KNCV
To eliminate TB

TUBERCULOSISFOUNDATION

ANNUAL REPORT 2013

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KNCV Tuberculosis Foundation would like to thank all partners for their collaboration and support in 2013

In the Netherlands

Academic Medical Centre Amsterdam

Aids Foundation East West

Aids Fund

Amsterdam Institute for Global Health & Development (AIGHD)

Center for Infectious Disease Control Netherlands/RIVM

Central Bureau for Fundraising

Committee for Practical TB Control Netherlands

Dr. C. de Langen Stichting voor Mondiale Tbc-bestrijding

Netherlands Ministry of Foreign Affairs / Development Cooperation

Netherlands Ministry of Health, Welfare and Sport

Dutch TB Laboratory partnership

Erasmus University Rotterdam

ETC Crystal

GGD Nederland, vereniging voor GGD'en

's-Gravenhaagse Stichting tot Steun aan de Bestrijding der Tuberculose

Leids Universitair Medisch Centrum

De Lotto

Stichting Madurodam Steunfonds (Madurodam Support Fund)

Medical Committee Netherlands-Vietnam

Ministry of Justice in The Netherlands and other countries

Municipal health services in The Netherlands

Nederlandse Vereniging van Artsen voor Longziekten en Tuberculose

Nederlandse Vereniging voor Medische Microbiologie

Our private donors

Radboud University Nijmegen

Royal Dutch Airlines – KLM Flying Blue program

Royal Tropical Institute

Stichting Loterijacties Volksgezondheid

Stichting Suppletiefonds Sonnevanck

Stop Aids Now!

Tuberculosis Vaccine Initiative (TBVI)

Vereniging van Artsen werkzaam in de Tbc-bestrijding

Verpleegkundigen & Verzorgenden Nederland,

Platform Verpleegkundigen Openbare Gezondheidszorg

VriendenLoterij

Mr. Willem Bakhuys Roozeboomstichting

ZonMW

And many others...

In other countries and globally

ABT/ZdravPlus program, Kazakhstan

Advanced Community Health Care Services Namibia (CoHeNa)

AERAS, USA

American Thoracic Society, USA

Armauer Hansen Research Institute (AHRI), Ethiopia

Aurum Institute, South Africa

Bill & Melinda Gates Foundation, USA

Cambodian Health Committee

CENAT, Cambodia

Centers for Disease Control and Prevention, USA

Cipto Mangunkusumo Hospital, Indonesia

CISM, Mozambique

Diponegoro University, Indonesia

Eli Lilly MDR-TB Partnership

European Centers for Disease Prevention and Control

European and Developing Countries Clinical Trials Partnership

Family Health International, USA

Foundation for Innovative New Diagnostics (FIND), Switzerland

Global AIDS Alliance

Global Fund to Fight Aids, Tuberculosis and Malaria

GSK Biomedicals, Belgium

Hain Life Sciences, Germany

Hasan Sadikin Hospital, Indonesia

Harvard Medical School, USA

HEAD, Cambodia

Indonesian Association Against Tuberculosis (PPTI)

International Centre for Diarrhoeal Disease Research, Bangladesh

Japan Anti-Tuberculosis Association

Kazak Tuberculosis Research Institute

Kenya Medical Research Institute (KEMRI)

Kenya AIDS NGO's Consortium (KANCO)

Kenya Association for the Prevention of Tuberculosis and Lung Diseases

Leprosy Mission International

Leprosy Mission, Nigeria

Makerere University, Uganda

Management Sciences for Health, USA

McGill University, Canada

Ministries of Health

National TB Reference Laboratories in the countries

Netherlands-African partnership for capacity development and clinical interventions against poverty-related diseases (NACCAP)

National TB Control Programs in the countries

NWO-WOTRO

Office of the US Global AIDS Coordinator

Partners in Health (PiH), USA

Persahabatan Hospital, Indonesia

PharmAcces

Population Services International (PSI), USA

Project Hope, Kazakhstan

RHAC, Cambodia

Stellenbosch University, South Africa

Stop TB Partnership

TB Alliance, USA

TB Europe Coalition, Brussels

TB Proof, South Africa

UNICEF -University Clinical Centre

University of Indonesia

The Union

United Nations Development Program

United States Agency for International Development

University of Cape Town-SATVI, South Africa

University of Gadjah Mada Indonesia

World Health Organization (Headquarters and Regions)

And many others...

1 FOREWORD

Children in Ethiopia
PHOTO BY NETTY KAMP

KNCV Tuberculosis Foundation (KNCV) looks back at an exciting and successful year with activities in more than 30 countries, empowering health care workers to fight tuberculosis. We want to take the opportunity to thank our private donors, the Unites States Government and Dutch partners, such as the Lotto and the Vriendenloterij, for their contribution to our work! As the lead partner of the global U.S. Agency for International Development (USAID) TB CARE I program, KNCV lives up to its 110 year reputation: saving lives, reducing suffering and containing the spread of TB. The ultimate aim is to eliminate a 'stubborn' disease through innovation and research. In 2013 over $52 million dollars was allocated to mission related goals of which only 2% on administration and financial control.

Dr. Kitty van Weezenbeek, Executive Director

For KNCV, 2013 was a year of significant change within and outside the organization.

The international TB control environment is more dynamic than ever due to the introduction of game-changing new tools for the diagnosis and treatment of challenging forms of TB such as multi-drug resistant TB (MDR-TB). With both TB program experts and researchers under its roof, KNCV is in an excellent position to apply these new technologies in innovative life-saving interventions for affected populations, most notably vulnerable groups at increased risk of TB such as the poor, migrants, prisoners and slum-dwellers.

Professor dr. Frank Cobelens, Scientific Director

The 2013 change in the Board of Directors reflects these developments which came with an increasing demand for specialized technical know-how and the development of a robust evidence base for new strategies to accelerate the elimination of a disease that still causes 1.3 million deaths a year and leaves families behind in despair and poverty. Hence, the choice for a content oriented Executive Director and a Scientific Director who is affiliated with an academic institution.
We are proud to lead this organization, we are proud of the work done by KNCV staff around the world and we will not rest until the job is done!


GLOBAL PLAN
Working groups
Policies & Guidelines
Coördination
Analyse Results
Technical Assistance
Country Strategic Plans
Funding
Analyses
Capacity Building
Implementation
M&E
TB PATIENT

Who we are

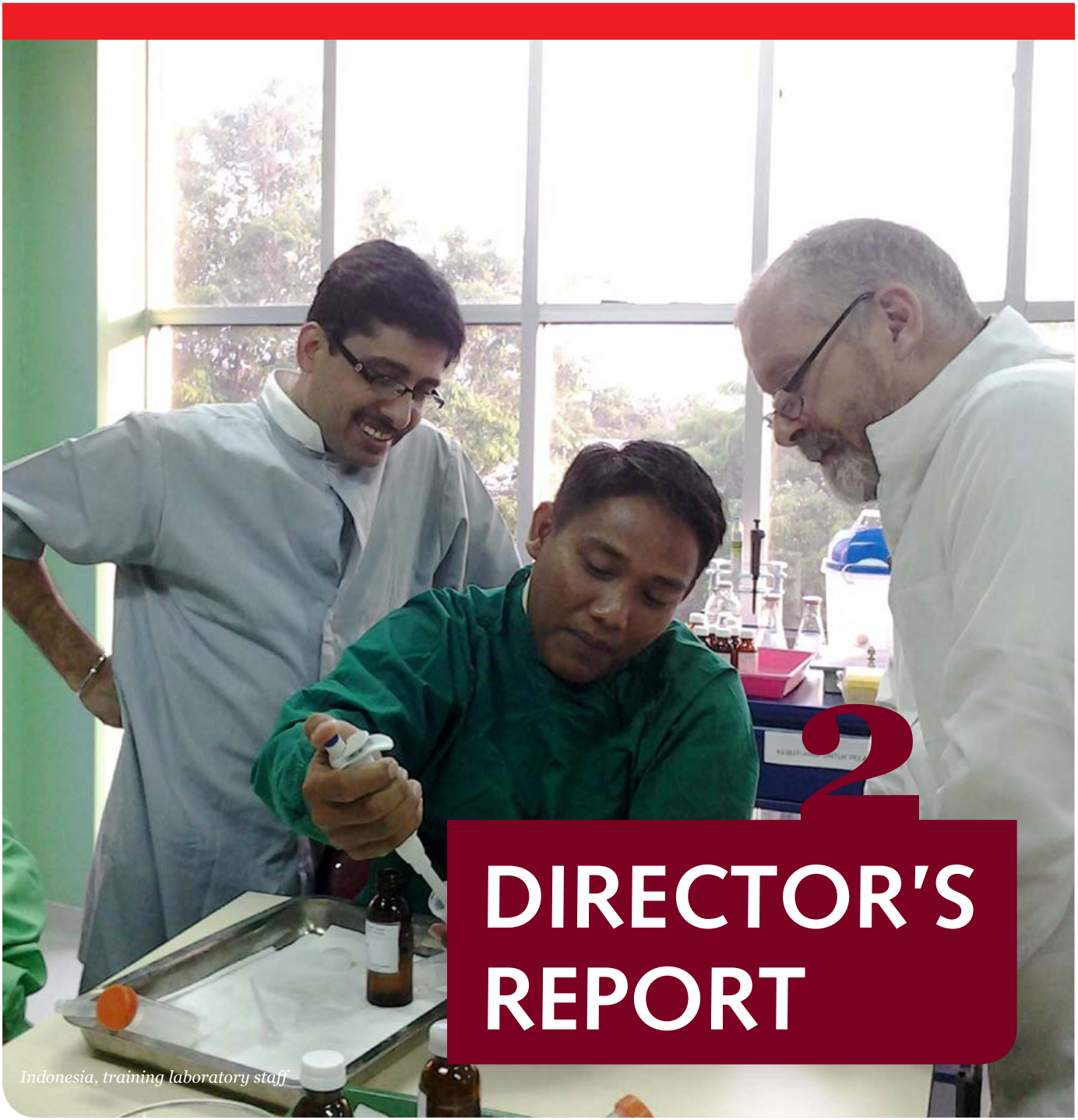
KNCV Tuberculosis Foundation is an international non-profit organization, committed to fighting tuberculosis (TB) worldwide and to strengthening health systems against TB. The organization consists of dedicated professionals – epidemiologists, doctors, nurses, researchers, and trainers. Our central office is in The Hague, Netherlands. In addition, our network comprised of two regional and 9 country offices. In 2013, KNCV professionals worked in more than 30 countries.

What is it what we do?

- Analyze the epidemiologic situation
- Analyze the orginization of health services for TB control
- Design a 5-year plan
- Cost it
- Mobilize funds
- Support implementation (e.g. training, policy, OR)
- Support monitoring & evaluation (M&E)
- Support prevalence surveys
- Evaluation

KNCV has identified three key program areas to focus on: TB/HIV, MDR-TB and laboratory strengthening. We pride ourselves in providing quality technical assistance to national TB programs, civil society and international organizations. Our growing international network of qualified and experienced consultants and researchers assist countries with a wide variety of services, ranging from strategic and operational planning, to technical assistance in specialized areas such as epidemiology, laboratory, TB/HIV, MDR-TB, surveillance and human resource development. KNCV identifies barriers and opportunities for TB control and addresses these by country-specific operational research projects and related guideline development. As such we cover all aspects of program design, implementation, evaluation and policy-development. KNCV has a track record assisting countries with the acquisition and implementation of projects funded by third parties, such as the Global Fund. As co-founders of the Stop TB Partnership, a worldwide coalition of TB control organizations and as active members of the Tuberculosis Coalition for Technical Assistance (TBCTA), KNCV plays a pivotal and influential role in international policy development and advocacy. Our general approach is depicted in figure 1 (on the left).

Our vision is: A world free of tuberculosis
Our mission is: The global elimination of TB through the development and implementation of effective, efficient and sustainable TB control strategies



Indonesia, training laboratory staff

2 DIRECTOR'S REPORT

Successes and contributions

The year 2013, the 110th year of KNCV's existence, has been one of worldwide battle against TB. Thanks to, among others, KNCV's efforts, this battle has seen many successes. Almost 6 million TB patients worldwide received treatment, saving the large majority of them from long-term illness and death. Over 100,000 patients with multidrug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB), both difficult to treat with common TB medication, received appropriate second-line treatment. This has prevented ten-thousands of deaths and further spread of these dangerous forms of TB to others. Many countries are witnessing a decline in numbers of new TB cases (incidence), and most of the world remains on track to achieve the 2015 Millennium Development Goal (MDG) targets in the reduction in TB incidence and mortality. In The Netherlands, the very cradle of KNCV's work, the reported number of TB patients struck an all-time low of 848 for the whole of 2013.

KNCV contributed to these successes through advice to National TB Programs, TB control support activities by its country offices, development of guidelines and training and implementation tools, and research. In line with our Strategy for 2011-2015 (Towards Equitable Access and Sustainable TB Control), these activities have focused on our key areas of work: drug-resistant TB; TB/HIV co-infection and infection control; new diagnostics for TB; TB in children; community engagement; and sustainable financing for health systems strengthening; An upcoming area of attention and work is Public Private Mix (PPM) models of care for TB control. We have furthermore helped to better understand the TB epidemic in various countries and monitor the impacts of TB control interventions through strengthening surveillance, epidemiological assessments, surveys of TB prevalence and drug resistance, and operational research.

The majority of the activities were carried out in the context of the U.S. Agency for International Development (USAID)-funded TB CARE I program. KNCV is proud to be the prime contractor for TB CARE I, the global mechanism for implementing USAID's TB strategy and the largest multi-partner, multi-country TB program in the world. Implementing this program in partnership with six other organizations, KNCV has been successful in achieving its targets one year ahead of planning. Through our advice to TB control programs and activities by our teams in TB CARE I-supported countries, numerous patients have been diagnosed and cured, and numerous health care workers have been trained and empowered to make this happen.

Challenges and external conditions

Notwithstanding these successes there are epidemiological and operational challenges. Still too many people worldwide (the WHO estimates around 3 million) have TB but remain without treatment, or receive treatment that is ineffective. This is often due to lack of access to diagnostic and treatment services, weaknesses in the health system, poor coordination between public and private care providers, and high out-of-pocket expenditures for patients. Of special concern is that still only 25% of patients with M/XDR-TB receive appropriate treatment. Although M/XDR TB can now be diagnosed rapidly and rapid tests are increasingly being used, treatment remains long, difficult to bear for patients and expensive, which hampers scale-up. And even though TB incidences are declining, this decline in most countries is very slow, and much more effort is needed to truly curb the epidemic.

In The Netherlands the low number of TB patients forces reorganization of TB services in order to maintain the specialist expertise needed to sustain this success.

Also the conditions for global TB control pose problems. Although domestic funding is increasing in several countries, donor funding remains essential in many. National TB programs reported for 2013 US$ 0.8 billion donor funding, but the need is estimated to be twice this amount. Similarly, in 2013 funding for TB-oriented research and development has declined for the first time in years while huge investments are needed in TB vaccine research, development of new drugs and diagnostics, and in operational research to effectively implement new TB control tools. These developments underscore the need for strong and sustained political commitment for TB control in countries that have large TB problems as well as in donor countries. It is encouraging that the Nether-

Zimbabwe
PHOTO BY NETTY KAMP

lands Government in November 2013 expressed in Parliament the importance of TB control, notably to reduce HIV-related morbidity and mortality, and acknowledged the contribution of Dutch technical organizations, academia and industry to this global endeavor. KNCV has taken steps, with the Dutch Government, to start realizing this commitment.

These challenges and external developments imply changing technical demands as well as a changing environment for TB control in general and for KNCV's operations in particular – relating to finance, technological innovation, and a shift of country needs and donor preferences towards specialized technical assistance. These present for KNCV a complex environment of challenges and opportunities.
Increasingly countries depend on the Global Fund for their basic TB services and the introduction of new tools, and the Global Fund's New Funding Model reserves an important role for technical agencies in the preparation of grant proposals. We have in 2013 started to prepare KNCV for a strong and prominent role in the technical support to countries to successfully apply for Global Fund grants under this New Funding Model. Also the US Government makes substantial contributions to TB control worldwide, with KNCV being an important partner for implementing USAID-funded TB programs.

With the advent of technological innovations such as new drugs and diagnostics we are entering an extremely dynamic phase in the history of the fight against TB with new ways of diagnosing, treating and managing the disease. Years of capacity building by KNCV and partners have resulted in a rather strong basic TB control capacity in many settings, which is ready to introduce and scale-up game-changing tools that have the potential to accelerate the elimination of TB. KNCV responds to requests of countries and donors to deliver specialized technical assistance in these areas, while carefully monitoring the effects and safeguarding gains made thus far.

Organizational Internal developments

In 2013 we have embarked on our tenure as Executive Director and Scientific Director. An important part of our charge is to lead KNCV in a way that we respond optimally to the increasing demand for specialized technical know-how, innovations and scientific evidence for (cost-) effectiveness and impact. It will further strengthen and expand KNCV's unique combination of TB program support and science, which in 2013 lead to involvement in an impressive 43 scientific publications.

Together we will help TB fighters around the world to alleviate human suffering, and take important next steps towards achieving our mission: **to eliminate TB**

Internal evaluation of KNCV's decentralization process against the background of our changing environment has made it clear that further regionalization is undesirable and unfeasible. The increasingly specialized nature of the required technical assistance and the lack of external funding for building and sustaining regional capacity for such assistance have prompted a more diversified approach. In that approach capacity building is primarily geared to the country offices (i.e. the level at which TB control is implemented). As a consequence, the shift in human resource capacity from KNCV's central office in The Hague to regional offices foreseen for 2013 has not been implemented.
In order to support the efforts to reach our strategic goals we have strengthened the project management systems. We developed a quality assurance system for our consulting work and started its implementation including, among others, a process for peer-review of assistance reports and other project deliverables. We also streamlined the grant application process by creating proposal development teams.

KNCV TUBERCULOSIS FOUNDATION IN KEY FIGURES

Spent on mission related goals € 52,023,796

Income from private fundraising € 1,632,296

Number of private donors 27,902

Income from third parties activities €1,183,428

Number of staff worldwide 224

% of expenses to fundraising 17,4%

% of expenses to administration and control 2,0%

Income from government grants €50,991,975

The year ahead – some highlights

KNCV's response in 2014 to address the TB control challenges will be focused yet multifaceted. Business as usual will not suffice. Innovation is essential, technologically as well as in the approaches to improve access to and quality of health services. Therefore, developing, piloting and scaling up such innovations will be at the core of our activities. Examples will be the responsible use of new TB drugs that are coming onto the market (bedaquiline, delamanid), the introduction of shortened first- and second-line treatment regimens, the accelerated scale-up of new diagnostics in ways that deploy them to maximum affordability and benefit to patients; innovative approaches to engaging civil society and private care providers into TB control; and alternative financial arrangements to alleviate the economic burden to TB patients. We will explore and support additional approaches to curb the TB epidemic, such as targeted active case finding to detect TB patients much earlier in their course of illness, and expanding diagnosis and preventive treatment of latent TB infection. We aim to increase our research efforts to field-tests promising novel interventions and determine the conditions needed for their scale-up ("implementation research"). And finally, we will respond to the increasing demand, and strengthen our expertise, for supporting countries in preparing applications and implementing Global Fund grants.

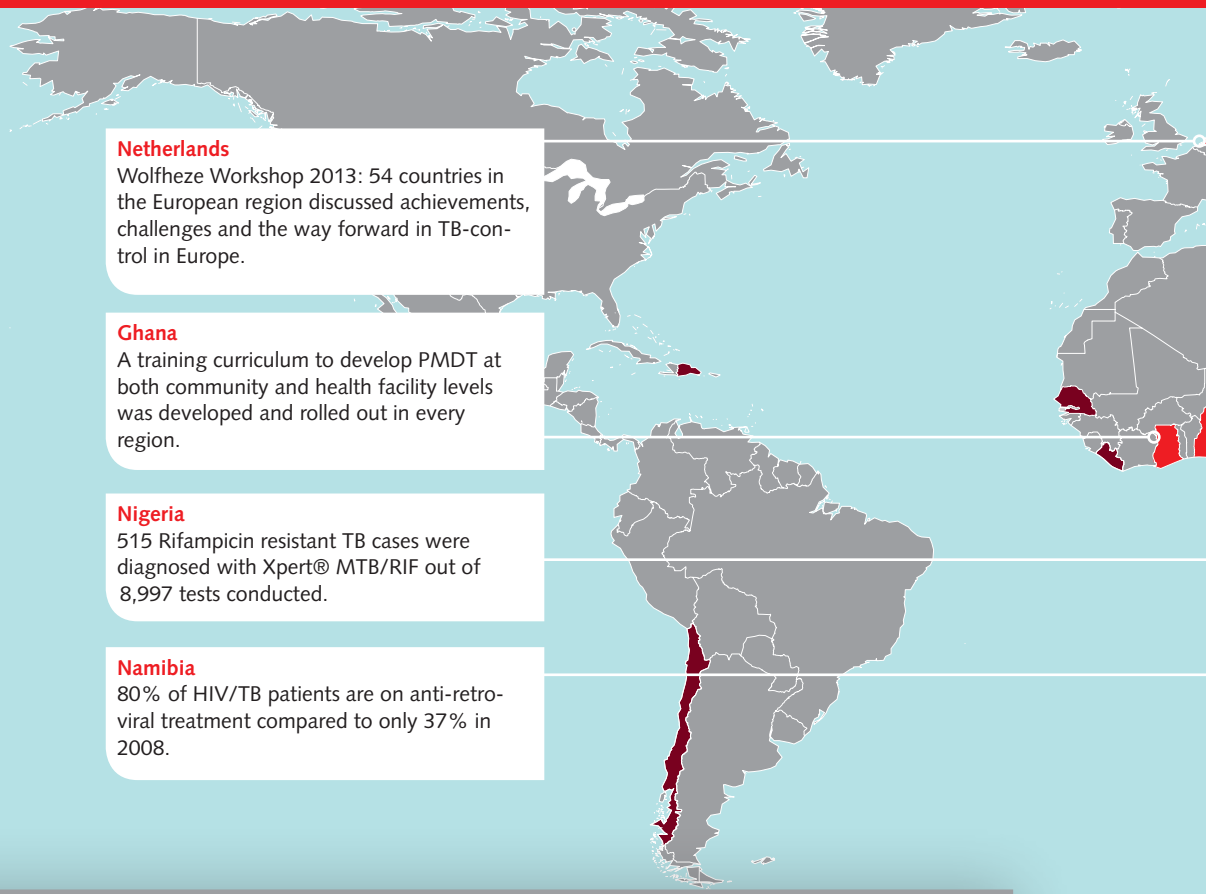
The budget for 2014 shows a total income of €53.3. Of that amount, €32.5 million is compensation for implemented activities by the TBCTA coalition partners for TB CARE I. Therefore, excluding consolidation, the income is budgeted at €20.8 million, which is €5.1 million less than the actual for 2013. Income from government grants is budgeted to decrease, related to the plans for activities under TB CARE I in 2014. Our share in third parties activities (e.g. lottery income) is budgeted to decrease compared to 2013, as well as our income from investments. The total level of consolidated expenditures amounts to €53.8 million. Once partners' activities are excluded, a budgeted cost level of €22.3 million is reached, which is €2.9 million lower than the actual for 2013. Overall the financial input to TB control in high prevalence countries is increasing compared to 2013, related to the pace of activities in the final full year of the TB CARE I program.

The year 2014 will be critical for KNCV's direction in the coming years. We will close our current strategic plan (2011-2015) one year earlier than envisaged and develop a new strategic plan (2015-2019) to respond to the changing environment, challenges and opportunities that TB control is facing globally and domestically. Our main source of current funding, the TB CARE I program, will come to an end one year ahead of planning and we have bid for the follow-on grant 'Challenge TB' for which USAID issued a Request For Applications on 30 December. We will need to diversify our funding base and will apply for the activities mentioned above for funding from various sources. Also, we will aim at attracting more core funding to enable us to do our work, and for that will critically evaluate and revise our strategy.
Finally, the changing needs of countries and donors make that our organization needs to be optimally equipped to develop and maintain high-level expertise, deliver project output and build local capacity in the countries where we work – for 2014 and beyond. To this end we will strengthen our internal organization, engage high-quality international experts as a flexible workforce under KNCV umbrella, and invest in young staff to become tomorrow's experts in the global fight against TB.

As directors we know ourselves surrounded and supported by many. By inspired and eager KNCV staff in offices and teams around the world, showing their great commitment to the organization and its cause. By our Board of Trustees, who gives us invaluable guidance and help for keeping KNCV on track in this extremely dynamic episode. By our many partners with whom we collaborate to fight TB, and by the donors who give us their confidence. Together we will help TB fighters around the world to alleviate human suffering, and take important next steps towards achieving our mission: to eliminate TB.

KITTY VAN WEEZENBEEK
Executive Director

FRANK COBELENS
Scientific Director



Netherlands
Wolfheze Workshop 2013: 54 countries in the European region discussed achievements, challenges and the way forward in TB-control in Europe.

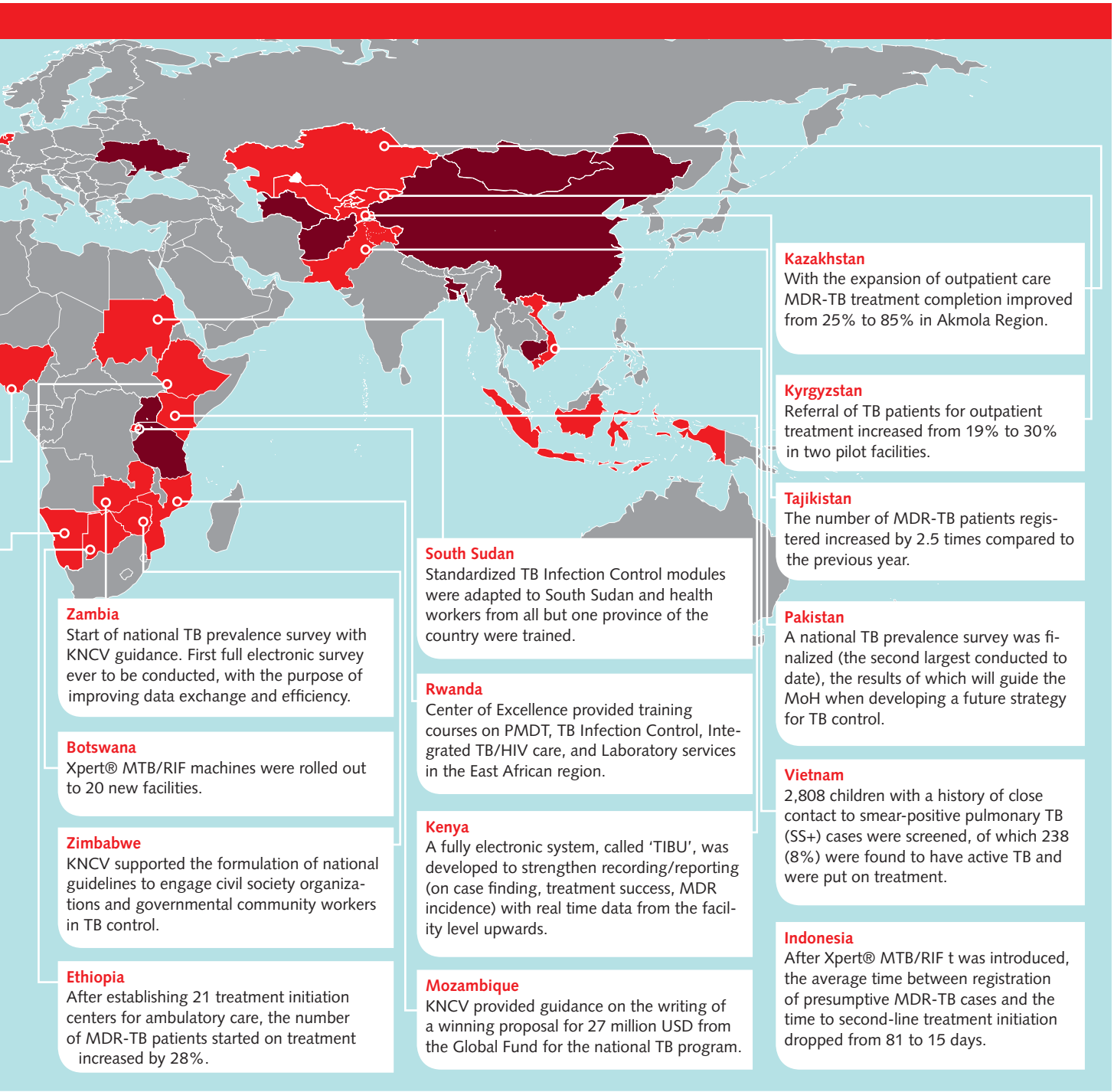
Ghana
A training curriculum to develop PMDT at both community and health facility levels was developed and rolled out in every region.

Nigeria
515 Rifampicin resistant TB cases were diagnosed with Xpert® MTB/RIF out of 8,997 tests conducted.

Namibia
80% of HIV/TB patients are on anti-retroviral treatment compared to only 37% in 2008.

3 COUNTRIES WHERE WE WORKED IN 2013 AND CORE COUNTRY HIGHLIGHTS

Core countries Other countries



Zambia
Start of national TB prevalence survey with KNCV guidance. First full electronic survey ever to be conducted, with the purpose of improving data exchange and efficiency.

Botswana
Xpert® MTB/RIF machines were rolled out to 20 new facilities.

Zimbabwe
KNCV supported the formulation of national guidelines to engage civil society organizations and governmental community workers in TB control.

Ethiopia
After establishing 21 treatment initiation centers for ambulatory care, the number of MDR-TB patients started on treatment increased by 28%.

South Sudan
Standardized TB Infection Control modules were adapted to South Sudan and health workers from all but one province of the country were trained.

Rwanda
Center of Excellence provided training courses on PMDT, TB Infection Control, Integrated TB/HIV care, and Laboratory services in the East African region.

Kenya
A fully electronic system, called 'TIBU', was developed to strengthen recording/reporting (on case finding, treatment success, MDR incidence) with real time data from the facility level upwards.

Mozambique
KNCV provided guidance on the writing of a winning proposal for 27 million USD from the Global Fund for the national TB program.

Kazakhstan
With the expansion of outpatient care MDR-TB treatment completion improved from 25% to 85% in Akmola Region.

Kyrgyzstan
Referral of TB patients for outpatient treatment increased from 19% to 30% in two pilot facilities.

Tajikistan
The number of MDR-TB patients registered increased by 2.5 times compared to the previous year.

Pakistan
A national TB prevalence survey was finalized (the second largest conducted to date), the results of which will guide the MoH when developing a future strategy for TB control.

Vietnam
2,808 children with a history of close contact to smear-positive pulmonary TB (SS+) cases were screened, of which 238 (8%) were found to have active TB and were put on treatment.

Indonesia
After Xpert® MTB/RIF t was introduced, the average time between registration of presumptive MDR-TB cases and the time to second-line treatment initiation dropped from 81 to 15 days.

