened in all regions. The initiative trained participants from all regions and succeeded in the completion of all stages of the OR process. The success of the program can be attributed to the team approach, 'learning while doing', integrated mentorship program and strong national ownership.

LESSONS FROM PSYCHO-SOCIO-ECONOMIC SUPPORT FOR TB PATIENTS

TB patients face many psychological, social and economic complications to treatment and care. This may result in lower adherence to treatment regimens, a greater loss to follow-up, and higher relapse and TB mortality rates. Delays in the diagnosis of multidrug-resistant (MDR) TB and the long duration of treatment after diagnosis create an even higher risk for MDR-TB patients. Well-designed and effectively implemented programs can reduce these problems and improve patients' adherence to treatment.
In 2014, KNCV worked together with Management Sciences for Health (MSH) and WHO to gather best practices on sustainable systems for social support from around the world, in order to learn what works in specific situations and what can be adapted to similar problems in other contexts. Examples from all over the world were studied: Indonesia, Kazakhstan, Latvia, Namibia, Netherlands, Tajikistan, Peru, Russian Federation and Rwanda. Lessons were drawn in terms of effectiveness, sustainability and possibility for scale-up on experiences with introduction of patient support, and the findings were published in November 2014.

Former TB patient giving patient support in Indonesia, photo by Trishanty Rondonuwu

Ully Ulwiyah Chair of the Patients Support Group, Jakarta, Indonesia

‘It helps to get support from other patients’

Great progress has been made in improving access to quality services for people with MDR-TB in Indonesia through a combined approach of innovative technologies and patient support. Ully Ulwiyah is active as Chair of the Patients Support Group (PETA) in Jakarta and as mother of three children. She is 28 years old and a former multidrug-resistant tuberculosis (MDR-TB) patient. She was cured two years ago, but she continues to support other patients. Ully Ulwiyah talks about the importance of shared experiences.

Photo: Mrs Ully and Chacha, now both in good health.

“I became ill with TB four months after my daughter Chacha was born. Chacha is now four years old.” says Ully Ulwiyah. “The Patients Support Group was established three years ago: it was my initiative, together with another patient who had the peer educator training from KNCV in Jakarta. Many people with MDR-TB have side effects and other problems. I want to help them. I don’t want other patients to experience the same problems and side effects that I had. The side effect I suffered from was depression. Even though I had a young child to care for, and a family, I felt loneliness. My experience at the hospital was traumatic. I was afraid to go to the hospital for treatment and I was also struggling with loneliness. It was traumatic to have to take the drugs every day. “

Through a KNCV program at Persahabatan hospital Ully Ulwiyah got advice from a social worker and other patients. This greatly helped and inspired her. “It helps to get support from others. I was cured of MDR-TB after 22 months of treatment. Now I want to share my experiences with others. I do not want to get MDR-TB again, and I do not want others to get MDR-TB. I want to fight MDR-TB. Now I give information about MDR-TB. I explain to a patient what it means for his or her family and the danger if you don’t take treatment.”

There are fifteen active members of the Patient Support Group; four men and eleven women. Ully Ulwiyah visits patients at the hospital on Mondays and Thursdays. “We educate and motivate new patients, and support them if they have bad side effects, like depression or hallucinations. I also visit patients at home if they default on treatment.”

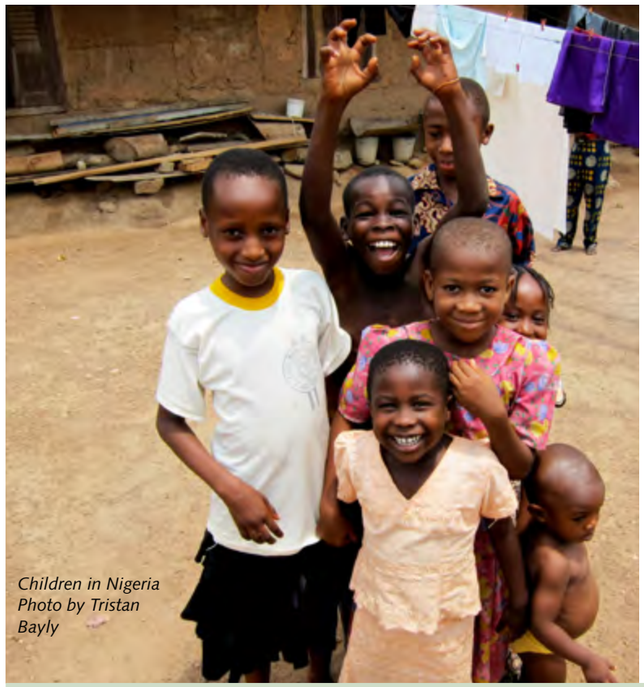
ACCESS TO QUALITY CARE

‘I explain to a patient what it means for his or her family and the danger if you don’t take treatment’

In Indonesia the introduction of Xpert MTB/RIF has greatly improved screening for TB/MDR-TB. The average time between registering and initiating treatment of MDR-TB patients has dropped from 81 days to only 15, and MDR-TB deaths between diagnosis and starting treatment dropped from 11 to 2 % in two years.

In some hospitals, however, up to 28 % of MDR-TB patients do not enroll in treatment for fear of side effects and severe socio-economic consequences. Former MDR-TB patients are actively involved as peer educators to support patients. Peer support groups give psychosocial support, acting as motivators and role models for other patients. Peer support builds on shared experiences and empathy, and leads to increased adherence to treatment.

5 QUESTIONS ABOUT OUR WORK TO IMPROVE ACCESS TO QUALITY TB CARE



Children in Nigeria Photo by Tristan Bayly

Of the 9 million people who get sick with TB every year, 3 million are 'missed' by health systems. We find that unacceptable, and strive daily for all people with TB to be found, diagnosed and cured – no matter what their social status, gender, religion w or age. This includes special attention for people with MDR-TB, people living with HIV and other vulnerable groups such as prisoners and children. It also means developing prevention programs and working on responsible scale-up of promising new diagnostic platforms and drugs.

1 What have we achieved in the fight against Multi Drug Resistant (MDR) TB?

The diagnosis and treatment of MDR-TB cases is accelerating in most countries where the KNCV-led TB CARE I program was running. In 2013, the most recent year for which data are available, 29% more MDR-TB patients were diagnosed than in 2010. Treatment initiation for MDR-TB improved considerably in 2013: 19% increase compared to 2012 and an 81% jump since 2010.

An important factor in the upscaling of diagnosis and treatment is the availability of the Xpert MTB/RIF test. Also the gap between patients diagnosed and patients on treatment is becoming smaller: from 31% in 2010 to only 4% in 2013.

However, as MDR-TB programs are scaled up, it is essential to also ensure the quality and completion of the second-line treatment. In many countries, treatment success rates remain low or even decrease as the complexities of managing more patients rise. In TB CARE I countries, the treatment success rate was 68.5% for those individuals who started MDR-TB treatment in 2011; this proportion was similar to that for the year 2010. So while we succeed in diagnosing more patients and putting them on treatment, there is still major work to be done to get people cured.

An important step forward in this is adapting a more patient-centered approach. In the Akmola Region of Kazakhstan, KNCV demonstrated how standard hospital-based treatment can be replaced by outpatient care for adult and pediatric TB/MDR-TB patients who are no longer infectious. This outpatient care led to an increase in treatment success rate for TB and MDR-TB patients combined from 66% in 2011 to 86% in 2013.

Compared to only 50% in 2010, in 2014 all TB CARE I supported countries have developed national TB infection control guidelines.

Also, providing patient-specific support to MDR-TB patients needs to become more routine practice, as there is strong evidence that this improves treatment adherence and treatment outcomes. Building on previous successes, in 2014 we invested in the direct support of MDR-TB patients in Ethiopia, Indonesia, Kyrgyzstan, Namibia, Nigeria and Tajikistan. To help them fight not only the medical, but also the psychological and economic problems that come with a long and burdensome MDR-TB treatment,

The Center of Excellence on PMDT Training, Kigali Rwanda

SCALING UP MEASURES AGAINST CHILDHOOD TB

Childhood TB presents specific challenges, which should be addressed with appropriate measures, including screening, diagnostics and preventive therapy. In 2014, KNCV continued to invest in the quality diagnosis and treatment of TB in children in among others Ethiopia, Indonesia, Kazakhstan, Kyrgyzstan, Nigeria and Tajikistan.
In Vietnam, a new strategy on the management of TB in children was piloted and subsequently successfully scaled up. To improve access to diagnosis and treatment for children with TB, an isoniazid preventive therapy service package was introduced in four pilot provinces. KNCV was responsible for the review and supervision in 35 districts and 611 communes within the four provinces. Next we provided technical advice and assistance to the National TB Program in the roll-out of this strategy to 18 provinces. TB among children is now incorporated into annual plans and includes the production of educational materials and including childhood TB data in routine reporting and reviews.
At the community level, KNCV is supporting community health workers who are following up children who are in close contact with an adult or adolescent with newly diagnosed pulmonary TB. An evaluation of the childhood TB program in Vietnam will be finalized in 2015.
In Nigeria, KNCV helped develop the national desk guide for the diagnosis and management of childhood TB. As a result, more than 2,000 children under the age of 5 were notified in 2014.

NIGERIA'S FIRST PILOT PROJECT FOR AMBULATORY PMDT ACCELERATES ACCESS TO MDR TB TREATMENT

The introduction of the rapid diagnostic test Xpert MTB/RIF in Nigeria has led to a rise in the number of people diagnosed with and requiring treatment for MDR-TB. Consequently, patients who needed immediate treatment were kept waiting or even refused admission by treatment centers. Nigeria has only ten MDR-TB treatment facilities, with a limited patient intake capacity. To ensure better access to appropriate care for people with MDR-TB, Nigeria revised the national Programmatic Drug-resistant TB (PMDT) guidelines so that alternative models of care could be introduced. A pilot study was launched to introduce ambulatory care in eight selected states. Three different treatment models were studied: hospital admission during the initial 3 months of treatment; hospital admission during the initial 8 months; and treatment completely in the community. Community-based care involved training general healthcare workers to deliver ambulatory care services, including home visits to patients; delivery of daily medications; nutrition counseling and assistance; and ensuring that patients take effective infection control measures.
The pilot study showed that treatment of people with MDR-TB in the community is both effective and feasible. The ambulatory MDR-TB treatment at community level is being scaled up so that, increasingly, patients do not necessarily need to wait for admission to facilities. Important factors for success include capacity building of supporting staff; logistical support for patients' daily transport for directly observed treatment (DOT); quality supervision and patient monitoring; and timely transport of laboratory samples and results.

Familiy in Ethiopia, photo by Netty Kamp

support included things like nutrition, transportation costs and psychological and counselling support, in combination with the management of side-effects from medications.

As in all KNCV programs, capacity building is an important part of our approach. Two examples of this for PMDT:

- The Center of Excellence on PMDT Training, based in Kigali (Rwanda), builds technical capacity on PMDT in the region. KNCV consultants on a regular basis give training on PMDT, but also other technical areas important to the region, such as childhood TB, infection control, and TB/HIV co-infection and laboratory strengthening.
- In Kazakhstan in 2014, we worked on a structural approach by creating a model of MDR-TB management in two regions and giving training on MDR-TB management to 20 clinicians from inpatient departments, 60 clinicians from outpatient departments and patient counselling training for 100 nurses.

2 How successful are the joint HIV/TB interventions?

In a high TB prevalence country, a person living with HIV is twenty to thirty times more likely to fall sick with TB than a person without HIV. This makes HIV one of the main drivers of the TB epidemic. TB is also the major cause of death among people living with HIV.

The latest data, concerning 2013, indicate that in the countries where KNCV is active 57% of all TB patients on treatment had HIV test results. The average of all countries is 48%. In other words: countries where we work are generally ahead of the curve.

That being said, there is quite a difference between regions and countries. As noted in the Directors' Report in Africa, 75% of TB patients know their HIV status, and in Central Asia the scale-up of HIV testing is generally going well. One of the KNCV-supported countries with the greatest improvements in HIV testing is Nigeria, where substantial investments in TB/HIV services were made and 88% of TB patients were tested for HIV by 2013. Indonesia, on the other hand, has a high TB incidence but limited HIV testing. Extra efforts are needed here in screening, reporting and treating latent TB infection among people with HIV by providing isoniazid preventive therapy (IPT). KNCV provided substantial support for the provision of IPT in Indonesia, as it did in Ethiopia. After successful pilot implementation in four hospitals in 2013, IPT has now been included in the national Indonesian TB policy. The National TB/HIV Forum supports an IPT scale-up in eight provinces, and in the second quarter of 2014, 94% of all the people known to live with HIV in these provinces were screened for TB. IPT provision is now introduced in seven provinces and implemented in 29 hospitals.

PATIENT CENTRED PALLIATIVE CARE

Access to palliative care is part of the continuum of care outlined in Kyrgyzstan's new systematic and comprehensive program approach to TB control. Palliative care is the patient-centered approach to care for chronically ill patients for whom treatment options are limited. Focusing on improving the overall quality of life of patients and their families, palliative care can be given at home or in hospitals. People who have drug-resistant TB (M/XDR-TB) are not always comfortable in hospital settings, where they are surrounded by other people who are very ill. Chronically ill patients may now choose treatment on an outpatient basis, provided that their families are able to care for them and that appropriate infection control measures are taken. The main challenge to home-based palliative care is that the patients are likely to be highly infectious. Palliative care for people with TB is similar to palliative care for other diseases for which the care needs to be tailored to the specific needs of the patients. For example, there may be more need to alleviate breathing difficulties and less need for pain killing. Furthermore, as new drugs for treating TB emerge, new drug regimens may be administered to these TB patients. But the paramount concern is infection control. Health workers and caregivers need special training to provide palliative care to this category of patients. In 2014 KNCV worked with the Postgraduate Institute (PGI) for continuous medical education to develop a training module for healthcare workers on TB-specific palliative care. Educational materials were also created to use when working with patients, caregivers and medical staff.

Giving information about TB, Ethiopia, photo by Netty Kamp

3 How did KNCV help to reach vulnerable patient groups?

Some population groups are more at risk of getting TB infected than others, or they (also) have more difficulties accessing regular healthcare. Among them are, for example, persons using drugs, migrants, mineworkers and people in prisons/detention centers. KNCV continued to work on improving the diagnosis, treatment and care of these groups, such as prisoners and prison staff in Ethiopia, Indonesia, Tajikistan, Kazakhstan, Mozambique and Nigeria.

In Indonesia, we successfully expanded activities into 16 new prisons in 2014, bringing the total number of prisons/detention centers (DCs) implementing DOTS and TB screening to 41. As a result, 89% of released inmates were successfully transferred to their referral health care facilities and continued their treatment and 99% of inmates with HIV were screened for TB.

Initiation of diagnosis and treatment of MDR-TB is accelerating in KNCV-supported countries such as Ethiopia, Indonesia and Nigeria, where treatment initiation tripled, quadrupled and increased five-fold from 2010, respectively.

TB patient in Nigeria
Photo by Tristan Bayly

A total of eight prisons/DCs successfully implemented cough surveillance to strengthen TB case finding. This is a part of the FAST strategy - to detect early, separate, and effectively treat inmates with TB.

In Nigeria KNCV worked to develop and scale-up TB screening, diagnosis and treatment systems for prisoners that have now been taken up by the entire prison system.

In Nigeria, KNCV worked to develop and scale-up TB screening, diagnosis and treatment systems for prisoners. These have now been taken up by the entire prison system and so far more than 6,341 inmates have been screened. In Tajikistan, we did a workshop for strategic planning for 20 prison administration staff members. Building on an assessment of the existing models for transitional care, implementation of activities will start in 2015.

4 What progress has been made in infection control?

Compared to only 50% in 2010, in 2014 all TB CARE I supported countries have developed national TB Infection Control (TB-IC) guidelines. In addition, all these countries have incorporated TB-IC in their overall national Infection Prevention and Control policy. And there are more country-specific achievements as well. In Ethiopia, for example, KNCV provided assistance in developing design and engineering standards for building healthcare facilities that focus on the prevention of airborne infections like TB. Following those standards, and much aware of the importance to prevent these infections, the government has now adopted complementary regulations for the building design of healthcare facilities. After South-Africa, Ethiopia is only the second country in the Sub-Saharan African region to have implemented these important regulations.

In Ethiopia, Nigeria, Zambia and Vietnam the FAST strategy was piloted. This strategy assumes that getting TB patients on effective treatment faster – using for example the new Xpert MTB/RIF tool – will reduce the transmission of TB. Preliminary data from the pilots in Zambia and Nigeria show a reduction in the average time it takes to diagnose people and get them on treatment. Also, there is an increased level of case detection. Based on these findings from twelve tertiary facilities in six states, Nigeria has included the FAST strategy in the revised national TB-IC guidelines.

KNCV continued to invest in facility level TB-IC implementation by offering training to facility level staff, giving technical assistance for facility risk assessments, assisting in the development of facility TB-IC plans, providing commodities such as surgical masks, respirators and fans and helping complete minor refurbishments.

5 What did KNCV do in 2014 to increase responsible use of new medicines and diagnostic tools?

The new tools to fight TB, both drugs and diagnostics, have great potential to accelerate the path towards TB elimination. However, at the same time there is the risk of mismanagement of these very tools with dramatic consequences for patients and public health. KNCV is at the forefront of a responsible implementation. In 2014 for instance:

- We helped develop a protocol for the introduction of bedaquiline, a new drug for MDR-TB treatment, and supported Indonesia, Kazakhstan and Vietnam in the development of country-specific versions of the protocol.
- Following the Expert Group meeting on delamanid in April 2014, we helped develop an interim guidance on the use of this new drug in the treatment of MDR-TB. This was approved by the World Health Organization (WHO) Guideline Review Committee in September 2014.
- We have been heavily involved in the implementation and scale-up of testing the Xpert MTB/RIF diagnostic system in countries such as Indonesia, Nigeria and Vietnam, from shortly after WHO endorsed the test in 2010. As a result, the number of patients diagnosed with rifampicin resistance (and confirmed as MDR-TB) has rapidly increased, saving lives and preventing transmission by adequate MDR-TB treatment.
- In Nigeria, KNCV is supporting the introduction of two hundred Xpert MTB/RIF platforms, specifically for testing PLHIV. This support is made possible by an HIV grant from the Global Fund.
- In Nigeria and Vietnam, we also act as a technical service provider for the company that manufactures the Xpert MTB/RIF platforms. We work on installation, calibration, training and troubleshooting.
- In Zimbabwe and Nigeria we are supporting a pilot project aimed at evaluating the utility of the Xpert MTB/RIF platform in HIV care settings. We also promote the use of this test to screen prisoners and health care workers.

