

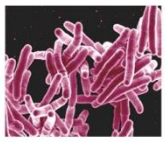

Annual Plan 2016

# Acceleration towards Tuberculosis Elimination

**December 2015**

KNCV TUBERCULOSEFONDS Stop TBC

www.kncvtbc.org

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# 1 Introduction

The 2016 annual plan is based on the new KNCV strategy 2015-2020 "In transition to TB Elimination" and is characterized by result oriented programming as was introduced in 2015.

The technical chapters of the annual plan reflect the three strategic areas of work under the new KNCV strategy: access to quality care; generation of a robust evidence base; and supportive health systems. The other chapters describe the KNCV institutional management and enabling environment, in the spirit of 'form follows function'.

The operational plan 2016 takes into account internal and external developments which we summarize below, and their consequences for our work and organization in the coming year.

## 1.1 Post 2015 Global Strategy for TB Prevention, Care and Control

In May 2014 the World Health Assembly approved the "Post-2015 Global Strategy and Targets for Tuberculosis Prevention, Care and Control", better known as the "END TB" strategy. This END TB strategy sets highly ambitious targets and marks an important shift to the ambition to eliminate TB as a public health problem globally. The following year 2015, WHO and partners, including KNCV, started translating the END TB Strategy into an operational framework, which is characterized by country specificity and rational priority setting. This approach very well fits the KNCV way of working at country level which is based on a comprehensive analysis of epidemiological, infrastructural and financial indicators. KNCV will support the END TB strategy through an effective mix of country-specific policy-development, technical assistance and operational research.

Research and Development (R&D) is one of the three pillars of the END TB strategy. Therefore, in 2015, KNCV took the initiative to convene leading Dutch TB scientists to develop a White Paper which describes the ' Dutch research potential' and specific areas of excellence in which a collaborative Dutch effort could bring major cutting edge value. Obviously, this consensus document will further guide KNCV research agenda setting.

In 2015, The Stop TB Partnership developed a five year global investment plan to Stop TB (2016-2020) that will guide resource-mobilization for the Global END TB Strategy. As a member of the Stop TB Coordinating Board, KNCV has contributed to this investment plan which will be an important advocacy and resource mobilization tool for the coming years.

### 1.1.1 "Challenge TB"

On 30 September 2014, KNCV was awarded a five year USAID funded grant "Challenge TB" (CTB), with a ceiling funding level of a record 525 million USD. CTB is characterized by an explicit country focus, which includes evidence-based workplan development, locally owned operational research and preference of local partners over international agencies. The directions set forth under CTB fit the ambitions of KNCV to deliver 'end to end' technical assistance very well. This includes a stronger 'implementing role' at lower levels, such as district level. This decentralized approach, as well as the increased collaboration with local CSO and local academia require strengthening of country management, including financial risk management.

KNCV is the lead agency in 11 CTB countries and the East Africa Regional program. In addition KNCV leads several Core Projects, including a multicountry project to measure the impact of interventions on TB transmission. Obviously, CTB, the USAID flagship TB programme, requires strong KNCV leadership, robust project and partner management and technical excellence to meet country and donor expectations. In 2015, KNCV established a strong operations division and a distinct CTB Project Management Unit to manage the project and will continue to strengthen this and other divisions to optimally support this USAID flagship programme.

KNCV will continue to be lead partner in Indonesia, Vietnam, Nigeria, Ethiopia, Botswana, Kyrgyzstan, and Tajikistan, and has assumed new lead positions in Tanzania, Malawi, Uzbekistan and Bangladesh. Although Kazakhstan did not buy in under Challenge TB, KNCV plans to keep a Regional Technical Hub in Almaty, with adaptation of staffing and terms of reference.

### 1.1.2 Dutch Government

The Ministry of Foreign Affairs (DGIS) supports KNCV with a 5 year €7.5 million cost share contribution to the USAID's Challenge TB project. The CTB-related 'DGIS project' focuses on private sector involvement and interventions at country level 'to make the Global Fund work'. KNCV and DGIS jointly develop the specific workplans.

The Dutch Government also prepares for the organization of the 2018 World AIDS Conference in Amsterdam, with a focus on Central and Eastern Europe. KNCV is committed to use its Wolfheze network and country presence to raise scientific interest and ensure TB/HIV success stories make it to the 2017 Wolfheze conference, in preparation for AIDS 2018. For that purpose, KNCV and Wolfheze partners established a Wolfheze TB/HIV working group that will become fully functional in 2016.

KNCV continues to work with Dutch and foreign HIV/AIDS partners to ensure integrated TB/HIV care at country level. KNCV was unable to join a coalition under the SRHR tender, but anticipates contributing to TB/HIV related interventions under the Bridging the Gaps programme.

### 1.1.3 Global Fund (GF)

The GF continues to be the most important external funding source for resource limited countries. KNCV is a key technical partner for the Global Fund: at country level KNCV supports national TB programs throughout the full grant cycle; at global level KNCV supports Global Fund policy and implementation processes; in governance, KNCV serves on the Finance and Operational Performance Committee of the GF board on behalf of the NGO Developed Country delegation.

During 2016 an area of intensive engagement for KNCV will be the technical support to foster country absorption of recently accessed Global Fund grants. In that context, KNCV will benefit from synergies between GF CTB and DGIS funding streams and deliver both technical and management support at country level, including longer-term country-based assistance packages.

The Global Fund strategic directions as currently emerging (targeted interventions, geared to sustainability and transition, focused on enabling health system interventions) inform our GF

supportive activities under the DGIS project. By the end of 2016, country allocations for the period 2018-2020 will be announced. Initial preparations for the next grant rounds, including strategic program reviews and planning, will commence in our country support work in the course of 2016

In 2016, KNCV will (re)consider whether it wants to get prepared to take on a possible PR role if the country situation offers such opportunity

### 1.1.4 Shifting and increasing TA demands

Country and donors increasingly demand an effective mix of long-term technical assistance at country level and highly-specialized short-term technical assistance missions in a number of technical areas. In addition, there is a shift to more comprehensive TA which includes implementation support at district level, including demonstration projects with research components. In 2016 KNCV will address the HRD consequences that come with the design and implementation of activities at district level.

In 2016, KNCV country offices will deliver long-term assistance in at least 11 countries with focus on comprehensive program implementation, research, capacity building and management support. Specialized missions will be coordinated through KNCV headquarters to cover a wide range of technical areas. KNCV will need to increase human resource capacity to be able to respond to TA requests in certain areas of expertise, including district level implementation. Therefore, in 2016, KNCV will recruit new technical staff and further strengthen TA procurement through the international pool of highly qualified free-lance consultants. In 2016, KNCV will continue the successful traineeship for young consultants.

## 1.2 Key internal developments

In 2015, a new organizational structure was introduced to increase efficiency and strengthen technical capacity, project management and resource mobilization. As expected, the significant change, as well as the arrival of many new (international) staff members came with some challenges and occasional misunderstandings about roles and responsibilities. These were identified during midsummer evaluations and addressed in the second half of 2015. We expect that KNCV will continue to further refine structure and related Standard Operation Procedures (SOP) in 2016.

In the 2015 annual report we referred to the need for robust Human Resource Management (HRM), to handle Challenge TB and the closure of TB CARE I. In 2016, we will review and address the HRM capacity, both in terms of competencies and quantity, to ensure the team can cover all aspects of HRM in a complicated the international environment KNCV operates in. Due to a high HRM work load in 2015 workplan components postponed delayed into 2016.

In 2016, KNCV will continue its search for core funding with financial support from the Stichting Mondiale Tuberculosebestrijding (SMT). This project started in 2015 and aims at identifying and implementing the most promising core funding opportunities. In addition, KNCV will continue to look for ways to limit expenditures. The move to a significantly cheaper office in 2015 is a good example of what KNCV can do to reduce spending.

# 2 Technical & programmatic areas

Wherever it engages, KNCV continues to deliver short-and long term TA, conduct relevant research and provide input into policy dialogue/development at national and international levels. In that context, KNCV is broadening its scope of work, in terms of both geographic and technical coverage. This essentially means that KNCV aims at providing end-to-end technical assistance ranging from demonstration projects at district level to global policy development and leadership in product introduction. Ideally, the 'geographic ends' will inform each other and future tools development. As for technical coverage, KNCV will seek to anticipate and strengthen new technical areas to be able to respond to evolving disease paradigms and health systems developments.

The broadened KNCV approach will have various human resource and managerial consequences to be addressed simultaneously. Examples are the shift towards working at subnational levels; the need for robust patient-based data systems; improved data utilization to build quality programming; and different approaches to risk mitigation.

Our technical work continues to focus on the USAID funded "Challenge TB" (CTB) project, where as stated above KNCV is the lead agency in 11 CTB countries and the East Africa Regional program. Additionally, we provide technical oversight and quality assurance of interventions in several countries with substantial CTB support and which are led by other coalition members, including Bangladesh and Myanmar.

Beyond CTB, we provide technical support for programs funded by the Dutch Ministry of Foreign Affairs (DGIS), the Eli Lilly Foundation and industry. In a novel collaboration, KNCV has entered into a private-non-profit partnership with Cepheid, manufacturer of the GeneXpert rapid molecular test, to prevent disruption to key laboratory services by providing in-country service and maintenance support .

In line with KNCV's strategy 2015-2020, we will to continue developing our programs according to the following 3 strategic objectives:

1. Improve access to early TB prevention and care for patients with all forms of tuberculosis (and achieve better individual outcomes and public health impact).

2. Generate a solid evidence base for existing and new tools and interventions.

3. Bolster the governance and management capacity of the National TB Programs (to ensure robust, responsive and inclusive national TB Control systems).

Our ultimate aim is to develop, test, evaluate and scale-up successful country specific, patient centered strategies and interventions that save lives and have public health impact.

During 2015, KNCV adapted its organizational structure to strengthen technical capacity and policy development, aligned with our strategic objectives. We operate through five thematic technical teams: Access and Quality Care; Laboratory and Diagnostics; Evidence; Health Systems and Key Populations; Netherlands and Elimination. Several crosscutting and time limited task

forces were also formed in 2015 and will continue to develop new approaches in specific areas, working towards demonstration projects and, ultimately, scale up.

Going forward into 2016, we will continue to evaluate new technological and programmatic innovations for adoption into our work, and look to strengthen the overall quality of our TA and associated deliverables. One such area is support for the expanded roll-out of new TB drugs and shortened regimens for the treatment of drug-resistant TB. Another will be coordination and harmonization of Global Fund (GF) related TA in CTB countries. For this purpose, a USAID financed GF hub is under discussion to be established with KNCV. The DGIS contribution will specifically be utilized to geographically expand and further strengthen and support the harmonization and optimization of the GF interventions.

For work in the Netherlands KNCV receives resources for TB control activities as outlined in the National TB Control Plan 2016-2020. This plan will direct TB control for the next five years.