4 BOARD OF TRUSTEES REPORT

Teenagers at TB Clinic in Kazakhstan
PHOTO BY BERT TOMSON

Supervisory governance in 2013

The Board of Trustees' main area of focus in 2013 concerned the succession within the Executive Board upon the retirement of Peter Gondrie and the subsequent transition in leadership. Advancing the envisaged transition from a collegial Executive Board to a single-headed statutory board a few years, the Board of Trustees announced the appointment of Dr. Kitty van Weezenbeek as Executive Director and Prof. Frank Cobelens as Scientific Director as of September 2014. Frank Cobelens divides his time equally between KNCV and the Amsterdam Institute of Global Health and Development (AIGHD); Kitty van Weezenbeek solely holds the statutory powers and responsibilities. The function of Director of Finance and Organization was discontinued. Throughout the succession process, the Recruitment and Appointment Committee consulted the full Board of Trustees on several occasions.

The Board of Trustees is proud to have recruited this team to the Executive Board. The Board considers technical excellence and strong academic grounding of KNCV's research and implementation science to be essential for leading the organization in the coming years and to strengthen its role as a global leader in TB control and to function as a center of excellence. KNCV's ambition is to play a pronounced role in bringing to fruition the opportunities offered through the development of cutting edge innovations and approaches, and their scaled-up implementation, thereby assisting to transform TB control. Linking implementation expertise and operational research at KNCV with academia engaged more broadly in clinical research and HIV/AIDS will position the organization more strongly for funding diversification. Such linkages further strengthen KNCV's capacity to respond to the ambitions of our principal donor, USAID, and the demand for technical guidance of countries working with Global Fund grants.
Grateful for the dedicated service of Peter Gondrie and Gerdy Schippers the Board of Trustees particularly commends their period of leadership for shaping KNCV into a globally operating organization, responding smoothly to and keeping pace with the administrative and organizational requirements of the expanding volume of work for USAID. In May 2013, the Board of Trustees marked Peter Gondrie's retirement after 18 years of service to KNCV (of which four years as Executive Director) with an inspiring

KNCV's ambition is to play a pronounced role in bringing to fruition the opportunities offered through the development of cutting edge **innovations and approaches**, and their scaled-up implementation, thereby assisting to transform TB control.

KNCV Symposium 2013
PHOTOS BY IS VORMGEVING

symposium on Community Participation in Combating TB on May 28, and a reception in the presence of TB control experts from the entire WHO Europe region gathered for the "Wolfheze Conference". In September the organization and the Board of Trustees bid a festive farewell to Gerdy Schippers.

On July 1, Dina Boonstra assumed delegated authorities as statutory director for the summer period, stepping down temporarily as Chair of the board of trustees. Executive management was handled by Maarten van Cleeff (Project Director TB CARE I) and Suzanne Verver (interim Head Unit Knowledge, Research and Policy); the management team meanwhile assumed a more pronounced role during the transition phase. On September 16, the new Executive Board assumed their positions. In the transition phase there was no Board of Trustees meeting.

Key areas governed

In addition to directing the transition in leadership over the course of 2013, the Board of Trustees, in their role and responsibility for strategic oversight, monitored progress and identified and/or emphasized the following areas:
Innovation as a key area for strengthening competitiveness of KNCV as service provider;

- Strategic positioning of the organization towards attracting and diversifying funding;
- Continued solid implementation of the TB CARE I project;
- Preparations for the next flagship TB program of USAID; Challenge TB. The announcement of the tender, anticipated in the second half of 2013, was finally released on December 30;
- Renewal of strategic direction; The Board of Trustees endorsed advancing the development of the next strategic plan by one year;
- Embedding financial responsibilities in the organization in view of the changed composition of the Executive Board.

Composition of the Board of Trustees and processes during 2013

The KNCV Board of Trustees statutorily is composed of five to seven members. The expertise areas reflected in the board are: public health, research, financial management, international development, organizational development and fundraising. In 2013, Sjaak de Gouw (Vice-Chair of the Board and Chair of Audit Committee) stepped down after completing two terms in office on behalf of GGD Nederland. Ton van Dijk of GGD Den Haag was appointed in May by the General Assembly, upon nomination by GGD Nederland. Ton van Dijk has a background in Public Health and Tropical Medicine. He currently is Director of Health and Care in the Municipality of The Hague. In October the Board of Trustees meeting appointed Dirk Dotinga as Vice-Chair of the Board of Trustees and Ton van Dijk as member of the Audit Committee. Maartje van Putten stepped down on July 1, when the appointment of the new Executive Board was announced and after completing two terms in office. With agreement of the General Assembly in May, it was decided to await the leadership transition

before filling this vacancy. A process to recruit a new member is currently in progress under the guidance of a nomination committee.
In 2013, the Board of Trustees held four regular meetings (February, April, October and November) and the Audit Committee met twice (April and November). As mentioned, the committee for the selection and appointment of the Executive Director met a number of times and consulted the full board. The appraisal and remuneration committee assessed the salary arrangements with the incoming Executive Board.

This year's annual self-assessment of the Board of Trustees (conducted in October) evaluated the recruitment and appointment process, salary arrangements, and the period over the summer, in which statutory authorities were temporarily assumed.
A lessons learned recommendation was, in future recruitment processes, to consult the Audit Committee already in the salary negotiation phase to better facilitate the process.
The Board of Trustees fully endorsed the process and outcomes of the recruitment process, acknowledging the exceptional personal effort and dedication to the future of KNCV of those serving on the Committee.
The Board of Trustees wishes to acknowledge the constructive dialogue and wise council received from the Works' Council in the process of leadership transition.
The International Advisory Council was consulted in February and contributed significantly in preparation of a strategic reflection on directions and positioning of the organization. The International Advisory Council did not hold an in-person meeting this year. During 2014 the Board of Trustees will assess the mandate and composition of the International Advisory Council.

The Board of Trustees,

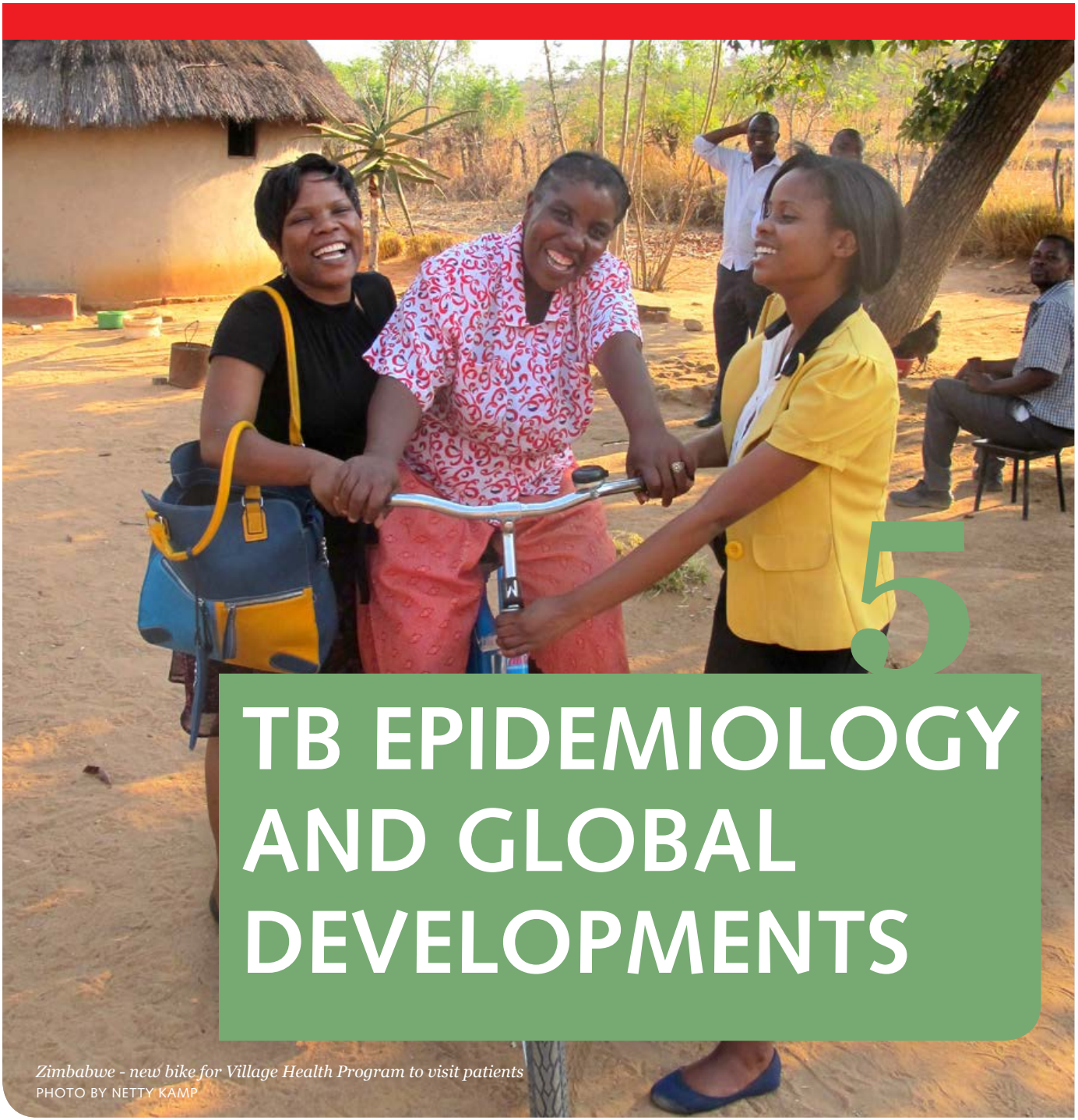
DINA BOONSTRA
Chair

DIRK DOTINGA
Vice Chair

Handing over award to Dr. Pablos-Mendez
PHOTO BY
ILSE VAN HEUSDEN

"Award for Eminence in TB Control"

On its 110th anniversary, KNCV honored the U.S. Agency for International Development (USAID) for its exceptional dedication and wise leadership in the worldwide fight against TB.
Gerdy Schippers, Director of KNCV:
On this occasion we proudly recognize the USA's tremendous contribution towards winning the battle against tuberculosis. We have now set the stage for a healthy future in which we can eliminate this persistent disease by building on the achievements so far.
Dr. Ariel Pablos-Mendez, Assistant Administrator for Global Health, accepted the "Award for Eminence in TB Control" on behalf of USAID during a luncheon ceremony at the residence of Mr. Rudolf Bekink, the Netherlands Ambassador in Washington D.C. Once every five years KNCV bestows this prize on a person or organization who has made an extraordinary contribution to the worldwide fight against TB. Prior recipients of the Award have been The National Tuberculosis Programs of Tanzania, Vietnam and Kenya.
The award consists of a medallion depicting Dr. Karel Styblo (1921 – 1998), the founder of the DOTS TB control strategy, an approach which revolutionized the worldwide fight against TB at the end of the 20th Century. The renowned Dutch sculptress Elisabeth Varga (1948 – 2011) designed the medallion on the occasion of KNCV's centennial anniversary in 2003.



5. TB EPIDEMIOLOGY AND GLOBAL DEVELOPMENTS

Zimbabwe - new bike for Village Health Program to visit patients
PHOTO BY NETTY KAMP

TB epidemiology[1]

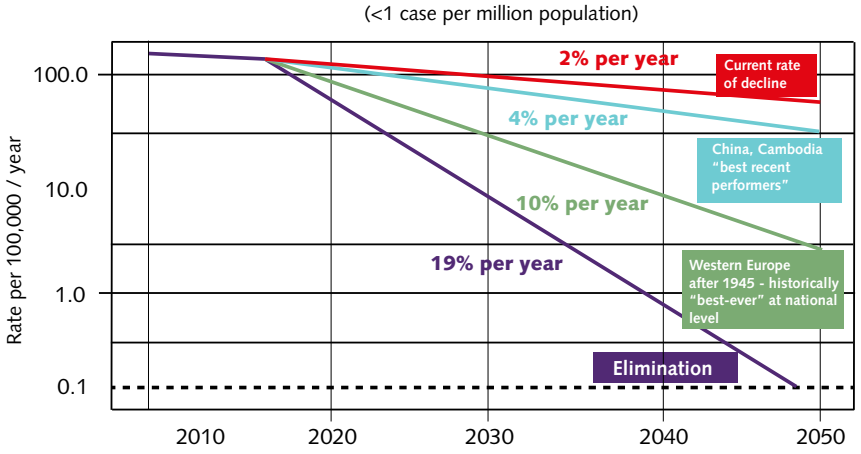
With 56 million TB patients successfully treated since 1995, 22 million lives saved since 1995, a 45% reduction in TB mortality since 1990 and high cure rates world-wide, global TB control efforts seem successful. Yet, TB remains a major global health problem.

In 2012, an estimated 8.6 million people developed TB and 1.3 million died from the disease. The rate of new TB cases has been falling worldwide for about a decade, but the rate of decline (2% per year) remains too slow to reach elimination by 2050 (see figure 5.1 different scenarios).

Furthermore, WHO estimates that about 3 million people with TB were 'missed' either because they were not diagnosed or because they were diagnosed but not reported. These missed cases represent human suffering such as unnecessary deaths and catastrophic expenditures for care in the unregulated private sector. At the same time, they pose a public health threat in the context of prolonged transmission and development of drug-resistance due to inadequate treatment in the private sector.

TB remains among the top three killers of women of reproductive age worldwide, with an estimated 410,000 TB deaths in 2012 among 2.9 million female TB patients. Transmission of TB in families is still a reality, and led to an estimated 530,000 children with TB.

Figure 5.1: Different scenarios for reaching TB elimination by 2050



[1] Source: WHO global TB report 2013; that gives epidemiology data for 2012

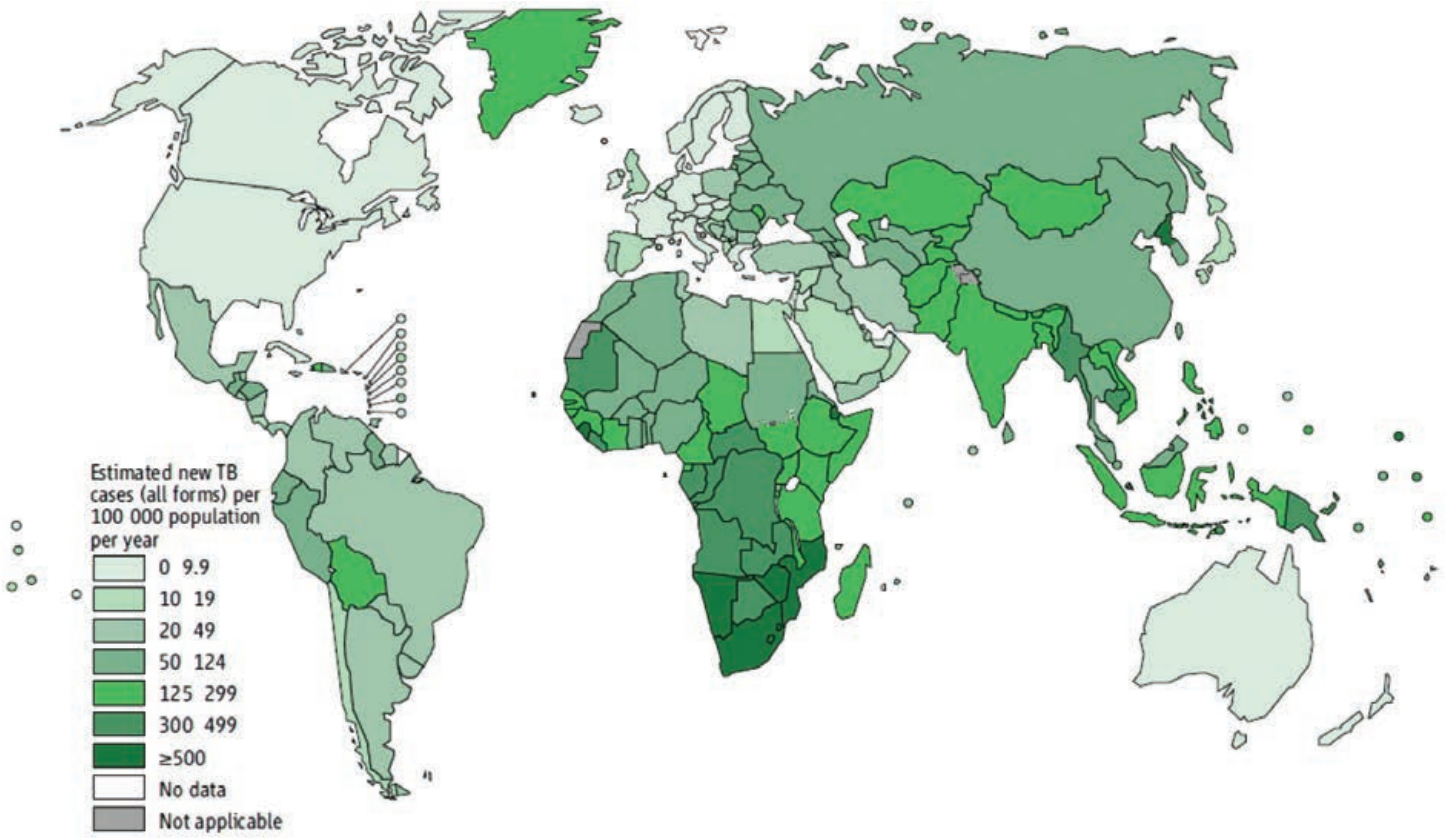


Figure 5.2: TB incidence by country. Source: WHO global TB report 2013

The estimated TB incidence rate at country level ranges substantially, with some countries facing a very high burden of TB with more than 1,000 patients per 100,000 population and other countries approaching elimination of the disease among their native populations. The Netherlands belong to the latter category and thus KNCV is in an excellent position to apply the lessons learnt in the Netherlands in countries around the world.

MDR-TB

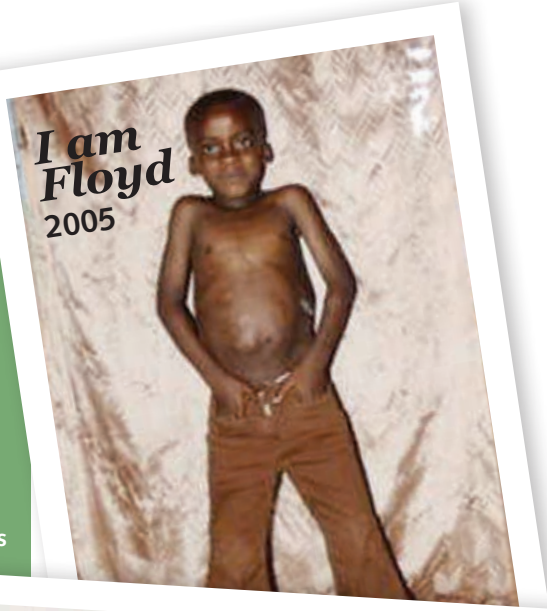
The emergence and spread of drug-resistant TB are a global concern. In 2012, an estimated 450,000 people developed MDR-TB and there were an estimated 170,000 deaths from MDR-TB. Although the capacity to diagnose MDR-TB continues to increase, progress towards targets for universal access to diagnosis and treatment of MDR-TB is far off track, with less than 25% of the estimated MDR-TB patients detected in 2012 and only 82% of them enrolled on treatment. As a result, MDR-TB continues to spread in affected communities.

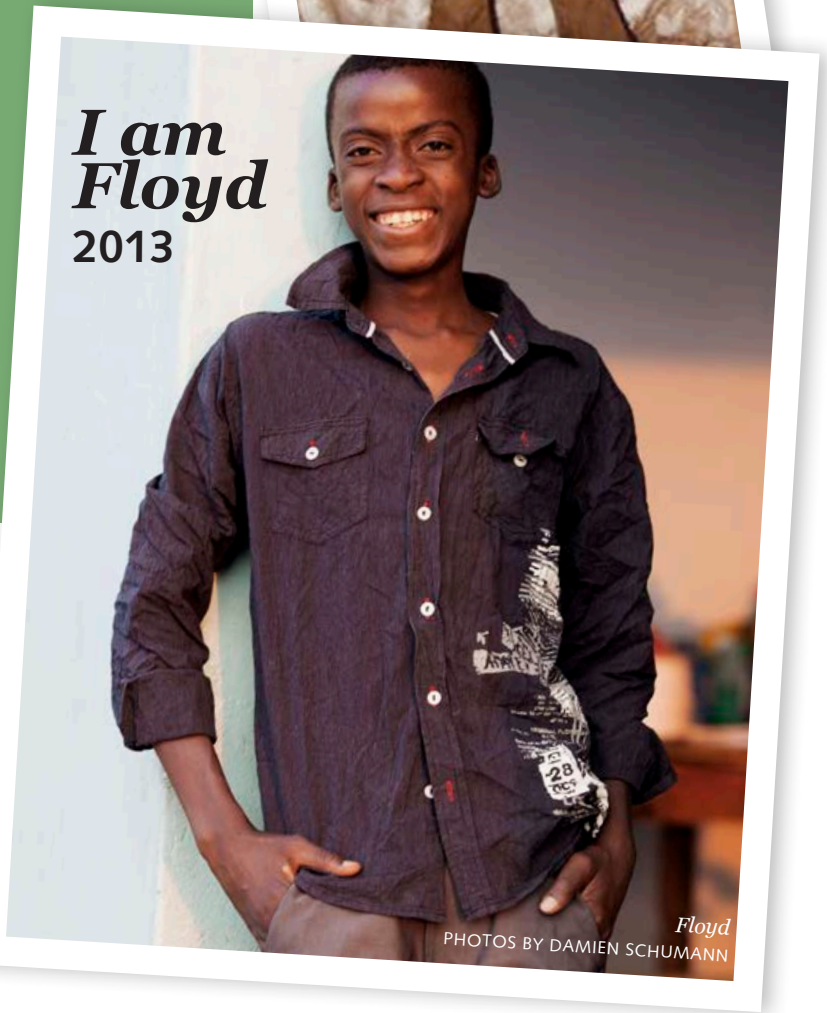
As such, MDR-TB constitutes a public health crisis in many settings; most notably in Eastern Europe and Central Asia. Inadequate treatment of MDR-TB leads to the emergence and spread of extensively drug-resistant TB (XDR-TB). XDR-TB,

People embody the importance of our work

People's testimonies inspire us in our work on a daily basis. Some even transcend the everyday: sometimes the simple words of a cured child have gone on to inspire policy makers and governments to do more in the fight against the world's three most infectious diseases.

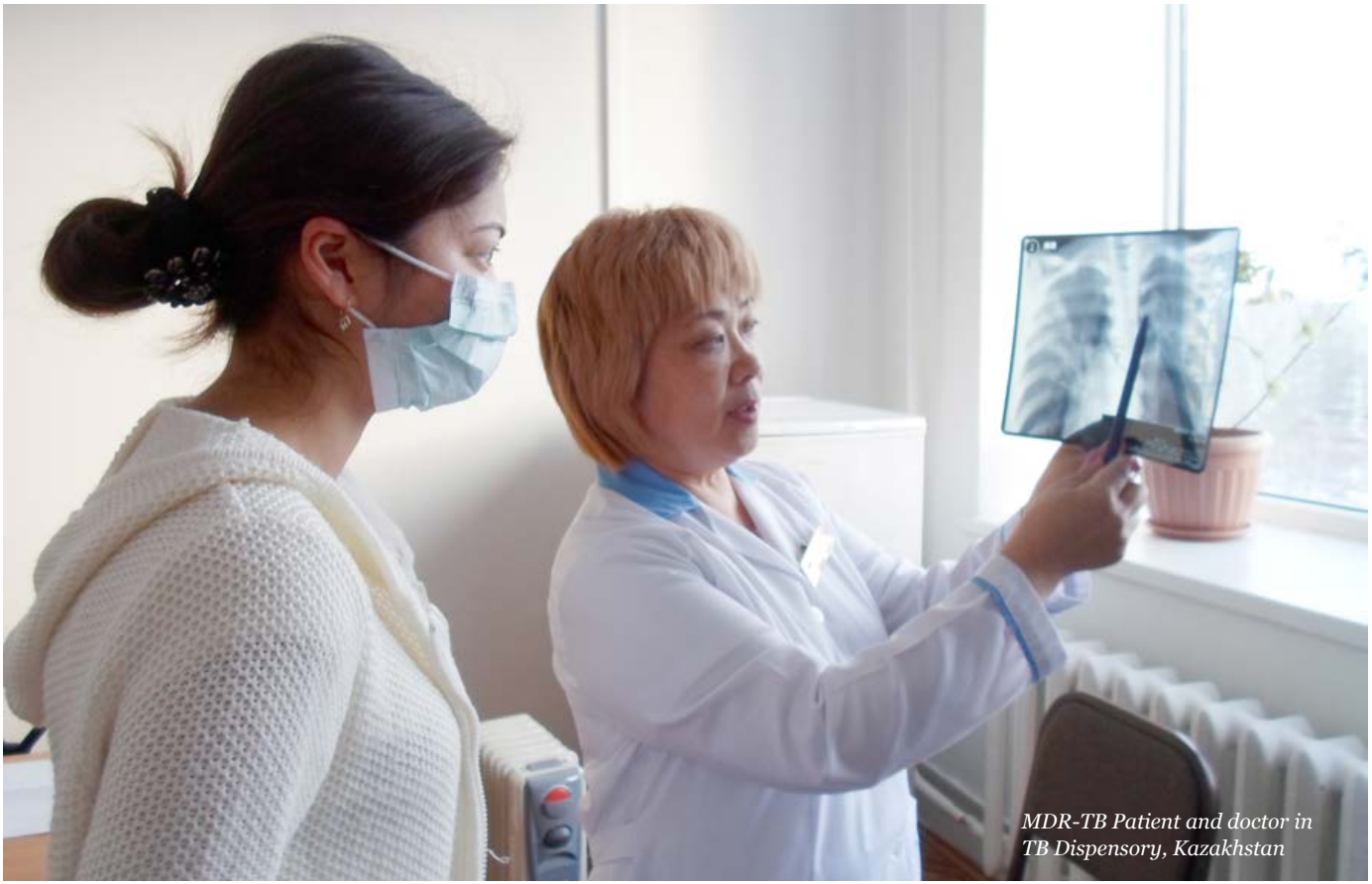
Floyd is such a child; his picture at age six gave a face to the call to the action on HIV/AIDS and TB of the Dutch Multiparty Initiative on HIV/AIDS and Sexual and Reproductive Rights, that got off to a start in March 2007. His inspiring story radiated the vitality that is possible even after a very rough start in life. After his sad early years (both his parents succumbed to HIV/AIDS and he suffered exclusion and maltreatment because of his TB) his testimony, and particularly his three simple words: I am Floyd, made a lasting impact. "I have regained my health, I received treatment and love, and I now live with my adopted brothers and sisters in the orphanage." In 2013, now a fun-loving and vivacious teenager, he called on governments to provide treatment and support to the women's groups that play such an important role in the fight against TB and HIV/AIDS http://www.hereiamcampaign.org/portfolio-post/floyd-tb-story/. He did so in his self-filmed video for the Here I am Campaign, a campaign which he inspired. In turn, the campaign brought to us many TB Champions as strong advocates for the work that we, the Global Health Community, do.





Floyd
PHOTOS BY DAMIEN SCHUMANN

We wish to acknowledge Jean Molenga who is raising Floyd, along with 20 other orphans, her brainchild the HEAL project in Zambia and Damien Schumann the Photographer.



MDR-TB Patient and doctor in TB Dispensory, Kazakhstan

which is very difficult to treat, has been reported in 92 countries.

TB/HIV

An estimated 1.1 million (13%) of the 8.6 million people who developed TB in 2012 were HIV-positive and three quarters of them live in the African region. Among them, 320,000 died of TB. Many countries have made considerable progress to address the TB/HIV co-epidemic. The coverage of Anti-Retroviral Therapy (ART) among TB patients and TB screening among people enrolled in HIV care increased significantly. However, uptake of Isoniazid Preventive Therapy (IPT) is still limited with only (31%) of eligible patients enrolled on IPT.

Global developments

The year 2013 will be remembered as the year of new technical advances and related research questions. In 2013, WHO issued interim guidance for the use of Bedaquiline, the first novel MDR-TB drug in four decades. In November 2013, the European Medicines Agency (EMA) recommended market authorization for the second new drug for MDR-TB, Delamanid. These two new drugs have the potential to turn the MDR-TB tide. The challenge is now to design new effective regimens and prevent the emergence of resistance to these drugs. Anticipating these developments, KNCV assisted several countries preparing for the safe introduction of new drugs.

Other technical advances concern the scale-up of new diagnostic tools. In 2013, KNCV worked closely with countries and local partners to scale-up the use of new tools such as Xpert® MTB/RIF for the rapid diagnosis of MDR-TB. The 2013 results show an enormous impact on MDR-TB detection and treatment outcomes.

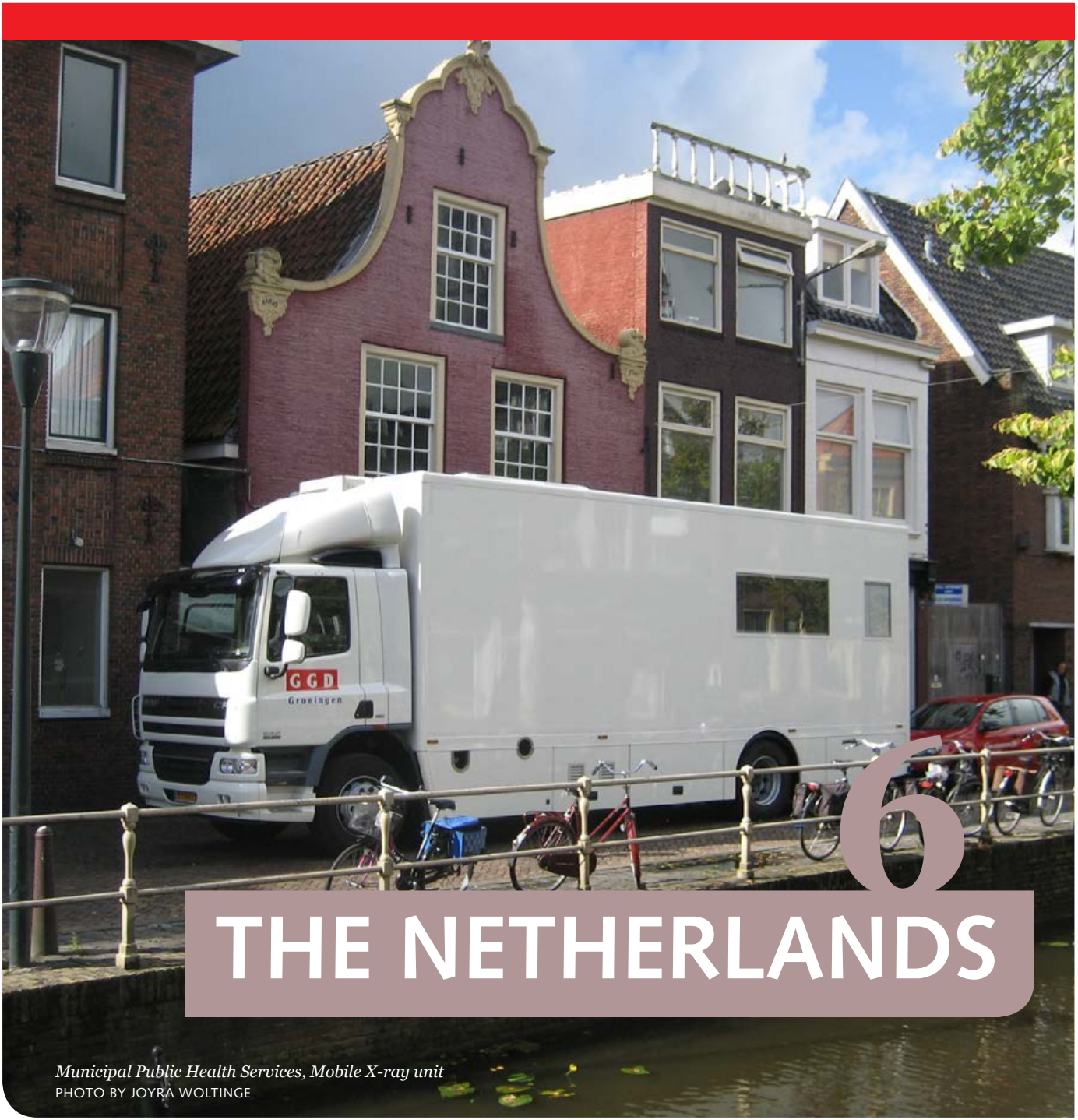
Floyd's inspiring personality and testimonial helped us bring back TB onto the agenda of the Dutch government.