GeneXpert training in Ghantsi Primary Hospital Botswana

Dr. Malik Adenov Chief Doctor of the National TB Center, Kazakhstan

"We now know the direction we have to take,"

SUSTAINABILITY

Kazakhstan was one of the first countries to implement the newly available technologies for rapid diagnostic testing.

Dr. Malik Adenov, Chief Doctor of the National TB Center in Kazakhstan, talks about the need of a programmatic approach to work towards sustainable TB control.

KNCV has been involved in TB control in Kazakhstan since 1997. In 2014, we gave technical and financial support to the development of guidelines for the Programmatic Management of Drug-resistant TB (PMDT). "National PMDT guidelines are very important to us," says Dr. Adenov. "The problem of MDR-TB in Kazakhstan is very relevant at the moment. At the same time there is the opportunity for implementing new technologies: technologies for the management of MDR-TB, for laboratory diagnostics, rapid diagnostic tests, and for new approaches to the treatment of MDR-TB. All these developments together mean that new guidelines are necessary."

The GeneXpert program is working very well: from initially four Xpert MTB/RIF machines there are now 24 machines for rapid diagnostic testing in the country. The NTP plans to place more Xpert machines close to the population. "Building on the good results we have achieved, we now know the direction we have to take. For further implementation we will be able to work very sustainably. A plan for TB and MDR-TB control is being implemented now without external financial support. This is possible because the Kazakhstan government continues its comprehensive support to the TB control system."

An important aspect of the fight against TB is the development of a national policy for ambulatory or outpatient care. Dr. Adenov: "Initially, providing outpatient care was a huge issue. There was a fear of losing oversight and control of the whole cycle of patient treatment. Specialists were concerned that this would result in lower cure rates. Another fear was that government financing would be cut if there was a shift to outpatient service delivery. Generally, all budget allocated to services are related to TB bedside care. During the implementation of the patient-centered pilot project in the Akmola region, a system was developed in which the budget was reallocated to ambulatory care, without the need for additional funds. This is yet another example of a sustainable approach. The NTP and the Ministry of Health have now decided to include this system in the national strategy."

"Another important new idea emerging from the Akmola project is the need for psychosocial support for patients. Local government has decided to increase funding so that we can continue to keep track of patients and motivate them while they are on treatment at home.

> "We hope to develop more new models of care in pilot sites, adapting them to local circumstances and then applying them to whole country."

We hope to develop more new models of care in pilot sites, adapt them to local circumstances and then apply them to whole country. To apply what we have learned to the whole country is a responsible process, but we are now ready to take that on."

5 QUESTIONS ABOUT HOW WE WORKED TOWARDS SUSTAINABLE TB CONTROL

We believe that the only way to ultimately eliminate TB is to embed TB control into national programs and involve all relevant parties. That is why we strive to support National TB Programs (NTPs) in engaging the private health care sector as a valuable partner in national TB control efforts, involving community organizations, increasing national political commitment and establishing sustainable financial strategies.

1 Why does KNCV engage the private health sector?

The non-governmental, for-profit health care sector is the first place many patients turn to when seeking care. They often have good reasons, as for example private clinics may be closer by or more patient-friendly than public ones. Unfortunately, many of these patients cannot afford all the visits and necessary medicines, the drugs they buy from private pharmacies are sometimes of poor quality, or they develop drug-resistant TB because of the private doctor not prescribing them the correct treatment regimen. Therefore, in 2014, KNCV continued to motivate the private and public sector to combine their strengths in public private mixes (PPM) instead of working separately. We have helped develop a toolkit to improve public-private partnerships for TB control amongst people who use drugs. Also, we assisted in the implementation of PPM activities in Botswana, Namibia, Nigeria and Indonesia.

We believe that TB is predominantly a social problem, and that diagnosis and care therefore require strong community involvement.

2 What kind of results have been achieved with public-private mixes?

In Indonesia great progress was made towards involving private clinics through the development of a TB certification system. Private practices that adhere to the quality standards in TB control can get certified, thereby gaining access to health insurance participation. Another example is Nigeria, where we facilitated the engagement of Patent Medicine Vendors and community pharmacists in 105 communities in six focus states, resulting in almost 2,500 patients being diagnosed.

3 In what way did KNCV involve community organizations?

We believe that TB is predominantly a social problem, and that diagnosis and care therefore require strong community involvement. This is why we make significant investments in community-based activities; for example, we help develop community-focused guidelines at the national level and engage local organizations to conduct community-based DOTS activities. In 2014, we invested in community-based work in several countries, such as Ethiopia, Kazakhstan, Kyrgyzstan, Indonesia, Mozambique, Namibia, Nigeria and Tajikistan.

In Botswana, a research project showed that Community TB Care (CTBC) approaches that use incentivized volunteers were of high quality and the most effective. CTBC approaches managed by civil society organizations were noted to be very effective for hard-to-reach populations. These results will guide the Ministry of Health to adopt an appropriate approach, which is then to be scaled up, taking into consideration less donor funding and more sustainable organized national TB control in the future.

ETHIOPIA: ENGAGING CIVIL SOCIETY

In the past two years Ethiopia had remarkable success by involving local civil society organizations (CSOs) in fighting TB.
In Addis Ababa's densely populated slums, there is a higher rate of TB transmission and greater vulnerability of disadvantaged populations than in the rural areas of Ethiopia. Women's organizations are very active in these urban slums. These CSOs are already engaged in HIV awareness-raising, reducing gender-based violence, and mother-and-child health promotion. The women's CSOs reach out to the women through traditional Ethiopian coffee ceremonies. Children run a high risk of TB infection when living in a house with someone who has untreated pulmonary TB, especially children under five years old. KNCV Ethiopia is working hard to raise public awareness of the risk of TB among children in collaboration with the National TB Program and the TB coordinator for Addis Ababa. A training curriculum has been developed to teach the CSO educators to recognize the symptoms of TB and to refer anyone with suspected TB. Community educators learn how to mobilize people, to counter stigma and to advocate for better access to patient-centered services. Based on the success of the past two years, the National TB Program is now also embracing this approach. KNCV has been asked to apply this model to other urban settings in the country. It is crucial to create more educational materials in Ethiopia's many languages and for more pictorial information. The materials can be used by opinion leaders in the community to urge people with symptoms of TB to seek early diagnosis and to make sure TB patients adhere to treatment.

Women's CSOs reach out to women through traditional Ethiopian coffee ceremony, photo by Netty Kamp

Respiratory Fit Test by KNCV Consultant Niesje Jansen

PATIENT CARE FROM A TO Z
E-LEARNING MODULE FOR DUTCH NURSES WORKING IN AMBULATORY CARE

Capacity building is one of the main activities of KNCV in the Netherlands. As the number of cases of TB decline, and correspondingly the number of healthcare workers is reduced, online learning becomes an increasingly valuable method for maintaining excellence in TB care.

In 2014, KNCV developed its first online course for Dutch nurses working in ambulatory care for TB in the Netherlands. This is a new approach to providing learners with all the basic knowledge and skills necessary to support a patient with TB and to assure that the treatment is successfully completed and the patient cured.

The principle of e-learning is to invite the learners to think through a topic or problem, ensure they receive immediate feedback on their answers, adding additional resources/information. The modules were built as a story with a logical flow and a clear begin and end. Three model patients were created, using actors. All methods were tested with users. The course was developed in close collaboration with TB nurses in the field. The e-learning course is certified by the professional nursing body. which nurses can follow in their own time. The course is suitable both as a refresher for experienced TB nurses and for training new TB nurses, who both can follow the course in their own time

Developing the e-learning module has helped to build our own capacity in innovative e-learning. We see many possibilities for applying this model to different target groups, including blended learning or in combination with mentoring and supervision.

In Indonesia, we initiated an approach involving former MDR-TB patients as peer educators. Patients are empowered to establish support groups in which patients can provide psychosocial support to other patients. Peer support is built on shared personal experience, focusing on individuals' strength rather than weaknesses. The approach has been successful and was spread out in PMDT sites in other Indonesian provinces. KNCV also started to support peer educators to conduct home visits to defaulters, as a result of which more than 40% of them resumed treatment. Further expansion of this initiative is hampered by limited resources for operations and training.

4 How has KNCV contributed to sustainable financing of TB control?

In 2014, we have successfully supported several countries with various elements of their applications (Concept Notes) to access funding from the Global Fund to Fight AIDS, TB and Malaria (GFATM) New Funding Model, such as Afghanistan, Botswana, Zimbabwe, Nigeria, Rwanda, Ethiopia and Vietnam. For many nations, funding by GFATM is essential to developing and scaling up TB control measures. For a successful application it is important that this is based on a sound and budgeted National Strategic Plan, including a recent epidemiological assessment, a programmatic gap analysis and plan towards sustainable financing.

NIGERIA:
ON THE ROAD TO EMBEDDING TB CONTROL

In Nigeria, KNCV supported the development of the National Strategic Plan for TB 2014 – 2020, which is closely aligned with the national health strategies. The plan includes activities to ensure that TB is integrated into national health insurance schemes, that patients receive support to complete treatment, especially for MDR-TB, and that surveillance and data collection systems for TB are fully compatible with the national health data system. One key objective focused on significantly increasing domestic contributions to TB control. The target is 50% of funding from domestic sources by 2020 (in 2014 it was 19% of the total TB budget).

Another important element on which Concept Notes are based focuses on the overall costs of the National TB Program and the costs of treating one TB patient using different strategic approaches. While some cost elements are straightforward, such as those of the TB drugs, other hidden costs of integrated services are more difficult to quantify.

5 What is the importance of costing tools?

We believe that countries need to replace dependency on donor funding with increased government budget allocations and revenue from insurance and corporate social responsibility financing. Sustainable financial strategies have to take this into account. In this respect, it is important for governments to improve cost-effectiveness and efficiency, so that results can be maximized with limited resources. To assist in this, we helped developing – within the framework of the TB CARE I program –a suite of four costing tools that donors and governments can use to model costs and analyze cost-effectiveness:

- TB Services Costing Tool;
- MDR-TB Cost Effectiveness Analysis Tool;
- TB Economic Burden Analysis Tool;
- Tool to Estimate Patients' Costs.

All tools are open-source, based in Microsoft Excel and intended for NTP planners and managers. Blank and example versions are available, as well as examples of country reports. The tools were developed and tested in individual countries but can be used by any country.

In 2014 we have successfully supported countries with various elements of their Concept Notes to access funding from the Global Fund.

ORGANIZATIONAL HIGHLIGHTS

Getting ready for the future

For the KNCV organization, 2014 was an important year of getting ready for the future. We worked on a new strategy for 2015-2020, based on a thorough analysis of the current state of TB control, threats and opportunities. We are very proud that our patroness, Her Royal Highness Princess Margriet, wrote the foreword to this strategic plan, which holds our vision, ambition and priorities for the next six years.

In October 2014, it was announced that for the fourth time in a row, USAID has selected KNCV to lead their flagship TB program, now called Challenge TB. With a ceiling of US$ 525 million in five years it is the largest TB program in the world, empowering us and our eight consortium partners to take great steps forward in the fight against the deadly disease. The start of Challenge TB also marked the ending of TB CARE I, the former USAID funded program, which we will formally close in 2015. We are proud to have contributed to saving more than 4 million lives through this extensive program, which ran for four years, and inspires us to continue the fight.

> In October 2014 it was announced that USAID, for the fourth time in a row, selected KNCV to lead their flagship TB program, now called Challenge TB.

To suit both our new strategy and the taking up of Challenge TB, we adapted the way KNCV is organized. Starting in 2015 we will be operating in three divisions working closely together, but each with their own expertise and responsibility: operations, technical assistance and finance. This will enable us to enlarge the output of our highly experienced consultants, supported by efficient and spirited project operations and financial staff. Dedicated and innovative support units include monitoring & evaluation, communication & fundraising, resource mobilization and HRM.

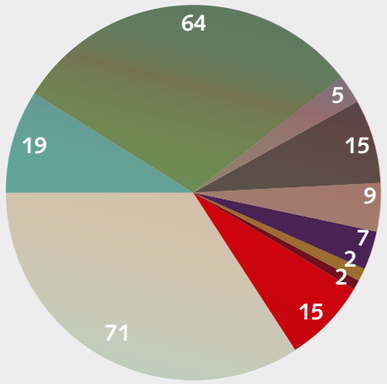
Sharing knowledge

As an international center of TB expertise, KNCV sees sharing knowledge among colleagues as a crucial value. In 2014, we organized 24 lunch meetings to share and

MAARTEN VAN CLEEFF AWARDED KAREL STYBLO PUBLIC HEALTH PRIZE

At the Union World Conference on Lung Health, KNCV 's Dr. Maarten van Cleeff, director of our USAID programs for the past 14 years, was awarded the prestigious Karel Styblo Public Health Prize. We are very proud of our colleague, for whom the prize is even more special because he worked with Karel Styblo himself as a young professional.

SOCIAL REPORT



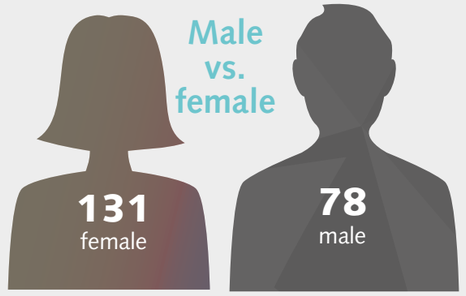
Staffing per country

as of 31.12.2014

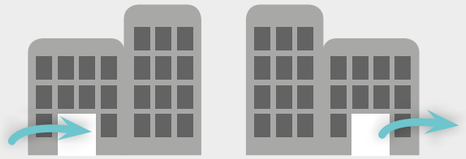
Nigeria **19**
Indonesia **64**
Vietnam **5**
Kazakhstan **15**
Namibia **9**
Tajikistan **7**
Kyrgyzstan **2**
Botswana **2**
Ethiopia **15**
Head Office
The Hague **71**

Sick leave at The Hague office was **5.8%** in 2014 versus **2.6%** in 2013, mainly due to several cases of long-term sick leave.

Male vs. female



Inflow/outflow



53 new staff

66 leaving staff *

* Because of the time between closing TB CARE I and starting Challenge TB, more people left in 2014 than in other years. More new colleagues will be recruited and will start in the first months of 2015.

ANNUAL SYMPOSIUM INSPIRES TO WORK TOGETHER

The room at the Nutshuis in The Hague was filled to capacity with stakeholders, member organizations and health professionals, for KNCV's Annual Symposium on May 20. In her opening address, Executive Director Kitty van Weezenbeek argued that achieving the post-2015 TB control targets requires a broad, multidisciplinary approach and the engagement of private sector health care providers and civil society. This view was adopted by the audience in a lively discussion, leading to the idea to create a Netherlands TB Platform, in which Dutch organizations, institutes and enterprises would collaborate closely along the entire chain of operations: from research and development to the implementation of technologies and interventions to enhance TB control.

Joep Lange

Omer Ahmed Omer

Felix Salaniponi

SAD FAREWELL

In the summer of 2014 we were confronted with the sudden loss of three highly esteemed and loved colleagues. Joep Lange, member of our Board of Trustees, inspiring mentor and friend and of invaluable importance to the fight against TB and HIV, was on board Malaysian Airlines MH17. Shortly before that fatal incident our country representative in Namibia, Omer Ahmed Omer, died following a short illness. We remember him as a very friendly, devoted, hardworking and enthusiastic team member. August saw the passing away of yet another remarkable TB fighter, Felix Salaniponi who worked for KNCV in Kenya, Ghana and Zimbabwe. We are sad, but filled with gratitude and pride to have worked with these inspiring people.

discuss experiences and new developments, international policies and guidelines in TB control. Two international meeting weeks took place to build KNCV staff's capacity, discuss organizational topics and strengthen teamwork worldwide. Through organization-wide discussions, KNCV staff contributed to the new strategy. To further strengthen the knowledge of our international staff, we developed several e-courses which will be launched in 2015.

Next generation

To get more young professionals engaged in the fight against TB, we developed KNCV's Young Professional Program, supported by Dr. C. de Langen Stichting voor Mondiale Tbc-bestrijding (SMT) and the 's-Gravenhaagse Stichting tot Steun aan de bestrijding van Tuberculose. The idea is to link international KNCV TB professionals to a new generation, combining a world of experience with new knowledge, skills and working dynamics. An appealing selection procedure gave candidates the opportunity to present themselves through new media and case studies. The 81 applicants came from the Netherlands and abroad, with backgrounds in Medicine, Social Sciences and Economy. The selected candidate will start in January 2015. We aim to expand the Young Professionals Program in 2015.

Diversifying the funding base

By far the largest proposal that KNCV developed and was awarded in 2014, is Challenge TB; USAID's new global TB Control project (2015-2019). Given the size of this project, which has a US$ 525 million ceiling, we expect that USAID will continue to be KNCV's largest donor in the foreseeable future. Nevertheless, KNCV made significant progress towards diversifying its funding base in terms of the number of donors.

First of all the Dutch Ministry of Foreign Affairs (DGIS) expressed its commitment to TB with a co-financing of 7.5 million euros into USAID's Challenge TB project. KNCV will use this funding to assist in 'making the Global Fund (GF) work'. The DGIS contribution will be used to strengthen and support Global Fund related processes at country level with technical assistance; and lastly to contribute to GF policy development processes. The related 2015 work plan is developed in close collaboration with DGIS.