Finally, capacity building throughout the KNCV structure remains a general area of continued focus for the Technical Division, to strengthen staff knowledge wherever we work in countries, regions and HQ. This will be done using a variety of approaches: e-learning courses, development of a basic consultant package, creation of a core KNCV training niche, and new learning/research collaborations with other academic centers. While the Young Professional program will bring in our first junior level consultants, HRD at country level will also be reviewed in a few key countries to identify opportunities for expanding local professional development pathways. The institution of mandatory quarterly home-weeks for the Division will continue to provide a mechanism for greater cross-KNCV collaboration and initiatives generation. Balancing the longer term with immediate needs to deepen the KNCV technical reach, we will also move forward to develop a KNCV flexible consultants network to work closely with us to deliver TA on a defined contract basis.

## 2.1 Focus Area 1: Access

**Strategic Objective 1:**

To improve access to quality prevention, early diagnosis and patient centered care for patients with all forms of TB within the framework of a comprehensive public health approach, to achieve better individual outcomes and public health impact.

**Approach**

In order to achieve the above strategic objective 1, KNCV will deliver comprehensive country specific packages of interventions in the following 4 key areas:

a. Prevention of transmission of TB

b. Prevention of progression from latent TB infection to TB disease

c. Early diagnosis and effective treatment of TB disease

d. Overcoming barriers for special patients' groups[1]

The country specific packages will continue to be jointly developed with the respective NTP, based on epidemiological data, a thorough gap and resource analysis, and in close consultation with key stakeholders. Emphasis is placed on rational priority setting, sustainability, and buy-in from relevant stakeholders.

*Key Result Area 1: Prevention of transmission of TB*

In the absence of an effective vaccine, prevention of TB infection mainly centers on minimizing the risk of transmission. This is achieved through implementation of **the FAST strategy** (Finding TB cases Actively, Separating safely, and Treating effectively). This strategy was developed under TB CARE I.

In 2016, KNCV will therefore:

- Promote and, where needed, introduce international TB-IC standards and guidelines; support countries in development/ revision of evidence based TB-IC strategies, plans, and SOPs, including the rational use of IC measures (all four levels) and equipment.
- Work with Infection Control and Prevention (ICP) programs to ensure that TB-IC becomes fully integrated in the general ICP policy and strategy of each country.
- Support countries in expanding the implementation of the FAST strategy in (DR)TB centers, HIV care and treatment centers, as well as general health facilities (prioritizing high volume hospitals) and relevant congregate settings.
- Develop training and supervision capacity on TB-IC in general and for FAST in particular as basic intervention in TB-IC.
- Work with HIV programs, in high-burden HIV countries, to make FAST and TB-IC an integral part of HIV quality care and a systematic component of supervision.
- Promote screening and surveillance of TB among health care workers (HCW) as part of a regular medical check up and right for HCWs, including HCW sensitive approaches to limit TB exposure among HIV infected HCWs.
- Support processes that contribute to increase public knowledge on TB, specifically on the prevention of transmission in communities and TB-affected households, thus reducing stigma and facilitating adherence and early health seeking behavior.

*Key Result Area 2: Prevention of progression from latent TB infection to TB disease*

Also absent an effective vaccine, prevention of progression from latent TB infection to disease is a key stategy to limit transmission and prevent both incident cases and mortality.

KNCV has a long history of detecting and treating persons with latent TB infection (LTBI) and knows the system requirements involved. We distinguish three target groups for LTBI: (1) recent exposure/infection (contacts), (2) previously infected individuals with clinical or social risk factors;

[1] Defined in each country

and (3) patients with untreated in-active TB disease, such as individuals with 'fibrotic' lesions. KNCV will follow a rational stepwise approach to improve, introduce and scale-up LTBI management, taking into account the country context and epidemiology. Following this logic, we will:

- Support the development, implementation and evaluation of interventions for **diagnosis and treatment of Latent TB Infection (LTBI)**. KNCV will use country-specific epidemiological evidence as well as its expertise from The Netherlands to prioritize target groups for LTBI screening and to design patient centered treatment modalities.
- Advocate and support scale up preventive treatment for LTBI for PLHIV and early ART initiation.
- Support the introduction and scale-up of contact investigation in line with WHO guidelines on Contact Investigation (CI) and management of LTBI, with focus on household contacts and contacts of DR-TB patients.
- Develop SOPs & contact tracing algorithms for the systematic examination and counselling of close contacts of (M)DR-TB patients.
- Develop and implement evidence based strategies for management of MDR-TB contacts.

*Key Result Area 3: Early diagnosis & effective treatment of TB disease*

Given several recent prevalence surveys that document higher national rates of active TB than previously estimated by WHO, countries must redouble their TB control efforts on ensuring universal access to early diagnosis of TB with provision of good quality, affordable and patient centered treatment and care. To this effect, KNCV will assist countries in assessing their delivery systems, addressing access barriers and scaling up successful approaches that engage providers across all key government sectors.

In 2016, KNCV will focus on the following areas:

Case Detection and diagnosis

- Promote the involvement of community members in early detection and referral of individuals with symptoms consistent with TB, as part of intensified case finding efforts.
- Support engagement of all care providers in case detection, diagnosis and notification of TB through strengthening public-public and public- private partnerships (PPP).
- Promote and support screening for TB of high-risk populations (see Focus Area 3 below, Dynamic Health Systems and Key populations).
- Assist countries in defining and introducing optimal diagnostic algorithms for all forms of TB, including MDR TB.
- Support selected countries to introduce automated reading software for digital radiography (CAD4TB).

- Continued strengthening of national laboratory networks with implementation of optimized diagnostic algorithms (and bacteriological follow-up of TB treatment), aligning with PMDT expansion and including laboratory quality management systems (LQMS).
- Further introduction and roll-out of GeneXpert MTB/Rif testing in all KNCV supported countries for all eligible groups, with anticipated support for the roll-out of the next generation Xpert Ultra cartridge.
- Capacity building for FL and SL drug resistance testing, using both molecular and phenotypic methods, and identifying new paradigms that shift next generation molecular diagnostics to lower tiers of the health system (as will be done in Indonesia through development of Intermediate Reference Labs at district/sub-district level).
- Increase access to mHealth technologies, including for example GXAlert, to link laboratory results to both providers and patients.
- Expand systems for specimen referral, quality management (QMS), external quality assurance (EQA) and appropriate bio-safety measures.
- Expand programs for preventive laboratory maintenance, including calibration and repair of GeneXpert machines, based on experience from Nigeria and Vietnam. Cepheid service provision will be expanded to Central Asian Republics (i.e. Tajikistan and Uzbekistan).
- Support specialized trainings for processing of non-sputum specimens for Xpert examination.
- Seek partnerships in (at least) three countries for joint development and utilization of the GeneXpert (Omni) platform designed for decentralized (POC) access to MTB/Rif and HIV Viral Load (VL) testing.
- Continue supporting countries with the shift from using light microscopy to LED fluorescence microscopy.

<u>Treatment</u>

- Accelerate our support to **scale-up Programmatic Management of drug resistant TB (PMDT)** with particular attention to the quality of care provided.
  - Ensure quarterly interim cohort assessments and clinical reviews take place to monitor PMDT implementation and identify and address problems early in MDR case management and support systems.
  - Support the uptake and roll-out of patient centered ambulatory MDR-TB care under appropriate infection control conditions.
  - Promote the development and utilization of clinical support hotlines and m-health tools for peripheral health workers to ensure adequate monitoring and management of side effects.
  - Assist in the development of appropriate hospital admission capacity for those patients who cannot (yet) be managed on an ambulatory basis

- Support the development of country-specific patient psychosocio-economic (PSE) support packages, which will contribute to minimizing treatment interruption.

- Facilitate the introduction and implementation of **new and repurposed drugs and shorter treatment regimens for M/XDR-TB** to improve treatment outcomes and prevent/reduce MDR-TB management costs. New approaches include the application of the 9-month regimen for eligible MDR-TB patients (without pre-XDR-TB) and the application of repurposed (such as Linezolid) and new drug containing regimens (with BDQ and DLM) for patients with pre-XDR, XDR TB and other complicated forms of MDR TB. Until ongoing trials are completed, KNCV will support introduction of this combined approach under operational research conditions by documenting the experiences for national scale-up and international dissemination. In this context, the KNCV "Access to Quality Care" team will work closely with other technical teams, most notably the team "Evidence Generation".
- To protect TB drugs from misuse, KNCV will assist countries in establishing control systems for public and private sector use

*Key Result Area 4: Overcoming barriers for special patient groups*

Attention will be given to support NTPs in addressing the needs of special patient groups/ key affected populations (e.g. urban poor, migrants, children, elderly, miners, prisoners, PWUD/PWID, PLHIV etc.), focusing on overcoming perceived and actual access barriers. KNCV will encourage collaboration with community organizations, Civil Society Organizations (CSOs) and other services, which in many cases already work with these target groups and have trusted relationships and services. Therefore, KNCV will:

- Assist countries in developing appropriate community engagement strategies and operational plans involving CSOs, private sector and relevant community partners. This will ensure access to quality and patient centered.
- Promote country owned and community driven planning of community based interventions, together with community organizations, affected populations, government and other relevant stakeholders (private and industrial health sectors).
- Encourage NTPs to set-up formal partnerships with these groups and sectors to promote early case finding, management of TB and LTBI, use of TB-IC measures, and ensure access to TB services as near as possible to the affected population. In this context, innovative, setting specific communication methodologies will be tested to decrease stigma and increase general awareness on TB.
- Work with countries on the development of intensified and/or **active case-finding (ICF/ACF) policies**, **strategies and standard operating procedures** for the early diagnosis of TB in high risk groups. These setting specific strategies will be developed after careful assessment and prioritization of high-risk groups, (e.g. HIV populations). Specific groups that will be targeted for active case-finding are prisoners, injecting drug users, urban poor, difficult to reach populations, patients with diabetes and health care workers. All interventions

should be carefully evaluated for future policy development. In Indonesia, for example, ICF strategies will be evaluated at the health center level.

Explore collaboration with occupational health services and the International Council of Nurses (ICN) to create on-site screening services at health facilities for HCWs and implement routine surveillance.

- Assist countries to scale up **TB/HIV** collaborative activities and fully integrated services for all patients with TB/HIV co-infection, especially **IPT and ART uptake,** and promote the use of new and shorter treatments for latent infection where possible.
- Improve prevention, case-detection, diagnosis and management of pediatric TB, supporting the scale-up of contact investigation, awareness among health staff and parents to recognize symptoms of pulmonary and extra pulmonary childhood TB. KNCV supports piloting and evaluating full integration of TB diagnostic and treatment services into the existing Reproductive, Maternal, Neonatal and Child Health Care (RMNCH)/ Ante Natal Care (ANC) services, ensuring routine screening for TB and efficient referral systems.
- Explore integrated approaches to TB and co-morbidities. The links between diabetes mellitus, smoking, alcoholism, chronic lung diseases, cancer, immunosuppressive treatment and malnutrition are well recognized.
- Specifically, in the Netherlands, continue to provide enablers and incentives for patients and their families in need, to help them complete treatment through the Fund for Special Needs. This support varies and includes financial support for patients without any income, food support, material support (e.g. a bicycle), etc. The use of this Fund over the last five years will be evaluated (together with former patients) and recommendations for its future use will be made in 2016.
- Also in the Netherlands, continue to involve patients in policy and guideline development, training, advocacy, research, communication, etc.; liaise with national organizations involved in care for TB risk groups (e.g. Lampion) and improve access to health services of persons at risk. Patient platforms were initiated in 2015. We will continue to organize these meetings with (former) TB patients and identify the needs, wishes and ways these (former) patients want to contribute.