KNCV is grateful to the Dutch Parliamentary Multiparty Initiative for their strong political backing and recognition of the fight against TB as an essential component of the fight against HIV/AIDS. Our partners in the field of HIV/AIDS and TB joined our call on the Dutch government to use the potential of Dutch expertise in the fight against the three diseases. On Tuesday 26 November 2013 KNCV and STOP AIDS NOW! handed over a petition to the Dutch MPs of the Committee on foreign trade and development aid. KNCV and STOP AIDS NOW! handed over a teddy bear to the MPs, with which they draw attention to children with HIV and TB in poor countries.

In 2013, the Global Fund developed their New Funding Model (NFM) for countries, which involves a complex sequence of steps for Global Fund applications. This is of utmost importance as many countries depend on the Global Fund for financing of their TB control programs. Recognizing the demand for NFM technical assistance, KNCV has been on the forefront in assisting countries with all components of the NFM. As such, KNCV actively contributes to resource mobilization and rational implementation of this funding mechanism, taking into account country-specific priorities.

Zimbabwe, rasing awareness TB symptoms at health facility

On the policy level, WHO and the Stop TB Partnership, of which KNCV is a founding member, developed the new post-2015 Global TB Strategy and new global targets for TB care, prevention and control. KNCV actively participated in this process that led to the approval of the proposed strategy by the WHO Executive Board which is the first step to adoption by the World Health Assembly in May 2014.



6 THE NETHERLANDS

Municipal Public Health Services, Mobile X-ray unit
PHOTO BY JOYRA WOLTINGE

KNCV has been coordinating TB control in the Netherlands since it was established in 1903 as "Nederlandse Centrale Vereniging tot bestrijding der Tuberculose", which means "Dutch Central Association to fight TB". In 1953 the "K" ("Koninklijk" which means "Royal") was added to the name, and the name was changed into KNCV.

Country Visit national TB Program The Netherlands
PHOTO BY PETER KOUW

As in most Western European countries, the TB epidemic in the Netherlands is declining. As a consequence special measures are needed to maintain clinical and programmatic expertise and experience. In the Netherlands, KNCV supports the implementation of the National TB Control Plan 2011-2015, that was developed in 2010 with KNCV support. KNCV collaborates closely with the National Institute for Public Health and the Environment (RIVM), the Municipal Public Health Services (MPHSs/GGDs) and other institutions, such as professional organizations involved in TB control. KNCV provides technical advice and advocates for quality and equitable services. Furthermore, KNCV's specific role in the Dutch TB program is developing evidence-based policies and guidelines, conducting research, contributing to knowledge management for professionals and provision of TB information to the Dutch public.

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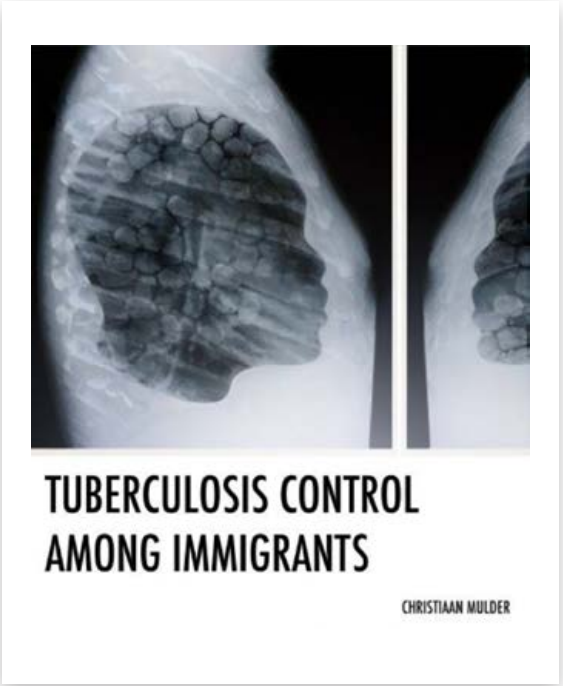
Policy and guideline development and other activities in 2013:

RIVM and KNCV organized the International Review ("Country Visit") of the national TB program in the Netherlands, which was carried out by eight international experts from WHO/Europe and ECDC. The review took place in the context of declining patient numbers, an all-time low of 848 patients in 2013. The



team reviewed human resource aspects of TB control, TB laboratory services and screening and contact investigation policies and practices. KNCV will translate the recommendations of the International Review Team into an Action Plan and closely monitor follow-up.

Policy and Guideline Development: KNCV supported the Committee for Practical TB Control (CPT) to update the following guidelines: i) TB/HIV management, ii) Risk group policy, iii) TB screening of Health Care Workers and iv) Prevention, and diagnosis and treatment of MDR-TB. These are much needed to help organizations to keep the number of TB patients low, reduce the risks of the spread of multi-drug resistant TB, and keep the knowledge and care about TB diagnosis and treatment up-to-date. KNCV and CPT will facilitate and evaluate the uptake of these new guidelines.

RESEARCH: Following a previous KNCV study on latent TB infection (LTBI) among immigrants, ZonMW[2] approved a study focused on a new strategy of screening immigrants for LTBI, looking at both organizational aspects in MPHSs as well as the acceptance of screening and preventive therapy by immigrants. Six MPHSs collaborated in the project and 726 immigrants were enrolled in the study; 91 were identified with LTBI and only 26 completed preventive therapy. KNCV uses these results from and recommendations from the International Review Team to inform policy-development TB screening among of immigrants.

KNOWLEDGE MANAGEMENT: KNCV annually supports training programs for TB professionals in the Netherlands. The Regional office The Netherlands & Europe contributed to 25 articles in 2013 and three issues of "Tegen de Tuberculose" were released.

Quality and equitable services: KNCV offers assistance to patients in a material way through the "Fund Special Needs" supported by Stichting Madurodam Steunfonds (Madurodam Support Fund).

[2] Zorgonderzoek Medische Wetenschappen

Wolfheze workshop 2013
PHOTO BY IS VORMGEVING

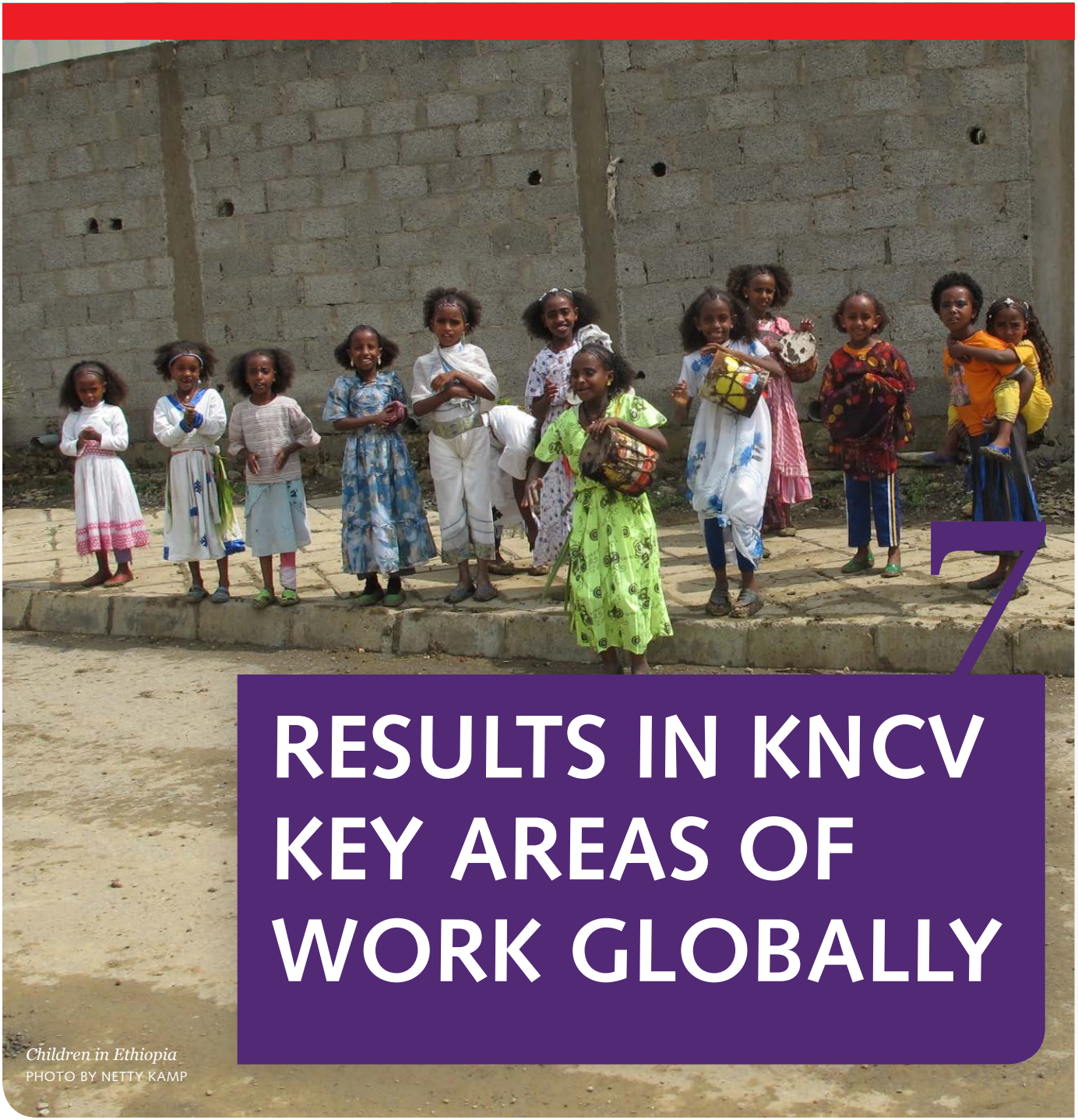
A Dutch patient's story

The emphasis of the Wolfheze Workshop was on the patient perspective. A Dutch patient told her story to the 200 TB experts from 54 countries: "*One day, I cycled to the hospital with my three year old son for a chest X-ray. The General Practitioner had referred me because of my persistent cough. The chest X-ray showed abnormalities. I was asked to put on a mask and was immediately directed to the pulmonologist. He told me I had TB and explained me about the disease. Then my three year old, who had fallen asleep, woke up and stared at me in my new outfit. He loved it, the mask. Shortly after that we left the room, both masked!*" The patient explained to the public how her life changed from one moment to the other, what the impact of having TB was, and how important it is for the patient to be supported by helpful and understanding TB professionals in a patient-centered way.

In 2013, 132 requests for financial assistance were approved. One example is a patient in the northern part of the Netherlands who received a bicycle enabling him to visit the hospital weekly because of the side effects encountered during treatment, and pay daily visits to the MPHS for directly observed treatment (DOT). KNCV will involve patients more in TB program issues. We want to motivate patients to share their experiences and will explore how they can be involved in making public information materials, guidelines, contribute to training sessions.

Contribution to European policy development and knowledge management

In 1990, KNCV and the International Union against Tuberculosis and Lung Disease (now The Union) initiated a European meeting to discuss interventions necessary to eliminate TB in Europe in the Dutch village Wolfheze. Since then, these meetings, so-called "Wolfheze Workshops", take place bi-annually. KNCV, together with WHO/Europe and ECDC organized the 2013 workshop back-to-back with the European Reference Laboratory Network and Surveillance Network meetings. The event attracted more than 200 participants from 53 countries. Prevention, diagnosis, treatment and care aspects of TB control in the European region were discussed, and three new working groups were established to address TB-related challenges with health financing, social determinants of health and intensive case-finding.



7

RESULTS IN KNCV KEY AREAS OF WORK GLOBALLY

Children in Ethiopia
PHOTO BY NETTY KAMP

To fight TB globally, KNCV implements, evaluates, adapts and develops comprehensive strategies to improve detection of TB patients and ensure that all identified cases are being cured. Knowing your epidemic is key to success as it informs where and how to target your interventions and reach the vulnerable groups in which TB continues to spread and take lives. With both epidemiologists and program experts under its roof, KNCV is in the favorable position to be able to effectively link epidemiology, programmatic innovations and operational research. Although we worked on all aspects of TB control, our key areas of work in 2013 were:

- Programmatic Management of Drug resistant TB (PMDT);
- TB/HIV and Infection Control;
- New diagnostics and laboratories strengthening;
- Sustainable Financing for Health Systems Strengthening (HSS);
- Community engagement and Patient Centered Services;
- Childhood TB;
- 'Know your Epidemic';
- Public Private Mix (PPM) care delivery models for TB control.

These contribute to achieving our strategic goals and for each of them we highlight our achievements of 2013 in this chapter.

7.1 Programmatic Management of Drug resistant TB

The scale-up of programmatic management of drug resistant TB (PMDT) is under way in many countries, with 35% more MDR-TB patients diagnosed in 2012[3] compared to 2011. At the same time health workers and patients are struggling to make treatment a success. KCNV supports countries to build and maintain capacity for quality of M/XDR-TB diagnosis and care during scale-up and decentralization of M/XDR-TB services.

In 9 countries where KCNV directly supported the programmatic management of drug resistant TB, the overall yield of diagnosis and treatment was 2.5 times the global average. In 2012 KNCV-supported countries managed to reduce the treatment gap to only 2%, meaning that 98% of diagnosed MDR-TB patients were actually enrolled on treatment.

Our systematic focus on increasing and matching MDR-TB diagnostic and treatment capacity saves lives, prevents XDR-TB, and will eventually have epidemiological impact through reduced transmission.

With three quarters of MDR-TB patients still undetected and untreated, KNCV has developed a comprehensive response to drug-resistant TB which constitutes a mix of policy-development at global and country levels, program support, introduction of new tools, and related case finding and treatment strategies, as well as research on medical and health systems aspects of MDR-TB.

In 2013 KNCV supported scaling up of PMDT in high-burden MDR-TB countries, under the USAID supported TB CARE I program, in Kazakhstan, Kyrgyzstan,

[3] The figure for 2013 is not yet available

Tajikistan, Uzbekistan, Ethiopia, Indonesia, Kenya, Mozambique, Namibia, Nigeria, Uganda, Vietnam, and Zambia. This was done in different ways:

Improved patient care

From hospital care to ambulatory care:
In many countries, MDR-TB patients are habitually hospitalized for treatment. This entails a huge burden for the patients, their families and the health system. Outpatient care for (MDR)TB patients is more patient-friendly, cost saving for both the TB program and the patients, and helps reduce transmission of (drug-resistant) TB in health care facilities. Furthermore, it reduces treatment delays, which are frequently caused by admission bed shortages, and thus minimizes further transmission and risk of adverse treatment outcomes. Therefore KNCV promotes and strives for universal outpatient care for TB and MDR-TB patients, while ensuring access to quality monitoring and low-barrier treatment of side effects in referral centers. One of the focus areas for this is Central Asia, where MDR-TB is widespread:
In Kazakhstan KNCV supported a pilot in Akmola region. By reducing 90 beds in TB facilities, funds were made available to support outpatient care and the provision of psycho-social support to patients. In the first three quarters of 2013, 320 out of 1,003 (MDR)TB patients were treated through outpatient care. Preliminary data show improvements in treatment outcomes. Dissemination of the initial positive results contributed to strong commitment by both the Ministry of Health and the National TB Program to the expansion of outpatient care in the entire country. Currently a national strategy is being developed for roll-out with KNCV support.
In Tajikistan and Kyrgyzstan, KNCV is piloting similar projects to enhance outpatient care while introducing innovative sustainable psycho-social support to enable patients to adhere to treatment. This includes introduction of relief from property taxes and utility payments, provision of food packages, and disability benefits.
In Ethiopia, KNCV supported the transition from a mainly hospital based to a predominantly ambulatory model of care, in pace with the establishment of 21 treatment initiation centers in 6 regions. The national PMDT and ambulatory care guidelines were updated in 2013, and over 400 patients started treatment under the ambulatory care model.
In Vietnam, KNCV worked on the alignment of scaling up of diagnostic and treatment services, with a special focus on mainstreaming the use of Xpert® MTB/RIF testing through training and on the job support of laboratory and clinical staff. Quality of treatment was enhanced through revision of the work of the treatment councils. Scale-up of PMDT achieved the target of over 900 patients diagnosed and enrolled on second line treatment in 2013.

PHOTO: KNCV BRANCH OFFICE IN TAJIKISTAN

Jumakhon Kayumov, chairman of the Jamoat Tanobchi of Temurmalik district, meeting with community leaders and activists.
"We used to look at TB as a medical issue but now we realize that it has many social implications. We should leave the patients tot deal with the disease on their own. In our traditions, village communities always provide support to those in need and TB patients now can rely on our support as well"

Table 7.1: Financial impact of TB illness experienced by (MDR)TB patients

	Ethiopia		Indonesia		Kazakhstan	
	TB	MDR-TB	TB	MDR-TB	TB	MDR-TB
Patients who lost their job	76%	72%	26%	53%	31%	41%
Patients hospitalized for TB	36%	82%	33%	62%	98%	100%
median duration of hospitalization (days)	40	80	7.5	10	90	195
% of patients reporting income loss due to TB	92%	79%	38%	70%	67%	56%
% reduction in median income	100%	100%	25%	100%	100%	100%
(for those reporting an income change)						
Patients who received assistance from government or other organizations	24%	73%	22%	34%	17%	27%
Coping costs						
patients who sold property	24%	38%	3%	21%	0%	1%
patients who took out loans	56%	41%	9%	27%	0%	4%
patients who received donations from family/ friends	N.A.	N.A.	32%	43%	57%	66%

Palliative Care: M/XDR-TB patients on treatment experience major physical and emotional suffering resulting from TB disease, co-morbidity, and serious side effects of treatment. To address the needs of these groups of patients in Kyrgyzstan, the concept of palliative care was introduced and a legal framework prepared which included development of: (1) regulations on provision of palliative care; (2) TB specific guidelines and clinical protocols; (3) training curricula on palliative care; and (4) information materials for patients and health care workers.

Socio-economic and psycho social support for patients

Although TB diagnosis and treatment are free in most high TB-burden countries, TB patients face costs due to charges for health services, costs for transport, accommodation, nutrition and suffer loss of income due to inability to work. In collaboration with MSH, KNCV collected data on the direct (out of pocket) and indirect (loss of income) costs of patients and their families related to the diagnosis and treatment of (MDR)TB in Kazakhstan, Indonesia and Ethiopia.

The findings shown in table 7.1 below detail the severe financial and social impact which TB and particularly MDR-TB have on the persons and families affected:

The inability to work and job loss were identified as the most important factors. If the patient is the breadwinner of the family, the combination of lost income and extra costs are generally catastrophic. Therefore, many patients do not even start or complete treatment, which results in unnecessary death and prolonged transmission of MDR-TB in the community. Therefore, KNCV made reducing financial burden for MDR-TB patients a priority and took country specific actions to build political commitment and community engagement to address this issue. KNCV has initiated psycho-social support in Indonesia and East Kazakhstan to enhance patients' ability to adhere to treatment.

Flexible packages for PMDT capacity building

With KNCV support the Regional Center of Excellence (CoE) on Programmatic Management of Drug Resistant Tuberculosis (PMDT) was established in Kigali, Rwanda, in 2010, aiming to build regional capacity to support the elimination of M/XDR-TB in the East African region. Since its

Table 7.2: overview of technical trainings

Technical area of training	2010	2011	2012	2013	Planned in 2014
PMDT	√	√	√	√	√
Laboratory strengthening		√	√	√	√
TB-IC		√	√	√	√
TB/HIV				√	√
Childhood TB					√
Study tours to Rwanda NTP			√	√	√

establishment the CoE has quickly expanded its international training curriculum and portfolio. In 2013, training courses were provided on PMDT, TB Infection Control, Integrated TB/HIV care, Laboratory services and organized Study Tours to the Rwanda NTP.

KNCV is also active in international policy development through the Global Drug resistant TB Initiative (GDI), the Global Laboratory Initiative (GLI), the regional Green light Committees (GLC's), the Global Drug Facility (GDF), and together with WHO/Europe and ECDC in the "Wolfheze movement"[4].

Accelerated scaling up of PDMT in 2014

In 2014 the focus will be on:

- *Further scale-up of (MDR)TB detection* through the roll-out of the Xpert® MTB/RIF test; ensuring that all MDR-TB patients diagnosed receive adequate treatment by increasing (ambulatory) treatment capacity, linking laboratory results to treatment decisions and reducing unnecessary delays.
- *Improving treatment results* through further development of in-country MDR-TB treatment centers;
- internet-facilitated treatment counseling; and support to the responsible deployment of innovative regimens and models of care.
- *Field implementation of newly approved drugs, especially for pre-XDR and XDR-TB.*

Monitoring of PMDT in Da Nang Vietnam

7.2 TB/HIV and TB Infection Control

Addressing the co-epidemic TB/HIV

Access to Anti-Retroviral Therapy (ART) among TB patients who are known to be HIV-positive, and access to Isoniazid Preventive Therapy (IPT) for HIV patients on ART therapy, remains the major issue in addressing the co-epidemic TB/HIV, at TB and HIV facilities alike. To further scale-up IPT and ART provision KNCV assists countries to decentralize these services to the most peripheral levels in the context of country-specific solutions to integrated TB/HIV care.

This included 'one-stop shop' services to facilitate access and referral, stigma-reduction, health education and social mobilization. KNCV played an active role in helping countries to incorporate appropriate budget lines in National Strategic Plans and TB/HIV Global Fund Concept Notes to ensure sufficient funding. We will continue this activity in the future, benefiting from new Global Fund instructions to develop simultaneous and coordinated applications for TB and HIV/AIDS Global Fund grants.

We also supported regional initiatives such as the East Central and Southern Africa Health Community (ECSA-HC) to strengthen collaborative TB/HIV activities.

[4] See "the Netherlands" chapter

PROGRESS AND ACHIEVEMENTS IN 2013:

In Kenya, KNCV took part in a randomized trial to improve the uptake of IPT. This trial demonstrated excellent completion rates and fewer contacts developing TB disease.

In Namibia, KNCV supported the TB/HIV Technical Working Group and Steering Committee that oversees the day-to-day operations of a demonstration project. The project enhances the 3 I's *(Intensified Case Finding, Isoniazid Preventive Therapy and Infection Control Practices)* in HIV clinics.

In Nigeria KNCV supported the development of national 3 I's Guidelines.

Through TB CARE I, KNCV supported the ECSA-HC to organize its first HIV, TB and other infectious diseases Experts Committee meeting. The workshop resulted in an Integrated HIV/AIDS, TB and Infectious Diseases Strategic Plan; a regional Tuberculosis Training Corridor[5]; Cross Border and Regional Programming in TB control; and the development of a policy on the management of M/XDR-TB in the ECSA Region. The meeting provided key input to the Directors Joint Consultative Committee (DJCC) meeting, whose recommendations are considered for resolution by the health ministers.

Through the Regional CoE in Rwanda, KNCV developed a course on integrated TB/HIV care promoting the "one-stop-shop" model of care. Participants from nine African countries attended this course on integrated TB/HIV care.

Community strategy test proves that IPT provision under program conditions is feasible and safe

In this community trial household contacts of 359 TB/HIV co-infected patients in 18 health facilities in high TB/HIV localities in Kenya were enrolled in either a control (614 contacts) or intervention group (641 contacts). In the control group contacts underwent the routine policy: invitation for screening at the clinic via the diagnosed TB patient with IPT offered to children under five years of age. In the intervention group, household contacts were actively followed up at their home through Community Health Workers (CHWs) and screened for active TB and offered HIV testing. If contacts were considered fit on the basis of a screening questionnaire they were offered 6 months IPT at home. Household contacts in both groups were followed up with monthly home visits over a period of 18 months. In the intervention group 637/641 (99%) contacts started IPT compared to 17/614 (3%) in in the control group. Of those starting IPT in the control group all we're children while in the intervention group 48% were children. IPT completion rate was over 90% in both groups and no serious adverse events were reports. In the control group ten (10) contacts developed active TB compared to only one(1) contact in the intervention group. The study concluded that IPT provision at household level by CHWs is safe and feasible. We expect that the results of this study will convince many other countries to scale-up the provision of IPT using the same community based approach, thus preventing new TB cases.

Assistant field coordinator and Community Health Care Worker checking files
PHOTOS BY JANE NABONGO

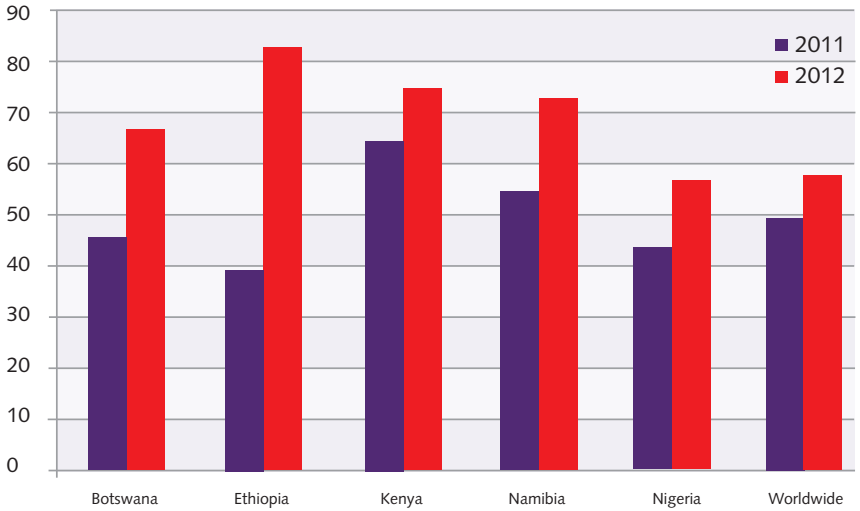
[5] Shared training circuit/corridor between countries for East and Horn of Africa by interlinking institutions and earmarking them for specific training in TB. This will help to relieve individual countries to invest hugely in specialized TB trainings in-country or sending long distances for specialized TB training.

JOINT PLANNING AND TECHNICAL ADVANCES FACILITATE INTEGRATED SERVICE TB/HIV DELIVERY IN 2014:
Regarding TB/HIV, KNCV continues to advance integrated TB/HIV service delivery by supporting countries in all steps of developing and implementing joint TB/HIV strategies. We will assist countries to formulate concept notes for the Global Fund, strengthen TB/HIV data management systems, and improve prevention, diagnosis and treatment. More specifically KNCV will assist Ethiopia, Indonesia, Nigeria, Kenya, and Tanzania to develop joint TB/HIV proposals to obtain funds from the Global Fund, scale up and evaluate the use of Xpert® MTB/RIF among PLHIV with presumed TB in Zimbabwe and Nigeria, support the incorporation of TB-IC criteria in the national hospital license and accreditation system in Indonesia an contribute to the WHO revision of TB/HIV indicators for the TB/HIV M&E Framework.

Global TB Infection Control (TB-IC)

TB Infection control (TB-IC) is top priority especially in high risk health facilities hosting HIV infected individuals and MDR-TB patients and congregate settings such as prisons. Until now, countries tend to focus on environmental control measures and personal respiratory protection, rather than on cheap and effective administrative controls such as prompt identification and separation of coughing patients and teaching of cough etiquette. Also, Health Care Workers (HCWs) are not sufficiently aware of the occupational risk of TB infection and the benefits of undergoing regular screening for TB. Therefore, KNCV continued to help national programs to develop and revise their national TB-IC guidelines and implementation plans including guidance on the monitoring of TB disease among HCWs. Together with TB CARE I and II partners, KNCV promotes the FAST[6] TB Infection Control Strategy for congregate settings, which emphasizes the most important administrative controls.

Figure 7.1: Impressive ART uptake in KNCV supported countries



Worldwide, the proportion of HIV infected TB patients on ART has increased from 49% in 2011 to 57% in 2012. In the African region the proportion increased from 46% to 55%. Against this background, the increase in five KNCV supported high burden countries is remarkable: from 49% in 2011 to 70% in 2012 (Sources: Global Tuberculosis Report 2012 and 2013)

PROGRESS AND ACHIEVEMENTS IN INFECTION CONTROL:
KNCV assisted in developing the national TB-IC guidelines of Kyrgyzstan, Uzbekistan, South Sudan and Djibouti, and the revision of the guidelines of Kazakhstan and Namibia. All guidelines include the FAST approach. In Ethiopia, KNCV assisted to significantly scale up facility level TB-IC and to develop national building design standards for health facilities preventing transmission of airborne infections. With support from the TB CARE I project, KNCV and TB CARE I partners developed a guide for national programs to monitor TB disease among HCWs. The risk of HCWs contracting TB disease is

[6] **F**inding TB cases - **A**ctively, - **S**eparating safely, and - **T**reating effectively. A focused approach to stopping TB spread in congregate settings.

TB Control in fragile states

KNCV has had to remain flexible with its mission to control TB when working in fragile states, where there is often a great need for TB control. For instance, in 2013, due to civil and political strife leading to safety concerns, KNCV was not able to send its staff to South Sudan and has pro-actively arranged that planned TB infection control trainings in-country would be conducted in a neighboring country. KNCV has established a similar mechanism for TB-infection control capacity building for National TB program representatives from Somalia.

a proxy indicator for measuring the effectiveness of TB-IC. In Zambia, as part of the TB CARE I Ndola district demonstration project, 50% of HCWs were screened for TB and HIV in six months, representing a first systematic approach to HCW screening in Africa.
In 2014, KNCV will assist countries with developing sound and prioritized TB-IC implementation plans, which include administrative controls that can reduce systems delay in diagnosis and start-of-treatment. Therefore, in Kyrgyzstan, Uzbekistan and Tajikistan, KNCV will further scale-up facility level TB-IC and implement the FAST strategy in Ethiopia, Indonesia and Nigeria.

7.3 TB Laboratory and diagnostic strengthening

Globally, a massive scale-up of laboratory services is needed in order to attain universal quality TB diagnosis by 2015, in line with the WHO Global Plan to STOP TB (2011-15) and the even more ambitious targets from the post-2015 strategy. Although smear-microscopy is still the cornerstone in diagnosis of pulmonary TB and for monitoring treatment response and outcome, faster and more sensitive laboratory tools need to be rolled out to diagnose smear-negative, extra-pulmonary and drug-resistant TB. Therefore, KNCV, focused on the roll-out of new WHO approved diagnostics such as LED FM and Xpert® MTB/RIF, while at the same time continuing to support quality assurance of smear microscopy.