KNCV in 2014 also successfully attracted other institutional donors in 2014: TB REACH/Wave 4 (Tajikistan), Capital for Good, Fund Life Sciences for Health and Development (LSH4D), The Global Fund (GFATM), Cepheid and USAID Tajikistan (sub award through Project Hope). In total 7 new donors were attracted in 2014 which is a steady increase compared to the previous year. We were able to realize this positive result due to a more streamlined internal proposal development process. Systems and tools to screen, analyze and develop funding opportunities were put in to place and we strengthened the capacity of the institutional fundraising unit as well as the skills of technical staff to develop proposals for institutional donors.

KNCV will continue to broaden its funding and donor base, building on the new institutional fundraising structures and systems that have been put in place during the course of 2014.

Campaigning and private fundraising in The Netherlands

Though competition in fundraising is growing because of fierce cuts in Dutch Government budgets, we successfully managed to keep our income from private donors on the same level as in 2013, even realizing a small increase. The income from legacies was lower than in 2013, but still higher than the prognosis for 2014.

More donors turned into regular givers, and the average gift was higher than the year before. However, the total amount of donors is declining, largely because we have mostly been supported by elderly people. To reverse this curve in 2015, we will invest in new fundraising approaches to attract a younger audience and engage them in our mission to eliminate the second most deadly infectious disease in the world.

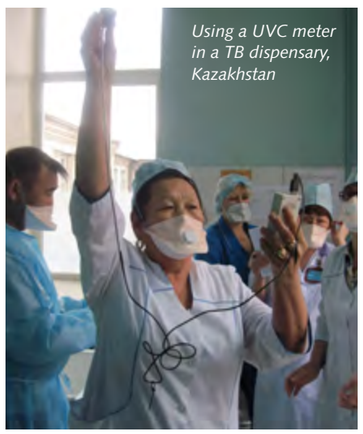
TB is not seen as a major issue in The Netherlands and to make this happen creative campaigning is crucial. In 2014 we had a very successful campaign around World Stop Tuberculosis Day on March 24. More than 20 Dutch celebrities – actors, writers, TV presenters and even our national astronaut – helped us in raising publicity for the TB cause. Our new Facebook page attracted more than 2,000 fans in less than two weeks. We will build on this success in 2015. Our websites had a growing audience in 2014, in some cases almost doubling the number of visits compared to 2013.

More than 20 Dutch celebrities – actors, writers, TV presenters and even our national astronaut – helped us in getting publicity for the TB cause.

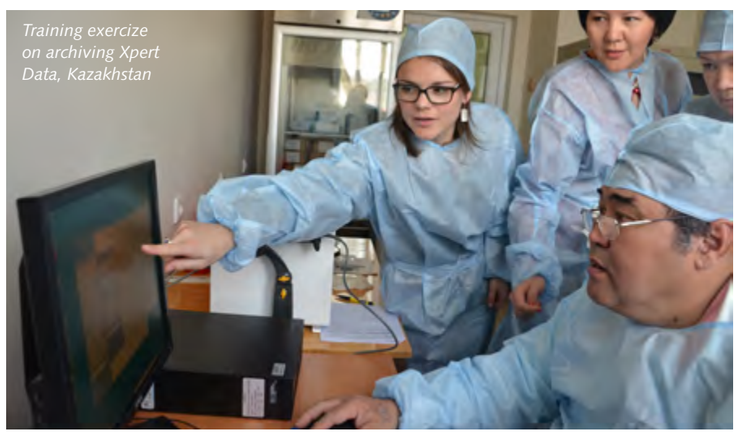
We greatly value the support from two Dutch lotteries, Lotto and De Vriendenloterij. Without their continuing financial contribution, and of course the people who play the lotteries on our behalf, we would not be able to continue our programs in The Netherlands.

GOVERNANCE REPORT

A succesfully treated DR-TB Patient and her children - Tajikistan



Using a UVC meter in a TB dispensary, Kazakhstan



Training exercize on archiving Xpert Data, Kazakhstan

BOARD OF TRUSTEES REPORT

Remembering Professor Joep Lange

The KNCV Board of Trustees is deeply saddened by the loss in July of our esteemed Member of the Board of Trustees, Joep Lange. He was aboard Flight MH 17, together with his partner Jacqueline van Tongeren, en route to the International Aids Conference in Melbourne. In Joep we lose an independent spirit and true friend.

We honor the gigantic legacy of Joep in the fight against HIV/AIDS and his dedication to fighting the co-epidemic TB and HIV/AIDS. We are immensely grateful for Joep's wise counsel and energy throughout his tenure in the Board since 2006. He led the way in nurturing ambition towards achieving the KNCV mission and played an important role in the leadership transition in 2013.

We sorely miss Joep's guidance as well as the warmth of his presence with us. We dedicate our efforts in his remembrance.

Supervisory governance in 2014

Gaining the Challenge TB award was a major achievement in 2014. Supervisory governance in the lead up to winning the tender process focused on preparing for the eventuality of not gaining the contract. Concurrently, we supported the leadership in the transition to a stronger organization, fit to meet the challenges and opportunities in TB control. Re-establishing the relationship with DGIS as a funding agency met the longstanding aspirations of the Board of Trustees, Joep Lange in particular.

Key areas governed

The key areas of attention and oversight for the Board of Trustees throughout 2014 were:

- guarding and preparing for the consequences of different funding scenarios;
- developing the Strategy 2015 - 2020 and repositioning the organization for the future;
- restructuring of the organization for effective operations and cost efficiencies;
- establishing an up-to-date salary structure in full compliance with industry standards;
- strengthening the human capital base of the organization;
- strengthening the capacity and efforts for funding diversification.

We note and commend the leadership for attracting strong and experienced staff to complement competencies available, for inspiring ambition to meet the challenges of today, and for early successes in accessing new categories of funding.

Looking ahead

Building on the achievements of 2014, and in charge of executing the Challenge TB program, KNCV, now stands at the threshold of a new era in leading international TB control. The scope of the Challenge TB program is formidable and exciting. It builds on the infrastructure and achievements of 14 years of program implementation for USAID. Such level of donor continuity and commitment is unique. The program will be leveraged by the DGIS grant and an expanded scope of additional contracts. KNCV has earned the donors' trust through hard work, and more hard work is surely ahead.

The coming years will stretch KNCV in many ways. In 2014 the organization has prepared itself by re-structuring for efficient delivery of services. The Board of Trustees is confident that KNCV will continue to rise to the occasion, as a fully dedicated team, in partnership with other organizations and affected communities, in-country and globally. We wish KNCV staff courage and personal fulfilment in meeting the challenges ahead.

The Board of Trustees,

Chair **Dina Boonstra**

Vice Chair **Dirk Dotinga**

- BOARD OF TRUSTEES REPORT
- GOVERNANCE REPORT AND EXTERNAL COMMUNICATION

GOVERNANCE REPORT AND EXTERNAL COMMUNICATION

Statutory name, legal state and place of residency

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' (KNCV or KNCV Tuberculosis Foundation) has its central office in The Hague, The Netherlands. The latest version of the statutes passed the notary deed on 23 August 2012 and can be found on our website.

General Assembly

The members of KNCV are organizations with a mission or task in the field of TB control. The General Assembly, comprising of 10 members, appoints the Board of Trustees and governs the activities of KNCV, thereby contributing to the statutory mission of the organization. The General Assembly may advise the Board of Trustees and the Executive Board. The General Assembly met on May 20th 2014.

Honorary members

Honorary members of KNCV are individuals who made a significant contribution to TB control and/or to KNCV as an organization. At present these are: Dr. M.A. Bleiker, Dr. A. Rouillon and Dr. H.B. van Wijk.

Board of Trustees

The Board of Trustees is charged with the supervisory governance of the organization, in conformance with the VFI Code of Good Governance. The General Assembly appoints members to the Board of Trustees. Members are appointed for a term of four years. A member is usually reappointed once and can be reappointed a second time for reasons of continuity. Membership of the Board of Trustees is without remuneration. Out of pocket expenses for attending meetings are reimbursed in addition to a generic expense compensation of €100 for each Board of Trustees meeting attended.

The full Board of Trustees meets four times a year, and once a year a retreat is held with the Executive Board and (members of) the Management team. Three permanent sub committees have been established with the following preparatory tasks:

- An Agenda Setting Committee to prepare the Board agenda;
- An Audit Committee to assess in detail the annual plan, annual report and the findings of the external auditor;
- An Appraisal and Remuneration Committee to assess the performance of the members of the Executive Board.

Depending on ongoing developments, temporary committees can be established on an ad hoc basis. In 2014 a nomination committee consisting of the Chair and Maurits Verhagen was charged with filling the vacancies in the Board of Trustees. Once annually a Member of the Board of Trustees attends a Works Council Meeting.

The members as per year end 2014 are:

• Mr. Willem Bakhuys Roozeboomstichting	• Nederlandse Vereniging van Artsen voor Longziekten en Tuberculose
• Stichting Medisch Comité Nederland-Vietnam	• Verpleegkundigen & Verzorgenden Nederland, Platform Verpleegkundigen Openbare Gezondheidszorg
• Dr. C. de Langen Stichting voor Mondiale Tbc-bestrijding	• GGD Nederland, vereniging voor GGD'en
• Vereniging van Artsen werkzaam in de Tbc-bestrijding	• Stichting Suppletiefonds Sonnevanck
• 's-Gravenhaagse Stichting tot Steun aan de bestrijding van Tuberculose	• Nederlandse Vereniging voor Medische Microbiologie

Supervisory governance during 2014

In May 2014, the General Assembly reappointed Dina Boonstra for a third term of two years and Joep Lange for a third term of four years. This was done in order to assure continuity in supervisory governance in an intensive period of transition following the entry of new leadership and the prevailing uncertainty on funding levels. The remaining vacancy, in a board composed of five to seven members, was left open to allow for flexibility following the outcome of the Challenge TB award process.

A nomination committee, comprising the Chair and Maurits Verhagen, is currently recruiting three members of the Board of Trustees to fill the existing vacancy, and the vacancies due to Joep Lange's decease and upcoming retirement from the Board of Trustees of Mrs. Xiaoling Sun.

In 2014 the Board of Trustees held four regular meetings (February, April, September and November) and one retreat meeting with Executive Board and Management Team. The Audit Committee met twice (April and November). The Appraisal and Remuneration Committee conducted performance assessments with Executive Board, sharing outcomes with the full Board. This year's annual self-assessment of the Board of Trustees was conducted in the September meeting. A member of the Board of Trustees attended the Works' Council meeting

MDR TB Patient receiving his medication

The Board of Trustees, at 31 December 2014 was as follows:

Member	Appointed	Expiring
Dina Boonstra, chair	May 2014 (3rd term)	2016
Dirk Dotinga, vice-chair	May 2012 (1st term)	2016, eligible for 2nd term
Xiaoling Sun	May 2011 (1st term)	2015, not available for 2nd term
Maurits Verhagen	May 2011 (1st term)	2015, eligible for 2nd term
Ton van Dijk	May 2013 (1st term)	2017, eligible for 2nd term
Two vacancies		

The members of the Board of Trustees have the following relevant other positions:

Member	Other positions
Dina Boonstra	CEO NDC Media Group;
Dirk Dotinga	Chair Alzheimer Nederland – region Haaglanden; Member of the Board of Trustees Haagse Milieu Services; Board Member Stichting Noodopvang Haaglanden
Maurits Verhagen	Medical doctor TB control Municipal Health Service 'Limburg-Noord'; Chair of the Committee Practical TB Control in The Netherlands
Xiaoling Sun	Supervisor Chinese DeHeng law office; Board Member CNEXPO foundation; Board Member Chinese Enterprises Association
Ton van Dijk	Director of public health (region Haaglanden); Director of medical disaster management (region Haaglanden)

in the fall and noted the constructive dialogue between the Executive Director and Works Council. In 2014 the International Advisory Council did not hold an in-person meeting in 2014. Early 2015 the Board of Trustees assessed the mandate and composition of the International Advisory Council and opted for convening annually an 'International Advice and Counsel' meeting on an ad hoc and topic focused basis.

Executive Board

The Executive Board governs the organization and is composed of a Chief Executive Officer (who holds statutory powers solely) and a Chief Scientific Officer. The Executive Board meets bi-weekly to discuss and formalize all required decisions concerning strategy, planning and control, monitoring and annual reporting, as well as to discuss issues arising from operational management. The Executive Board is supported by a Management Team, which is composed of the three division directors (Finance, Operations and Technical Services), Director Challenge TB and the heads of the supporting units and the board secretary/advisor public affairs.

The Executive Board presently consists of:

Member	Appointed
Kitty van Weezenbeek, Chief Executive Officer	September 16, 2013
Frank Cobelens, Chief Scientific Officer	September 1, 2013

Both directors have indefinite employment contracts. Their performance individually and as a team is assessed by the Appraisal and Remuneration Committee of the Board of Trustees. The committee reports their findings to the full Board of Trustees.

International Advice and Counsel meeting

During 2014, KNCV reviewed the International Advisory Council. Attendance at the IAC meetings had been unsatisfactory and a choice was made to convene experts on specific topics once a year on an ad hoc basis. The Board of Trustees and the organization wish to express their gratitude to the members of the International Advisory Council for their wise counsel and dedication to KNCV.

Works Council

In 2014 elections for the Works Council were held. Ineke Huitema and Edine Tiemersma were re-elected. The composition of the Works Council changed at the end of 2014. Susan van den Hof resigned from the Works Council early January 2015 as she assumed a new position in the restructuring of the organization.

In the course of 2014, the Works Council provided advice on the following issues: the restructuring plan, the closing of the Regional office Kenya, the first draft of the Modus Operandi; the Works Council further expressed consent on the Social Paragraph 2014-2015. This Social Paragraph describes the process of placement procedures. Furthermore, together with human resources management (HRM) the Works Council has clarified the policy for reimbursement of commuting expenses and has provided input to the action plan of the Risk Assessment and Evaluation, highlighting issues on work pressure.

We have done our utmost to be the eyes and ears of the organization and represent the colleagues in discussions on the issues that were important for all employees. The Works Council trusts to have done so while striking a constructive balance between the employees' wellbeing, interests and working conditions on the one hand and the organiza-

The members of the Executive Board have the following relevant positions and responsibilities:

Director	Organization	Position	Qualitate Qua /Personal	Period
Kitty van Weezenbeek	Dr. C. de Langen Stichting voor Mondiale Tuberculosebestrijding (SMT)	advisor	QQ	Indefinite
	's-Gravenhaagse Stichting tot Steun aan de Bestrijding van Tuberculose	advisor	QQ	Indefinite
	Coordinating Board of the Stop TB Partnership	member	QQ	Indefinite
Frank Cobelens	AIGHD Foundation	employee	Personal	Indefinite
	Academisch Medisch Centrum, Global Health department	Honorary position	Personal	Annual renewal

Women in Ethiopia, photo by Netty Kamp

At the end of December 2014, the Works Council members were:

Member	Appointed	Expiring
Ineke Huitema, Chair	2014 (2nd term)	2018, eligible for 3rd term
Susan van den Hof, Vice Chair	2011 (1st term)	2016, eligible for 2nd term
Jenny Klein	2012 (1st term)	2016, eligible for 2nd term
Irma Lamp	2013 (1st term)	2016, eligible for 2nd term
Edine Tiemersma	2014 (2nd term)	2018, eligible for 3rd term

tion's interests on the other hand.

Quality control

KNCV considers quality as an essential hallmark of all the work we do. To ensure quality in our activities, deliverables, and results, in 2014 the organization embarked on a systematic review of processes that support standardized, high-quality performance. This includes the creation of standards of excellence for essential processes, such as providing short-term technical assistance through consultancies at country level or developing high-quality work plans and reports. In addition, the organization is preparing lists of required competencies for general consultants and for specific technical areas. These efforts will, in the course of 2015 be supported by simple checklists, updated and streamlined templates for reporting, and professional development plans to give consultants the tools and skills they need to succeed. The existing system of peer review for documents and presentations continues, as will annual performance appraisal and our active gathering of feedback from clients. With the hiring of additional staff focused on quality and monitoring and evaluation, we have in 2014 augmented our capacity to identify opportunities for improvements and to support them through strengthened systems. By engaging all KNCV staff in discussions on challenges to quality and potential solutions, we aim to strengthen a culture of continuous quality improvement and increase adoption of standards for excellence across all consultants and country offices.

To sustain the quality of internal management and processes within the organization, KNCV uses a cycle of strategic and annual planning, implementation, monitoring and evaluation, adaptation of plans and accounting for results. This process has been described in the document "Management and supervision of KNCV, the Good Governance Code applied." The overall functioning of the organization and progress of the implementation of plans is continuously monitored by the Management Team, Executive Board as well as regularly reviewed in Board of Trustees meetings. For the projects and programs funded by institutional donors, interim reports are sent to the funders and evaluated for effectiveness and efficiency. External oversight and auditing of the administrative and financial operations is carried out by PriceWaterhouseCoopers Accountants NV. The external auditor was appointed by the General Assembly in 2011. The directors have regular progress meetings with the auditor. Every year, the auditor reports his findings to the Audit Committee. All audit reports and management letters are shared with the Board of Trustees.

Compliance to ethical fundraising standards is tested using guidelines from the Central Bureau for Fundraising in The Netherlands (CBF) and sector organization, Vereniging van Fondsenwervende Instellingen (VFI).