## 2.2 Focus Area 2: Evidence

### 2.2.1 Strategic Objective 2:

To generate a solid evidence base for existing and new tools and interventions

**Approach**

KNCV will strive to remain among the top-3 leading TB research groups, as evidenced by impact on policy, research output and successful collaborations, in 4 key result areas:

a. Implementation research: evidence for scale-up

b. Operational research

c. Population epidemiology

d. Research capacity building in the above three areas

KNCV will continue to generate the necessary evidence base for policy change and development and for programmatic implementation strategies. This will be achieved through focused and prioritized implementation of quality research in the above key result areas. We will continue building on KNCV's long tradition of linking operational and epidemiological research to technical assistance and program implementation, as well as its widely recognized experience in all regions of the world.

#### *2.2.1.1 Key Result Area 1: Implementation research: evidence for scale-up*

KNCV's implementation research aims at translating innovations in TB control interventions into policy and practice through gathering of evidence about their performance at programmatic scale. Such "evidence for scale-up" is needed by governments, donors and other policy makers to take decisions about rolling out particular interventions. We take great care to conduct 'pragmatic' studies in a systematic and scientifically robust manner while ensuring that these interventions are tested in realistic conditions beyond the usual tightly controlled research environments. Besides viability, we also assess cost effectiveness, acceptability, and feasibility to justify its scale up in low resource settings.

Within "Challenge TB" several multi-country research projects have been initiated covering broad issues in TB control: transmission of TB, prevention of TB and active case finding.

- Transmission of TB. In a series of multi-year studies, we will measure the effect of USAID supported TB control interventions on TB transmission in 5 countries, among which are Indonesia and Tanzania. Interventions to be evaluated will include intensified case finding in facilities, decentralization of treatment of MDR-TB patients, household contact tracing and others. We will use genotyping of sputum samples and repeated surveys of latent TB infection to measure transmission. In 2016 the baseline studies will start.
- Prevention of TB. In a multi-country, multi-year trial among HIV-infected persons, we will compare the effect of different treatment regimens on TB incidence. This study is a two part, open label, individually randomized, pragmatic trial comparing a single round of weekly high dose rifapentine and isoniazid for three months (3HP) to six months of

isoniazid (6H) (Part A), and periodic 3HP (p3HP) to a single round of 3HP (Part B). The study will take place in South Africa, Mozambique and either Malawi or Ethiopia. KNCV will delegate management authority of the conduct of the trial to the Aurum Institute. KNCV will assume the role of trial sponsor meaning that KNCV is responsible for oversight of the trial and overall management. Enrollment will have started by early 2016 and participants will be followed for 24 months for development of TB and other endpoints such as completion of preventive treatment, major side effects leading to prematurely stopping preventive treatment, and mortality.

- Testing novel packages of diagnostics for case finding. KNCV will lead studies using a combination of older/newer tools, including mobile digital chest X-ray with automated reading systems (CAD4TB), mobile GeneXpert units, and m-health solutions for symptom screening and reminders, to evaluate the efficacy and cost-effectiveness of these methods in relation to and in association with other approaches. Specifically, in Indonesia, KNCV will assess intensified TB case finding strategies using novel algorithms among community health center attendants of specific high risk groups (e.g. elderly, persons previously treated for TB) using a cluster randomized study design. We will furthermore prepare research proposals for resistance testing algorithms to triage patients with MDR-TB for short second-line treatment regimens, and for evaluation of novel assays to predict progression to TB disease among those with LTBI.
- Establishment of TB specific pharmacovigilance systems in countries introducing new drugs and regimens for MDR-TB patients (including the new drugs Bedaquiline and Delamanid). I ndonesia and Vietnam are among the first countries that will pilot the programmatic introduction of Bedaquiline in respective cohorts of 100 patients each. These patients will be carefully monitored on drug safety aspects using an active pharmacovigilance approach, which will be implemented by the NTP in close collaboration with the national pharmacovigilance centers in these countries.
- Prevention of TB in the Netherlands. Starting from December 2015, KNCV and partners received funding from the Dutch government (ZonMW) for a comprehensive pilot study program to develop an optimized screening and treatment program for LTBI in three different groups of immigrants: immigrants, asylum seekers, and refugees. We will use a step-wise approach in implementation and collect qualitative and quantitative data in all pilots, starting with a pilot among immigrants in 2016. Qualitative results and lessons learned from the different pilots will not only be used to improve the intervention within the specific target population, but also to improve and guide the pilots in the other target groups. Quantitative results from the pilot study on uptake of LTBI screening and PT will be used as input to assess the long term impact in terms of costs and cases averted of different LTBI strategies.

#### *2.2.1.2 Key Result Area 2: Operational research*

Operational research is intended to provide locally relevant solutions to locally defined problems (and may yield results that are useful in similar settings elsewhere), with priorities that are generally locally defined. This classical notion of operational research in TB control is, for KNCV's purposes, distinguished from implementation research by its non-intervention nature.

In 2016, KNCV will assist countries to generate more evidence on how to prevent, diagnose and treat TB, addressing local conditions, and to evaluate the role of stigma. In addition to our traditional role in supporting countries with surveillance, surveys, and training courses, we will continue to take a more proactive, catalytic role in determining which OR studies are most informative and work to incorporate their results into policy and practice.

In addition to the DRTB treatment innovations and evaluations noted above, OR projects include:

- Sustainable strategies to find "missing cases" i.e. strategies that lead to better case detection. In Malawi KNCV will support development of a protocol to evaluate ACF activities in urban settings.
- Assessing under-notification. In Nigeria, an inventory study will be conducted to assess the role of the public and private sector in under-notification of TB patients. KNCV will also support a similar study in Indonesia to be led by WHO.
- Understanding stigma. In early 2016, KNCV will host an international expert meeting on the quantitative measurement of TB stigma. This meeting will review the evidence base for current stigma reduction strategies and set a stigma research agenda for the coming years.
- Determining more sensitive and specific screening and diagnostic algorithms for finding all TB cases, including drug-resistant, HIV-infected, and pediatric. Concerning MDR-TB, for example in Ethiopia, an alternative strategy to enhance MDR-TB case detection will be evaluated whereby Xpert testing will be done for all presumptive TB cases in urban Addis Ababa region.
- Evaluate results of the Nigeria National AIDS Control Agency project, led by KNCV and funded by Global Fund, with an embedded operational research component on the yield of intensified-case finding efforts among PLHIV with establishment of an expanded GeneXpert network dedicated to enhanced TB diagnosis among PLHIV

#### *2.2.1.3 Key Result Area 3: Population epidemiology*

Over the years, KNCV has built a wealth of expertise in surveys and surveillance to measure the extent and course of the TB epidemic at the population level in a variety of settings. This includes technical assistance to develop and improve surveillance systems, utilize surveillance data as well as designing, conducting and analyzing TB prevalence and incidence surveys, surveys of LTBI in children/adolescents and drug resistance surveys.

In 2016 KNCV will:

- Continue assisting countries in gathering and analyzing epidemiologic data at national and sub-national levels, and to translate findings into policy and practice (epidemiological assessments & surveillance system reviews).
- Support Ethiopia and Burma to investigate their changes in case notification trends over the last years and ascertain the true direction/implications for policy development and planning.

- Assist Mozambique, Vietnam and Botswana with planned prevalence surveys that will also test new screening and diagnostic approaches and mobile technologies.
- Assist Zimbabwe and Malawi to conduct a drug resistance survey. Zimbabwe will finalize data collection by the end of 2016. Malawi is preparing to undertake a repeat drug resistance survey to measure whether there is a change in drug resistance levels compared to the last survey of 2010/2011. The survey is anticipated to start in 2016.
- Continue collaboration with the LSHTM in improving the TIME Model and gathering data to populate the TIME model for country specific use.

#### *2.2.1.4 Key Result Area 4: Research capacity building*

To realize its 2015-2019 research agenda, KNCV will continue to invest in expertise and build scientific collaborations. Not a research institute as such, KNCV takes a pragmatic view to balance in-house expertise against involving outside expertise through collaborations that maximize efficiencies of each respective partner. In 2016, KNCV aims to:

- Build capacity. Train NTP staff, staff of collaborating organizations and local academic groups in research methods, data analysis and paper writing in at least Bangladesh, Nigeria, Namibia, Tajikistan and Tanzania.
- Support national OR bodies and related research agendas. In Ethiopia, KNCV will continue to support the Tuberculosis Research Advisory Committee (TRAC) to enhance OR capacity in the country. By the end of 2015, a competitive OR grant scheme will be launched for the teams trained in 2012-2014 to capitalize on capacity already built. The primary focus will be on fostering collaborations between academia and national program staff. Technical and financial support will also be provided to the annual TRAC conference where young researchers are encouraged to present their OR studies.
- Foster knowledge exchange. In Malawi, KNCV will facilitate a meeting with the national Research Group, a forum representing all research partners, to enhance turning research results into action.
- Share Dutch TB knowledge and experiences. This work will continue on several levels through 'KNCV lunch meetings' and in publications. One new activity for 2016 is to frame and publish Dutch TB knowledge and experience in a manuscript about contemporary TB control in a low-incidence country, incorporating the objectives of the Dutch National TB Control Plan 2016. Additionally, KNCV will organize two national research meetings in the Netherlands to bring support to local researchers (e.g. GGDs, students).

## 2.3 Focus Area 3: Health Systems and Key Populations

### 2.3.1 Strategic Objective 3:

Bolster the governance and management capacity of the National TB Programs (NTPs) to ensure robust, responsive and inclusive national TB Control systems.

**Approach:**

Effective TB Control at country level requires strong technical and managerial leadership to ensure sound control strategies, responsible resource management, adequate response to opportunities and capacity to overcome challenges. We promote a holistic, joint approach involving all public and private stakeholders, ensuring optimal use of resources with each constituency contributing to a unified, comprehensive national TB control strategy.

KNCV will reach the above strategic objective 3 through delivering comprehensive country specific technical assistance packages in the following 5 key areas:

1. Strategic governance, policy development and operational planning
2. Sustainable finance and affordable services for all
3. Enhanced performance across sectors and leveraging health resources of countries, including community systems strengthening and engagement
4. Interoperable surveillance & monitoring systems
5. Optimizing TB care to groups under-served by current systems[2]

#### *2.3.1.1 Key Result Area 1: Strategic governance, policy development, and operational planning,*

During 2014-2015, most countries either revised or developed new National TB Strategic Plans (NSPs). The impetus was largely to prepare for the Global Fund's New Funding Model (NFM). KNCV technical staff assisted many countries with development of technically sound plans, thus forming the basis for a successful program. KNCV will continue to support NTPs in the development and implementation of their NSPs based on a thorough gap and situation analysis and through prioritized and costed action plans. KNCV will also strive to improve the planning processes by developing and fine tuning existing planning and assessment tools, and by providing training and mentoring to key NTP and local partners.