TB laboratory services strengthening

In 2013, KNCV organized trainings and external quality assurance programs for microscopy in Botswana, Indonesia, Nigeria and Vietnam. To improve the diagnostic capacity among persons co-infected with TB and HIV, KNCV supported integration of a combination of LED FM and Xpert® MTB/RIF into the TB and AIDS Control Programs in Botswana and Nigeria. In Indonesia, KNCV supported all aspects of laboratory network strengthening, including culture capacity and introduction of new tools.
The focus in 2014 for KNCV will be to continue to aid countries, on a case-per-case basis, to re-tool their laboratory networks and design country-specific diagnostic algorithms that result in increased and early case detection of all forms of TB.


Scooter transport of sputum samples to clinic

Xpert® MTB/RIF platform roll-out

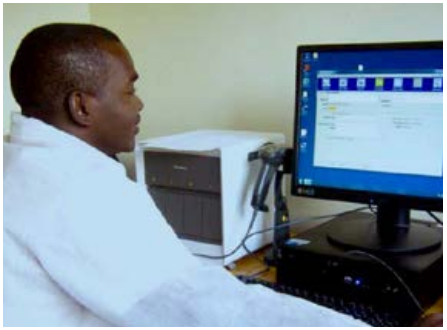
Recognizing the potential of the Xpert® MTB/RIF test for improving TB diagnosis in general and the diagnosis of MDR-TB in particular, KNCV developed a critical pathway of steps required for the rational and quality roll-out and use of Xpert® MTB/RIF. In 2013, KNCV maximized the full utilization of its cadre of capable laboratory, clinical and programmatic experts to provide state-of-the-art programmatic advice and training for Xpert® MTB/RIF test roll-out. Local staff was recruited and trained in Nigeria, Indonesia and Vietnam to increase in country capacity. In 2013, KNCV directly supported the roll-out of Xpert® MTB/RIF

in Botswana, Ethiopia, Indonesia, Kazakhstan, Kyrgyzstan, Nigeria, Tajikistan, Vietnam and Zimbabwe, and contributed to policy-development in regional and global fora. As a result, in Tajikistan for example, MDR-TB detection increased 2.5-fold and in Nigeria, more than 250 persons were enrolled on MDR-TB treatment as a direct result of KNCV support to Xpert® MTB/RIF roll-out. A similar approach in Kazakhstan and Indonesia led to shorter diagnostic delays which reduced treatment delays from 3-4 months to less than 2 weeks. Shortening of diagnostic delays were also observed in a KNCV supported project in Zimbabwe. Last but not least, KNCV contributed to a cluster randomized trial of Xpert® MTB/RIF use in Brazil, in collaboration with the Bill and Melinda Gates Foundation and other partners. Xpert® MTB/RIF implementation led to a 59% increase in notification of laboratory-confirmed TB, and a modest, not significant, 15% increase in notification of all forms of TB.

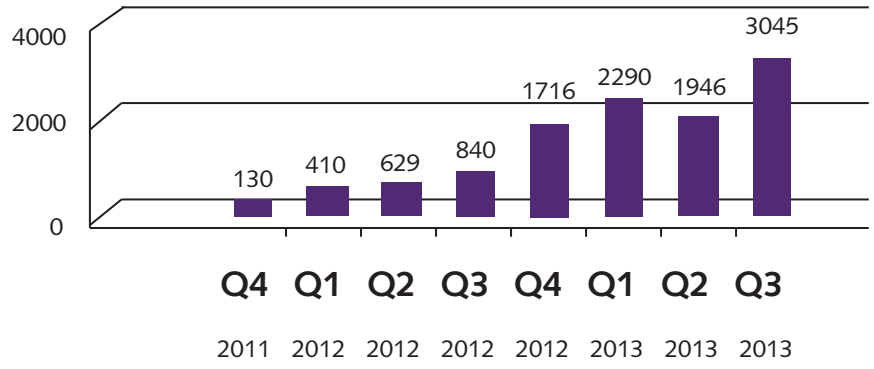
In 2014, KNCV will continue to support the Xpert® MTB/RIF roll out and initiate additional projects for using standardized mobile TB screening with Xpert® MTB/RIF among high risk groups and will further support countries to develop capacity to expand Xpert® MTB/RIF testing among children and extra-pulmonary TB patients.

KNCV's contributions to guideline and policy development

Handbook for National TB Laboratory Strategic Plan Development. Conceptually, this Handbook allows countries to re-tool their laboratory networks to better address effective, timely and quality-assured diagnosis of TB using WHO-recommended tools. This tool was endorsed by the Global Laboratory Initiative (GLI). KNCV also had the lead in the development of internationally standardized training materials for laboratory and clinical use of Xpert® MTB/RIF and updated the TB CAP laboratory toolbox, with standard operating procedures on novel WHO-endorsed diagnostic techniques. New international TB microscopy laboratory guidelines, supported by KNCV, were endorsed by the GLI in 2013. KNCV co-coordinated, under the TB CARE I mechanism, the 2nd African Regional Training Workshop on Xpert® MTB/RIF in July 2013 in Gaborone, Botswana. This practical hands-on workshop provided a platform for nearly 100 participants from 12 African countries to discuss the expanded use of Xpert® MTB/RIF for (MDR-) TB detection among PLHIV.



In 2014, KNCV will continue to participate actively in global fora for laboratory and diagnostic strengthening. Together with the Netherlands Royal Tropical Institute (KIT), KNCV will develop a best practices guideline for ISO 15189 accreditation, based on successes in Botswana, Uganda and Benin and finalize a project to develop standardized quality indicators for all WHO-endorsed laboratory techniques. KNCV will advocate for and contribute to demonstration projects of novel diagnostic technology platforms to generate evidence of their potential effectiveness in programmatic settings.



Total Sputa Tested with Xpert MTB/RIF
Q4 2011-Q3 2013 (Nigeria)

7.4 Community engagement, partnerships and patient centered services

Advocacy, Communication and Social Mobilization (ACSM) are strategic interventions to achieve the goals of the Stop TB Strategy, aiming at behavior change, improvement of case detection and treatment adherence, reduction of stigma and discrimination, empowerment of patients and communities affected by TB, and mobilization of resources for TB through increased political commitment. The acronym ACSM is now making place for more general understandable concepts covering the same principles, like community engagement and patient centered services. The creation of an enabling environment for patients and communities to be genuine partners is key in these approaches for a successful implementation of both quality patient centered services as well as engagement of civil society in TB control activities.

In order to find the "missing" (non-detected) TB patients, which often are to be found among key affected populations and those difficult to reach, KNCV promotes community engagement interventions with these groups to raise their awareness of the problem and jointly seek local solutions. We support the planning of community engagement and communication interventions with NTPs and CSOs in different ways and at different levels and stages, for instance as part of National Strategic Plan development. Patient-Centered Approaches (PCA) have been piloted and models developed in the Central Asia Region (CAR) region. Applying a patient-centered approach is an important strategy to improve the quality of TB services, better treatment outcomes and less suffering for families. In 2013 the PCA project provided the evidence for the effectiveness of these approaches in 5 countries: Cambodia, Indonesia, Mozambique, Zambia and Nigeria.

Support to strategic planning of community engagement interventions

In 2013, participatory workshops were held for strategic national and sub-national planning of ACSM activities with NTPs and stakeholders like CSOs, informal providers and prison staff in Zambia and Namibia. During these workshops the TB problems were analyzed and solutions were developed together with the stakeholders, resulting in strategies and concrete action plans. The in-country developed interventions will be implemented with support of all civil society stakeholders involved. Mozambique is implementing provincial ACSM plans and will incorporate the ACSM plan in the NSP. Likewise, KNCV assisted Vietnam with the development of the ACSM component of their NSP.

Mid-Term Reviews were held as a step prior to the preparation of the NSP and as a requirement for Global Fund applications. A KNCV Community Engagement expert participated in the Namibian and Ethiopian country reviews, ensuring that community engagement, communication strategies for behavior and social change, and patient-centered services were specifically evaluated. Special attention was given to the prison populations and how to engage them effectively in TB control. In 2013, KNCV also supported the formulation of national guidelines for community engagement in Zimbabwe, based on the WHO guidelines developed with KNCV support in 2012.

Empowerment of TB patients and psycho social support

In Indonesia KNCV initiated psycho-social support to MDR-TB patients through social workers. Subsequently MDR-TB patients organized themselves into Peer Educator Groups. KNCV developed a concept paper based on this experience, describing objectives, strategies, methods and steps to be taken to establish such empowering peer educator groups among MDR-TB or TB patients. KNCV is developing this model further and expanding it nationwide through large Faith Based Organizations, which have huge networks.

In Kazakhstan KNCV initiated psycho-social support (PSS) to TB and MDR-TB patients involving social workers and

psychologists. Based on this experience in East Kazakhstan Oblast (EKO), KNCV is further developing the model and expanding it nationwide, linking it to the recently introduced outpatient ambulatory TB care approach in the country. Prior to the intervention a needs assessment was conducted, which showed that the majority of patients are in need of either psychological or social support. In 2014 results will be available to show the impact of PSS on treatment outcomes.

In Tajikistan and Kyrgyztan TB staff and PHC workers have been trained on Patient-Centered Approaches to develop awareness and change their attitude towards patients.

Ethiopia: This poster was made to raise awareness of the public on TB transmission from adult to children who are in close contact/e.g. household/. And, it also provides information on possibility to prevent TB through IPT in children if they are brought to health facilities for contact screening.

Communication materials development to improve infection control in CAR region

KNCV developed information and education materials on infection control (cough etiquette and personal protection) support material for patients' and health workers' behavior change in Tajikistan and Kyrgyzstan. These materials are used for training TB and PHC staff and are displayed as posters and brochures in health care facilities. Similarly KNCV developed information and education materials for palliative care in different care settings.

Dissemination of Good Practices in Community Participation

KNCV organized a mini symposium on Community Participation in The Hague in connection with the European Wolfheze TB Conference[7]. KNCV presented good practices like the successful establishment of 70 municipality Stop TB Committees in the Dominican Republic resulting in an increased number of early detected TB patients in 2013, the use of the advocacy and patient empowerment instrument Photovoices, and the school youth mobilization activities in Santo Domingo. The youth produced more than 100 mural paintings with TB messages on public walls.

Another example of good practices given was that of TB mobilizing activities in Romania among Roma youth, for example pictures and videos made by school youth and theater shows by out-of-school youth. Roma are a vulnerable and difficult to reach population with 10 times higher TB incidence than the general population.

Evidence base for community engagement and patient-centeredness.

Several studies have been carried out to measure effectiveness or impact of patient-centered approaches in TB control and community engagement:

- The Patient-Centered Approach (PCA) tool was implemented in five countries: Cambodia, Indonesia, Mozambique, Nigeria and Zambia. Baseline and end line data were collected to measure change. The project activities ended in 2013 with all countries having plans to scale up implementation to other parts of the country. The results show there was a significant improvement in knowledge of patient rights due to the introduction of the Patient's Charter. An encouraging result was the general feeling of empowerment by both patients and providers due to the PCA package and in particular the Patient's Charter. The Charter was described as a tool much appreciated both by providers and patients, because it describes patient's rights but also their responsibilities. The study also provided important information on financial barriers and (self)stigma that is relevant for policy development.
- KNCV provided technical support to a qualitative study in Mozambique in collaboration with partner FHI and carried out by a local NGO. The study explored knowledge, attitude and practices, including stigma and misconceptions related to TB. Important findings on gender related cultural misconceptions will be used in the development of communication materials.
- In 2012 and 2013, KNCV trained wom-

[7] See chapter "The Netherlands"

"I would like to do the TB health education now with the inmates… They would love it, they need to be empowered.."

Interview with Ruth Chivasa, village health worker Whawha, Gwuru province, Zimbabwe present at the community training.

Ruth Chivasa, 31 years, is a VHW in Whawha, Gwuru province. Her mother died of TB as she believed it was caused by witchcraft and did not go for treatment.

Before, since 2007, Ruth was a HIV care giver in her community in the time HIV was beating hard on the population without good access to ART. As the wife of a prison officer she volunteered for the care taking of the many bed ridden HIV patients among the 2000 prison staff and families. She tells: "it was in my position to help people in need, it was just a call of God". She attended many patients but also many passed away as there was no treatment.

In 2010 she followed a 3 weeks course of VHW, followed by a 6 weeks training at the prison clinic, and later a 5 weeks refresher training. After that she worked in maternal and child care as well as HIV/AIDS. She says: "first I panicked, but later I enjoyed it".

"I supported a prisoner's officer wife who was infected with HIV and had TB, and at that time I was not afraid but now with this MDR-TB I am very afraid and want to learn about it. I don't have protective clothes and worrying about who is going to take care of me if I become sick with MDR TB? I am not yet working with TB now, also because many people still hide their status, and nurses and VHWs do not collaborate in the prison. I would like to do the health education now on TB with the inmates (around 3000) as they are currently very much neglected. The information on TB for inmates would spread quickly to other prisons also. The inmates would love it! How to take care of themselves, helping others. They need empowerment and more knowledge."

en's Civil Society Organizations (CSOs) in crowded poor neighborhoods in Addis Ababa in TB control. Outcomes and impact of these activities are measured to create evidence for further expansion and use in Ethiopia and other countries.

- KNCV carried out a study in Namibia to measure cost-effectiveness of community based TB activities funded by Global Fund and USAID. Results will be available in 2014.

Plans for 2014

- Awaiting the outcomes of the studies to community engagement and patient-centered approaches still running in Namibia, Ethiopia and Kazakhstan, implementation and expansion of successful experiences and tools will be one of the main activities for 2014.
- A training curriculum including participant and trainer manuals for Community Engagement will be developed in Zimbabwe including all the new insights on TB control. This will be made available for other countries to be adapted to local situations.
- Vulnerable groups like prison populations, miners and urban slum dwellers will be addressed by developing specific targeted advocacy and social mobilization activities.

Photovoices

Photovoices is an instrument using photography to help people to identify, represent and manifest their needs related to TB. It captures experiences from the perspective of the most vulnerable. The photography gives them a chance to recognize their strengths, priorities and worries related to life and to the disease, giving a voice to those who normally are not heard. It also promotes the generation of knowledge and a critical dialogue around the most important issues related to TB through discussions about the pictures.

"What I most like about my work is that I can give love to, and receive love from my TB patients with whom I work day to day"
(HTTP://WWW.TBCARE1.ORG/VOICES)

"They discuss and share with friends, leaving the new one out. That is how I felt, left out..."
(HTTP://WWW.TBCARE1.ORG/VOICES)

"I feel very sorry for my niece.. She has TB, and the fear and despair stops her from listening to her doctor.. She has no desire to live"
(HTTP://WWW.TBCARE1.ORG/VOICES)

"For me there are two worlds, this side of the wall where we the patients are and the other side where the healthy people are"
(HTTP://WWW.TBCARE1.ORG/VOICES)

"My neighbor is more than a sister. When I let my head hang down, she lifted it up. She told me she was with me and that I should have faith that my treatment would cure me"
(HTTP://WWW.TBCARE1.ORG/VOICES)

7.5 Sustainable financing for Health Systems Strengthening

The provision of sustainable TB services depends to a great extent on the organization of the overall health system. Weak health systems may constitute barriers to providing TB services. KNCV considers Health Systems Strengthening (HSS) as a contribution to removing the barriers and to creating sustainable conditions for TB service delivery.
KNCV defined, in 2011, its role for addressing HSS aspects in the following two, closely interlinked, main areas of (1) identifying and addressing HS obstacles / constraints to TB control and (2) maximizing the opportunities to anchor/embed TB control into the general health system. For HSS KNCV focuses its attention on financing and governance aspects, since other aspects are covered by other KNCV thematic areas.

Honorable Minister of Health and Special Services of Namibia, Dr Richard N. Kamwi, officially launching the National ACSM Strategic Plan document, March 31, 2014.
Credit: National TB and Leprosy Programme/MoHSS

Progress and achievements in 2013

KNCV has focused its HSS efforts in 2013 on developing a KNCV policy for sustainable financing of TB services. In three countries in the African region, Mozambique, Nigeria, and Ethiopia, the financing of TB services was analyzed. The analysis looked particularly at how predictable domestic and external allocations were and which costs categories of TB services were prioritized for domestic funding, such as TB medicines and TB diagnostics. For each country an action plan was developed to make the financing of TB services more sustainable. The study also urged the need for developing long term financing strategies, in which domestic funding will gradually be enhanced, which fits in with the New Funding Model (NFM) strategy of the Global Fund that requires increasing levels of counterpart funding with increasing levels of income of countries.
A highlight in 2013 was the "HSS scan", developed by KNCV during 2011, tested with support from WHO and TB CARE I in 2012, finalized in 2013, and accepted for publication by WHO/Europe, together with the white paper on HSS and MDR-TB. The "HSS scan" will help countries to improve their health systems on TB service delivery. In 2013, KNCV was co-chairing the WHO/Europe task force on MDR-TB and HSS, in particular in former Soviet countries in Eastern-Europe and Central Asia. A major challenge is the need to reform the financing structure of TB services to a system that limits admission of TB patients in hospitals to those who need special medical care and promotes quality TB service delivery on an ambulatory basis.

Challenges and plans for 2014

Our efforts in 2014 will focus on developing instruments to facilitate the preparation and implementation of the Global Fund New Funding Model requirements and country specific analyses and solutions.

7.6 Childhood TB

World Health Organization (WHO) estimates in 2012 revealed that up to 74,000 children die from TB each year and children account for around half a million new cases annually. The actual burden of TB in children is likely to be higher, especially given the challenge in diagnosing childhood TB. Many childhood deaths caused by TB are reported in global statistics as deaths due to HIV, pneumonia, malnutrition or meningitis. For historical reasons, such as the focus on infectious patients, children have long been neglected. KNCV recognizes that we urgently need better diagnostic tools and algorithms; child-friendly anti-TB drugs; better instruments for the quantification of childhood TB; country-specific strategy development which includes all providers; scale-up of contact tracing and preventive therapy; and increased advocacy.

KNCV engagement in childhood TB:

Countries in which KNCV operates were engaged in a number of activities related to childhood TB in 2013. The major ones include:

In Vietnam a new strategy on management of childhood TB, which involves a shift from pediatricians to general practitioners and nurses has been successfully piloted. A total of 1,480 health care staff were trained and in 9 months, 2,808 children with a history of TB exposure were screened, of which 238 (8%) were found to have active TB and put on treatment. Encouraged by the successful pilot project, the NTP has decided to expand the project to 21 provinces over a period of 2 years.

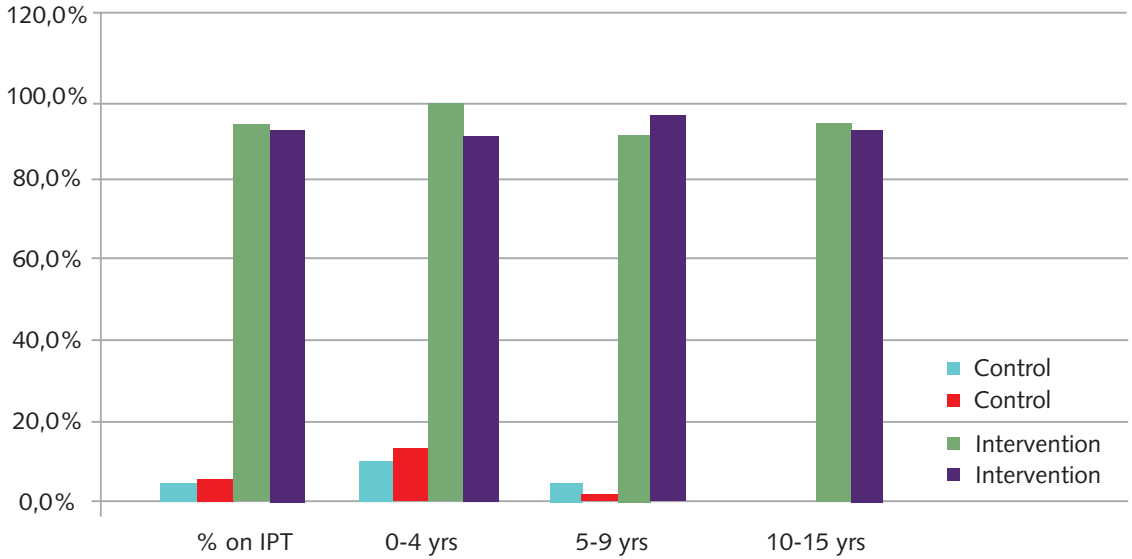
In Nigeria KNCV provided technical and financial support for the management of pediatric TB drugs and the engagement of pediatric professional organizations. KNCV and partners are implementing operational research projects, which involve referral behavior of local madrasas (Islamic religious schools) in Nigeria; the performance of a childhood TB scoring chart in Indonesia; and protocols to identify obstacles for women and children to access MDR-TB care in Vietnam.


PHOTO BY BERT TOMSON

Plans ahead in Childhood TB

In 2014, KNCV will expand its role and visibility by contributing to the evidence base for childhood TB control through evaluating the feasibility and impact of innovative interventions, with a focus on increasing case detection, while reducing the costs and burden for families and health systems. Proposed innovative interventions include pediatric contact tracing (in households of infectious TB patients) using mobile phone pre-screening; pediatric TB diagnosis by nurses as part of task shifting; strategic TB referral by community health workers in Integrated Community Case Management (ICCM) programs; and community-based referral of symptomatic children.

ARM	3_Sex	total child contacts ≤ 15 yrs	total on IPT	% on IPT (all age groups)	0-4 yrs	5-9 yrs	10-15 yrs
Control	Female	177	9	5.1%	10.7%	4.6%	0.0%
Control	Male	145	8	5.5%	13.5%	2.3%	0.0%
Intervention	Female	166	158	95.2%	100.0%	91.8%	95.6%
Intervention	Male	159	150	94.3%	91.5%	96.8%	94.0%



A new approach: children under 5 years of age 75% better protected

In the same community trial mentioned in the TB/HIV section KNCV demonstrated a 90% reduction in TB among vulnerable households affected by HIV in a cluster-randomized control trial of community-based treatment of TB infection in Kenya. This ground breaking community model protected children under 5 years of age 75% better than the existing approach. KNCV's novel approach will be adapted and expanded to new country contexts: In this study in Kenya IPT (Isoniazid Preventive Therapy) coverage reached very high levels following the intervention of offering IPT at household level. IPT was offered at household level to vulnerable households affected by HIV following a simple screening tool to check for eligibility and fitness. The control group followed the national policy in principle, which is: IPT for children under 5 years was provided in one clinic.

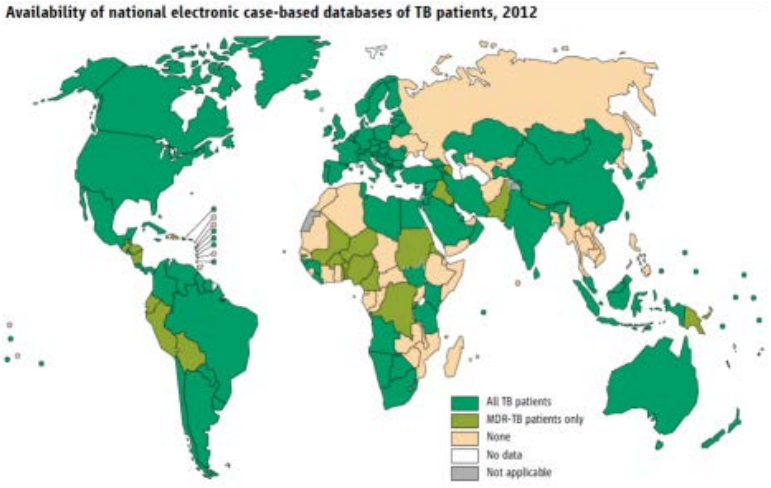
7.7 Knowing your Epidemic

Surveillance & data management

When high quality data are available TB control efforts can be targeted where they are most needed and have the highest impact. TB surveillance has been standardized over the last decades and although most countries have at least a basic surveillance framework in place, many systems remain sub-optimal and/or data are not used to inform policy-development. KNCV has been assisting its core countries with optimizing their surveillance system, including a shift from paper to electronic based systems.

In 2013 KNCV stepped up the application of e- and m-health in TB control. We assisted Kenya in the implementation of its new TB surveillance system called 'TIBU' for digital data collection, data transfer and data reports. The system was developed with KNCV's assistance and uses tablets and computing in the cloud through a telephone connection. We also led the 'e & m health project' for improved access to quality assured drugs for MDR-TB patients. This led to better drug forecasting, improved global forecasting, to close collaboration with the Global Drug Facility and complimentary research by technical partners, such as Interactive Research and Development (IRD). The results of the project will be utilized to inform policies and the design of pilot projects in 2014 on MDR drug management.

Adapting recording and reporting to electronic systems including M/XDR-TB: KNCV supported Kenya and Vietnam in the revision of their recording and reporting systems, ensuring alignment with new WHO definitions and incorporating implementation of Xpert® MTB/RIF. KNCV also contributed to the development of a standard data dictionary and software to be used globally for forecasting of second line TB treatment drug needs, in close cooperation with an international expert group, including WHO. KNCV assisted in integrating the data dictionary in the routine TB surveillance of Vietnam and Kenia. In Kazakhstan, KNCV assisted in developing national M&E indicators and their incorporation in the reporting system of the electronic TB surveillance system.



Epidemiological assessments

Epidemiological assessments are critical for the development of national strategic plans, which now form the basis for the new funding model of the Global Fund. KNCV together with WHO and other technical partners have developed standardized terms of reference for such assessments and have conducted assessments in Zimbabwe, Rwanda and Ethiopia.

Prevalence surveys

KNCV is a core member of the subtask force for prevalence surveys of the global Task Force on Impact Measurement. Meetings of the subgroup resulted in international harmonization of approaches to plan and analyze nationwide prevalence surveys. KNCV continued support for the conduct of prevalence surveys in several countries. Rwanda's first national TB prevalence survey was completed in 2013 indicating that the TB burden was much lower than previously estimated calling for a refocus of the national TB control strategy. Zambia started field data collection of their first national survey

PAKISTAN PREVALENCE SURVEY

Since TB was declared a national emergency by the Pakistan government in 2001, DOTS has been scaled-up rapidly, and collaboration with the private sector was set up. This led to an increase in estimated case detection rate from 5% in 2001 to 69% in 2011. "However, there remained a need to get a precise estimate of the burden of TB in the country", says Dr Ejaz Qadeer, manager of the National Tuberculosis Control Program (NTP) of Pakistan, "and that is why the Ministry of Health of Pakistan planned to conduct a national TB prevalence survey, with the help of internationally renowned technical partners." KNCV was contracted as the main technical partner in the survey and provided support to all aspects of the survey, from protocol development, data collection, and data cleaning, to data analysis and report writing. Experts from KNCV conducted more than 20 technical missions and backstopping at its headquarters. In Pakistan, there was a KNCV team available that assisted the NTP with monitoring of data collection and that provided input to expert review committee missions. "The support received from KNCV has been very helpful to us. For example, the experts have helped us to increase the participation rate from initially below 60% to just over 80%.", says Dr Qadeer.

The survey included 133,000 adult individuals in 95 sub-districts (tehsils) sampled proportional to population size, which made it the second largest TB prevalence survey conducted to date. The execution of the survey was a major undertaking due to the large sample size, widespread geographical coverage, logistic challenges, extreme weather conditions and specific security concerns. Also data cleaning and validation proved to be a major challenge. "KNCV experts have spent months in Pakistan to work shoulder to shoulder with our data management team. This made it possible to present a final report in August 2013." The results show that among adults, there are 396 TB cases per 100,000 inhabitants in Pakistan (95% confidence interval, 332-458). "This is in line with the previous WHO estimate (376 (181–641))", says Dr Qadeer, "but the survey has considerably narrowed the confidence interval around the estimate. Also, we have gained more insight in the distribution of the disease over sex and age classes, and over geographical areas. The results of the survey have been used by Global Fund and will certainly guide the Ministry of Health and Planning for developing a future strategy for TB control in the country and to allocate adequate resources to achieve local and millennium development goals related to TB", concludes Dr Qadeer.

"The support received from KNCV has been very helpful to us"

Dr. Qadeer, on the picture at the left, with the Minister of Health and his NTP staff at the background

which is the first fully electronic survey ever being conducted and important lessons will be provided. The report of the Pakistan prevalence survey was finalized.

Key Affected Populations

As the general TB epidemic seems to decrease in many countries, more focus is needed on risk groups that are now called Key Affected Populations. KNCV focuses on TB/HIV co-infected patients, childhood TB, migrants and TB among prisoners and health care workers. In South Africa we contributed to aligning stakeholders in TB and HIV care provision for underground miners. TB rates are excessively high among miners, many of whom are HIV co-infected and also suffering from silicosis. Often they are migrant laborers from Swaziland, Lesotho, Botswana and Mozambique who face significant barriers accessing diagnosis and care.

Operational research

KNCV is strong in linking operational research (OR) to policy development and evidence based implementation. Lessons learned on how to best control the TB epidemic are documented and shared with relevant audiences. We have assisted Mo-

zambique and Tajikistan in developing an operational research agenda. We taught operational research protocol development and/or analysis to 95 participants in 3 countries in 2013 (Cambodia, Nigeria, and Ethiopia). OR protocol development courses from 2012 and 2013 combined, led to 17 research projects in 4 countries (Cambodia, Nigeria, Ethiopia, Namibia) starting in 2013; of which 7 finished data collection. Main subjects were reducing delay and increasing referral of presumptive TB cases by community health workers; improving case finding by screening; contact tracing; collaboration with private sector; decentralization; operational challenges in MDR-TB treatment; and improving treatment adherence.

7.8 Public Private Mix care delivery models for TB control

Importance of Public Private Mix (PPM)

Over 40% of people with TB live in the WHO South-East Asian region. In 2011, this region had an estimated 5 million people with TB and 480,000 TB deaths[8]. Especially in Asia, but also in some African countries (Nigeria, Kenya, South Africa), the size of the private sector is large and growing, and therefore engagement of this sector (PPM) is crucial to achieve universal access for patients suffering from TB. Private providers are often the first point of contact and care for over 60% of TB patients, while public health care systems are overstretched. In Indonesia and the Philippines, the volume of first-line drugs sold outside the national TB program is larger than the volume of TB drugs provided by the NTP. But PPM is not only relevant for Asian countries: the contribution of private-for-profit and not-for-profit providers in Ethiopia, Kenya, and Nigeria are also significant.

Engaging all care providers is crucial to find and notify more patients and to ensure that they get affordable quality treatment and care.

Engaging all care providers is crucial to find and notify more patients and to ensure that they get affordable quality treatment and care. This is of utmost importance as catastrophic out of pocket expenditures in the for profit sector result in interruption of treatment, in drug-resistance and unnecessary suffering of families.

For most high-prevalence countries strengthening regulations is considered the way forward to achieve large scale expansion of PPM for TB. A combination of carrots (collaboration, accreditation) and sticks (regulation) is now considered the most effective approach in high burden settings. KNCV has a dual approach to PPM, which involves both advocacy at

[8] WHO global report 2013

PPM in Indonesia

Indonesia has a strong and comprehensive strategy in place to engage all providers. In 2012, around 20% of the total TB cases in the country were detected and notified by non-NTP providers. The national TB program, with support of KNCV, is working towards further scaling up PPM to reach the remaining 30%-40% of TB patients who are currently not reached by quality TB care services. Care providers being engaged include, lung clinics/hospitals, public and private hospitals, private practitioners, prisons, NGOs, corporate sector, and, military and para-statal hospitals.
KNCV focuses more and more on supporting the NTP in strengthening policies and regulatory systems. This is done through establishing mandatory case notification, and implementing provider certification and accreditation of hospitals:

(1) Improve coordination and ensure networking: KNCV supported the establishment of PPM teams in 25 districts located in 7 TB CARE I supported provinces, with the purpose of improving coordination and ensuring networking between major stakeholders, i.e. local health services, hospitals, private providers and professional societies, prison department, laboratories, workplaces etc., resulting in an increased notification of TB patients, including in public and private hospitals.