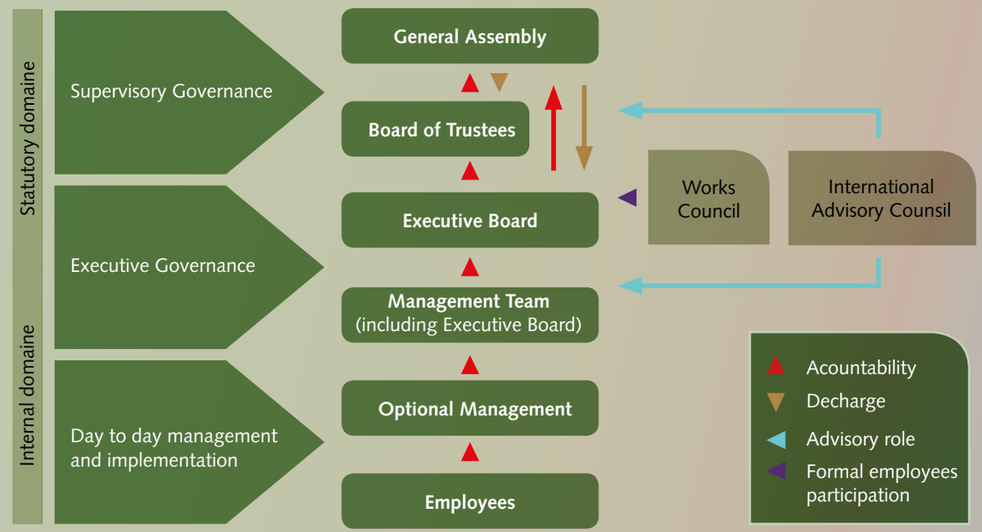
Risk management

In 2014, the organizational risks of the primary processes and operations were identified and updated in a risk assessment report. The following were identified as subjects for further improvement:

a. The various insurances, procured by field offices, need to be inventoried and assessed on completeness.
b. A policy was introduced to actively reduce the number of cash payments. Cash reduction plans from all country offices were combined and made mandatory for all offices. This will be followed up during internal audit missions and will be a subject at the annual International Finance Meeting.
c. The representation of KNCV Tuberculosis Foundation in other countries requires that responsibilities and powers are to be clearly delegated. Absolute clarity between the Executive Board, the unit heads, and the country representatives about this delegation, and about the (legal) limitations thereof is essential and requires strengthening. The agreements will be put down in writing.
d. In addition to the employment contract and the job description, a document is created which explicitly specifies the powers of a country representative.
In 2015 the field office manual will be transformed into a virtual environment on the E-portal where field offices can find all procedures and tools needed for managing their office.
The delegated responsibilities and authorities have meanwhile been described in the field office manual and confirmed to field office managers upon the start of their employment.

Zimbabwe - Hospital
photo by Jeroen van Gorkom

Figure 1: KNCV model for governance and management



External Quality Hallmarks

KNCV is subject to the governance and quality requirements of the CBF, and since July 1998 has received the CBF certificate up to 2015. CBF is currently reviewing the certificate following the submission of all required documentation early February 2015. The document "Management and governance at KNCV - the code for Good Governance Code application" describes our governance structure, management procedures and regulations in detail. A summary of the accountability report, outlined below, is sent annually to the CBF.

Codes of conduct

KNCV has a number of codes of conducts which guide staffs' ethical behavior and protects their employment with the organization. These are:

- General code of conduct, updated early 2015.
- Code of Conduct for the use of E-mail, Social Media, Internet and Telephone Facilities;
- Policy and protocol for undesirable behavior at work;
- Whistle blower policy.

Media policy

KNCV uses national and international (social) media to raise the profile of its work in fighting to control TB. Through the media (online and offline) we aim to reach the general public, professionals, politicians and policy makers. We strive for transparency and report our successes and mistakes. We keep a close eye on anything relevant appearing in the media and actively engage in discussion with the public, our stakeholders and critics. We respond immediately to messages that are not based on facts or correct representations of our work. We actively monitor information and the (social) media concerning TB control and our organization and react to current developments and possible (negative) publicity, if and when these arise.

Summary of the CBF accountability report on management and governance

Any fundraising organization with the CBF quality hallmark has to demonstrate how the three principles for good governance are being applied. These are:

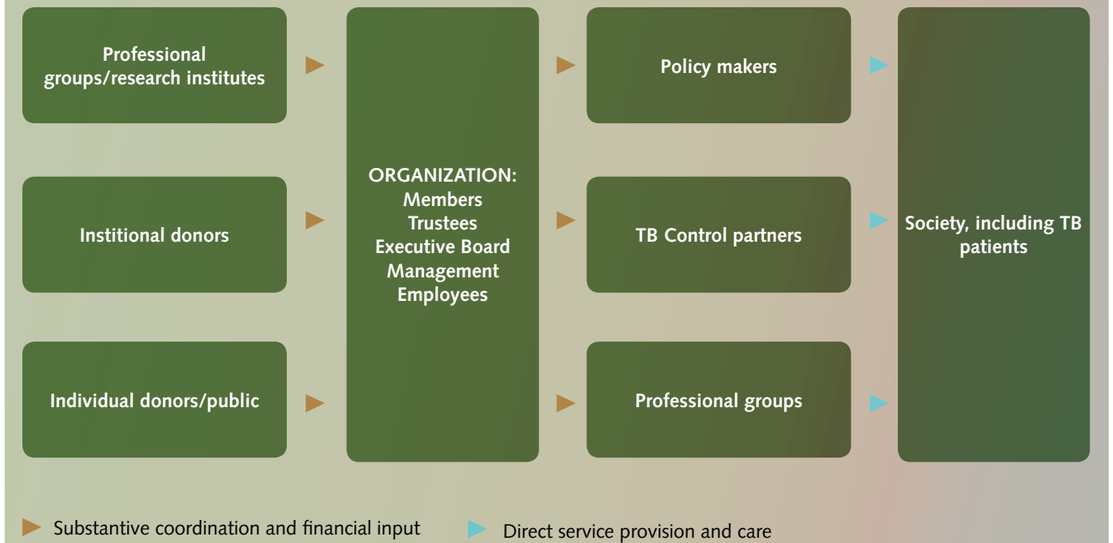
- Division of tasks in governance, management and operations;
- The continuous improvement of efficiency and effectiveness in mission related activities;
- Optimizing the communication and relationships with stakeholders.

This Annual Report contains a summary of the accountability report. The actual report was submitted to the CBF.

Ad 1. Division of tasks in governance, management and operations

KNCV has described its governance and management structure in the document:

Figure 2: KNCV partner network



'Management and governance at KNCV - the code for Good Governance Code application'. Through the development, management and maintenance of this document, we seek to achieve the following:

- Implement the requirements for governance and ensure there are sufficient visible 'checks and balances'.
- Frequently audit the management and governance structure in order to assess and comply with new developments according to relevant regulations and laws.
- Create a frame and guideline for the different management layers in the organization and connect the various policy documents and by-laws. The document serves as a manual for all governance bodies and their appointed members.

In figure 1 on page 49 a schematic overview of the governance structure is explained.

In addition to the articles of association, the operational modalities of all governance structures are described in the following regulations and documents, available upon request:

- Rules and Regulations for the General Assembly;
- Rules and Regulations for the Board of Trustees;
- Rules and Regulations for the Audit Committee;
- Rules and Regulations for the Remuneration and Assessment Committee;
- Rules and Regulations for the Executive Board;
- Rules and Regulations for the Management Team;
- Rules and regulations with regard to the relation between the Works Council and the Executive Board.

Ad2. The continuous improvement of efficiency and effectiveness in mission related activities

KNCV has developed and implemented a set of mechanisms to continuously and coherently strive for improvement in its operations, especially in terms of efficiency and effectiveness. These include:

- A planning, monitoring and evaluating process composed of a strategic long term plan and an annual planning and control cycle, for mission related goals, for resource allocation and enabling environment. Performance indicators are used to assess the progress in reaching strategic and organizational goals.
- A procedure for assessing new projects and/or acquisition proposal development.
- Monitoring and evaluation systems at project and institutional level.

Ad 3. Optimizing the communication and relationships with stakeholders

KNCV is part of a large partner network of public and private organizations and individuals, all contributing to the realization of our mission.
The structure and composition of our network is outlined in figure 2.

Creating and maintaining support (both material and immaterial), transparency, and accountability in all our processes is the focus of our communication with all stakeholders. The overall goal of our corporate communication is to support our mission by creating, maintaining, and protecting KNCV's reputation, prestige, and image. Our communication with stakeholders is based on the following principles:

- we are transparent and report on our successes and lessons learned;
- we communicate pro-actively, where possible;
- we communicate in unambiguous and consistent key messages;
- we tailor our communication messages and media to reach our key audiences and target groups.

We use a diversity of methods to communicate with our growing network of stakeholders, striving for greater transparency and dynamic interactions.
We encourage all stakeholders, including private donors, to share their opinions, ideas and complaints with us by telephone, e-mail or postal mail. The responsible unit head or officer will address the issue and communicate directly with the sender. Complaints are formally registered and monitored.

In addition to our continuous operational engagement with key stakeholders, including TB-affected populations at country, regional and global level, KNCV also ensures that a diversity of perspectives are reflected in our governance structures and processes; In addition to annually convened International Advice and Counsel meetings, the organization also seeks stakeholder participation at other important moments, for example:

- During the strategy development process every five years;
- By participating in knowledge exchange forums;
- By monitoring and evaluating (e.g. donor satisfaction survey);
- By inviting ideas and complaints through the website.

Accountability to stakeholders is ensured both prior to and after implementation. The results are presented at the General Assembly meetings, on the website, in newsletters and in project reports.

Indonesia, cured TB patient travelling to the hospital for follow-up care

FINANCIAL REPORT

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Children in Indonesia,
© M. Bushue

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FINANCIAL INDICATORS AND MONITORING DATA

Financial data 2010-2015

The financial statements have been prepared in accordance with the Dutch Accounting Standard for Fundraising Institutions (RJ650). According to the 650 Guideline for annual reporting of charities and the requirements from the CBF a number of financial monitoring data is shown for a longer period in table 8:

MONITORING DATA	standard	Actual 2010	Actual 2011	Actual 2012	Actual 2013	Actual 2014	Budget 2015	Average for 3 years
spent on the mission compared to total expenses	not applicable	96.7%	95.6%	96.6%	96.7%	95.7%	95.9%	96.3%
spent on the mission compared to the total income		95.2%	98.1%	95.4%	96.0%	95.2%	97.6%	95.5%
spent on private fundrasing compared to income	max. 25%	23.2%	20.4%	23.8%	17.4%	24.6%	30.2%	21.8%
spent on administration and control compared to total expenses	5- 10%	2.2%	2.6%	1.9%	2.0%	2.5%	2.2%	2.1%
spent on administration and control compared to total expenses excluding TBCTA coalition share in activities[1]	5-10%	4.0%	4.9%	3.8%	5.1%	5.0%	4.7%	4.6%

Table 1: Financial monitoring data compared to standards

In total KNCV Tuberculosis Foundation generated less income in 2014 (45,2 million) than was planned (53,3 million) and also compared to 2013 (€ 54,2 million).
Total expenditures in 2014 were € 45,0 million, which is € 8,8 million lower than budgeted. The decrease is caused by lower expenditures in the category "TB in high prevalence countries". Expenditures in the categories "fundraising" showed an increase compared to budget and expenses for "administration and control" showed a decrease compared to budget.

Expenditures on the mission (R7)

Compared to total expenses, since 2010, over 95% of KNCV's budget is being spent on mission related activities. This indicator is closely monitored. Influences on the indicator can be due to (temporarily) increases and decreases of expenditures for fundraising and for administration and control. Compared to the total income, expenditures on the mission (in percentage) can differ from the previous indicator because in some years earmarked reserves and funds are used to cover the expenditures or there is a surplus occurring.

[1] TB CARE I is partly implemented by partners in the Tuberculosis Coalition for Technical Assistance (TBCTA).

KNCV's policy for costs for fundraising (R8)

With regards to expenditures for fundraising, KNCV Tuberculosis Foundation complies to the guidelines issued by the CBF. Calculated as an average over a 3 year period, the costs cannot be higher than 25% of the income from own fundraising activities. As a consequence of our ambitions and modest position in the private fundraising market, we have chosen to stay close to the possible maximum, as witnessed in 2014, and reflected in the budget for 2015. Uncertain and unpredictable factors in this strategy are the level of success of using new fundraising methods and the income from legacies. KNCV's internal policy on level of costs for fundraising is that if, in the course of a budget year, the results are not satisfactory, we adjust our budgets downwards in order to prevent a percentage above the 25% standard. Expenses in 2014 are 24,6% of the income from own fundraising activities, exactly the 25% maximum. The 3-year average is 21,8%. The budgeted percentage for 2015 is above the 25% maximum. This is related to an investment in new fundraising approaches planned for 2015, which we expect to show results from 2016. The three year average based on 2013, 2014 and the budget for 2015 is at 24,1%.

KNCV's policy for administration and control costs (R9)

The allocation of costs to the category 'administration and control' is done using the guideline and recommendations of the VFI, published in January 2008. The CBF requires an organization to have an internal standard for this cost category. KNCV uses 5% of the total costs as a minimum and 10% as a maximum. The reasons for this range of percentages are:

- Our activities are funded by private, corporate and public donors, all of whom demand the highest level of transparency and accountability on what has been spent to the mission and the allocation to projects.
- We want to spend as much of our resources as possible in an efficient and effective manner in order to realize our mission. Smooth running of operations and adequate decision making-, management- and control processes contribute to that.
- On the one hand, the costs for these processes cannot be so high without taking resources away from the mission. And, on the other hand, they should not be too low because then the quality of our management cannot be guaranteed. We use therefore a minimum and a maximum standard.
- With regard to determining a range between the minimum and maximum, the organization must also take into account the widely fluctuating levels of activities within projects and contracts, funded by institutional donors. In the realization of plans, the organization depends on the available resources and implementation pace of third parties. The level of managerial and administrative efforts required, do not immediately respond in an equal way and pace. For this reason also, the average rate over a period of several years is presented.

In 2014, the percentage of 2.5% is slightly higher than what was budgeted for (2.2%). Additional expenses for consultants (HRM and IT) are the cause of this increase. Also, due to the decreased level of coalition activities compared to budget (related to the end of the TB CARE I project) the percentage of costs spent on administration and control is higher than planned. The percentage of costs spent on administration and control related to total expenses excluding coalition activities (5.0%) is within the set norm.

Internal monitoring data

In addition to the guidelines issued by the CBF, we also monitor the progress of our activities using other indicators; both for our own internal management and for reporting to institutional donors These include:

- The number of project days realized compared to planned days; In 2014 a total number of 9,885 project days were planned and 10,389 were realized, which is 105% of the planned days. In 2013 this was 101%.
- Indirect costs compared to direct personnel costs made in The Hague, as an internal method; All project days in total represent an amount in direct personnel costs. All other personnel costs and costs for facilities are accounted for as indirect costs. In 2014, the planned percentage of indirect costs on direct costs was 91.2%, and realized is 100.25%. The increase in 2014 compared to the budget is due to a number of longer sick leaves and additional expenses for IT and HRM consultants.

- Indirect costs compared to direct personnel costs made in The Hague, in compliance with the USAID rules for accounting; Although the methodology does not differ drastically from our internal methodology, some cost categories and personnel categories included in our internal method have to be excluded as indirect costs in the USAID method. According to the USAID calculation the percentage for 2014 is 88.03%, while 82.11% was planned. In 2013 the percentage was 75,60%. The increase in percentage is caused by a number of longer sick leaves and additional expenses for IT and HRM consultants. The increase in indirect cost percentage is not in line with our long term aim to be more cost effective and mitigating actions for 2015 onwards have been planned.

The results of our internal key performance data shows an improvement compared to last year. Our goal to reach the planned number of direct days (100%) has been realized (105%).

Budget 2015 and possible risks

The full budget for 2015 is shown in the Statements of Income and Expenditure. The total income is budgeted on a consolidated level of €55.8 million. Of that amount, €30.0 million is compensation for implemented activities by the coalition partners of Challenge TB. Therefore, excluding consolidation, the total income is budgeted at €25.8 million, which is €1.7 million higher than the actual for 2014.
Income from government grants is budgeted to increase, related to the plans for activities in the first year of Challenge TB. Income from our share in third parties activities (e.g. lottery income) is budgeted to increase slightly. Investment income is budgeted conservatively at the same level as the budget for 2014. No unrealized gains and losses on investments are budgeted.

The total level of consolidated expenditures amounts to €56.7 million. Excluding the partners' activities, this leads to a total budgeted cost level of €26.7 million, which is €1.6 million higher than the actual for 2014. TB control in high prevalence countries is increasing compared to 2014, related to the activities in the first year of the Challenge TB project.

A number of budgetary and control risks can be identified:

- Controlling the balance between direct and indirect days is crucial for the financial results.
- A large part of KNCV's income for personnel fees is in US dollars. We have included an exchange rate in the budget of US$1.32 against €1. The actual rate at time of budgeting was US$ 1.25 (2 November 2014) and the dollar rate has increased to US$ 1.08 against € 1 since then. Careful liquidity planning and making use of simple hedging techniques will be needed to further control the risk. A strong dollar improves our competitive position and cost effectiveness in US$.
- A large part of the budget is for material costs in countries for the Challenge TB program. There is a risk that costs are identified as unallowable for USAID by independent auditors in countries or by the independent auditor who executes the overall audit.
- The income from legacies is budgeted at €300,000. This is an average amount reached in the past years, but this income is very difficult to estimate and the amount can be significantly higher or lower.

A contingency budget of € 200.000 has been included to deal with unexpected fall backs or to react to valuable opportunities.

Long term financial plan

An indication of a longer term financial plan is depicted in table 9. This overview excludes the reservation and use of a decentralization budget, because of its incidental character.
Possible growth of regional activities is not included, because it is hard to predict and it highly depends on access to funding and success of acquisition processes.