[2] Examples of populations within systems who may be under-served: attendees of health care facilities, contacts of TB cases, deep pit miners, factory workers, persons with previous TB, healthcare workers, laboratory staff, mentally ill and elders in residential settings, military personnel, persons with diabetes, PLHIV enrolled in HIV care, prisoners, prison staff, refugees, internally displaced populations (IDPs), transportation workers, etc.

Support for strategic and operational planning occurs at the global and national levels. In 2016, at the global level, KNCV will:

- Continue to advise the GF secretariat and participate in the policy dialogue through the NGO Developed Country Constituency and as member of the TRP.
- Participate and contribute to other relevant global fora (GF, STP, STAG). At the international level, KNCV will strengthen its role as TB advocate through intensified advocacy, better communication of compelling data/results and active participation in relevant global TB and non-TB fora.
- Continue to participate in GF – lead working groups such as the Measurement of Quality Services Initiative and TB/HIV Service Integration.
- Continue to participate in GF governance structures as a voting member of the Finance and Operational Performance Committee of the GF Board on behalf of the NGO Developed Country Constituency. In this capacity KNCV contributes to financial policies of the GF and in turn gains insights into the directions for GF investment policies. This strengthens KNCV policy perspectives and informs our guidance of NTPs for accessing and implementing GF grants.

At the national level, KNCV will:

- Ensure that planning through all KNCV programs and projects are aligned and complimentary with the countries' NSPs.
- Assist countries to fulfill basic NFM requirements such as national program reviews, gap analysis and NSP development, etc. before developing a Global Fund Concept Note (CN).
- Support all KNCV - countries in development and adjustment of national screening policies and regulations, based upon data-driven risk group prioritization and rational algorithm selection.
- Assist countries to enhance national management and service delivery capacities. This will include support to HRD planning and implementation through review and revision of training curricula and the organization and provision of training in collaboration with local/regional training centers. Furthermore, we will assist in curriculum development for pre-service training, collaborating with professional associations to update continuing medical education programs (CME) and advise HR departments of Ministries of Health on TB related accreditation and training certification schemes. These approaches are especially relevant as countries move toward better integration of TB/HIV service provision.
- Develop and test related e-health and m-health solutions in target countries that address communication and information feedback gaps. Improved transfer of data/information should result in more rapid diagnostic test results and treatment initiation/adaption. These platforms can also be used to facilitate information flow from facilities to communities and back.

*2.3.1.2 Key Results Area 2: Sustainable finance and affordable services*

Many low and middle income countries depend on international funding for basic and/or advanced TB control initiatives. The new global (WHO) strategic goals will require increased long-term international and national investments, especially for the development and operationalizing of initiatives associated with the introduction of new tools. KNCV will support countries to access domestic and international funding sources. KNCV central office will work in tandem with country office staff and partners to ensure multidisciplinary approaches to resource mobilization and assist National TB Program management with the development of prioritized budgeted annual work plans. In countries with a KNCV office, we will guide and assist in the coordination of processes for optimal planning and utilization of available resources (especially, but not limited to, resources from key donors: Global Fund, PEPFAR and USAID Challenge TB).

Some key activities in 2016 will be to:

- Evaluate the cost-effectiveness of different models of MDR-TB care in Nigeria to inform national MDR-TB policy.
- Evaluate the cost effectiveness of different models of case finding in Burma and Indonesia to inform the national strategic planning process and GF concept note development.
- Facilitate a WHO-led CTB core project to measure TB patient costs in three countries. The Project aims to inform national and global policies on prevention of catastrophic costs for families affected by TB.
- Assist countries to address hidden costs of TB care such as user fees, registration fees, diagnostic fees, and transport costs.
- Assist countries to assess the comparative return on investment from GeneXpert Ultra, digital chest X-ray (CXR), CAD4TB and other mobile services versus business as usual in Mozambique, Nigeria, Malawi, Ethiopia and Burma. In collaboration with the LSHTM, explore the feasibility to develop long-term (20-25 years) costing and financing models that include phasing out scenarios of external funding.
- Explore approaches that combine national push (regulatory) and pull (financing) mechanisms to improve access/care. Expanding health systems financing opportunities (such as Universal Health Care, national insurance schemes, performance based financing) linked to facility accreditation and GP certification are opening novel avenues for engaging hospitals and the private sector in a growing number of countries. Indonesia, for example, represents a unique opportunity given the expanding reach of its national health scheme (JKN) for public health facilities and GPs.

*3.3.1.3 Key results Area 3: Enhanced performance across sectors and leveraging health resources of countries, including community systems strengthening and engagement*

Many countries, including those with originally strong public TB services, are confronted by a service delivery shift from public to private sector throughout all levels of society, including the

poor. KNCV recognizes this reality as an opportunity and will continue to support processes that strengthen referral and quality assurance mechanisms for private sector providers. Simultaneously, KNCV will initiate and guide National TB Control Programs to operate more outside the usual boundaries of the Ministry of Health by supporting them to strengthen their advocacy capacity within the MoH and towards other government sectors. NTPs are encouraged to establish formal partnerships with prisons and mining companies to promote early case-finding, infection control measures and LTBI treatment, and establish TB services as near as possible to the affected population. KNCV will continue to spark these collaborations.

This multi-sectorial approach is crucial for reaching vulnerable groups, the uptake of new tools, ensuring sufficient staffing levels and facilitating public-public and public-private collaboration. In 2016, KNCV will:

- Catalyze transparent and formal collaboration among Ministries of Labor, Education, Justice, Police/Migration, Defense, Commerce etc. to ensure that TB services reach those at-risk and in-need.

- With DGIS funding in Nigeria, Kazakhstan and The Philippines, KNCV will use existing frameworks of patient centered care to expand service delivery models to private providers.

The aim is to increase supply of and affordable access to quality TB screening, diagnosis and care by incentivizing adherence to national (and professional) standards established by domestic programs. Linkages with civil society organizations will serve to push demand for access/care by increasing awareness of TB, promoting early health seeking behavior and providing support to patients and families once diagnosed and treatment is initiated. These efforts will be complementary to other private sector engagement efforts noted already under Access.

#### *3.3.1.4 Key Results Area 4: Interoperable Monitoring and Surveillance Systems*

High quality data in accessible formats facilitate effective management of TB programs and patient services across all providers. Demand for integrated financial, commodity and program performance data from an array of stakeholders is growing. Ensuring that the data systems of CBOs, NGOs and private providers provide the essential information that national programs need is a growing challenge and opportunity. The tools to render the information are evolving rapidly. KNCV is looking to address these challenges of integration, interoperability and compatibility of data systems. We advocate the use of affordable, flexible open source software and open standards and the use of a countrywide personal unique identification numbers.

KNCV already supports TB surveillance and data systems in several Asian and African countries. Surveillance activities focus mainly on the transition from paper-based registration systems that aggregate TB information as it moves up the management chain to case-based electronic recording and reporting systems. Long-term support is focused on country-ownership and in-country capacity building to ensure sustainability and adaptability to changing information demands.

In 2016, KNCV will:

- Assess the magnitude of under-notification by the private sector in the TB surveillance system in Lagos, Nigeria, and support mandatory reporting systems requirements in Indonesia.
- Initiate support to new countries (e.g. Burma, Malawi and Ethiopia) and continue surveillance support in others (e.g. Vietnam).
- Provide technical assistance to countries seeking to move from a paper based system to interoperable case-based and/or electronic systems (e.g. Mozambique, Indonesia). Ensure higher quality data collection aligned with appropriate M&E systems through design, introduction, monitoring, supervision and better integration of these systems (e.g. Vietnam, Malawi, Indonesia).
- Continue support for the strengthening of comprehensive R&R systems that link laboratory, drug stores and treatment sites.
- Continue support for the development and integration of appropriate recording and reporting systems for LTBI interventions, especially for children and PLHIV.
- Ensure integration into and/or exchange with other national disease M&E systems (as is currently requested by many countries), specifically opportunities to link TB and HIV reporting systems for better patient and program management.
- Leverage the Dutch TB experience in national and international knowledge sharing and policy development, e.g. through the tbc-online application, participation in the joint ECDC/WHO Euro Surveillance Networks for TB and in publications.

#### *2.3.1.5 Key Result Area 5: Optimizing TB care to groups under-served by current systems*

There are several key populations at risk for TB whereby their environment constitutes a higher risk of exposure such as in congregate and health care settings; whose risk is increased due to co-morbidities (PLHIV, diabetes, silicosis and smoking), or due to extremes of age (young children and the elderly). Many populations at-risk for TB are also present within institutions that are unaware or ill-equipped to address TB.[3] These include groups for whom geographical access is not the barrier, but rather a systems weakness (e.g. verticality, lack of coordination). While there is overlap with Focus Area 1 (Access. Key Result Area 4: Overcoming barriers for special patient groups), the approaches employed here are directed to broader systems: within countries, outside countries at regional levels and across unique ecosystems.

[3] Under-served groups within system can include attendees of health care facilities, children under 5, contacts of TB cases, deep pit miners, factory workers, persons with previous TB, healthcare workers, laboratory staff, mentally ill and elders in residential settings, military personnel, persons with diabetes, PLHIV enrolled in HIV care, prisoners, prison staff, refugees, internally displaced populations (IDPs), transportation workers,

In 2016 KNCV will explore and support efforts in:

- Occupational health systems approaches. KNCV will work with SADC countries on improving screening, diagnosis and treatment in the mining/extractive industries.
- Ecosystems approaches. With continued large population migration to cities and TB prevalence surveys that confirm high rates of TB in these settings, it is essential to evolve our approaches to TB control. KNCV will work with partners in Nigeria, Malawi, and Ethiopia to develop and implement a framework for URBAN TB control in selected cities to focus on improving access in particular for men and other at–risk populations that comprise the urban poor
- National self-assessment approaches. Using the KNCV Childhood TB benchmarking tool, we will work to expand national self-assessments tied to action plan development, as was recently tested in Vietnam and Bangladesh.