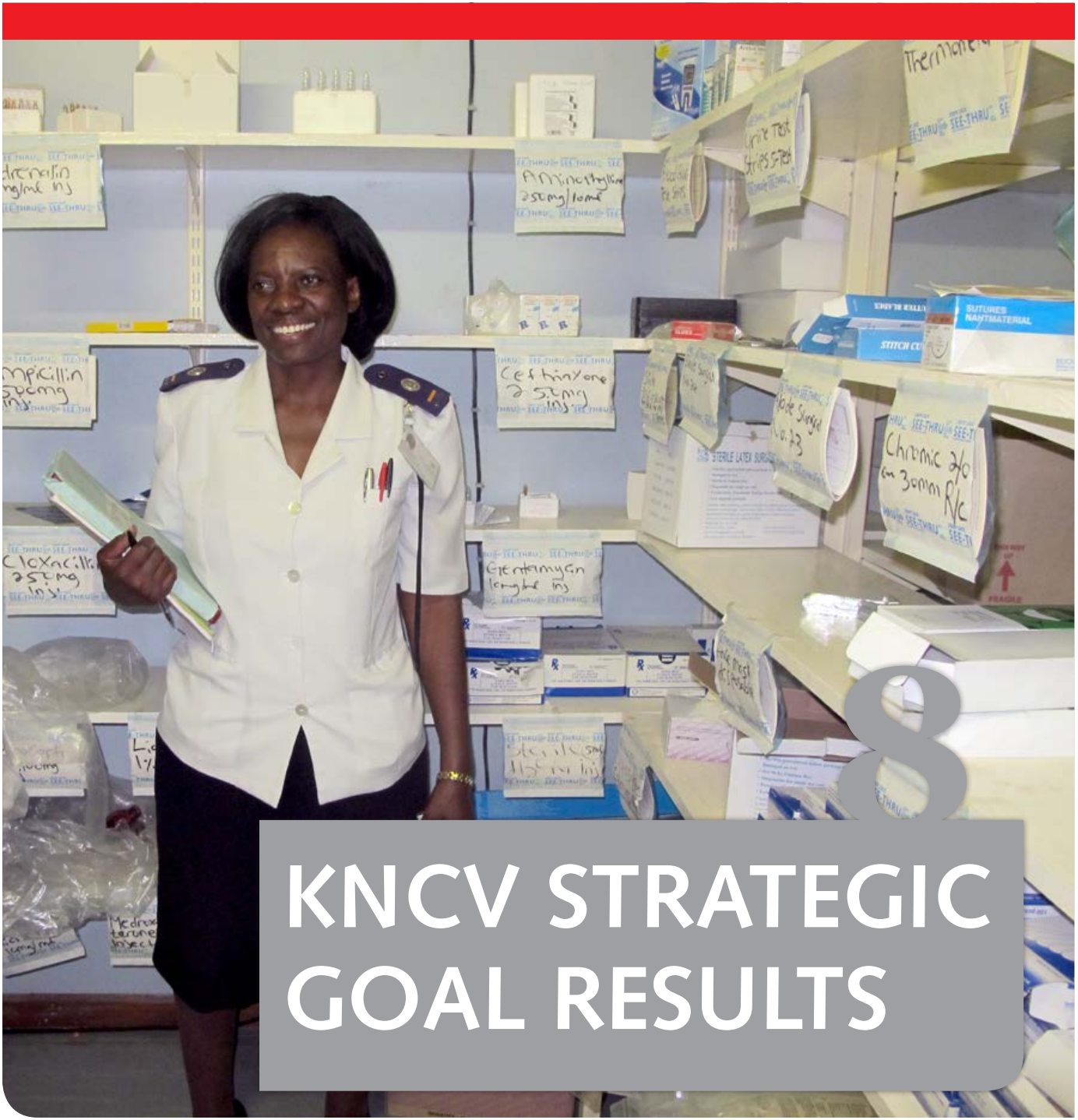
(2) Expand implementation of International Standards for Tuberculosis Care (ISTC): KNCV works with the American Thoracic Society (ATS) to expand implementation of ISTC by collaborating with professional societies and their members: Starting from 2010 till June 2013 more than 4,000 TB cases were notified by almost 100 pulmonologists. These cases would not have been reported if these practitioners were not involved. Gradually patient cohorts show a decreasing default rate and improving treatment success rate. 269 private providers are now collaborating and notifying cases to the NTP.

(3) Furthermore KNCV-Indonesia, through TB CARE I, made strong progress in regulation of private practitioners by the endorsement of "Standards for Medical Practice on TB Care (PNPK) by professional societies". These standards are essential to ensure standardization and quality of TB care delivered by private providers, and provide a formal basis for certification under the Indonesia Medical Association (IMA). KNCV supported the IMA in the development of a framework for private provider certification, which will be piloted and implemented in 2014. Good progress has also been achieved in the implementation of hospital accreditation for TB control: KNCV through TB CARE I facilitated development and finalization of an assessment instrument that facilitates surveyors to evaluate the status of DOTS implementation in hospitals, based on the accreditation standards for TB control. The next step will be to include TB Infection Control in the accreditation standards.

(inter)national level and practical interventions at local levels such as establishment of PPM teams for engagement of hospitals and other private providers such as pharmacies.

Good progress in PPM is noticeable in most parts of Asia– in 2012 almost every fifth patient in Indonesia and the Philippines was notified by non-NTP care providers.

KNCV significantly contributed to PPM successes in Indonesia: Medical associations endorsed the International Standards for Tuberculosis Care (ISTC) and have included these into national Clinical Standards; the number of hospitals being linked to the NTP has increased significantly with a substantial contribution to TB Case Notification.



8 KNCV STRATEGIC GOAL RESULTS

In this chapter we highlight the key results for 2013 in relation to the goals in our strategic plan 2011 -2015 that have not yet been mentioned or covered in the previous chapter.

Strategic goal 1: Evidence-based policy and guideline development

KNCV remained at the forefront of international policy and guideline development. KNCV staff continued their active membership, in some as chair, in many policy making bodies at national and global levels. These include a wide variety of working-groups (IC, GLI, TB/HIV), strategic fora (STAG), expert committees, and guideline committees under the umbrella of the WHO, the Stop TB Partnership, the Union, and Dutch TB control. KNCV contributed to 19 international guidelines, policy documents and tools such as *"A Practical Handbook for National TB Laboratory Strategic Plan Development"*, the "WHO Handbook of Analysis of Surveillance data" and the "WHO Screening and Active Case Finding Guidelines". KNCV also contributed to 43 scientific TB publications (see annex 1) and is actively involved in Global Fund related platforms including the analytical work of the NGO Developed Country Delegation to the Global Fund Board.

Strategic goal 2: Generating evidence through epidemiological and operational research

Research agendas: In about half of KNCV's 18 core countries[9] KNCV contributed to the TB research agendas. In Ethiopia the national Tuberculosis Research Advisory Committee expanded the coverage of operational research to all regions. At country as well as global level KNCV made a substantial contribution to surveillance and data management, epidemiological assessments, prevalence surveys and operational research, as described in detail in section 7.7.
Research capacity and quality: In 2013, KNCV staff supervised and contributed financially to 15 PhD and six graduate students in seven countries, of whom four finished their PhD and two their graduate studies in 2013. KNCV supported PhD students and TB researchers in Kazakhstan, South-Africa, Uganda, Kenya and Cambodia in writing scientific papers.
In Ethiopia, Ghana, Indonesia, Namibia, Nigeria and Zambia KNCV contributed to the training of 20 to 50 people in Operational Research (OR). In 10 out of 17 KNCV core countries (59%) at least one KNCV supported research project was completed with a local principal investigator in a key role. In at least seven core countries recommendations from KNCV supported research were included in national strategic plans, action plans, guidelines, codes of conduct etc.

[9] KNCV 2013 core countries: Botswana, Ethiopia, Ghana, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Mozambique, Namibia, Netherlands, Nigeria, Pakistan, Rwanda, South Sudan, Tajikistan, Vietnam, Zambia, Zimbabwe

Strategic goal 3: Equitable access to TB services

As described in detail in the previous chapter, KNCV contributed in many ways to increased access to quality TB services, for general and high risk populations. KNCV consultants supported Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan, Afghanistan, Botswana, China, Namibia, Nigeria and Zimbabwe to develop country specific strategies/interventions to increase referral of symptomatic people; reduce systems barriers related to diagnosis and treatment; identify and prioritize vulnerable and high risk populations; include all providers and ensure quality of care and related monitoring and evaluation. KNCV systematically included work with vulnerable groups like children, mobile and migrant populations (nomads, refugees, migrant workers), drug users and prisons. This for instance included social mobilization and active case finding among inmates in Zambia, Mozambique, Namibia, Ethiopia and Zimbabwe. Nigeria started screening of all prisoners. KNCV consultants also assisted in improving access to medicines, to ambulatory care and psycho-social support, patient-centered approaches to improve adherence to treatment, access to rapid diagnostics for prison systems, and access to diagnosis and treatment of MDR-TB patients in eight countries.

Strategic goal 4: Enable comprehensive service provision

The strength of KNCV is the ability to develop comprehensive technically sound prioritized and budgeted national strategic plans, which are tailored to national health systems and country specific situations. In the previous thematic chapters we described our contributions to comprehensive service provision through specialized areas of TB control, but one vital cross-cutting element was left out: human resource development. Whereas donors cover commodities, human resource capacity remains the responsibility of Governments and is often inadequate. Therefore, KNCV has supported countries to strengthen Human Resources for Health (HRH) capacity of National Tuberculosis Programs. KNCV consultants contributed to HRD analysis, training (of trainers), curriculum development, and organizational capacity building in the field of HRM. They also participated in national review missions to evaluate implementation of National TB Strategic plans with a special focus on human resource capacity.

Strategic goal 5: Organizational learning, knowledge management and supporting culture

In 2013, KNCV continued to implement its Knowledge Management and Organizational Learning Strategy (KMOL) strategy with lunch presentations, journal clubs, research fora, international meeting weeks twice a year, thematic working groups, organizing and participation in international conferences, staff capacity building, the e-portal, consultancy quality checks, and E-learning. All together these activities create many opportunities within KNCV for sharing and learning, and ensure the capacity building for high quality consulting.

Three junior international consultants, two at the Regional Africa Office and one at Central Office were recruited and mentored on the job by their senior colleagues. A Management Development Training was organized for directors of the regional offices and some country offices. Country Directors are coached on the job by their team leaders in the Netherlands. KNCV developed an E-learning system in 2012 with the ambition to develop blended learning programs, combining e-learning and face to face learning. In

2013 KNCV developed and pilot tested the online Data Management Course. Based on this experience KNCV is developing other courses, for both KNCV staff and external audience, e.g. on curriculum development, PMDT, laboratory and quality consultancy. In 2013 KNCV organized 27 lunch presentations with technical, programmatic and policy topics, in which the majority of staff participated, including participants from country and regional offices, by skype or conference call.

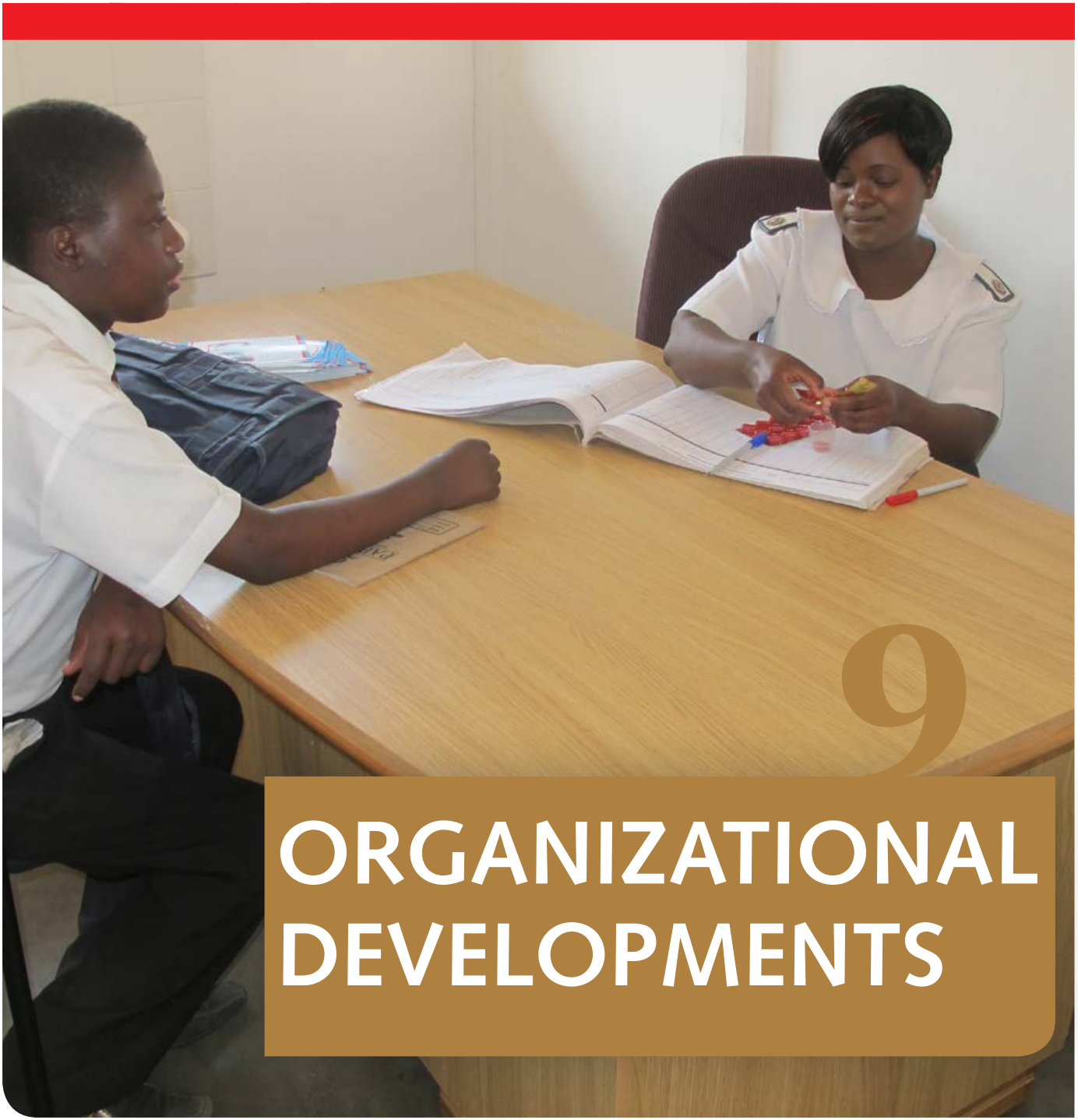
Strategic goal 6: Structure and enabling environment

KNCV conducted a Mid Term Review at central office level to assess staff satisfaction with the organizational structure and enabling environment of KNCV. In general staff is satisfied with the opportunities they have for learning and with the collaboration and information exchange between team members and departments. Recommendations were made to improve the connection between learning and the primary process.

Fundraising: In June 2013, the Unit Fundraising and Marketing (F&M) introduced a new way of working through so-called proposal teams. In addition F&M designed a new mechanism called the Proposal Assessment & Development Team (PADT). The PADT will facilitate systematic analysis, preparation and resource allocation for all institutional funding/proposal development in KNCV.

The new system will also encourage closer collaboration between the different geographical/ technical units and the unit F&M. The regional offices of Africa and Central Asia finalized strategic plans, which provide a basis for further institutional funding development.

Cloud based IT: KNCV wants to have a single centralized and cloud based ICT infrastructure with central administration, which creates a uniform ICT experience for all employees worldwide. As a first step in this process, at the end of 2013 all email accounts from all employees have been migrated to Office 365, thus creating one global email environment for all employees. The next step will be to make all corporate files accessible based on a cloud solution.



9 ORGANIZATIONAL DEVELOPMENTS

Structure of the organization

KNCV's position as a niche organization in TB control, the shift in demand by countries and donors towards specialized technical assistance, and the opportunities that technological developments are currently bringing, all make it essential for KNCV to sustain and improve the quality, depth and innovative competitiveness of its technical work. KNCV's organizational structure needs to optimally support this excellence, but also ensure the efficiency of its project management activities. In 2013 KNCV recognized that several aspects of the organizational structure need to be revised to "make KNCV fit for the future" that comes with new technical opportunities and changing country needs and donor demands

Therefore, in September 2013, the new Board of Directors reviewed the status, results and budgetary consequences of the decentralization of KNCV services in the broader context of strategic planning in a rapidly changing global TB environment. The analysis included region-specific circumstances such as volume and nature of technical assistance needs; potential and capacity for regional resource mobilization; donor demands; housing and staffing costs as well as a critical assessment of required technical and support capacity at central level.
The conclusion was that the mere absence of funding for regional office operations, and the region-specific demands for technical assistance, complicate decentralization to regional offices in Africa and Asia, whereas the situation in the Central Asia Region (CAR) is still favorable. Also, the current dynamic environment of new tools, technologies and related policy development requires a critical multidisciplinary mass of technical and project management capacity at central office level, that cannot be decentralized to the regions as was originally planned. Lastly, there is an increased need for country based technical assistance and capacity-building.
Therefore, KNCV opts for a flexible and rational approach towards decentralization so as to achieve sustainable and high quality TB care at country level that reaches the patients that are the very reason of KNCV's existence.

As a consequence, KNCV decided to continue to strengthen the regional and country offices in CAR, but to close the

KNCV regional office in Africa and cancel plans for a regional office in Asia. At the same time, KNCV took steps to further intensify technical assistance in Africa and Asia through a dual approach of i) strong country presence for day to day support on technical and managerial issues and ii) highly specialized TA missions to innovate TB control and deliver Global Fund New Funding Model (NFM) related assistance. In relation to the latter, KNCV decided to establish an international network of senior consultants based in the respective regions and elsewhere, who will all be involved in KNCV knowledge sharing and quality assurance systems. In addition, it was agreed to intensify operational research as relevant to both country-specific and regional research questions.

KNCV feels confident that we will be able to further strengthen KNCV technical assistance and technology transfer through this effective mix of country presence and specialized missions.
Regional activities in Africa - such as inter-country support mechanisms, cross-border research or initiatives under regional Global Fund TB grants - will be managed from relevant KNCV country offices or The Hague, depending on the scope of work.

Monitoring and Evaluation (M&E) system

In view of advancing the formulation of a new Strategic Plan, the current Monitoring and Evaluation (M&E) system was reviewed at the end of 2013 to see how the M&E system can be adapted at strategic, organisational and project level, linking it to organizational learning.

Strategic M&E: Along with the new Strategic Plan, KNCV intends to develop a "lean and clean" M&E plan, with clear targets and a limited number of measurable key indicators that can also serve for project monitoring. This Strategic M&E plan will not only capture information on indicators but also other useful information, such as success stories, important actors and factors, difficulties that need to be addressed, etc. Thus, the M&E system will not only serve strategic steering, but also other purposes including communication, advocacy and lobbying, organizational learning and reporting.

Organisational M&E: we will continue to monitor and improve our organizational capacity, ensuring the high quality of services of KNCV. Along with developing a new Strategic Plan the present organizational monitoring system will be adapted to enhance systematic monitoring as a management tool and improvements of organizational capacity.

Project monitoring: In the last quarter of 2013 a simplified project monitoring system was developed that is piloted at the moment. This system makes it easier to get a good overview of progress and results of projects.

Diversifying the funding base – institutional funding

KNCV's fundraising unit saw a change in staffing in 2013 with the Unit Head Fundraising and Marketing (Unit F&M) leaving the organization in May 2013. 2013 is also marked as the year in which a new and more systematic approach to institutional fundraising was introduced.

The total institutional donor income in 2013 increased with 14% compared to 2012. This increase was mainly the result of an increase in USAID funding for TB CARE I coalition partners. Funding from other institutional donors increased slightly. But USAID still represents 97% of KNCV's total grants income from institutional donors.

While KNCV has attracted other donor funds in 2013 for instance from the Eli Lilly MDR-TB partnership, the Bill and Melinda Gates Foundation and the Rotterdam Global Health Initiative (RGHI), it has not yet led to a significant increase in the share of non-USAID funds. It is expected that the new system in combination with a new structure of the Unit F&M in 2014, will enable KNCV to make more progress in the diversification of its funding base. Finally, with the creation of the position of scientific director and the associated strong links with the Amsterdam Institute for Global Health Development, KNCV aims for a strong position to attract new funds for implementation research.

Trends in private fund raising

For fundraising it is important to strengthen KNCV's private donor base. One of the strategies to strengthen and increase our donor base is to make use of mailings. The aim is to increase the response percentage and the average amount donated to KNCV.

In 2013 we approached 205.000 prospects. The number of new donors was slightly lower than what was expected, possibly because of the recession. Also, there is stiff competition from other charities. More than ever before, people are receiving multiple prospect mailings form organizations seeking donations. On the other hand the average amount donated was higher than expected. Apparently, if people decide to donate, they are likely to give a higher amount.

The total number of active private donors that donated to KNCV in 2013 was 27.902 (4.600 structural donors). Although we invest in finding new donors there was a decrease of 6,4% in 2013. This is probably due to ageing of our donors and due to less response on prospect mailings.

Additionally, KNCV approached its structural donors with the request to increase the amount of their gift. This was very successful: about 24% of these donors raised their gift with an average amount of almost €29 a year, an increase of 60%.

The part of our income from legacies in 2013 was also substantial: we received € 478.644 from 16 legacies. We noticed an increase of legacies from donors who were approached with one of our campaigns to inform private donors about the option to include KNCV in their will.

The income received each year from the Dutch Charity Lotteries is highly appreciated. The 'Lotto' donates an annual amount, which is the same for all Dutch health Organizations. The 'Vrienden Loterij' even provides the opportunity to positively influence our lottery income. Part of the contribution is a fixed percentage of the total revenues (so called un-earmarked lottery income). The other part can be earmarked by the lottery participants as a contribution to our work (earmarked lottery income). In 2013 we received €340,000 from the Lotto and €796,199 (including € 91.634 in earmarked income) from the 'VriendenLoterij'.

Lotto.

VRIENDEN LOTERIJ

10 SOCIAL REPORT

Health Center in Ethiopia
PHOTO BY NETTY KAMP

KNCV has at the end of 2013 approximately 224 employees working worldwide. There are 64 employees working in central office in The Hague, The Netherlands and 160 employees working in our 2 regional- and 9 country offices.

Inflow and outflow

In 2013, 11 employees were contracted in the central office, 13 employees left the organization for various reasons. The majority of these employees found a new position in another organization.

The figures in table 2 show that the sick leave percentage decreased by 0.3% compared to 2012.
The average sick leave percentage for the workforce in the Netherlands is 3.8% in the first half of 2013[10]. The sick-reporting frequency increased slightly. The average sick leave in days decreased in 2013 due to recovery of long-term sick leave of employees.

Missions to country offices

In 2013 6 country offices have been visited by the HRM Manager. Besides harmonization of the HRM principles and policies in these offices, there was a wish from the country representative officers to have teambuilding sessions, conducted by the HRM Manager. Due to the closing of the country office in Kenya also a training to prepare staff on the labor market has been provided. The implementation of the local security plans got special attention during these missions.

Risk Assessment and Evaluation

As requested by the Dutch law, KNCV has conducted a Risk Assessment and Evaluation (RA&E). An important issue that can be concluded from the RA&E is that the percentage of employees who experience work pressure as too high increased from 43% (measured in 2009) to 54%. A plan of action has been formulated to address specific outcomes of the RA&E and will be implemented in the next years.

HRM analyzed the possibilities and consequences of implementing Work Shifting (Working independent from place and time). Work Shifting is already in use for specific function groups (technical consultants), but for a limited number of days per week as a center of expertise such as KNCV requires an optimal exchange of information and experiences between staff members that cannot be realized by distant communication solutions. Therefore Work Shifting will not be implemented for the whole organization.

[10] Source: Central Bureau of Statistics the Netherlands not published yet for the whole year.

Figure 10.1: staffing per Unit in central office

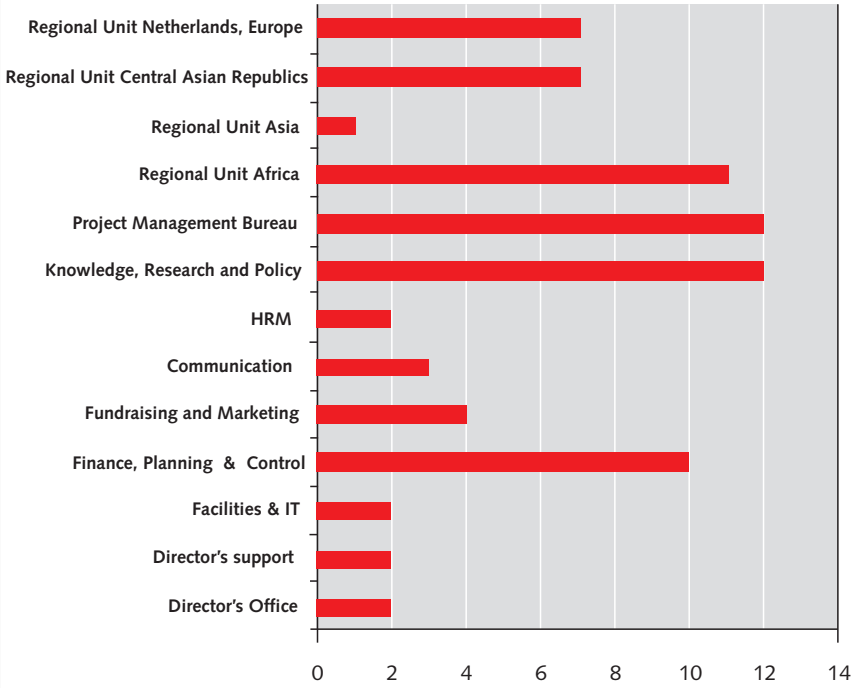


Figure 10.2: Staffing in KNCV country offices

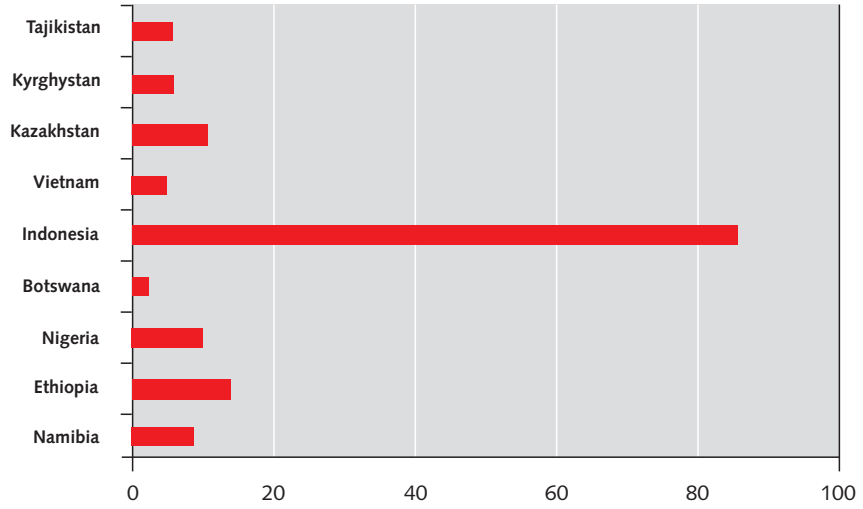


Table 10.1: Details of inflow and outflow 2013

Activity	# of employees	
	In	Out
Retirement	-	2
Temporary replacement - maternity leave/vacancies	2	-
Natural attrition - central office	9	11
Total	**11**	**13**

Table 10.2: Sick leave without pregnancy leave

Indicator	2009	2010	2011	2012	2013
Sick leave percentage	3.7%	3.3%	4.2%	2.9%	2.6%
Sick reporting frequency	1.3	1.0	1.0	0.9	1.0
Average sick leave in days	12.1	22.4	18.1	20.9	12,1

Figure 10.3: Gender balance at KNCV central office

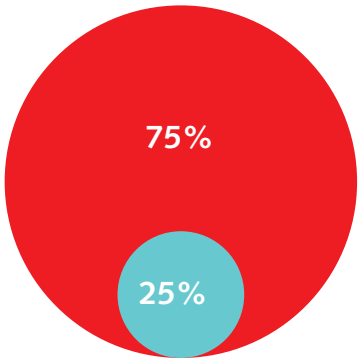


Figure 10.4: Age structure KNCV central office

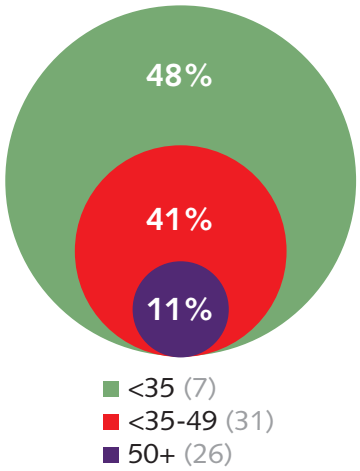
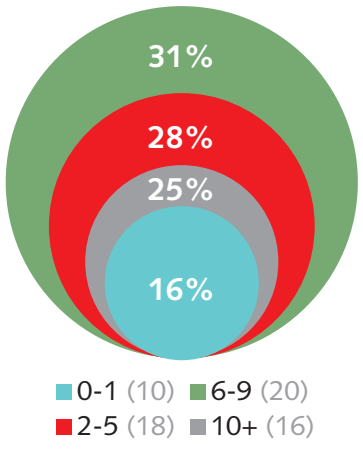
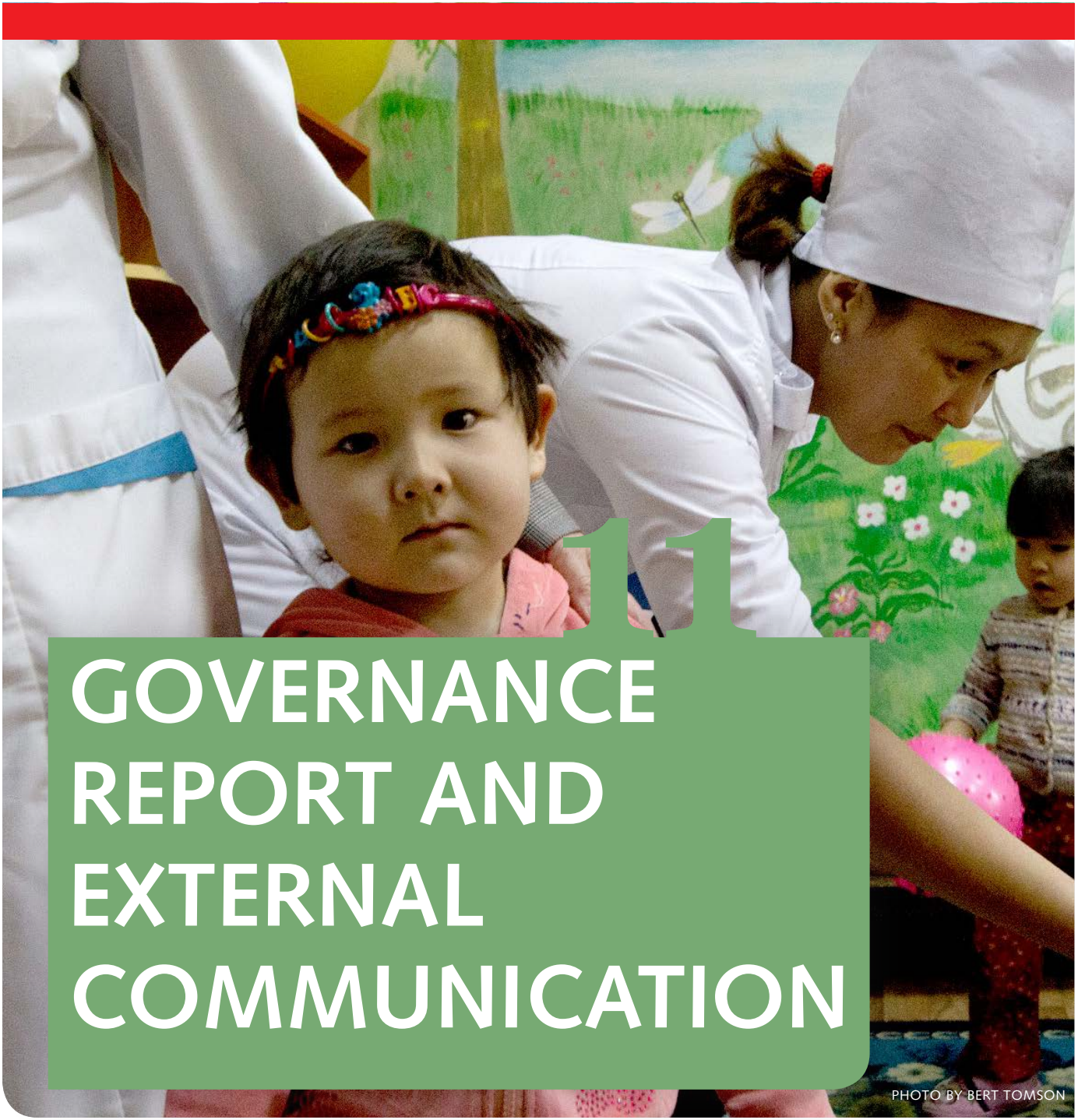


Figure 10.5: Years of employment at KNCV central office





11 GOVERNANCE REPORT AND EXTERNAL COMMUNICATION

PHOTO BY BERT TOMSON

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 may 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 optimally, thereby contributing to the statutory mission of the organization. Moreover, the General Assembly may advice the Board of Trustees and the Executive Board. The General Assembly met on May 28th 2013. The members as per year end 2013 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

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, conforming to the Code of Good Governance as endorsed by the VFI and CBF and as accounted for in Chapter Three above. 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, in special circumstances, for a maximum of two terms. Membership of the Board of Trustees is a voluntary position without remuneration (as dictated by the governance code). Out of pocket expenses to attend meetings are reimbursed in addition to a generic expense compensation of € 100 for each Board of Trustees meeting attended. Trustees are enabled to develop competencies for supervisory governance by attending a relevant course.