PROFIT & LOSS ACCOUNT

	Budget 2015	Long term forecast 2016	Long term forecast 2017	Long term forecast 2018
	In € 1 mln	*In € 1 mln*	*In € 1 mln*	*In € 1 mln*
Organizational costs				
Personnel related costs	8,49	8,66	8,64	8,61
Regional office costs	-	-	-	-
Other indirect costs	1,81	1,73	1,77	1,80
Subtotal organizational costs	10,30	10,39	10,40	10,41
Charged to projects	-9,71	-10,00	-10,00	-10,00
Total organizational costs not charged to projects	0,59	0,39	0,40	0,41
Investment and general income	0,12	0,12	0,12	0,12
Net result organizational costs	-0,47	-0,27	-0,28	-0,29
Activity costs				
Costs for fundraising	0,48	0,49	0,50	0,51
Other activity costs	0,27	0,27	0,27	0,27
Total Activity costs	0,75	0,76	0,77	0,78
Activity income				
Own fundraising	0,97	1,00	1,00	1,00
Lotteries	1,09	1,10	1,10	1,10
Total Activity income	2,06	2,10	2,10	2,10
Net result Activities	1,31	1,34	1,33	1,32
Project costs				
Charges organizational costs	9,71	10,00	10,00	10,00
Travel and accommodation	0,58	0,58	0,58	0,58
Material costs	15,03	20,00	20,00	20,00
Expenses coalition partners TBCARE I/ Challenge TB	30,00	35,00	35,00	35,00
Total Project costs	55,32	65,58	65,58	65,58
Project income				
Funding donors - fee	8,13	8,30	8,46	8,63
Funding donors - travel and accommodation	0,55	0,55	0,55	0,55
Funding donors - other direct project costs	14,46	19,90	19,90	19,90
Endowment funds contribution	0,31	0,31	0,31	0,31
Other income for projects	0,01	0,01	0,01	0,01
Income coalition partners TBCARE I/ Challenge TB	30,00	35,00	35,00	35,00
Total Project income	53,47	64,06	64,23	64,40
Net result Projects	-1,85	-1,51	-1,35	-1,18
General Result (minus is a deficit)	**-1,01**	**-0,45**	**-0,30**	**-0,15**
Covered by earmarked reserves / donated to earmarked reserves	**-0,78**	**-0,40**	**-0,30**	**-**
Influence on/movements other reserves	**-0,23**	**-0,05**	**0,00**	**-0,15**

Table 2: Long Term Financial Plan 2015-2018

FINANCIAL STATEMENTS 2014

BALANCE SHEET KNCV TUBERCULOSIS FOUNDATION PER 31 DECEMBER 2014

In Euro, after result appropriation

Assets		12/31/2014		12/31/2013	
Immaterial fixed assets	B1		-		-
Fixed Assets	B2		240.624		370.422
Accounts Receivable	B3	31.527.842		23.674.317	
Investments					
-Shares	B4	1.729.494		1.755.664	
-Bonds	B4	2.965.492		3.375.630	
-Alternatives	B4	922.029		573.581	
Cash and Banks	B5	13.497.523		8.786.733	
Current Assets			50.642.380		38.165.925
Total			**50.883.004**		**38.536.347**

Liabilities		12/31/2014		12/31/2013	
Reserves and funds	B6				
- Reserves					
Continuity reserve		7.180.533		6.423.985	
Decentralization reserve		1.084.791		1.149.543	
Earmarked project reserves		1.497.168		1.680.898	
Unrealized exchange differences on investments		651.136		794.464	
Fixed Assets reserve		240.624		370.422	
			10.654.252		10.419.311
- Funds					
Earmarked by third parties		476.515		463.281	
			476.515		463.281
Various short term liabilities	B7				
-Taxes and social premiums		318.587		886.805	
-Accounts payable		552.270		357.921	
-Other liabilities and accrued expenses		38.881.380		26.409.028	
			39.752.237		27.653.754
Total			**50.883.004**		**38.536.347**

STATEMENT OF INCOME AND EXPENDITURE KNCV TUBERCULOSIS FOUNDATION 2014

in euro

		Budget 2015	Budget 2014	Actual 2014	Actual 2013
Income					
- Private fundraising	R1	1.360.300	1.313.800	1.593.139	1.632.296
- Share in third parties activities	R3	1.092.500	1.092.500	1.075.270	1.183.428
- Government grants	R4	53.134.300	50.728.100	42.051.486	50.991.975
- Investment income	R5	145.000	147.000	480.559	363.320
- Other income	R6	18.700	18.700	15.300	13.161
Total Income		55.750.800	53.300.100	45.215.754	54.184.180
Expenses					
Expenses to mission related goals	R7				
- TB control in low prevalence countries		1.087.700	1.028.400	1.021.907	1.096.898
- TB control in high prevalence countries		50.850.100	49.099.100	40.289.380	49.381.534
- Research		1.654.200	961.000	1.140.021	951.277
- Education and awareness		834.400	651.600	580.628	594.088
		54.426.400	51.740.100	43.031.936	52.023.796
Expenses to fundraising	R8				
- Expenses private fundraising		410.800	349.900	392.094	283.768
- Expenses share in fundraising with third parties		51.100	50.700	21.240	49.516
- Expenses government grants		573.600	357.500	375.810	309.229
- Expenses on investments		43.500	42.200	44.439	43.354
		1.079.000	800.300	833.582	685.866
Administration and control	R9				
- Expenses administration and control		1.244.100	1.230.800	1.102.062	1.096.873
Total Expenses		56.749.500	53.771.200	44.967.580	53.806.536
Surplus / Deficit		**-998.700**	**-471.100**	**248.174**	**377.644**
Spent on mission compared to total expenses		95,9%	96,2%	95,7%	96,7%
Spent on mission compared to total income		97,6%	97,1%	95,2%	96,0%
Spent on private fundraising compared to income		30,2%	26,6%	24,6%	17,4%
Spent on administration and control compared to total expenses		2,2%	2,3%	2,5%	2,0%
Result appropriation					
Surplus / Deficit appropriated as follow					
Continuity reserve		-202.400	3.500	468.021	187.036
Decentralization reserve		-289.500	-111.100	-64.752	-119.655
Earmarked project reserves		-448.900	-319.100	-183.730	115.180
Unrealized differences on investments		P.M.	P.M.	145.199	250.743
Fixed Assets reserve		-	-	-129.798	-43.934
Earmarked by third parties		-57.900	-44.400	13.234	-11.726
Total		**-998.700**	**-471.100**	**248.174**	**377.644**

EXPENSE ALLOCATION KNCV TUBERCULOSIS FOUNDATION 2014

Expenses

	Budget 2015	Budget 2014	Actual 2014	Actual 2013
Grants and contributions	28.000	28.000	21.975	42.155
Purchases and acquisitions	15.832.600	11.776.200	12.210.704	15.981.346
Outsourced activities	30.000.000	32.500.000	23.134.198	28.492.071
Publicity and communication	756.000	708.500	612.483	589.744
Personnel	8.811.000	7.379.800	7.756.300	7.462.850
Housing	447.500	544.000	486.646	473.310
Office and general expenses1)	649.200	650.300	537.194	547.087
Depreciation and interest	225.200	184.400	208.079	217.972
Total	**56.749.500**	**53.771.200**	**44.967.580**	**53.806.536**

1) Including incidental profits and losses

Allocation to destination — **Related to the mission goals**

Actual 2014	Low prevalence countries	High prevalence countries	Research	Education and Awareness
Grants and contributions	17.746	-	4.229	-
Purchases and acquisitions	253.586	11.570.355	327.293	-
Outsourced activities	-	23.134.198	-	-
Publicity and communication	-	904	-	292.042
Personnel	669.894	4.913.285	732.399	253.344
Housing	36.278	335.892	36.078	16.633
Office and general expenses	29.688	213.659	25.388	11.862
Depreciation and interest	14.715	121.086	14.634	6.747
Total allocated	**1.021.907**	**40.289.380**	**1.140.021**	**580.628**

Allocation to destination

	Income fundraising				Administration & Control
	Private fundraising	Share in third parties activities	Grants	Investments	
Grants and contributions	-	-	-	-	-
Purchases and acquisitions	-	-	58.909	-	561
Outsourced activities	-	-	-	-	-
Publicity and communication	300.542	18.996	-	-	-
Personnel	60.195	2.244	282.417	17.279	825.244
Housing	4.653	-	17.013	402	39.696
Office and general expenses	24.817	-	11.005	275	220.500
Depreciation and interest	1.887	-	6.466	26.483	16.061
Total allocated	**392.094**	**21.240**	**375.810**	**44.439**	**1.102.062**

CASH FLOW STATEMENT KNCV TUBERCULOSIS FOUNDATION 2014

		Actual 2014		Actual 2013	
Surplus/ (Deficit) excl interest		236.689		360.968	
Interest paid/ received		11.485		16.676	
Total surplus / (Deficit)		248.174		377.644	
Depreciation - Fixed Assets		180.240		195.907	
Cash Flow from income and expenditure	C1		428.414		573.551
Investments		87.860		-463.061	
Accounts receivable		-7.853.525		26.468.322	
Non-current liabilities		-		-	
Current liabilities		12.098.483		-26.954.550	
Increase/ (Decrease) net working capital	C2		4.332.818		-949.289
Cash flow from operational activities	C3		4.761.232		-375.738
Disinvestments fixed assets		4.602		-1.826	
Investments fixed assets		-55.044		-150.147	
Cash flow from investments fixed assets	C4		-50.442		-151.973
Net cash flow			4.710.790		-527.711
Cash and banks as at 1 January			8.786.733		9.314.444
Cash and banks as at 31 December			13.497.523		8.786.733
Increase/ (Decrease) Cash on hand			4.710.790		-527.711

NOTES TO THE FINANCIAL STATEMENTS

Guideline 650 for accounting and reporting

KNCV Tuberculosis Foundation is subject to the 650 Guideline for Annual Reporting by Fundraising organizations. In the attached statements, the financial results of all activities and projects are presented according to the formats of the 650 Guideline. In the following notes the composition of the Balance Sheet is analyzed and commented. Furthermore, significant deviations between the 2014 results and budget and between 2014 and 2013 as shown in the Statement of Income and Expenses are clarified.

Consolidation

KNCV Tuberculosis Foundation is the prime contractor of a US government (USAID) funded program TB-CARE I, which runs from 1 October 2010 up to 30 September 2015 and a US government program Challenge TB, which runs from 1 October 2014 up to 30 September 2019. The programs are partly implemented by partners in the Tuberculosis Coalition for Technical Assistance (TBCTA). These implementation parts, the consequential current account positions and the contractual commitments towards the donor are taken into account in both the balance sheet and the statement of income and expenses of KNCV Tuberculosis Foundation. At the de-central level, where KNCV has a regional office and country offices, subaccounts are maintained for all local financial transactions. The subaccounts are fully consolidated in both the balance sheet and the profit & loss statement.

The book value of fixed assets ultimo 2014 amounts to € 240.624, which is lower than 2013. All fixed assets are used for operational management of the organization, like office inventory, office reconstructions and ICT equipment. KNCV does not possess any mission related assets which are activated on the balance sheet. Investments in new fixed assets for 2014 amounting to €55.044 were for, ICT equipment. Total depreciation is calculated at € 180.240. Assets that are no longer in use and are completely depreciated have been divested for an amount of € 48.169.
Tangible fixed assets are those assets needed to operationally manage the business. No assets have been included in the tangible fixed assets figures that have been directly used in the scope of the main activities.

Accounts receivable (B3)

The balance of accounts to be received is €31.5 million, which is €7.9 million higher than in 2013. The bulk of this amount consists of current account balances with projects, accounts receivables from donors and the financial contractual relation with coalition partners. Overall, the annual level of activities executed influences this balance significantly. Acquiring more or less grants from institutional donors can lead to a structural and significant decrease or increase of the amount.

Balance sheet per 31 December 2014 - Assets

Fixed Assets (B2)

Movements in the tangible fixed assets are as follows:

NOTES TO THE BALANCE SHEET AS AT 31 DECEMBER 2014

Assets

B2 Fixed Assets

Movements in the tangible fixed assets are as follows:

	Office reconstruction work	Office inventory	Computers	Total
as at 1 January, 2014				
Cost / Actual value	376.973	369.674	792.340	1.538.987
Accumulated depreciation	-318.400	-294.470	-555.695	-1.168.565
Book value	**58.573**	**75.204**	**236.645**	**370.422**
Increase / (Decrease) 2014				
Acquisitions	-	-	55.044	55.044
Disinvestments	664	-5.683	-43.150	-48.169
Depreciation on disinvestments	-664	6.767	37.464	43.567
Depreciation	-37.612	-34.295	-108.333	-180.240
	-37.612	**-33.211**	**-58.975**	**-129.798**
as at 31 December, 2014				
Cost / Actual value	377.637	363.991	804.233	1.545.861
Accumulated depreciation	-356.676	-321.998	-626.563	-1.305.237
Book value	**20.961**	**41.993**	**177.670**	**240.624**

	31/12/2014	31/12/2013
B3 Accounts receivable		
Dr. C. de Langen Foundation for Global TB control	55.033	526
Interest (on bonds)	33.228	32.918
Lotteries	231.489	305.354
Current Accounts project countries	2.997	-
Receivable USAID TB CARE I	334.989	257.152
Receivable USAID Challenge TB	210.312	-
Debtors	63.844	227.733
Payments in advance general	364.176	258.687
Payments in advance projects	46.213	451.506
Legacies in process	112.909	344.445
Other receivables	2.772	112.945
Accounts receivable USAID based on agreement	30.069.880	21.683.051
	31.527.842	**23.674.317**

The total account receivable from USAID for the TBCARE I and Challenge TB project, based on approved project workplans, increased with € 8.4 million to € 30.0 million. This amount is directly related to the work still to be performed in the close out year of TB CARE I and for the Challenge TB project amounts under projects to be executed and accounts payable to coalition partners represented under liabilities. The receivables include an amount of EUR 0 in receivables that fall due in more than one year.

Investments (B4)

KNCV Tuberculosis Foundation follows a defensive investment risk profile: 70% fixed income securities (country bonds or bonds with at least an A-rating), 20% shares (in participatory funds or in high value equity) and 10% real estate and alternatives. Management of the portfolio is outsourced to ABN AMRO/ MeesPierson.

- KNCV's objective is to optimize the return on investments, taking into account that:
- The risk of revaluation has to be minimized and a sustainable result has to be achieved by spreading tactics (allocation, time planning) and careful selection of new investments;
- Consistency in growth and composition of the portfolio, i.e. no significant fluctuations over time;
- Leading to a predictable cash flow, which supports the annual budget of the organization without being too dependent on its results;
- Maintaining the long-term value the of investments, i.e. the value of invested assets have to keep pace with the evolution of inflation;
- The influence on the whole portfolio of yield reduction of individual segments is limited;
- The portfolio only consists of sustainable investments, i.e. complies with the general definition of sustainability as used by investment banks and in relation to KNCV's mission.

The performance of ABN AMRO/MeesPierson as an administrator of the portfolio is assessed by the Audit Committee of the Board of Trustees annually and on a more frequent basis by the Executive Director and the Director Finance. The bank is instructed to take decisions for selling and buying within the limits of KNCV's investment and treasury policy.

The composition and results of the portfolio is described below and depicted in tables 10 to 13. As far as is relevant a comparison with 2013 is shown.

To determine the maximum level of investments, the level of the existing reserves and funds is used as a guiding target. In principle, 10% of total reserves is kept as liquidity, which leads to a maximum available level for investments of 90%. Calculations based on this principle shows that as per 1 January 2014, € 8.6 million was available and as per 1 January 2015, € 9.0 million. Both balance value (€5.6 million) and market value (€5.7 million) of the investments are below the maximum. Naturally, apart from this mathematical approach, an assessment of the situation on the market is also taken into account when transactions take place.

In table 10 the allocation of assets according to the reporting of ABN AMRO/MeesPierson is shown.[2] Part of the bank balance is attached to the investment portfolio and is kept as revolving fund for transactions in investments. This amount is therefore taken into account in the table. In 2013 this amount decreased due to investments in bonds and stocks. Ultimo 2014 bonds are underweighted compared to the target. The total of shares, real estate and alternatives is overweighed. All asset categories stay within the range allowed according to the investment policy.

B4 Investments	Shares	Bonds [2)]	Alternatives	Total
Balance as at 1 January, 2014	1.755.664	3.375.630	573.581	5.704.875
Purchases and sales	-204.754	-474.454	255.088	-424.120
Redemption of bonds	-	-	-	-
Realized stock exchange result	4.304	20.342	63.732	88.378
Unrealized stock exchange result	174.280	79.880	29.628	283.788
Amortization	-	-35.906	-	-35.906
Balance as at 31 December, 2014	**1.729.494**	**2.965.492**	**922.029**	**5.617.015**

[2)] Stock Exchange value of bonds as at 31 December, 2014 is € 3.090.339,-

Investment	Investment policy		1 January 2014		31 December 2014	
	Range	Target	In € million	%	In € million	%
Bonds	80-50%	70%	3,40	55,7%	3,10	49,2%
Shares/Real Estate/Alternatives	0-50%	30%	2,30	37,7%	2,60	41,3%
Liquidities		0%	0,40	6,6%	0,60	9,5%
Total			6,10	100,0%	6,30	100,0%

Table 10: Asset allocation ultimo 2014 compared to the policy (source: Quarterly report ABN AMRO/MeesPierson)

Bonds are mostly from the national government and from national financial institutions. Shares and real estate funds are all tested against sustainability criteria with underlying values in European and worldwide operating companies. In principle, bonds are bought with a long term investment horizon. The remaining running period is categorized in table 11.

Duration bonds			
Running period remaining	2012	2013	2014
0 to 2 years	6%	0%	0%
2 to 5 years	0%	28%	22%
5 to 8 years	18%	24%	25%
>8 years	75%	48%	53%

Table 11: Maturity of bonds

[2] These figures differ from the figures in the financial statements due to valuation based on market value.