**The Netherlands**

The Netherlands team of KNCV will continue its programmatic functions and support in 2016 for evidence-based policy and guideline development in the Netherlands by organizing the Committee for Practical TB Control (CPT). The CPT is a multidisciplinary meeting of professionals involved in Dutch TB Control and consists of both private and public providers. Quarterly, CPT meetings will be organized to discuss and decide on new guidelines and TB control policies. A plenary meeting will be organized together with the TB professional associations on a specific topic. KNCV will participate in the CPT working groups on specific topics and participate in working groups of other professional organizations (e.g. associations for TB nurses, pulmonologists, and medical microbiologists). We will update the guidelines, protocols and work instructions and the concept of the guideline system now that major guidelines are revised and up to date. Other activities for 2016 include:

- Support for a program of regional TB consultants/coordinators in the Netherlands, which forms the link between GGDs/regions and the national level. KNCV will assist in setting up Regional TB Expert Centers (RECs) through the RIVM-CIb secondment.
- Implement and monitor the objectives of the National TB Control Plan 2016-2020 for The Netherlands e.g the gradual change towards targeted LTBI in migrants.
- Collaborate with GGD GHOR Nederland and other organizations on screening programs of immigrants, asylum seekers and prisoners. It will monitor the TB transmission and clusters in close collaboration with the national reference laboratory of the RIVM-CIb and with the GGDs. It will advise professionals and organizations and provide technical support to RIVM-CIb on TB disease surveillance.
- Organize the secretariat of the plenary review committee (‘plenaire visitatiecommissie’) and conduct two regional visitations/reviews.

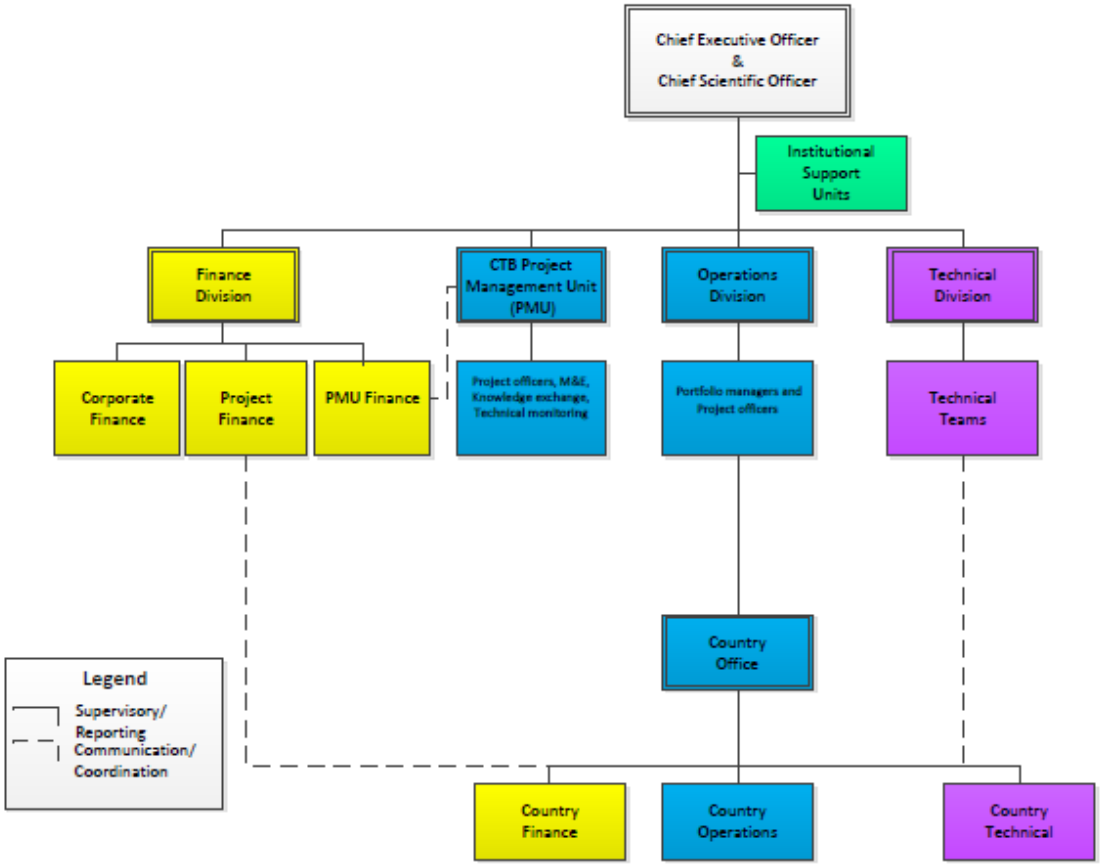
- Monitor and periodically evaluate the screening policy of risk groups in the Netherlands. The periods to evaluate screening were defined in the National TB Control Plan. The next evaluation period is 2011-2015. In 2016, data will be collated and validated on yield and efficiency of TB screening programs for immigrants, asylum seekers and prisoners. The evaluation reports are planned to be completed in 2017.
- Develop curricula and provide continuous education to professionals and offer TB specific training courses in the Netherlands, e.g. the e-learning course for TB public health nurses and the contact investigation course. KNCV also participates in TB courses organized by other organizations (e.g. Nederlandstalige Tuberculose Diagnostiek Dagen (NTDD)) and is co-organizer of the European Advanced Course on Clinical Tuberculosis that will take place in Helsinki, Finland in 2016.
- Participate as national representative in World Health Organization European Region (WHO Euro) or European Centre for Disease Prevention and Control (ECDC) technical meetings, such as the WHO Task Forces on "Childhood Tuberculosis" and "Latent TB Infection" and the Wolfheze Working Groups on "Financing TB Control". We will also participate in the annual meeting of the joint ECDC/WHO Euro Surveillance Networks for TB and the WHO Euro-supported Technical Advisory Group (TAG).
- Continue to produce and distribute TB health education materials in different languages and in various ways on selected topics to organizations involved in TB control. KNCV will produce 3 editions of the Dutch journal 'Tegen de Tuberculose', that provides information and education to professionals and policy makers in the Netherlands.

# 3 Institutional Management & Enabling Environment

## 3.1 KNCV organizational structure and project management

In 2015, KNCV has introduced a new organizational (figure 1) structure that will make the organization 'fit for the future'.

*Figure 1: New Organizational Structure (simplified)*




**A. Project Management**

In 2016, the Operations Division will focus on the following four priority areas;

1. **Ensuring the successful management of Challenge TB projects**; our plan in 2016 is to continue developing plans and budgets for all Challenge TB projects, monitor the implementation and ensure timely and quality technical and financial reporting. Currently, Challenge TB has operations in 21 countries and East Africa region. In addition we have six core projects. We expect that the total 2016 project budget will be over $80 million USD of which, around 40% ($32 million USD) will be spent by KNCV. While the Operations Division is responsible for the management of all 21 Challenge TB country projects, our additional and most important task is to manage 12 KNCV country offices. These are Botswana, CAR-Tajikistan, CAR-Kyrgyzstan, CAR-Uzbekistan, East Africa Region, Ethiopia, Indonesia, Malawi, Namibia, Nigeria, Tanzania and Vietnam. Among those CAR-Uzbekistan, East Africa Region, Malawi and Tanzania offices are new. Rapid and successful aligning of these new offices with the remaining KNCV country offices will be our main goal.

2. **Successful management of the DGIS project;** this project is an important re-start of KNCV's strategic relationship with DGIS. The success of this project will play a critical factor in continued and increased support after 2019. Therefore, a multi-disciplinary internal

advisory committee was recently established to provide strategic direction for the project. In 2016, our plan is to ensure that this advisory committee works effectively to ensure that DGIS project implementation is successful and outputs are delivered according to plan.

3. **Consolidating the management of Global Portfolio (non-Challenge TB projects);** In addition to Challenge TB, KNCV is actively engaged in developing new proposals and implementing small or large couple dozen projects not funded by USAID. However, as of now we are still working on developing a management system for all non-Challenge TB projects which we call the Global Portfolio. Note that DGIS project, being closely aligned with CTB, is treated separately and outside of this Global Portfolio. The management of projects other than CTB will be strengthened by the development of a standard project ID, registration, description, planning, budgeting and reporting templates. This will be fully implemented by the first quarter of 2016. A team of a Portfolio Manager and a Project Officer have been assigned to manage the Global Portfolio.

4. **Introduction of a new project management system**; our plan in 2016 is to develop and implement a system to align project activities to the vision and strategy of the organization, improve internal and external communications, improve staff performance and morale, and monitor project performance. This system will be used for all projects led by KNCV. We will develop a balanced scorecard to monitor five perspectives of project performance, namely;

a. Implementation performance
b. Financial performance
c. Staffing and operations
d. Relations management
e. Achievement of results/outcomes

**B. Staffing and Staff Development**

**Staff Development;** Operations Division staff, both at the HQ and in the field work in a very dynamic and challenging environment. In order to successfully manage a wide variety of core, regional and country projects as well as the partners and donors, the staff at all levels should be able to acquire and develop new management and leadership skills and improve and update their project management practices. Currently a three-year Management Development Program is being designed. This program will be flexible and continuous, linking staff's development to the goals of the job and the organization. As a first step, in late 2015 a management skills needs assessment for the HQ staff was conducted. As expected, since this is such a diverse group the needs are also very diverse. Based on the data below are top four topics that were identified for a formal training package for 2016;

- Innovation, vision, creativity, taking initiative, problem-solving and decision-making
- Risk Assessment and management
- Monitoring and Evaluation
- Strategic planning

- Quality awareness and managing, according to quality standards and procedures

A similar assessment will be conducted for the field staff before the end of 2015.

The new structure aims at strengthening of both project management and technical capacity. The new Technical Division will consist of 5 technical teams which will be responsible for program content, quality of outputs and technical innovations. The Operations Division bears overall responsibility for planning and reporting and monitoring of all projects. The principal reporting and management line is from country offices to Country Portfolio Managers, leadership of the Operations Division, to the Chief Executive Officer. Members of the Operations, Technical and Finance Divisions will collaborate in country teams, which are coordinated by portfolio managers. The objective for 2016 is to strengthen the workplanning processes, ensuring an optimal match between country needs, workplans and selected consultants. Knowledge Management and Organizational Learning will be integrated within the three divisions.

## 3.2 IT and Facility Management

### 3.2.1 Information Technology environment

The focus on IT and Facilities is to provide reliable, up to date and flexible IT solutions which are able to respond to scenarios of both expansion and scale down. In that context we distinguish IT management in the Hague and in the country offices as the latter face development country challenges.

### 3.2.2 Office housing

In May 2015 KNCV successfully moved to a significantly cheaper but more functional office located at Benoordenhoutseweg 46, The Hague. Some additionally required logistic procedures will be introduced in 2016.

## 3.3 Institutional Fundraising

Following the restructuring of KNCV in 2015, the unit Resource Mobilization proceeded in further strengthening KNCV's internal capacity for institutional fundraising.

## 3.4 Governance and Public Affairs

### 3.4.1. Advocacy

In 2016 KNCV advocacy in the Netherlands continues to be aimed at enlarging the Dutch policy space for TB and HIV/AIDS. Our approach is to select and initiate highly targeted advocacy, basing the message and 'asks' on a structured stakeholder engagement process after a careful mapping of the stakeholder field. This approach, as developed in the Capital for Good advocacy project and implemented in 2015, is proving convincing and convening for political and administrative environments alike.

KNCV's role in Global Fund policy advocacy will continue by serving on the Finance and Operational Performance Committee of the GF board on behalf of the NGO Developed Country delegation as well as within the broader engagement on this delegation.