The full Board of Trustees meets three to four times a year. In addition, three permanent sub committees have been established with the following preparatory tasks:

- An agenda setting committee to prepare the full board meeting;

- 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; for example, in 2013 the recruitment committee continued the selection process for the Executive Director and a selection committee was established to fill the vacancy arising after the retirement of Maartje van Putten.

In June 2013 the Works Council met with and was consulted formally by the recruitment committee of the Board of Trustees prior to formalizing the appointments to the Executive Board.

In 2013, the Board of Trustees met on 12 February, 23 April, 14 October and 12 November.
As accounted for in the Report of the Board of Trustees in Chapter 3 the Board met in executive session (i.e. without the attendance of the Executive Board) to evaluate its own functioning and performance, making explicit areas for improvement and evaluating the outcomes of a complex recruitment process. Henceforth all regular Board of Trustees meetings start with an executive session.

Executive Board

As elaborated on in Chapter 3, the organization has transitioned from a collegial Executive Board to a one-headed statutory board. The financial function has been embedded at management level.

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

Member	Appointed	Expiring
Drs. D. Boonstra, chair	May 2010 (2nd term)	2014
Drs. D.S. Dotinga, vice-chair	May 2012 (1st term)	2016, eligible for 2nd term
Prof. Dr. J. Lange	May 2011 (2nd term)	2014
Mrs. X. Sun	May 2011 (1st term)	2015, eligible for 2nd term
Drs. M. Verhagen	May 2011 (1st term)	2015, eligible for 2nd term
Mr. Ton van Dijk	May 2013 (1st term)	2017, eligible for 2nd term

The Board of Trustees, at 31 December 2013 was as follows:

D. Boonstra	Board member of the Cornelis Jetses Foundation and board member of the Questionmark Foundation
J. Lange	Professor of Global Health, Head of the Department of Global Health Academic Medical Center University of Amsterdam, Executive Scientific Director Amsterdam Institute for Global Health and Development, chairman Supervisory Board PharmAccess Foundation, Advisor to the Board of the Health Insurance Fund
X. Sun	Supervisor Chinese DeHeng law office, board member CNEXPO foundation, board member Chinese Enterprises Association
M. Verhagen	Medical doctor TB control Municipal Health Service 'Limburg-Noord', chair of the Committee Practical TB Control in The Netherlands
D.S. Dotinga	Chair Alzheimer Netherland – region Haaglanden, member of the Board of Trustees Haagse Milieu Services
A.A.H.M. van Dijk	Director of public health (region Haaglanden) and director of medical disaster management (region Haaglanden)

The Executive Board presently consists of:

Member	Appointed
C.S.B. van Weezenbeek, MD, PhD, MPH, Executive Director	September 16, 2013
Prof. F.G.J. Cobelens, Scientific Director	September 1, 2013

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

Director	Organization	Position	Qualitate Qua /Personal	Period
C.S.B. van Weezenbeek	Dr. C. de Langen Stichting voor Mondiale Tuberculosebestrijding (SMT)	advisor	QQ	Indefinite
C.S.B. van Weezenbeek	's-Gravenhaagse Stichting tot Steun aan de Bestrijding van Tuberculose	advisor	QQ	Indefinite
F.G.J. Cobelens	AIGHD Foundation	employee	Personnal	Indefinite
	Academisch Medisch Centrum, Global Health department	Honorary position	Personnal	Indefinite

At the end of December 2013, the Works Council members were:

Member	Appointed	Expiring
I. Huitema, chair	2010 *(1st term)*	2014, *eligible for 2nd term*
S. van den Hof, vice chair	2011 *(1st term)*	2016, *eligible for 2nd term*
J. Klein	2012 *(1st term)*	2016, *eligible for 2nd term*
E. Tiemersma	2013 *(1st term)*	2014, *eligible for 2nd term*
I.Lamp	2013 *(1st term)*	2016, *eligible for 2nd term*

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. For the period between the retirement of Peter Gondrie (in May) through the moment (September 16) when the new Executive Director assumed her position, the Board of Trustees appointed two members of the Management Team as advisors to the person holding statutory authorities solely, Gerdy Schippers and Dina Boonstra consecutively. The Executive Board is supported by a Management Team, in which all unit heads participate as well as key staff involved in human resource management and acquisition.

International Advisory Council

To ensure continuous strategic inputs from our international network, KNCV has established an International Advisory Council, which meets at least once a year. In 2013, one distance consultation took place mid-February in preparation of the reflective discussion of the Board of Trustees with the Executive Board and Management Team on strategic directions and positioning of the organization. Council members are: Dr. Shahimurat Shaimovich Ismailov (Kazakhstan), Prof. Dr. Anthony Harries (United Kingdom), Mr. Ezio Tavora dos Santos Filho (Brazil), Dr. Jeremiah Muhwa Chakaya (Kenya), Dr. Wang Lixia (China). In 2013 retired from the International Advisory Council. KNCV expresses its gratitude to Frits van der Hoeven (The Netherlands) for many years of service and wise counsel and Mrs. Dorette Corbey (The Netherlands) for her engagement in recent years.

Works Council

The occupation of the works council changed: Katja Lumelova was succeeded by Edine Tiemersma, and Irma Lamp replaced Eveline Klinkenberg.
The Works Council advised the Board of Trustees on a new structure for the Board of Directors and has supported the appointment of Kitty van Weezenbeek as the new Executive Director and Frank Cobelens as Scientific Director. In the advice, the council did express concern about and request attention for internal management issues in the transition period and thereafter. Furthermore, together with human resources management (HRM) the council has clarified the policy for reimbursement of commuting costs. Also, we provided input to the Risk Assessment and Evaluation, both to the questionnaire and the draft report of the results with action plan.

Quality control

We consider feedback from clients an important source of information to improve the quality of our consultancies. Our con-

sultants are trained to ask for client feedback and use this information to improve individual performance and to contribute to KNCV's internal Quality Consultancy discussions. Practicing feedback with clients and colleagues are big steps in an international and intercultural working environment, with different perceptions of feedback and openness.

Through peer reading of consultancy reports, we seek to harmonize KNCV's reporting standards among consultants in the different regions and with different technical backgrounds. This includes both writing skills and content. Since 2012, Quality Consultancy has become part of the performance appraisal and feedback from clients will be used to improve our consultancy practices. In terms of opportunities for improvement in this area, a shared understanding on the core quality consultancy standards needs to be strengthened. Likewise, how do we put "Capacity Building", "Multidisciplinary team work" and "Partnership" into practice? With de-centralization and new consultants that join KNCV in different parts of the world, we need to safeguard KNCV's core values and re-discuss these values with colleagues, who have different backgrounds.

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 and regularly discussed during every Board of Trustees meeting. For the projects and programs funded by institutional donors, interim reports are sent to the funders and evaluated for effectiveness and efficiency through external reviews. 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 2013, 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 risk of bad debts from advance payments can be further mitigated by performing annual audits and by making monthly analyses of outstanding amounts and new requests, related to the level of spending.

External Quality Hallmarks

KNCV is subject to the governance and quality requirements of the CBF and has, since July 1998, received the CBF certificate up to 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. Changes in CBF requirements and internal changes have led to new versions of the document. 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;
- 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. 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. Where possible we engage in discussion with our stakeholders and critics.

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:

1. Division of tasks in governance, management and operations;
2. The continuous improvement of efficiency and effectiveness in mission related activities;
3. 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.

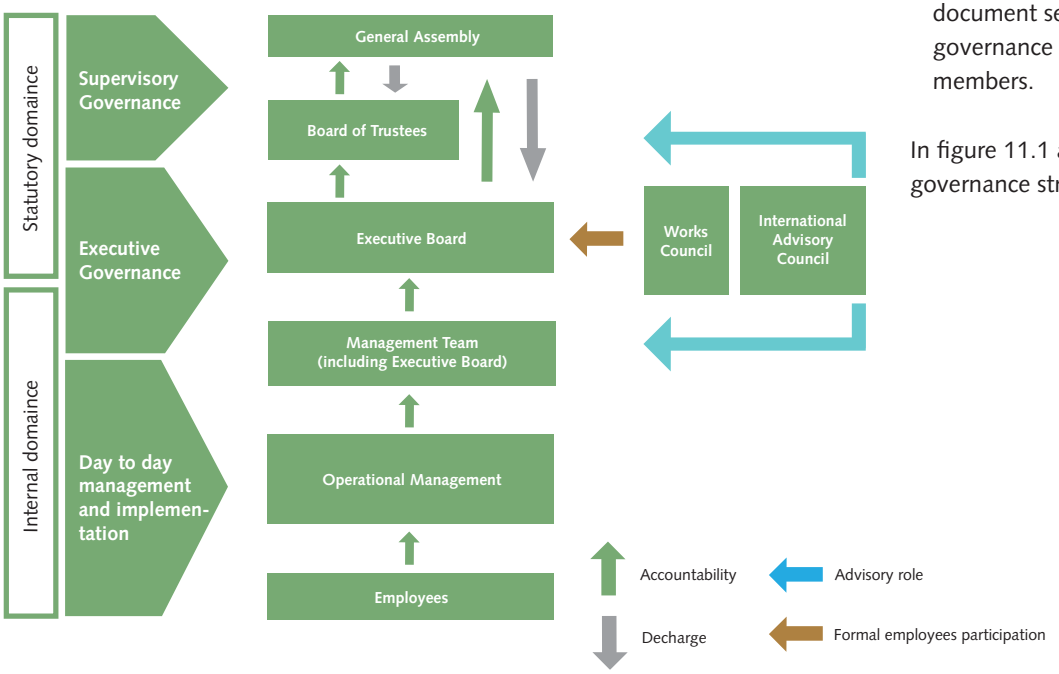
Ad 1. Division of tasks in governance, management and operations

KNCV has described its governance and management structure in the document: '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 11.1 a schematic overview of the governance structure is explained.

Figure 11.1: KNCV model for governance and management



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

- 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, both for mission related goals and for resources. Performance indicators are used to assess the progress in reaching strategic goals.
- A procedure for assessing potential new projects or acquisition proposal development, in order to prepare the decision making process at unit level and in the Management Team.
- Monitoring and evaluation systems for major projects and at institutional level.

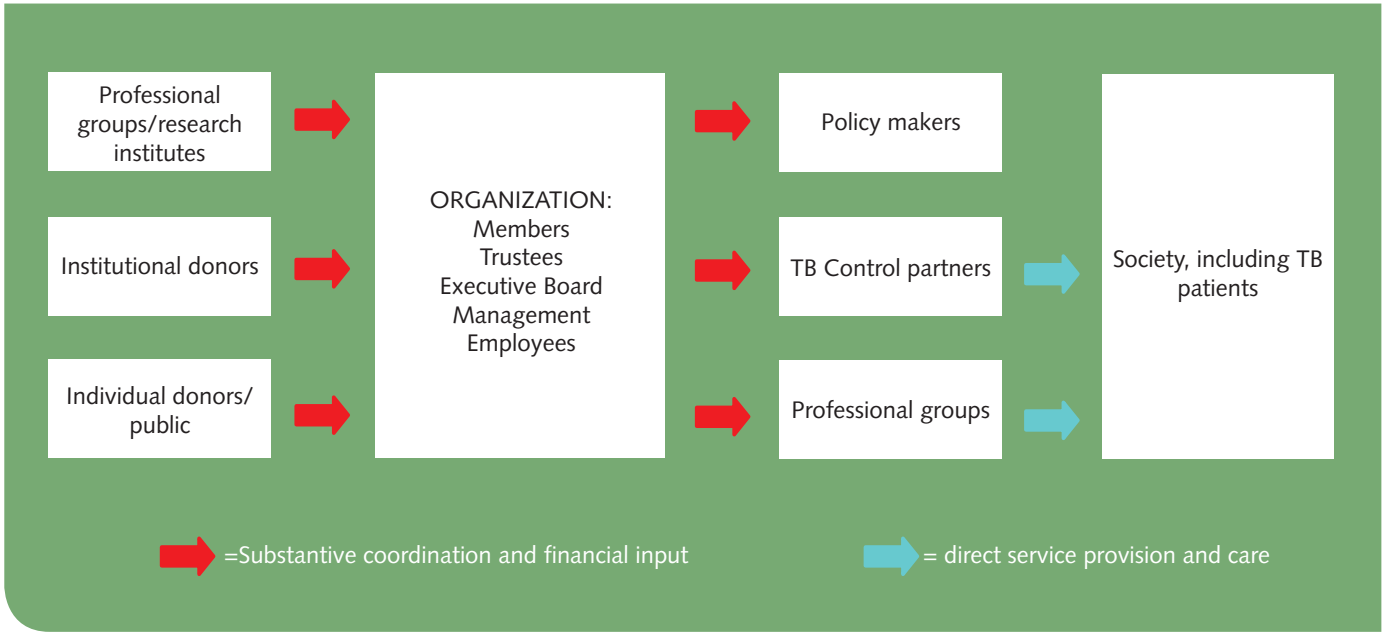
Ad 3. Optimizing the communication and relationships with stakeholders

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 11.2.

Creating and maintaining support (both tangible and intangible), 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, to maintaining, and to protecting KNCV's reputation, prestige, and image. Our communication with our

Figure 11.2: KNCV partner network



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.

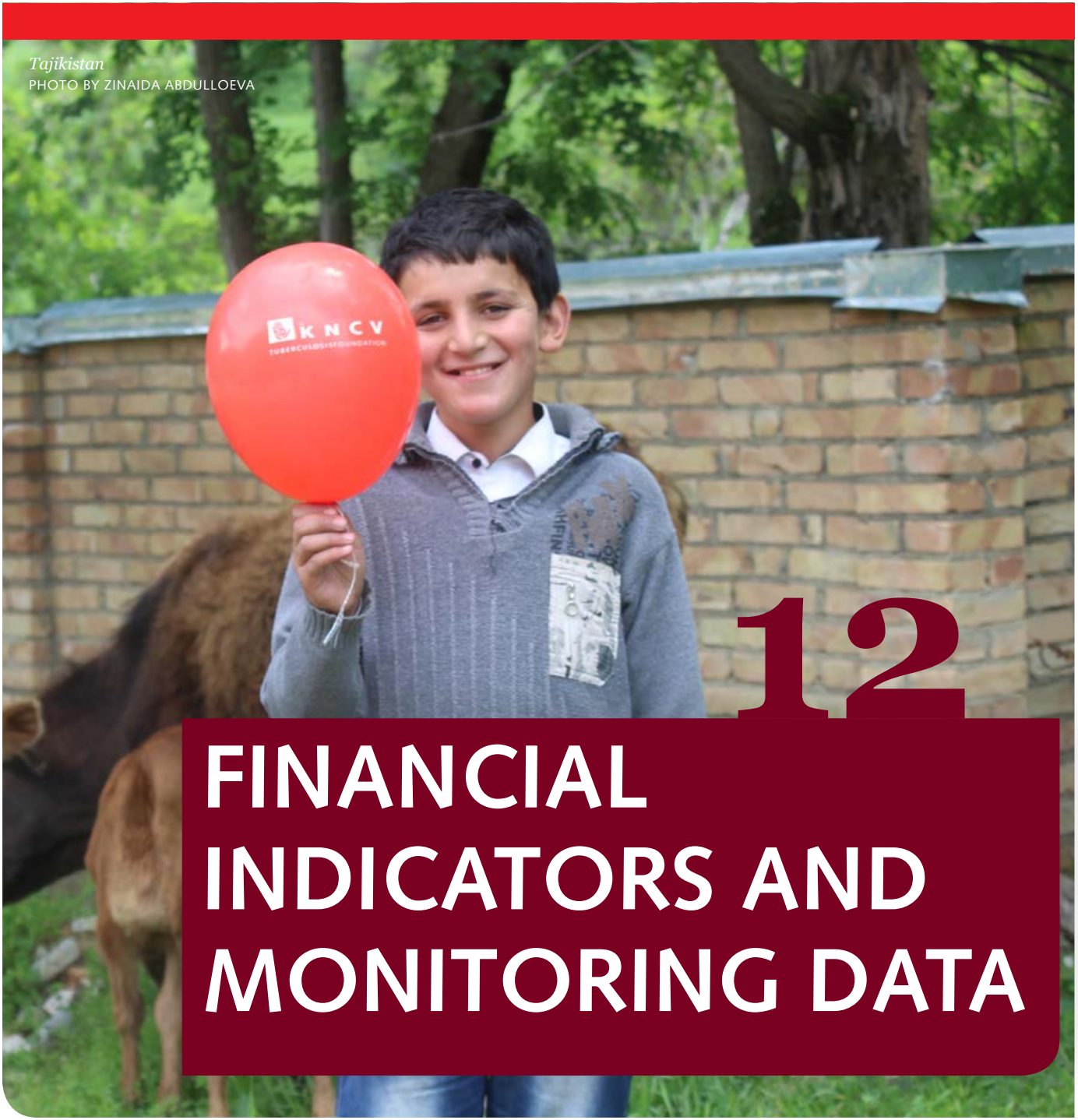
We use a diversity of methods to communicate with our growing network of stakeholders, striving for greater transparency and dynamic interactions.

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; Apart from the yearly involvement of the International Advisory Council, 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 taking part in the monitoring and evaluation systems (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.



Tajikistan
PHOTO BY ZINAIDA ABDULLOEVA

12 FINANCIAL INDICATORS AND MONITORING DATA

Financial data 2009-2014

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 12.1:

In total KNCV generated more income in 2013 (€ 54,2 million) than was budgeted (€ 52,8 million) and also compared to 2012 (€ 49,7 million).
Total expenditures in 2013 were € 53,8 million, which is € 0,2 million higher than budgeted. The increase is caused by additional expenditures in the category "TB in high prevalence countries". Expenditures in the categories "fundraising" and "administration and control" showed a decrease compared to budget.

Expenditures on the mission (R7)[11]

Since 2010, over 95% of KNCV's budget is being spent on mission related activities as compared to total expenses. This indicator is closely monitored. Influences on the indicator can be caused by (temporarily) increases and decreases of expenditures for fundraising and for administration and control.

The indicator 'spent on mission compared to total income' has shown a percentage over 95% since 2010 as well.

KNCV's policy for costs for fundraising (R8)

With regards to expenditures for fundraising, KNCV 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 2011 and 2012, and reflected in the budget for 2013. 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

Table 12.1: Financial monitoring data compared to internal standards

Monitoring data	Standard	Actual 2009	Actual 2010	Actual 2011	Actual 2012	Actual 2013	Budget 2014	Average for 3 years
Spent on the mission compared to total expenses	Not applicable	91,6%	96,7%	95,6%	96,6%	96,7%	96,2%	96,4%
Spent on the mission compared to total income		86,4%	95,2%	98,1%	95,4%	96,0%	97,1%	96,5%
Spent on private fundraising compared to income	Max. 25%	16,9%	23,2%	20,4%	23,8%	17,4%	26,6%	20,4%
Spent on administration and control compared to total expenses	5-10%	n/a	2,2%	2,6%	1,9%	2,0%	2,3%	2,1%
Spent on administration and control compared to total expenses excluding TBCTA coalition share in activities	5-10%	5,7%	4,0%	4,9%	3,8%	5,1%	5,8%	4,3%

[11] References are to financial statements on page 78 and onwards.

are not satisfactory, we adjust our budgets downwards in order to prevent a percentage above the 25% standard. Expenses in 2013 are 17.4% of the income from own fundraising activities, well below the 25% maximum. The 3-year average is 20.4%. The low percentage for 2013 is caused by lower expenses due to staff vacancies during the year and also by higher income, due to higher legacy income compared to 2012.

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 2013, the percentage of 2.0% is lower than what was budgeted for (2.5%). Savings in various cost categories (for example housing and ICT) have been realized in 2013. Also, due to the increased level of TBCTA coalition activities for TB CARE I compared to budget the percentage of costs spent on administration and control is lower than planned. The percentage of costs spent on administration and control related to total expenses excluding coalition activities (4.3%) is below 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 2013 a total number of 10.779 project days were planned and 10.878 were realized, which is 100.9% of the planned days. In 2012 this was 98.7%.

- Indirect costs as a percentage of direct personnel costs made at central office 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 2013, the planned percentage was 88.31%, and realized is 81.98%. The decrease in 2013 compared to the budget is due to savings in various cost categories. The indirect cost as a percentage of total direct project costs (excluding TBCTA coalition partner share) is 18.8% (budget 19.9%).
- Indirect costs compared to direct personnel costs made at central office, 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 2013 is 75.60%, while 78.65% was budgeted. The lower percentage compared to budget is in line with the development of the internal indirect cost rate percentage over the last years. The lower percentage in 2013 is caused by savings on various cost categories. The decrease in indirect cost percentage is in line with our long term aim to be more cost competitive.

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 (100.9%). Implementation of a new online monitoring tool during the course of 2012 has helped to achieve this goal.

Budget 2014 and possible risks

The full budget for 2014 is shown in the Statements of Income and Expenditure. The total income is budgeted on a consolidated level of €53,3 million. Of that amount, €32,5 million is compensation for implemented activities by the TBCTA coalition partners of TB CARE I. Therefore, excluding consolidation, the income is budgeted at €20,8 million, which is €4,9 million less than the actual for 2013. Income from government grants is budgeted to decrease, related to the plans for activities in the final year of TB CARE I. Income from our share in third parties activities (e.g. lottery income) is budgeted to decrease, as well as investment income. No unrealized gains and losses on investments are budgeted.
The total level of consolidated expenditures amounts to €53,8 million. Excluding the TBCTA coalition partner activities, this leads to a total budgeted cost level of €21,3 million, which is €4,0 million lower than the actual for 2013. TB control in high prevalence countries is decreasing compared to 2013, related to the pace of activities in the final year of the TB CARE I program.

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$1,3 against €1. The actual rate at time of budgeting was US$ 1,3190 (1 November 2013). Careful liquidity planning and making use of simple hedging techniques will be needed to further control this risk.
- A large part of the budget is for material costs in countries for the TB CARE I program. There is a risk that costs are identified as unallowable for USAID by auditors in countries or by the auditor who executes the overall audit.
- The income from legacies is budgeted at €250,000. This is an average amount reached in the past years, but it can vary.

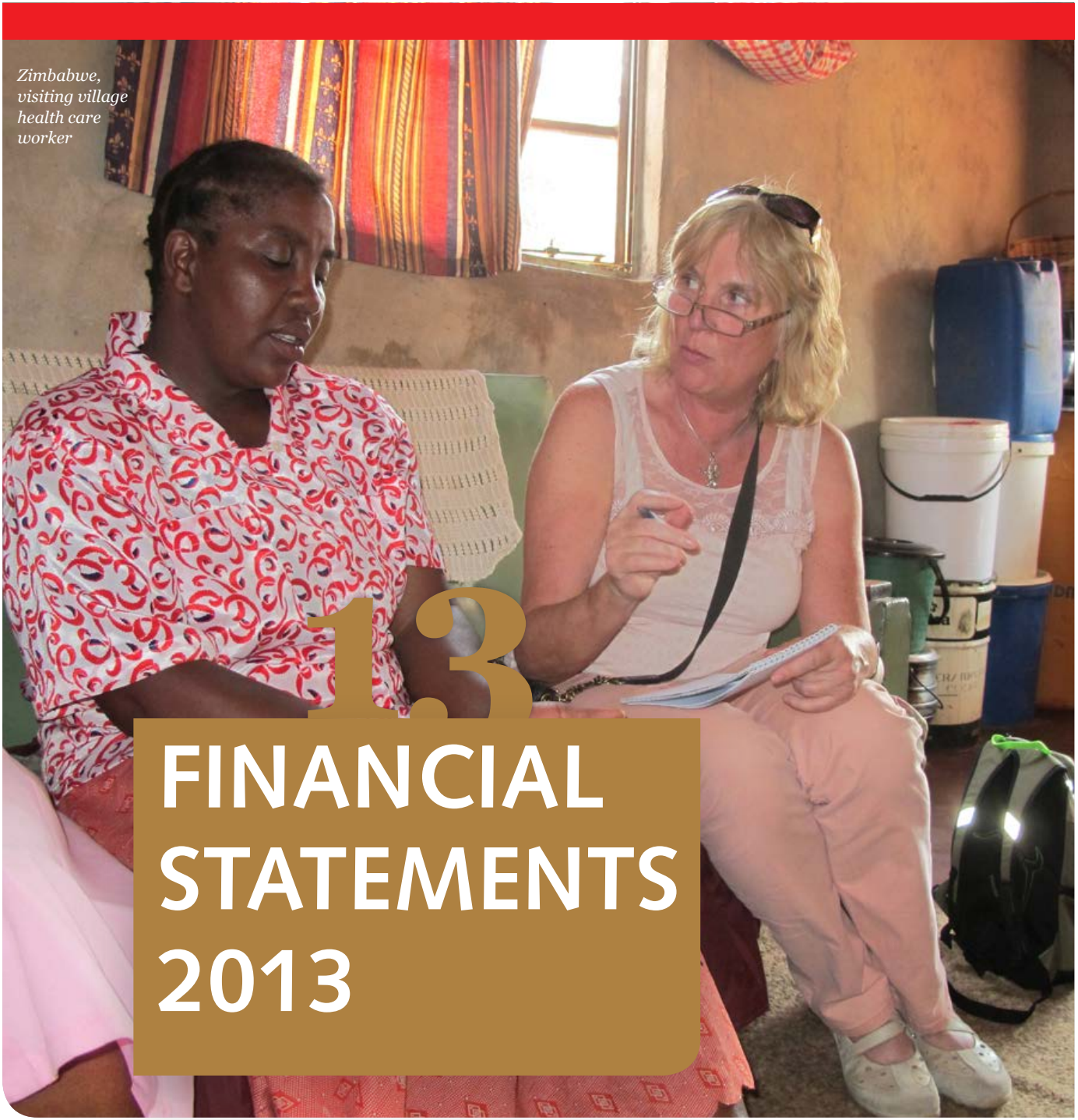
A contingency budget of €200,000 has been included to deal with unexpected fall backs or to react to valuable opportunities.

Long term financial plan

An indication of a longer term financial plan is depicted in table 12.2. The plan indicates that any deficits are planned to be covered from earmarked reserves. This overview excludes the reservation and use of a decentralization budget, because of its incidental character. Possible growth of regional and country offices and their activities is not included, because it is hard to predict and it highly depends on access to funding and success of acquisition processes. An updated long term financial plan will be made as part of the development of KNCV's strategic plan 2015-2020.