BREAKDOWN INVESTMENTS PORTFOLIO 2014

Fund	Interest %	Nominal value 1/1	Historic purchase value 1/1	Value in balance sheet 1/1	Transactions in reporting year nominal: Purchased	Sold	Redemption of bonds	Transactions in reporting year in actual prices: Purchased	Sold	Redemp-tion of bonds	Nominal value 31/12	Historic purchase value 31/12	Value in balance sheet 31/12
Shares													
ABN Amro Global Sri Equit acc			124.950	132.563					13.753			121.336	137.679
ASN Duurzaam Fund 3			99.072	131.622				1.443	8.863			94.708	144.159
ASN Environment and Waterfund			77.739	106.912					11.160			70.775	105.277
Luxellence sust Europe eq			84.830	136.427				24.187	9.196			104.172	158.021
Calvert Soc. Inv. FND-A-Eq. Port			174.443	225.655					26.365			160.797	227.190
Calvert Int. Eq. Fund a 1/1000			157.488	200.413					50.504			125.968	156.373
Celsius Sust Emerging Markets			149.169	153.505				110.493	69.861			199.313	215.118
F&C portf Stewardship int			86.667	135.464					30.365			106.631	120.571
Henderson Global Care Fd			108.077	150.640					49.290			113.580	119.732
ING Duurzaam Aandelen Fonds			105.239	122.660				1.232	29.309			82.580	112.953
Kempen Sust small cap			86.455	140.623				3.259	11.022			84.145	134.750
Triodos Sust. Eq. Fund dis			90.692	119.180				123	35.802			63.440	97.671
Subtotal shares		**-**	**1.344.822**	**1.755.664**				**140.736**	**345.488**	**-**	**-**	**1.327.445**	**1.729.494**
Real estate/Alternatives													
CFS Retail Prop Trust			69.462	54.839				95.834	171.314			-	-
Hammerson Plc a GBP 0.25			29.101	30.091				55.948	98.191			-	-
Land Securities Group			67.996	80.280				93.523	192.387			-	-
Triodos vastgoedfonds NV			69.698	32.971					29.975			-	-
Triodus Renewable Europe			26.610	28.082				28.262	57.537			-	-
Triodus II/Microfin I cap			180.784	224.631					231.708			-	-
Unibail - Rodamco			30.555	42.279				84.927	133.269			-	-
Units Respons glb Micro fin fd			75.983	80.408					81.426			-	-
Previum Sustainable Alternatives			-	-				892.400				892.400	922.028
Subtotal real estate/altern.		**-**	**550.189**	**573.581**				**1.250.894**	**995.807**	**-**	**-**	**892.400**	**922.028**
Bonds													
BNG 10-17	2,500	95.000	101.460	99.288			95.000			101.745	-	-	-
Duitsland 09-20	1,750	290.000	345.422	332.226							290.000	345.422	325.188
Ierland 04-20	4,500	-	-	-	230.000			272.504			230.000	272.504	265.420
Ned.Water. Bank 12-19	1,625	100.000	102.072	101.727							100.000	102.072	101.382
Ned.Water. Bank 05-20	3,875	140.000	160.272	155.446							140.000	160.272	152.872
Ned.Water. Bank 08-18	4,375	175.000	204.340	198.472							175.000	204.340	192.604
Nederland 08-18	4,000	115.000	135.240	115.000			115.000			130.870	-	-	-
Nederland 09-19	4,000	195.000	221.968	214.664							195.000	221.968	210.731
Oostenrijk 2017	4,300	335.000	393.873	379.155		335.000				378.919	-	393.873	-
Rabobank 10-17	3,375	150.000	150.000	150.000							150.000	150.000	150.000
SSGA euro sustainable corp bonds	perp	1.643.645	1.555.433	1.629.652				134.161	276.398		1.487.412	1.438.094	1.567.295
Subtotal bonds		3.238.645	3.370.080	3.375.630	230.000	335.000	210.000	406.665	276.398	611.534	2.767.412	3.288.545	2.965.492
Total		**3.238.645**	**5.265.092**	**5.704.875**	**230.000**	**335.000**	**210.000**	**1.798.295**	**1.617.693**	**611.534**	**2.767.412**	**5.508.390**	**5.617.014**

Table 12: Composition of the investment portfolio and historical values

An overall result of 8,3% (benchmark: 13,7%; 2013: 5,2%) is realized. Below, a comparison between our 2014 portfolio, the benchmark and the results for 2013 is shown per asset category:

- Bonds; 2014 6,1 %, benchmark 13,2%[3], 2013 0,7%
- Shares; 2014 13,6%, benchmark 14,1%[4], 2013 20,0%.
- Real estate/alternative assets; 2014 15,1%, benchmark 16,0 % [5], 2013 1,0%.
- Liquidity available for investments; 2014 1,5 % (includes investment expenses), benchmark 0 %[6], 2013 -1,7%.

In absolute terms and in comparison with the long term expected result of 5% the portfolio performed satisfactory. Compared to the benchmark it only performed marginally better, mostly due to overweighing of shares. The result for real estate was negatively affected by change of one fund from a semi-open end fund to a closed- end fund. Bonds showed a low return, with Dutch and German bonds in general even showing a negative return.

In table 6 and figure 3, as required by the sector organization for charities, VFI, the investments results over a 5 year period are depicted. The figure also shows the accumulated result over the years.

Table 6: Investment results 2010-2014

5 Year period overview

Description	2010	2011	2012	2013	2014
Bond income	148.093	105.740	88.899	109.447	78.764
Depreciation of amortization	-	-	-12.496	-35.906	-26.842
Dividend	21.161	18.094	34.085	28.435	44.986
Realized exchange results	48.771	8366	99.942	-6.075	226.913
Unrealized exchange results	176.480	-104.208	275.842	250.743	145.253
Interest on cash on hand and deposits	34.266	25.585	17.948	16.676	11.485
Gross investment income	428.771	53.577	504.220	363.320	480.559
Investment expenses	19.781	28.690	17.500	19.754	26.320
Net investment income	**408.990**	**24.887**	**486.720**	**343.566**	**454.239**

Net investment income 2010-1014

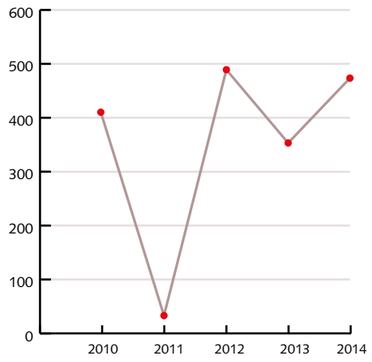


Figure 3

[3] 50% EU, 40% world and 10% emerging markets.

[4] Citigroup EGBI all maturities.

[5] 50% GPR250 Global (vastgoed), 50% 3 months euribor + 2%.

[6] 3 months Euribor.

The Executive Board confirms that all transactions in 2014 have been executed in compliance with the Investment Policy. This has been monitored by analyzing the monthly and quarterly reports of the investment bank and by discussing the results during periodical meetings.

Cash and banks (B5)

The balance of cash and banks increased compared to 2013, with €4.7 million to a level of €13.5 million. The main reason for this increase is that an advance payment for project expenses for TB CARE I and Challenge TB for the first two months of 2015 was received at the end of December. Ultimo 2014 no deposits were available, because interest rates on deposits during 2014 were still not more beneficiary to the result than balances on savings accounts.
Part of the bank balance is still available for long term investment in shares or bonds, once there are more positive developments in the global financial markets.

	31/12/2014	31/12/2013
B5 Cash and banks		
Immediately available		
Petty cash	5.941	8.944
ING	284.326	439.978
ABN AMRO bank	1.151.155	405.471
ABN AMRO (USD account)	4.828.865	2.977.761
ABN AMRO investment account	575.706	434.986
ABN AMRO Challenge TB	3.302.993	-
ABN AMRO TBCARE I	1.097.827	2.882.367
Bank accounts country offices	2.250.710	1.637.226
	13.497.523	**8.786.733**

Balance sheet per 31 December 2014 - Liabilities

Reserves (B6)

- Continuity reserve

  The continuity reserve serves as a buffer for unexpected fall backs, both in expenditures and in income. The objective of the reserve is to temporarily guarantee the continuity of the activities, while having enough time to take measures to adjust the organizational structure and –volume to fluctuations in the volume of mission related activities. For this continuity demand, the Board has not earmarked the reserve with a specific spending destination.
  We use 1 to 1.5 times the estimated and budgeted expenditures for the organization for one year as a reasonable maximum level of the reserve. Mission related activity expenditures are excluded of the calculation. Based on the budget for 2015 for organizational costs (€10.1 million) the continuity reserve's maximum is €10.1 to €15.2 million. The reserve ultimo 2014, €7.2 million, stays well within the maximum (0.7 times the budget for organizational costs in 2015). The underlying risks to be covered by the continuity reserve are analysed each year during the annual planning and budgeting process. At that point possible risks are identified and, if possible, quantified to calculate the maximum amount needed in the continuity reserve. It is expected that the risk of discontinuity of (parts of the) organization and long term commitments can be covered by the current level of the continuity reserve.
  During the period 2011 – 2013 the amount that was added to the revaluation reserve for unrealized investment gain has been too high, due to an incorrect allocation to realized and unrealized investment gains.

The total investment income per year was represented correctly, but divided between realized and unrealized investment gains incorrectly. For this reason an amount of € 288,527 was deducted from the revaluation reserve and added to the continuity reserve.

	Balance as at 1/1/2014	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2014
Continuity reserve	6.423.985	288.527	-	468.021	7.180.533

- Earmarked project reserves

  Some parts of our equity have been earmarked by the Board to a number of specific objectives, with approval of the Board of Trustees. This gives the organization the possibility to either anticipate on unexpected opportunities or to give extra focus to strategic areas. In the coming years, parts of the reserves will be used for extra activities in innovation, research and high- and low prevalence TB control. In 2014, an amount of €201.730 has been withdrawn from the earmarked project reserves for these kinds of activities. For 2015 €434.000 is budgeted to be used.

	Balance as at 1/1/2014	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2014
Fund national policy planning	232.434	-	-	-30.635	201.799
Fund international policy planning	232.966	-	-	-	232.966
Fund research policy planning	219.579	-	-	-20.553	199.026
Fund special needs	112.823	-	-	18.254	131.077
Fund E-learning (SVOP)	53.474	-	-	-43.251	10.223
Fund innovations	328.838	-	-	-68.336	260.502
Fund capacity building	500.784	-	-	-39.209	461.575
Total earmarked by the board	1.680.898	-	-	-183.730	1.497.168

- Decentralization reserve

  The Decentralization Reserve is the portion of reserves which is dedicated by the Board of Trustees to serve as a buffer for expenses related to the planned decentralization of the organization.
  In 2014, the decentralization reserve was allocated towards expenses to be incurred for the capacity building of country office staff in the years 2014-2017. In 2014, the amount of €64.752 was withdrawn from this reserve.

	Balance as at 1/1/2014	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2014
Decentralization reserve	1.149.543	-	-	-64.752	1.084.791

- Unrealized exchange difference on investments

  This reserve serves as a revolving fund for unrealized exchange results on investments, which are not available for mission related activities until they are actually realized. In compliance with Guideline 650, unrealized exchange results are accounted for in the Statement of Income and Expenditure and are therefore part of the surplus or deficit in the annual accounts. Ultimo 2014 the reserve contains € 651.136.

The movement in the reserve is as follows:

	Balance as at 1/1/2014	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2014
Total revaluation reserve	794.464	-288.527	-	145.199	651.136

The movement of € 288,527 represents the amount that was corrected on the revaluation reserve for the period 2011-2013 and added to the continuity reserve.

- Fixed Assets reserve

  KNCV Tuberculosis Foundation separates equity, needed to finance the remaining value of fixed assets, which is allowed by Guideline 650. In 2014, the reserve decreased to an amount of €240,624.

Balance at 1 January, 2014		**370.422**
Add: purchases fixed assets	55.044	
Less: sale of fixed assets	-48.169	
Less: depreciation of fixed assets	-180.240	
Add: depreciation on sale or disinvestments	43.567	
Movement in reserve		-129.798
Balance at 31 December, 2014		**240.624**

Funds earmarked by third parties (B6)

In the past, some resources received from third parties have not been used in full and still have an earmarked spending purpose. In the coming years, parts of these funds will be used for international and research activities. Most of the funds do not have spending deadlines. Use of the funds is budgeted according to the activity plans. In 2014 an amount of € 69,313 is used.
In 2014 an amount of € 55.000 was received the Dr. C. de Lange Stichting voor Mondiale Tuberculosebestrijding (SMT) for a KNCV Young Talent Scolarship program. Part of this amount was used in 2014, an amount of € 48,217 was added to an earmarked fund to be used in 2015.

	Balance as at 1/1/2014	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2014
Fund TSRU	155.513	-	-	3.535	159.048
Fund Special Needs	255.610	-	-	0	255.610
Funds Van Geuns	44.223	-	-	-36.348	7.875
Unspent Funds for objectives	7.935	-	-	-2.170	5.765
Young Talent Scolarship	-	-	-	48.217	48.217
	463.281	**-**	**-**	**13.234**	**476.515**

Fund Tuberculosis Surveillance and Research Unit (TSRU)

In 1993 the financial management of the TSRU was transferred to KNCV Tuberculosis Foundation, being one of the members of the TSRU. KNCV Tuberculosis Foundation henceforth became responsible for the funds transferred to it, its corresponding financial management and reporting to the steering Committee of the TSRU. The utilization of these funds has no time limit.

Fund special needs

This fund was established from the funds arising out of the dissolved "De Bredeweg" foundation in 1979 and subsequent related additions. All rights and responsibilities to these funds were given to KNCV Tuberculosis Foundation but may only be utilized for the continuation of the dissolved foundation's works. The utilization of these funds has no time limit. Should the KNCV Fund special needs under earmarked project reserves run out of funds this Fund special needs can be utilized for that purpose.

Van Geuns Foundation

The Dr. H.A. van Geuns Foundation donated an amount of € 65.931 in 2013 for the project "E-learning Module Praktische Tuberculosebestrijding Sociaal Verpleegkundigen". This project will be finalized in 2015.

Unspent funds for mission related goals

This fund relates to the reservation of underspending on projects that were co-financed by third parties. In consultation with these third parties it is yet to be agreed how these funds will be utilized. During the last few years the funds have been used for in TB/HIV research in Kenya and capacity building of local staff.

Various liabilities (B7)

The total of Various liabilities has increased from €26.4 million in 2013 to €38.9 million in 2014 and includes under Other liabilities €27.9 million of contractual committed projects still to be executed for USAID and €5.1 million value of sub-agreements with coalition partners. As clarified on the Accounts receivable side, the level of projects and activities agreed in grants is the main cause for fluctuation in the liabilities. A large part of Other Liabilities and Accrued Expenses is taken up by a provision for leave hours, which have not been used by employees up to now. The level of the amount for this provision at the end of 2014 is €639,599 million, which is higher than the amount in 2013. The increase is a result of a significant increase of outstanding leave days for a limited number of staff members.

B7 Various short term liabilities

	31/12/2014	31/12/2013
Taxes and social premiums		
Income tax	296.610	284.997
Social premiums	21.977	601.808
	318.587	**886.805**
Accounts payable	552.270	357.921
Other liabilities and accrued expenses		
Provision for holiday pay	210.770	225.466
Provision for annual leave	639.599	589.150
Declarations from staff	24.670	16.719
Audit fees	40.104	33.885
Payable WHO	77.610	80.281
Current account - Dutch Ministery of Foreign Affairs	710.077	40.932
Bakhuijs Roozeboomstichting	-	15.000
Current Accounts project countries	-	59.822
Other donors	534.776	45.015
Other liabilities	67.591	63.921
Project payables KNCV country offices	863.841	226.273
Current account USAID	2.541.192	978.238
KNCV projects to be executed	-112.767	-26.228
Other	1.423	-194
Accruals TBCTA partners balance	300.301	326.129
Projects to be executed under TB CARE I	27.918.184	7.337.298
Accounts payable TB CARE I coalition partners	5.064.010	16.397.321
	38.881.381	**26.409.028**

All current liabilities fall due in less than one year. The fair value of the current liabilities approximates the book value due to their short-term character.

Liabilities not included in the balance sheet

Office rental contract

In 2005 a rental contract was signed by KNCV Tuberculosis Foundation with a third-party lessor for its offices on 17 Parkstraat in the Hague. The rental contract was for 10 years, ending on 31 December, 2014. In 2014 this was extended until 30 June 2015. The annual rent is € 398.412 including maintenance fee and VAT). A € 86.256 bank guarantee has been issued in favour of the lessor.
In 2015 a rental contract was signed by KNCV Tuberculosis Foundation with a third-party lessor for offices on Benoordenhoutseweg 46 in the Hague (Van Bylandthuis). The rental contract is for 5 years, ending on 31 May 2020, with an option to extent for 5 years. The annual rent is € 248.369 including maintenance fee and VAT). A € 62.092 bank guarantee will be issued in favor of the lessor.
The rental contract for KNCV Tuberculosis Foundation's regional office in Almaty, Kazakhstan is € 26.628 annually. This contract ends 31 December 2015.

Conditional commitments

TBCARE I

Of the total amount of US$ 229.990.000 in the cooperative agreement for TB CARE I (2010-2015) an amount of US$ 226,003,683 has been obligated and planned. Of this amount US$ 214,295,872 has been expensed.

Challenge TB

On 30 September 2014 KNCV Tuberculosis Foundation signed a cooperative agreement with USAID for a five year program with a ceiling of US$ 524,754,500 and a cost share of US$ 36,732,815.

TBCAP and TBCARE I

The audit according to the USAID guidelines of the fourth year of TB CARE I still has to be conducted. As a consequence, the indemnities of the related project expenditures have not been finalized. Their costs and revenues are accounted for in the profit and loss statement for 2014. For this uncertainty, which is based on currently known data, the financial impact cannot be estimated.

TBCARE I cost share

The cooperative agreement between KNCV and USAID for TBCARE I shows a cost share of 15,7% of total expenses, to be divided between all TBCARE I coalition partners. Based on the total expenses until 31 December 2014 this amounts to US$ 35,325,000. Until 31 December 2014 the declared cost share is US$ 32,438,979.

Statement of Income and Expenditure

In the following sections, all actual results are compared with the budget and with the previous year actual results.

Income

In total KNCV Tuberculosis Foundation generated less income in 2014 (€ 45,2 million), compared to 2013 € 54,2 million).

In table below the total income for 2014 is compared with the budget and with 2013. In the tables to follow each income category is further clarified.

Total income	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
Own share	20,80	22,12	25,69	6%	-16%
Coalition partners share	32,50	23,10	28,49	-29%	-23%
Total	53,30	45,22	54,18	-15%	-20%

The biggest decrease was realized in income received from government grants, specifically from USAID for activities performed by coalition partners under TB CARE I.

Private fundraising	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
	1,31	1,59	1,63	21%	-3%

Private fundraising income was 20% higher than planned, mostly due to higher legacy income and income from other private donors, such as SMT. The decrease compared to 2013 is caused by lower legacy income compared to 2013.