Specific areas for advocacy include:

- TB positioning in the AIDS 2018 conference, a bid to bring the Union Conference to the Netherlands in 2018 as well as linking the two conferences programs.
- Global Fund advocacy and policy engagement
- Positioning the Dutch TB research field during the Dutch EU presidency

### 3.5 Communication and private fundraising

In 2015 we have worked on a stronger base to raise the visibility of and support for our mission. We incorporated our four different websites into one, which will allow us to better involve our different audiences in different aspects of our work. We adopted a new database system, with many more possibilities to communicate with different donors in different ways. Also we brought our fundraising brand *Stop TBC* back under the KNCV Tuberculosis Foundation umbrella, and strengthened our logo typography, to enhance brand building and recognition. Last but not least we tested other fundraising methods to get to know our donors better and engage new audiences.

For 2016 we plan to follow up on this path. Our priorities will be:

- Work on a clear KNCV voice and visibility through our country offices and involvement in research and policy making
- Raise awareness for TB in general and KNCV in particular using a multimedia approach
- Build strong cases for support and involve people by sharing powerful stories
- Improve donor loyalty with a more personalized approach
- Extend our network by being more outgoing and visible and creating opportunities for dialogue offline and online

### 3.6 Finance, Planning & Control

The scale up of Challenge TB involves guiding (new) country offices in Financial Management, Internal Controls and USAID rules and regulations. In 2016 the use of the database for budget monitoring will be fully operational and will allow for better progress tracking and analysis across countries. Monitoring of financial and legal reliability of local partners will be an important element of the work. Both at HQ and in countries we will make ourselves more geared to dealing with a multi-donor environment. This includes gathering, sharing and filing knowledge on donor guidelines and budgetary restrictions as well as setting up local accounting and time writing systems that are able to handle more than one donor/ project.

Internal audit missions will be performed according to the internal audit plan and quality consulting guidelines and outcomes registered based on the registration tool.

### 3.7 Human Resource Management

The complexity of global operations, with offices all over the world, requires robust HRM operations, including recruitment, legal risk management and adequate safety and security management. In addition, solid HRM instruments are necessary to enable the organization to advance organizational learning and knowledge management, and ensure optimal development and retention of staff. This is of utmost importance as the age distribution among KNCV consultants requires development and mentoring of young promising staff members.

In 2015 we reviewed the security policy; implementation has started in 2015 and will be completed in 2016. Also the in-house security workshops for traveling staff will be continued. Safety and health policy and protocols will be further enforced.
The demand driven market and donor dependency are important reasons for creating a flexible workforce, which will allow KNCV to respond to changing staff needs. We will explore the legal and operational aspects of different types of contracts and introduce options that that will support our country and consultancy work.
Recruitment and retention remain important as KNCV's need for excellent staff continues. Young professionals programs will be continued and performance management will help KNCV to increase the quality of its staff and nurture these into future managers and leaders in TB elimination.

# 4 Monitoring & Evaluation

As part of the Strategic Plan 2015 – 2020 KNCV has defined 43 indicators:

I. 8 KPIs (key performance indicators) will provide the monitoring framework for measuring progress in relation to our mission objectives.

II. 12 strategic indicators reflect the KNCV focus areas: access, evidence, and supportive systems.

III. 23 institutional indicators will measure progress in relation to operational efficiency and staying fit-for-future.

Development of the above indicators has been finalized, and final baseline measurements have been collected as of October 2015, with minimal ongoing baseline data validation.

### 4.1. Key Performance Indicators[4]

**1. Increase bacteriologically confirmed notifications to 60% among all forms TB notifications by 2020.**

Description: Substantial increase (number and %) in case notification of bacteriologically confirmed cases[5] in target countries:

a. for total population

b. for population served by KNCV, if this can be disaggregated

c. key populations (where data is collected by countries)

The indicator for total population is in line with the Global Fund M&E framework. The indicator for key populations will differ per country. Only countries with electronic surveillance systems can measure indicator for key populations.

Purpose: This indicator is intended to reflect whether increased case finding strategies and activities, and more sensitive diagnostics such as Xpert and LED microscopy have led to more bacteriologically confirmed cases. We focus on bacteriologically confirmed cases to avoid counting cases that have only been clinically confirmed (i.e. without bacteriological confirmation) and therefore might be over-diagnosed.

Baseline: 50% of all forms notifications are SS+/Bac+ (n = 9).

Target: Increase SS+/Bac+ (bacteriologically confirmed) notifications to 60% among all forms TB notifications (n = 11).

**2. Reduce TB mortality among notified cases by 35% by 2020.**

Description: The proportion of TB patients who died among those notified to the NTP. In some countries with reliable vital statistics, the total TB mortality may be used. We will calculate this both for all forms cases and for bacteriologically confirmed cases. We may use the recently proposed mortality/notification indicator where applicable.

Purpose: The WHO's End TB strategy aims to reduce TB mortality by 35% by 2020. Although it is recognized that the mortality rate in notification cohorts is an underestimate of actual TB mortality, the actual mortality is often not measurable in countries with weak vital statistics. We will increase efforts to measure TB mortality more accurately. This is also a Global Fund indicator.

Baseline: 10% mortality among TB cohort notified in 2013 (n = 10).

Target: Reach 6.5% mortality among TB cohort notified in 2018. This would be a 35% reduction of the 10% mortality rate baseline. (n = 11).

In most countries the TB mortality rate in a notification cohort is between 5 and 10%; however, initial defaulters who may be more likely to die are often not notified. The initial focus will be to measure mortality more accurately before achieving a reduction. A reduction of 35% in 5 years may be realistic.

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[4] All baselines are weighted averages based on estimated country population (2013 or 2014 depending on the indicator).

[5] In the strategic indicators we have also included an indicator (1.3) on the proportion of cases that is bacteriologically confirmed.

**3. Complete treatment for 90% of all detected drug-sensitive TB cases by 2020.**

Description: This is the proportion of successfully treated DS-TB patients (cured and treatment completed) among those notified. We will calculate this both for all DS-TB cases and for bacteriologically confirmed DS-TB cases only. Until recently patients who did not start treatment were not included in this indicator. They should be included in future.

Purpose: This indicator is traditionally used by all countries and donors, and it represents the total care chain for the patients (reporting these as lives saved is very inaccurate).

Baseline: 86% (2013 cohort) (n = 9).

Target: 90% (n = 11).

**4. Initiate treatment for all identified drug-resistant patients by 2020.**

Description: Increase in proportion of diagnosed persons with rifampicin resistant TB initiated on second line treatment. The majority of patients with rifampicin resistant TB have MDR-TB, and therefore this indicator measures roughly what proportion of MDR cases starts appropriate treatment.

Purpose: This indicator still needs improvement in many countries, although it does not measure what proportion of estimated MDR cases are actually diagnosed. The latter is difficult to measure since the number of MDR-TB cases in the country is dependent on WHO estimates. This is also a Global Fund indicator.

Baseline: 73% (n = 9).[6]

Target: 100% (n = 11).

**5. Test all TB patients for HIV by 2020.**

Description: 100% of TB patients should be screened for HIV. This is a composite indicator as in African countries the proportion tested is often very high, while in many Asian countries the testing proportion is still low. This is also a Global Fund indicator.

Purpose: Measure improvement in access to services through collaboration between TB and HIV programs.

Baseline: 86%(n = 8).

Target: 100% (n = 11).

[6] The unweighted baseline is 81%, and five out of nine responding countries reported second line treatment initiation rates approximately 90% or higher. Several countries with large populations and treatment initiation rates below 75% contributed to the lower weighted baseline of 73% shown above.

**6. Start all TB/HIV co-infected patients on anti-retroviral therapy by 2020.**

Description: All TB/HIV co-infected patients should be started on anti-retroviral therapy. This is a Global Fund indicator.

Purpose: Measure improvement in access to services through collaboration between TB and HIV programs.

Baseline: 56% (n = 8).[7]

Target: 100% of TB HIV co-infected patients should be on ART by 2020 (n = 11).

**7. Introduce measurement by NTPs of catastrophic health care expenditures for people with TB and their families in all target countries by 2020.**

Description: Number of countries measuring proportion of people or families experiencing WHO defined level of catastrophic costs (direct health care expenditures corresponding to >40% of annual discretionary income (income after basic needs, such as food and housing). Indirect costs of care (e.g., transport) and income loss are not included.

Purpose: On average, TB patients in low-and middle-income countries face medical expenses, costs of seeking/staying in care, and income loss equivalent to more than 50% of his or her annual income. Approximately 60% of costs are related to income loss, and about 50% of costs are incurred before diagnosis. Strategies to reduce catastrophic costs include ensuring universal health coverage, access to essential services, and essential social transfers. This indicator will be designed to measure the proportion of people with TB facing catastrophic health care expenditures as defined by WHO.

Baseline: 0%**.**

Target: Within three years (2015 – 2017), the target is that countries participating in the WHO's catastrophic costs study will be routinely measuring the proportion of families experiencing catastrophic costs due to TB care as defined by the WHO, while the target for 2020 is that all (n = 11) NTPs in KNCV target countries will be measuring this.

**8. Prevent more people from developing active TB disease by 2020.**

Description: Originally this was proposed to be calculated by doing a one-time modeling, as it is difficult to measure. The number of individuals developing active TB disease is shown in incidence estimates as part of the WHO Global TB Report.

Purpose: Internationally, the quantity and quality of models on TB transmission is increasing rapidly. KNCV considered using these to estimate prevented new active TB disease in our target countries. Since a large Challenge TB project is planned on this issue, we also considered taking an actual measurement in selected countries.

Baseline: To be decided.