Table12.2: Long Term Financial Plan 2014-2017

Profit & Loss account	Budget 2014	Long term forecast 2015	Long term forecast 2016	Long term forecast 2017
	In € 1 mln	In € 1 mln	In € 1 mln	In € 1 mln
Organizational costs				
Personnel related costs	7,13	7,00	7,06	7,17
Regional office costs	0,33	0,36	0,40	0,40
Other indirect costs	1,46	1,35	1,35	1,35
Subtotal organizational costs	8,92	8,71	8,81	8,92
Charged to projects	-8,32	-8,32	-8,32	-8,32
Total organizational costs not charged to projects	0,60	0,39	0,49	0,60
Investment and general income	0,13	0,10	0,10	0,10
Net result organizational costs	**-0,48**	**-0,29**	**-0,39**	**-0,50**
Activity costs				
Costs for fundraising	0,51	0,50	0,50	0,50
Other activity costs	0,10	0,12	0,12	0,12
Total Activity costs	**0,62**	**0,62**	**0,62**	**0,62**
Activity income				
Own fundraising	0,96	0,98	0,99	1,00
Lotteries	1,09	1,10	1,10	1,10
Total Activity income	2,05	2,08	2,09	2,10
Net result Activities	**1,44**	**1,46**	**1,47**	**1,48**
Project costs				
Charges organizational costs	8,32	8,32	8,32	8,32
Travel and accomodation	0,56	0,70	0,70	0,70
Material costs	11,15	15,40	15,20	15,20
Expenses coalition partners TB CARE I	32,50	25,00	25,00	25,00
Total Project costs	**52,53**	**49,42**	**49,22**	**49,22**
Project income				
Funding donors - fee	6,94	7,04	7,15	7,25
Funding donors - travel and accomodation	0,53	0,67	0,67	0,67
Funding donors - other direct project costs	10,81	14,90	14,90	14,90
Endowment funds contribution	0,31	0,31	0,31	0,31
Other income for projects	0,01	0,02	0,02	0,02
Income coalition partners TB CARE I	32,50	25,00	25,00	25,00
Total Project income	51,09	47,94	48,05	48,15
Net result Projects	**-1,43**	**-1,48**	**-1,17**	**-1,07**
General Result (minus is a deficit)	-0,47	-0,31	-0,09	-0,09
Covered by earmarked reserves / donated to earmarked reserves	-0,47	-0,31	-0,09	-0,09
Influence on/movements other reserves	**0,00**	**0,00**	**-0,00**	**0,00**



Zimbabwe, visiting village health care worker

13 FINANCIAL STATEMENTS 2013

BALANCE SHEET KNCV TUBERCULOSIS FOUNDATION PER 31 DECEMBER 2013

In Euro, after result appropriation

Assets		12/31/2013		12/31/2012	
Immaterial fixed assets	B1		-		-
Fixed Assets	B2		370.422		414.356
Accounts Receivable	B3	23.674.317		50.142.639	
Investments	B4	5.704.875		5.241.814	
Cash and Banks	B5	8.786.733		9.314.444	
Current Assets			38.165.925		64.698.897
Total			**38.536.347**		**65.113.253**

Liabilities		12/31/2013		12/31/2012	
Reserves and funds	B6				
- Reserves					
Continuity reserve		6.423.985		6.236.948	
Decentralization reserve		1.149.543		1.269.198	
Earmarked project reserves		1.680.898		1.565.718	
Fund national policy planning		232.434		266.330	
Fund international policy planning		232.966		236.230	
Fund research policy planning		219.579		237.413	
Fund Special Needs		112.823		112.823	
Fund E-learning (SVOP)		53.474		60.000	
Fund innovation		328.838		350.000	
Fund Capacity building		500.784		302.922	
Unrealised exchange differences on investments		794.464		543.721	
Fixed Assets reserve		370.422		414.356	
			10.419.311		10.029.941
- Funds					
Earmarked by third parties		463.281		475.007	
			463.281		475.007
Various short term liabilities	B7				
-Taxes and social premiums		886.805		744.908	
-Accounts payable		357.921		255.661	
-Other liabilities and accrued expenses		26.409.028		53.607.736	
			27.653.754		54.608.305
Total			**38.536.347**		**65.113.253**

STATEMENT OF INCOME AND EXPENDITURE KNCV TUBERCULOSIS FOUNDATION 2013

in euro

		Budget 2014	Budget 2013	Actual 2013	Actual 2012
Income					
- Private fundraising	R1	1.313.800	1.349.400	1.632.296	1.402.093
- Share in joint campaigns	R2	-	-	-	-
- Share in third parties activities	R3	1.092.500	1.092.500	1.183.428	1.243.932
- Government grants	R4	50.728.100	50.207.800	50.991.975	46.485.082
- Investment income	R5	147.000	120.000	363.320	504.220
- Other income	R6	18.700	19.900	13.161	30.748
Total Income		53.300.100	52.789.600	54.184.180	49.666.075
Expenses					
Expenses to mission related goals	R7				
- TB control in low prevalence countries		1.028.400	1.093.900	1.096.898	1.043.213
- TB control in high prevalence countries		49.099.100	48.535.600	49.381.534	44.555.570
- Research		961.000	1.170.900	951.277	1.169.108
- Education and awareness		651.600	659.700	594.088	608.112
		51.740.100	51.460.100	52.023.796	47.376.003
Expenses to fundraising	R8				
- Expenses private fundraising		349.900	318.000	283.768	333.845
- Expenses share in fundraising with third parties		50.700	53.300	49.516	49.135
- Expenses government grants		357.500	369.400	309.229	311.073
- Expenses on investments		42.200	46.200	43.354	38.756
		800.300	786.900	685.866	732.809
Administration and control	R9				
- Expenses administration and control		1.230.800	1.324.500	1.096.873	955.293
Total Expenses		53.771.200	53.571.500	53.806.536	49.064.105
Surplus / Deficit		-471.100	-781.900	377.644	601.970
Spent on mission compared to total expenses		96,2%	96,1%	96,7%	96,6%
Spent on mission compared to total income		97,1%	97,5%	96,0%	95,4%
Spent on private fundraising compared to income		26,6%	23,6%	17,4%	23,8%
Spent on administration and control compared to total expenses		2,3%	2,5%	2,0%	1,9%
Result appropriation					
Surplus / Deficit appropriated as follow					
Continuity reserve		3.500	100.600	187.036	168.800
Decentralization reserve		-111.100	-500.000	-119.655	38.471
Earmarked project reserves		-319.100	-260.800	115.180	209.303
Unrealised differences on investments		P.M.	P.M.	250.743	275.842
Fixed Assets reserve		-	-60.000	-43.934	-55.301
Earmarked by third parties		-44.400	-61.700	-11.726	-35.145
Total		**-471.100**	**-781.900**	**377.644**	**601.970**

EXPENSE ALLOCATION KNCV TUBERCULOSIS FOUNDATION 2013

in euro

Expenses

	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Grants and contributions	28.000	58.000	42.155	53.753
Purchases and acquisitions	11.776.200	16.931.300	15.981.346	16.023.270
Outsourced activities	32.500.000	26.242.300	28.492.071	23.834.055
Publicity and communication	708.500	663.200	589.744	686.015
Personnel	7.379.800	7.942.700	7.462.850	7.288.731
Housing	544.000	464.700	473.310	421.491
Office and general expenses[1)]	650.300	1.031.800	547.087	559.118
Depreciation and interest	184.400	237.500	217.972	197.672
Total	**53.771.200**	**53.571.500**	**53.806.536**	**49.064.105**

[1)] Including incidental profits and losses

Allocation to destination

Actual 2013	Related to the mission goals			
	Low prevalence countries	High prevalence countries	Research	Education and Awareness
Grants and contributions	17.727	-	24.428	-
Purchases and acquisitions	329.669	43.987.006	155.824	-
Outsourced activities	-	-	-	-
Publicity and communication	-	-	-	376.660
Personnel	676.401	4.764.922	702.781	188.894
Housing	36.313	324.850	36.835	15.424
Office and general expenses	20.472	175.323	14.858	6.180
Depreciation and interest	16.316	129.433	16.550	6.930
Total allocated	**1.096.898**	**49.381.534**	**951.277**	**594.088**

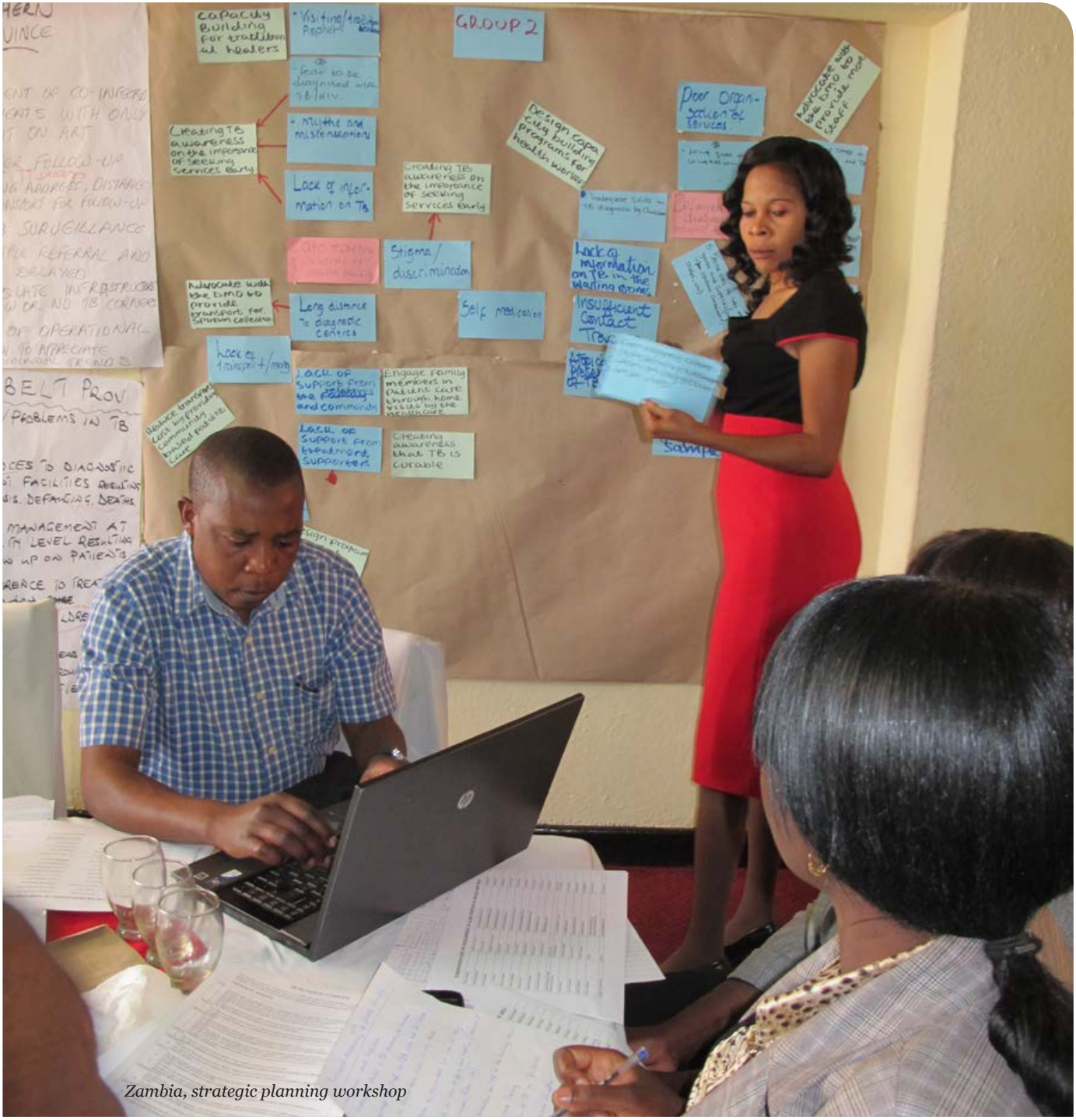
Allocation to destination

	Income raising			Administration & Control
	Private fundraising	Share in third parties activities	Grants	Investments	
Grants and contributions	-	-	-	-	-
Purchases and acquisitions	-	-	-	-	918
Outsourced activities	-	-	-	-	-
Publicity and communication	170.505	36.122	6.457	-	-
Personnel	79.385	12.635	270.613	22.461	744.757
Housing	5.516	410	17.354	615	35.994
Office and general expenses	25.883	164	7.094	247	296.865
Depreciation and interest	2.478	184	7.710	20.030	18.340
Total allocated	**283.768**	**49.516**	**309.229**	**43.354**	**1.096.873**

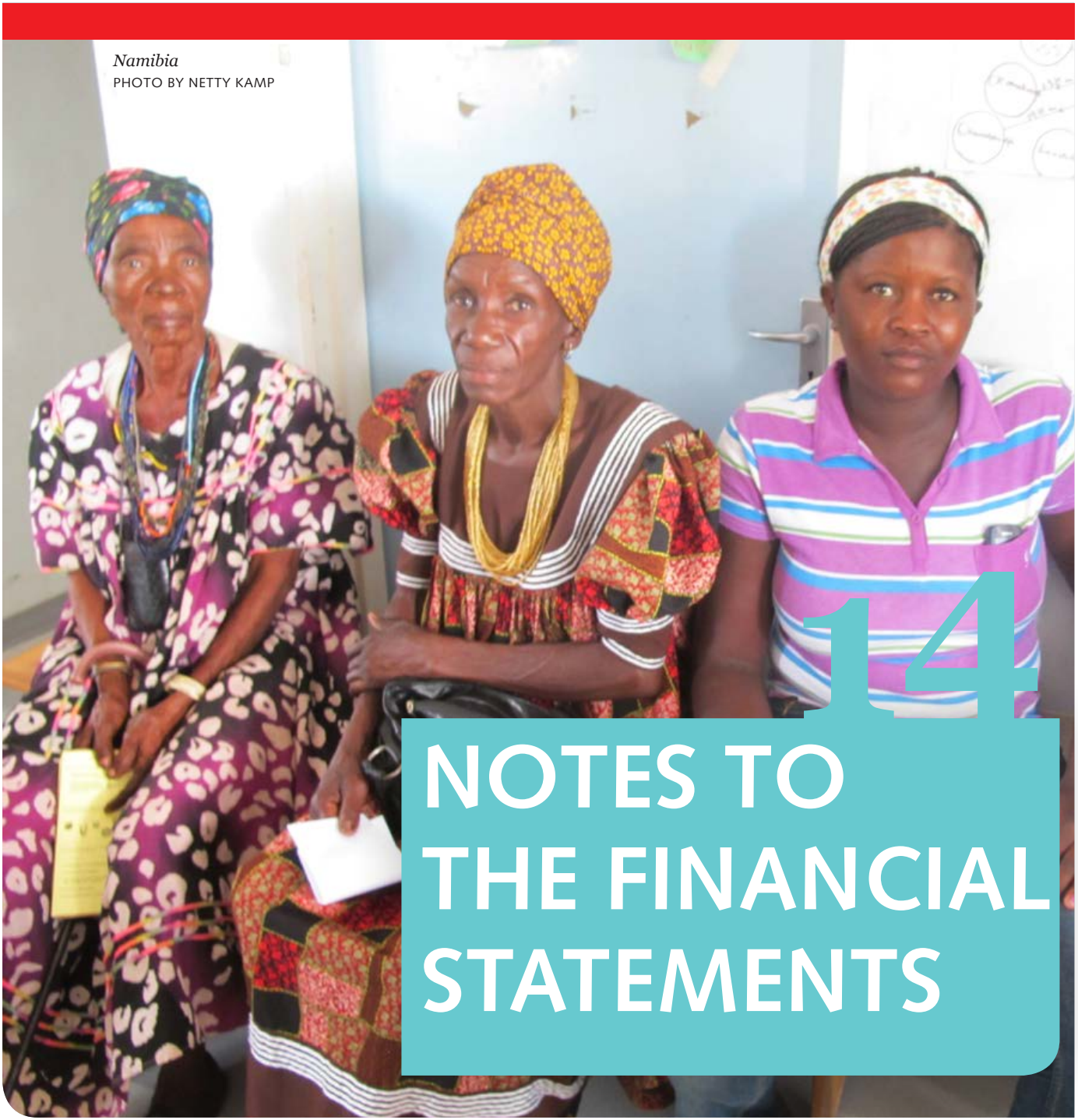
CASH FLOW STATEMENT KNCVTUBERCULOSIS FOUNDATION 2013

in euro

		Actual 2013		Actual 2012	
Surplus/ (Deficit) excl interest		360.968		584.022	
Interest paid/ received		16.676		17.948	
Total surplus / (Deficit)		377.644		601.970	
Depreciation - Fixed Assets		195.907		177.765	
Cash Flow from income and expenditure	C1		573.551		779.735
Investments		-463.061		-1.074.101	
Accounts receivable		26.468.322		-29.173.916	
Non current liabilities		-		-	
Current liabilities		-26.954.550		33.805.419	
Increase/ (Decrease) net working capital	C2		-949.289		3.557.402
Cash flow from operational activities	C3		-375.738		4.337.137
Desinvestments fixed assets		-1.826		6.710	
Investments fixed assets		-150.147		-129.174	
Cash flow from investments fixed assets	C4		-151.973		-122.464
Net cash flow			-527.711		4.214.673
Cash and banks as at 1 January			9.314.444		5.099.771
Cash and banks as at 31 December			8.786.733		9.314.444
Increase/ (Decrease) Cash on hand			-527.711		4.214.673



Zambia, strategic planning workshop



Namibia
PHOTO BY NETTY KAMP

14 NOTES TO THE FINANCIAL STATEMENTS

Guideline 650 for accounting and reporting

KNCV 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 2013 results and budget and between 2013 and 2012 as shown in the Statement of Income and Expenses are clarified.

Consolidation

KNCV 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. The program is partly implemented by partners in the Tuberculosis Coalition for Technical Assistance (TBCTA). 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.
At the de-central level, where KNCV has regional offices 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.

Balance sheet per 31 December 2013 - Assets

Fixed Assets (B2)

Movements in the tangible fixed assets are as follows:

	Office reconstruction work	Office inventory	Computers	Total
as at 1 January, 2013				
Cost / Actual value	376.973	374.954	736.823	1.488.750
Accumulated depreciation	-280.723	-264.693	-528.978	-1.074.394
Bookvalue	**96.250**	**110.261**	**207.845**	**414.356**
Increase / (Decrease) 2013				
Acquisitions	-	-	150.147	150.147
Desinvestments	-	-5.280	-96.673	-101.953
Depreciation on disinvestments	-	5.280	98.499	103.779
Depreciation	-37.677	-35.057	-123.173	-195.907
	-37.677	**-35.057**	**28.800**	**-43.934**
as at 31 December, 2013				
Cost / Actual value	376.973	369.674	792.340	1.538.987
Accumulated depreciation	-318.400	-294.470	-555.695	-1.168.565
Bookvalue	**58.573**	**75.204**	**236.645**	**370.422**

The book value of fixed assets ultimo 2013 amounts to € 370.422, which is lower than 2012. 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 2013 amounting to €150.147 were for ICT equipment. Total depreciation is calculated at € 195.907. Assets that are no longer in use and are completely depreciated have been divested for an amount of € 101.953.
Tangible fixed assets are those assets needed to operationally manage the business. No assets have been included in the tangible fixed assets figure, that have been directly used in the scope of the main activities.

Accounts receivable (B3)

The balance of accounts to be received is €23,7 million, which is €26,4 lower than in 2012. 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.

	31/12/2013	31/12/2012
Accounts receivable (B3)		
Dr. C. de Langen Foundation for Global TB control	526	-
Interest (on bonds)	32.918	32.622
Lotteries	305.354	385.051
Receivable USAID TB CARE I	257.152	-
Debtors	227.733	170.371
Payments in advance general	258.687	361.778
Payments in advance projects	451.506	1.038.103
Legacies in process	344.445	170.620
Accounts receivable USAID based on agreement	21.683.051	47.979.789
Other receivables	112.945	-
Interest paid on TB CARE I	-	4.306
	23.674.317	**50.142.639**

The total account receivable from USAID for the TB CARE I project, based on approved project workplans, decreased with € 26,3 million to € 21,7 million. This amount is directly related to the work still to be performed in the final full year of TB CARE I and amounts under projects to be executed and accounts payable to coalition partners represented under liabilities.
All receivables fall due within one year.

Investments (B4)

KNCV 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 Manager Finance, Planning & Control. 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 14.1 to 14.3 on the next page. As far as is relevant a comparison with 2012 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 2013, € 8.3 million was available and as per 1 January 2014, € 8,6 million. Both balance value (€5,7 million) and market value (€5,8 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 14.2 on the next page the allocation of assets according to the reporting of ABN AMRO/MeesPierson is shown[12]. 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 2013 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.

Investments (B4)	Shares	Bonds [2)]	Alternatives	Total
Balance as at 1 January, 2013	1.355.627	3.140.914	745.273	5.241.814
Purchases and sales	139.387	284.614	-169.702	254.299
Redemption of bonds	-	-	-	-
Realised stock exchange result	1.058	-7.750	617	-6.075
Unrealised stock exchange result	259.592	-6.243	-2.607	250.742
Amortizatie	-	-35.905	-	-35.905
Balance as at 31 December, 2013	**1.755.664**	**3.375.630**	**573.581**	**5.704.875**

[2)] Stock Exchange value of bonds as at 31 December, 2013 is € 3.460.817,-

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

Table 14.1: Composition of the investment portfolio and historical values

Fund	Interest %	Nominal value	Historic purchase value	Value in balance sheet	Transactions in reporting year nominal			Transactions in reporting year in actual prices			Nominal value	Historic purchase value	Value in balance sheet
		1/1	1/1	1/1	Purchased	Sold	Redemption of bonds	Purchased	Sold	Redemption of bonds	31/12	31/12	31/12
Shares (00300)													
ABN Amro Global Sri Equit acc				-				124.950				124.950	132.563
ASN Duurzaam Fund 3			92.900	126.879				2.923	28.905			66.918	131.622
ASN Environment and Waterfund			49.999	75.625				9.810				59.809	106.912
Aviva morl/Luxellence sust Eur			76.675	119.457					11.287			65.388	136.427
Calvert Soc. Inv. FND-A-Eq. Port			59.965	121.908				73.060				133.025	225.655
Calvert Int. Eq. Fund a 1/1000			84.015	102.952				73.071				157.086	200.413
Celsius Sust Emerging Markets			198.072	214.116					48.669			363.519	153.505
F&C portf Stewardship int			65.099	106.547				5.400				70.499	135.464
aHenderson Global Ind. Future			106.328	117.280								106.328	150.640
ING Duurzaam Aandelen Fonds			129.057	128.908				1.129	26.507			232.587	122.660
Kempen Sust small cap			78.139	120.625				2.730	11.708			69.161	140.623
Triodos Sust. Eq. Fund r share			89.520	121.331				426	27.038			62.908	119.180
Subtotal shares		-	1.029.769	**1.355.628**				**293.499**	**154.114**	-	-	1.512.178	**1.755.664**
Real estate/Alternatives (00305)													
CFS Retail Prop Trust			106.507	100.953					38.441			68.066	54.839
Hammerson Plc a GBP 0.25			55.293	56.889					26.091			29.202	30.091
Land Securities Group			-					67.996					80.280
Triodos vastgoedfonds NV			87.736	51.076					1			87.735	32.971
Triodus Renewable Europe			-	62.200					31.881			31.881-	28.082
Triodus II/Microfin I cap			-	212.372					-			-	224.631
Simon Property Group. Inc			24.740	55.132					55.000			30.260-	-
Unibail - Rodamco			103.540	141.011				329	99.421			4.448	42.279
Units Respons glb Micro fin fd			-	65.640				12.808				12.808	80.408
Subtotal real estate/altern.		-	377.816	**745.273**				**81.133**	**250.835**	-	-	140.118	**573.581**
Bonds (00320)													
BNG 10-17	2,500	95.000	100.000	100.717							95.000	100.000	99.288
Duitsland 09-20	1,750	290.000	290.000	339.264							290.000	290.000	332.226
ING Groep NV 02-13	5,250	198.000	198.000	198.000			198.000		198.000		-	-	-
Ned.Water. Bank 12-19	1,625	-		-	100.000			102.072			102.072	102.072	101.727
Ned.Water. Bank 05-20	3,875	140.000	159.544	158.020							140.000	159.544	155.446
Ned.Water. Bank 08-18	4,375	-	-		175.000			204.340			204.340	204.340	198.472
Nederland 08-18	4,000	115.000	115.000	115.000							115.000	115.000	115.000
Nederland 09-19	4,000	195.000	221.078	218.597							195.000	221.078	214.664
Oostenrijk 2017	4,300	-	-	-	335.000			393.873			393.873	393.873	379.155
Rabobank 10-17	3,375	150.000	150.000	150.000							150.000	150.000	150.000
SSGA euro sustainable corp bonds	perp	1.861.316	1.754.854	1.861.316	50.579	268.250		50.579	268.250		1.643.645	1.537.183	1.629.652
Subtotal bonds		3.044.316	2.988.476	**3.140.914**	**660.579**	**268.250**	**198.000**	750.864	466.250	-	3.328.930	3.273.090	**3.375.630**
Total		3.044.316	4.396.061	**5.241.815**	660.579	268.250	198.000	1.125.496	871.199	-	3.328.930	4.925.386	**5.704.875**

Table 14.2: Asset allocation ultimo 2013 compared to the policy (source: Quarterly report ABN AMRO/MeesPierson)

Investment	Investment policy		1 January 2013		31 December 2013	
	Range	Target	In € million	%	In € million	%
Bonds	80-50%	70%	3,10	53,4%	3,40	55,7%
Shares/Real Estate/Alternatives	50-0%	30%	2,10	36,2%	2,30	37,7%
Liquidities		0%	0,60	10,3%	0,40	6,6%
Total			**5,80**	**100,0%**	**6,10**	**100,0%**

Table 14.3: Maturity of bonds

Running period remaining	2011	2012	2013
0 to 2 years	0,0%	6,3%	0%
2 to 5 years	40,5%	0,0%	28%
5 to 8 years	15,4%	18,6%	24%
>8 years	44,1%	75,1%	48%

Table 14.4: Investment results 2009-2013

Description	2009	2010	2011	2012	2013
Bond income	150.681	148.093	105.740	88.899	109.447
Depreciation of amortization	-	-	-	-12.496	-35.906
Dividend	10.704	21.161	18.094	34.085	28.435
Realized exchange results	23.168	48.771	8366	99.942	-6.075
Unrealized exchange results	178.371	176.480	-104.208	275.842	250.743
Interest on cash on hand and deposits	102.265	34.266	25.585	17.948	16.676
Gross investment income	465.189	428.771	53.577	504.220	363.320
Investment expenses	19.055	19.781	28.690	17.500	19.754
Nett investment income	**446.134**	**408.990**	**24.887**	**486.720**	**343.566**

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 14.3.

An overall result of 5.2% (benchmark: 5.1%; 2012: 9.9%) is realized. Below, a comparison between our 2013 portfolio, the benchmark and the results for 2012 is shown per asset category:

- Bonds; 2013 0.7%, benchmark 2.2%[13], 2012 9.3%
- Shares; 2013 20.0%, benchmark 17.7%[14], 2012 18.0%.
- Real estate/alternative assets; 2013 1.0%, benchmark 0.8%[15], 2012 12.7%.
- Liquidity available for investments; 2013 -1.7% (includes investment expenses), benchmark 0.1%[16], 2012 0.0%.

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 over-weighing 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 13 and figure 10, 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.

[13] 50% EU, 40% world and 10% emerging markets. [14] Citigroup EMU Government Bond Index all maturities. [15] 50% Rel Value, 50% 3 months euribor + 2%. [16] 3 months Euribor.

The Executive Board confirms that all transactions in 2013 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.

KNCV incurs risk regarding the valuation of securities disclosed under financial assets. The organization manages market risk by spreading tactics (allocation, time planning) and imposing limits. Currency exchange risk for KNCV largely concerns exposure on positions in US dollars and various local currencies. Management has determined, based on a risk assessment, that these currency risks can be mitigated by careful liquidity planning and simple hedging techniques. No forward exchange contracts are used. No financial derivatives for interest rate risk are contracted with regard to the receivables.
KNCV does not have any significant concentrations of credit risk.

Cash and banks (B5)

The balance of cash and banks decreased compared to 2012, with €0,5 million to a level of €8,8 million. The main reason for this decrease is the decreased bank balance in country offices due to more stringent cash flow planning.
Ultimo 2013 no deposits were available, because interest rates on deposits during 2013 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.

Figure 14.1: Investment results over a five year period

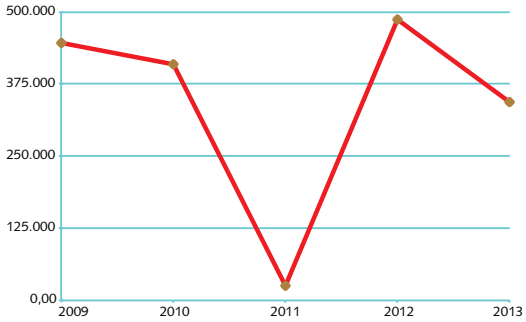


Figure 10: Net investment income 2009-2013

	31/12/2013	31/12/2012
Cash and banks (B5)		
Immediately available		
Petty cash	8.944	7.789
ING	439.978	409.242
ABN AMRO bank	405.471	82.527
ABN AMRO (USD account)	2.977.761	2.831.838
ABN AMRO investment account	434.986	556.835
ABN AMRO TB CARE I	2.882.367	1.587.990
Bank accounts country offices	1.637.226	3.838.223
	8.786.733	**9.314.444**

Balance sheet per 31 December 2013 - Liabilities

Reserves (B6)

• Continuity reserve

The continuity reserve serves as a buffer for unexpected fallbacks, 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.

As a reasonable maximum level of the reserve, the organization uses 1 to 1.5 times the estimated and budgeted expenditures for the organization for one year. Mission related activity expenditures are excluded of the calculation. Based on the budget for 2014 for organizational costs (€8,8 million) the continuity reserve's maximum is €8,8 to €13,2 million. The reserve ultimo 2013, €6,4 million, stays well within the maximum (0.7 times the budget for organizational costs in 2014). The underlying risks to be covered by the continuity reserve are analyzed 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.

	Balance as at 1/1/2013	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2013
Continuity reserve	6.236.948	-	-	187.036	6.423.985

• 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 2013, an amount of €184.820 has been withdrawn from the earmarked project reserves for these kinds of activities and € 300.000 has been added as a reserve for capacity building at central level. For 2014 €349.140 is budgeted to be used.

	Balance as at 1/1/2013	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2013
Fund national policy planning	266.330	-	-	-33.896	232.434
Fund international policy planning	236.230	-	-	-3.264	232.966
Fund research policy planning	237.413	-	-	-17.834	219.579
Fund special needs	112.823	-	-	-	112.823
Fund E-learning (SVOP)	60.000	-	-	-6.526	53.474
Fund innovations	350.000	-	-	-21.162	328.838
Fund capacity building	302.922	-	-	197.862	500.784
Total earmarked by the board	**1.565.718**	**-**	**-**	**115.180**	**1.680.898**

• 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 2011, the decentralization reserve was formed to the amount of €1.230.727 to account for expenses to be incurred in the regionalization process during the years 2012-2015. In 2013, the amount of €119.655 was withdrawn from this reserve.

• Revaluation reserve

	Balance as at 1/1/2013	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2013
Decentralization reserve	1.269.198	-	-	-119.655	1.149.543

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 2013 the reserve contains €794.464.
The movement in the reserve is as follows:

	Balance as at 1/1/2013	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2013
Revaluation reserve	543.721	-	-	250.743	794.464

• Fixed asset reserve

KNCV separates equity, needed to finance the remaining value of fixed assets, which is allowed by Guideline 650.
In 2013, the reserve decreased to an amount of €370,422.

Funds earmarked by third parties (B6)

Balance at 1 January, 2013		414.356
Add: purchases fixed assets	150.147	
Less: sale of fixed assets	-101.953	
Less: depreciation of fixed assets	-195.907	
Add: depreciation on sale or disinvestments	103.779	
Movement in continuity reserve		-43.934
Balance at 31 December, 2013		**370.422**

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 2013 an amount of €11.726 is used.
In 2013 an amount of € 65.303 was received from the Van Geuns Foundation for the development of E-courses. Part of this amount was used in 2013, an amount of € 44.223 was added to an earmarked fund to be used in 2014.
Fund Tuberculosis Surveillance and Research Unit (TSRU)
In 1993 the financial management of the TSRU was transferred to KNCV, being one of the members of the TSRU. KNCV henceforth

	Balance as at 1/1/2013	Movements	Withdrawals	Profit & loss appropriation	Balance as at 31/12/2013
Fund TSRU	154.974	-	-	539	155.513
Fund Special Needs	255.610	-	-	-	255.610
Funds Van Geuns	-	-	-	44.223	44.223
Unspent Funds for objectives	64.423	-	-	-56.488	7.935
	475.007	**-**	**-**	**-11.726**	**463.281**

Total funds earmarkd by third parties

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 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.