R1 Income from private fundraising	Budget 2015	Budget 2014	Actual 2014	Actual 2013
Donations and gifts				
Sonnevanck Foundation	15.000	18.000	18.000	18.000
Mr. Willem Bakhuijs Roozeboom Foundation	15.500	20.000	20.000	20.000
Dr. C. de Langen Foundation for global TB Control	283.000	270.000	330.500	270.500
Direct marketing activities	545.000	686.000	574.327	588.608
Gifts- other	50.000	25.000	61.405	55.145
Total donations and gifts	**908.500**	**1.019.000**	**1.004.232**	**952.253**
Contributions by association members	500	500	440	510
Sponsoring	50.000	-	-	-
Legacies and endowments	300.000	250.000	316.604	440.578
Other income from private fundraising	101.300	44.300	271.863	238.955
Total income from private fundraising	**1.360.300**	**1.313.800**	**1.593.139**	**1.632.296**

Share in third party activities	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
	1,09	1,08	1,18	-1%	-9%

Income from third party campaigns decreased with 1% compared to budget, and 9% compared to 2013 due to the fact that income for 2013 was estimated too high.
The income from third party campaigns consists of contributions from two large Dutch lottery organizations: the **VriendenLoterij** and **De Lotto.** The amount consists of earmarked sold lottery tickets, general participation in the lotteries and settlements from previous years. The latter is caused by the fact that each year at the time of the closing date, the contribution from De Lotto is not announced yet and is therefore based on an estimate. Deviations from this estimate are accounted for as settlements from previous years. In the budget we always chose to estimate the income from lotteries conservatively, which is the cause of the difference with the actual figure.

		Budget 2015	Budget 2014	Actual 2014	Actual 2013
R3 Income from fundraising by third parties					
Settlement previous years		-	-	-19.495	43.295
Vriendenloterij	earmarked lottery tickets	770.000	770.000	73.213	91.634
Vriendenloterij	non-earmarked lottery tickets			709.677	704.565
De Lotto		322.500	322.500	311.875	343.934
Total from fundraising third parties		**1.092.500**	**1.092.500**	**1.075.270**	**1.183.428**

Government grants	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
Own share	18,23	18,95	22,50	4%	-19%
Coalition partners share	32,50	23,10	28,49	-29%	-23%
Total	**50,73**	**42,05**	**50,99**	**-17%**	**-21%**

KNCV's 2014 share in the USAID funded programs TBCARE I and Challenge TB, with € 40.5 million, amounts to 96% of the total figure for government grants.
The contribution to TB control in The Netherlands from the CIb has decreased to €0.6 million in 2014, as a result of an announced three year grant reduction. The budgeted amount for this grant in 2015 will be € 0.6 million. From a large group of other smaller government donors, a total of €1.0 million was received, which is higher than the budgeted amount. For 2014, government grants determined 93% of KNCV's budget.

	Budget 2015	Budget 2014	Actual 2014	Actual 2013
R4 Government grants				
Center for disease control	554.590	621.854	611.956	710.922
USAID	18.433.381	16.846.696	17.335.128	21.153.169
WHO			118.204	30.914
Global Fund/GFATM	4.146.329	759.550	243.860	79.421
Other Donors			608.140	525.478
Subtotal	23.134.300	18.228.100	18.917.288	22.499.904
USAID grants coalition partners	30.000.000	32.500.000	23.134.198	28.492.071
Total government grants	**53.134.300**	**50.728.100**	**42.051.486**	**50.991.975**

Investment income and other income	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
	0,17	0,50	0,36	194%	28%

With the investment portfolio and interest on bank balances KNCV we earned an amount of €0.33 million as realized income and made a profit of € 0.15 million as unrealized exchange differences. The unrealized part was not budgeted for, which explains the difference with the budget. In 2013, the unrealized exchange differences were a profit of €0.25 million. The increase compared to 2013 is caused by higher realized exchange gains in 2014.

	Budget 2015	Budget 2014	Actual 2014	Actual 2013
R5 Income from investments				
Dividends	25.000	20.000	44.986	28.435
Bond earnings	90.000	94.000	60.764	91.447
Bond earnings on behalf of Fund Special Needs	18.000	18.000	18.000	18.000
Realized exchange gains	-	-	226.913	-6.075
Unrealized exchange results	-	-	145.253	250.743
Interest on cash on hand and deposits	12.000	15.000	11.485	16.676
Depreciation of amortization of bond value	-	-	-26.842	-35.906
	-			
Total from investments	**145.000**	**147.000**	**480.559**	**363.320**
Total cost investments (Reported under expenses investments)	26.000	26.000	26.320	19.754
Net investment income	**119.000**	**121.000**	**454.239**	**343.566**
R6 Other Income				
Endowment funds fee on administration & control costs	5.500	5.500	5.500	5.500
Miscellaneous	13.200	13.200	9.800	7.661
Total Other Income	**18.700**	**18.700**	**15.300**	**13.161**

Expenditure

Total expenditures in 2014 were € 44.97 million, which is € 8.8 million lower than budgeted. The decrease is caused by lower expenditures in the category "TB in high prevalence countries", mainly for TBCTA coalition partners. Expenditures in the category "fundraising" showed a small increase compared to budget and expenditures in the category "administration and control" showed a decrease compared to budget.

In table below the total expenses for 2014 are compared with the budget and with 2013. In the tables to follow each income category is further clarified.

Total expenditure	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
Own share	21,27	21,87	25,32	3%	-16%
Coalition partners share	32,50	23,10	28,49	-29%	-23%
Total	**53,77**	**44,97**	**53,81**	**-16%**	**-20%**

96.0% of the total income is spent on mission related activities. The decrease of € 8.8 million compared to 2013 is, again, caused by lower expenses from coalition partners, mainly due to the close out of TB CARE I and the delayed startup of Challenge TB.

Expenses to mission related goals	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
Own share	19,20	19,90	23,53	4%	-18%
Coalition partners share	32,50	23,10	28,49	-29%	-23%
Total	**51,70**	**43,00**	**52,02**	**-18%**	**-21%**

In 2014, 95.7% of all expenses are spent on mission related activities. In 2013, this percentage was 96.7%. The activities in low prevalence countries took 2% of the total amount, high prevalence countries 94%, research activities 3% and education/awareness 1%. The decrease compared to 2013 runs parallel with the decrease in income from government grants and can be fully clarified by the decreased pace of TBCARE I activities in "TB high prevalence countries", due to the close out of the project.

	Budget 2015	Budget 2014	Actual 2014	Actual 2013
R 7 Expenses to mission related goals				
- TB control in low prevalence countries	1.087.700	1.028.400	1.021.907	1.096.898
- TB control in high prevalence countries				
-- executed by KNCV	20.850.100	16.599.100	17.155.182	20.889.463
-- executed by TB CARE I coalition partners	30.000.000	32.500.000	23.134.198	28.492.071
- Research	1.654.200	961.000	1.140.021	951.277
- Education and awareness	834.400	651.600	580.628	594.088
Total expenses to the mission	**54.426.400**	**51.740.100**	**43.031.936**	**52.023.796**

Specification - per country, independent from nature of the project	Budget 2015	Budget 2014	Actual 2014	Actual 2013
Netherlands	1.028.900	1.179.800	1.235.380	1.268.213
Africa				
- Regional Office	-	169.300	14.742	96.280
- Botswana	386.200	235.300	260.700	236.793
- Congo	-	-	13.117	-
- Ethiopia	2.111.300	1.900.300	2.053.850	1.849.148
- Ghana	7.400	67.400	111.559	99.866
- Kenya	162.300	16.600	101.661	1.965.005
- Liberia	-	-	1.731	14.567
- Malawi	-	-	341	-
- Mozambique	199.900	230.200	196.688	217.819
- Namibia	2.597.500	1.743.100	1.268.741	1.637.099
- Nigeria	2.953.900	2.423.700	2.896.351	3.853.452
- Rwanda	-	10.300	50.919	53.827
- Senegal	-	-	-	9.407
- South Sudan	29.800	65.000	8.671	49.216
- Tanzania	-	56.200	96.029	49.164
- Uganda	-	-	15.631	928.865
- Zambia	185.900	251.700	285.747	221.952
- Zimbabwe	124.100	148.100	272.017	180.121
Subtotal Africa	8.758.300	7.317.200	7.648.495	11.462.581
Asia				
- Afghanistan	-	33.400	56.126	73.587
- Bangladesh	-	45.000	44.745	2.034
- Cambodia	16.300	66.400	15.745	46.842
- China	-	-	-	36.570
- India	-	-	15.498	-
- Indonesia	4.124.500	3.692.200	3.297.135	4.151.011
- Pakistan	-	-	66.135	193.831
- Vietnam	714.500	710.300	858.949	569.697
Subtotal Asia	4.855.300	4.547.300	4.354.333	5.073.572
South America				
- Chili	-	-	-	6.757
- Dominican Republic	-	-	-	234.379
Subtotal South America	-	-	-	241.136
Eastern Europe				
- Regional office	-	158.100	51.393	32.225
- Kazakhstan	81.300	870.000	1.030.701	892.584
- Kyrgyzstan	635.100	636.500	647.510	618.358
- Moldova		-	5.606	-
- Mongolia	-	-	-	24.174
- Ukraine	-	16.700	16.332	27.730
- Uzbekistan	41.900	35.900	153.846	87.578
- Tajikistan	1.104.800	918.400	1.021.151	742.490
- Turkmenistan	-	-	-	23.087
Subtotal Eastern Europe	1.863.100	2.635.600	2.926.539	2.448.226
Non-country or region related projects	8.931.300	4.358.016	4.699.880	3.802.025
TB CARE I coalition partners	30.000.000	32.500.000	23.134.198	28.492.071
Expenses charged to other expenditure categories [5)]	-1.010.500	-797.816	-966.889	-764.028
Total expenses to the mission	**54.426.400**	**51.740.100**	**43.031.936**	**52.023.796**

[5)] This specification is based on the method KNCV Tuberculosis Foundation applies for costs to donor projects and contracts to be allocated, what is needed for internal management and external accountability project. To reconcile with the allocation to the four main objectives as reported in the format of Guideline 650 for annual reporting of fundraising organizations a separate line is included.

Expenses to fundraising	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
	0,80	0,83	0,69	4%	17%

In all categories of fundraising and acquisition activities, including those for private fundraising, €0.8 million was spent. This was higher than the budget and also higher than the level of 2013. For private fundraising a percentage of 24,6% of the income has been spent as costs. This is below the CBF maximum %.

Administration and control	Budget 2014 in € million	Actual 2014 in €million	Actual 2013 in € million	% difference budget	% difference last year
	1,23	1,10	1,10	-11%	0%

Costs for administration and control were 11% lower than planned. Savings were realized on other expense categories (IT, housing). Compared to 2013, the costs are at the same level.

	Budget 2015	Budget 2014	Actual 2014	Actual 2013
Personnel expenses				
Salaries	6.443.200	5.343.200	5.703.331	5.778.928
Accrued annual leave	46.600	33.000	74.326	-34.946
Social security premiums	643.000	404.600	463.133	382.833
Pension premiums	647.700	530.100	518.970	487.942
External staff/temporary staff	150.000	130.000	393.386	233.664
Expenses regional offices	188.300	160.000	74.976	42.289
Capacity building decentralization	2.500	111.100	17.961	102.138
	8.121.300	6.712.000	7.246.083	6.992.848
Oncharged staff expenses to third parties	-	-	-	-
Sub total	8.121.300	6.712.000	7.246.083	6.992.848
Additional staff expenses				
Commuting allowances	98.350	105.850	91.066	87.364
Representation	6.000	3.450	1.055	5.719
Social event	5.200	4.500	9.396	7.439
Congresses and conferences	52.000	35.000	42.532	25.718
International contacts	56.500	30.000	48.003	39.727
Training & Education	129.800	106.900	76.090	95.094
Recruitment	10.000	10.000	9.499	21.693
Insurance personnel	20.000	16.000	15.584	13.247
Catering	22.000	20.000	16.959	16.565
Works council	21.600	27.200	16.977	13.158
Expenses regional offices	19.900	-	50.382	56.275
Other	218.350	278.900	104.181	76.578
Sub total	659.700	637.800	481.724	458.577
Other human resource management costs				
Development of tools	20.000	15.000	25.832	5.458
Safety training	10.000	15.000	2.661	5.967
Sub total	30.000	30.000	28.493	11.425
Total personnel expenses	**8.811.000**	**7.379.800 0**	**7.756.300**	**7.462.850**
Average number of fte's	87,6	73,0	71,4	75,4

	Budget 2015	Budget 2014	Actual 2014	Actual 2013
Housing expenses				
Rent	273.400	332.000	314.198	305.704
Repairs and maintenance	4.000	4.000	5.011	3.760
Cleaning expenses	40.000	45.000	42.230	42.636
Utilities	71.100	78.000	67.688	72.756
Insurance and taxes	1.800	1.800	3.081	1.869
Plants and decorations	28.000	60.800	12.900	9.286
Housing expenses regional offices	29.200	22.400	41.538	37.299
Total housing expenses	**447.500**	**544.000**	**486.646**	**473.310**
Office and general expenses				
General office supplies	18.500	12.000	8.876	7.471
Telephone	39.000	31.000	31.892	27.946
Postage	12.000	12.000	9.908	10.875
Copying expenses	33.000	31.000	31.064	27.819
Maintenance - machines, furniture	1.000	1.000	566	259
Professional documentation	4.200	4.500	3.625	2.348
IT costs	180.700	158.700	102.730	95.371
Audit fees	73.500	73.500	93.014	73.670
Board of Trustees	10.000	10.000	8.237	8.875
Consultancy	52.500	32.500	128.170	36.882
Bank charges	20.000	20.000	20.746	21.354
Reorganization expenses	-	-	10.460	113.712
Other	175.500	172.300	78.463	60.819
Office and general expenses regional offices	29.300	91.800	9.443	59.686
Total office and general expenses	**649.200**	**650.300**	**537.194**	**547.087**
Depreciation and interest				
Office reconstruction work	22.500	37.400	37.612	37.677
Office inventory	42.600	34.000	34.295	35.057
Computers	131.600	77.500	108.636	123.174
Regional offices	2.500	9.500	1.378	144
Investment costs	26.000	26.000	26.158	21.920
Total depreciation and interest	**225.200**	**184.400**	**208.079**	**217.972**

Operating result

The balance between income and costs is a surplus of €0.3 million, while a deficit of €0.5 million was planned. The main causes of the difference with the budgeted figures are incidental: a realized investment income of €0.2 million, higher income from private fundraising, mainly legacies and other income € 0.3 million, and lower expenses for administration and control (€0.1 million).
A proposal for appropriation of the result is presented as part of the annual report, on page 87.

Cash flow statement

The increase in cash and banks in 2014 is caused by a positive cash flow from income and expenses and a positive cash flow resulting from the increase in project liabilities compared to project receivables. This results in a positive cash flow from operational activities and a negative cash flow from tangible fixed assets (investments).

ACCOUNTING POLICIES

Organizations' general data

The 'Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose' (KNCV, using the name KNCV Tuberculosis Foundation) resides at Parkstraat 17 in The Hague[1], The Netherlands. Under its Articles of Association, KNCV Tuberculosis Foundation has as its statutory objective:
The promotion of the national and international control of Tuberculosis by, amongst others:

1. Creating and maintaining links between the various institutions and people in the Netherlands and elsewhere in the world who are working to control tuberculosis;
2. Generating and sustaining a lively interest in controlling tuberculosis through the provision of written and verbal information, holding courses and by promoting scientific research relating to tuberculosis and the control of it;
3. Performing research in relation to controlling tuberculosis;
4. Providing advice on controlling tuberculosis, and
5. All other means which could be beneficial to the objective.
6. As a subsidiary activity, it may develop and support similar work in other fields of public health.

General accounting policies

The accounting policies are unchanged compared to the previous year.

GUIDELINE 650

The annual account is drafted in accordance with the Reporting Guideline for Fundraising Institutions, Guideline 650.

VALUATION

The general principle for the valuation of assets and liabilities, as well as the determination of results, is the historical purchase price. Unless otherwise stated, assets and liabilities are stated at the values at which they were acquired or incurred.

TRANSLATION OF FOREIGN CURRENCIES

The annual accounts are in euros. Assets and liabilities in foreign currencies are translated at the official rates of exchange ruling at the balance sheet date.
Transactions in foreign currencies are translated at the applicable exchange rate on the date of the transaction. The resulting exchange differences are accounted for in the profit and loss account.

BALANCE SHEETS OF LOCAL KNCV REPRESENTATIVE OFFICES

The balance sheets of KNCV representative offices are consolidated in KNCV Tuberculosis Foundations' balance sheet per asset/ liability group against the exchange rates as at 31 December 2014.

Accounting policies - assets and liabilities

TANGIBLE FIXED ASSETS

The tangible fixed assets have been valued at historic acquisition prices less cumulative depreciation using the following deprecation rates:

- Office (re)construction 10 years
- Office inventory 5 years
- Computers 3,3 years

An assessment is made annually to see if additional depreciation of fixed assets is deemed necessary based on the actual value of the assets.

INVESTMENTS

With respect to investments, KNCV has set-up an investment policy. The essence of the policy is to invest only when it concerns such an excess of liquidities that they cannot be used in the short term for the main activities. As far as that is the case the derived objectives will be: risk avoiding investments and realizing as optimum as possible returns which will be durable for the duration. For that reason KNCV is investing predominantly in bonds. The policy of the board will also be directed at hedging price risks by reserving unrealized exchange differences in the reserve 'unrealized gains/losses on investments'. Shares are revaluated at market value.
Direct investments in bonds are valued at amortized costs, as they are not held for trade. The difference between acquisition price and the redemption value are brought to the Statement of Income and Expenditure over the remaining term of the bond.
Investments in bond funds are recognized at fair value. Unrealized capital gains will be accounted for in the reserve for 'unrealized gains/losses on investments'.

CASH AND BANKS

Cash and bank balances are freely disposable, unless stated otherwise, and are accounted for at nominal value.

RECEIVABLES AND LIABILITIES CONCERNING PROJECTS

Receivables and liabilities concerning projects consist of received respectively paid advances in behalf of various international projects. They are valued at nominal value.
The actual expenses are deducted from the advances. Reservations for bad debts are deducted from the book value of the receivable.

COALITION CONSOLIDATION

In the annual accounts 2014 all receivables and liabilities concerning the USAID program have been fully consolidated, including those sub-agreed to coalition partners. The receivables represent the amount obligated to the coalition on both contracts minus the amounts already received. The liabilities represent the part of the obligation that still needs to be executed. This liability is shown separately for KNCV and other coalition partners.