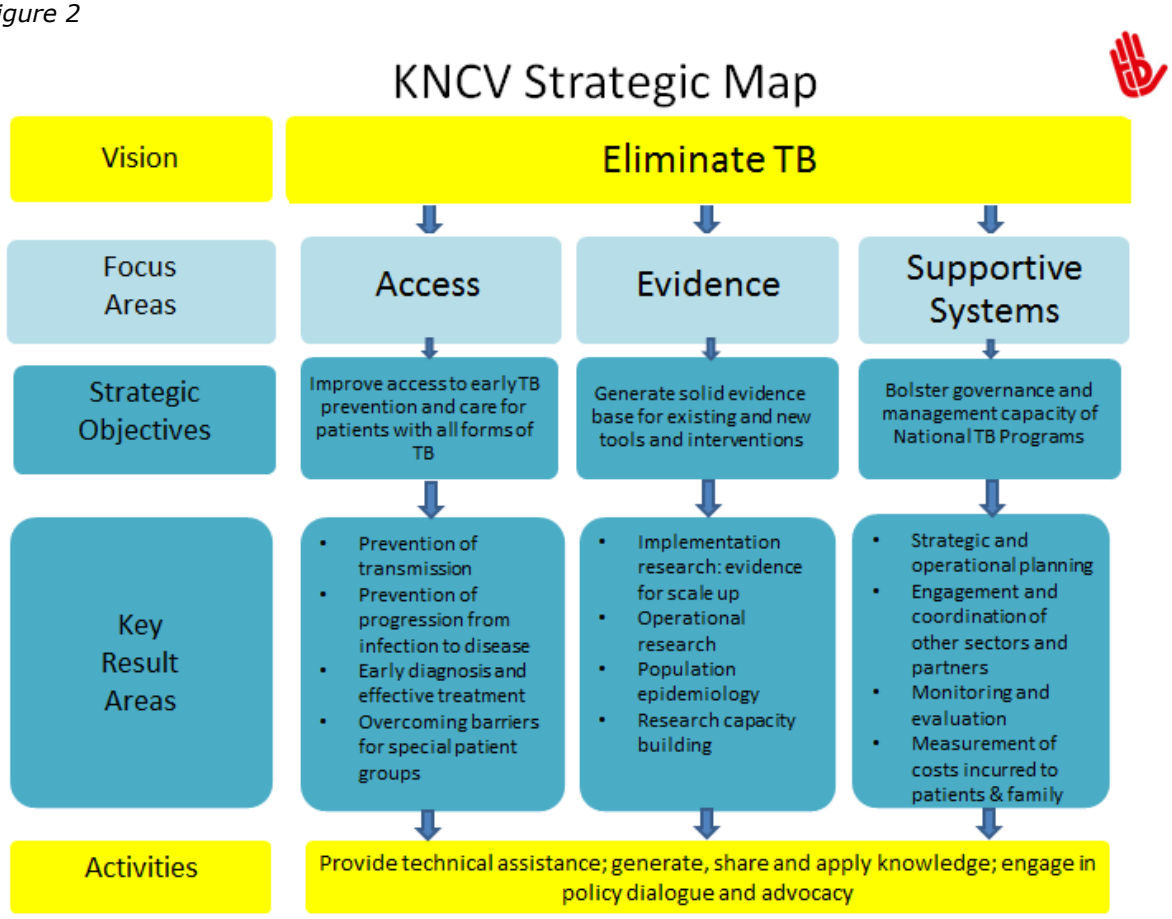
Target: To be decided.

[7] The unweighted baseline is 80%, and indeed six out of eight responding countries reported ART initiation higher than 70%. One country with a large population and low ART initiation rate (27%) contributed heavily to the 56% baseline shown above.

### 4.2. Strategic indicators

KNCV strategic indicators reflect the Strategic Map below Figure 2 (*source: KNCV Strategic Plan 2015-2020*).

*Figure 2*



KNCV's strategic indicators based on this Srtrategic Map are summarized in the table below.

**Table 1 : Strategic Indicators**

| **Focus Area: ACCESS** | | |
|---|---|---|
| **Strategic objective:** Improve access to early TB prevention and care for patients with all forms of tuberculosis and achieve better individual outcomes and public health impact | | |
| Key Result Area | Strategic Indicators | Indicator specifications |
| 1.1: Prevention of transmission | 1.1: Proportion of target countries that have developed, implemented and monitored country specific TB-IC and laboratory biosafety strategies effectively by 2020 | **Baseline (2014):** 36% (4/11 countries)<br>**Target (2020)**: All target countries have developed, implemented and monitored country specific TB-IC and lab biosafety strategies effectively. |
| 1.2: Prevention of progression from infection to disease | 1.2: Proportion of target countries that have developed, implemented and monitored contact investigation and screening policies and strategies by 2020 | **Baseline (2014):** 27% (3/11 countries)<br>**Target (2020)**: All target countries have developed, implemented and monitored CI and screening policies and strategies. |
| 1.3: Early diagnosis and effective treatment | 1.3: Annual percent increase in proportion of notified cases that are bacteriologically confirmed in target countries | **Baseline (2014):** 0.3% increase (50.6% in 2013 to 50.9% in 2014)<br>**Target (2020)**: Among all target countries, 60% of all forms notifications are bacteriologically confirmed. |
| 1.4: Overcoming barriers and ensuring equitable access for special patient groups | 1.4: Proportion of target countries that have developed, implemented and monitored country specific strategies to address barriers and ensure equitable access for special patient groups by 2020 | **Baseline (2014):** 18% (2/11 countries)<br>**Target (2020)**: All target countries have developed, implemented and monitored country specific strategies to address barriers and ensure equitable access for special patient groups. |
| **Focus Area: EVIDENCE** | | |
| **Strategic objective:** Generate solid evidence base for existing and new tools and interventions | | |
| Key Result Area | Strategic Indicators | Indicator specifications |
| 2.1: Implementation research: evidence for scale up | 2.1: Proportion of KNCV supported intervention studies/ demonstration projects resulting in a publication with contribution of KNCV staff as co-author | **Baseline value (2014)**: 17/17 [8] (from 2011 – 2014)<br>**Target (2020)**: 80% within 3 years of project completion |

[8] Vietnam accounts for 13/13 of these publications.

| | | |
|---|---|---|
| 2.2: Operational research | 2.2: Number of research publications/reports that have contributed to international or local country guidelines/policies | **Baseline value (2014)**: 7<br>**Target (2020)**: At least 10 in total |
| 2.3: Population epidemiology | 2.3: Number of successfully completed population epidemiology relevant studies (e.g. prevalence and/or drug resistance survey) w/ substantial support of KNCV | **Baseline value (2014)**: 1<br>**Target (2020)**: At least 1 per year (i.e. at least 5 in total) |
| 2.4: Research capacity building | 2.4: Number of publications resulting from KNCV led research capacity building activities | **Baseline value (2014)**: 14<br>**Target (2020)**: 4 per year |
| **Focus Area: Supportive Systems SUPPORTIVE SYSTEMS** | | |
| **Strategic objective:** Bolster sustainable governance and management capacity of National TB Programs | | |
| Key Result Area | Strategic Indicators | Indicator specifications |
| 3.1: Strategic and operational planning | 3.1: Proportion of target countries that have a valid, evidence-based, prioritized, costed, and endorsed national strategic plan, used for annual planning [9] | **Baseline value (2014)**: 8/11 (73%)<br>**Target (2020)**: All KNCV-supported countries have an up-to-date NSP throughout up to and including 2020. |
| 3.2: Engagement and coordination of other sectors and partners | 3.2: Proportion of private providers and facilities notifying TB cases to NTP | **Baseline value (2014):** TBD [10]<br>**Target (2020):** 50% of private providers/facilities in 8/11 countries |
| 3.3: Monitoring and evaluation | 3.3: Proportion of target countries that have a countrywide implementation of a patient based electronic recording and reporting system | **Baseline value (2014)**: 3/11 (27%)<br>**Target (2020)**: 6 of 11 target countries w/ countrywide implementation |
| 3.4: Measurement of catastrophic costs incurred by TB patients and their families | 3.4: Proportion of target countries that have collected routine data on individuals experiencing catastrophic costs at least once | **Baseline value (2014):** 0%<br>**Target (2020):** 11 of 11 target countries |

[9] Although many countries have recently developed such plans, they need new ones within the next 5 years.

[10] Approximately 12% of notified cases come from private providers/facilities (n = 4 target countries); however, we will measure the % of PPs notifying TB cases to the NTP.

# 5. The budget for 2016

## 5.1 Budget according to the CBF reporting format

In table 1 the budget for 2016 is depicted in compliance with the regulations set by the Central Bureau for Fundraising (CBF). The following paragraphs highlight the specifics of the budget.

*Table 1: Budget 2016 in compliance with CBF regulations*

| | Actual 2014 | Budget 2015 | Prognosis 2015 | Budget 2016 |
|---|---|---|---|---|
| **Income:** | | | | |
| - Income from own fundraising | 1,593,138 | 1,365,800 | 1,430,700 | 1,609,100 |
| *Activities Fundraising* | 952,776 | 965,500 | 991,500 | 1,095,500 |
| *SMT and other endowment funds* | 368,500 | 313,500 | 295,000 | 385,800 |
| *Non-gouvernmental project subsidies* | 271,863 | 86,800 | 144,200 | 127,800 |
| | | | | |
| - Income from joint fundraising activities | | - | | |
| - Income from activities third parties | 1,075,270 | 1,092,500 | 1,055,000 | 1,092,500 |
| - Government subsidies | 42,051,486 | 53,060,100 | 49,789,900 | 73,327,000 |
| - Income from investments | 480,559 | 145,000 | 165,900 | 135,700 |
| - Other income | 15,300 | 13,200 | 14,800 | 16,400 |
| **Total income** | 45,215,753 | 55,676,600 | 52,456,300 | 76,180,700 |
| | | | | |
| **Expenses:** | | | | |
| **Expenses to KNCV Tuberculosisfoundation's mission** | | | | |
| - TB control in low prevalence countries | 1,021,907 | 1,008,300 | 820,700 | 820,200 |
| - TB control in high prevalence countries | 40,289,380 | 50,777,500 | 47,562,500 | 71,243,300 |
| - Research | 1,140,021 | 1,707,600 | 1,283,800 | 1,475,300 |
| - Communication and advocacy | 580,628 | 841,600 | 881,400 | 869,900 |
| | | | | |
| **Expenses to acquisition of funds** | | | | |
| - Costs for own fundraising activities | 392,094 | 424,000 | 352,000 | 365,900 |
| - Costs for joint fundraising activities | - | - | 600 | - |
| - Costs for activities by third parties | 21,240 | 51,100 | 51,300 | 51,500 |
| - Costs to acquire subsidaries | 375,810 | 569,300 | 472,300 | 622,700 |
| - Costs for investments | 44,439 | 43,400 | 43,300 | 42,800 |
| | | | | |
| **Management and control** | | | | |
| - Costs for management and control | 1,102,062 | 1,261,300 | 1,265,500 | 1,310,200 |
| | | | | |
| | | | | |
| **Total expenses** | 44,967,580 | 56,684,100 | 52,733,400 | 76,801,800 |
| | | | | |
| **Nett result** | **248,174** | **1,007,500-** | **277,100-** | **621,100-** |

The deficit of almost € 0.6 million is completely covered by the use of earmarked reserves (€ 0.7 million). The total income is budgeted on a consolidated level of € 76,2 million. Of that, € 41,4 million is compensation for activities implemented by the coalition partners of Challenge TB. Total income budgeted for 2016 is € 20,5 million higher than budgeted for 2015. This substantial increase is fully justified by a greater amount for activities in countries for the Challenge TB project, both for KNCV and for coalition partners. Income from government subsidies is planned for a total of € 73,3 million, while income from other sources is € 2,9 million. The latter mainly consists of private fundraising and lottery income. In the private fundraising category project funding from nongovernmental sources is also included. The amount of € 73,3 million from government subsidies is dominated by the income from USAID. A breakdown of the total amount is shown in table 2.