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 MDR-TB research in Kazakhstan and capacity building of local staff.

Various liabilities (B7)

The total of various liabilities has decreased from €53,6 million in 2012 to €26,4 million in 2013 and includes under other liabilities €7,3 million of contractual committed projects still to be executed for USAID and €16,4 million value of sub-agreements with TBCTA 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 2013 is €589.150 million, which is lower than the amount in 2012. The decrease is a result of a new leave hours policy that was implemented in 2012, in which measures were included that would prevent significant increases in the provision.
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-

Various short term liabilities (B7)

	31/12/2013	31/12/2012
Taxes and social premiums		
Income tax	284.997	310.692
Social premiums	601.808	434.216
	886.805	**744.908**
Accounts payable	357.921	255.661
Other liabilities and accrued expenses		
Provision for holiday pay	225.466	311.286
Provision for annual leave	589.150	695.219
Declarations from staff	16.719	57.192
Audit fees	33.885	21.091
USAID	-26.228	-
Payable WHO	80.281	62.915
Current account - Dutch Ministery of Foreign Affairs	40.932	60.000
Bakhuijs Roozeboomstichting	15.000	20.000
Current Accounts project countries	59.822	790.632
Other donors	45.015	89.108
Other liabilities	63.921	87.845
Project payables KNCV country offices	226.273	122.530
Current account USAID	978.238	1.758.777
Other	-194	-5.995
Accruals TB CARE I	326.129	82.102
Projects to be executed under TB CARE I	7.337.298	16.843.769
Accounts payable TB CARE I coalition partners	16.397.322	32.611.265
	26.409.028	**53.607.736**

term character.

Liabilities not included in the balance sheet

Office rental contract

In 2005 a rental contract was signed by KNCV with a third-party lessor for its offices on 17 Parkstraat in The Hague. The rental contract lasts for 10 years, ending on 31 December, 2014. The annual rent is € 395.650 including maintenance fee and VAT. A € 86.256 bank guarantee has been issued in favor of the lessor. The rental contract for KNCV 's regional office in Almaty, Kazakhstan is US$ 5.400 annually. This contract ends 20 September 2014. The rental contract for KNCV 's regional office in Nairobi, Kenya ends 30 April 2014. The rent for 2014 is € 5.000 including VAT.

Conditional commitments

TB CARE I
Of the total amount of US$ 225.000.000 in the cooperative agreement for TB CARE I an amount of US$ 191.507.913 has been obligated and planned. Of this amount US$ 161.637.125 has been expensed. In January 2014 an additional commitment of US$ 4.990.000 has been received.

TBCAP and TB CARE I
The audit according to the USAID guidelines of the third 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 2013. For this uncertainty, which is based on currently known data, the financial impact cannot be estimated.

TB CARE I cost share
The cooperative agreement between KNCV and USAID for TB CARE I shows a cost share of 15.7% of total expenses, to be divided between all TB CARE I coalition partners. Based on the total expenses until 31 December 2013 this amounts to US$ 25.245.494. Until 31 December 2013 the declared cost share is US$ 24.338.312.

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 generated more income in 2013 (€ 54,2 million), compared to 2012 € 49,7 million).
In table 14.5 the total income for 2013 is compared with the budget and with 2012. In the tables to follow each income category is further clarified.

Table 14.5: Total income

Total income	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Own share	26,55	25,69	25,90	-3%	-1%
Coalition partners share	26,24	28,49	23,80	9%	16%
Total	**52,79**	**54,18**	**49,70**	**3%**	**8%**

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

Table 14.6: Private fundraising (R1)

	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Private fundraising	1,35	1,63	1,40	21%	14%

Private fundraising income was 21% higher than planned and also higher than 2012, mostly due to higher legacy income and income from other private donors, such as Van Geuns Stichting.

Income from private fundraising (R1)	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Donations and gifts				
Sonnevanck Foundation	18.000	18.000	18.000	18.000
Mr. Willem Bakhuijs Roozeboom Foundation	20.000	20.000	20.000	20.000
Dr. C. de Langen Foundation for global Tuberculosis	270.000	270.000	270.500	320.000
Direct marketing activities	686.000	634.400	588.608	614.319
Gifts- other	25.000	40.000	55.145	140.435
Total donations and gifts	**1.019.000**	**982.400**	**952.253**	**1.112.754**
Contributions by association members	500	500	510	530
Sponsoring	-	-	-	-
Legacies and endowments	250.000	250.000	440.578	204.772
Other income from private fundraising	44.300	116.500	238.955	84.037
Total income from private fundraising	**1.313.800**	**1.349.400**	**1.632.296**	**1.402.093**

Table 14.7: Share in third parties activities (R3)

	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Share in third party activities	1,09	1,18	1,24	8%	-5%

Income from third party campaigns increased with 8% compared to budget, but decreased compared to 2012 due to the fact income for 2012 was estimated correctly and less income was booked as settlement for previous years, whereas is 2012 an additional amount for 2011 was taken into account.
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 causes the difference with the actual figure.

Table 14.8: Income from fundraising by third parties (R3)

	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Settlement previous years	-	-	43.295	95.144
Vriendenloterij earmarked	770.000	770.000	91.634	64.917
Vriendenloterij non earmarked			704.565	683.871
De Lotto	322.500	322.500	343.934	400.000
Total from fundraising third parties	**1.092.500**	**1.092.500**	**1.183.428**	**1.243.932**

Table 14.9: Government grants (R4)

Government grants	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Own share	23,97	22,50	22,70	-6%	-1%
Coalition partners share	26,24	28,49	23,80	9%	16%
Total	**50,21**	**50,99**	**46,50**	**2%**	**9%**

KNCV's 2013 share in the USAID funded program **TB CARE I,** with €49,7 million, amounts to 97% of the total figure for government grants.
The contribution to TB control in The Netherlands from the CIb has decreased to €0,7 million in 2013, as a result of an announced three year grant reduction. The budgeted amount for this grant in 2014 will be € 0,6 million.
From a large group of other smaller government donors, a total of €0,6 million was received, which is higher than the budgeted amount. For 2013, government grants determined 94% of KNCV's budget.

Government grants (R4)	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Center for disease control	621.854	691.854	710.922	717.982
USAID	16.846.696	22.986.055	21.153.169	21.312.302
WHO		61.492	30.914	30.564
Global Fund/GFATM			79.421	72.572
Other Donors	759.550	226.099	525.478	517.607
Subtotal	18.228.100	23.965.500	22.499.904	22.651.027
USAID grants coalition partners	32.500.000	26.242.300	28.492.071	23.834.055
Total government grants	**50.728.100**	**50.207.800**	**50.991.975**	**46.485.082**

KNCV's 2013 share in the USAID funded program TB CARE I, with €49,7 million, amounts to 97% of the total figure for government grants.
The contribution to TB control in The Netherlands from the CIb has decreased to €0,7 million in 2013, as a result of an announced three year grant reduction. The budgeted amount for this grant in 2014 will be € 0,6 million.
From a large group of other smaller government donors, a total of €0,6 million was received, which is higher than the budgeted amount. For 2013, government grants determined 94% of KNCV's budget.

Table 14.10: Investment income and Other income (R5 and R6)

	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Investment income and other income	0,12	0,36	0,50	200%	-39%

Income from investments (R5)	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Dividends	20.000	15.000	28.435	34.085
Bond earnings	94.000	82.000	91.447	70.899
Bond earnings on behalf of Fund Special Needs	18.000	18.000	18.000	18.000
Realised exchange gains	-	-	-6.075	99.942
Unrealised exchange results	-	-	250.743	275.842
Interest on cash on hand and deposits	15.000	5.000	16.676	17.948
Depreciation of amortization of bond value	-	-	-35.906	-12.496
Total from investments	**147.000**	**120.000**	**363.320**	**504.220**
Total cost investments (Reported under expenses investments)	26.000	26.000	19.754	17.500
Nett investment income	**121.000**	**94.000**	**343.566**	**486.720**
R6 Other Income				
Endowment funds fee on administration & control costs	5.500	5.500	5.500	5.500
Miscellaneous	13.200	14.400	7.661	25.248
Total Other Income	**18.700**	**19.900**	**13.161**	**30.748**

Expenditure

Total expenditures in 2013 were € 53,8 million, which is € 0,2 million higher than budgeted. The increase is caused by additional expenditures in the category "TB in high prevalence countries". Expenditures in the categories "fundraising" and "administration and control" showed a decrease compared to budget.
In table 14.10 the total expenses for 2013 are compared with the budget and with 2012. In the tables to follow each income category is further clarified.

Table 14.11: Total expenditure

96.0% of the total income is spent on mission related activities. The increase of € 4,7 million compared to 2012 is, again, caused by higher expenses from coalition partners, mainly due to the earlier workplan approval in 2013, where in 2012 many country activities for TB CARE I showed a somewhat delayed start up.

Total expenditure	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Own share	27,33	25,32	25,30	-7%	-0%
Coalition partners share	26,24	28,49	23,80	9%	16%
Total	**53,57**	**53,81**	**49,10**	**0%**	**9%**

Table 14.12: Expenses to mission related goals (R7)

Expenses to mission related goals	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Own share	25,22	23,53	23,60	-7%	-0%
Coalition partners share	26,24	28,49	23,80	9%	16%
Total	**51,46**	**52,02**	**47,40**	**1%**	**9%**

In 2013, 96,7% of all expenses are spent on mission related activities. In 2012, this percentage was 96.6%. The activities in low prevalence countries took 2% of the total amount, high prevalence countries 92%, research activities 2% and education/awareness 1%. The increase compared to 2012 runs parallel with the increase in income from government grants and can be fully clarified by the increased pace of TB CARE I activities in "TB high prevalence countries".

Expenses to mission related goals (R7)	Budget 2014	Budget 2013	Actual 2013	Actual 2012
- TB control in low prevalence countries	1.028.400	1.093.900	1.096.898	1.043.213
- TB control in high prevalence countries				
-- executed by KNCV	16.599.100	22.293.300	20.889.463	20.721.515
-- executed by TB CARE I coalition partners	32.500.000	26.242.300	28.492.071	23.834.055
- Research	961.000	1.170.900	951.277	1.169.108
- Education and awareness	651.600	659.700	594.088	608.112
Total expenses to the mission	**51.740.100**	**51.460.100**	**52.023.796**	**47.376.003**

Specification - per country, independent from nature of the project	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Netherlands	1.179.800	1.217.200	1.268.213	1.223.262
Africa				
- Regional Office	169.300	-	96.280	150.301
- Angola	-	-	-	85.024
- Botswana	235.300	236.600	236.793	208.092
- Ethiopia	1.900.300	1.974.500	1.849.148	1.893.194
- Gambia	-	-		-18.349
- Ghana	67.400	76.500	99.866	38.818
- Guinée Bissau	-	-	-	32.861
- Kenya	16.600	1.582.300	1.965.005	3.143.014
- Liberia	-	-	14.567	-
- Mozambique	230.200	182.500	217.819	147.110
- Namibia	1.743.100	1.945.200	1.637.099	1.513.878
- Nigeria	2.423.700	4.147.600	3.853.452	2.307.339
- Rwanda	10.300	212.800	53.827	32.510
- Senegal	-	-	9.407	12.610
- South Africa	-	548.900	-	88.447
- South Sudan	65.000	76.900	49.216	78.163
- Tanzania	56.200	133.600	49.164	47.060
- Uganda	-	398.300	928.865	459.873
- Zambia	251.700	227.100	221.952	112.627
- Zimbabwe	148.100	153.700	180.121	85.993
Subtotal Africa	**7.317.200**	**11.896.500**	**11.462.581**	**10.418.565**
Asia				
- Afghanistan	33.400	3.300	73.587	21.234
- Bangladesh	45.000	-	2.034	-
- Cambodia	66.400	49.200	46.842	72.268
- China	-	-	36.570	-
- Indonesia	3.692.200	5.275.200	4.151.011	3.922.142
- Pakistan	-	17.900	193.831	305.620
- Vietnam	710.300	988.700	569.697	1.813.787
Subtotal Asia	4.547.300	6.334.300	5.073.572	6.135.051
South America				
- Brasil	-	14.800	-	-
- Chili	-	-	6.757	-
- Dominican Republic	-	56.200	234.379	686.661
- Peru	-	-	-	131
Subtotal South America	**-**	**71.000**	**241.136**	**686.792**
Eastern Europe				
- Regional office	158.100	-	32.225	10.705
- Belarus	-	-	-	634
- Kazakhstan	870.000	1.007.000	892.584	655.379
- Kyrgyzstan	636.500	644.000	618.358	401.157
- Mongolia	-	-	24.174	-
- Ukraine	16.700	-	27.730	6.620
- Uzbekistan	35.900	80.400	87.578	89.592
- Tajikistan	918.400	610.000	742.490	266.974
- Turkmenistan	-	-	23.087	9.884
Subtotal Eastern Europe	2.635.600	2.341.400	2.448.226	1.440.945
Non-country or region related projects	4.358.016	3.735.500	3.802.025	4.220.830
TB CARE I coalition partners	32.500.000	26.242.300	28.492.071	23.834.055
Expenses charged to other expenditure categories [5)]	-797.816	-378.100	-764.028	-583.497
Total expenses to the mission	**51.740.100**	**51.460.100**	**52.023.796**	**47.376.003**

[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 seperate line is included.

Table 14.13: Expenses to fundraising (R8)

	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Expenses to fundraising	0,79	0,68	0,73	-14%	-7%

In all categories of fundraising and acquisition activities, including those for private fundraising, €0,7 million was spent. This was lower than the budget and also lower than the level of 2012, mostly due to staff vacancies. For private fundraising a percentage of 17,4% of the income has been spent as costs. This is well within the CBF maximum of 25%.

Table 14.13: Administration and control (R9)

	Budget 2013 in € million	Actual 2013 in € million	Actual 2012 in € million	% difference budget	% difference last year
Administration and control	1,32	1,10	0,96	-17%	12%

Costs for administration and control were 17% lower than planned. Savings were realized on a number of other expense categories (ICT, housing). Compared to 2012, the costs are 12% higher, caused among other things by severance payment to a departing director.

Operating result
The balance between income and costs is a surplus of €0,4 million, while a deficit of €0,8 million was planned. The main causes of the difference with the budgeted figures are incidental: an unrealized investment income of €0,3 million, higher income from private fundraising, mainly legacies € 0,3 million, higher income from lotteries € 0,1 million and lower expenses for administration and control (€0,2 million).
A proposal for appropriation of the result is presented as part of the annual report, on page 109.

Cash flow statement
The decrease in cash and banks in 2013 is caused by a positive cash flow from income and expenses and a negative cash flow from both investments and the increase in project liabilities compared to project receivables. This results in a negative cash flow from operational activities and a negative cash flow from tangible fixed assets (investments).

Table 14.15: Organizational expenses 2013

	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Personnel expenses				
Salaries	5.343.200	5.706.200	5.778.928	5.604.928
Accrued annual leave	33.000	-	-34.946	46.878
Social security premiums	404.600	446.700	382.833	364.255
Pension premiums	530.100	548.700	487.942	465.153
Saving arrangements	-	-	-	-
External staff/temporary staff	130.000	137.200	233.664	224.271
Expenses regional offices	160.000	294.900	42.289	107.817
Capacity building decentralization	111.100	135.000	102.138	97.078
	6.712.000	7.268.700	6.992.848	6.910.380
Oncharged staff expenses to third parties	-	-27.900	-	-2.925
Sub total	6.712.000	7.240.800	6.992.848	6.907.455
Additional staff expenses				
Commuting allowances	105.850	115.300	87.364	93.334
Representation	3.450	5.100	5.719	10.480
Social event	4.500	3.800	7.439	2.756
Congresses and conferences	35.000	35.000	25.718	27.499
International contacts	30.000	29.000	39.727	16.331
Training & Education	106.900	115.300	95.094	100.677
Recruitment	10.000	10.000	21.693	8.118
Insurance personnel	16.000	16.100	13.247	15.857
Catering	20.000	18.300	16.565	16.188
Works council	27.200	27.000	13.158	12.761
Expenses regional offices	59.800	-	56.275	-
Other	278.900	312.000	76.578	73.495
Sub total	637.800	686.900	458.577	377.496
Other human resource management costs				
Development of tools	15.000	10.000	5.458	965
Safety training	15.000	5.000	5.967	2.815
Sub total	30.000	15.000	11.425	3.780
Total personnel expenses	**7.379.800**	**7.942.700**	**7.462.850**	**7.288.731**
Average number of fte's central office The Hague	73,0	81,1	75,4	91,8

Operating result

The balance between income and costs is a surplus of €0,4 million, while a deficit of €0,8 million was planned. The main causes of the difference with the budgeted figures are incidental: an unrealized investment income of €0,3 million, higher income from private fundraising, mainly legacies € 0,3 million, higher income from lotteries € 0,1 million and lower expenses for administration and control (€0,2 million).

A proposal for appropriation of the result is presented as part of the annual report, on page 118.

Housing expenses	Budget 2014	Budget 2013	Actual 2013	Actual 2012
Rent	332.000	325.400	305.704	299.557
Repairs and maintenance	4.000	4.100	3.760	1.807
Cleaning expenses	45.000	45.800	42.636	40.887
Utilities	78.000	76.300	72.756	58.766
Insurance and taxes	1.800	1.800	1.869	1.695
Plants and decorations	60.800	11.300	9.286	8.395
Housing expenses regional offices	22.400	-	37.299	10.384
Total housing expenses	**544.000**	**464.700**	**473.310**	**421.491**
Office and general expenses				
General office supplies	12.000	14.200	7.471	9.035
Telephone	31.000	28.400	27.946	29.799
Postage	12.000	15.300	10.875	10.573
Copying expenses	31.000	30.500	27.819	31.426
Maintenance - machines, furniture	1.000	1.000	259	561
Professional documentation	4.500	5.100	2.348	4.333
IT costs	158.700	157.400	95.371	98.249
Audit fees	73.500	48.000	73.670	107.094
Board of Trustees	10.000	10.000	8.875	70.101
Consultancy	32.500	32.500	36.882	20.619
Bank charges	20.000	15.000	21.354	24.152
Reorganization expenses	-	500.000	113.712	61.529
Other	172.300	174.400	60.819	48.842
Office and general expenses regional offices	91.800	-	59.686	42.805
Total office and general expenses	**650.300**	**1.031.800**	**547.087**	**559.118**
Depreciation and interest				
Office reconstruction work	37.400	37.800	37.677	37.780
Office inventory	34.000	36.500	35.057	36.423
Computers	77.500	137.200	123.174	105.960
Regional offices	9.500	-	144	-
Investment costs	26.000	26.000	21.920	17.509
Total depreciation and interest	**184.400**	**237.500**	**217.972**	**197.672**

Cash flow statement

The decrease in cash and banks in 2013 is caused by a positive cash flow from income and expenses and a negative cash flow from both investments and the increase in project liabilities compared to project receivables. This results in a negative 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, The Netherlands. Under its Articles of Association, KNCV Tuberculosis Foundation has as its statutory objective:
The promotion of the national and international control of TB by, amongst others:

a. creating and maintaining ties between the different institutions and persons in the Netherlands and elsewhere in the world, that are working towards the prevention and control of TB;
b. raising awareness for the prevention and control of TB and keeping the awareness alive through the dissemination of written and oral information, by causing courses to be held and by promoting scientific research concerning TBand its control;
c. conducting research concerning the fight against TB;
d. giving advice about ways to prevent and control TB, as well as
e. by undertaking any and all other activities which may be conducive to these objects.

KNCV may, as a side activity, develop and support similar work in other areas 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 financial statements are presented in euros, which is the functional and presentation currency of KNCV. 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' balance sheet per asset/ liability group against the exchange rates as at 31 December 2013.

Related parties
Statutory directors and other key management of KNCV and close relatives are regarded as related parties. Significant transactions with related parties, if applicable, are disclosed in the notes insofar as they are not transacted under normal market conditions. The nature, extent and other information is disclosed if this is required for to provide the true and fair view.

Accounting policies - assets and liabilities

Tangible fixed assets (B2)
The tangible fixed assets have been valued at historic acquisition prices less cumulative depreciation using the following depreciation rates:

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

At each balance sheet date, KNCV tests whether there are any indications of assets being subject to impairment. If any such indications exist, the recoverable amount of the asset is determined and recognized in the income statement.

Investments (B4)
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 and alternative investments 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'. Transaction costs are expensed in the income statement. All investments are at the free disposal of KNCV.

Cash and banks (B5)
Cash and bank balances are freely disposable, unless stated otherwise, and are accounted for at nominal value.

Receivables and liabilities (B3 and B7)
Trade receivables are recognized initially at fair value and subsequently measured at amortized cost. If payment of the receivable is postponed under an extended payment deadline, fair value is measured on the basis of the discounted value of the expected revenues. Interest gains are recognized using the effective interest method. When a trade receivable is uncollectible, it is written off against the allowance account for trade receivables.
Liabilities are initially recognized at fair value.
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.

Coalition consolidation

In the annual accounts 2013 all receivables and liabilities concerning the USAID program TB CARE I 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.

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 (R1)
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.

Share in fundraising third parties (R3)

Contributions from lotteries are included in the financial year in which they are received or committed.

Grants (R4)
Grants are allocated to the period to which the related costs are recognized.

Investment income and other income (R5 and R6)
Interest paid and received is recognized on a time-weighted basis, taking account of the effective interest rate of the assets and liabilities concerned.

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 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 2013 was 109%. Pension premiums compared to the previous year changed from 23.8% to 24.4% for retirement. The percentage for disability remained at a level of 0.4%.

Operational lease

Leases in which a significant portion of the risks and rewards incidental to the ownership are retained by the lessor are classified as operating leases. Payments made under operating leases (net of any incentives received from the lessor) are charged to the income statement on a straight-line basis over the period of the lease.

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', 'Expenses private fundraising' and 'expenses government grants' 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'

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.

Materials used for supporting the fundraising message (for examples letters to donators, newsletters) contain also information about the disease TB and TB 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 2013 **In compliance with standard reporting form of VFI**

Name Position in the board	P.C.F.M. Gondrie Executive Director		G.T.M. Schippers Director of Finance & Organization		C.S.B. van Weezenbeek Executive Director		F. Cobelens Scientific Director	
Contract								
Legal status	Indefinite		Indefinite		Indefinite		Indefinite	
Number of hours	40		40		40		20	
FTE	41,67%		100%		29,33%		16,67%	
Period for reporting year	1/1 - 6/5		1/1 - 31/12		16/9 - 31/12		1/9 - 31/12	
Remuneration								
Annual income								
Gross salary	36.282		108.106		31.373		17.664	
Holiday allowance	4.063		10.362		3.127		1.760	
Extra month	3.397		8.664		2.614		1.472	
Variable/performance allowance								
Subtotal		43.742		127.132		37.114		20.896
Social securities, employers part	1.854		6.507		2.881		2.856	
Taxable allowances	4.482		-		-		-	
Pension premium, employers part	3.957		13.611		30.758		2.328	
Other allowance, long term	-		-		3.000		-	
End of contract payment	-		105.304		-		-	
Payment in relation to beginning of contract (relocation)	-		-		3.275		-	
		10.293		125.422		39.914		5.183
Total remuneration 2013		**54.034**		**252.554**		**77.028**		**26.079**
Total remuneration 2012		158.833		145.879		-		-

Notes to the remuneration of the management

The Board of Trustees has, upon the recommendation of the Remuneration Committee, determined the remuneration and 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 annual remuneration policy and remuneration, KNCV adheres to VFI's advisory scheme for the annual 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) and the rules and standards of the Dutch Government, being an organization which receives government funds.

Under the VFI advisory scheme, a maximum annual remuneration is determined on the basis of weighted criteria. At KNCV, this weighting was performed by the Remuneration Committee. This resulted in a base 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. The maximum remuneration for the former executive director P. Gondrie and the former Director of Finance & Organization G. Schippers was 87% of € 140,046, which is € 121,840.

In 2013, the actual incomes of management for the purposes of assessment of compliance with VFI's maximum annual remuneration were as follows: P. Gondrie € 43,742 (1 FTE/5 months) including € 4,482 taxable allowances; G. Schippers €127,132 (1 FTE/12 months)[17], K. van Weezenbeek € 37,114 (1

[17] Mrs. Schippers was relieved of her duties as director as of 1 July 2013, but was employed by KNCV Tuberculosis Foundation until 31 December 2013.

[18] An additional Pension Fund contribution for Mrs. Van Weezenbeek was agreed upon for a total amount of US$ 109,998, of which 1/3rd (US$ 36,666) was payable in 2013. The remaining amount will be paid in 2014 and 2015.

	In €
Continuity reserve, contribution	187.036
Decentralization reserve, withdrawal	-119.655
Earmarked project reserves, contribution	300.000
Earmarked project reserves, withdrawal	-184.820
Unrealized exchange differences on investments, contribution	250.743
Fixed asset fund, withdrawal	-43.934
Third party earmarked funds, withdrawal	-11.726
	377.644

FTE/ 3,5 months)[18], F. Cobelens € 20,896 (0,5 FTE/ 4 months). KNCV's directors are contracted for a 40-hour workweek.

The income for Mrs. Van Weezenbeek, in absolute terms, is within the VFI standards. The income for Mr. Cobelens, in absolute terms, is above the VFI standard by 11,9% based on a maximum annual remuneration of 80% of € 140,046. The income for Mrs. Schippers, in absolute terms, was above the VFI standard by 4,3% based on a maximum annual remuneration of 87% of € 140,046. The Board of Trustees takes the view that the salaries match 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 an director with the expertise and background needed to advocate for KNCV's viewpoints in the global policy development for TB control. The gross salary expenses (gross salary, 13th month and holiday allowance) of the Executive Board on an annual basis will decrease with 6%, when compared with the previous Board. The decrease in absolute terms will be approximately 30%, due to the transition from two full time directors to one statutory Executive Director and one half time (50%) Scientific Director.
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.

It is further noted that Mrs. Schippers was paid an end of contract payment of € 105.304,-. This exceeds the standards from the Dutch Governments "Wet normering bezoldiging topfunctionarissen (semi) publieke sector" (WNT) which indicates a maximum of one year's remuneration with a maximum of € 75,000. The end of contract payment for Mrs. Schippers is based on the formally agreed employment contract conditions (as agreed in 2004, preceding the WNT).

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 22 April 2014 and 20 May 2014, we propose to appropriate the surplus of 2013 according to the following division:

The withdrawals are specified on pages 91 and 92 of the financial statements. KNCV s policy towards reserves and funds is clarified on page 91.

Events occurring after the balance sheet date

There have been no material post balance sheet events that would require adjustments to KNCV 's Financial Statements per 31 December 2013.
On 17 February 2014, after balancing all arguments, the Executive Board decided that KNCV will close the regional office for Africa in Nairobi, Kenya as per 1 May 2014 and cancel the plans for a regional office in Asia. Instead, KNCV will focus on country presence for optimal support and transfer of knowledge at national level. The closure of the regional office in Nairobi will result in redundancy for three staff members.

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 KNCV Tuberculosefonds

We have audited the accompanying financial statements 2013 of KNCV Tuberculosefonds, Den Haag, which comprise the balance sheet as at 31 December 2013, the statement of income and expenditure for the year then ended and the notes, comprising a summary of accounting policies and other explanatory information.

Management's responsibility

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the Guideline for annual reporting 650 "Charity organisations" of the Dutch Accounting Standards Board. Furthermore, management 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 union'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 union's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, 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.

Opinion

In our opinion, the financial statements give a true and fair view of the financial position of KNCV Tuberculosefonds as at 31 December 2013, and of its result for the year then ended in accordance with the Guideline for annual reporting 650 "Charity organisations" of the Dutch Accounting Standards Board.

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Announcement according to the directors' report

We have read the directors' report in order to identify material inconsistencies, if any, with the audited financial statements. Based on reading the directors' report we established that the directors' report is consistent with the information in the financial statements and that the directors' report contains all information required by Guideline for annual reporting 650 "Charity Organisations" of the Dutch Accounting Standards Board. We have not audited or reviewed the information in the directors' report.

Rotterdam, 15 May 2014
PricewaterhouseCoopers Accountants N.V.

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	Central Bureau for Fundraising in The Netherlands
CHW	Community Health Workers
CIb	Centrum Infectieziektenbestrijding (Center for Infectious Disease Control in the Netherlands)
CoE	Center of Excellence
CPT	Committee for Practical TB Control
CSOs	Civil Society Organizations
DJCC	Directors Joint Consultative Committee
DOT(S)	Directly Observed Treatment (Short-course)
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 TB Initiative
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GGD Nederland	The Association of GGDs (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
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
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
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 (KNCV Tuberculosis Foundation)
LED FM	Light-emitting diode fluorescence microscopy
LTBI	Latent TB 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 TB Control Program
OR	Operational Research
PADT	Proposal Assessment & Development Team
PCA	Patient-Centered approaches
PFZW	Pension fund for health care

PHC	Primary Health Care
PhD	Doctor of Philosophy
PLHIV	People living with HIV
PMDT	Programmatic Management of Drug-resistant Tuberculosis
PNPK	Standards for Medical Practice on TB Care (Indonesia)
PPM or PPM/P	Public Private Mix/Partnership
pre-XDR	Pre–XDR-TB referred to MDR-TB with resistance to either any fluoroquinolone or at least one SLID (but not both)
PSS	Psycho-Social Support
QQ	Qualitate Qua
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
SS+	Smear-positive pulmonary TB

STAG (TB)	Strategic and Technical Advisory Group (for Tuberculosis)
SVOP	Stichting Voorzieningenfonds Oud-Personeelsleden
TA	Technical Assistance
TB	Tuberculosis
TB/HIV	TB Human Immunodeficiency Virus
TB-IC	TB 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: Tuberculosis Collaboration and Coordination, Access to TB Services for All People, Responsible and Responsive Management Practices, Evidence-based project M&E
TIBU	TB surveillance system for digital data collection, data transfer and data reports in Kenya
TSRU	Tuberculosis Surveillance and Research Unit
US	United States
USAID	United States Agency for International Development
USD	US Dollar

VAT	Value-Added Tax
VFI	Vereniging van Fondsenwervende Instellingen
VHW	Village Health Worker
WHO	World Health Organization
WHO/Europe	World Health Organization Regional Office for Europe
WNT	Wet normering bezoldiging topfunctionarissen (semi) publieke sector
Xpert® MTB/RIF	A cartridge-based, automated diagnostic test that can identify TB and resistance to rifampicin by nucleic acid amplification technique
XDR-TB	Extensively Drug-Resistant Tuberculosis
ZonMW	Zorgonderzoek Medische Wetenschappen

Annex 1. List of scientific publications 2013

1. Buregyeya E, Nuwaha F, **Verver S**, Criel B, Colebunders R, Wanyenze R, Kalyango JN, Katamba A, **Mitchell EMH**. Implementation of tuberculosis infection control in health facilities in Mukono and Wakiso districts, Uganda. BMC Infect Dis 2013;13:360.

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11. **Huyen MN**, **Tiemersma EW**, Kremer K, de Haas P, Lan NT, Buu TN, Sola C, **Cobelens FG**, van Soolingen D. Characterization of Mycobacterium tuberculosis isolates lacking IS6110 in Vietnam. Int J Tuberc Lung Dis 2013;17(11):1479-85.

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nated with new tuberculosis vaccines in HIV-infected adults. Pub Health Ac 2013;3(1):31–7.

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