[1] Address as of 18 May 2015 is Benoordenhoutseweg 46, The Hague

Accounting policies – Statement of Income and Expenditure

ALLOCATION TO ACCOUNTING YEAR

Income and expenditure are allocated to the periods to which they relate.

DEPRECIATION FIXED ASSETS

Depreciation on fixed assets is calculated at fixed percentages of cost or actual value, based on the estimated useful life of the assets.

LEGACIES AND ENDOWMENTS

Benefits from legacies and endowments are included in the financial year the legacy is announced, at 75% of the value calculated by the external clearing agency. The remaining balance, which can be influenced by fluctuations in value of houses and investments, is included in the financial year of receipt.

GRANTS

Grants are allocated to the period to which the related costs are recognized.

COALITION CONSOLIDATION

In the annual accounts 2014 all income and expenses concerning TBCARE I have been included, including the part sub-agreed to coalition partners.

SHARE IN FUNDRAISING THIRD PARTIES

The contributions from lotteries will be included in the financial year in which they are received or committed.

INCOME AND EXPENSES CONCERNING PROJECTS

Income and expenses concerning projects are allocated to the periods to which they relate and in which they can be accounted for as declarable to a donor, provided that the amount can be determined reliably. This also counts for purchased materials and equipment which are accounted for as expenses in the period in which they are acquired.

PENSION CONTRIBUTION

KNCV Tuberculosis Foundation's pension scheme qualifies as a defined benefit plan. The defined benefits are based on an average pay system. The pension scheme has been effectuated with the sector pension fund for health care (PFZW). In accordance with an exemption in the guidelines for annual reporting the defined benefit plan has been accounted as a defined contribution plan in the annual statements. This means that the pension premiums are charged in the income statement as incurred. Risk due to salary increases, indexation and return on fund capital could change KNCV's yearly contribution paid to the pension fund. With respect to these risks no provision has been taken into account in the financial statements. Information with regard to any deficits and consequences hereto for future pension premiums is not available.
The pension funds coverage grade ultimo 2014 was 102%. Pension premiums compared to the previous year remained unchanged at 24,4% for retirement. The percentage for disability remained at a level of 0.4%.

ALLOCATION EXPENDITURE

All expenditure is allocated to three main categories 'objectives (main activities)', 'raising income' and 'administration and control'. Furthermore expenditure is allocated to organizational units, which activities can be matched to the three main categories. When units are active or supportive for other units the expenses will be internally charged based on internal keys. The table below shows which category fits with the specific organizational unit and the key for the internal charge. The percentages of staff expenses are estimations based on experience or based on actual time writing.

ORGANIZATIONAL UNIT	CHARGE ARGUMENT
Netherlands, low prevalence	All expenses charged on 'TB control in low prevalence countries'
Other countries, high prevalence	3% of staff expenses charged on 'Expenses government grants'
	All other expenses charged on 'TB control in high prevalence countries'
Project management	3% of staff expenses charged on 'Expenses government grants'
	All other expenses charged on 'TB control in high prevalence countries'
Research	3% of staff expenses charged on 'Expenses government grants'
	All other expenses charged on 'Research'
Communication	All expenses charged on 'Information, education and awareness'
Fundraising	Absolute expenses charged on 'Expenses actions from third parties'
	Staff expenses charged on 'Information, education and awareness' (33%) and 'Expenses private fundraising' (67%) based on timewriting.
	40% of all other expenses charged on 'Information, education and awareness'
	60% of all other expenses charged on 'Expenses private fundraising'
Directors office	Grants to third parties for scientific research charged on 'Research'
	Expenses for public affairs charged on 'Information, education and awareness'
	2% of staff expenses charged on 'Expenses fundraising third parties'
	3% of staff expenses charged on 'Expenses government grants'
	3% of staff expenses charged on 'Expenses financial assets'
	All other expenses charged on 'Expenses administration and control'
Human resource management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Facility management	Based on amount of FTE of units charged on four objective-categories, expenses private fundraising and expenses administration and control
Finance Planning & Control	Staff exclusively working for project finance is charged to the objective-categories
	All other expenses charged on 'Expenses administration and control'

Materials used for supporting the fundraising message (for examples letters to donators, newsletters) contain also information about the disease tuberculosis and tuberculosis control. The percentage of expenses from fundraising that is charged on 'Information, education and awareness' is determined by a prudent estimate of the amount of information supplied in all materials.

Accounting policies – cash flow statement

The cash flow statement is determined using the indirect method, presenting the cash flow separately as the sum of the shortage or surplus and the costs for depreciation.
Cash flows in foreign currencies are included using an average exchange rate. Currency fluctuations and income and expenses from interest are added to the cash flow from operational activities.

Executive remuneration — **In compliance with standard reporting form of VFI**

Name	C.S.B. van Weezenbeek		F. Cobelens	
Position in the board	Executive Director		Scientific Director	
	Indefinite		Indefinite	
Contract	40		20	
Legal status	100%		50%	
Number of hours	1/1 - 31/12		1/1 - 31/12	
FTE				
Period for reporting year				
Remuneration				
Annual income				
Gross salary	106.838		52.991	
Holiday allowance	6.577		3.444	
Extra month	8.904		4.416	
Variable/performance allowance	-		-	
Subtotal		122.319		60.851
Social securities, employers part	9.985		9.755	
Taxable allowances	9.000		-	
Pension premium, employers part	46.601		6.978	
Other allowance, long term	-		-	
Payment in relation to beginning of end of contract	-		-	
		65.586		16.733
Total remuneration 2014		**187.905**		**77.584**
Total remuneration 2013*		**77.028**		**26.079**

No loans, advances nor guarantees are issued to members of the Executive Board or members of the Board of Trustees. The members of the latter are only reimbursed for expenses made.

Notes to the remuneration of the management

The Board of Trustees has, upon the recommendation of the Remuneration Committee, determined the amount of the management remuneration and additional benefits to be paid to management. The remuneration policy is regularly reviewed, most recently in September 2013, when a new Board of Directors was installed. In determining the remuneration policy and remuneration, KNCV Tuberculosis Foundation adheres to VFI's advisory scheme for the remuneration of the management of charitable organizations ("Adviesregeling Beloning Directeuren van Goede Doelen") and the code of governance for charitable organizations ("Code Wijffels"; see www.vfi.nl).
Under the advisory scheme[7], a maximum annual remuneration is determined on the basis of weighted criteria. At KNCV Tuberculosis Foundation, this weighting was performed by the Remuneration Committee. This resulted in a so-called basic score for management positions ("Basis Score voor Directiefuncties" - BSD) of 500 points and a maximum annual remuneration of 92% of €140.046 for 1 FTE in 12 months for the statutory director, which is €128.842.
The maximum annual remuneration for the Scientific Director is 80% of € 140.046 for 1 FTE, € 56.018 for 0,5 FTE.

[7] Advisory scheme for remuneration of directors, VFI, September 2011

* Not a full year

In 2014, the actual incomes of management for the purposes of assessment of compliance with VFI's maximum annual remuneration were as follows: K. van Weezenbeek € 122.319 (1 FTE/ 12 months), F. Cobelens € 60.851 (0,5 FTE/ 12 months). KNCV's directors are contracted for a 40-hour workweek.
Mrs. Van Weezenbeek's income is below the VFI standard. The income for Mr. Cobelens, in absolute terms, is above the VFI standard by 9%. The Board of Trustees takes the view that the salary matches the skills and competencies required for successfully fulfilling a position in the (inter)national medical and scientific environment. A lower remuneration would make it impossible to recruit a scientific director with the expertise and background needed to advocate for KNCV's viewpoints in the global policy development fore for TB control.
In the financial statements, the size and composition of the management remuneration is reported in the notes to the statement of operating income and expenditure. Besides the annual income, management remuneration also includes the national insurance and pension contributions and, if applicable, any severance payments upon termination of employment.
Apart from compliance with the VFI remuneration advisory scheme, KNCV Tuberculosis Foundation also has to comply with the rules and standards of the Dutch Government, being an organization which receives government funds. The income of the directors complies with the standard as used by the Dutch Government.

Result appropriation

The annual accounts and the annual report are prepared by the Board of Directors. The annual accounts and the annual report are adopted by the General Assembly.

To the Board of Trustees and the General Assembly, in their respective meetings of 21 April 2015 and 20 May 2015, we propose to appropriate the surplus of 2014 according to the following division:

	In €
Continuity reserve, contribution	468,021
Decentralization reserve, withdrawal	-64,752
Earmarked project reserves, contribution	-
Earmarked project reserves, withdrawal	-183,730
Unrealized exchange differences on investments, contribution	145,199
Fixed asset fund, withdrawal	-129,798
Third party earmarked funds, contribution	55,000
Third party earmarked funds, withdrawal	-41,766
	248,174

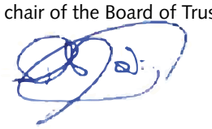
The withdrawals are specified on pages 70 and 71 of the financial statements. KNCV Tuberculosis Foundation's policy towards reserves and funds is clarified in chapter Accounting policies.

Events occurring after the balance sheet date

In 2015 a rental contract was signed by KNCV Tuberculosis Foundation with a third-party lessor for offices on Benoordenhoutseweg 46 in the Hague (Van Bylandthuis). The rental contract is for 5 years, ending on 31 May 2020, with an option to extent for 5 years. The annual rent is € 248.369 including maintenance fee and VAT). A € 62.092 bank guarantee will be issued in favor of the lessor. There have been no material post balance sheet events that would require adjustments to KNCV Tuberculosis Foundation's Financial Statements per 31 December 2014.

Dina Boonstra
Chair of the Board of Trustees

Dirk Dotinga
Vice chair of the Board of Trustees



Kitty van Weezenbeek
Executive Director

Independent auditor's report

To: the board of trustees of Koninklijke Nederlandse Centrale Vereniging tot Bestrijding der Tuberculose (KNCV)

We have audited the accompanying financial statements 2014 of Koninklijke Nederlandse Centrale Vereniging tot Bestrijding der Tuberculose (KNCV) (hereafter: KNCV Tuberculosefonds), The Hague, which comprise the balance sheet as at 31 December 2014, the statement of income and expenditure for the year then ended and the notes, comprising a summary of accounting policies and other explanatory information.

Board of directors' responsibility

The board of directors is responsible for the preparation and fair presentation of these financial statements in accordance with Dutch Accounting Standard 650 'Fundraising institutions' of the Dutch Accounting Standards Board. Furthermore, the board of directors is responsible for such internal control as it determines is necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Dutch law, including the Dutch Standards on Auditing. This requires that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 board of directors, as well as evaluating the overall presentation of the financial statements.

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

Ref.: e0354865

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Opinion

In our opinion, the financial statements give a true and fair view of the financial position of KNCV Tuberculosefonds as at 31 December 2014, and of its result for the year then ended in accordance with Dutch Accounting Standard 650 'Fundraising institutions' of the Dutch Accounting Standards Board.

Announcement concerning the management board report

We have read the management board report in order to identify material inconsistencies, if any, with the audited financial statements, and as a result of this have established that the management board report is consistent with the information in the financial statements and that the management board report contains all the information required by Dutch Accounting Standard 650 'Fundraising institutions' of the Dutch Accounting Standards Board. We have not audited or reviewed the information in the management board report.

The Hague, 20 May 2015
PricewaterhouseCoopers Accountants N.V.

Original has been signed by: M. van Ginkel RA

LIST OF ABBREVIATIONS

ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
AIGHD	Amsterdam Institute for Global Health and Development
ART	Anti-Retroviral Therapy
ATS	American Thoracic Society
BSD	Base Score for Management positions
CAR	Central Asia Region
CBF	Centraal Bureau Fondsenwerving (Central Bureau for Fundraising in The Netherlands)
CEO	Chief Executive Officer
CHW	Community Health Workers
CIb	Centrum Infectieziektenbestrijding (Center for Infectious Disease Control in the Netherlands)
CoE	Center of Excellence
CPT	Commissie voor Praktische Tuberculosebestrijding (Committee for Practical Tuberculosis Control in the Netherlands)
CSOs	Civil Society Organizations
DGIS	Directoraat-generaal Internationale Samenwerking (Netherlands Ministry of Foreign Affairs)
DJCC	Directors Joint Consultative Committee
DOT(S)	Directly Observed Treatment (Short-course)
E&M Health	Electronic & Mobile Health
ECDC	European Centre for Disease Prevention and Control
ECSA	East Central and Southern Africa
ECSA-HC	East Central and Southern Africa Health Community
EKO	East Kazakhstan Oblast
EMA	European Medicines Agency
F&M	(Unit) Fundraising and Marketing
FAST	Finding TB cases Actively, Separating safely, and Treating effectively
FHI	Family Health International
FTE	Full-time equivalent
GDF	Global Drug Facility
GDI	Global Drug-resistant Tuberculosis Initiative
GF/GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGD (Nederland)	Gemeenschappelijke Gezondheidsdienst (Municipal Health Services/MPHS in the Netherlands)
GLC	Green Light Committee
GLI	Global Laboratory Initiative
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GPS	Global Positioning System
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resource Management
HS	Health Systems
HSS	Health Systems Strengthening
IAC	International Advisory Council
3 I's	Intensified Case Finding, Isoniazid Preventive Therapy and Infection Control Practices
IC	Infection Control
ICCM	Integrated Community Case Management
ICT	Information and Communication Technology
IMA	Indonesia Medical Association
IPT	Isoniazid Preventive Therapy
IRD	Interactive Research and Development
ISTC	International Standards for Tuberculosis Care
IT	Information Technology
IUATLD	International Union Against Tuberculosis and Lung Disease (Union)
JKN	National Health Insurance System (Indonesia)
KIT	Koninklijk Instituut voor de Tropen (Netherlands Royal Tropical Institute)
KMOL	Knowledge Management and Organizational Learning
KNCV	Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose (Royal Netherlands Tuberculosis Association)
LED FM	Light-emitting diode fluorescence microscopy
LSH4D	Fund Life Sciences Health and Development
LTBI	Latent Tuberculosis Infection
M&E	Monitoring and Evaluation
M-health	Mobile health
MDG	Millennium Development Goal(s)
MDR	Multidrug-resistant
MDR-TB	Multidrug-resistant Tuberculosis
(MDR)TB	(MDR)TB denotes both MDR-TB and other Tuberculosis
M/XDR-TB	Multidrug-resistant and Extensively drug-resistant Tuberculosis
MoH	Ministry of Health
MP	Member of Parliament

MPH	Master in Public Health
MPHS	Municipal Public Health Services in the Netherlands (GGDs)
MSH	Management Science in Health
MTB	Mycobacterium Tuberculosis
NGO	Non-Governmental Organization
NFM	New Funding Model
NSP	National Strategic Plan
NTP	National Tuberculosis Control Program
OR	Operational Research
PADT	Proposal Assessment & Development Team
PCA	Patient-Centered Approach(es)
PFZW	Pensioenfonds Zorg en Welzijn (Pension fund for health care)
PGI	Postgraduate Institute
PHC	Primary Health Care
PhD	Doctor of Philosophy
PiH	Partners in Health
PLHIV	People living with Human Immunodeficiency Virus
PMDT	Programmatic Management of Drug-resistant Tuberculosis
PNPK	Standards for Medical Practice on Tuberculosis Care (Indonesia)
PPM or PPM/P	Public Private Mix/Partnership
pre-XDR	Pre–XDR-TB refers to MDR-TB with resistance to either any fluoroquinolone or at least one second-line injectable (but not both)
PSS	Psycho-Social Support
QQ	Qualitate Qua
R&D	Research and Development
RA&E	Risk Assessment and Evaluation
RGHI	Rotterdam Global Health Initiative
RIF	Rifampicin
RIVM	Rijksinstituut voor Volksgezondheid en Milieu (National Institute for Public Health and the Environment)
RJ650	Dutch Accounting Standards for Fundraising Institutions
SMT	Dr. C. de Langen Stichting voor Mondiale Tbc-Bestrijding (Dr. C. de Langen Foundation for Global TB Control)
SS+	Smear-positive pulmonary TB
STAG-TB	Strategic and Technical Advisory Group (for Tuberculosis)
SVOP	Stichting Voorzieningenfonds Oud-Personeelsleden (Foundation services fund former employees)
TA	Technical Assistance
TAG-TB	European Technical Advisory Group on Tuberculosis Control
TB	Tuberculosis

TB/HIV	Tuberculosis and/or Human Immunodeficiency Virus
TB-IC	Tuberculosis Infection Control
TBCTA	Tuberculosis Coalition for Technical Assistance
TB CAP	Tuberculosis Control Assistance Program
TB CARE I	USAID funded project implemented by the TBCTA coalition (led by KNCV): Tuberculosis Collaboration and Coordination, Access to Tuberculosis Services for All People, Responsible and Responsive Management Practices, Evidence-based project Monitoring & Evaluation
TIBU	TB surveillance system for digital data collection, data transfer and data reports in Kenya
TSRU	Tuberculosis Surveillance and Research Unit
UNION	International Union Against Tuberculosis and Lung Disease
US	United States of America
USAID	United States Agency for International Development
US$	US Dollar
VAT	Value-Added Tax
VFI	Vereniging van Fondsenwervende Instellingen (Association of Fundraising Organizations)
VHW	Village Health Worker
VvAwT	Vereniging van Artsen werkzaam in de Tuberculosebestrijding (The Dutch Association of Medical Doctors in TB control)
WHO	World Health Organization
WHO/Europe	World Health Organization Regional Office for Europe
WNT	Wet normering bezoldiging topfunctionarissen (semi) publieke sector (Law on standard remuneration of executives (semi) public sector0
Xpert® MTB/RIF	A cartridge-based, automated diagnostic test that can identify Tuberculosis and resistance to rifampicin by nucleic acid amplification technique
XDR-TB	Extensively Drug-Resistant Tuberculosis
ZonMW	Zorgonderzoek Medische Wetenschappen (The Netherlands Organization for Health Research and Development)

Colofon

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Children Indonesia, © M. Bushue

KNCV
To eliminate TB

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CBF VOOR GOEDE DOELEN

ANBI