*Table 2: Breakdown of Government Subsidies 2016*

| Category | Budget 2015 | | Budget 2016 | |
|---|---|---|---|---|
| | *In € 1 mln* | *In %* | *In € 1 mln* | *In %* |
| CIb for activities Netherlands | 0.55 | 1% | 0.51 | 1% |
| DGIS* | 0.12 | 0% | 0.76 | 1% |
| USAID: | | | | |
| - Project management Challenge TB/ TB CARE I | 2.62 | 5% | 2.36 | 3% |
| - KNCV activities fees and travel related to technical assistance | 3.94 | 7% | 5.08 | 7% |
| - KNCV material costs and country expenses | 11.85 | 22% | 21.27 | 29% |
| - Activities implented by coalition partners | 30.00 | 57% | 41.39 | 56% |
| Subtotal USAID | 48.40 | 91% | 70.09 | 96% |
| Other government subsidies | 3.98 | 8% | 1.96 | 3% |
| **Total** | **53.06** | **100%** | **73.33** | **100%** |

*At the time the revised budget for 2015 was approved income for DGIS was not fully allocated yet.

The total level of consolidated expenditures amounts to € 76,8 million, which is € 20,1 million higher than budgeted for 2015. This is also explained by higher budgeted costs in countries for Challenge TB projects. These costs are based on approved and draft year 2 workplans. TBCTA Partner expenses amount to € 41,4 million in 2016 compared to € 30,0 million in the budget for 2015.

Table 3 shows a breakdown in percentages for the various expenditure categories. The largest part of the expenses goes to activities for TB control in high prevalence countries.

*Table 3: Division of expenditures 2014-2016*

| Relative division of expenditures | Actual 2014 | Budget 2015 | Prognosis 2015 | Budget 2016 |
|---|---|---|---|---|
| Expenses to KNCV Tuberculosis Foundation's mission | | | | |
| - TB control in low prevalence countries | 2.3% | 1.8% | 1.6% | 1.1% |
| - TB control in high prevalence countries | 89.6% | 89.6% | 90.2% | 92.8% |
| - Research | 2.5% | 3.0% | 2.4% | 1.9% |
| - Communication and advocacy | 1.3% | 1.5% | 1.7% | 1.1% |
| Subtotal | 95.7% | 95.9% | 95.9% | 96.9% |
| Expenses to acquisition of funds | 1.9% | 1.9% | 1.7% | 1.4% |
| Management and control | 2.5% | 2.2% | 2.4% | 1.7% |
| Total | 100.0% | 100.0% | 100.0% | 100.0% |

]

# Annex 1 - Abbreviations

| | |
|---|---|
| ACF | Active Case Finding |
| ACSM | Advocacy, Communication and Social mobilization |
| AIDS | Acquired Immune Deficiency Syndrome |
| AIGHD | Amsterdam Institute for Global Health and Development |
| AMC | Academic Medical Centre Amsterdam |
| AMR | Anti-Microbial Resistance |
| ANC | Ante-Natal Care |
| ART | Anti-Retroviral Therapy |
| BDQ | Bedaquiline |
| CAD4TB | Computerized Automated Diagnostic X-ray reading software for TB screening |
| CAR | Central Asian Republics |
| CBF | Centraal Bureau Fondsenwerving (Central Bureau for Fundraising) |
| CBTBCO | Civil Society and Community Based TB Care Organizations |
| CDC | Centers for Disease Control and Prevention (USA) |
| CfG | Capital for Good |
| CI | Contact Investigation |
| CIb | Centrum Infectieziektenbestrijding (Center for Infectious Disease Control in the Netherlands) |
| CME | Continued Medical Education |
| CN | (Global Fund) Concept Note |
| COE | Center of Excellence |
| CPT | Commissie Praktische Tuberculosebestrijding (Committee for TB Control Policy Development) |
| CSO | Civil Society Organization |
| CTB | Challenge TB, USAID-funded project implemented by the TBCTA coalition |
| CXR | Chest X-ray |
| DGIS | Directorate-General for International Cooperation in The Netherlands |
| DOTS | Direct Observed Therapy Short-course |
| DLM | Delanamid |
| DS-TB | Drug-sensitive Tuberculosis |
| DST | Drug-Sensitivity Testing |
| (DR)TB | (Drug-Resistant) tuberculosis |
| DR-TB | Drug-Resistant tuberculosis |
| DRTB | Drug-Resistant tuberculosis |
| E&M | Electronic & Mobile |
| EB | Executive Board |
| ECDC | European Center for Disease Prevention and Control |
| ECSA | Eastern Central Southern Africa Health Community |
| EDCTP | European and Developing countries Clinical Trials Partnership |
| EU | European Union |
| EMA | European Medicines Agency |
| END TB strategy | "Post-2015 Global Strategy and Targets for Tuberculosis Prevention, Care and Control" |
| EQA | External Quality Assurance |
| ERS | European Respiratory Society |
| FAST | (strategy) Finding TB cases Actively, Separating safely, and Treating effectively |

| | |
|---|---|
| FL(D) | First-Line (Drugs) |
| FTE | Full Time Equivalent |
| GDF TRP | Global Drug Facility Technical Review Panel |
| GeneXpert® MTB/RIF | Rapid diagnostic test for diagnosing Mycobacterium Tuberculosis and rifampicin-resistance |
| GF(ATM) | Global Fund (to fight AIDS, Tuberculosis and Malaria) |
| GGD | Gemeentelijke of Gemeenschappelijke Gezondheidsdienst (Municipal Health Services in the Netherlands) |
| GGD GHOR Nederland | GGD GHOR Nederland (De vereniging voor publieke gezondheid en veiligheid) |
| 6H | Association for public health and safety in The Netherlands<br>Six months of isoniazid |
| HCW | Health Care Worker(s) |
| HIV | Human Immunodeficiency Virus |
| HMC | Health Ministers Conference |
| 3HP | Weekly high dose rifapentine and isoniazid for three months |
| HQ | (Headquarters) KNCV Central Office in The Hague |
| HRD | Human Resource Development |
| HRH | Human Resources for Health |
| HRM | Human Resource Management |
| HSS | Health Systems Strengthening |
| IC(P) | Infection Control (& Prevention) |
| ICCM | Integrated Community Case Management |
| ICF | Intensified Case Finding |
| ICN | International Council of Nurses |
| ICP | Infection Control and Prevention |
| ICR | Indirect cost rate |
| ICT | Information and Communication Technologies |
| ID | Identification / Identifier |
| IDPs | Internally Displaced Populations |
| IPT | Isoniazid Preventive Treatment |
| IT | Information Technology |
| KMOL | Knowledge Management and Organizational Learning Strategy |
| KNCV | KNCV Tuberculosis Foundation |
| Labs | Laboratories |
| LAM | Lipoarabinomannan strip-test |
| LED | Light-Emitting Diode |
| LQMS | Laboratory Quality Management Systems |
| LSHTM | London School of Hygiene and Tropical Medicine |
| LTBI | Latent TB Infection |
| M&E | Monitoring & Evaluation |
| MAP | Managerial Assistance Package |
| MDR-TB | Multidrug-resistant Tuberculosis |
| (M)DR-TB | denotes both Multidrug-Resistant Tuberculosis and Drug-Resistant Tuberculosis |
| MKB | MKB (outsourcing) Small and medium enterprises |
| MoH | Ministry of Health |
| MT | Management Team |

| | |
|---|---|
| NFM | (Global Fund's) New Funding Model |
| NGO | Non-Governmental Organization |
| NICRA | Negotiated Indirect Cost Rate Agreement |
| NSP | National Strategic Plan |
| NTDD | Nederlandstalige Tuberculose Diagnostiek Dagen |
| NTP | National TB Control Program |
| OHT | One Health Tool |
| ORIO | Ontwikkelings Relevante Infrastructuur Ontwikkeling |
| p3HP | periodic 3HP (3HP - Weekly high dose rifapentine and isoniazid for three months) |
| PA | Public Affairs |
| PADT | Proposal Assessment Development Team |
| PCA | Patient Centered Approach(es) |
| PDP | Personal Development Plans |
| PEPFAR | U.S. President's Emergency Plan For Aids Relief |
| PHC | Primary Health Care |
| PLHIV | People Living With Human Immunodeficiency Virus |
| PMDT | Programmatic Management of Drug-resistant Tuberculosis |
| PMTCT | Prevention of Mother To Child Transmission |
| PMU | (Challenge TB) Project Management Unit |
| POC | (Point Of Care) decentralized access |
| PPM/P | Public Private Mix/Partnership |
| PSCM | Procurement & Supply Chain Management |
| PT | Preventive Therapy |
| PWUD | Persons Who Use Drugs |
| PWID | People Who Inject Drugs |
| QMS | Quality Management System |
| R | Rifampicin |
| R&R | Recording and Reporting |
| RCC-TB | Regional Coordinating Committee on Tuberculosis Control and Care |
| REC | Regional TB Expert Centers |
| RIVM | Rijksinstituut voor Volksgezondheid en Milieu (National Institute for Public Health |
| RM | and the Environment) |
| | Resource Mobilization |
| RMNCH | Reproductive, Maternal, Neonatal and Child Health |
| SL(D) | Second-Line (Drugs) |
| SMT | Stichting Mondiale Tuberculosebestrijding / Dr C. de Langen Stichting voor |
| | Mondiale Tuberculosebestrijding |
| SOP | Standard Operating Procedures |
| SRHR | Sexual and Reproductive Health and Rights |
| STAG (TB) | Strategic and Technical Advisory Group (for Tuberculosis) |
| STP | STOP TB Partnership |
| SVOP | fund for e-Learning |
| SWOT | (Analysis) Strengths, Weaknesses, Opportunities, Threats |
| TA | Technical Assistance |
| TAG | Technical Advisory Group (WHO) |
| TB | Tuberculosis |
| TBCTA | Tuberculosis Coalition for Technical Assistance |

| | |
|---|---|
| TB CARE I | Tuberculosis Control project 2010-2014 agreement I, funded by USAID |
| TB REACH | Multi-year grant support from the Canadian International Development Agency administered by the World Health Organization |
| TB TEAM | The WHO TB Technical Assistance Mechanism |
| TBD | To Be Determined |
| TDR-TB | Totally Drug-Resistant TB |
| TIME | TB Impact Model and Estimates |
| TRP | Technical Review Panel |
| TSRU | Tuberculosis Surveillance Research Unit |
| UNION | International Union against tuberculosis and lung diseases |
| USAID | United States Agency for International Development |
| US-FDA | United States Food and Drug administration |
| Van Geuns Fund | Dr. H.A. van Geuns Stichting |
| VAT | Value Added Tax |
| VFI | Vereniging van Fondsenwervende Instellingen (Association of Fundraising Organizations in The Netherlands) |
| VL | Viral Load |
| VRGT | Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding (Flemish Lung and Tuberculosis Association) |
| VWS | Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, The Netherlands) |
| WHO | World Health Organization |
| WHO/Euro | World Health Organization Regional Office for Europe |
| XDR-TB | Extensively Drug-Resistant TB |
| Xpert | See GeneXpert |
| ZON MW | Zorg Onderzoek Nederland – Medische Wetenschappen (The Netherlands Organization for Health Research and Development) |